Essex Sexual Health Needs Assessment

Summary

Good sexual health enables healthy relationships, planned pregnancies and prevention of disease. It is important to all individuals throughout their life course which contributes to maintaining and improving population health. Most of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and populations.

Sexual ill health is not equally distributed within the population, with geographical areas and particular population groups experiencing disproportionate amounts of poor sexual health.

This sexual health needs assessment aims to understand the current sexual health of the Essex population, and any gaps in service provision). It explores the evidence of what works to improve sexual health and makes recommendations for areas of improvement for consideration by the various organisations responsible for components of the sexual health "system" in Essex.

Recommendations:

- Sexual health service to improve data recording to assist understanding of service engagement and associated inequities. This include improving report of outcomes for those with disability, Looked After Children and those leaving care, LGBTQ+, Sex Workers, those engaging with chemsex, immigrants, gypsy travellers and those in or transitioning from the criminal justice system
- Public health responses to MSM and risk in relation to HIV and other STIs need to be able to reach not only identified gay and bisexual men but also target men identifying as heterosexual.
- Maximise the opportunity of Integrated Care Systems and partnership opportunities for more integrated approaches to governance, planning and delivery (eg. HIV treatment & prevention and access to contraception)
- Closely monitor HIV testing vs HIV late diagnosis rates in the Essex population. Learn from HIV late diagnosis through look backs of missed opportunities.
- Seek to understand current opportunities and challenges to increase condom distribution across Essex
- Monitor impacts of Over The Counter contraceptive pill availability (may remove barriers to access but also increase inequalities for those who cannot afford)
- Monitor new and emerging threats such as Mgen, antibiotic resistant infections

Introduction (include aim & purpose and definition of scope)

Sexual Health is an important public health issue. Prevention, early diagnosis and high quality, timely treatment are important public health interventions to improve reproductive and sexual health. Easy access to contraception can reduce unplanned pregnancies, which can impact on families and public-sector services. Sexually transmitted infections (STIs) can potentially have serious implications for the health and wellbeing of infected individuals and be costly to healthcare services. If undiagnosed and therefore untreated, STIs can cause a range of complications and long-term health issues.

Since the Health and Social Care Act (2012)[1], the commissioning of sexual and reproductive health services has been shared across Local Authorities (LAs), Clinical Commissioning Groups (CCGs) and NHS England (NHSE). An understanding of these responsibilities is important in enabling organisations to work in partnership to provide the public with integrated and accessible services. Table 1 explains how this responsibility is currently shared across different organisations in England.

Table 1 Organisational responsibility for commissioning sexual and reproductive health services.

Local Authorities	Clinical Commissioning Groups	NHS England
Comprehensive sexual health services including most contraceptive services and all prescribing costs, excluding GP provided contraception	Most abortion services	Contraception provided as an additional service under GP contract (delegated to clinical commissioning groups)
STI testing and treatment, chlamydia screening and HIV testing	Sterilisation	HIV treatment and care (including drug costs for PEPSE)
Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies.	Vasectomy	Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs (delegated to clinical commissioning group)
	Non-sexual health elements of psychosexual health services	Sexual health elements of prison health services
	Gynecology including any use of contraception for non-contraception purposes	Sexual assault referral centres
		Cervical screening
		Specialist fetal medicine services

Source: Public Health England- Health Matters

Making it Work[2] recommends that sexual and reproductive health services are provided with the patient at the centre, with commissioning organisations working closely together to ensure that services are holistic, integrated and collaborative. The Local Government Association[3] further recommends collaborative commissioning to improve outcomes for patients.

It is important to understand the need for services when planning and implementing delivery. This understanding enables appropriate service for the local population.

There are several different types of need, as illustrated in Table 2 below.

Table 2 Types of need (Bradshaw).

Type of need	Definition	Example
Normative need	Need that is decided by experts.	Vaccinations Blood borne virus testing
Felt need	Need that is felt by individuals	Symptoms of STIs
Expressed need (demand)	Felt need that results in attending services	Going to a sexual health service
Comparative need	The comparison of needs between and within different population groups which may or may not be seen through engagement with services	Some groups of people may require different service (for example Looked After Children are likely to have specific sexual and reproductive health needs that require tailored services)

This needs assessment will mainly investigate expressed need, based on people accessing services or being diagnosed with a condition. There will be people who may experience symptoms (felt need) but do not access services, potentially because the services are not known to them, or because the stigma associated with services prevents them from engaging. In addition, there may be groups of people where the evidence states that they are at an increased risk of

STIs or unplanned pregnancy (normative need) but these groups do not see themselves as such. It is therefore important that services are aware of who isn't engaging and make efforts to reduce/remove barriers to access.

There are three approaches to health needs assessment:

1. Epidemiological. This approach considers the epidemiology of the condition, current service provision, and the effectiveness and cost-effectiveness of interventions and services.
2. Comparative. This approach compares service provision between different populations. Large variations in service use may be influenced by a number of factors.
3. Corporate. This approach is based on eliciting the views of stakeholders including professionals and the public.

This needs assessment will incorporate elements of all three approaches.

The aims of this needs assessment are to:

- Influence the strategic direction of sexual and reproductive health workstreams across Essex
- Inform prevention and commissioning activity, guiding and influencing organisations across Essex.

The needs assessment will do this through analysing and presenting information of local population sexual and reproductive health needs, defining evidence-based approaches to improving sexual health and suggesting options for future approaches.

Outside of scope:

This needs assessment will not consider need specific to sexual violence, the human papillomavirus

(HPV) vaccination programme, cervical screening programme and vaccinations delivered by Sexual Health Service (eg. Hepatitis A). It also doesn't consider HIV Treatment, Gynaecological specific treatments eg. fertility or menopause. The assessment doesn't consider sexual health testing and treatment delivered in private clinics or prisons

Intelligence on current situation: At risk groups

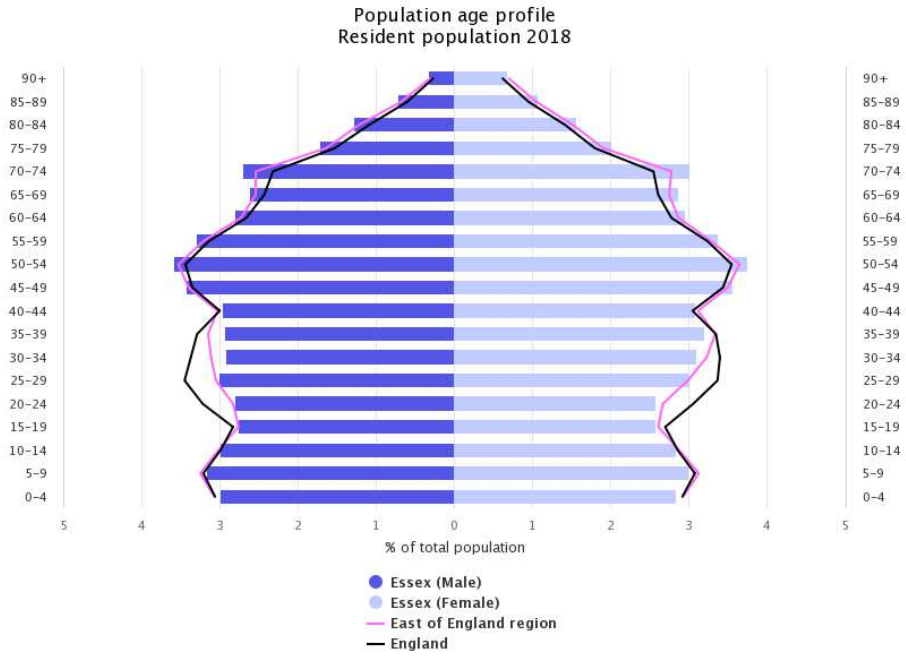
Age and Sex:

The age profile of districts in Essex are likely to have a significant impact on the need for sexual health services in each area. Young adults have the highest rates of abortion (which peak at the age of 22 in England and Wales), and the highest number of unplanned pregnancies (62% of which occur in 20-34-year old's in the UK)[4,5]. They are also more likely to be diagnosed with common STIs such as chlamydia, gonorrhoea, herpes and warts compared with other age groups (rates are highest in the 20-24 age group in the UK)[6,7]. These figures could be in part due to the higher number of sexual partners and less reliable condom use reported in young adults[8]. However, they could also be related to higher rates of sexual health clinic attendance[9], and increased chlamydia screening of under 25s through the National Chlamydia Screening Programme (NCSP).

It is important to note that although the risk of most STIs reduces with advancing age, people remain sexually active (and continue to have new sexual partners) into older age, meaning that they are still susceptible to infection[9]. In fact, the incidence of STIs in older people may be rising, although due to small numbers increases in STI diagnosis among people 65 years and older should be interpreted with caution.

The below population pyramid shows that Essex has an age structure with a similar proportion of females to the regional and national average for under 50's and a slightly lower proportion of males, however there are a greater proportion of older people in both sexes in Essex.

Figure 1: Population Pyramid for Essex Resident population 2018:



The latest population estimates for Essex suggest there are 1,489,189 people residing in Essex. Using the age groupings selected within the Sexual health services we can estimate the percentage of the Essex population who engaged with an Essex Sexual Health Service in 2019/20, this is detailed in the table below, split by Age and Sex.

Table 3: Essex Sexual Health Service attendance by age group

	% of estimated Essex population attending SH service 2019-20		
Age group	**All**	**Male**	**Female**
<15	0.0%	0.0%	0.1%
15	1.0%	0.3%	1.7%
16-19	11.5%	6.4%	17.0%
20-24	23.3%	16.6%	30.6%
25-34	12.0%	10.1%	13.7%
35-44	4.5%	4.1%	5.0%
45-64	1.3%	1.4%	1.2%
65+	0.1%	0.2%	0.1%

There are an estimated 384,556 Females aged 13-44 years (childbearing age) across Essex. This information is particularly important for the organisation of sexual health services for women, including cervical screening, colposcopy, contraception and teenage pregnancy services. The above table shows a higher proportion of females are engaged with the Essex Sexual Health Service than males, particularly in the 20-24 age group.

Deprivation:

Poor sexual health and unintended teenage pregnancy and abortion are strongly linked with area deprivation. For example, there is a 6-fold difference in teenage conceptions and birth rates between the poorest areas in England and the most affluent.[10] In addition, under-18 conceptions can lead to socioeconomic deprivation and low levels of educational attainment.[10]

The table below shows the number of registrations to an Essex Sexual Health Service since 2016 split by the Indices of Multiple Deprivation (IMD) decile of their residence. IMD's use a number of health and social indicators to create a score for every postcode in the country, these are grouped into 10 (deciles) and ranked low to high. IMD decile 10

is the most deprived areas and IMD decile 1 is the least. When calculating the rate per 1,000 of that decile's population we can see that the more deprived an area the higher the rate of registrations to a Sexual Health Service.

Table 4: Essex Sexual Health Service Registrations by IMD decile

IMD decile	Registrations since 2016	Population estimated for each decile	Rate of registrations per 1,000 population
1	4,440	51,760	85.8
2	6,993	75,441	92.7
3	10,156	125,251	81.1
4	11,899	146,581	81.2
5	12,959	177,825	72.9
6	10,777	167,729	64.3
7	10,132	168,262	60.2
8	11,876	200,922	59.1
9	9,729	188,260	51.7
10	9,487	187,158	50.7

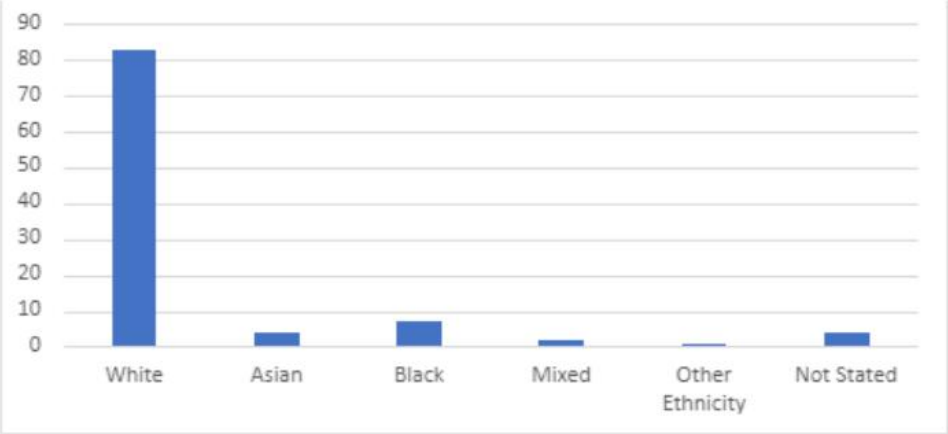
Ethnicity:

The prevalence of different ethnic groups has important implications for the sexual health needs of the population. Evidence suggests that black Caribbean people, black African men and mixed ethnicity women have more sexual health clinic use compared with white British men and women.[11] In addition, black Caribbean men and mixed ethnicity women are more likely to report a recent STI compared with white British men and women[11]. The number of new HIV diagnoses among UK heterosexual adults in 2018 was also highest in black African adults[12]. These ethnic differences are not necessarily due to a greater prevalence of disease in these groups. Instead, they could reflect differences in knowledge and health seeking behaviour and indicate that other groups are underdiagnosed.[13,14]

Emergency contraception use also appears to vary according to ethnicity. For example, in one survey, Indian and Pakistani women were less likely to report having used emergency contraception than white British women[15]. Again, it is unclear whether this is due to a reduced need for emergency contraception in these populations or to a reluctance/inability to access services.

The below graph shows registrations to the Essex Sexual Health Service by ethnic group since 2016.

Figure 2: Proportion of new Registrations to Essex Sexual Health Service by Ethnicity 2016-2021



Disability:

People with physical disabilities encompass a broad population, including those with concomitant mental and cognitive impairments. People with physical disabilities have significant sexual and reproductive health disparities when compared with the general population and higher rates of sexual distress. There are specific sexual health concerns for men and women with physical disabilities and approach to their care needs to be interdisciplinary[16]. There is limited evidence concerning the sexual health of people with learning disabilities[17].

Disability is currently not a routinely reported field in Essex Sexual Health Service data collection so it is not possible to know what proportion of those using the service are disabled.

Looked After Children (LAC):

In 2020 Essex had 1071 children who were in the care of Essex County Council. LAC experience poorer sexual health outcomes than adolescents who have never been in looked after care. These include increased rates of early sexual activity, greater numbers of lifetime sexual partners, poorer contraceptive use, and increased rates of STIs, teenage pregnancy/parenthood, sexual exploitation/assault and rape[18]. Local Authorities have a duty to safeguard and promote the welfare of the children they look after. This includes the promotion of good sexual health. Statutory guidance suggests that sexual health should be a key area of focus for promoting the health and wellbeing of looked after children, with a particular focus on care leavers, however there appears to be a lack of evidence of how best this is done for this cohort. The National Institute for Health and Care Excellence (NICE) provides some relevant recommendations on tailoring contraceptive services for socially disadvantaged people[10], although this is not specific to LAC.

LAC Status has not previously been reported in the dataset for the Essex Sexual Health Service and so has not been collected. For this reason it is not possible to know what proportion of those using the service are or were LAC. Whilst this is not reportable by the service, it is recorded as part of the ESHS holistic clinical assessment with Disclosure of LAC status being recorded as a 'vulnerable person'.

LGBTQ+

There are not currently accurate figures of the size of the LGBTQ+ population across Essex or nationally.

A 2021 ONS report using 2019 data[19] highlighted that the proportion of the UK population aged 16 years and over identifying as heterosexual or straight has decreased from 94.6% in 2018 to 93.7% in 2019. The report estimates that 2.7% of the UK population identified themselves as Lesbian, Gay or Bisexual (LGB). Of all age groups, younger people (aged 16-24 years) were most likely to identify as bisexual than as LGB. There is variation between regions London most likely to identify as LGB (3.8%), the East of England proportion of the population identifying as lesbian, gay or bisexual is 2.1%.

MSM

The term 'MSM' is intended *"to encompass the full range of men engaging in same sex sexual activity, regardless of their expressed sexual orientation or identity*[20]. In 2018, 75% of diagnoses of infectious syphilis nationally were amongst gay, bisexual and other MSM[21].

Nationally, diagnosis rates of syphilis, gonorrhoea and chlamydia are greatest in HIV-diagnosed MSM. Of new STI diagnoses nationally in MSM in 2019, gonorrhoea (44%) and chlamydia (30%) were the most common[22]. Public Health England suggest that whilst increases in gonorrhoea may be due to improved detection it may also be due to increases in high risk sexual behaviour such as chemsex, group sex and increased partner numbers and condomless anal intercourse. The increased use of online contact sites and apps is also considered to be a potential factor in increased high-risk activity.

Analysis of HIV diagnoses between 2002 and 2010 found that at least 6% of self-reported heterosexual men may have been infected with HIV through sex with other men, and as many as 21% of black African heterosexual men[23]. Of all MSM groups, heterosexual identifying men who have sex with men are most likely to be diagnosed with late stage HIV and may also be placing heterosexual partners at higher risk[24].

This means that public health responses to MSM and risk in relation to HIV and other STIs need to be able to reach not only identified gay and bisexual men but also target men identifying as heterosexual.

Chemsex:

Chemsex is *"the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience"* [25], commonly involving crystal methamphetamine, GHB / GBL and mephedrone, as well as other stimulants and ketamine. Chemsex and broader 'sexualised drug use' (SDU) (involving a wider range of substances) can increase the risks of physical harm (including overdose, sexual assault, and physical injury), blood borne virus, STI transmission and mental health problems**Error! Bookmark not defined.**[,26].

Whilst most MSM do not use drugs, or engage in chemsex, national data from 2011-14 Crime Surveys for England and Wales reported that drug use was around three times higher among gay and bisexual men (12%) than heterosexual men (4%), with use of stimulants five times higher, methamphetamine 15 times higher and alkyl nitrates 19 times higher[27,28].

There is evidence of subgroups of MSM participating in chemsex and SDU across the UK, though prevalence estimates vary greatly[29]. Evidence from studies highlight the importance of effective harm reduction information, and for sexual health services to be gay / MSM friendly and able to address concerns about chemsex, drug use and psychosocial aspects of health arising from the activity.

Lesbian, Bisexual and Women who have sex with women:

UK evidence suggests that the sexual health needs of lesbian, bisexual and women who have sex with women is neglected[30]. Whilst Lesbian and Bisexual women may have their own specific sexual health needs, there can be a lack of recognition of these. This cohort may have higher rates of some STIs, primarily bacterial vaginosis, however they may be less likely to have undertaken STI testing than heterosexual women[31].

