Top 100 Keywords from the JSNA Sexual Health Chapter

The top 100 key words were taken from this Sexual Health JSNA Chapter (Excluding commonly used words). The size of the word represents how often it was used in this chapter -larger meaning the word was used more frequently.

Document Control

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JSNA– Sexual Health Chapter

Table of Contents

Tables

Figures

Executive Summary

While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. Reducing rates of teenage pregnancy, protecting vulnerable groups from sexual abuse and exploitation, and improving diagnosis of HIV all have an impact on the quality of life for those affected, as well the resources required to respond to poor sexual health.

This JSNA chapter inevitably focuses on what is wrong with the sexual health of the people of Havering, as its purpose is to advise commissioners and service providers on what are the issues in order to help to plan and deliver services. However, it should be borne in mind that loving relationships, physical touch and sex can bring a range of health benefits, including lower blood pressure, improved heart health, and the ability to cope with stress. The World Health Organisation defines good sexual health as *"… a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence"*[1].

This is the first time for Havering, that poor sexual health has been described in terms that describe both the physical impact and societal aspects of poor sexual health. It describes how poor sexual health is both a result of – and a precursor to – a wide range of societal ills. Poor sexual health has complex consequences, affecting the individual concerned, their families, the community and wider society. The three main features of poor sexual health are (1) unintended or unsafe pregnancy, (2) sexually transmitted infections, and (3) sexual exploitation and abuse. All of these features can be interlinked and also associated with wider social issues, such as alcohol and drug misuse, domestic violence, low levels of education, and poor mental health.

With one in six pregnancies being unplanned and two of the six being ambivalent, this means that half of pregnancies result in babies being born into families that are, at the very least, not actively seeking the arrival of a new child. Whilst the "surprise" of an unintended pregnancy can be a real joy for some parents, for many women and their partners an unplanned pregnancy brings additional pressures and challenges, in addition to existing stresses. Even where there is joy of an unintended pregnancy, this can be overshadowed by financial worries and stresses. Whilst an unplanned pregnancy can be a challenge at any age, it is particularly challenging for adolescents, as teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation, and poverty, with the impact being felt by both the mother and the child.

The rates of sexually transmitted infections (STIs) are rising. Whilst this may be due in part to improved detection and reporting, it remains the case that many infections are asymptomatic, which means that the infection statistics are likely to be just the tip of the iceberg. Co-infections are common, and being infected with an STI makes transmission of HIV easier. HIV infection is becoming an increasing global public health concern; the early symptoms of infection are similar to influenza, and then there are no further symptoms for several years. During this time, many people are unaware that they have been infected, which means that they (1) could be infecting others, and (2) their own health will deteriorate as they will not be receiving treatment.

Women's health is affected by undiagnosed STIs. Left untreated, chlamydia can lead to pelvic inflammatory disease and ultimately infertility, and contracting human papilloma virus (HPV) is a risk factor for cervical cancer. Infections in pregnancy, including sexually transmitted infections such as HIV and hepatitis B, can be passed on to the baby. In addition, with the exception of hepatitis B, the human body does not build immunity to STIs and (other than HPV vaccination) there are no immunisations available to prevent an STI. Therefore, it is possible to contract STIs repeatedly, and if an individual is treated for an STI, and their partner (or partners) remains untreated, then an infection can be passed back and forth.

[1] WHO (2006). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002. Geneva, World Health Organization.

Sexual violence and abuse, where there is either forced or unwanted sexual activity by one person on another, or where vulnerable people are exploited by groups or individuals, is the third and arguably most concerning element of sexual ill health. Recent court cases involving the dreadful sexual exploitation of children have illustrated how sexual exploitation and abuse is often hidden and unnoticed, and how vulnerable young girls and boys can be abused, leaving them traumatised and scarred for life. Other criminal acts, including sexual violence against girls and women is a particular public health concern, including female genital mutilation which has devastating health consequences for girls and women; trafficking and enforced prostitution, and girls who are sexually exploited by their peers through gang membership.

As with many health outcomes, sexual health is patterned by socioeconomic inequalities, with those from disadvantaged groups often being more at risk of poor sexual health outcomes, such as infections and unwanted pregnancies. These groups include, for example, people with learning difficulties, where parents and foster carers find it more difficult to talk and respond to the sexual development of a child who has a learning difficulty, and where services may not provide information in a form that is accessible to people with learning difficulties. Young people who are looked after, or who have left care, are also more at risk of poor sexual health outcomes; the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect can result in the inability to form healthy, loving, respectful and safe relationships and can thus result in poorer sexual outcomes. Some ethnic minority groups may also experience poorer sexual health, where religion and/or culture influence attitudes and moral judgements towards sexuality, sex and sexual health. The social norms and views about teenage pregnancy, attitudes towards the acceptability of contraception (and types of contraception), views about HIV status, and about people who are lesbian, gay, bisexual or transgender, although primarily influenced by the dominant culture, are also influenced by micro-cultures, and by individual faith. Despite efforts to normalise testing, there is often stigma and shame associated with seeking healthcare for sexually transmitted infections. This is particularly the case for HIV testing, where the fear of negative social consequences of a positive HIV test can deter some people from getting tested. Once diagnosed, people living with HIV are particularly vulnerable to discrimination and negative attitudes.

In terms of inequalities in sexual health this chapter does not attempt to describe the factors that influence each and every aspect of sexual health, although it does make recommendations for further (and broader) needs assessments to be undertaken for some groups, where the wider influences on health overall can be holistically considered along with higher risks of poorer sexual health

As this chapter will illustrate , tackling poor sexual health requires a broad and integrated strategy; one that seeks to influence attitudes about healthy and respectful relationships, builds the resilience and capabilities of young people to commence safe sexual relationships when it is the right time for them to do so, equips professionals and the wider community to recognise and respond to sexual violence, provides information and advice to all in the community about contraception and where effective contraception can be obtained, and ensures that all who are sexually active know how to protect themselves and their partners from sexually transmitted infection. Such a strategy will need the involvement of schools and parents, health professionals, social care professionals, substance misuse commissioners and providers, abortion and maternity service providers, community safety experts including those with knowledge of domestic violence / prostitution, and community and faith leaders.

The key points and recommendations that are described throughout this chapter are summarised below under headings of the three main features of poor sexual health:

- Unintended or unsafe pregnancy,
- Sexually transmitted infections, and
- Sexual exploitation and abuse.

There is a final set of key points and actions that describe how commissioners, providers and stakeholders can work together to focus on prevention, health improvement, and address inequalities.

