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# JSNA Report 2013

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## Sexual Health

**Delivering meaningful, healthier, longer lives for the people of  
Northamptonshire**

## Introduction

- Sexual health is the capacity and freedom to enjoy and express sexuality without exploitation, oppression or physical or emotional harm.
- Sexual health problems include sexually transmitted infections, human immunodeficiency virus (HIV) infection, unintended pregnancy, abortion, fertility problems and sexual dysfunction.
- Rates of common sexually transmitted infections are rising nationally. In 2010/11, the incidence of gonorrhoea rose by 25% and that of syphilis by 10%.
- In England, the highest rates of acute sexually transmitted infections occur in 15- to 24-year olds.
- Poor sexual health is linked to low socio-economic status.
- Risky sexual behaviours and some adverse sexual health outcomes are closely linked to other unsafe behaviours such as alcohol misuse.
- The improvement of sexual health is highly cost-effective and depends largely on prevention of transmitted diseases and relationship education, such as
- education and health promotion to increase awareness, encourage respectful relationships, fewer sexual partners and promote consistent condom use
- screening for sexually transmitted infections
- easy access to sexual health services, with a focus on groups at highest risk, in order to reduce transmission of sexually transmitted infections.
- [The recent changes to the commissioning of health care have increased the complexity of the commissioning and provision of sexual health services.](#)
- Open-access sexual health services are now commissioned by local authorities, and abortion services are commissioned by clinical commissioning groups.
- NHS England commissions HIV treatment services. Improvements in sexual health will depend on effective coordination by these agencies.
- This report covers sexually transmitted infections including HIV, contraception and unwanted pregnancy. It includes adolescence and adulthood.

## Key points

- Sexual health services are known to be highly cost effective.
- Poor sexual health is experienced unequally according to age, gender, ethnicity and sexual orientation, and access to service also varies by these characteristics. However, much local data on inequalities were suppressed for reasons of confidentiality.
- Northamptonshire has similar rates of Chlamydia screening to the England average, and higher HPV vaccination coverage, yet 65% of HIV diagnoses

are late, above England rates, so preventive opportunities are reduced and health care costs increased

- Under 18 conception rates are below England rates, but the reducing trend in rates over the past decade has reversed in Corby, Kettering and South Northamptonshire.
- Services are not meeting demand; rates of most sexually transmitted infection have risen in Northamptonshire since 2009, but remain lower compared to England, while rates of HIV infection are above the England rate.
- Local contraceptive services are mainly accessed by young women and not men or older women. While there is good primary care access to long-acting reversible contraceptives, there is lower access to early abortions compared to England.

## Recommendations

### Prevention

1. *Northamptonshire should produce a sexual health strategy.*

The strategy should

- Have strong leadership.
- Be based on the [National Framework for Sexual Health Improvement in England](#) published in March 2013.
- Prioritise the prevention of poor sexual health
- Join up working with a focus on outcomes, which address the wider determinants of sexual health
- Promote the commissioning high-quality services, with clarity about accountability, meeting the needs of more vulnerable groups
- Include good-quality intelligence about services and outcomes for monitoring purposes
- Enjoin a holistic approach that recognises other physical and mental health problems may result from sexually transmitted diseases and sexual relationship problems.

2. *Northamptonshire should review sex and relationship education in schools.*

The following elements are of particular importance:

- Use a range of evidence-based teaching methods to suit different learning styles, including skills-based programmes, interactive techniques and combined school- or college-based and family-based learning opportunities.
- Set clear health goals – for example, to prevent sexually transmitted infections or prevent homophobic bullying. Be clear about the specific behaviour needed

to achieve these goals – for example, using condoms and reducing the number of sexual partners to prevent STIs.

- Build on existing knowledge and provide information that helps children and young people to develop their knowledge, understanding, attitudes and skills and to appreciate the benefits of responsible, healthy and safe choices.
- Include information about sexual health that
  - Clarifies misconceptions about contraception and the prevention of STIs
  - Increases children and young people's understanding of the short-term and long-term effects of alcohol and drugs on sexual behaviour.
- Adopt active learning techniques that build on pupils' and students' existing knowledge, encourage them to explore their attitudes and allow them to practise their personal and social skills.
- Include activities that they can do with their parents and family. This might include preparing questions for a visitor to the class, such as a teenage parent.
- Ensure teachers, lecturers and tutors, health professionals, young people's practitioners such as youth workers and those who work with parents and carers have access to continuing professional development.

These measures will help address risky sexual behaviour and reduce sexually transmitted infections, HIV and teenage pregnancy, and improve knowledge of services available.

### 3. *Northamptonshire should promote the prevention and early treatment of sexually transmitted infections and HIV.*

- Ensure that information about local services is available in a range of formats, and is widely available from a range of outlets.
- Such outlets should include health centres, pharmacies, opticians, community services, libraries, schools, workplaces, community organisations.
- Use local indicators to monitor and evaluate the success of prevention initiatives.
- A recent study of GPs in Haringey evaluated the impact of an educational intervention (with no financial incentive) for GP practices. It found that:
  - the intervention was associated with a substantial increase in the number of HIV tests done over a 19-month period
  - the number of HIV-positive diagnoses identified in Haringey general practices rose from an average of 9.5 per annum before training to a projected 22 per annum after training (on the basis of the last six months' data)
  - the highest increases in HIV testing were seen in the locality with the highest prevalence of HIV.

- Promote the provision of a range of more specialist sexual health services in primary and community care
- Encourage non-traditional locations such as schools, colleges, youth clubs to provide education and information about services
- Use new technology such as websites and smart phone apps to communicate with young people and newly diagnosed patients with HIV so they can manage their condition more effectively eg 'myHIV'.

4. *Northamptonshire should ensure condoms are freely available in venues where there is risky sexual behaviour such as bars and nightclubs.*

- Evidence from the *Got it Covered* campaign in 2009 showed that young people did not want to carry condoms for fear of being thought promiscuous.
- Therefore having them freely available in appropriate venues will help prevent unwanted pregnancy, HIV and other sexually transmitted infections.
- Safe sex messages in these venues should be promoted also.

## Testing and Treatment

5. *Integrate primary and community contraceptive and sexual health services in order to improve access to men, older women, men who have sex with men (MSM) and Black minority ethnic groups.*

- This will increase coverage and comprehensiveness of services to prevent and treat sexually transmitted infections, HIV and unwanted pregnancy.
- Ensure that there are clear care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.

6. *Northamptonshire should map current services for STIs, HIV, teenage pregnancy, contraception and identify service gaps or access difficulties*

- Guidance from NICE has found that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intra-uterine system or the intrauterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms.
- However, a condom should also always be used to protect against STIs.
- Research with young women having abortions and repeat abortions found that
  - some young people continue to have unprotected sex when they are fully aware of the possible consequences and when they do not want to become pregnant

- there is a poor understanding of fertility among young women, and this contributes to inconsistent contraceptive use;
- some young people struggled to use their preferred methods of contraception effectively (principally condoms and the pill, which are user dependent)
- abortion was viewed as immoral by many young women and this makes decision making difficult when faced with unplanned pregnancy.
- Patient and public involvement (PPI) is important to assess the quality of current services including the accessibility in terms of geography, opening hours, cultural sensitivity and whether they meet patients' needs.
- The London Sexual Health Programme has a website which provides a practical [toolkit to assist in PPI](#).
- Speaking to clinicians and staff in the sexual services together with PPI will allow an assessment of geographical distribution of services in relation to local need so gaps can be filled.

7. *Review of multifaceted approach to teenage pregnancy services for Corby, Kettering and South Northamptonshire and address gaps appropriately.*

[A multifaceted approach is needed to reduce teenage conceptions](#) with the following four strands are:

- A media campaign to give young people accurate information about sex.
- Local joined-up action, eg education and health working together, targeting high-risk groups such as children leaving care.
- Development of Sexual Relationship Education (SRE) in and out of school, and improved access to sexual health and contraception services.
- A positive, coordinated support for young pregnant women and their partners. This includes improving educational attainment for teenage boys and girls.
- Evidence-based multifaceted inputs are required to address teenage pregnancy in high incidence areas, including targeting services to particular groups such as looked after children.

8. *Expand HIV testing.*

- More effort should be made to diagnose HIV in people registering with their GP or during hospital attendance, especially among minority ethnic groups.
- GP point-of-care testing could be considered.

9. *Review abortion services to improve population access to early abortion.*

- Women who request an abortion should have early access to services, as the earlier in pregnancy an abortion is performed the lower the risk of complications.

- Unwanted pregnancy is experienced by women from all social backgrounds. The numbers of abortions nationally has increased slowly until 2008 and have remained relatively stable since then. However, repeat abortions have risen over the last decade and there was a further 2% increase in 2011, when 36% of all abortions were repeats. Abortion rates have fallen in younger age groups but are increasing in older women.
- The review should address inequitable access to abortions for Nene CCG residents and will aim to recommend how improved access to early abortion will be achieved.

### The key early priorities are

- Improve sex education, information about services and the communication of risk
- Develop preventive services targeted to at risk-populations and improved early HIV diagnosis
- Improve equity of access to abortion services.