Lesbian, bisexual and women who have sex with women are also likely to experience unmet needs across the UK in relation to reproductive health, with research highlighting barriers to accessing sexual health services, maternity and infertility treatment services based on the heterosexual / heteronormative assumptions of services and practitioners[26]. Whilst, therefore, there can be a focus on gay, bisexual and MSM within 'LGB' sexual health provision, it is important to consider the needs of lesbian, bisexual and women who have sex with women when developing accessible reproductive and sexual health services.

Transgender and Non Binary:

Trans is a term used to describe people whose gender identity differs from the sex they were assigned at birth. The term encompasses a range of identities including trans man, trans woman, transgender, genderqueer, non-binary and agender.

Evidence also shows that prevalence rates for bacterial sexually transmitted infection can be higher amongst trans people[32]. Trans people may also need sexual health services that are responsive to, and can link with support around, gender dysphoria, as well as being able to offer knowledgeable services for those who are considering, are in the process of, or have completed gender transition.

Transgender people, as a group, may experience severe disadvantage, prejudice and discrimination in accessing appropriate and timely health care[33,34]. Trans individuals can experience multiple barriers when accessing sexual health provision, from gender segregation in clinical spaces to mis-gendering or making assumptions about sexual activity[29].

Sex workers:

The broad definition of 'sex work' is disputed, but generally covers activity where sex is exchanged for money, accommodation, drugs, status or other goods. Formal, or commercial, sex-work is regarded as a commercial activity where adults receive money in exchange for sexual services. Whilst estimates of a sex worker population are difficult for many reasons (including definition, reluctance to disclose etc.), a 2015 study estimated the total number of adults

involved in sex work across the UK to be around 72,800[35]. An estimated 65% of this population were female sex workers (FSWs), with 35% male (MSWs) or transgender.

Sex work takes place in a range of venues and for a range of reasons, from 'survival sex work', by those in social and economic need, to high income escort work. Street-based sex work, which is often low income survival sex, is estimated to account for around 10-15% of overall sex-work, with off-street work including sex-work from private residences, hotels, saunas and brothels. Recent years have witnessed an increase in online contacts and off-site work[36]. There is also evidence to suggest that an increasing number of migrant women have become involved in sex work. Many of these women are considered to be vulnerable, with a 2010 study suggesting that around 15% were trafficked**Error! Bookmark not defined.**.

Factors associated with sex work, such as multiple sexual partners, violence and drug use, pose increased risks to sex workers. Sex workers can also experience additional barriers to accessing sexual and other health services. Studies of male and female sex workers accessing sexual health services in England found both increased risks of some STIs (chlamydia and gonorrhoea, as well as HIV in MSWs) and higher reinfection rates than the wider population[37,38]. Female sex workers are also considered to be at an increased risk of cervical cancer due to high HPV exposure[39].

Undocumented or irregular migrants

For undocumented women, an unplanned pregnancy can result in significant emotional and economic hardship. They often have more limited access to contraception, and limited mobility so travelling outside their country of residence to access services is not an option. Restrictive access to contraception and to termination of pregnancy therefore has a disproportionately negative impact of undocumented women and girls.[40,41]

HIV testing, prevention and treatment services to refugees and migrants, regardless of their immigration status should be provided nationally and locally. Migrants and refugees – and particularly undocumented migrants – remain a priority for HIV prevention and treatment for the ECDC, which has identified social exclusion, inadequate access to HIV services, and fear of stigmatisation as factors increasing the likelihood of HIV infection after their arrival in UK and other European countries.[42]

Although HIV testing and treatment is exempt from charging, there is substantial confusion surrounding health-care eligibility, both among patients and professionals. Vital opportunities for the diagnosis of STIs including HIV in other, chargeable health-care settings are lost by deterring access.[43,44,45]

Those who had experienced non-volitional and transactional sex were also more likely to be HIV positive. Women, men, and unaccompanied asylum-seeking children may experience sexual and gender-based violence in their country of origin and en-route to or in the UK. Men who have sex with men are particularly at risk of HIV acquisition after migration. Based on these findings, migrants in the UK might be at increased risk of HIV and sexually transmitted infections[46].

Migrant status has not previously been reported in the dataset for the Essex Sexual Health Service and so data has not been collected. For this reason, it is not possible to know what proportion of those using the service were from migrant populations. Whilst this is not reportable by the service, it is recorded as part of the ESHS holistic clinical assessment with disclosure of undocumented/migrant status being recorded as a ‘vulnerable person’.

Criminal Justice System:

NHSE&I is responsible for commissioning most healthcare for people in prisons and young offender institutions in England. Services are commissioned on the principle of equivalence. This means that people in prison should be able to access barrier protection and lubricants, genitourinary medicine (GUM) services, appropriate sexual health screening programmes (such as chlamydia screening) and immunisations as they would in the community.

NICE guidance recommends that people who are in prison should be offered information about STIs and available sexual health services, and should have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them[47]. Guidance from the National Health & Justice Team, Public Health England on Public Health

services for people in prison states that all people in prison and other places of prescribed detention are entitled to: be aware of means of accessing condoms and contraception in prisons as well as access to social and life skills modules on relationship and sex education (RSE). There should also be access to a GUM service (either provided externally or in house)[48].

Gypsy and Traveller

People from Gypsy and Traveller societies are also particularly vulnerable to poor sexual health. Some Gypsy and Traveller communities have significant challenges around sexual health, gynaecological matters and pregnancy related issues especially if women are being cared for by male staff.[49] An estimated 200,000 and 300,000 Gypsies, Roma and Travellers live in the UK: two thirds are settled in homes rather than travelling. Low rates of cervical and breast screening have been found amongst these communities, with women expressing particular reluctance to attend clinics with no guarantee of female staff. Most are also opposed to sex education and information about contraception at school. Parents cite inclusion of sex education in the school curriculum as a reason for non-attendance or early school leaving.[50]

Gypsy and Traveller communities in particular experience difficulties accessing sexual health services and are often reluctant to seek treatment because of their cultural beliefs about health or an underestimation of the seriousness of a condition. The nomadic lifestyle complicates access to appropriate care: registration can be difficult, information is not being shared, and patients may have difficulty articulating their needs. [49,50]

Gypsy/ Traveller status has not previously been reported in the dataset for the Essex Sexual Health Service and so data has not been collected. For this reason, it is not possible to know whether what proportion of those using the service are or were from the Gypsy/ Traveller community. Whilst this is not reportable by the service, it is recorded as part of a holistic clinical assessment, with Disclosure of Gypsy/ Traveller status being recorded within free text.

The outreach service from the Essex Countywide Traveller Unit encourage engagement with education including RSE, as well as supporting individuals to access sexual health services. Insight from this service suggests that clarity of information of where to go for sexual health services, availability of appointments and distance to travel to clinics have all been barriers to access.

Sexual Health Service Data:

Open access services

Local Authorities are mandated to deliver open access sexual health services (Health and Social Care Act 2012), data from the Essex Sexual Health Service suggests that we are a net exporter of service provision (in 2019/20 around 5% of Essex resident sexual health provision is delivered by services outside of Essex, although the Covid-19 pandemic has led to more localised provision). Factors affecting out of area access include; proximity to London and commuting for work, proximity to other geographical neighbours (eg. Thurrock, Southend and Hertfordshire) and those who are university students in other areas of the country.

The data used in the following sections is for Essex residents who may be users of the Essex Sexual Health Service or out of area services. The data for 2019 has been used as the most up to date data not interrupted by the Covid-19 pandemic. Trend data does include data from 2012-2020 and in all cases there is a drop off during 2020 as a result of Covid-19.

STI diagnosis and prevalence

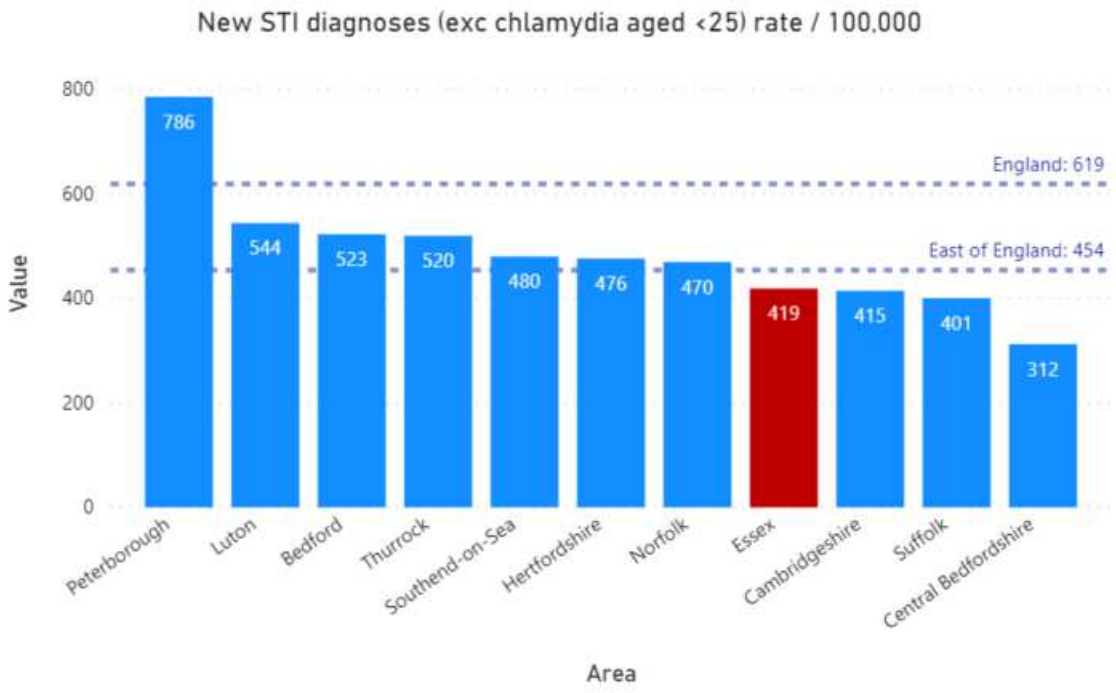
STI testing and positivity

STIs are infections that are spread primarily through person-to-person sexual contact. According to the World Health Organization, throughout the world more than 1 million people acquire an STI every day. Prevention and control of STIs through barrier contraception can help reduce the spread of HIV and reduce the risk of unplanned pregnancy. The range of STIs that occur commonly varies between different countries. Non-UK born patients may present in

England with STIs that are less commonly seen here. There are more than 30 different specific sexually transmissible bacteria, viruses and parasites. The most prevalent in England are considered in this section.

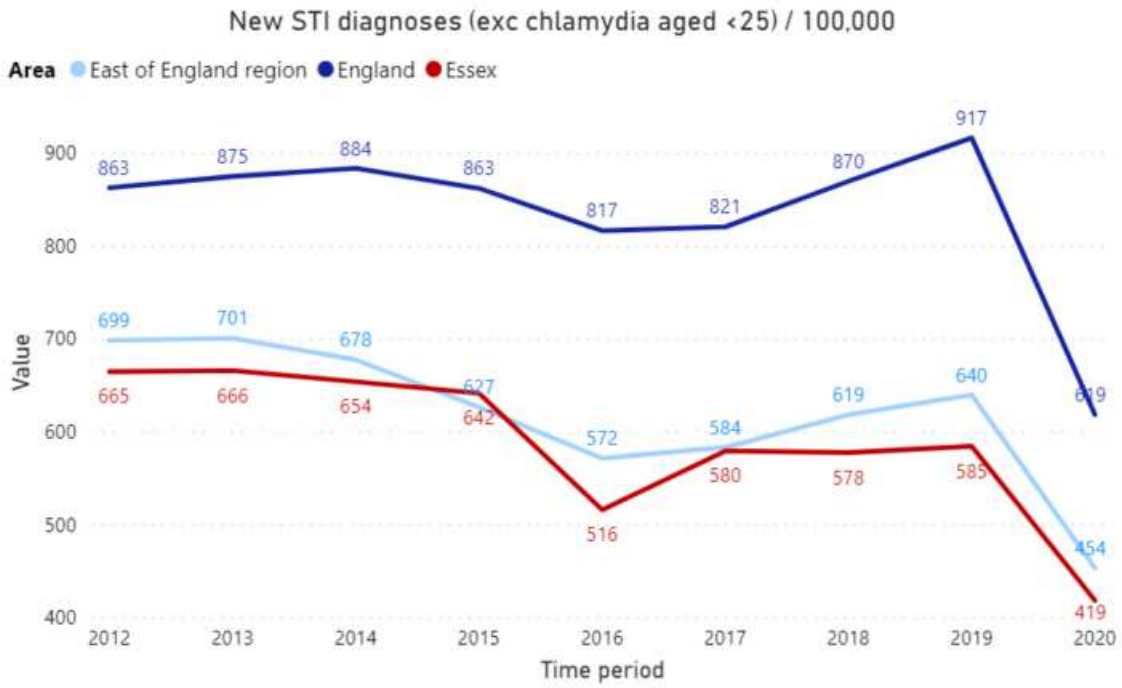
The graph below shows STI diagnoses excluding chlamydia in those aged under 25 per 100,000, comparing Essex to other Local Authorities in the East of England and the England average. The graph shows that Essex had significantly fewer STI diagnoses during 2019 than the England average. This is against a testing rate that is slightly lower than the East of England average and lower than the England average.

Figure 3: 2019 New STI diagnosis (excluding chlamydia aged ,25) per 100,000 by East of England Upper Tier Local Authority



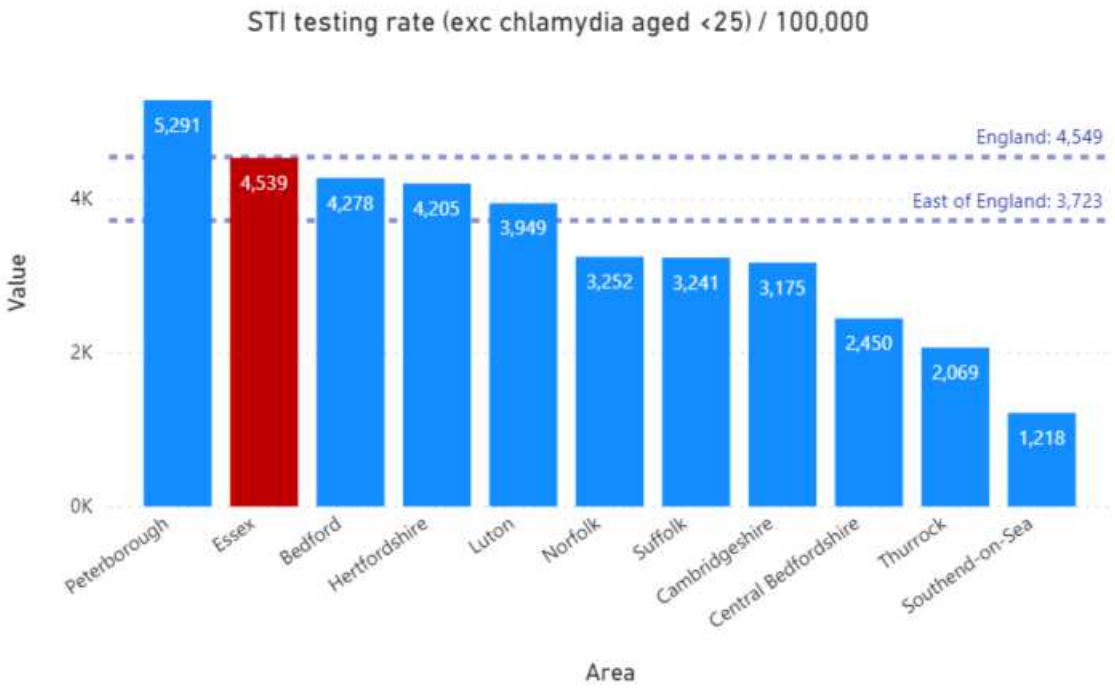
The 2019 data follows a trend of Essex having a rate of diagnosis that is below the England average. The below graph shows Essex compared to the England average over the past 7 years.

Figure 4: New STI diagnosis (excluding chlamydia aged <25) per 100,000 for Essex 2012-2019



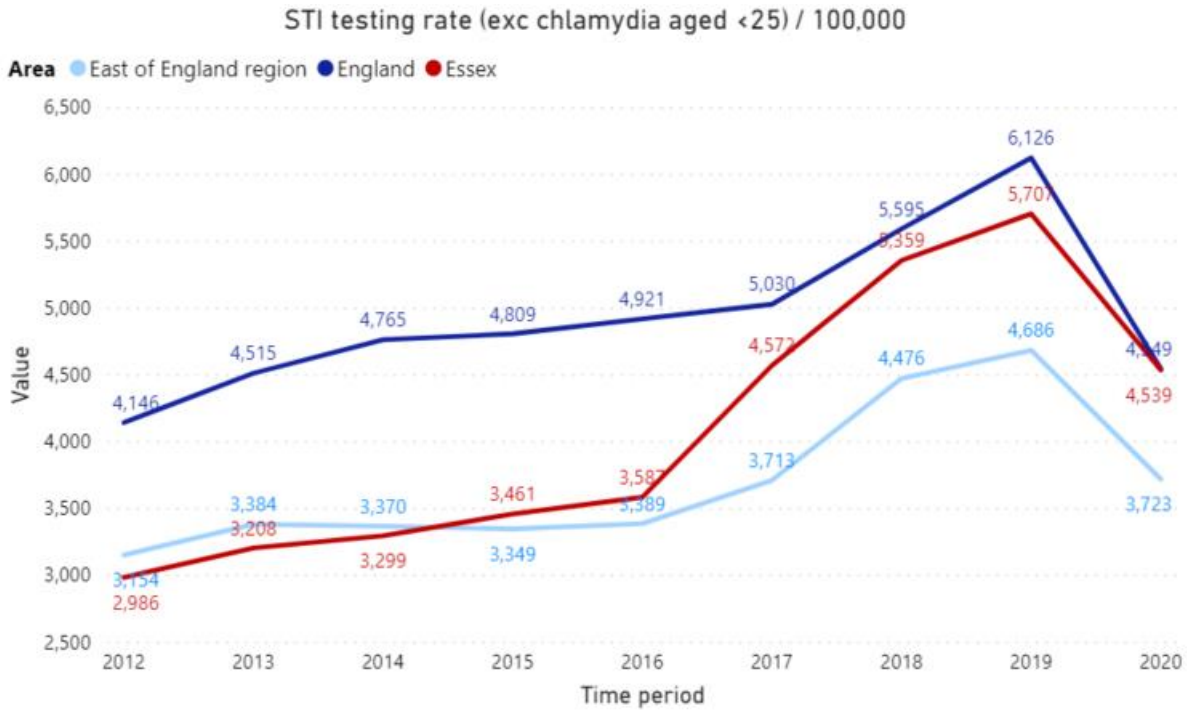
STI diagnosis rates can be affected by the testing rate in the population, the below graph shows variation in the testing rates for all STI's excluding Chlamydia in those aged under 25 across the East of England during 2019. Essex has a testing rate significantly lower than the England average but similar to the East of England average.