Unintended or unsafe pregnancy

Key points

- Rates of under 18 conceptions have fluctuated in the past, but since 2008 there has been a steep decline
- The steep decline is mostly attributed to reductions in rates of conceptions among 16 and 17 year olds
- Although small in absolute numbers, three year trends of under 16 conceptions shows that Havering remains above England, London (and even inner London) rates
- High rates of under 18 conceptions that lead to abortions
- Exceeds the national average for repeat abortions, both for those aged under 25, and those aged over 25
- Significantly worse rates for ectopic pregnancy admissions, compared to England and statistical neighbours (although similar to London)
- Significantly lower rate than England and statistical neighbours for GP prescribed Long Acting Reversible Contraception (LARC)
- Natsal survey: 1 in 6 pregnancies unplanned, 2 of 6 ambivalent. Just half of pregnancies planned

Recommendations

Objective	Action
• Increase uptake of long-acting reversible contraception (LARC), especially among 18-25 year old women	• LBH to commission sexual health services that increase uptake of LARC • LBH to ensure that school nurses provide information on reliable methods of contraception, including signposting to reliable websites and apps
• Increase uptake of intra-uterine devices (IUD) as emergency contraception	• LBH to commission sexual health services that provide/signpost to IUD as emergency contraception
• Ensure that midwives have appropriate knowledge of contraceptive methods, including LARC, and contraception when breastfeeding	• CCG to ensure that maternity services have appropriately trained midwives
• Ensure that appropriate advice on contraception is given by maternity services to pregnant women, that the midwife checks with the woman after birth that a method of contraception has been chosen	• CCG to ensure that maternity services audit advice given about contraception (pre and post birth), and that service user feedback is used to improve advice and information
• Ensure that health visitors discuss contraception with new mothers	• LBH to ensure that advice given by health visitors is audited, and that service user feedback is used to improve advice and information
• Ensure that there is a clear pathway for women to access contraception after birth, including options for contraception to be provided by the midwifery service, referrals into contraception services, and follow up at the 6-8 week check	• CCG to ensure that maternity services has a pathway into contraception services • CCG to consider options for contraception to be provided by the midwifery service • LBH to ensure that integrated sexual health service provider engages with GPs in order that good quality contraception advice is given to women at the 6-8 week check

Objective	Action
• Ensure contraception is discussed before abortion (including LARC), and develop a referral pathway for follow up post abortion, including using communication methods most acceptable to the woman	• CCG to ensure that abortion providers discuss contraception during pre-abortion counselling and that there is a referral pathway into contraception services post-abortion using the most appropriate communication methods
• Understand further the reasons for ectopic pregnancy	• LBH Public Health to support CCG and work with relevant services to investigate the reasons for ectopic pregnancies
• Reduce risks of ectopic pregnancy: reducing smoking pre-conception, increase identification of non-symptomatic chlamydia infection in young people, increase awareness and detection of pelvic inflammatory disease	• LBH to commission stop smoking services to engage with contraception services to ensure that women contemplating pregnancy are supported to stop smoking • LBH to ensure that commissioned chlamydia screening service improves detection rate
• Gain a greater understanding of infertility and miscarriage to inform commissioning plans and health improvement plans	• LBH Public Health to undertake a maternal health need assessment to include infertility and miscarriage

Sexually transmitted infections (STIs)

Key points

- Young people most at risk of STIs
- Other at-risk groups are: men who have sex with men (MSM) and black Africans
- MSM bear a disproportionate burden of ill-health in three areas: sexual health and HIV, mental health, use of alcohol, drugs and tobacco
- Rates of sexually transmitted infections increasing - possibly due to improved detection and reporting
- Many infections are asymptomatic
- Infection statistics likely just the tip of the iceberg, with many undetected infections
- Women's health affected by undiagnosed STIs: pelvic inflammatory disease/infertility
- Chlamydia is the most common STI
- Significantly higher rates of diagnoses and gonorrhoea diagnoses than statistical neighbours (although similar to England and lower than London)
- Chlamydia rates in Havering lower than England although rates of herpes and warts higher than England, which could indicate low detection of chlamydia
- Lower uptake of HIV testing among both women and men in GUM than statistical neighbours, England and London
- 50% of people diagnosed with HIV in 2011 were diagnosed late, which increases the risk of infection being passed on
- Havering's prevalence of diagnosed HIV lowest of all London boroughs and remains the only borough with less than 2 per 1,000, although there are wards where prevalence is greater than 2 per 1,000

Recommendations

Objective	Action
• Focus on prevention of STIs	• LBH to ensure that school nurses increase knowledge and awareness of STIs among young people • LBH to commission sexual health services that emphasise prevention, including using all available modern technology • LBH to ensure that all sexual health

Objective	Action
	providers of STI testing include health promotion advice for those who test both positive and negative • LBH to increase registration with C-card scheme
• Ensure that ante-natal and newborn screening programme is being delivered locally so that babies are identified that are at risk as a consequence of maternal sexual health, including screening for HIV, and babies completing immunisation and serology testing for Hep B	• Director of Public Health, through the Health Protection Forum, to seek assurance of effectiveness of ante-natal and newborn screening
• Seek information on numbers of partners of women identified as HIV positive in pregnancy where partners have not been informed of HIV status	• Director of Public Health, through the Health Protection Forum, to seek information on partners of women identified as HIV positive in pregnancy where partners have not been informed of HIV status
• Normalise and increase uptake of HIV testing, especially among high risk communities	• LBH health improvement network to train health champions from among the African community to promote HIV testing • LBH to commission HIV prevention programmes that target venues where at-risk communities congregate • CCG to ensure that A&E tests for HIV as part of the suite of blood testing, including auditing the uptake of HIV testing and responding to audit findings • CCG to promote to GPs the advisability and regularity of HIV testing among at-risk groups, including MSM • LBH to ensure that sexual health services engage in national promotion days, including World Aids Day and National HIV testing week with localised information • LBH to commission sexual health services that facilitates ease of access to HIV testing (i.e. remote testing/postal testing)
• For any late diagnoses of HIV, to identify where there were missed opportunities for diagnosis and reduce the likelihood of reoccurrence	• HIV services to undertake a look back of all people who are diagnosed late, to understand the lessons, and disseminate the learning as appropriate to primary, community, and secondary care providers • LBH to evaluate the effectiveness of new patient registration HIV point of care testing
• Gain a greater understanding of how people who are injecting drug users access sexual health services	• LBH to ensure that an audit is undertaken in drug treatment services

Objective	Action
• Explore whether substance misuse services (drugs, alcohol, tobacco) engage with MSM on STI (and HIV) prevention	• LBH to explore how substance misuse services engage with MSM