This needs assessment should be read in conjunction with the report on alcohol.

### Why is sexual health important in Northamptonshire?

Sexual health is the capacity and freedom to enjoy and express sexuality without exploitation, oppression or physical or emotional harm. Sexual health problems include sexually transmitted infections, human immunodeficiency virus (HIV) infection, unintended pregnancy, abortion, fertility problems and sexual dysfunction.

The population of Northamptonshire has a similar age profile to the UK as a whole, and 88% are of white ethnicity. The largest conurbation with the highest need for sexual health services is Northampton. [The proportion of people in their reproductive years is expected to remain stable to 2020](#), except in Corby. Here, the population increased by 15% between 2001 and 2011, mainly among men aged 25 to 34 years and women aged 25 to 29 years. This increased population will increase the need and demand for contraceptive and sexual health services.

In 2005, the Government estimated that approximately 6% of the UK population are gay men, lesbians or bisexuals – about 32,000 Northamptonshire residents. Among these groups, data are only available for men who have sex with men.

Rates of common sexually transmitted infections are rising nationally. In 2010/11, the incidence of gonorrhoea rose by 25% and that of syphilis by 10%. [In England, the highest rates of acute sexually transmitted infections occur in 15 to 24 year olds.](#) Poor sexual health is closely linked to other unsafe behaviours such as alcohol use and to low socio-economic status. [Risky sexual behaviours and some adverse sexual health outcomes are associated with excess alcohol consumption.](#)

The economic facts about sexual health include

- It is estimated that, based on current spend, sexual health services will account for around one-quarter of the funds to be transferred to local authorities in April 2013 for their new public health responsibilities.
- Evidence demonstrates that spending on sexual health interventions and services is cost effective. For every £1 spent on contraception, £11 is saved in other healthcare costs.
- The provision of contraception saved the NHS £5.7 billion in healthcare costs that would have had to be paid if no contraception at all was provided.
- National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 demonstrated that long-acting reversible contraceptives are more cost effective than condoms and the pill. If more women chose to use these methods there would be cost savings.
- Early testing and diagnosis of HIV reduces treatment costs: £12,600 per annum per patient, compared with £23,442 with a later diagnosis.
- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person.
- Improvements in the rates of partner notification result in a reduced cost per chlamydia infection detected.
- More work is needed to assess the impact that improving sexual health can have on wider local authority and other budgets. This should particularly focus on the impacts caused by reducing unwanted pregnancies and HIV transmission.
- Further work is needed to assess the savings Northamptonshire could make if cost effective commissioning was undertaken to promote sexual health and reduce unwanted pregnancies and sexually transmitted diseases including HIV.

The improvement of sexual health is highly cost-effective. It depends largely on preventive measures, such as

- education and health promotion to increase awareness, encourage fewer sexual partners and promote consistent condom use
- screening for sexually transmitted infections
- easy access to sexual health services, with a focus on groups at highest risk, in order to reduce transmission of sexually transmitted infections.

The recent health and social care reforms have increased the complexity of commissioning and provision of services. Abortion services are commissioned by clinical commissioning groups (CCGs), but open access sexual health services are now commissioned by local authorities. Improvements in sexual health will depend on effective coordination of these services.

## What is the local picture?

Data on variation by age, gender, ethnicity, marital status and disability are provided where available.

### **Sexually transmitted infections**

[Risk groups](#) for sexually transmitted infections include those with socio-economic deprivation, young people and men who have sex with men. Rates of acute STIs are highest in residents of urban areas.

Rates in England have risen over the past three years. [This is likely to be due to increased transmission through unsafe sex](#), together with improved detection eg better availability of community-based chlamydia screening.

Rates of acute sexually transmitted infections in Northamptonshire are lower compared to England (Table 1). There was a problem with recording of sexually transmitted infections in Kettering, so after excluding this data, rates are highest in Northampton. There are likely to be more opportunities for sexual contacts in Northampton, for example in clubs and bars.

**Table 1: Incidence of sexually transmitted infections (STIs) per 1000 population, districts in Northamptonshire, 2012**

	Gonorrhoea	Syphilis	Warts	Herpes	Chlamydia		All acute STIs	No. acute STIs
					15-24 years	Over 25 years		
Corby	29.2	1.6	114	68.2	934.3	126.6	592.5	365
Daventry	19.2	1.3	91	37.1	960.3	93.6	421.4	329
East Northamptonshire	19.6	3.5	100	57.6	794.4	93.2	460.5	400
Kettering	16.0	1.1	102	44.8	7115.8*	153.8*	1239.3	1163
Northampton	51.3	4.7	138	65.9	1541.3	194.0	828.7	673
South Northamptonshire	10.5	1.2	79	30.4	782.1	55.5	355.8	304
Wellingborough	29.1	2.6	108	45.0	1147.1	111.3	531.5	402
Northamptonshire	29.5	2.7	110	52.3	1,927.3	131.6	680.7	4724
England	45.9	5.4	135	58.4	1,979.1	160.0	803.7	426821

Source: [Public Health England](#)

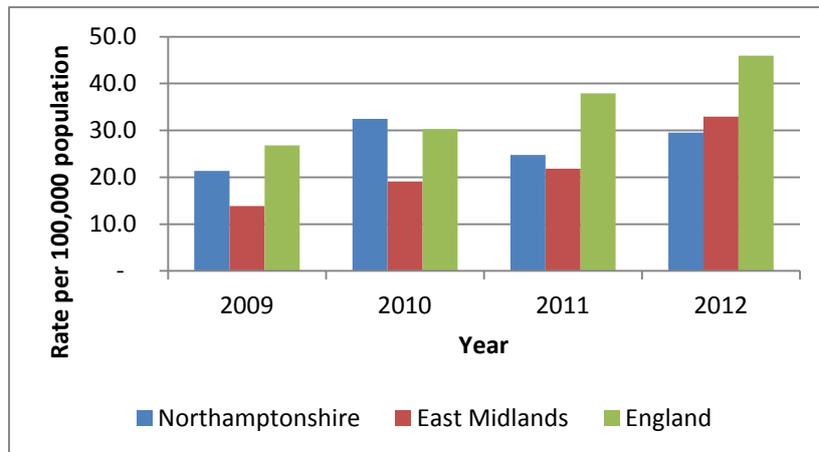
\*The data for Chlamydia for Kettering are inaccurate due to inaccurate post codes. This is now corrected.

Between 2009 and 2012, the incidence of sexually transmitted infections in Northamptonshire changed as follows:

- Gonorrhoea: 38% increase (from 146- 205 infections)
- Herpes: 25% increase (from 286- 363 infections)
- Syphilis: 11% decrease (from 21-19 infections)
- Chlamydia: 3.8% increase (2009 to 2011 only) (from 2490-2623 infections)
- Genital warts: 20% decrease.(from 940-764 infections)

The large increase in gonorrhoeal infections between 2009 and 2012 is similar to that seen for England and the East Midlands as a whole. This is of concern because gonococcal resistance to antimicrobials is increasing. [The Gonorrhoea Resistance Action Plan for England and Wales](#) (April 2013) makes recommendations on ensuring prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission.

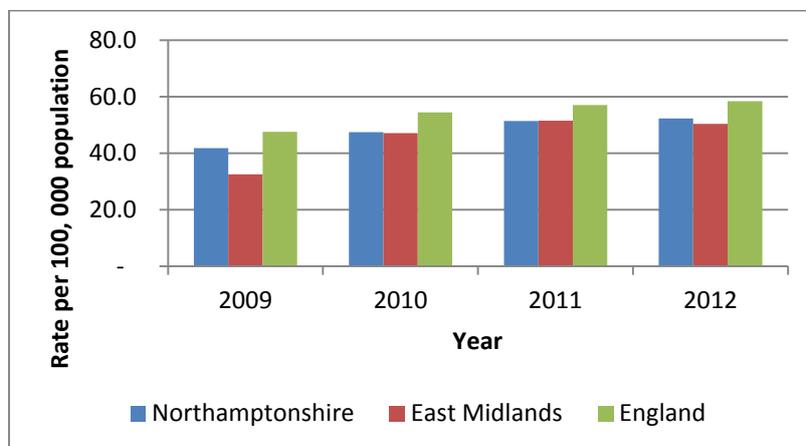
**Figure 1: Trend in incidence rates of gonorrhoea, Northamptonshire, 2009 to 2012**



Source: [Public Health England](#)

The increase in Herpes infection is also of concern and may be linked to the late diagnosis of HIV infection (see below), and needs monitoring. The trend in diagnosis rates of Herpes mirrors the national and regional trends, see Figure 2.