Figure 5: 2019 STI testing rate (exc chlamydia aged <25) per 100,000 by East of England Upper Tier Local Authority



The 2019 data follows a similar trend to previous years, the graph below shows STI testing rates in Essex compared with the England average over the past 7 years.

Figure 6: 2019 STI testing rate (exc chlamydia aged <25) per 100,000 for Essex 2012-2019



Positivity rates are the percentage of people who test positive of all the people that take a test. A high positivity rate suggests that there may be high prevalence, however targeted testing can also impact on positivity rate as a perfectly targeted testing programme would result in 100% positivity. Essex's positivity rate in 2019 was the same as the East of England average and lower than the England average.

Figure 7: 2019 STI testing positivity rate (excluding Chlamydia aged <25) per 100,000 by East of England Upper Tier Local Authority

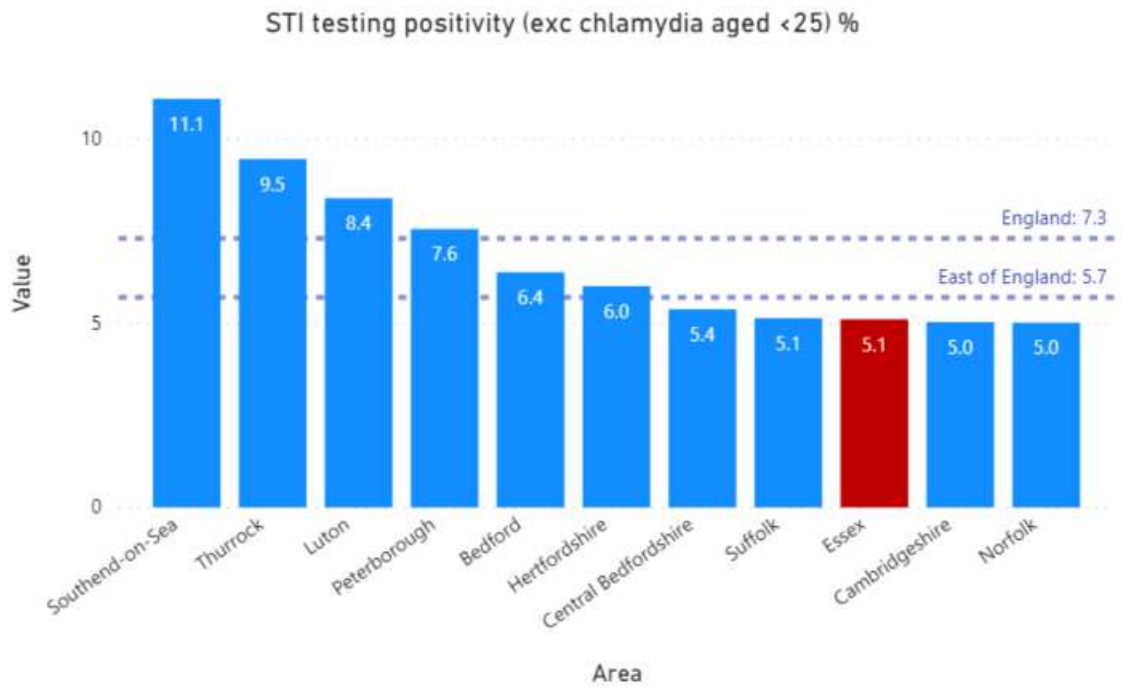
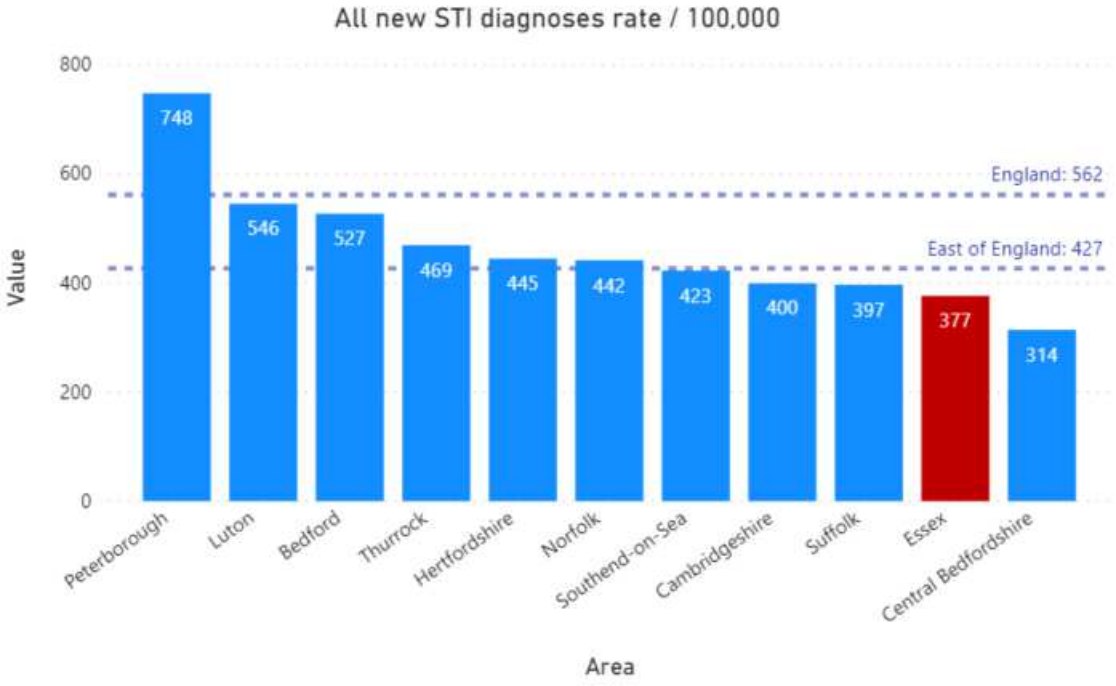


Figure 8: 2019 All STI diagnosis rate per 100,000 by East of England Upper Tier Local Authority

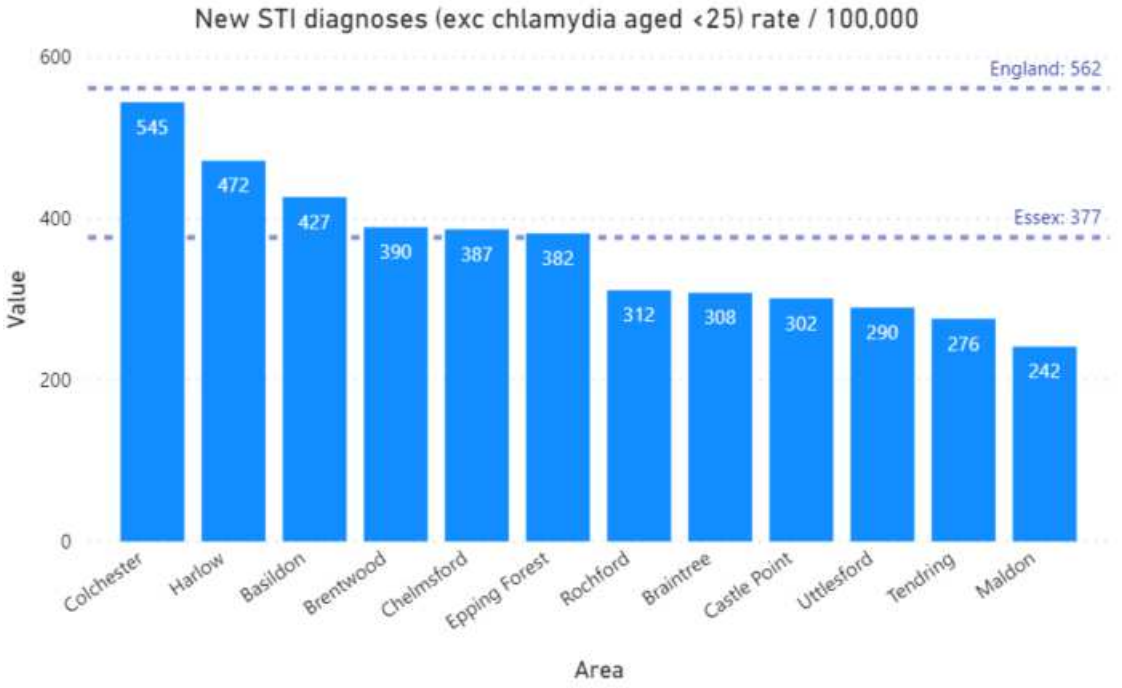
The graph below shows the STI diagnosis rate for all STI's in East of England during 2019. Essex had a significantly lower rate (525 per 100,000) than the England average (816 per 100,000), and similar to the East of England average.



Comparisons within Essex:

There is variation within Essex around STI diagnosis rates, testing rates and positivity rates. Figure 9 shows that in Colchester STI diagnosis rates are statistically similar to the England average in 2019, all other districts are lower than the England average.

Figure 9: 2019 All STI diagnosis rate per 100,000 by Essex lower tier Tier Local Authority



STI testing rates also vary between the districts within Essex, Figure 10 shows that Harlow has the highest testing rate (20835 per 100,000) which is higher than the England average. Harlow is statistically similar to the England average. All other districts have a rate that is statistically significantly lower than the England average (19654 per 100,000).

Figure 10: 2019 STI testing rate (exc chlamydia aged <25) per 100,000 by Essex lower tier Tier Local Authority

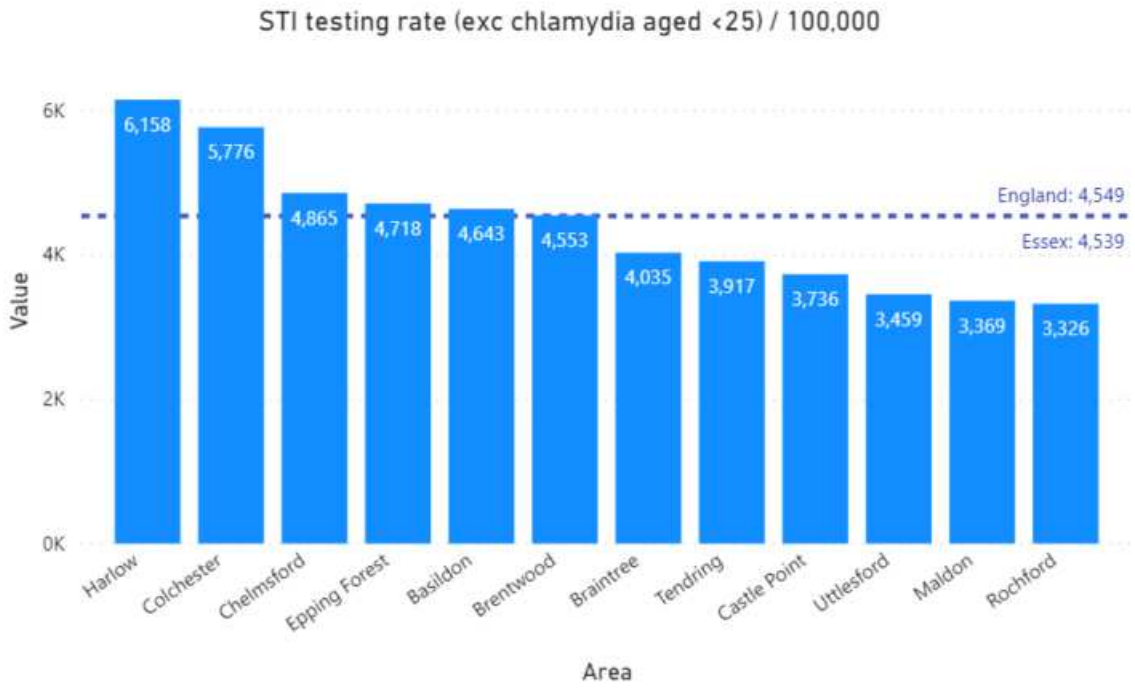
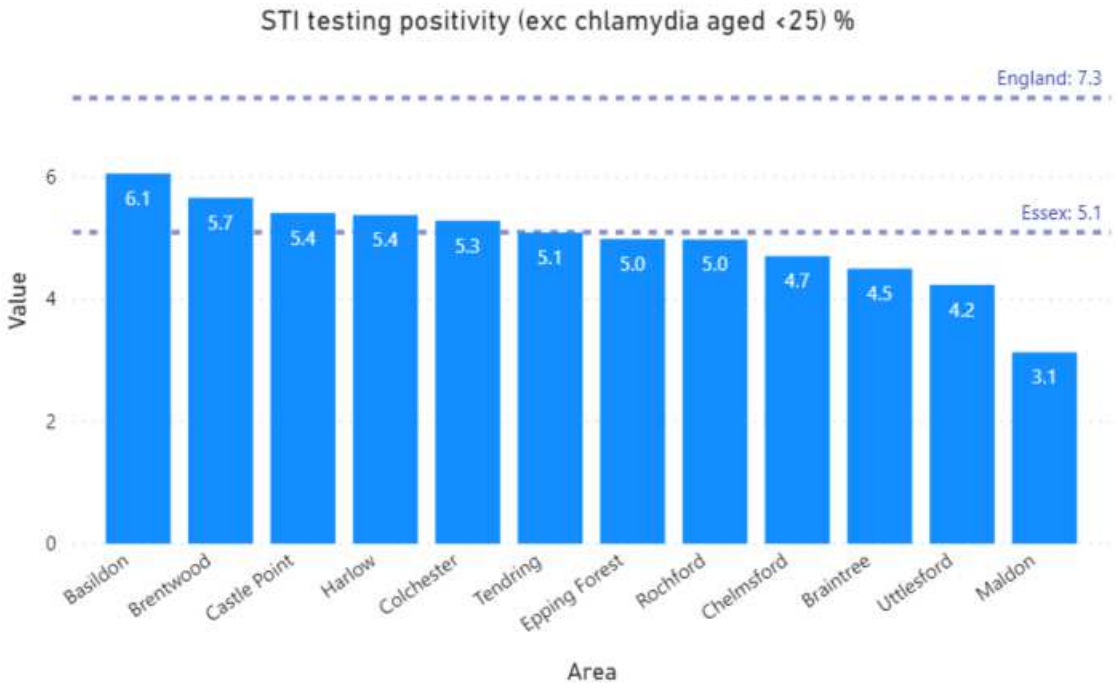


Figure 11 shows that all Essex districts have an STI testing positivity rate that is lower than the England average of 7.3%.

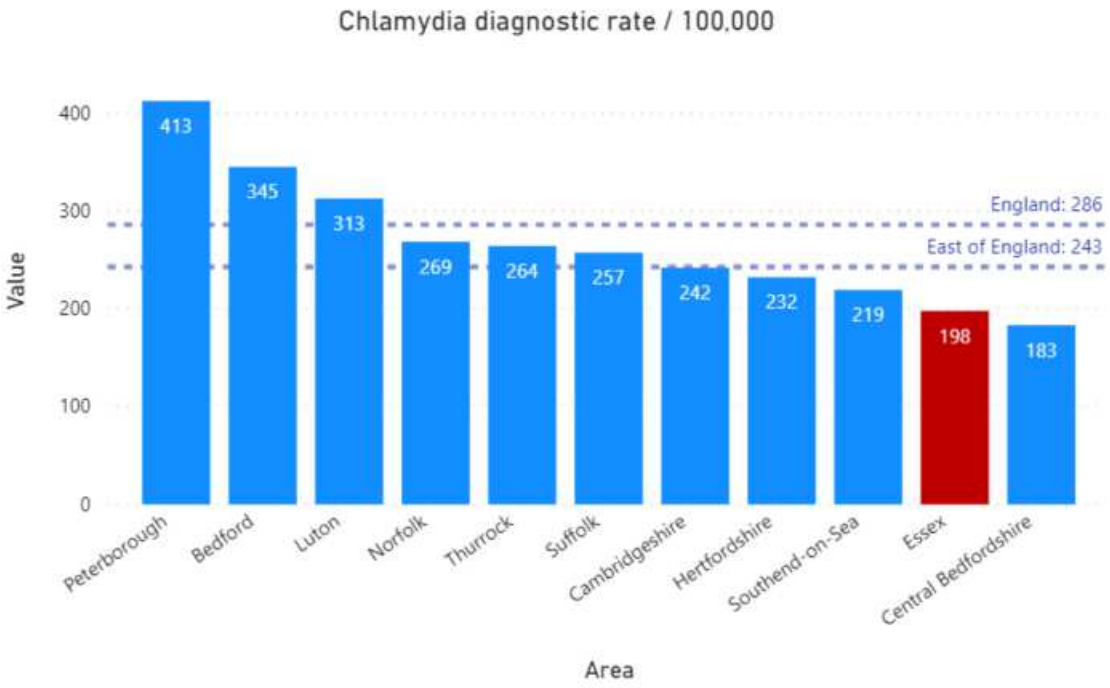
Figure 11: 2019 STI testing positivity % (exc chlamydia aged <25) by Essex lower tier Tier Local Authority



Chlamydia

Chlamydia is a bacterial infection, it is one of the most common sexually transmitted infections in the UK. It is easily treated with antibiotics however it doesn't usually cause symptoms and infection can cause pelvic inflammatory disease and infertility if left untreated. While chlamydia infections are more commonly found among young adults aged <25 years, women and men aged 25 years and over are also at risk of chlamydia. In 2019 Essex had a lower diagnostic rate than the England and East of England rate.

Figure 12: 2019 All age Chlamydia diagnostic rate per 100,000 across East of England Upper Tier Local Authorities



The 2019 data follows a stable 7 year trend showing that Essex has a lower diagnostic rate than the England average.