Sexual exploitation, violence and abuse

Key points

- Exploitation: situations where food/drugs/alcohol/affection etc received in return for sexual acts (gang-related)
- Sexual violence: any unwanted sexual act or activity including rape, sexual assault, rape within marriage/relationships, forced marriage, so-called honour-based violence, female genital mutilation, trafficking, ritual abuse
- Sexual harassment
- Sexual abuse can include stalking, sexting
- Female genital mutilation: carried out between infancy and age of 15: 47 maternities in a 2 year period 2009-2011 with identified FGM
- Forced marriage: 1 in 2012
- Honour based violence: 3 in three years
- Trafficking and enforced prostitution: 27 brothels advertised in 2008 (13th highest in London) – no local statistics but anecdotal
- Mostly against girls and women, although not exclusively so

Recommendations

Objective	Action
• Providers of all sexual health services to evidence that they are competent and trained to undertake motivational interviewing with young people to identify young people who are at risk of sexual exploitation.	• LBH to ensure that sexual health service providers undertake audits of training and effectiveness of motivational interviewing
• All children and young people understand consent, sexual consent and issues around abusive relationships.	• LBH-led Healthy Schools programme and school nursing service to contribute to SRE in schools to ensure children and young people understand sexual consent, and the different needs of boys and young men are acknowledged
• A free telephone helpline be available for vulnerable people at risk of sexual exploitation, and school nurses to be contactable via text messaging (children, young people and parents/carers)	• LBH to commission the integrated sexual health service to provide a helpline for young people to call • LBH to ensure that school nurses can be contacted by a range of methods, including text messaging
• Sex workers to be signposted / referred as appropriate, including to services that support exit from prostitution and for support for those who have been trafficked. Friends or relatives should not act as interpreters for people accessing sexual health services.	• LBH to ensure that sexual health providers have referral pathways in place. • LBH to ensure that all commissioned sexual health services specifically exclude friends or relatives acting as interpreters for clients/patients

Improving sexual health and reducing health inequalities: strategic

Key points

- Requires a broad and integrated strategy with links to associated risk factors
- Is not just about treatment, but also a focus on prevention
- Requires building resilience and capabilities of young people to commence safe sexual relationships when right to do so
- Relies on communities having knowledge of sexual health, including how to make the right choices to prevent poor sexual health, such as effective methods of contraception
- Requires the involvement of schools, parents, health professionals, social care professionals, substance misuse commissioners/providers, abortion and maternity services, community safety, community and faith leaders

Recommendations

Objective	Action
• Develop a sexual health alliance that aims to improve sexual health amongst the population, and to include representation by services that can address associated risk factors (i.e. drugs and alcohol), and which engages with schools, parents, health professionals, pharmacists, social care professionals, substance misuse commissioners/providers, abortion and maternity services, community safety, and which includes representation on behalf of those that experience sexual health inequalities; appropriate community and faith leaders, young people, looked after young people, people with learning difficulties	• LBH to establish a sexual health alliance
• Develop a teenage pregnancy strategy, in consultation with stakeholders	• LBH Public Health to develop a teenage pregnancy strategy

• Consider undertaking further needs assessments for groups that experience poorer health outcomes including poor sexual health, including looked after children and those leaving care, people with learning difficulties, and people who are lesbian/gay/bisexual/transgender, and offenders (considering the different needs of male, female and young offenders)	• LBH/CCG to consider further needs assessments for specific groups:
	  • looked after children and those leaving care
	  • people with learning difficulties,
	  • people who are lesbian/ gay/ bisexual/ transgender, and
	  • offenders

Introduction

While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. Reducing rates of teenage pregnancy, protecting vulnerable groups from sexual abuse and exploitation, and improving diagnosis of HIV all have an impact on the quality of life for those affected, as well the resources required to respond to poor sexual health.

Over recent years, there have been year-on-year increases in the rates of sexually transmitted infection. This is partly explained by the aetiology of STIs; that immunity cannot be acquired and so individuals can be repeatedly infected, partly explained by attitudes and behaviour; with more people starting sexual activity at a younger age, people having more sexual partners during their lifetime and a willingness to take risks, and partly because of improved detection.

In 2013, the implementation of the Health and Social Care Bill 2012 resulted in responsibilities for commissioning of sexual health being transferred from the (now abolished) Primary Care Trusts (PCTs) to a range of other agencies. Local Authorities became responsible for commissioning open-access sexual health services (sexually transmitted infections and contraception) and HIV prevention. The newly established national commissioning board, operating as NHS England, became responsible for commissioning HIV treatment, cervical screening, HPV vaccinations, and GP-provided sexual health services that are part of GP contracts. And the newly established Clinical Commissioning Groups became responsible for abortion services. With the possible exception of drug and alcohol treatment programmes, these were local authorities' first experiences of commissioning clinical treatments.

Historically, sexual health services had been provided by acute hospital trusts, often as part of a PCT block contract arrangement. In an attempt to improve services for sexual health, there was a move by most PCTs to pay for sexual health service activity through "payment by results" (PbR), in order that acute hospitals channelled sufficient investment into sexual health clinics. A national tariff was published that described charges for a first and follow up visit to Genitourinary Medicine (GUM). The charges were enhanced by applying a Market Forces Factor, which was a calculation that took into account regional variances in the costs of providing services, so for example, services provided by an inner London acute trust costs were assumed to cost more than those provided by an outer London trust services. In reality, a better description of this system would be "payment by activity", as the "results" were largely limited to detecting cases of ill-health and providing a treatment, not to prevention or improving outcomes. Currently there are discussions across London to agree a tariff that pays providers according to the complexity of the intervention; so, for example, payment for an intervention to repeat dispense of condoms would be less than, say, inserting a long term contraceptive device. However, whilst this might improve some aspects of provision, the focus nonetheless remains on treatment, and does not take into account changes required to prevent infection and reduce risk-taking behaviours; which are the new opportunities now available as a result of commissioning responsibilities transferring to local authorities.

Services themselves are provided by a range of organisations, including general practice, pharmacies, acute hospitals, and the voluntary and independent sector.

This chapter and its recommendations recognise the complexities and opportunities presented by the new commissioning arrangements, the need to engage with many and varied service providers and stakeholders, and the impact of wider determinants and associated risk factors such as alcohol and drug misuse, domestic violence, low levels of education, and poor mental health. This chapter has been developed to enable local commissioners to ensure that the right services are made available to improve sexual health, and for local stakeholders to collaborate effectively to prevent poor sexual health and address inequalities in sexual health.