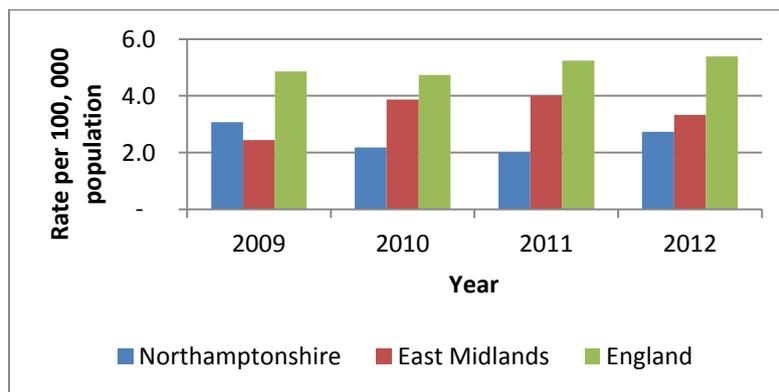
**Figure 2: Trend in incidence rates of Herpes, Northamptonshire, 2009 to 2012**



Source: [Public Health England](#)

The downward trend in syphilis infections is in the opposite direction to that in England during 2009-12 (Figure 3). This needs monitoring, due to the apparent rise seen in 2012 compared to 2011.

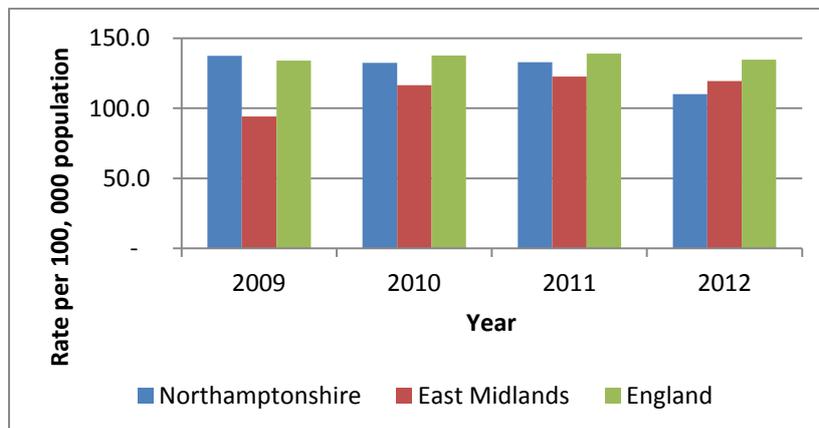
**Figure 3: Trend in incidence rates of syphilis, Northamptonshire, 2009 to 2012**



Source: [Public Health England](#)

[The Human Papilloma Virus \(HPV\) vaccination programme](#) in girls aged 12 to 13 years began in 2008. Rates of HPV infection fell in Northamptonshire from 137/100,000 in 2009 to 110/100,000 in 2012, in contrast to the East Midlands and England (Figure 4). In the next ten years, there is likely to be a large fall in the number of sexually transmitted wart infections, as the HPV vaccination programme in teenage girls takes effect. Rates of cervical cancer, which is mainly caused by HPV, are also likely to reduce.

**Figure 4: Trend in incidence rates of genital warts, Northamptonshire, 2009 – 2012**



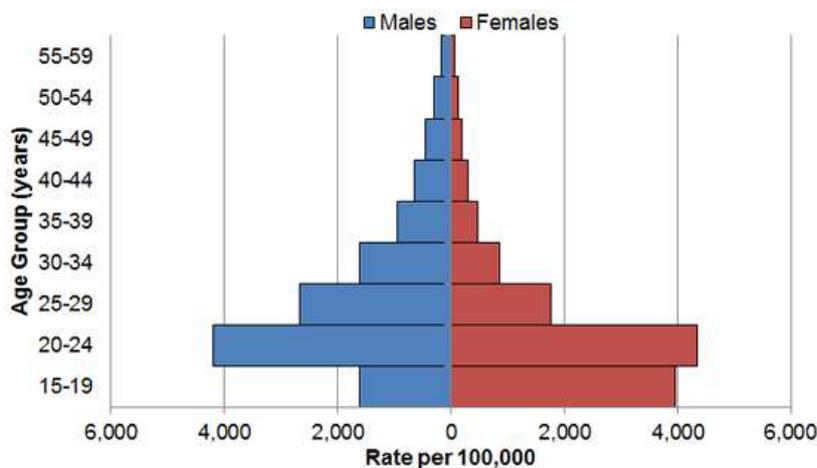
Source: [Public Health England](#)

Since 2008, it has been national policy to increase the uptake of Chlamydia screening in 15 to 24 year olds. Overall rates of diagnosed Chlamydia infections are much higher in 15 to 24 year olds compared to 25+ year olds. While the way of recording Chlamydia infections changed in 2012, making trend data a non-comparable, from 2009 to 2011, rates of Chlamydia infections per 100,000

populations increased in 15 to 24 year olds, but remained stable in older age groups. This is due mainly to increased screening and testing in the younger age group, but may also reflect a higher number of sexual partners in young people.

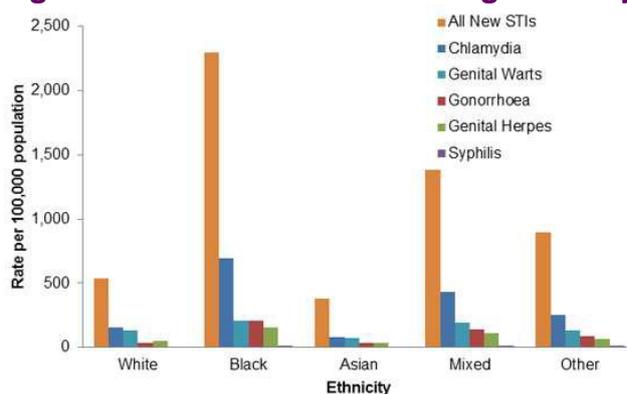
The incidence of sexually transmitted infections is closely linked to age and gender, ethnicity and to socio-economic status (Figures 5 and 6). There is no local data but the national findings are likely to apply to the local population.

**Figure 5: Rates of acute STI diagnoses by age group and gender, 2012, England**



Source: [Public Health England](#)

**Figure 6: Rates of acute STI diagnoses by ethnicity and STI, 2012, England**



Source: [Public Health England](#)

These data suggest that prevention must be targeted to specific groups. For example, safe sex messages apply to all age groups but they must be targeted particularly to young people. Other target groups include men who have sex with men and people who inject drugs. Further information and guidance is available from [Public Health England](#).

## HIV

Human immunodeficiency virus (HIV) infection has been increasing in incidence since the 1980s. People may be undiagnosed, newly diagnosed, or diagnosed and on treatment. [About one quarter of people infected in England are unaware of their infection](#). If the UK estimated prevalence of HIV of 1.5/1000 population (all ages) is applied to the Northamptonshire population of 691,900 this would equate to an expected total number of 1037 people with HIV (diagnosed and undiagnosed).

In 2012 the [UK new HIV diagnosis rate was estimated as 1/10,000/year](#). When this is applied to the Northamptonshire population, an estimated 69 new HIV infections could be prevented per annum through preventive interventions.

HIV diagnosed prevalence in Northamptonshire in 2012 was [1.8/1000 population in people aged 15-59 years](#) (1245 people), but it is higher in some districts, and highest in Northampton (Table 2). Geographical prevalence is similar to that seen for STIs.

**Table 2: Diagnosed prevalence rates of HIV and number living with HIV, districts in Northamptonshire, 2012**

	Prevalence rates per 1000 population aged 15-59	Numbers receiving HIV – related care
Corby	2.1	88
Daventry	0.4	22
East Northamptonshire	0.9	49
Kettering	1.2	65
Northampton	2.8	378
South Northamptonshire	0.5	27
Wellingborough	1.6	74
Northamptonshire	1.8	827
East Midlands	0.86 ( 2007)	not known
England	2.0	not known

Source: Public Health England, SOPHID data

The main routes of transmission are shown in Table 3 (data is only available at regional level). [Forty eight per cent of infections were acquired by men who have sex with men](#) in 2012 in England, in contrast to the East Midlands, where a lower proportion of HIV infection is acquired through men who have sex with men, compared to England (Table 3).

**Table 3: New diagnosis by probable route of HIV transmission, Midlands and East of England and England, 2012**

%	Midlands and East of England	England
Heterosexual	64.2	47
Sex between men	28.8	48
IVDU	3.5	5
Mother-to-child	1.9	2
Other	1.6	-

Source: [Public Health England](#)

[People aged 15-24 years are most at risk](#), regardless of their sexuality, as they do not perceive themselves to be at risk.

[Safe sex programmes](#) promoting condom use and HIV testing remain a priority in Northamptonshire for

- Young heterosexual populations
- Black African and Caribbean communities
- MSM
- People who inject drugs
- Pregnant women.

These groups should take extra care to restrict the number of partners and use condoms during sexual intercourse when at home or abroad. In other words, the same groups need targeting with safe sex messages as those at risk of STIs, see above. In addition, earlier diagnosis of HIV among the whole population means that preventive measures can prevent unintentional sexual transmission.

Highly active antiretroviral therapies (HAART) have resulted in substantial reductions in AIDS incidence and deaths, which, in turn, has led to [an increase in the number of people needing long-term treatment](#). [People living with HIV now have a life expectancy about 13 years below that of the general UK population](#).