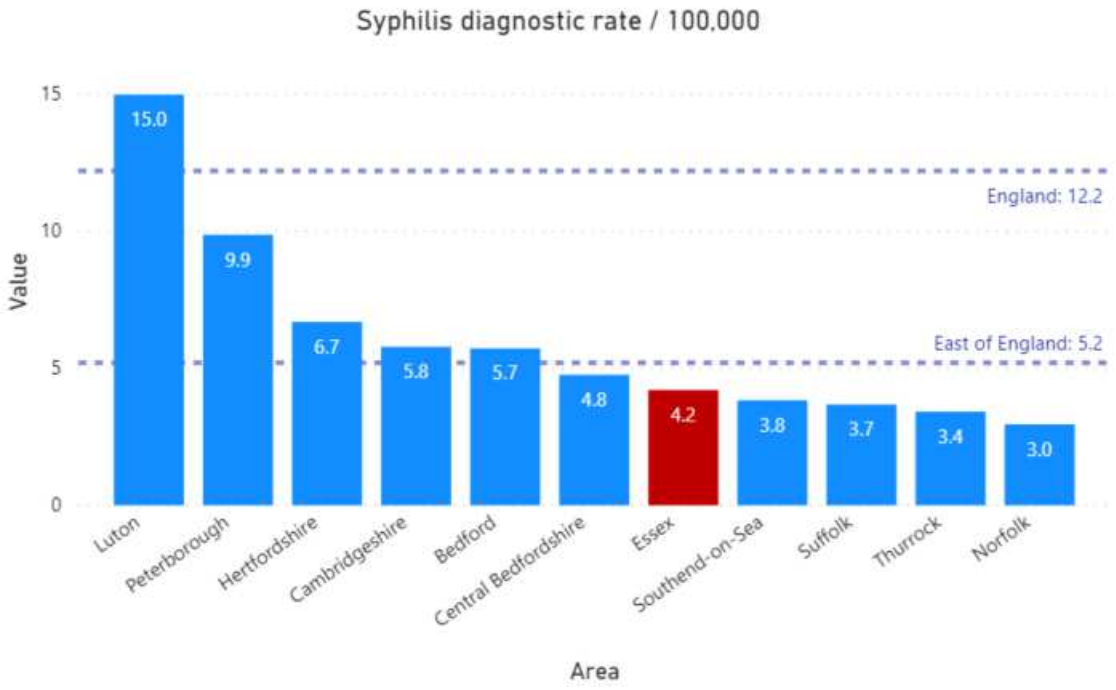
Diagnosis rates for Chlamydia may be affected by the proportion of the population tested. Since 2012 Essex's proportion of 15-24 year olds screened for Chlamydia has been below the England average. However it is important to note that the Chlamydia screening programme is changing from 2021 and will now be based on a harm reduction approach, opportunistically testing young females as opposed to the previous blanket approach for anyone 15-24years old.

Chlamydia diagnosis rates in Essex are consistently lower than the England average, however the proportion of the population between 15-24 (highest risk age range) screened is also below the England average. In 2019 Chlamydia diagnosis rate in those aged 25+ (583 per 100,000) were significantly less than the England average (900 per 100,000).

Syphilis

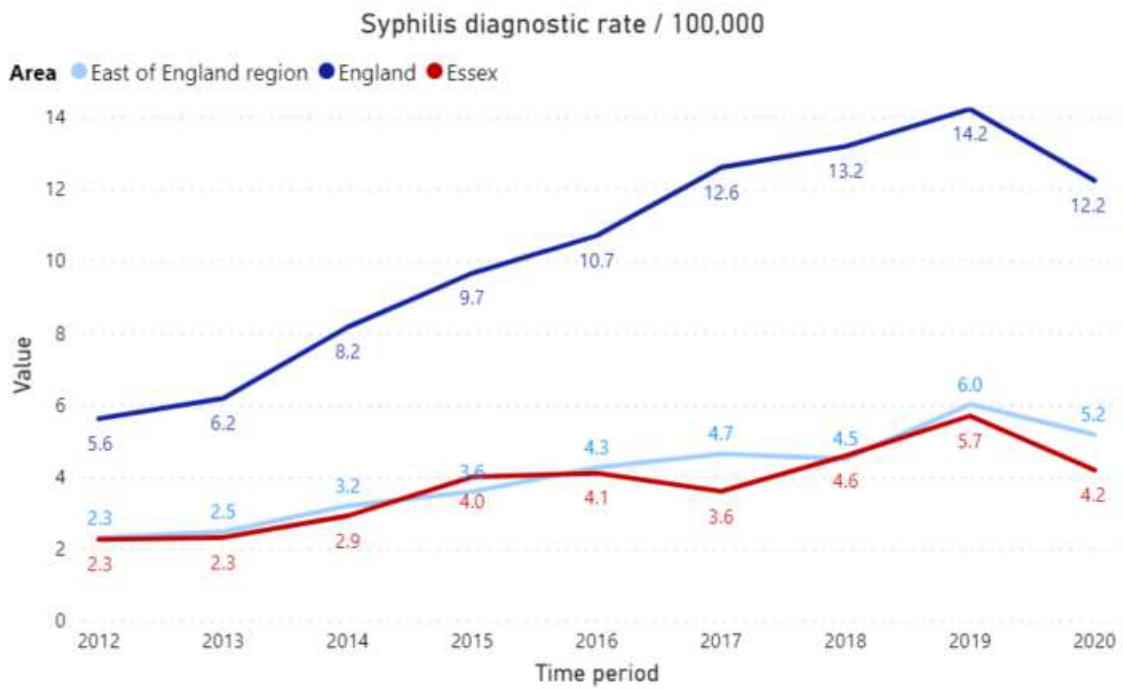
Syphilis is a bacterial infection, it can usually be treated with antibiotics however the symptoms are not always obvious. Men who have sex with men (MSM) have increased risks of syphilis among whom incidence has increased over the past decade, however there are also cases in those who identify as heterosexual. The below graph shows diagnostic rates vary across the East of England, with Essex having a lower diagnostic rate than the England average but statistically similar to regional neighbours.

Fig 13: 2019 Syphilis diagnostic rate per 100,000 in East of England by Upper Tier Local Authorities



Syphilis diagnosis is lower in Essex than the England average, the below graph shows that this has historically been the case, however it is important to note that both the national and regional and local trend is upwards.

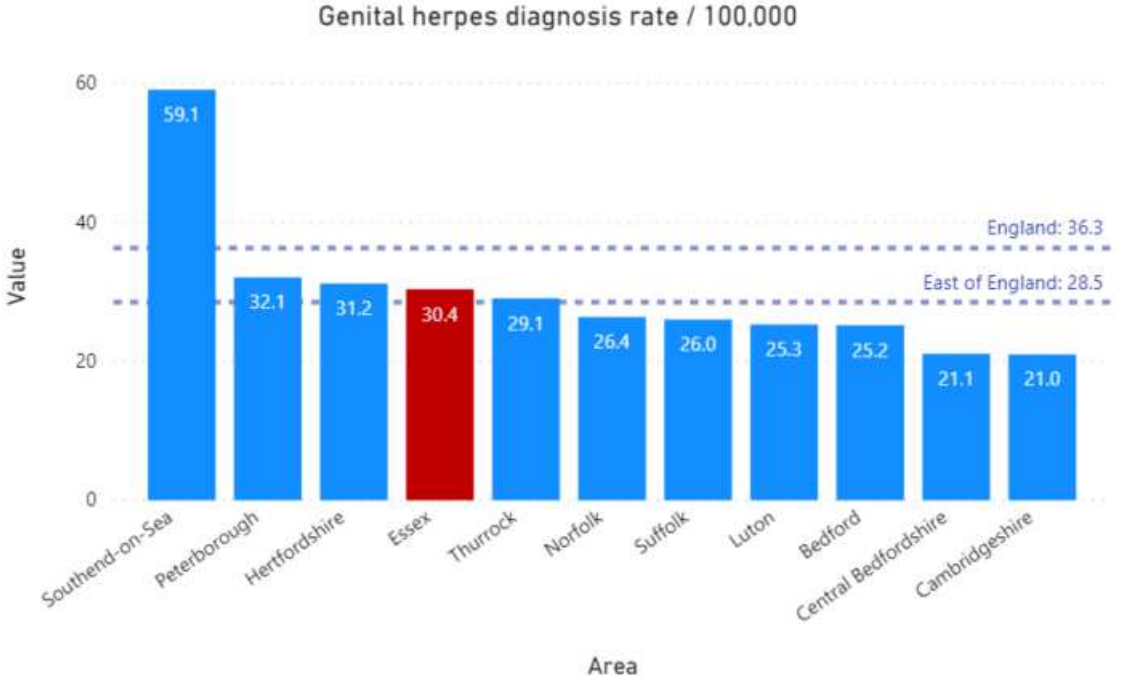
Fig 14: Syphilis diagnostic rate per 100,000 in Essex between 2012-2019



Genital Herpes

Genital Herpes is a viral infection, it is the most common ulcerative STI seen in England, recurrent infections are common and patients often require multiple treatments. In Essex Herpes diagnosis rates are lower than the England average, however compared to the East of England, Essex's diagnostic rates were significantly higher during 2019.

Fig 15: 2019 Genital Herpes diagnostic rate per 100,000 in East of England by Upper Tier Local Authority



Herpes diagnosis rates have fluctuated between 61.3 and 44.2 per 100,000 in Essex over the past 7 years, however it has been below the England average for the past 4 years. However, compared to the East of England region Essex has had higher rates of diagnosis over the past 3 years.

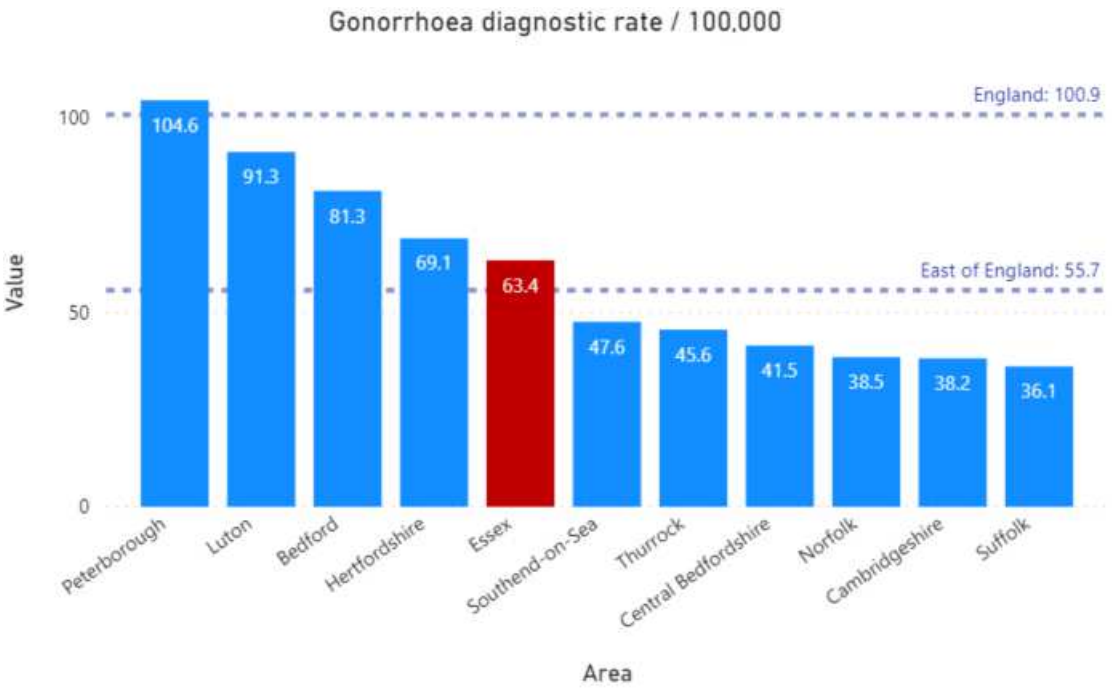
Gonorrhoea

Gonorrhoea is a bacterial infection with similar long term risks to Chlamydia (pelvic inflammatory disease or infertility if not treated). Infections with gonorrhoea are more likely than chlamydia to result in symptoms.

Gonorrhoea is on the rise in England and across the East of England Region. Compared to the England average Essex currently has a statistically significantly lower diagnosis rate. However compared to the East of England average, diagnosis rates are significantly higher in Essex.

Essex is following the same increasing trend over the past 3 years as almost every other local authority in the East of England.

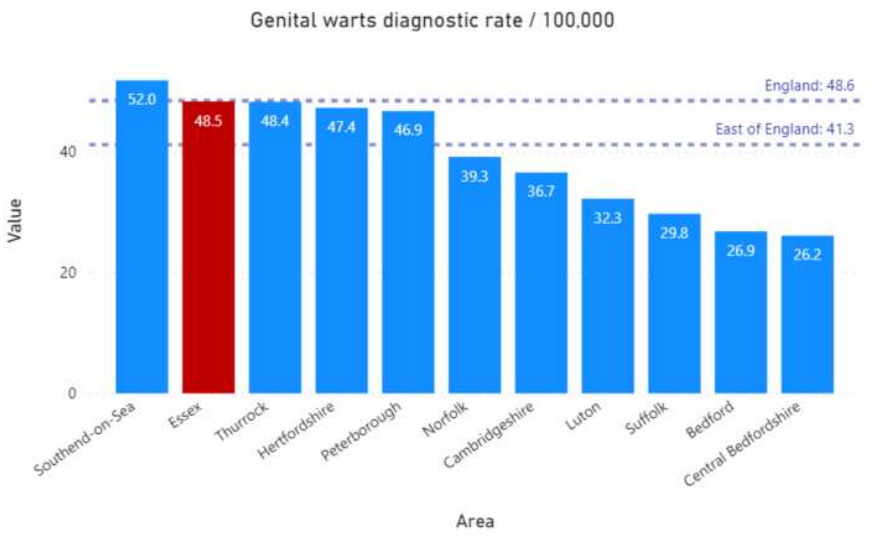
Figure 16: 2019 Gonorrhoea diagnostic rate per 100,000 in East of England by upper tier Local Authority



Genital Warts

Genital warts are caused by a virus (HPV) there are many types of HPV with a small number of them being linked to cervical cancer. Genital warts diagnosis rate is falling across England and the East of England region, the situation is similar in Essex with a falling trend that is significantly lower than the England average. However the 2019 data does show Essex having a statistically higher diagnostic rate than the East of England average.

Figure 17: 2019 Genital Warts diagnostic rate per 100,000 in East of England by upper tier Local Authority



Emerging Threats: Drug resistant STIs and Mgen

Increasing resistance and decreasing susceptibility to antimicrobials used to treat STIs has reduced treatment options for some STIs. This is particularly the case for gonorrhoea, as there are no classes of antimicrobials to which gonorrhoea has not developed resistance. As a result of this, first-line gonorrhoea treatment in the UK was recently changed from dual therapy of ceftriaxone with azithromycin, to monotherapy with ceftriaxone at a higher dose.

Fortunately, ceftriaxone resistance remains rare in the UK. However, in 2018, there were 3 cases of extensively drug-resistant gonorrhoea detected in the UK, which included ceftriaxone resistance.

Mycoplasma genitalium (Mgen) is a bacterial infection that can cause non-specific urethritis in males and pelvic inflammatory disease in women. The infection doesn't always have symptoms and historically hasn't been routinely tested for by sexual health services. However, testing capability is improving which may see diagnosis (and therefore recorded prevalence) increase.

Conclusions:

- STI testing rate generally lower than the England Av, but similar to East of England (EoE) average
- STI positivity rate generally lower than England Av but similar to EoE
- STI diagnosis rates generally lower than England Av but similar to EoE
- Colchester and Harlow have a higher STI diagnosis rate than other Essex districts (close to England Av)
- Testing rates vary, Colchester and Harlow have higher testing rates
- Harlow and Tendring have higher test positivity rates
- Essex's STIs profile is similar to England and East of England
- Increases in Syphilis diagnosis is a national, regional and local issue of concern
- Increases in Gonorrhoea also a concern that should be monitored
- Increasing threat of Drug Resistant strains of STIs and Mycoplasma genitalium (Mgen) need to be monitored as areas of increasing concern.

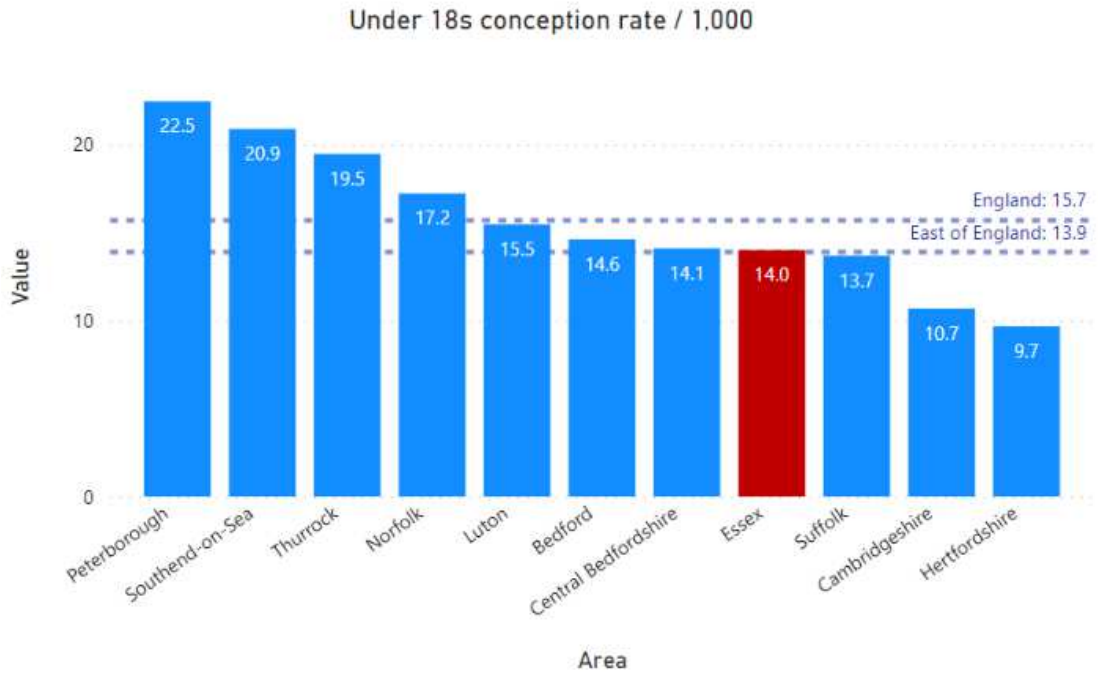
U18 Conception:

Conceptions

Under 18 Conception rate is falling nationally, however young people in England still experience higher teenage birth rates than their peers in Western European countries[51], teenagers remain at highest risk of unplanned pregnancy[52], inequalities in rates persist between and within local authorities[53], and outcomes for young parents and their children are still disproportionately poor[54], contributing to inter-generational inequalities. Essex has had a similar reduction and in 2019 had statistically fewer under 18 conceptions per 100,000 15-17 year old females.

The graph below illustrates variation between local authorities in the East of England for Under 18 conceptions during 2019. Essex's rate is statistically lower than the England average, but just above East of England.