Chapter approach

This chapter pulls together and summarises all relevant available data and information on sexual health as it relates to residents in Havering in order to support local stakeholders to:

- Identify what are the challenges for sexual health in the borough, and consider how these can be addressed
- Identify the assets and opportunities within the borough to promote good sexual health,
- Define or refine strategies aimed at promoting sexual health, and
- Support commissioning appropriate services to meet current and likely future needs.

Throughout this chapter, where appropriate and subject to data availability, local (Havering) rates, percentages and other measures have been compared and benchmarked against England, London, other London boroughs, and other similar local authorities (also referred to as "statistical neighbours"). In some cases, for reasons of clarity and simplicity, only Bexley (because it is Havering's closest statistical neighbour) is used to compare with Havering measures out of all the statistical neighbours. Where this chapter presents data that describe inequalities, it should be borne in mind that reasons for poor sexual health are complex and, as mentioned earlier in this introduction, are influenced by a range of socio-economic, cultural, environmental, social and community factors, which include fears of discrimination, as well as individual lifestyle choices.

The data and information used in this chapter have been largely derived or adapted from authoritative national sources such as Public Health England (PHE) and the Office of National Statistics (ONS). However, where there was lack of data from such authoritative sources and/or where possible, local data were sourced and used. Although appropriate references have been made where necessary, it is recommended that this chapter is read together with other chapters (particularly the Demographics Chapter, and the Children and Young People Chapter) of the JSNA[2].

Whilst this chapter was in production, more recent data, particularly for the sections on Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) – became available. The new information made little difference to the overall picture, needs and issues highlighted in these sections. A refresh of this chapter within 18 months will incorporate any new information available.

Where appropriate and where published, assessments and recommendations by the National Institute for Health and Care Excellence (NICE) are summarised within the body of this chapter. Not all NICE recommendations are fully described in the local recommendations. However, any local actions that are recommended should be assumed to be delivered in accordance with NICE evidence and guidance.

[2] haveringdata.net/research/jsna.htm

Sexual & Reproductive Health Profiles: Tabular Summary for Havering

The Sexual and Reproductive Health (SRH) profiles have been developed by Public Health England (PHE) to support local authorities, public health leads and other interested parties to monitor the sexual and reproductive health of their population and the performance of local public health related systems. They are presented as interactive maps, charts and tables that provide a snapshot of sexual and reproductive health across a range of domains and topics. The SRH profiles are mainly grouped into five domains: Key Indicators; HIV and STIs; Reproductive Health; Teenage Pregnancy; Wider Determinants of Health.

Table 1 to Table 5 are tabular summaries for Havering, compared to England, London and other local authorities in the same deprivation decile (upper tier local authorities grouped into 10 levels of deprivation). The "Key Indicators" domain (see Table 1) provides an overview of sexual and reproductive health and includes relevant indicators in the Public Health Outcomes Framework (PHOF). Table 2, Table 3 and Table 4 respectively provide an overview of "HIV and STIs", "Reproductive Health" and "Teenage Pregnancy". The "Wider Determinants of Health"[3] domain (see Table 5) provides an overview of wider influences on sexual health such as alcohol use, and other topics particularly relating to teenage conceptions such as education and deprivation level.

For more information on all the indicators, visit the SRH profiles online at http://fingertips.phe.org.uk/profile/sexualhealth. This section should either be regularly updated (annually or biennially) and made available to local stakeholders or the online resource should be promoted and regularly utilised by local stakeholders.

Table 1: Snapshot of PHE's Sexual and Reproductive Health Profiles (Key Indicators), Havering compared to deprivation decile, London and England

Indicator	Period	Compared to:		
		England	London	Deprivation decile[4]
Rate of syphilis diagnoses per 100,000 population	2013	Havering has a significantly better rate	Havering has a significantly better rate	Havering has a similar rate
Rate of gonorrhoea diagnoses per 100,000 population	2013	Havering has a similar rate	Havering has a significantly better rate	Havering has a significantly worse rate
Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24	2013	Havering has a significantly worse rate	Havering has a significantly worse rate	Havering has a significantly worse rate

[3] There are a number of definitions of the determinants of health, but most recognise that health outcomes are influenced by biological and hereditary factors, individual lifestyle factors, social and community networks, and general socio-economic, cultural and environmental conditions.

[4] This refers to the local authorities that are grouped into ten clusters, based on their deprivation profile. This compares Havering with the other similar local authorities.

Indicator	Period	Compared to:		
		England	London	Deprivation decile[4]
Proportion of population aged 15 to 24 screened for chlamydia, measured separately in GUM and non-GUM settings (PHOF indicator 3.02ii)	2013	Havering has a significantly worse proportion	Havering has a significantly worse proportion	Havering has a similar proportion
Rate of first episode genital warts diagnoses per 100,000 population	2013	Havering has a significantly worse rate	Havering has a similar rate	Havering has a significantly worse rate
Rate of first episode genital herpes diagnosis per 100,000 population	2013	Havering has a significantly worse rate	Havering has a similar rate	Havering has a significantly worse rate
Uptake of HIV testing among men who have sex with men (MSM) measured in GUM	2013	Havering has a significantly worse uptake	Havering has a significantly worse uptake	Havering has a significantly worse uptake
Percentage of adults (aged 15 or above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (PHOF indicator 3.04)	2011-13	Havering has a similar percentage	Havering has a similar percentage	Havering has a similar percentage
Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years	2013	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly higher rate
HPV vaccination coverage (females 12-13 years old)	2012/13	Havering has a significantly worse coverage	Havering has a significantly worse coverage	Havering has a significantly worse coverage
Percentage of NHS-funded abortions under 10 weeks gestation	2013	Havering has a significantly better percentage	Havering has a similar percentage	Havering has a similar percentage
Percentage of repeat abortions in women aged under 25 years	2013	Havering has a significantly worse percentage	Havering has a similar percentage	Havering has a significantly worse percentage
Rate of GP prescribed long acting reversible contraception (LARC) per 1,000 females aged 15-44	2013	Havering has a significantly lower rate	Havering has a significantly higher rate	Havering has a significantly lower rate
Rate of conceptions per 1,000 females aged 15-17	2012	Havering has a similar rate	Havering has a similar rate	Havering has a similar rate
Percentage of conceptions to those ages under 18 years that led to an abortion	2012	Havering has a significantly higher percentage	Havering has a significantly higher percentage	Havering has a significantly higher percentage

Indicator	Period	Compared to:		
		England	London	Deprivation decile[4]
Rate of sexual offences per 1,000 population	2013/14	Not compared	Not compared	Not compared

Source: Sexual and Reproductive Health Profiles, Public Health England

Table 2: Snapshot of PHE's Sexual and Reproductive Health Profiles (HIV and STIs), Havering compared to deprivation decile, London and England