### Teenage pregnancy

Teenage pregnancy is a problem nationally and locally; rates in England are the highest in Europe. In 1998, the Government's Teenage Pregnancy Strategy laid out plans to halve the under-18 conception rate by 2010. However, the under-18 conception target was not met nationally or locally. Between 1998 and [2010 the under 18 conception rate in England reduced by 15.3%, and that in Northamptonshire reduced by 16%](#). The current Government has pledged to continue to reduce rates. The [evaluation of the teenage pregnancy strategy](#) in 2001 found that

- Young people and parents both expect that most young people will have their first sexual experience between 16 and 17 years of age.

- Young people and parents support Sex and Relationships Education being a statutory part of the national curriculum.
- 86% of parents believe there would be fewer teenage pregnancies if parents talked more to their children about sex and relationships.
- Over 80 per cent of parents agree young people should have access to confidential contraceptive services, even if they are under 16.

A multifaceted approach to reduction of teenage pregnancy is needed (see evidence section), with a particular focus on sex education and accessible contraceptive services for young people. Improving educational attainment will have a major impact in deprived areas.

There is wide geographical variation in under-18 conception rates within the County. The rates are strongly associated with deprivation: in Northampton, Wellingborough and Corby under 18 conception rates are high, [levels of deprivation are higher and educational attainment is lower at age 16](#) compared to England. The highest under-18 conception rate in Northamptonshire is in Corby: 59/1000 women aged 15 to 17 (Table 4). Corby also has the lowest proportion of teenage conceptions ending in abortion in Northamptonshire. This suggests there may be reduced access to abortion services in Corby or that there are fewer unwanted pregnancies.

In 2011, the [under 18 conception rate](#) for Northamptonshire was 33.1/1000 females aged 15-17. Rates fell in the East Midlands and England and Northamptonshire from 1998 -2010 (Table 4). Between 2006-8 and 2008-10 the decline in all areas slowed, especially in Northamptonshire. Within the county, between 2006-8 and 2008-10 under 18 conception rates increased in Corby, and Kettering (Table 4). The rate in South Northamptonshire also increased during this period but small numbers indicates wide confidence levels and year-on-year variation (see Table 6).

**Table 4: Conception rates per 1000 women aged 15-17, districts in Northamptonshire, from 2006/8 to 2008/10**

	2006-2008	2007-2009	2008-2010	% change 2006-8 to 2008-10	Rate change from 1998-2010	% conceptions ending in abortion 2008-10
Corby	54.0	54.0	59.0	9.3	-22.9%	33.0
Daventry	30.0	32.0	30.0	0.0	15.6%	50.0
East Northamptonshire	29.0	31.0	28.0	-3.4	-28.5%	48.0
Kettering	37.0	41.0	41.0	10.8	4.4%	42.0
Northampton	50.0	48.0	45.0	-10.0	-15.5%	44.0
South Northamptonshire	16.0	18.0	18.0	12.5	-19.0%	66.0

Wellingborough	49.0	50.0	48.0	-2.0	-14.3%	48.0
East Midlands	39.9	39.2	37.3	-6.5	-17.1%	44.0
Northamptonshire	38.9	39.4	38.2	-1.7	-23.5	45.0
England	41.0	40.2	38.1	-7.1	-15.3%	50.0

Source: [Chimat](#) and [Sexual Health Balanced scorecard](#)

The under 18 conception rate is projected to rise slightly to 2015 and remain stable to 2025.

**Table 5: Forecast conception rate per 1000 females aged 15-17, 2015, 2020 and 2025, Northamptonshire, East Midlands and England**

	2015	2020	2025
Northamptonshire	36.6	36.6	36.6
East Midlands	33.1	31.5	30.0
England	33.7	32.1	30.6

Source: [Chimat](#)

In 1998, there were 531 conceptions to women aged 15-17 years, falling to 450 in 2010. The following table shows the number of under-18 conceptions in each district in Northamptonshire. Northampton has the highest number of under-18 conceptions.

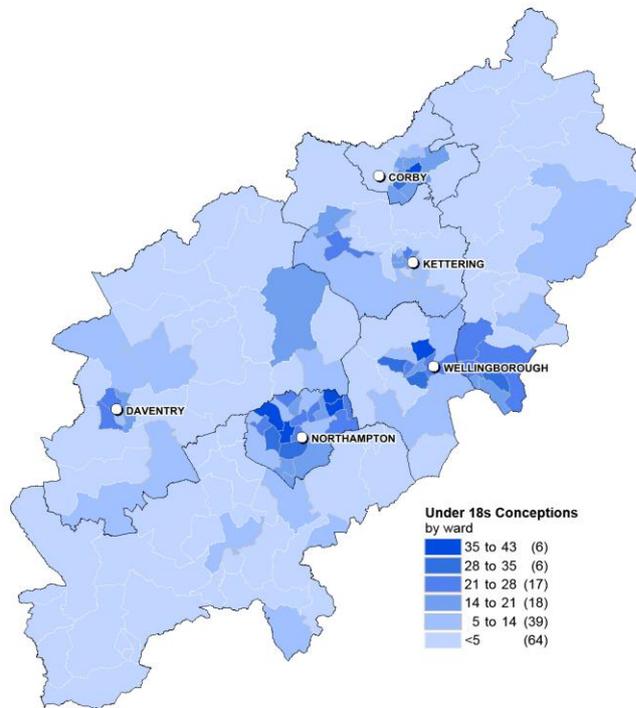
**Table 6: Number of conceptions in 2010 among women aged 15-17, districts in Northamptonshire.**

	Number of Conceptions
Northamptonshire	450
Corby	69
Daventry	41
East Northamptonshire	40
Kettering	60
Northampton	152
South Northamptonshire	28
Wellingborough	60

Source: [Sexual Health Balanced Scorecard](#)

This data is mapped in Figure 7.

**Figure 7: The number of conceptions by area in under 18 year olds, Northamptonshire, 2007-9**



## Under-16 conceptions

Under-16 conception rates show a similar pattern of geographical variation and association with deprivation to under-18 conceptions. Conception rates in Northamptonshire were lower compared to England in 2011. Rates decreased across England, the East Midlands region and Northamptonshire between 2006/8 and 2009/11 (Table 7).

The highest rates are in Corby and Wellingborough, the same geographical pattern seen among 15-17 year olds. The small numbers of conceptions mean rate changes may vary significantly from year to year, preventing further conclusions (Table 7).

**Table 7: Trend in conception rates in under 16 year olds per 1000 women aged 13-15 years, districts in Northamptonshire**

	2007 - 2009	2008-2010	2009-11	Number of conceptions 2008-10	% change 2006-8 to 2009-11	% conceptions ending in abortion 2009-11
Corby	10.9	12.2	10.9	38	-0.9	65.7
Daventry	6.5	6.7	7.1	30	36.5	67.7
East Northamptonshire	7.0	7.1	6.5	40	-5.8	57.1
Kettering	9.8	9.2	8	44	3.9	51.3
Northampton	9.3	8.9	8	92	-18.4	50.0
South Northamptonshire	4.5	3.7	2.8	19	-26.3	85.7
Wellingborough	11.2	10.5	9.8	42	4.3	59.0
Northamptonshire	8.4	8.1	6.3	305	3.9	56.7
East Midlands	7.7	7.4	6.9	1,746	-9.2	61.1
England	7.9	7.4	6.7	20,153	-15.2	65.7

Source: [Chimat](#)

## What interventions are effective?

### Prevention

[Evidence](#) indicates that programmes that teach only about delaying first sex (abstinence-only programmes) are ineffective for preventing or reducing sexual risk behaviours, have no effect on the initiation of sexual behaviours or the maintenance of sexual abstinence and may have no impact on sexual activity.

Programmes are likely to be more effective if they bring together education about relationships, sexual health and alcohol and substance misuse components of PHSE

education. Those that only offer information on safer sex and contraceptive use may have positive but limited effects on the prevention of sexual risk behaviour, in particular limited effects on contraceptive use.

Long-term positive impacts on alcohol use and sexual behaviour in young adulthood follow programmes focusing on social development interventions, for example, those that focus on friendships and family relationships in younger age groups and develop communication, decision-making and negotiation skills, and are designed to positively influence behaviour in later life when combined with school- and family-based interventions.

HIV and sexual risk-reduction programmes can improve sexual health and HIV knowledge.

HIV and sexual risk-reduction programmes may improve personal and social skills, including behavioural prevention skills and condom negotiation skills in the short term.

HIV and sexual risk-reduction programmes can increase condom use or protected intercourse in the short to medium term.

There is evidence that a sex and relationships education programme, Safer Choices may be cost-effective and cost saving. It involves a planned curriculum involving role-playing, role model stories, parent newsletters, homework and school-community linkages.

Young people aged 13-17 felt that education on sex and relationships was delivered too late to be of practical use. Many had experienced sexual activity prior to it; there was also concern however that if it was delivered too early it may influence young people's wish to have sex.

Flexibility is important in designing PSHE education, for example offering young people the opportunity to participate in, plan and evaluate PSHE education, involving them in activities to identify what is most relevant to their lives, using their feedback to improve lessons and giving them opportunities to act as peer educators.