Fig 18: 2019 Under 18 conceptions per 1,000 in East of England by upper tier Local Authority

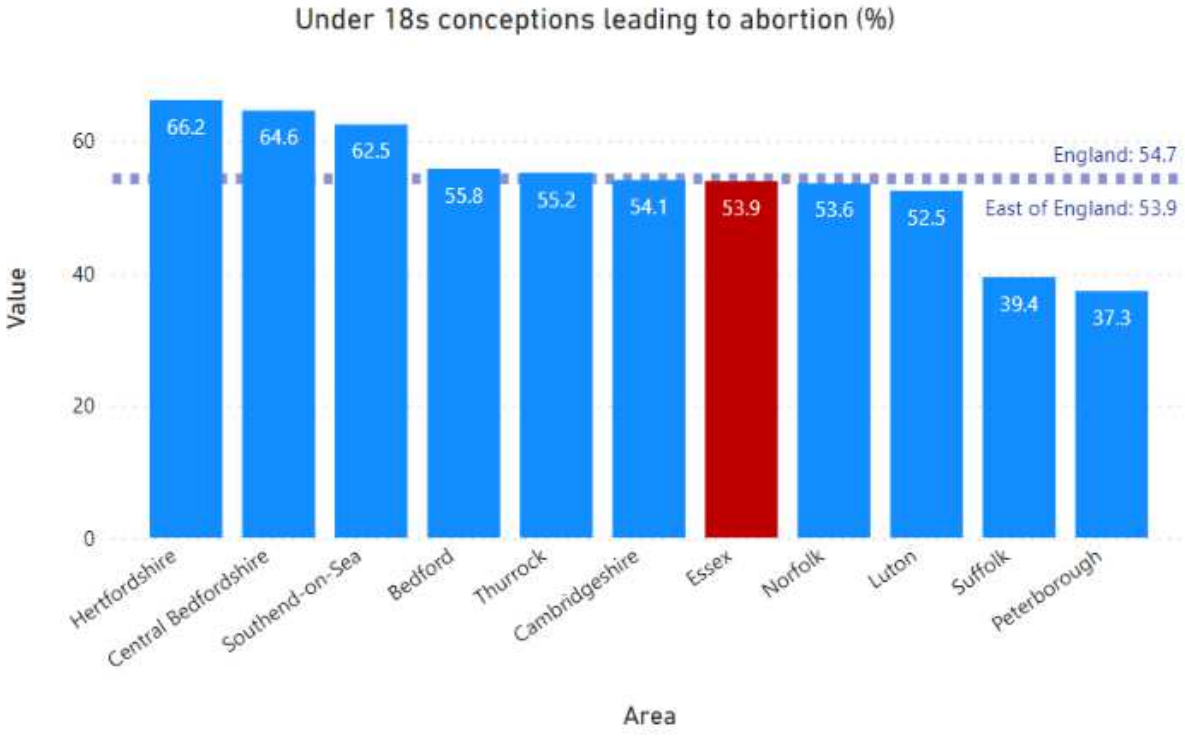


Conceptions leading to abortion

The proportion of under 18 conceptions that lead to abortion has been increasing both nationally and in Essex. However, in 2019 Essex saw a significant drop from 61% to 53.9%, which goes against the England increasing trend and is now lower than the England average (54.7%) and level with the East of England average.

The graph below illustrates variation between local authorities in the East of England for Under 18 conceptions leading to abortion during 2019. Essex's rate now ranks 5th lowest in the region, having been much higher the previous year.

Figure 19: 2019 Percentage of under 18 conceptions leading to abortion in East of England by upper tier Local Authorities

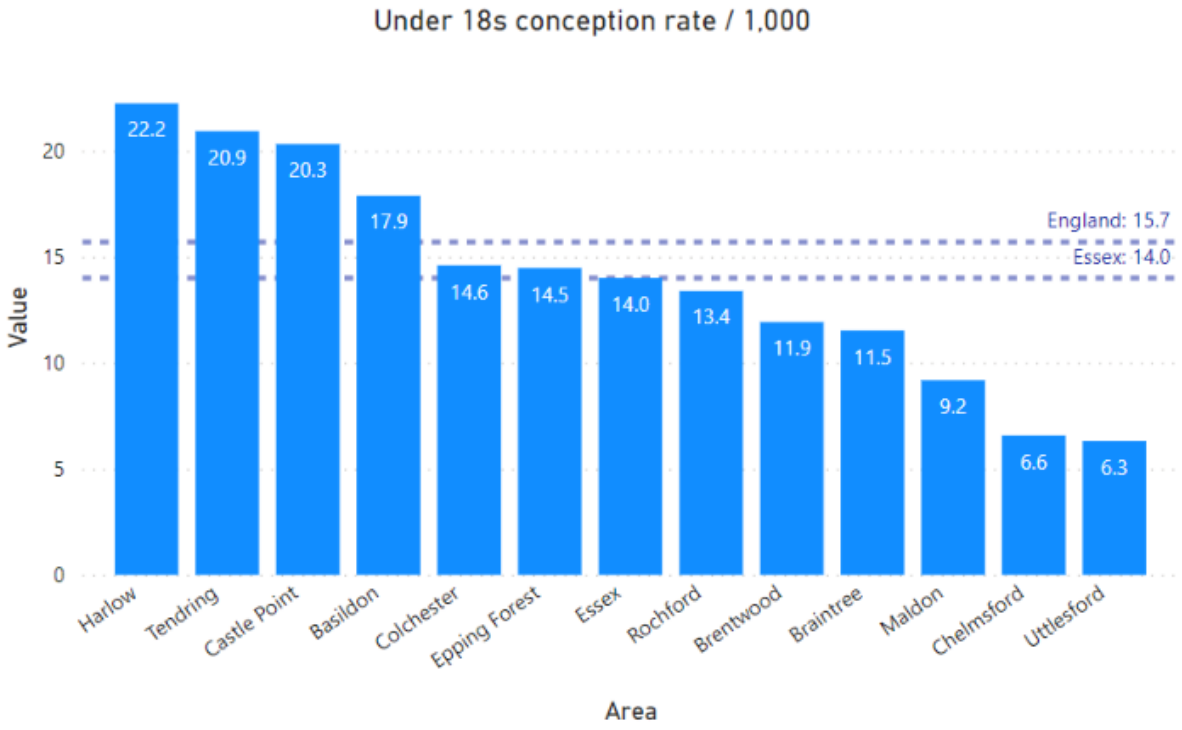


U25 repeat abortions

Over a quarter of abortions in under 25's in England are repeat abortions. This may be an indicator of lack of access to good quality contraception services and advice as well as problems with individual use of contraceptive method. The proportion of repeat abortions in Essex (30.7%) is statistically similar to the England average. In 2018 and 2019 the proportion in Essex increased to become statistically significantly higher than the East of England average, however in 2020 this returned to similar levels to the regional average.

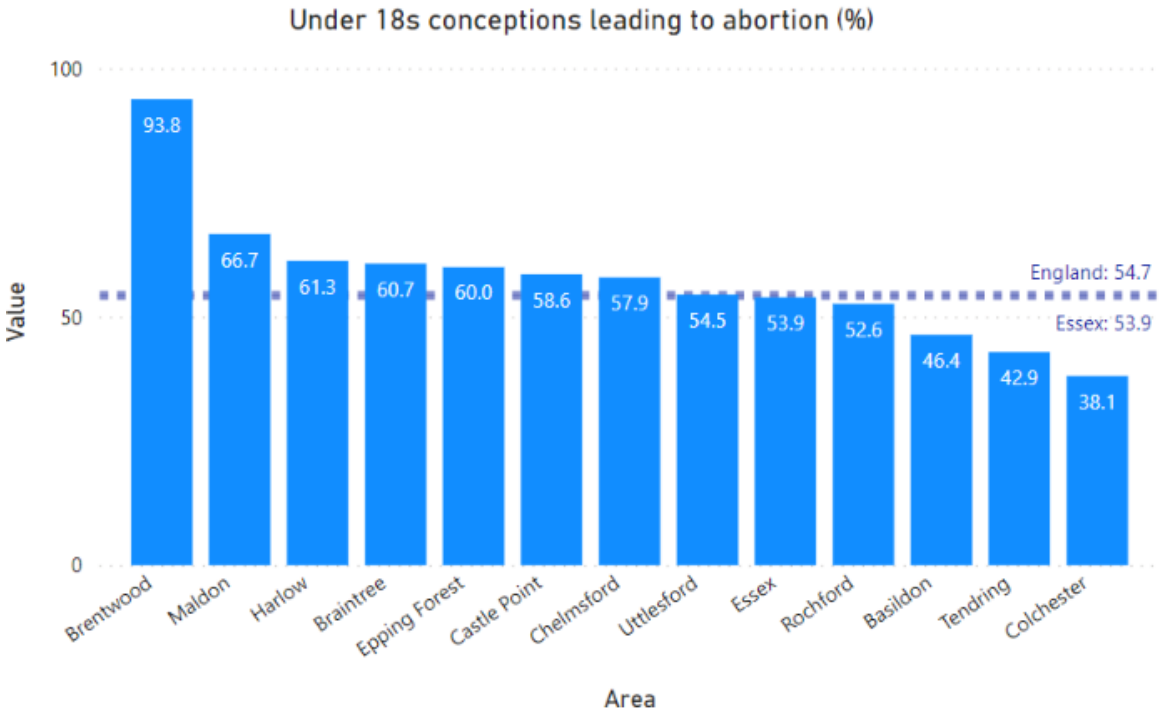
There is significant variation within Essex in regards to under 18 conception. The graph below shows conception rates per district, however it is important to note that these are relatively small numbers.

Fig 20: 2019 under 18 conception rate per 100,000 by Essex District



The graph below shows the proportion of U18 conceptions leading to abortion in districts. Abortion is a complex decision with multiple determinant factors and whilst there appears to be a national and local trend that is slightly increasing proportion of under 18 conceptions leading to abortion it is important to consider that these are small numbers when making inferences from the data.

Figure 21: 2019 Proportion of under 18 conceptions leading to abortion in Essex by district



Conclusions:

- Nationally Under 18 conception rates have been declining since the mid-2000's
- Essex has a under 18 conception rate that is significantly lower than the England average and similar to the East of England average.
- Rates of Under 18 conception are significantly higher in Harlow and Tendring than the Essex average
- There is stable Under 18 abortion rate across Essex but 2019 rates are significantly higher than England average in Brentwood
- Abortion % is generally quite volatile due to low numbers at district level- Rochford, Uttlesford, Epping Forest, Brentwood, are potential outliers when looking at the last 10 years of data.
- Info sharing between providers including maternity services could improve care and support for those under 18 who conceive.

HIV

HIV (human immunodeficiency virus) is a virus that damages the cells in the immune system. When diagnosed early there are very effective drug treatments that enable most people with the virus to live a near-normal lifespan in good health. However, when diagnosis is late the prognosis and associated care costs are significantly worse.

The below graphs show HIV diagnosed prevalence in 2019 at County level and districts within Essex.

Figure 22: HIV diagnosed prevalence 2019 in East of England by upper tier Local Authority

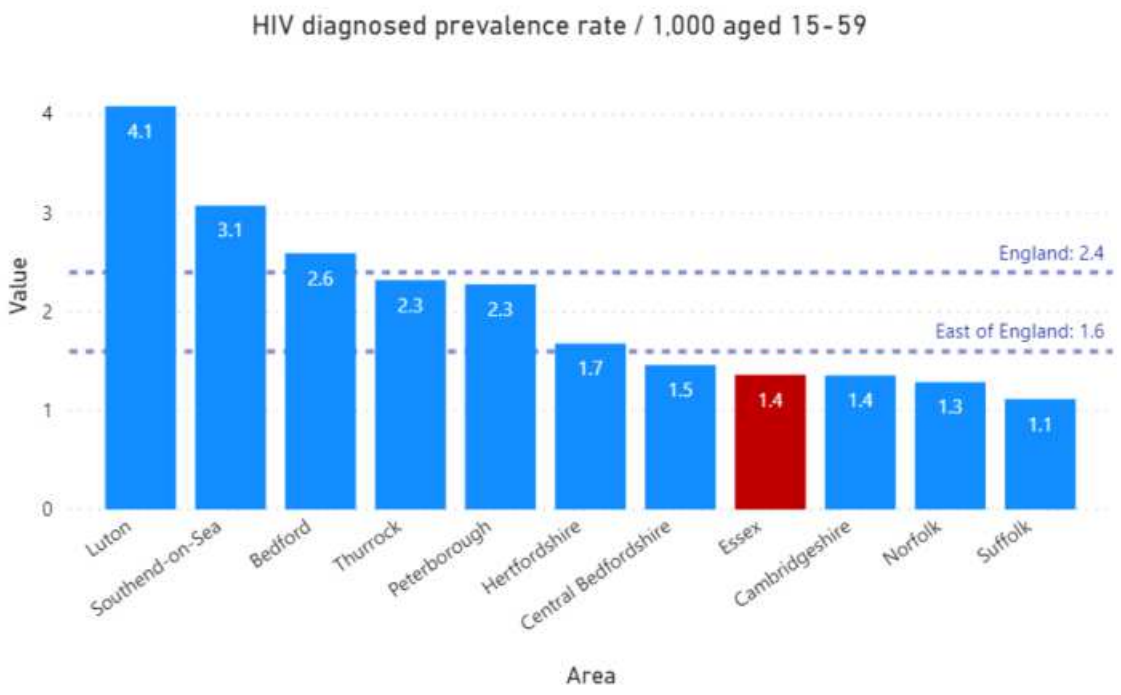
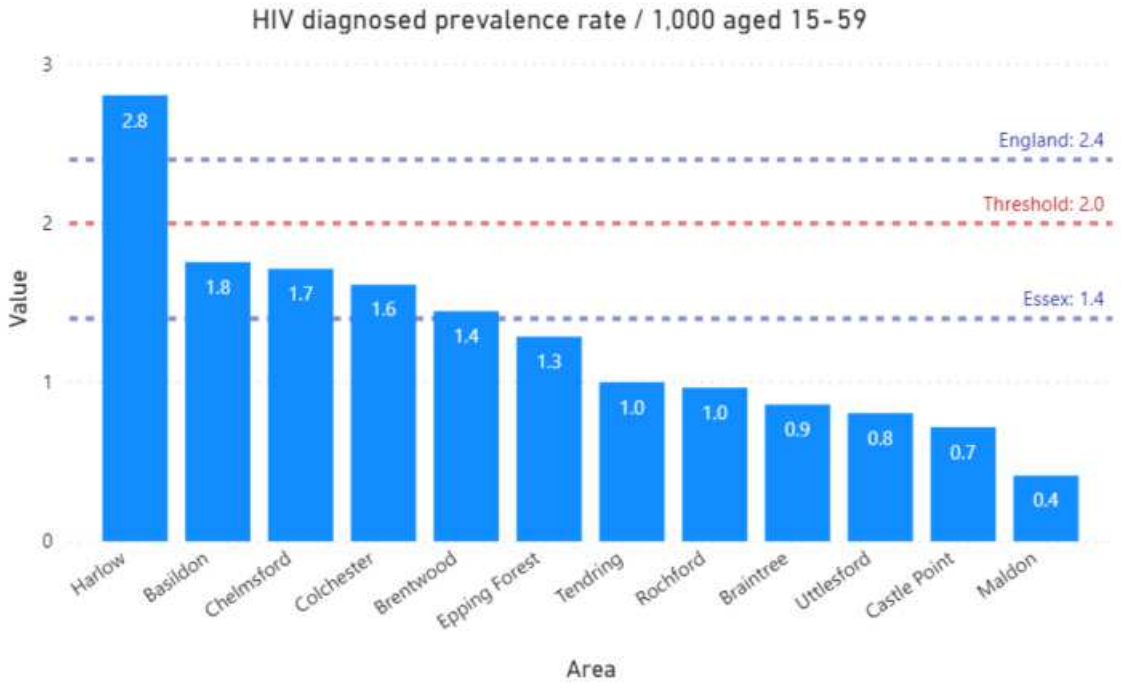


Figure 23: HIV diagnosed prevalence 2019 in Essex by district authority.

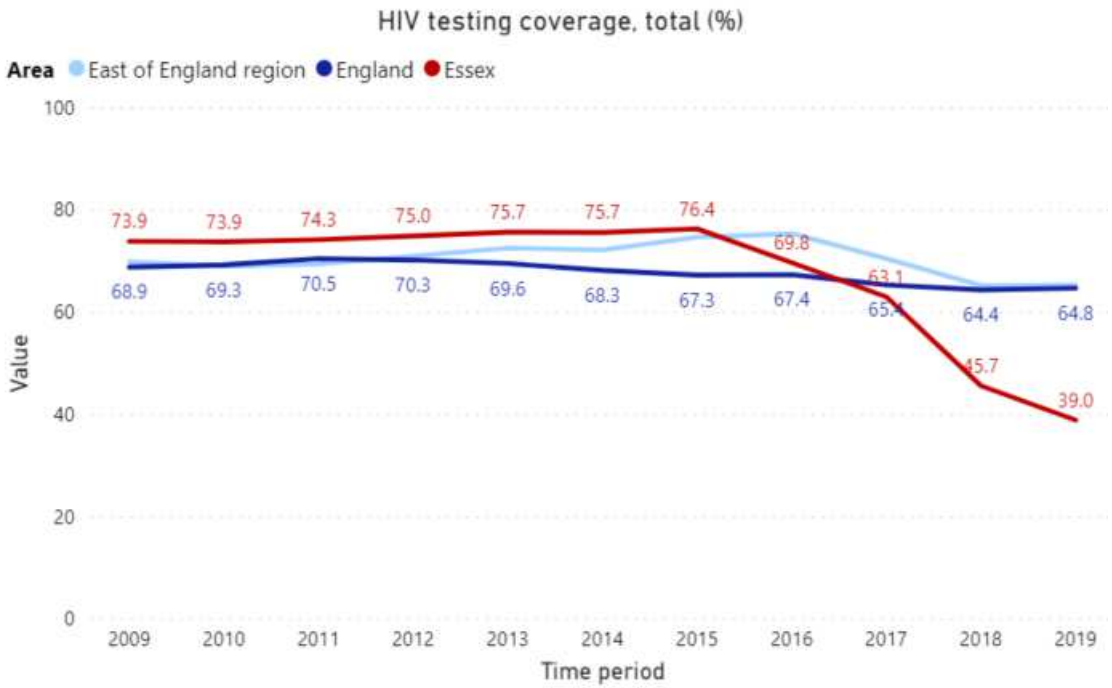


HIV Testing and Diagnosis

Essex has historically had testing coverage that is similar to the England average, however in the last three years the nationally published data has shown a reduction and suggests that Essex has lower testing coverage than the England average. Testing coverage is an important measure as low testing coverage could result in individuals not knowing their HIV status and increased risk of late diagnosis (when individuals seek treatment once symptomatic, usually with worse outcomes). In 2019, 11,793 tests were completed, this equates to 39% of eligible attendees in whom a HIV test was accepted. However, reviewing this data has uncovered some potential coding issues that may mean that the below data is inaccurate, this is being reviewed by the sexual health provider and commissioners and may result in retrospective adjustment. The early findings of this review suggest that the 2019 figure would be

adjusted to 90.8% which would put Essex above the England average. The below graph shows the official data from the Public Health Outcomes Framework and shows a reduction in testing compared to the England average.