Indicator	Period	Compared to:		
		England	London	Deprivation decile
Rate of syphilis diagnoses per 100,000 population	2013	Havering has a significantly better rate	Havering has a significantly better rate	Havering has a similar rate
Rate of gonorrhoea diagnoses per 100,000 population	2013	Havering has a similar rate	Havering has a significantly better rate	Havering has a significantly worse rate
Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24	2013	Havering has a significantly worse rate	Havering has a significantly worse rate	Havering has a significantly worse rate
Rate of chlamydia diagnosis per 100,000 young people aged 15 to 24, pre-2012 data	2011	Havering has a significantly worse rate	Havering has a significantly worse rate	Havering has a significantly worse rate
Proportion of population aged 15 to 24 screened for chlamydia, measured separately in GUM and non-GUM settings (PHOF indicator 3.02ii)	2013	Havering has a significantly worse proportion	Havering has a significantly worse proportion	Havering has a similar proportion
Proportion of population aged 15 to 24 screened for chlamydia, measured sperately in GUM and non-GUM settings, pre-2012 data	2011	Havering has a similar proportion	Havering has a significantly worse proportion	Havering has a significantly better proportion
Rate of first episode genital warts diagnoses per 100,000 population	2013	Havering has a significantly worse rate	Havering has a similar rate	Havering has a significantly worse rate
Rate of first episode genital herpes diagnosis per 100,000	2013	Havering has a significantly worse rate	Havering has a significantly better rate	Havering has a significantly worse rate
Uptake of HIV testing among men who have sex with men (MSM) measured in GUM	2013	Havering has a significantly worse uptake	Havering has a significantly worse uptake	Havering has a significantly worse uptake

Indicator	Period	Compared to:		
		England	London	Deprivation decile
Uptake of HIV testing among women measured in GUM	2013	Havering has a significantly better uptake	Havering has a significantly worse uptake	Havering has a similar uptake
Uptake of HIV testing among men measured in GUM	2013	Havering has a significantly worse uptake	Havering has a significantly worse uptake	Havering has a significantly worse uptake
Coverage of HIV testing among men who have sex with men (MSM) measured in GUM	2013	Havering has a similar coverage	Havering has a similar coverage	Havering has a similar coverage
Coverage of HIV testing among women measured in GUM	2013	Havering has a significantly better coverage	Havering has a significantly better coverage	Havering has a similar coverage
Coverage of HIV testing among men measured in GUM	2013	Havering has a similar coverage	Havering has a significantly worse coverage	Havering has a similar coverage
Percentage of adults (aged 15 or above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (PHOF indicator 3.04)	2011-13	Havering has a similar percentage	Havering has a similar percentage	Havering has a similar percentage
Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years	2013	Havering has a significantly lower rate	Havering has a significantly lower rate	Havering has a significantly higher rate
HPV vaccination coverage (females 12-13 years old)	2012/13	Havering has significantly worse coverage	Havering has significantly worse coverage	Havering has significantly worse coverage

Source: Sexual and Reproductive Health Profiles, Public Health England

Table 3: Snapshot of PHE's Sexual and Reproductive Health Profiles (Reproductive Health), Havering compared to deprivation decile, London and England

Indicator	Period	Compared to:		
		England	London	Deprivation decile
Percentage of NHS-funded abortions under 10 weeks gestation	2013	Havering has a significantly better percentage	Havering has a similar percentage	Havering has a similar percentage
Percentage of repeat abortions in women aged under 25 years	2013	Havering has a significantly worse percentage	Havering has a similar percentage	Havering has a significantly worse percentage
Rate of abortions per 1,000 female population aged 15 – 44	2013	Havering has significantly worse rate	Havering has similar rate	Havering has significantly worse rate
Rate of GP prescribed long acting	2013	Havering has a significantly	Havering has a significantly	Havering has a significantly

Indicator	Period	Compared to:		
		England	London	Deprivation decile
reversible contraception		lower rate	higher rate	lower rate
Rate of pelvic inflammatory disease (PID) admissions per 100,000 female population age 15-44	2012/13	Havering has a similar rate	Havering has a similar rate	Havering has a similar rate
Rate of ectopic pregnancy admissions per 100,000 female population aged 15–44	2012/13	Havering has a significantly worse rate	Havering has a similar rate	Havering has a significantly worse rate
Rate of cervical cancer registrations per 100,000 female population	2009-11	Havering has a similar rate	Havering has a similar rate	Not compared

Source: Sexual and Reproductive Health Profiles, Public Health England

Table 4: Snapshot of PHE's Sexual and Reproductive Health Profiles (Teenage Pregnancy), Havering compared to deprivation decile, London and England

Indicator	Period	Compared to:		
		England	London	Deprivation decile
Rate of conceptions per 1,000 females aged 15-17	2012	Havering has a similar rate	Havering has a similar rate	Havering has a similar rate
Rate of conceptions per 1,000 females aged 13-15[5]	2012	Havering has a similar rate	Havering has a similar rate	Havering has a similar rate
Percentage of conception to those aged under 18 years that led to an abortion	2012	Havering has a significantly higher percentage	Havering has a significantly higher percentage	Havering has a significantly higher percentage
Rate of abortions per 1,000 females aged 15-17 (based on year of conception)	2012	Havering has a significantly higher rate	Havering has a similar rate	Havering has a significantly higher rate
Rate of births per 1,000 females aged 15-17 (based on year of conception)	2012	Havering has a significantly better rate	Havering has a significantly better rate	Havering has a significantly better rate

Source: Sexual and Reproductive Health Profiles, Public Health England

[5] Havering is in a relative worse position for under 16 conception rates. See more information in the Under 16 Conception, Maternity and Abortion section.