### **Sexually transmitted infections and HIV**

The Gonorrhoea Resistance Action Plan for England and Wales (April 2013) makes recommendations on ensuring prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission.

NICE has published guidance on

- [Prevention of sexually transmitted infections and under 18 conceptions](#), recommending consistent use of condoms and reducing the number of sexual partners as the best way of preventing sexually transmitted infections
- [Increasing the uptake of HIV testing among men who have sex with men](#)
- [Increasing the uptake of HIV testing among Black Africans in England](#).
- [Increasing testing for Hepatitis B and C in high risk settings including GUM clinics](#)
- The National Aids Trust published guidance in 2013 on
- [Reducing late diagnosis of HIV](#) which is associated with a poorer prognosis, by routine opt-out testing in areas of prevalence greater than 2/1000 population, partner notification, community HIV testing and the use of financial incentives to encourage testing.

[Earlier HIV diagnosis is essential to effective prevention. The Health Protection Agency published specific advice for the prevention in at-risk groups \(young adults, men who have sex with men, people who inject drugs, pregnant women and people at risk through their occupation\).](#)

The British Association of Sexual Health and HIV has published the [UK National Guideline for the use of post-exposure prophylaxis for HIV following sexual exposure](#).

### Teenage Conceptions

[A multifaceted approach is needed to reduce teenage conceptions](#). The four strands are

- A media campaign to give young people accurate information about sex,
- Local joined-up action, eg education and health working together, [High risk groups need to be targeted](#), for example children leaving care.
- Development of SRE in and out of school, and improved access to sexual health and contraception services,
- Positive, coordinated support for young pregnant women and their partners. This includes improving educational attainment for teenage boys and girls.

### Contraception

A woman should be able to make an informed decision on her preferred contraceptive method. A comprehensive range of services should be available and accessible to people of all ages, gender, sexuality, religion, and marital status.

NICE has recommended increased use of long-acting reversible contraceptives (LARCs), which are not user-dependent and [more cost-effective than the oral contraceptive pill](#). [Other cost-effective elements of sexual health services include access to emergency contraception, reducing the delay in abortion and prophylactic treatment for chlamydia prior to abortion](#).

## Abortion

First trimester abortion is safer and can be performed medically or surgically by vacuum aspiration. [Medical methods for early termination of pregnancy are safe and effective.](#) [Screening for Chlamydia is effective in reducing pelvic infection, including screening before surgical abortion.](#)

## What is the pattern of services in Northamptonshire at present?

Some of the services in Northamptonshire have been described above eg Chlamydia screening. Services here are described under prevention, primary and community care and secondary care. [Further information is available from the Northamptonshire NHS Foundation Trust website.](#)

## Prevention

Prevention includes education on harms to health of poor sexual health, together with information on how individuals can protect themselves. Information on where to go for help and advice is also needed. This empowers people to avoid an STI, HIV or unwanted pregnancy and to seek testing and treatment early.

School-based sex education is part of the National Curriculum. In the 2009/10 Tell Us National School survey, [17% of pupils aged 12- 15 years in Northamptonshire reported they had not received any sex education.](#) This is significantly higher than the England rate of 13%. Only 47% said they found the information and advice on sex and relationships helpful compared to 53% for England. This may be a partial explanation for high teenage conception and STI rates in the County. School-based services are offered at 36 of 39 secondary schools (92%), a higher proportion than nationally (29%). While described as comprehensive, a service review is needed given the above findings.

In Corby, a pilot HIV Prevention Partnership between the voluntary sector (Sunrise) and the NHS has been in place since 2011, based at Oakley Medical Centre. Activity includes HIV education and HIV testing, . This is an important programme as it is targeted prevention aimed at the Black African population of Corby. Public Health England recommends this ethnic minority population is a target group for preventive activities, see above.

The [HPV vaccination programme](#) immunises girls aged 13 against HPV virus at school, so reducing genital warts infection and cervical cancer. Vaccination rates are above England rates (Table 8), and have shown reduced wart diagnoses (Figure 4). This is a major element of the prevention of cervical cancer and reducing sexually transmitted HPV and genital wart infections.

**Table 8: HPV vaccination coverage, Northamptonshire and England, 2011/12**

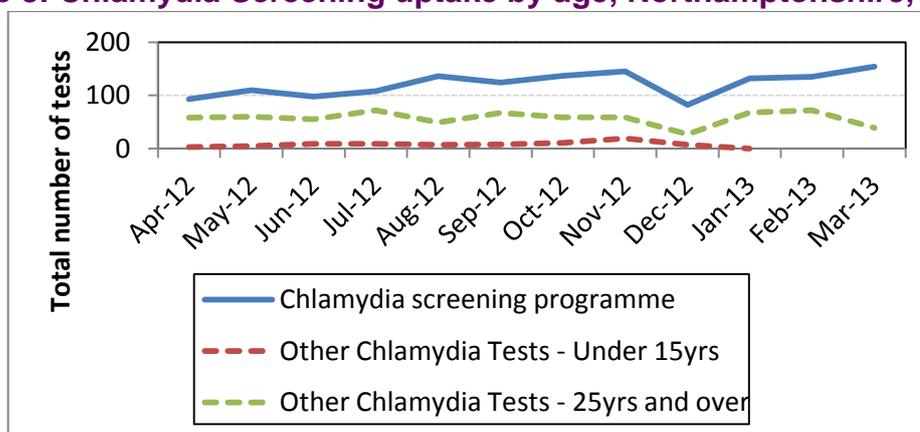
	2011/12
Northamptonshire	92.8
England	86

Source: [Public Health England](#)

## Screening

Chlamydia screening is carried out in pharmacies, GPs and in hospital antenatal services. Midwives have been given incentives to test for Chlamydia. Until 2012, there was also an outreach worker encouraging Chlamydia screening at the time of termination of pregnancy. Figure 8 shows that the local Chlamydia screening programme has resulted in an increase in the number of tests since December 2011, while Chlamydia testing for other reasons, such as post termination of pregnancy, has remained static. The proportion screened is similar to England rates (Figure 10), but progress has been in screening women and more men now need to be screened. The ratio of uptake for Chlamydia screening for men to women is 1:2, see Figure 10.

**Figure 8: Chlamydia Screening uptake by age, Northamptonshire, 2012/13**



Source: Sexual Health Monitoring Matrix 2012

[National HIV testing guidelines](#) recommend routine HIV testing where prevalence is over 2/1000 population aged 15 to 59, in GUM clinics, in people admitted to hospital or newly registering with a general practice. Locally, HIV testing occurs routinely at antenatal booking assessments, and the GU services in Northampton and Kettering.

In 2012 92% of new attendees at GUM clinics in Northamptonshire were offered an HIV test and 84% had a test done. In December 2011, a project started to test for HIV in A&E. GPs in Northamptonshire do not currently test for HIV. The Northamptonshire Sexual Health Action Plan aims to get GPs to test for HIV.

## Primary and Community care - Contraception

Following a review it was highlighted that the sexual health and contraception in Northamptonshire needed to be changed, with integrated sexual health and contraceptive services, and accessible opening hours (personal communication from public health department). It is now in the process of integrating its sexual health services and its contraceptive services, in order to widen community clinic opening hours to weekday evenings and Saturday mornings. This will be complete by January 2014.

The following [Young people's community](#) services are provided

- Contraceptive services are offered across 7 sites, 6 colleges and 12 community sites. There are also telephone consultations with under 20's who have accessed EHC via the pharmacy provision, Targeted support with vulnerable groups such as looked after children with referrals from CAF, social workers etc, C-Card Scheme Pharmacies and Northampton Hospital provide condoms and emergency contraception. [Young people aged 16-25 years can register for a C-card which entitles them to free condoms available from a number of outlets.](#)
- The Young People's Community Outreach Contraception Pilot aims to prevent second unplanned conceptions. Since May 2010, there have been 665 referrals of which 378 are in receipt of contraception. LARC was the method chosen for 71.5% with an implant retention of 80%.
- Pharmacy Emergency Hormonal Contraception scheme: 58/124 community pharmacies are currently signed up to deliver EHC to under 25's. Between 1 April and 30 Sept 2011, there were 976 EHC consultations, with most activity (34%) carried out by two Northampton pharmacies. 52% of young women have accessed EHC previously, and 88% cite burst condom or no contraception as the reason for requiring EHC.

For this report not all information on the contraceptive services provided by pharmacies, community clinics and GPs was available. However, LARC provision in primary care is higher compared to England (Table 9). There was a slight increasing trend from April 2011 to August 2013. This may be due to the outreach contraception pilot, see above.

**Table 9: LARC provision in primary care services in Northampton and England, 2012/13**

	Rate per 1000 women aged 15 to 44 years
<b>Northamptonshire PCT</b>	67.3
<b>East Midlands</b>	62.3
<b>England</b>	49.0

Source: [Public Health England](#)

### Secondary care – contraception and abortion

Compared to England, NHFT relied more on prescribing user-dependent methods and less on long acting reversible contraceptives in 2011/12 (Table 10). Women aged 20 to 34 years are less likely to use these services compared to services across England as a whole.