Figure 24: HIV testing coverage in Essex 2009-2019

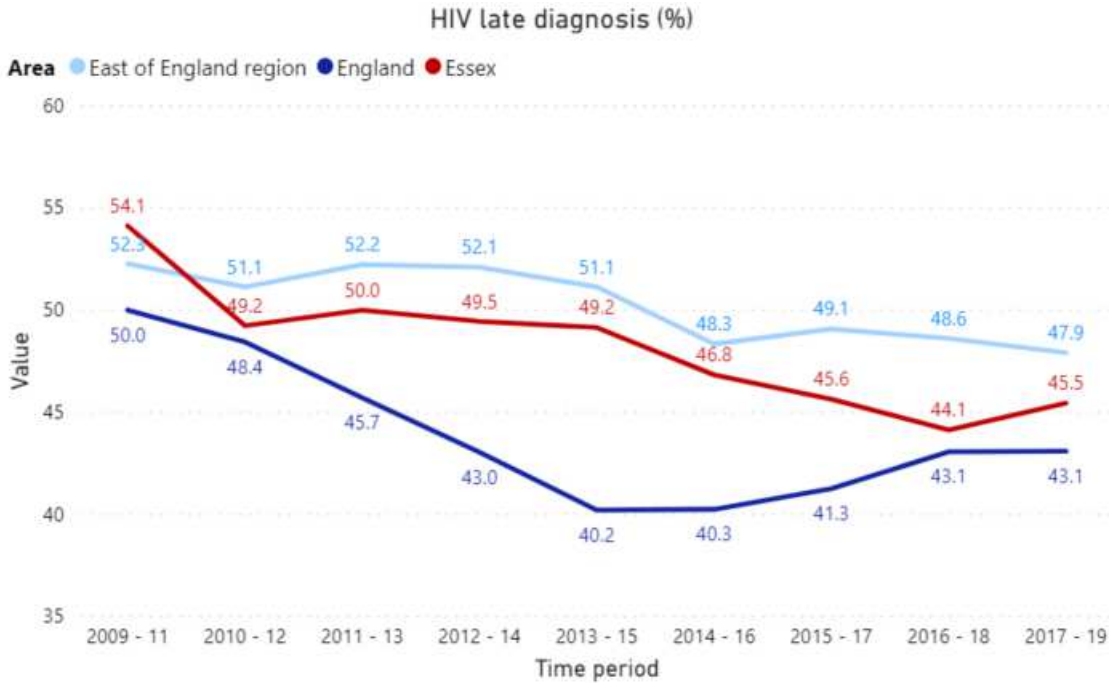


It is important that this reduction in testing does not result in an increase in individuals with un-diagnosed HIV, which can lead to increased transmission of disease and increased late diagnosis of HIV, both of which have significant public health impacts.

Late Diagnosis

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed promptly. When diagnosed late the outcomes for those with HIV infection are significantly worse and the health costs are significantly worse. The below graph shows HIV late diagnosis trends in Essex plotted against the England average. In 2019 late diagnosis was similar to the England average and the East of England average.

Figure 25: HIV late diagnosis in Essex between 2009-2019



Between 2017-2019 late diagnosis in heterosexual men (57.9%) and women (51.4%) was significantly higher than late diagnosis in MSM (32.6%). There is some district variation in late diagnosis however due to relatively small numbers it is difficult to make inferences from this.

Conclusions:

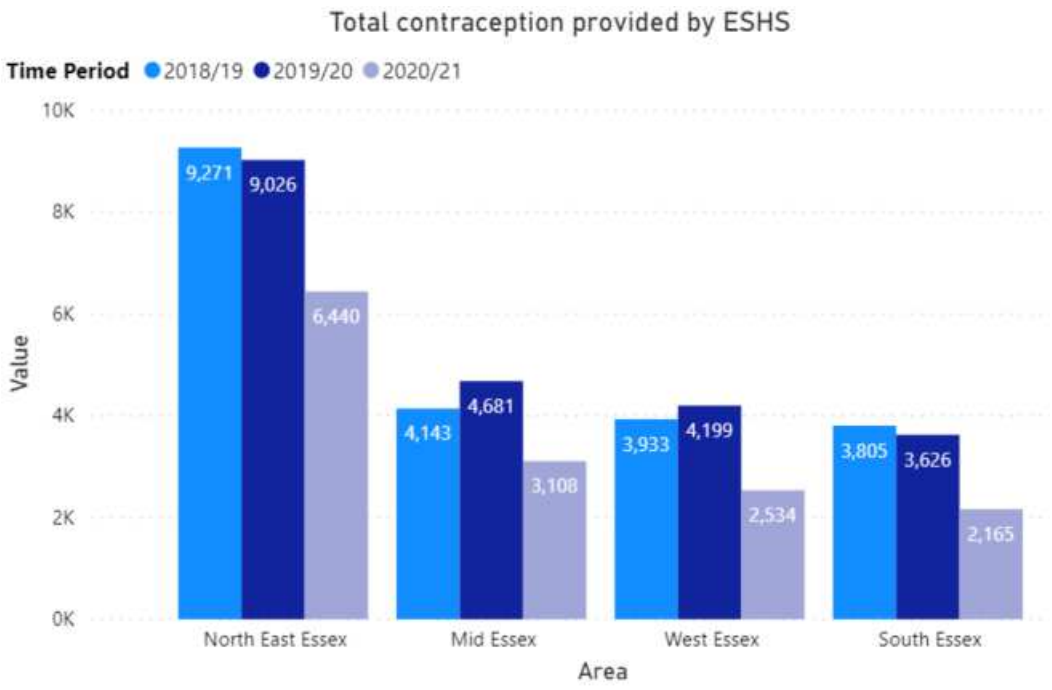
- A change in testing approach by the Essex Sexual Health Service doesn't appear to have impacted late diagnosis figures, but we should closely monitor this, starting with activity to further understand potential coding issues in reporting.
- Any late diagnosis is a demonstration of failure of the system- costs are high for the patient and healthcare system. Late diagnosis should be retrospectively looked back to understand themes/trends in missed opportunities: https://www.bhiva.org/file/ZMUlAWemzIPrG/PositionStatementLateDiagsFinal.pdf https://www.bhiva.org/LateDiagnosesDeaths
- Harlow is above the 2% prevalence threshold which should trigger more significant testing effort.
- Geographical areas with poorer performance for late diagnosis may be opportunities to improve early recognition of disease.

Contraception

The provision of contraception is widely recognised as a highly cost-effective public health intervention[55,56]. This is because it reduces the number of unplanned pregnancies which bear high financial costs to individuals, the health service and to the state[57,58].

The Essex Sexual Health Service and primary care provide publicly funded contraception across the County. The data report shows distribution of various types of contraception by quadrant (four geographies within Essex; South, West, North East and Mid). This data demonstrates higher provision of contraception regardless of type in the North East. This is summarised below through total items. Contraception provision in 2020/21 dropped across Essex as a result of the Covid-19 pandemic, it is not known how much this drop is due to reduced demand vs reduced availabililty.

Figure 26: Total contraception provided by ESHS by quadrant 2018/19- 2020/21



The data above does not take into account condoms distributed as part of the eC-Card scheme. The scheme is a condom distribution scheme providing free condoms to young people aged 16-24 (and under 16s after an assessment), there is a mobile app to support effective and appropriate use. Table 5 shows eC-Card registrations (numbers of people signing up to the scheme) and transactions (number of requests for condoms from those who are registered) between April 2018 and March 2021.

Table 5: eC-Card Registrations and Transactions between April 2018-March 2021

	18-19	19-20	20-21*
eC-Card Registrations	339	346	178
eC-Card Transactions	437	881	416

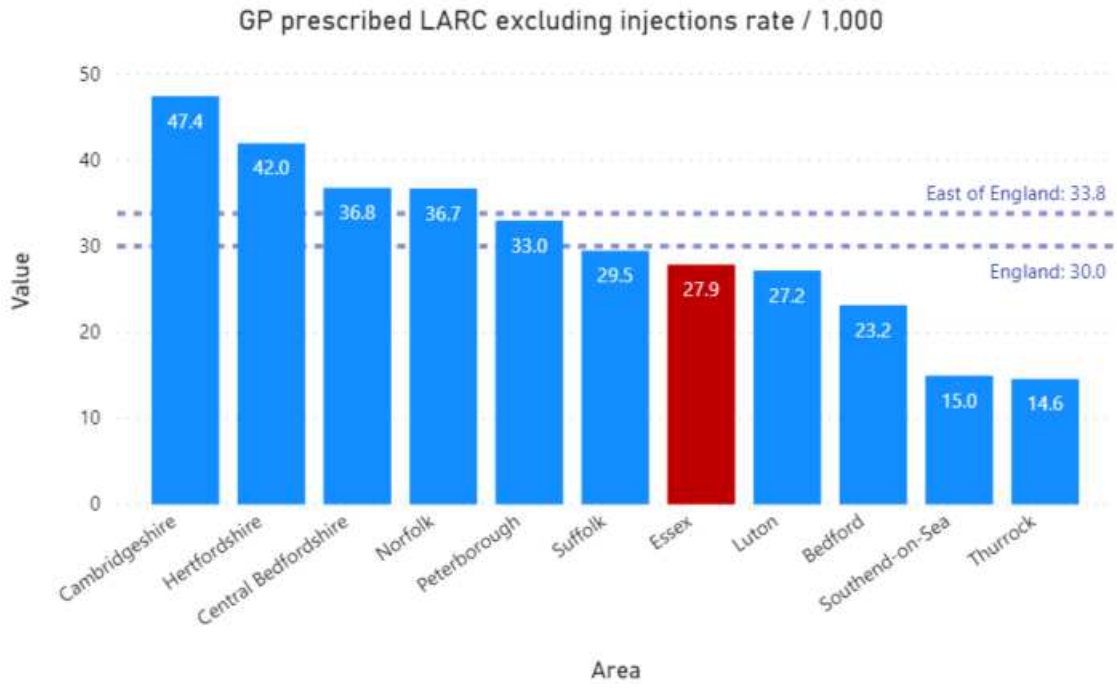
*The 2020-21 year will have been impacted by Covid lockdowns.

Current eC-Card outlets have been mapped using the SHAPE tool (see data pack).

Long Acting Reversable Contraception (LARC)

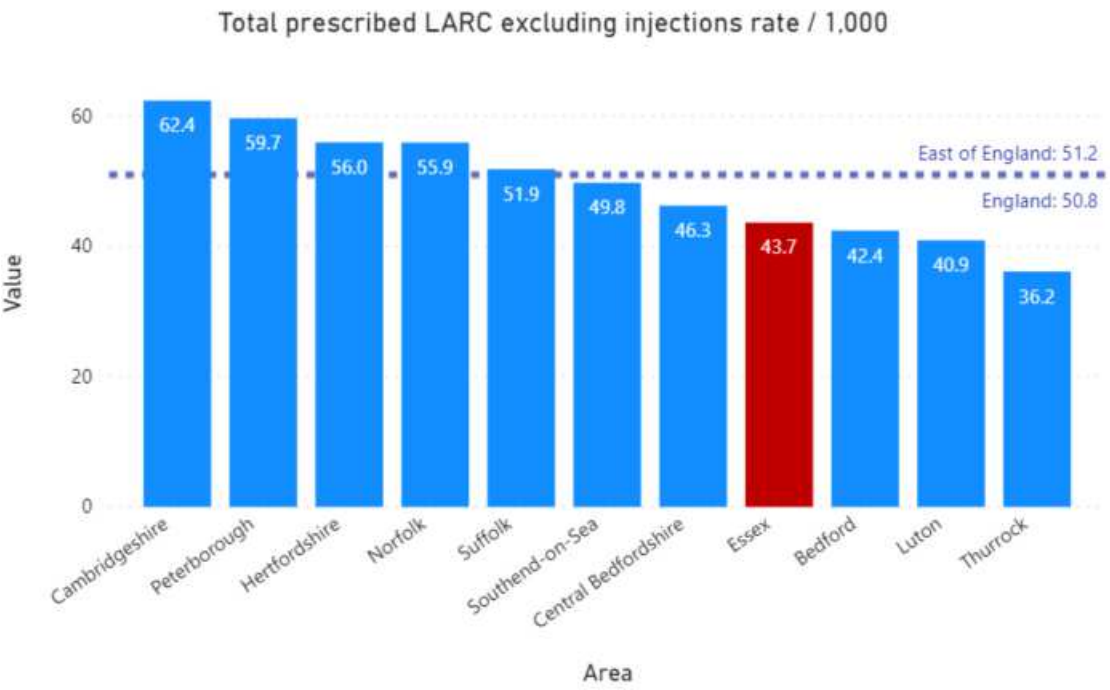
LARCs are the most effective methods of contraception and are also reversible, meaning that once you stop using that method fertility returns. LARC delivery is often prescribed by primary care providers, delivering care close to home for residents. Essex has a lower rate of LARC prescribing in both primary care and by sexual health services than the England average?. The graph below shows Essex primary care prescribed LARC rates in 2019 compared to England and East of England local authorities. Historically the rates in Essex have been fairly stable, either similar to or just below the England average.

Figure 27: 2019 GP Prescribed LARC (excluding injection) per 1,000 in East of England by upper tier Local Authority



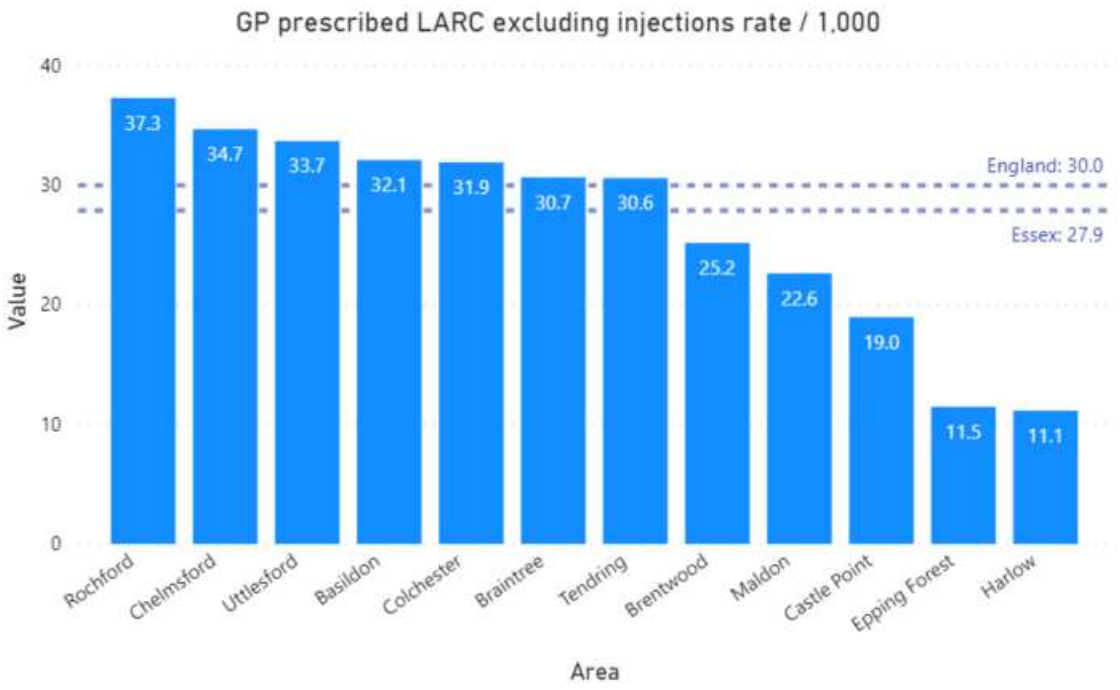
The graph below shows total LARC (primary care and SHS prescribed), in each of the previous 5 years Essex has been below the England average and East of England average.

Figure 28: 2019 Total LARC excluding injections per 1,000 in East of England by upper tier Local Authority



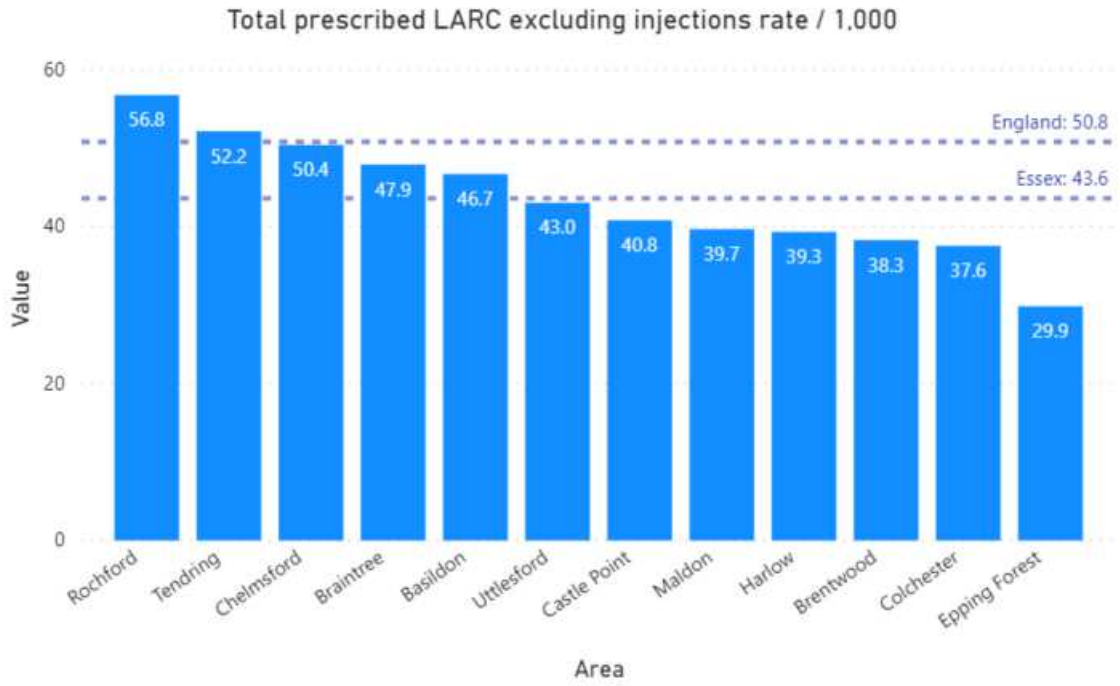
There is significant variation in the rates of LARC prescribed in primary care within Essex. Harlow has seen a reducing trend in GP prescribed LARC over the last 4 years and now has the lowest rate in Essex. Epping Forest and Castle Point and Maldon have consistently been below the England average.