Table 5: Snapshot of PHE's Sexual and Reproductive Health Profiles (Wider Determinants of Health), Havering compared to deprivation decile, London and England

Indicator	Period	Compared to:		
		England	London	Deprivation decile
Rate of under 18s alcohol – specific hospital admissions per 100,000 population	2010/11-2012/13	Havering has a significantly better rate	Havering has a similar rate	Not compared
Percentage of people in an area living in the 20% most deprived areas in England (IMD2010)	2012	Havering has a significantly better percentage	Havering has a significantly better percentage	Havering has a significantly better percentage
Percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only. PHOF indicator 1.01ii	2011	Havering has a significantly better percentage	Havering has a significantly better percentage	Havering has a significantly worse percentage
GCSE achieved 5A*-C inc. Eng & Maths	2012/13	Havering has a significantly better percentage	Havering has a similar percentage	Havering has a significantly better percentage
Percentage of 16-18 year olds not in education, employment or training (NEET)	2013	Havering has a significantly better percentage	Havering has a significantly worse percentage	Havering has a significantly better percentage
Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)	2012/13	Havering has a similar percentage	Havering has a significantly worse percentage	Havering has a similar percentage
Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	2013	Havering has a significantly better rate	Havering has a significantly better rate	Havering has a significantly better percentage

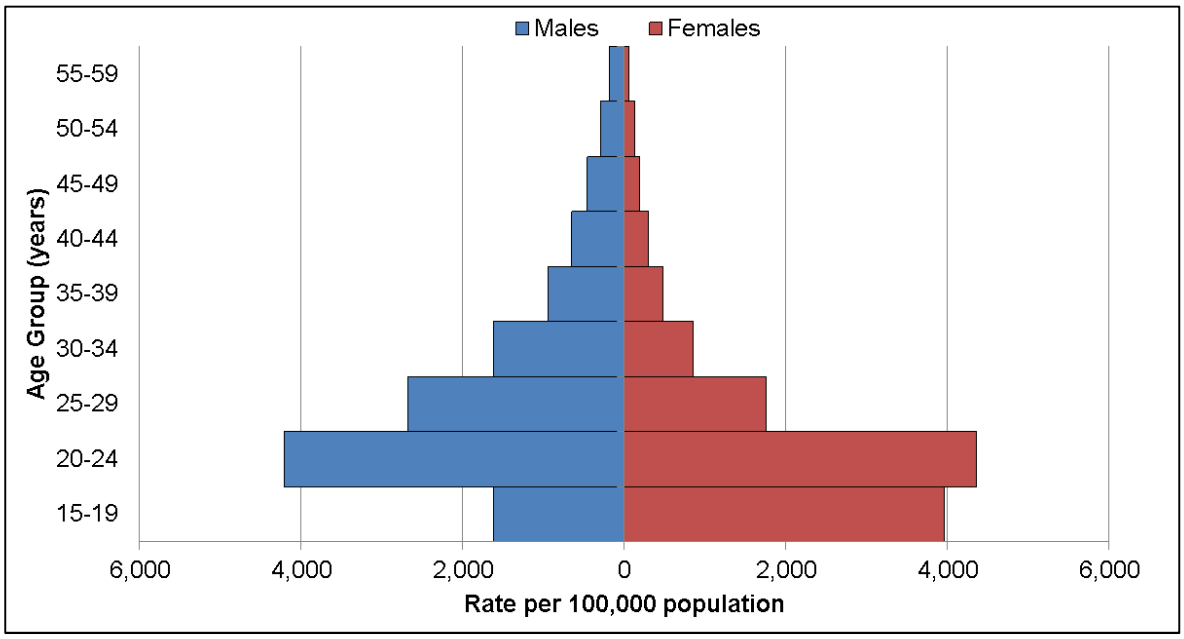
Source: Sexual and Reproductive Health Profiles, Public Health England

Sexually Transmitted Infections (STIs)

Sexually Transmitted Infections (STIs) are caused by more than 30 different bacteria, viruses and parasites that are spread by sexual contact. They can lead to chronic diseases, AIDs, pregnancy complications, infertility, cervical cancer and death. A person can have an STI without having obvious symptoms of disease, but common symptoms include increased discharge, pain or ulcers. Eight of the more than 30 pathogens known to be transmitted through sexual contact have been linked to the greatest incidence of illness. Of these eight infections, four are currently curable: syphilis, gonorrhoea, chlamydia and trichomoniasis. The other four are viral infections and are incurable, but can be mitigated or modulated through treatment: hepatitis B, herpes, HIV and HPV. Some STIs can increase the risk of HIV acquisition three-fold or more.

As highlighted by Figure 1, STIs are more prevalent in younger age groups (particularly the 15-19, 20-24 and 25-29 age groups). In the 15-19 years age group, STIs disproportionately affect women, with approximately 4 out of 100 women in this age group being diagnosed with an STI in one year. Whereas commencing with the 25-29 years age group, STIs disproportionately affect men.

Figure 1: Rate of acute STI diagnoses per 100,000, by gender and age group, in England, 2012



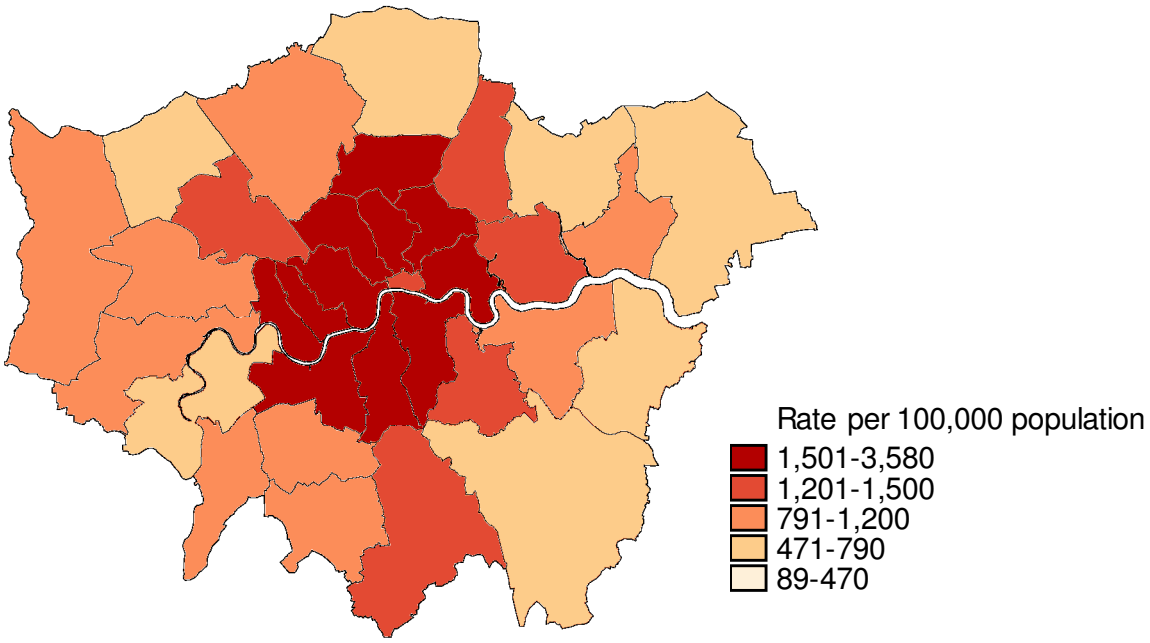
Data source: Public Health England

If STIs are left undetected and untreated, they may result in long terms problems. For example, in women, chlamydia can spread to the uterus, ovaries or fallopian tubes and lead to pelvic inflammatory disease which in turn can lead to infertility, and increases the risk of miscarriage and ectopic pregnancy. For both men and women, chlamydia can lead to reactive arthritis.