**Table 10: Contraceptive services provided by secondary care, by methods and age, 2011/12, Northamptonshire, East Midland and England**

	LARC contraceptives as a proportion of total first contacts for contraception (%)	User dependent methods as a proportion of total first contacts for contraception (%)*	Other methods as a proportion of total first contacts for contraception (%)	1 <sup>st</sup> Contact women under 20 (%)	1 <sup>st</sup> Contact women aged 20-34 (%)	1 <sup>st</sup> Contact women aged 35 and over (%)
<b>NHFT</b>	24	75	0	27	44	29
<b>East Midlands</b>	36	72	2	29	48	23
<b>England</b>	28	63	3	23	51	26

\* includes hormonal contraceptives. Sterilisations excluded.

Source: [Health and Social Care Information Centre from KT31 and SHHAD returns](#)

- NHFT undertakes training for primary and community staff on Chlamydia screening, LARC etc, including child protection responsibilities and how to use the common assessment framework appropriately.
- A total of 700 prescriptions of [emergency hormonal contraception](#) was dispensed by NHFT in 2011 /12. The numbers prescribed Emergency contraception doubled from 40 in April 2011 to 88 in August 2013. While adding to contraceptive choice, the use of EHC can be considered an indicator of partial unmet need for contraceptive services, especially non-user dependent methods.
- Abortions are commissioned from NHFT, St Mary’s Hospital, Kettering and British Pregnancy Advisory Service. The highest quality service is provided by BPAS, with a limited service provided by NHFT (personal communication public health department). Abortions before 10 weeks can be performed

medically or surgically, [with medical abortion being a safe alternative to surgical abortion](#).

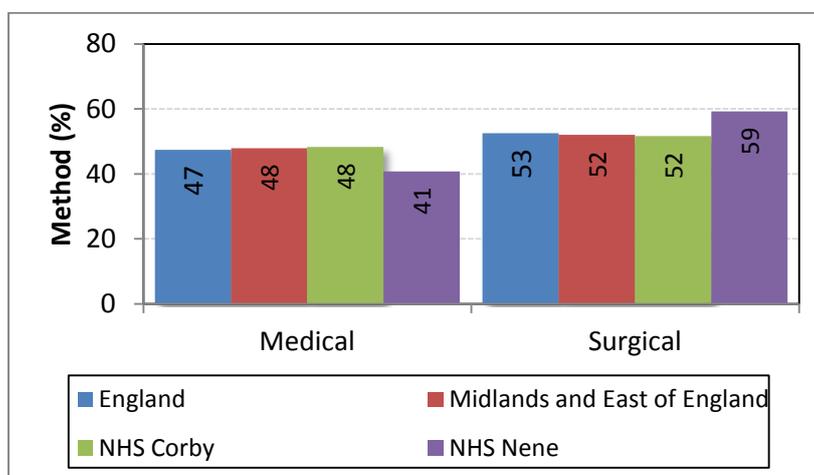
- There appear to be wide inequalities in access to abortion between Nene and Corby CCGs, including poor access to NHS-funded abortions in Corby, poor access to early abortion under 10 weeks in Nene and Corby CCG residents, and poor access to medical abortion for Nene CCG residents, compared to England (see Table 11 and Figure 9).

**Table 11: Early Abortions by CCG, Northamptonshire, 2012**

	Number (%) Under 10 weeks	% 10 weeks +	Total NHS funded abortions	% NHS funded carried out in Independent sector	% medical abortion
Nene CCG	1247(68)	32	1837	53	41
Corby CCG	129 (55)	45	235	17	48
England	132745 (78)	22	171237	64	47

Source: [Sexual Health Balanced Scorecard](#)

**Figure 9: Method of abortion, Northamptonshire, East Midland and England, 2012**



Source: [Chimat](#)

A lower proportion of under 18 conceptions ended in abortion in Northamptonshire (46%), compared to in England (49%), and 1% fewer under-16 conceptions ended in abortion compared to England in 2011 (Tables 4 and 7). These data suggest access to abortions for young women is lower than in England as a whole. This substantiates findings above of sub-optimal access for Corby CCG residents.

### Genito-urinary medicine (GUM) services

Two hubs exist for GU services based in NHFT and St. Marys Hospital with spokes across the county. Full integration of contraceptive and sexual health services has been initiated to provide a better quality and accessible service for the people of

Northamptonshire This could be extended through full integration of contraceptive and sexual health services and by supporting GPs in providing sexual health services.

### **HIV services**

HIV services are provided at the NHFT, and St Mary's Hospital, Kettering, with routine testing of all service users. The UK estimated prevalence of HIV is 1.5/1000 population all ages. With the population of Northamptonshire at 691,900 this would equate to an expected number of 1037 people with HIV.

There were 827 people known to HIV services as HIV positive in Northamptonshire as at March 2013, an increase from 789 in April 2012. Assuming the same prevalence rate as the UK as a whole, this would mean up to 210 people may be unaware of their HIV status. Of those known to services, 78% (643) were on anti-retroviral therapy. The proportion on HIV drugs has risen from 69% in April 2011, suggesting access to specialist treatment has improved.

The numbers of people seen for HIV care across the East Midlands region, with data suppressed at local authority level, in 2012 by risk group for HIV prevention are as follows:

- Black African 1269
- Men who have sex with men 860
- Young adults 16-24 years 109
- People who inject drugs 80
- Black Caribbean 55.

Hence Black Africans and MSM are high prevalence groups for whom specific preventive services are needed.

A late diagnosis of HIV is one where the CD4 cell count is less than 350 cells/ml at diagnosis. Compared to England, 65% of HIV diagnoses in Northamptonshire are made late (Table 13). Late diagnosis is the most important predictor of morbidity and short-term mortality among those with HIV infection, since starting anti-retroviral therapy early improves prognosis. Monitoring late diagnosis rates is essential to evaluate the success of HIV expanded testing.

**Table 12: Late diagnosis (CD4<350/mm3 within three months of diagnosis), Northamptonshire and England, 2009-2011**

	% diagnosed late	Confidence intervals
Northamptonshire	64.8	56.8 - 72.2
England	47	-

Source: APHO [Sexual Health Balanced scorecard](#)

- [It is estimated that 24% of HIV infections were undiagnosed in the UK in 2011, and that diagnosis is least likely in heterosexual men and women born outside Africa.](#)

## What inequalities are there in health status and access to services?

Inequalities have been described above in health status for

- STIs by age, gender (Table 1, Figure 5), ethnicity (Table 13), and socioeconomic status (Figure 7)
- HIV prevalence by age, ethnicity, and geographical area (Table 2, and by sexual behaviour)
- Under 18 and 16 conceptions prevalence by geographical area, a proxy for socioeconomic status (Tables 4, 7 and Figure 8).

For example, compared to white or other groups, people of black ethnic origin are three times more likely, people of mixed ethnic origin are twice as likely, and people of Asian minority as half as likely to receive a STI diagnosis in Northamptonshire (Table 13).

**Table 13: Proportion of Acute STIs diagnosed by ethnic group in GUM clinics in 2012 compared to the general population, districts in Northamptonshire, 2012**

<b>%</b>	<b><i>Black</i></b>	<b>% in general population</b>	<b><i>Not specified</i></b>	<b>% in general population</b>	<b><i>white</i></b>	<b>% in general population</b>	<b><i>mixed</i></b>	<b>% in general population</b>	<b><i>Other</i></b>	<b>% in general population</b>	<b><i>Asian/Asian British</i></b>	<b>% in general population</b>
<b>Corby</b>	3.9	0.9	0	-	93.4	96.2	1.5	1.1	0.6	0.4	0.6	1.6
<b>Daventry</b>	1.4	0.9	1.1	-	93.1	94	2.5	1.1	0	0.8	1.8	2.4
<b>East Northamptonshire</b>	2.2	1.1	0.8	-	94.8	95.2	0.3	1.2	0.8	0.8	1.1	1.6
<b>Kettering</b>	2.7	0.9	0.4	-	92.4	94.3	2.5	1.0	0.6	0.8	1.4	2.8
<b>Northampton</b>	10.1	3.0	0.7	-	77.3	87.9	7.8	2.2	1.2	2.1	2.8	4.8
<b>South Northamptonshire</b>	1.5	1.2	6.1	-	90.1	95.3	1.5	1.2	0.4	0.8	0.4	1.7
<b>Wellingborough</b>	9.0	2.9	1.4	-	82.6	88.7	4.1	2.1	1.1	0.9	1.9	5.4

Source: Northampton Observatory and Local Authority sexually transmitted infections and HIV epidemiology report (LASER): 2012

Inequalities in access to services exist for

- Early abortion (Table 11)
- Medical abortion (Figure 7)
- Chlamydia screening by gender (Figure 11)
- Contraceptive services for women over 35 years and men (Table 10 and user survey)
- Access to early diagnosis of HIV for all at-risk groups.

## Costs of sexual health services

For this report not all financial information was available. [CCGs now commission abortions and vasectomies, local authorities commission open-access sexual health services, and NHS England commissions HIV treatment and care](#). It is not possible to provide a further commentary on these data as they need validating.