Figure 29: 2019 GP prescribed LARC excluding injections per 1,000 in Essex by District



When primary care LARC is combined with Sexual Health Service provided LARC there is less variation, however there are still some stand out geographies with low rates and most districts are below the England average (50.8 per 1000 females aged 15-44). Epping Forest, Harlow, Maldon, Castle Point and Brentwood have historically been below the England average for this indicator. Colchester and Uttlesford had reductions in their rates during 2019.

Figure 30: 2019 Total prescribed LARC excluding injections per 1,000 in Essex by District

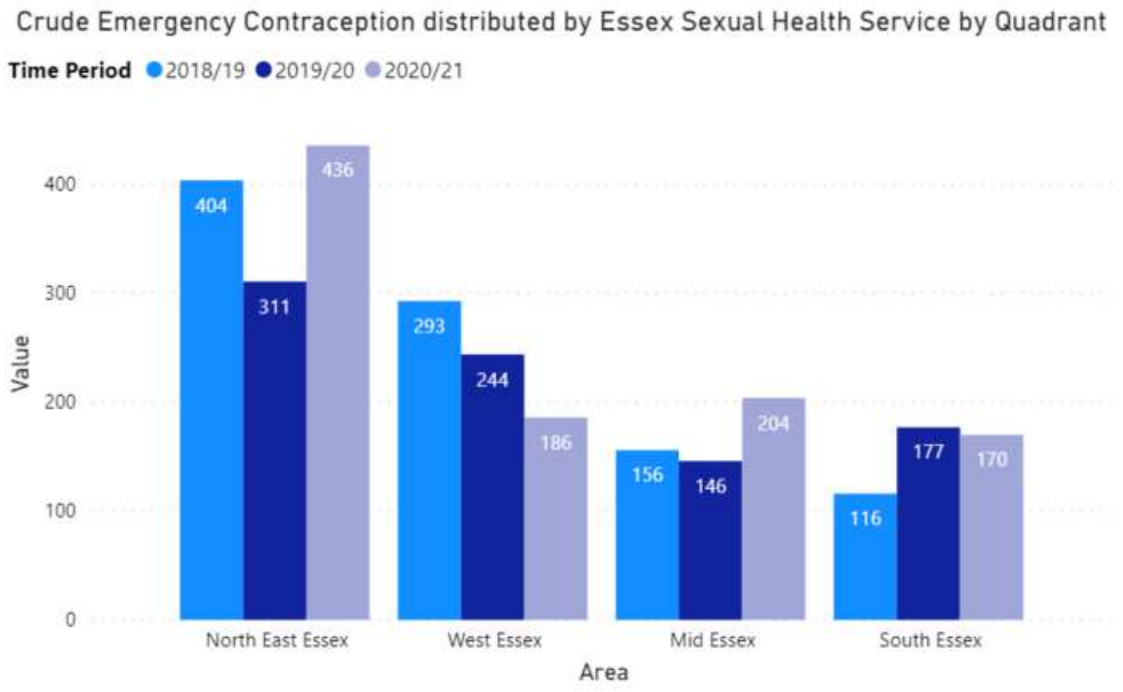


Both of the above LARC measures exclude injections due to the repeat nature of injected LARC.

Emergency Hormonal Contraception (EHC)

Emergency contraception can prevent pregnancy after unprotected sex or if the contraception you have used has failed. The EHC recorded data below does not provide a full picture of all EHC use across Essex as there is further provision from pharmacies, hospitals and EHC purchased over the counter.

Figure 31: Crude EHC distributed by ESHS by quadrant between 2018/19-2020/21



Conclusions:

- LARC provision appears to vary across Primary Care in Essex, Sexual Health Service activity moderates some of the apparent inequity however it doesn't do this fully
- There appears to be significant variation between contraception provision across the four quadrant areas that the sexual health service covers, reasons for this this should be explored further.
- Contraception use is very much a personal choice (both whether it is used and what type) qualitative insight from Essex residents may be helpful to understand need further.

Qualitative insight:

Stakeholder Engagement:

As part of the corporate needs assessment we facilitated 2 staff workshops with the sexual health service and 3 wider stakeholder workshops with a range of organisations represented by professionals who work in Essex. These workshops were delivered online via MS Teams and aimed to sense-check the emerging recommendations from data, identify any areas that we have missed and identify barriers and enablers to implementing the recommendations.

Opinions of emerging recommendations:

Figure 32 shows the scores that each recommendation received across 55 questionnaires. There was a wider range in those recommendations with lower average scores (indicating that whilst they were important to some respondents they may not be important to all). These findings should be considered if there is a need to prioritise implementation of recommendations.

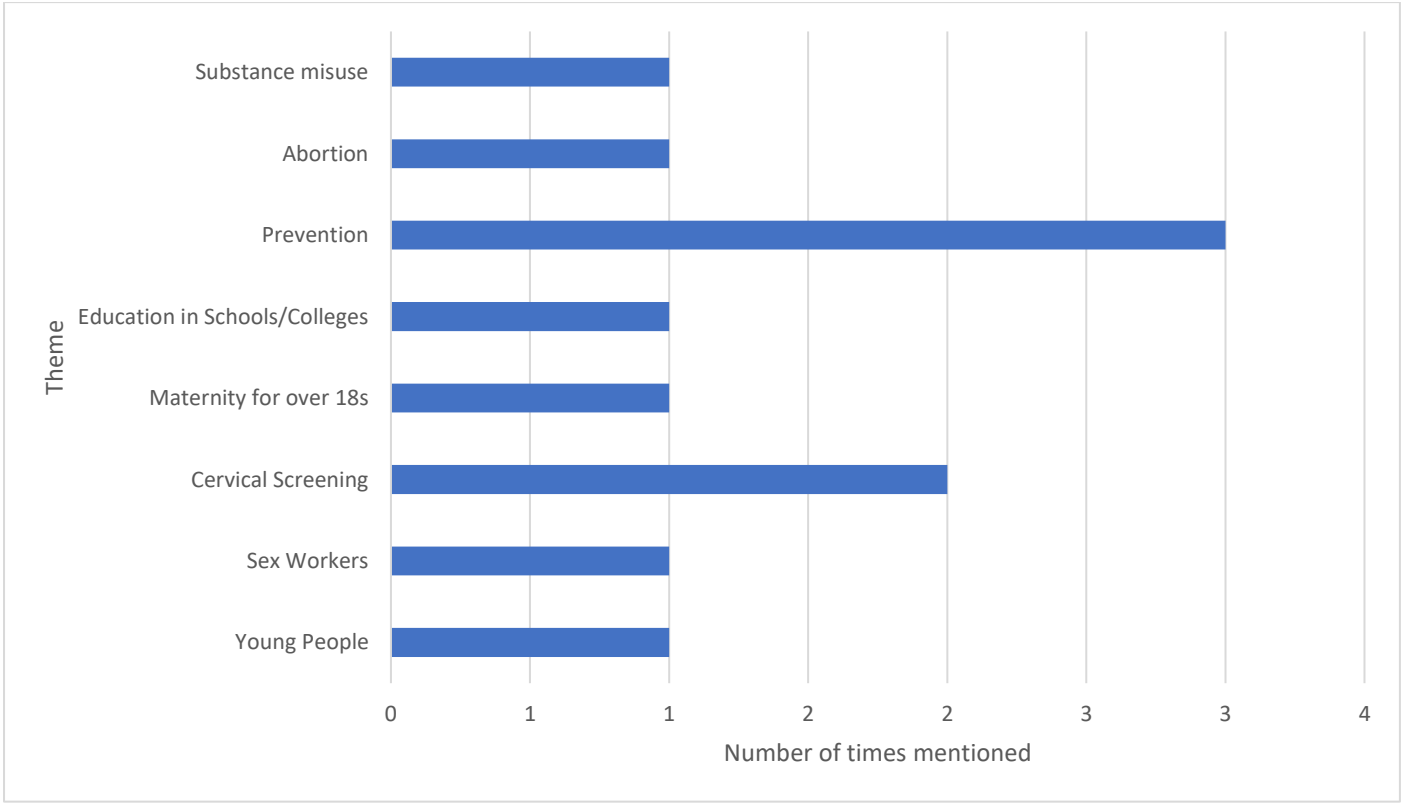
Figure 32: Recommendations average scores from workshop participants

*Green = 3-5 range, yellow= 2-5 range, red= 1-5 range

Thematic Analysis of discussions

The discussions that took place and free text responses to the Slido survey were grouped into these around area's that hadn't been picked up in the recommendations ("Areas we've missed") and barriers and enablers to implementation of the recommendations. The below graphs show some of the topics that were common within discussions. These will be considered within the short, medium and long term action plans that are in response to the health needs assessment.

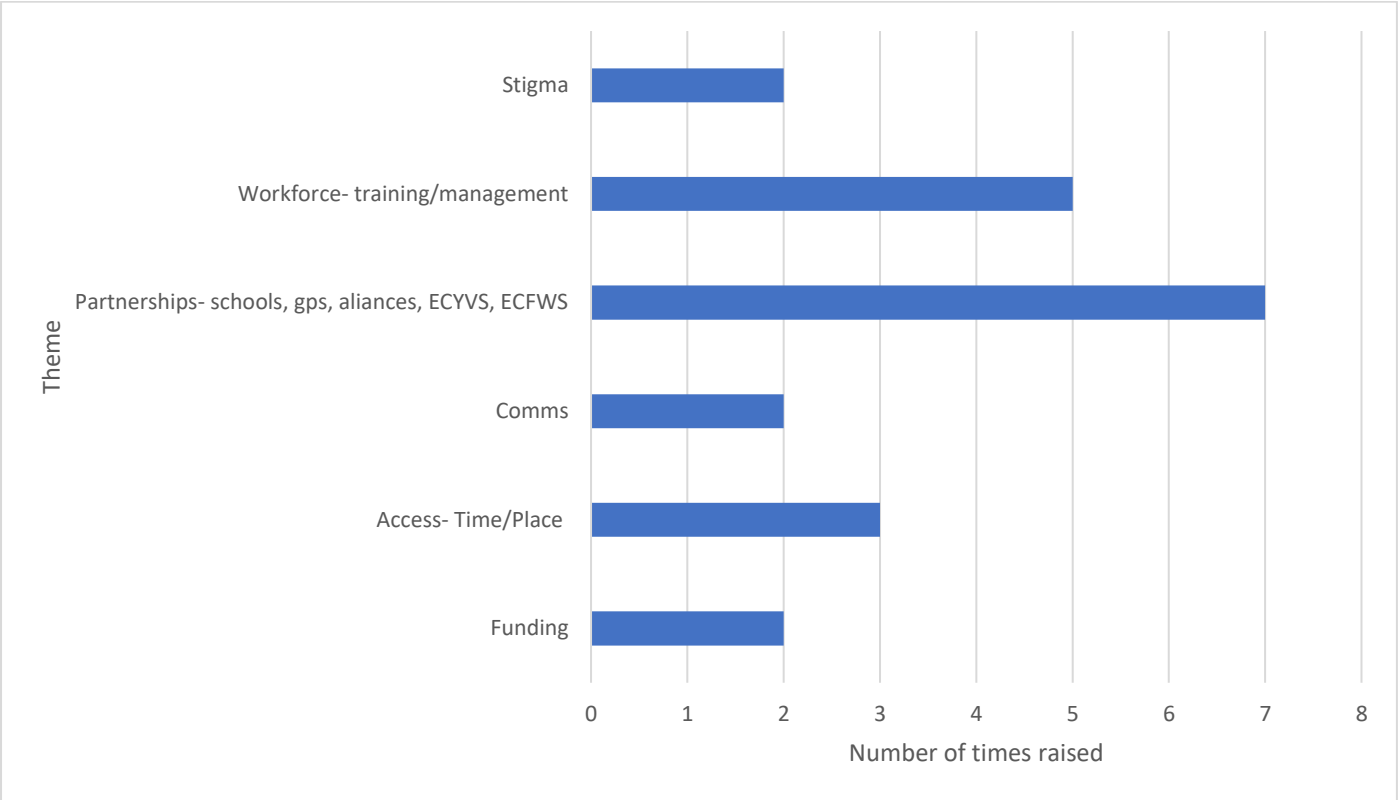
Figure 33: Thematic analysis- "Areas we've missed"



Discussions around prevention concluded that prevention should be a cross cutting theme across all sexual health workstreams.

Opportunities for sexual health services to deliver cervical screening when appropriate should be picked up by commissioners as part of wider governance ambitions.

Figure 34: Thematic Analysis: Enablers and Barriers to implementation:



Many of the factors discussed above were identified as potential barriers as well as enablers, emphasising the need to maintain and develop strong partnerships and consider the training competencies for the wider public health workforce.

Young peoples survey:

From July-September 2021 Essex County Council conducted a survey for young people aged 16-25, on the topic of relationships and sex education. This survey sought to gather views around young people's sexual health needs within Essex, what further information they would like regarding sexual health and relationships, and where they like to get this information.

The survey received 251 respondents, 22% of which were from Castle Point. The majority of respondents were 16-18 (84%) and 63% disclosed their sex as female.

The table below shows the headline findings from the survey:

Table 6: Headline findings from the children and young peoples survey

Young people look to online sources (including social media) for information on most topics. However they are most likely to turn to friends/family for information on healthy relationships, puberty and menstruation, and to schools for information on STIs, and contraception methods.
Young people would most like to know more about 'steps to take after unprotected sex', followed by 'healthy and respectful relationships'. (*N.B. Interpretations of 'steps to take after unprotected sex' may include info about STIs and choices around pregnancy).* Most free text comments around additional themes young people would like to learn more about related to more comprehensive education in schools, consent, tackling stigma and unrealistic ideas from pornography, LGBTQ+ relationships, contraception, and women's sexual health and experiences.
Condoms are the contraceptive method which young people are most aware of how to access, with IUS and IUDs being the least known methods.
The GP and pharmacy is where young people felt most comfortable accessing contraception, however this varies for males and females. Young people felt least comfortable accessing contraception from the School Nurse.
Most respondents felt fairly confident that they would know how to access contraception after unprotected sex, but around 20% said they would not feel confident in knowing how to do this.
Responses suggest most young people have not needed to access emergency contraception, but of those who have, most found it very easy or fairly easy.

Evidence of what is effective

Relationships and Sex Education:

There is good international evidence that relationships and sex education, particularly when linked to contraceptive services, can have a positive impact on young people's knowledge and attitudes, delay sexual activity and/or reduce pregnancy rates[59,60,61].

In England compulsory relationships education for primary pupils and RSE was introduced for secondary pupils from September 2020**.** This measure lays the foundations for universal prevention - equipping all children and young people to make safe, well-informed decisions about relationships, pregnancy and sexual health. It also signals a fantastic opportunity for councils to work closely with schools and parents in their local areas to ensure high quality RSE gives children and young people age-appropriate knowledge and information on contraception, safe sex and healthy relationships.

Parents / Carers and other Trusted adults all have a role to play in the education of children and young people and this is particularly relevant when it comes to RSHE and teaching young people about healthy relationships, looking after themselves and staying safe.

The Local Government Association (LGA), RSE Hub, Sex Education Forum and PHE published a briefing providing more detail of how councils can help[62].

Condom Distribution

Condoms are the only contraception that can prevent the transmission of STIs and reduce the number of unwanted pregnancies. Easily accessible condoms to young people and at-risk adults are an important intervention to protect health and reduce unwanted pregnancies. Condom distribution within educational settings and locations that target young people can provide a good introduction to wider sexual and reproductive health services[63].

Condom distribution schemes (CDS) need to be targeted so that they are available for local populations who are at increased risk of contracting a STI. For young people, multi-component schemes including condoms, lubricant and information and/or training are recommended. Condom provision should include reliable information about sexual and reproductive health and clear pathways into services should be available.

PHE research in 2017 investigated the provision of condom distribution schemes across England[64]. The research looked at all CDS, but separated them into C-Card (a distribution scheme aimed at young people aged under 25 years) and

other CDS, including single and multi-component schemes. Most areas in England have a CDS. The C-card schemes are particularly attractive for young people, with 78% of scheme users being 15-19 year olds. There was lower uptake than expected in the 20-24 age range. The research found that there was good repeated uptake of the scheme but fewer new registrations in 2015. Pharmacy was the most popular venue. There was low uptake in the transgender community. The other types of CDS explored in the research were targeted at a range of groups that were at a greater risk of STIs, such as men who have sex with men, sex workers etc. These schemes were mainly run out of GP surgeries.

Condom distribution through a multi-component scheme is cost effective when taking into account the costs of treating STIs. A model containing chlamydia, gonorrhoea, syphilis and HIV incidence in a target group of 13-18 year olds showed that a CDS prevented 1,373 STIs, leading to a cost saving of £758,947. The incremental cost effectiveness ratio was £45,856. When expanding the target group to 13-25 year olds, the ICER reduced to £17,411, when considering STIs only. This reduction is due to the increased number of STIs diagnosed in this group. Including training to reduce condom breakage reduces the ICER again to £14,469, illustrating the benefits of including training in multicomponent distribution schemes.

Contraception

There are a range of contraception methods available including barrier methods and oral contraception, and long acting reversible contraception (LARC), which is not dependent on the user once in place.

Table 7: Types of contraception available.