In 2012 (the most recent year for which data are available), there was an estimated 742 per 100,000 persons resident in Havering diagnosed with an acute STI (chlamydia, warts, herpes, gonorrhea, and syphilis), i.e. more than 7 out of every 100. Figure 2 and Figure 3 show that this rate is lower than the majority of the other London boroughs (7th lowest rate compared to other London boroughs). This is unsurprising as Havering has a population that is much older than other London boroughs, and as Figure 1 illustrates, STIs are more common among younger people.

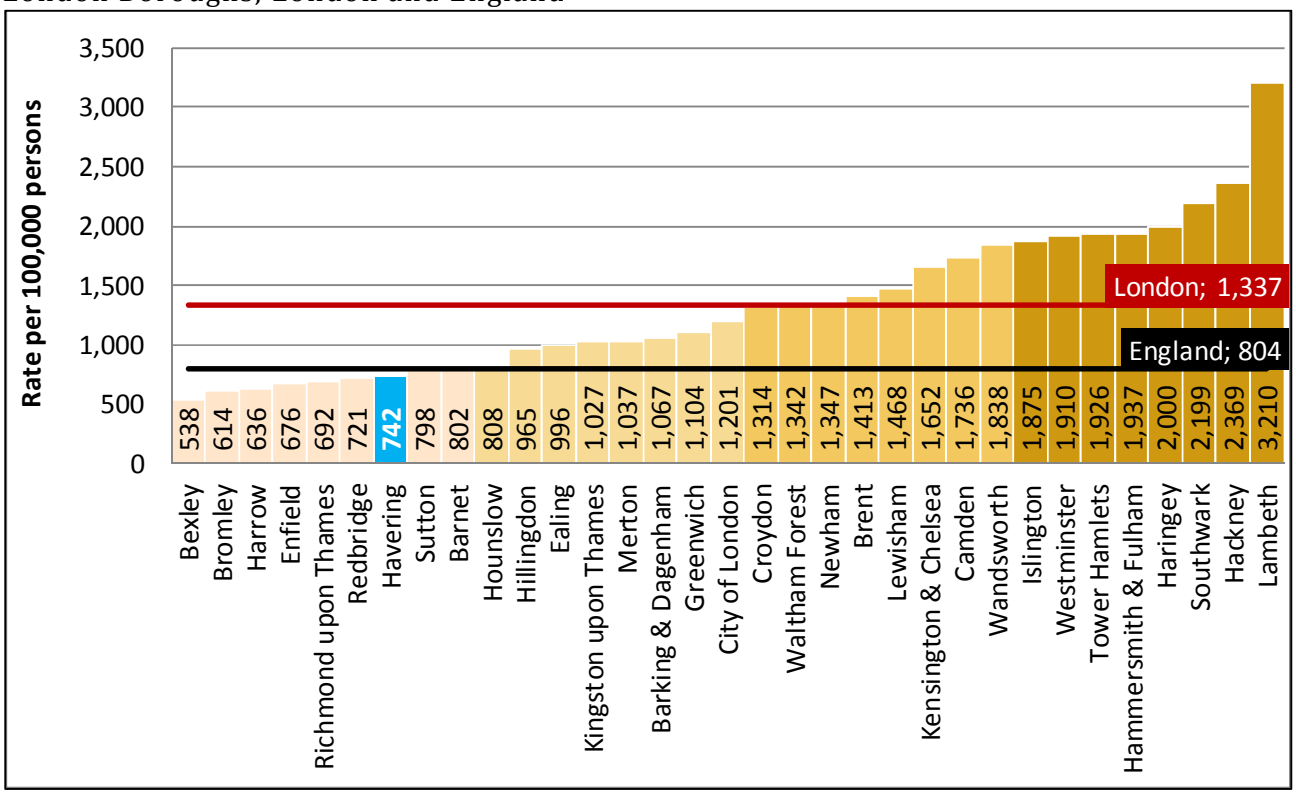
Figure 3 further suggests that the 2012 rate of acute STI diagnoses per 100,000 in Havering is also lower than both London and England. In addition, the 2012 rate of acute STI diagnoses per 100,000 in Havering is in the second lowest quartile of similar English local authorities and almost the same as their average rate (see Figure 4).

Figure 2: Rates of acute STI diagnoses per 100,000 in London by local authority of residence, 2012



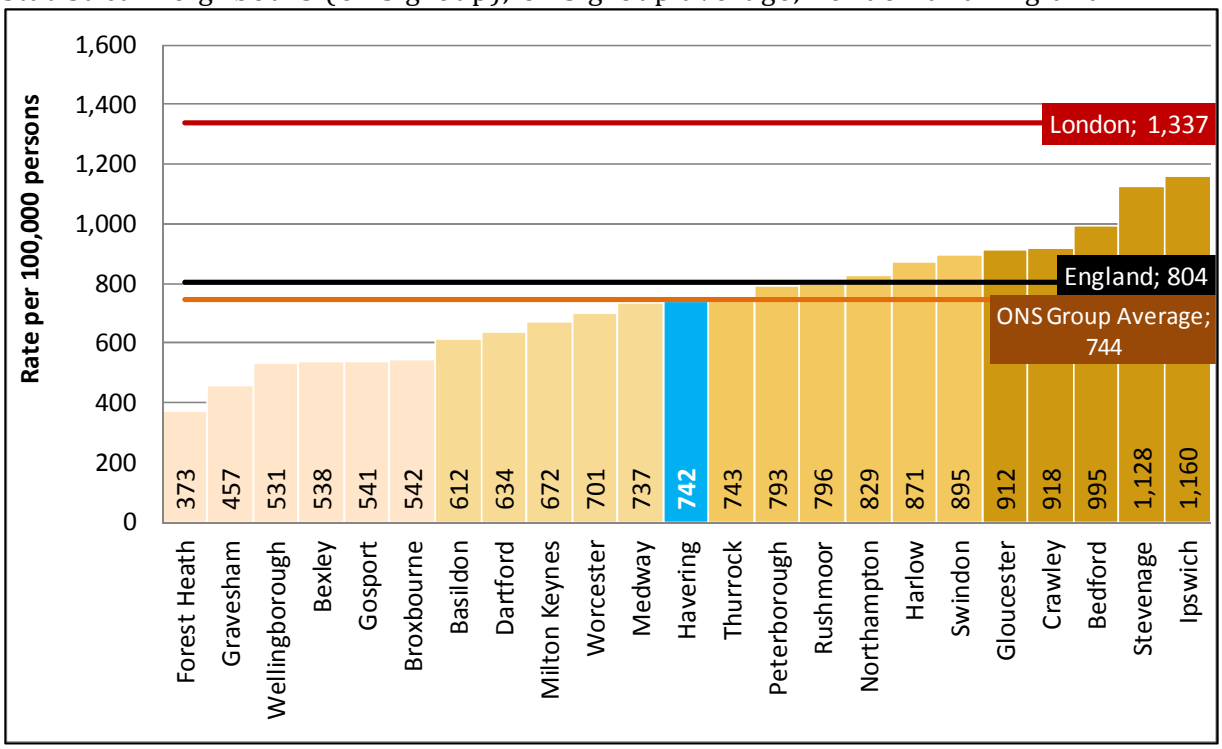
Data from routine GUM clinic returns; chlamydia data source includes community settings
Source: Public Health England