**Table 14: Local authority spend, Northamptonshire, 2012/13**

Service	Budget £
Contraception Services	1,250,605
Young People family planning	148,454
GUM	2,322,501
Chlamydia	684,531
HIV prevention	100,000
Total	4,506,091

Source: Northamptonshire Public Health Department

CCG spend on abortion is shown below. The throughput and cost per procedure for a termination of pregnancy ranges almost two-fold. BPAS is the cheapest but also the highest quality with respect to post-abortion contraception.

**Table 15: CCG Spend on abortion services, Northamptonshire, 2011/12**

BPAS	738	£297,357.00	£402.92
KGH	501	£385,360.00	£769.18
NGH	742	£541,580.00	£729.89

Source: Public Health Department

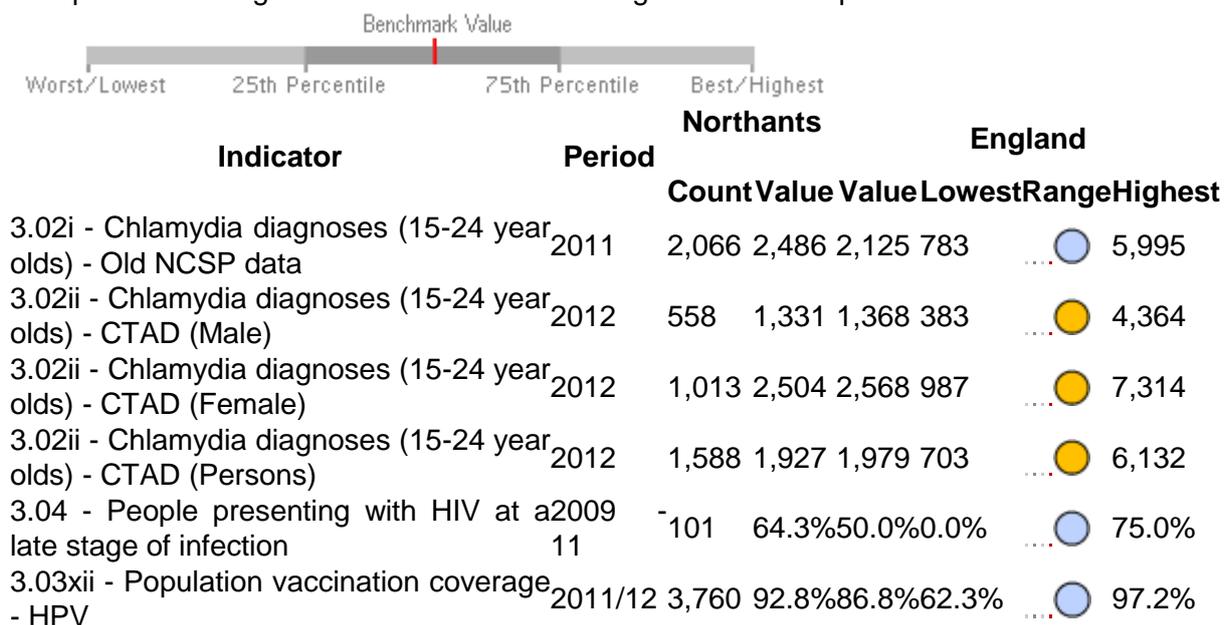
It was not possible to calculate spend per head or benchmark with other areas due to lack of information.

## What is the evidence of progress?

Performance is shown against the relevant Public Health Outcome Framework Indicators below.

**Figure 10: Public Health Outcomes Framework sexual health indicators for Northamptonshire**

Compared with England: ● Lower ● Similar ● Higher ○ Not compared



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There is good progress on

- HPV vaccination and Chlamydia screening (in women) see above. For example, rates of HPV vaccination are higher than England rates and a 20% reduction in infections occurred during 2009-12. Pharmacies are central to this expansion of Chlamydia screening.
- Some preventive programmes for HIV eg The HIV Prevention Partnership for Black Africans at risk of HIV in Corby.
- Reducing under 18 teenage conceptions, in most areas.

- The proportion of people living with HIV on antiretroviral therapy has increased.
- Provision of long-acting reversible contraceptives in primary care is good. However where women request repeat prescriptions of EHC, this suggest unmet need for non-user dependent contraceptive methods. There is good access in Corby to early medical abortions.
- Plans to integrate sexual health services and contraceptive services by Northampton Healthcare Foundation Trust will be complete by January 2014. This will provide evening and Saturday opening in future which is not available at present. Improved access may stabilise the STI infection rate.

## What is the perspective of the public, patients and carers?

There is incomplete information on service users' views, as services do not routinely monitor these. For this report, primary analysis of data from a small (277) user survey was undertaken, and shows the following demographics and preferences for sexual health services.

**Figure 11: User Survey Analysis March 2013**

Characteristic	Proportion surveyed %
<i>Demographics</i>	
Female gender	80
White Ethnicity	81
Black/black British	4.5
Asian	4.2
Mixed	7.5
Age 15-25	69
Aged 25-50	27
Aged 51+	2.9
<i>Knowledge about existing services</i>	
Found out about the service from a teacher	33
Found out about the service from friends	23
Found out about the service from school nurse	17.5
Found out about the service from parents	16.7
<i>Preferred place of contraceptive service</i>	
When needing contraception would most prefer to go to specialist clinic in town centre	37.5
When needing contraception would most prefer to go to a GP	29
When needing contraception would most prefer to go to school/college	13.7

<i>Preferred place of service for sexually transmitted infections</i>	
When needing testing/treatment for an STI would most prefer to go to specialist clinic in town centre	41
When needing testing/treatment for an STI would most prefer to go to a GP	31
<i>Preferred access to service</i>	
Preferred time to attend for contraceptive /STI advice – midweek evening	41
Preferred time to attend for contraceptive /STI advice – midweek day time	32

Source: Public Health Department, March 2013

This survey supports findings elsewhere (Table 10) that clinics are less accessible to men and women over 25 years. For both contraception and sexually transmitted infections service users preferred to go to a specialist clinic in the town centre, followed by their GP, even though their GP would be closer to their home. This suggests there may be a perception that community services are less good, or alternatively, since most people live in urban areas, a clinic in a town centre provides easy access.

## What more do we need to know?

Better information is needed on

- Geographical location of services in relation to need
- Sexually transmitted infections and HIV in people of different socio-economic class, age gender and sexual orientation – small numbers have suppressed their publication
- Sexual health services provided by primary and community contraceptive clinics, and on the degree to which contraceptive services are integrated with them
- The user experience of primary care contraceptive services and abortion services
- The comprehensiveness of teenage pregnancy services in Corby and Kettering.
- Why there is poor satisfaction with school sex and relationships education in the Tell us Survey.
- Expenditure on sexual health by the local authorities, CCGs and NHS England.

## What are the recommendations to improve and support commissioning and forward planning to ensure quality of care and value for money?

A new [national commissioning framework for regional and local sexual health services](#) was published in 2013. Sexual health services should be prioritised since they are highly cost effective. [Health economic benefits](#) of sexual health services are as follows:

- There is strong evidence that investment in sexual and reproductive health & HIV services will reduce future costs to the NHS and to local authority public health budgets.
- Prompt access to high quality sexual health clinical and health promotion services will reduce the onward transmission of sexually transmitted infections (STIs), preventing avoidable expenditure.
- Over £100m in health costs could be saved annually across the country by increasing the use of long acting reversible contraception (LARC).
- The health cost of providing lifetime treatment for people with HIV is increasing nationally by £1 billion each year. Each time a person is prevented from getting HIV, the NHS saves over £350,000. By applying the 2012 UK new HIV diagnosis rate of 1/10,000 population to the Northamptonshire population, an estimated 69 infections are preventable at a saving of £24million.
- People whose HIV is undiagnosed are at particular risk of passing on HIV, and those diagnosed late in the course of their infection are more costly to treat. Reducing the proportion of HIV infections diagnosed late therefore offers significant health economic benefits.
- For every £1 spent on contraceptive services, the net gain to the NHS has been estimated to be £11.

### Prevention

Preventive measures include

- education and health promotion to increase awareness, encourage fewer sexual partners and promote consistent condom use
- screening for sexually transmitted infections
- easy access to sexual health services, with a focus on groups at highest risk, in order to reduce transmission of sexually transmitted infections.

In Northamptonshire, there are rising rates of STIs (gonorrhoea, Chlamydia and herpes), and teenage conceptions rose in Corby and Kettering and South

Northamptonshire between 2008-9 and 2008-10. This suggests safe sex messages are not being communicated effectively.

Thought needs to be given to targeting education, information and risk communication to specific risk groups, including young people, black minority ethnic populations and MSM. There appears to be good coverage but limited quality of education to young people in education, and limited work with black minority ethnic populations. No work with MSM was reported. The extent to which vulnerable groups outside education are targeted is unknown, and therefore likely to be limited. This has particular relevance for young socially disadvantaged people in Corby, Kettering and Wellingborough where it would contribute to reducing teenage conceptions. One quarter of HIV infections are in people who are unaware of their risk or status, particularly non-African born heterosexual men and women. There is good progress on Chlamydia screening but in women rather than men.