Type	What is it	Effectiveness	Advantage	Disadvantage
Long Acting Reversible Contraception				
Contraceptive implant	A small flexible rod placed under the skin of the upper arm that released progestogen	Perfect use: >99% Typical use: .99%	Works for several years	Requires a small procedure to fit and remove it
Intrauterine device (IUD)	A small plastic and copper device placed in the uterus (womb)	Perfect use: >99% Typical use: >99%	Works for 5 or 10 years depending on type but can be taken out earlier	Periods may be heavier, longer and more painful
Intrauterine System (IUS)	A small, T-shaped, progestogen-releasing plastic device placed in the uterus (womb)	Perfect use: >99% Typical use: >99%	Works for 3,4 or 5 years but can be taken out sooner. Periods often become lighter, shorter and less painful.	Irregular bleeding or spotting is common in the first 6 months.
Contraceptive injection	An injection of progestogen	Perfect use: >99% Typical use: >94%	Works for 8 or 13 weeks.	Cannot be removed from the body so side effects may continue whilst it works and for some time afterwards.
User Dependent Methods				
Contraceptive patch	A small patch stuck to the skin that releases estrogen and progestogen.	Perfect use: >99% Typical use: >91%	Can make bleeds regular, lighter and less painful.	May be seen and can cause skin irritation.
Combined pill (COC)	A pill containing estrogen and progestogen, taken orally	Perfect use: >99% Typical use: >91%	Often reduces bleeding and period pain, and may help with premenstrual symptoms	Missing pills, vomiting or severe diarrhea can make it less effective
Progesterone-only pill (POP)	A pill containing only progestogen, taken orally	Perfect use: >99% Typical use: >91%	Can be used if you smoke and are over 35	Late pills, vomiting or severe diarrhea can make it less effective

Source: Sexwise, 2018[65]

Women should be provided with information regarding the range of contraception available, and be supported to select a contraception to meet their needs. NICE guidance regarding the provision of long-acting reversible contraception[66] outlines that LARC is more cost-effective than other user dependent contraception and increasing uptake of LARC will reduce the numbers of unwanted pregnancies. All providers of contraception should provide LARC or have suitable pathways into a provider that does. All healthcare professionals fitting LARC should have adequate training and experience.

The provision of contraception to young women is particularly important in relation to reducing unplanned pregnancies. The NICE public health guidelines focusing on contraception services for under 25s[67] recommends that commissioners work across localities to ensure that comprehensive, open access contraception services are available at convenient locations. These services should also have pathways into other sexual and reproductive health services,

maternity and termination services and other support services. Schools and colleges should work closely with providers to signpost to services or provide access to contraception within the education setting.

NICE have produced a Quality Standard in relation to contraception[68] that provides a route to maintain an oversight of contraception provision across all sexual and reproductive health services. Services should be targeted to young people and it is particularly important that young women living in poorer areas are able to access services, both through appropriate advertising and non-judgmental staffing. Services must also allow adequate time to talk through contraception options with young people, with reference to protecting against STIs and emergency contraception as appropriate.

Healthcare professionals should discuss contraception with pregnant women to support the choice of a contraception to use once baby is born, and this choice of contraception should be provided before women leave maternity services. Contraception should also be provided as part of termination of pregnancy services.

Public Health England have undertaken work to quantify the economic benefits of contraception[69]. Modelling by PHE suggests that the number of births in England would increase by 11.1% (based on 2016 birth numbers and equating to 73,720 additional live births in one year) if publicly funded LARC provision was replaced with condom and oral contraceptive pill use.

The return on investment (ROI) figures are outlined in Table 8, which shows that the ROI in public funded sectors during the 10 years for every £1 spent on publicly funded contraception.

Table 8: ROI of publicly funded contraception in healthcare, non-healthcare and total public sectors over 1, 5 and 10 years based on an investment of £1.

Time Horizon	Sector		
	Healthcare	Non-Healthcare	Total Public
1 year	£1.51	£0.36	£1.86
5 year	£2.82	£1.82	£4.64
10 year	£3.68	£5.32	£9.00

It is important to note that these figures are based on assumptions regarding changes in behaviour should contraception no longer be available, however this analysis illustrates that contraception is therefore an important evidence-based, cost-effective intervention.

The third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) explored a range of sexual and reproductive health questions, some of which involved contraception. This study[70] shows that males and females were accessing contraception from a range of venues (during 2010-2012). Of women who had had vaginal sex in the previous 12 months, 59.1% obtained their contraception from primary care and this was the most popular venue. Retail sites were the second most popular venue (28.6%), with pharmacy being the main outlet used. Men were less likely to access primary care (15.3%) than women (59.1%). Community clinics were accessed less than primary care and retail venues by both men (21.3%) and women (23.0%). However, the groups accessing these community venues were younger and at greater risk of poor sexual health. It is important to consider the impact of Covid-19 on primary care and clinic access in the immediate and medium term future.

Emergency Contraception:

Emergency contraception can prevent pregnancy after unprotected sex or if the contraception in use has failed, such as a broken condom or missed oral contraceptive pill. Emergency contraception is available both orally (EHC), and through an IUD. The IUD is the most effective method of emergency contraception and should be recommended for consideration by all suitable women who have had unprotected sex and do not want to conceive[71]. EHC can be available in pharmacies and IUDs are only available through specialist services or primary care. If women access a

pharmacy and request an IUD, there should be a pathway into primary care or specialist sexual health services to enable this. Pharmacies are an important component of sexual and reproductive health services as they can increase access and reduce inequalities[72], especially where pharmacies are the main healthcare providers within a deprived area. However, it is important to ensure that these services are quality assessed and that there is an effective distribution of providers within a locality to meet need.

Teenage Pregnancy:

Measures to reduce teenage pregnancy need to be both universal and targeted. Although two-thirds of young people do not have sex before 16 years, by 20 years, 85% will have experienced vaginal intercourse, so all young people need good RSE and access to services to prevent early pregnancy and look after their sexual health.

Universal prevention programmes are also essential to reduce rates by a substantial margin. Some young people, however, will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration providing the means and the motivation to prevent early pregnancy. Reaching young people most in need, involves looking at area and individual level associated risk factors. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates. At an individual level, the factors most strongly associated with pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care leaver. Other associated risk factors include first sex before 16 years, experience of sexual abuse or exploitation, alcohol use, and experience of a previous pregnancy. Young people who have experienced a number of these factors will be at significantly higher risk.

The NICE Public Health Guideline (3): sexually transmitted infections and under-18 conceptions: prevention covers one to one interventions to prevent sexually transmitted infections (STIs) and under-18 conceptions. The aim is to reduce the transmissions of chlamydia and other STIs, and reduce the rate of pregnancies among women aged under 18[73].

More background information and advice on tackling teenage pregnancy is provided in Public Health England's joint paper with the Local Government Association (LGA) published January 2016 'Good progress but more to do - Teenage pregnancy and young parents'[74]. They have also produced two documents to support councils in making further progress, A teenage pregnancy prevention framework[75], and a framework for supporting teenage mothers and young fathers[76]. These frameworks suggest 10 key factors of effective local strategies to reduce under 18 teenage conceptions as per Figure 35 below.

Figure 35: Ten key factors in addressing teenage pregnancy: the importance of a whole system approach.

Source: PHE and LGA

Sexual Health Screening:

The aim for STIs is to maximise the prevention and reduction of the incidence and prevalence of each STI to the lowest level possible. Incidence refers to the number of new cases of a disease over a particular time e.g. the number of new cases of chlamydia in 2018-2019. Prevalence is the number of people living with a condition at a given time e.g. the number of people with HIV in 2018. Government guidance suggest this can best be achieved though collaborative whole system commissioning on the following areas.

- open access to SHSs, in person or online
- relationships and sex education (RSE)
- PHE's national HIV Prevention and Sexual Health Promotion programme
- the National Chlamydia Screening Programme (NCSP)
- the National HPV Immunisation Programme
- the Syphilis Action Plan
- Condom distribution schemes
- Management of local STI outbreak and incidents

Current guidelines recommend [77]

- Annual STI screening (inc. HIV testing) for all who have condomless sex with new or casual partners.
- Chlamydia screening for all sexually active under 25 year olds annually and on change of sexual partner.
- Annual STI (inc HIV testing) for all gay, bisexual and other men who have sex with men and every three months if having condomless sex with new or casual partners.

The first two recommendations are listed as for "all" attenders at sexual health services. A specific target is listed only for MSM. This recommends that 97% of men should be offered an STI screen at each new episode of care.

HIV

UK National Guidelines for HIV Testing 2008 recommended that Local Authority and NHS bodies consider implementing routine HIV testing for all general medical admissions as well as new registrants in primary care where the diagnosed HIV prevalence exceeds 2 in 1,000 population aged 15 to 59 years[78].

In 2017, guidelines were updated by NICE HIV testing guidelines, which is co-written with Public Health England. This guidance defines high HIV prevalence local authorities as those with a diagnosed HIV prevalence of between 2 and 5 per 1,000 and extremely high prevalence local authorities as those with a diagnosed HIV prevalence of 5 or more per 1,000 people aged 15 to 59 years[79]. When this is applied to national late HIV diagnosis data, it shows that two-thirds of late HIV diagnoses occur in high-prevalence and extremely-high-prevalence local authorities. This means that if this recommendation is successfully applied in high and extremely-high-prevalence areas, it could potentially affect two-thirds of late diagnoses nationally.

Testing frequency varies depending on risk, BHIVA/BASHH/BIA adult HIV testing evidence based guidelines[80] suggest a range of test frequencies for different cohorts including annual testing and quarterly (every 3 months). Those cohorts that the evidence suggest quarterly tests include MSM reporting:

- Condomless anal intercourse with partner(s) of unknown or serodifferent HIV status, where the contact is not known to be virologically supressed (i.e. not protected by Treatment as Prevention (TaSP)), over the last 12 months;
- Multiple or anonymous partners since the last HIV test;
- More than 10 sexual partners, over the last 12 months;
- Drug use during sex in the last 6 months.

Those diagnosed late incur twice the direct medical costs for HIV care in the first year after diagnosis compared with those diagnosed early. This is largely due to increased inpatient hospital care costs, which are 15 times higher for those diagnosed late. Subsequent HIV care costs, for those diagnosed late, remain 50% higher in the years following diagnosis due to increased rates of hospital admission and increased costs of providing treatment[81].

Point of care testing (POCT) is a type of HIV test that is undertaken with the patient present, it is recommended by NICE in areas with high levels of HIV late diagnosis. Blood is taken from a finger prick and results are ready between approximately one and 20 minutes[82]. There are a number of benefits to POCT, namely that the results are received straight away and if positive, the person is not alone for the diagnosis. There is a smaller margin for technical error resulting in a more accurate test result, although a full confirmatory test would still be required. Rapid tests are a cheaper method for testing and have shown to be effective[83]. NICE has advocated for expanding testing outside clinical settings by engaging community organisations, developing local strategies to increase testing, and by providing rapid HIV tests. Testing in non-medical settings such as community HIV testing, self-sampling and self-testing for HIV broadens the options available to people wishing to take an HIV test.

Local stakeholders should learn from “look backs” of episodes of late and very late HIV diagnosis. The BHIVA standards of care for people living with HIV suggest that services should undertake a review of all patients diagnosed late (CD4 count ,350 cells/mm^3) or very late (CD4 count ,200 cells/mm^3 or an AIDS-defining event within 3 months of diagnosis), with “look back” of previous engagement with healthcare services. This review should include provision of summary information to commissioners to aid greater understanding of interventions to reduce late diagnosis. Whilst this will be voluntary, there is a nationally standardised approach developed by BHIVA and PHE.

Pre-exposure prophylaxis (PrEP) when used consistently by individuals at risk of HIV infection is highly effective at preventing HIV acquisition. When taken daily, PrEP is highly effective at preventing HIV transmission from sex or injection drug use. Studies have shown that PrEP reduces the risk of getting HIV from sex by about 99% when taken daily[84,85,86]. It is very probable that this scale-up of PrEP use will have a substantial effect at reducing underlying HIV incidence, however there are some concerns that it may lead to a rise in other STI’s due to potential reduction in condom use.

Digital:

Online sexual health services include the provision of health promotion information, online ordering of contraception or STI testing kits and signposting to in-person sexual health services.

The Faculty of Sexual and Reproductive Health (FSRH) and BASHH have endorsed these innovations for their potential to enable and empower users to access their healthcare in ways other than a traditional face to face consultation. The UK government has similarly endorsed online SRH services on the basis that the open access model may facilitate more rapid treatment and partner notification and thus reduce the risk of STI complications and infection spread. [87]

Online services may also help manage demand for services, particularly among lower risk and asymptomatic patients.

FSRH and BASHH have outlined five standards for providers of online SRH services to maintain in order to ensure any new commissioned online services are provides good quality care[88]. They recommend that services must be

1) Safe: This encompasses the requirement for services to have appropriate processes and procedures in place around safe remote prescribing, safeguarding, staff training and risk management.
2) Effective: This requires providers to consider capacity and consent of service users. It also covers the need for appropriate information governance, record keeping and advertising standards.
3) Caring: Services must be accessible to all and treat users with kindness, respect, compassion, dignity and confidentiality.
4) Responsive: Providers must show engagement and responsiveness to user concerns, complaints and suggestions.
5) Governance and leadership: Providers must demonstrate that services are well led with strong corporate governance and aim for a culture of learning and innovation.

Chlamydia screening programme:
The National Chlamydia Screening Programme (NCSP) changed in August 2021 to focus on reducing reproductive harm of untreated infection in young women.

Opportunistic screening (that is the proactive offer of a chlamydia test to young people without symptoms) should focus on women (including cisgender women, transgender men and non-binary (assigned female at birth) people who have not had hysterectomy or bilateral oophorectomy), combined with:

- reducing time to test results and treatment
- strengthening partner notification
- re-testing after treatment

In practice this means that chlamydia screening in community settings, such as GPs and pharmacies, will only be proactively offered to young women. Services provided by sexual health services remain unchanged.

Everyone can still get tested if needed, but men will not be proactively offered a test unless an indication has been identified, such as being a partner of someone with chlamydia or having symptoms.

Current interventions in Essex

Essex Sexual Health Service:

Provide has been the service provider in Essex county since 2016, they lead a consortia of providers who work collaboratively to deliver the service. In 2019-20 there were 61,828 first appointments completed in sexual health service clinics supporting residents around a range of sexual health issues.

The Integrated Sexual Health Service model aims to improve sexual health by providing easy access to services. The service delivers open access, where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and accessible locations. The service was designed to be provided using a 'Hub and Spoke' model. This means that there will be central 'hubs' providing a full range of services from Level 1 to Level 3, and a number of additional 'spoke' clinics that provide a minimum of Level 1 and Level 2 services, spread across Essex.

Pre-level 1 Self-managed care e.g. health promotion, condom distribution, asymptomatic opportunistic chlamydia screening

Level 1 Basic – Primary care e.g. contraception provision by GPs and Pharmacies

Level 2 Intermediate – delivery in spoke clinics e.g. asymptomatic and symptomatic STI provision including HIV testing and uncomplicated contraception provision

Level 3 Complex – delivered in the hub e.g. complicated and recurrent STI provision and complicated contraception.

The Service's 'dual-trained' contraception and sexual health staff are able to provide a seamless 'one-stop-shop' that enables service users to receive all the services they need, whether contraception, sexual health, or both in one appointment. The central booking system and triage system implemented has meant that the service has moved away from what was historically a service that operated on a predominately 'drop-in' basis to a service that is able to prioritise individuals based on their level of need/risk and offer appointments as appropriate.

The Sexual Health Service deliver a range of Relationships and Sex Education related topics in schools. They also offer a range of bespoke RSE training aimed at Professionals, Voluntary Youth Workers, Parents/Carers and Foster Carers.

Teenage Pregnancy Action Plan:

The Essex Teenage Pregnancy Prevention group is a multi-agency partnership focusing on reducing unplanned teenage pregnancy across the County. The group has developed a whole system action plan to reduce teenage conceptions and terminations whilst also ensuring support for pregnant teenagers and young parents. The group's focus is based on the 10 domains from within the teenage pregnancy prevention framework.

Essex Healthy Schools:

The Essex Child and Family Wellbeing Service delivered by HCRG Care Group and Barnardos. The service currently supports 88% of schools in Essex to take actions to improve the health and wellbeing of children and young people. The programme is currently being reviewed and updated but will continue to focus on pertinent issues including delivery of high quality PSHE and Emotional Wellbeing. The aim for the new programme will be to increase engagement further, particularly amongst secondary schools.

Next steps for Essex

This Health Needs Assessment will inform future commissioning and strategy for Sexual Health in Essex. The below recommendations will be useful to develop a strategic ambition for sexual health in Essex, this should include aspirations for services and system wide approaches to prevention, early identification and treatment of sexual health issues. These strategic ambitions will be realised over the long term, however there are some opportunities in the short to medium term to improve services and partnerships to deliver improvements in population sexual health.

Overarching Recommendations:

1. Develop more integrated system approaches to governance, planning of sexual health services
2. Improve engagement and communications with residents about their sexual health, to promote preventative messages, encourage appropriate access to treatment and improve services.

Partnership and Integration

3. Improve timely information sharing between providers including maternity services to improve care and support for those under 18 who conceive.
4. Take focused action to tackle Harlow's HIV prevalence (above 2 per 1000 threshold)
5. Work collaboratively to address variation in LARC provision across Essex

Prevention

6. Support for men who have sex with men (MSM) and risk in relation to HIV and other STIs need to be able to reach not only identified gay and bisexual men but also target men identifying as heterosexual.
7. Seek to understand current opportunities and challenges to increase condom distribution across Essex.

Equity

8. Improve data recording and reporting to gain a better understanding of potential inequities Sexual Health outcomes across Essex
9. Closely monitor HIV testing vs HIV late diagnosis rates in Essex population. Learn from HIV late diagnosis events through retrospective look backs to identify missed opportunities.
10. Monitor impacts of over the counter contraceptive pill availability
11. Monitor new and emerging threats such as Mgen and drug resistant infections

Conclusions

Overall the sexual health of Essex is good when compared to England and is similar to East of England. However, there appears to be variation within Essex and burden of sexual ill health is likely to be disproportionate across the population; young people, black and ethnic minority groups and MSM are more likely to suffer sexual ill health.

Rates of under 18 conceptions leading to abortion in Essex has fluctuated between being similar to or higher than England average in the past, there is some variation between districts across Essex (note small numbers which may make small random changes make large changes to rates at a district level)

Changes in HIV testing approach in last 3 years by SHS doesn't appear to have impacted late diagnosis figures but we should monitor this closely. Any late diagnosis is a demonstration of failure of the system- costs are high for the patient and healthcare system.

There appears to be significant variation between contraception provision across the four quadrant areas that the sexual health service covers, reasons for this this should be explored further. LARC provision appears to vary across Primary Care in Essex, Sexual Health Service activity moderates some of the apparent inequity however it doesn't do this fully.

There is a need to improve partnerships from both a strategic and operational perspective, focused improvement on these relationships will allow opportunities to increase preventative activity, improve equity in access to testing and treatment which can improve outcomes.

Appendix 1: Data Pack

Further backing data used in the development of this Health Needs Assessment

SHNA%20data%20report%20v5.docx

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