### **Treatment services**

STI and HIV treatment services must be highly accessible to all groups, including vulnerable groups. Sexual health is not part of Nene CCG or Corby CCG strategic documents, or the Northamptonshire Health & Wellbeing Strategy. Only Priority 3 of [The Northamptonshire Health & Wellbeing Strategy](#), stated as “Tackling alcohol and drugs issues to protect communities and improve lives”, will assist in the reduction of unwanted pregnancies/acute sexually transmitted infections, through reduced risky sexual behaviour.

STI and HIV treatment services must be highly accessible to all groups, including vulnerable groups. Early diagnosis of HIV is important as earlier treatment improves prognosis, and is cost saving to the NHS (£350,000 per infection prevented). To date, it is known that the opening hours of clinics have been restricted and contraceptive and sexual health services are not integrated. In primary care there is no HIV testing, and limited sexual health provision. This is relevant since STI rates are increasing, and 65% of people with HIV are diagnosed late.

Public Health England has identified HIV at risk groups (young people, black minority ethnic, MSM, intravenous drug users and pregnant women) but outreach testing only occurs in Drug & Alcohol Services, and with black minority ethnic groups in Corby, so missing opportunities in primary care and other venues.

Contraceptive services need to be accessible throughout the reproductive years and of high quality. Yet services appear less accessible to men and women over 35 years. There is good provision of LARC in primary care, but not in hospital services. Corby residents and young people have lower access to abortion services compared to England, and teenage conceptions have increased in Corby, Kettering and

Wellingborough. Abortion services locally show a large variation in cost and quality. A gap analysis is needed.

There is a Northamptonshire Sexual Health Strategy Delivery Action Plan 2011/13. This is comprehensive, but not targeted or prioritised.

Benchmarking costs at local level is not yet possible. [The CCG Commissioning for Value insight packs](#) do not cover local authority commissioned services. Local authorities have had the responsibility to commission open access comprehensive sexual health services since April 2013. All sexual health expenditure needs validating.

The earlier detection and treatment of HIV is a priority. This means education and information and risk communication to specific risk groups, including young people, black minority ethnic populations, MSM, IVDU. Outreach services should be extended in the high prevalence areas – Corby and Northampton. For this report local level data on vulnerable groups was suppressed, but this needs to be shared sensitively with providers and GPs in order to target services.

The optimal way to extend provision and provide a cost-effective and user-friendly service would be to commission primary and community contraceptive and sexual health services as one service, working to the same outcomes to:

- Ensure services are fully integrated
- Map service gaps for STIS, HIV, teenage pregnancy, contraception
- Expand HIV testing
- Review abortion services for quality and access.
- 

## Recommendations

### Prevention

1. *Northamptonshire should produce a sexual health strategy.*

The strategy should

- Have strong leadership.
- Be based on the [National Framework for Sexual Health Improvement in England](#) published in March 2013.
- Prioritise the prevention of poor sexual health
- Join up working with a focus on outcomes, which address the wider determinants of sexual health

- Promote the commissioning high-quality services, with clarity about accountability, meeting the needs of more vulnerable groups
- Include good-quality intelligence about services and outcomes for monitoring purposes
- Enjoin a holistic approach that recognises other physical and mental health problems may result from sexually transmitted diseases and sexual relationship problems.

## 2. Northamptonshire should review sex and relationship education in schools.

The following elements are of particular importance:

- Use a range of evidence-based teaching methods to suit different learning styles, including skills-based programmes, interactive techniques and combined school- or college-based and family-based learning opportunities.
- Set clear health goals – for example, to prevent sexually transmitted infections or prevent homophobic bullying. Be clear about the specific behaviour needed to achieve these goals – for example, using condoms and reducing the number of sexual partners to prevent STIs.
- Build on existing knowledge and provide information that helps children and young people to develop their knowledge, understanding, attitudes and skills and to appreciate the benefits of responsible, healthy and safe choices.
- Include information about sexual health that
  - Clarifies misconceptions about contraception and the prevention of STIs
  - Increases children and young people’s understanding of the short-term and long-term effects of alcohol and drugs on sexual behaviour.
- Adopt active learning techniques that build on pupils’ and students’ existing knowledge, encourage them to explore their attitudes and allow them to practise their personal and social skills.
- Include activities that they can do with their parents and family. This might include preparing questions for a visitor to the class, such as a teenage parent.
- Ensure teachers, lecturers and tutors, health professionals, young people’s practitioners such as youth workers and those who work with parents and carers have access to continuing professional development.

These measures will help address risky sexual behaviour and reduce sexually transmitted infections, HIV and teenage pregnancy, and improve knowledge of services available.

3. *Northamptonshire should promote the prevention and early treatment of sexually transmitted infections and HIV.*

- Ensure that information about local services is available in a range of formats, and is widely available from a range of outlets.
- Such outlets should include health centres, pharmacies, opticians, community services, libraries, schools, workplaces, community organisations.
- Use local indicators to monitor and evaluate the success of prevention initiatives.
- A recent study of GPs in Haringey evaluated the impact of an educational intervention (with no financial incentive) for GP practices. It found that:
  - the intervention was associated with a substantial increase in the number of HIV tests done over a 19-month period
  - the number of HIV-positive diagnoses identified in Haringey general practices rose from an average of 9.5 per annum before training to a projected 22 per annum after training (on the basis of the last six months' data)
  - the highest increases in HIV testing were seen in the locality with the highest prevalence of HIV.
- Promote the provision of a range of more specialist sexual health services in primary and community care
- Encourage non-traditional locations such as schools, colleges, youth clubs to provide education and information about services
- Use new technology such as websites and smart phone apps to communicate with young people and newly diagnosed patients with HIV so they can manage their condition more effectively eg 'myHIV'.

4. *Northamptonshire should ensure condoms are freely available in venues where there is risky sexual behaviour such as bars and nightclubs.*

- Evidence from the *Got it Covered* campaign in 2009 showed that young people did not want to carry condoms for fear of being thought promiscuous.
- Therefore having them freely available in appropriate venues will help prevent unwanted pregnancy, HIV and other sexually transmitted infections.
- Safe sex messages in these venues should be promoted also.

## **Testing and Treatment**

5. *Integrate primary and community contraceptive and sexual health services in order to improve access to men, older women, men who have sex with men (MSM) and Black minority ethnic groups.*

- This will increase coverage and comprehensiveness of services to prevent and treat sexually transmitted infections, HIV and unwanted pregnancy.

- Ensure that there are clear care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.

6. *Northamptonshire should map current services for STIs, HIV, teenage pregnancy, contraception and identify service gaps or access difficulties*

- Guidance from NICE has found that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intra-uterine system or the intrauterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms.
- However, a condom should also always be used to protect against STIs.
- Research with young women having abortions and repeat abortions found that
  - some young people continue to have unprotected sex when they are fully aware of the possible consequences and when they do not want to become pregnant
  - there is a poor understanding of fertility among young women, and this contributes to inconsistent contraceptive use;
  - some young people struggled to use their preferred methods of contraception effectively (principally condoms and the pill, which are user dependent)
  - abortion was viewed as immoral by many young women and this makes decision making difficult when faced with unplanned pregnancy.
- Patient and public involvement (PPI) is important to assess the quality of current services including the accessibility in terms of geography, opening hours, cultural sensitivity and whether they meet patients' needs.
- The London Sexual Health Programme has a website which provides a practical [toolkit to assist in PPI](#).
- Speaking to clinicians and staff in the sexual services together with PPI will allow an assessment of geographical distribution of services in relation to local need so gaps can be filled.

7. *Review of multifaceted approach to teenage pregnancy services for Corby, Kettering and South Northamptonshire and address gaps appropriately.*

[A multifaceted approach is needed to reduce teenage conceptions](#) with the following four strands are:

- A media campaign to give young people accurate information about sex.

- Local joined-up action, eg education and health working together, targeting high-risk groups such as children leaving care.
- Development of Sexual Relationship Education (SRE) in and out of school, and improved access to sexual health and contraception services.
- A positive, coordinated support for young pregnant women and their partners. This includes improving educational attainment for teenage boys and girls.
- Evidence-based multifaceted inputs are required to address teenage pregnancy in high incidence areas, including targeting services to particular groups such as looked after children.

#### *8. Expand HIV testing.*

- More effort should be made to diagnose HIV in people registering with their GP or during hospital attendance, especially among minority ethnic groups.
- GP point-of-care testing could be considered.

#### *9. Review abortion services to improve population access to early abortion.*

- Women who request an abortion should have early access to services, as the earlier in pregnancy an abortion is performed the lower the risk of complications.
- Unwanted pregnancy is experienced by women from all social backgrounds. The numbers of abortions nationally has increased slowly until 2008 and have remained relatively stable since then. However, repeat abortions have risen over the last decade and there was a further 2% increase in 2011, when 36% of all abortions were repeats. Abortion rates have fallen in younger age groups but are increasing in older women.
- The review should address inequitable access to abortions for Nene CCG residents and will aim to recommend how improved access to early abortion will be achieved.

## Appendix: References

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