Figure 3: Rates of all acute STI diagnoses per 100,000 in 2012, Havering compared to London Boroughs, London and England



Data Source: Public Health England (Table 3 – Number & rates of acute STI diagnoses in England, 2009 – 2012; Data type: residence data)

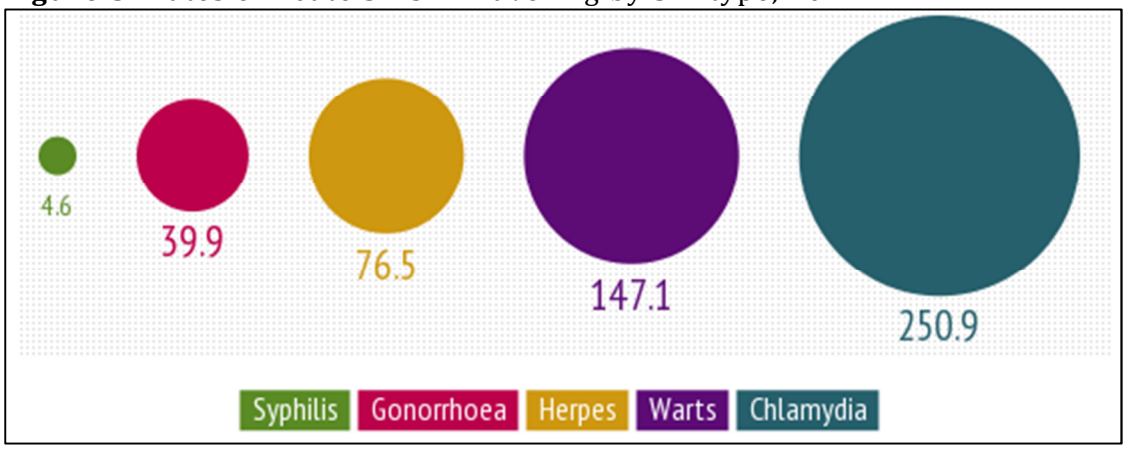
Figure 4: Rates of all acute STI diagnoses per 100,000 in 2012, Havering compared to statistical neighbours (ONS group), ONS group average, London and England



Data Source: Public Health England (Table 3 – Number & rates of acute STI diagnoses in England, 2009 – 2012)

There are over 30 types of sexually transmitted infections (STIs), ranging from pubic lice to HIV. Public Health England collects data on sexual health services and STIs but publishes information on the five most common STIs (namely syphilis, gonorrhoea, herpes, warts, and chlamydia). Figure 5 shows that Chlamydia is the most common STI in Havering (with 251 diagnoses rate per 100,000 of the population in 2012). With the least rate of acute diagnoses (5) per 100,000 of the population in 2012, Syphilis is the least common sexually transmitted infection (STI) in Havering.

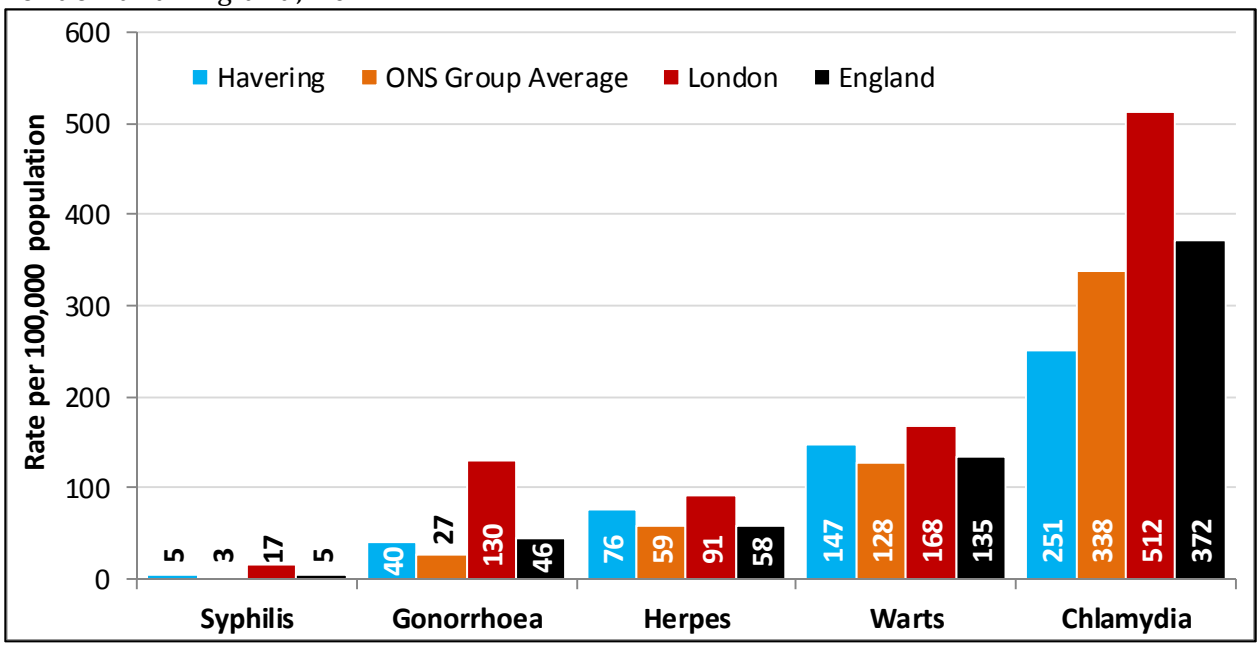
Figure 5: Rates of Acute STIs in Havering by STI type, 2012



Data Source: Public Health England (Table 3 – Number & rates of acute STI diagnoses in England, 2009 – 2012)

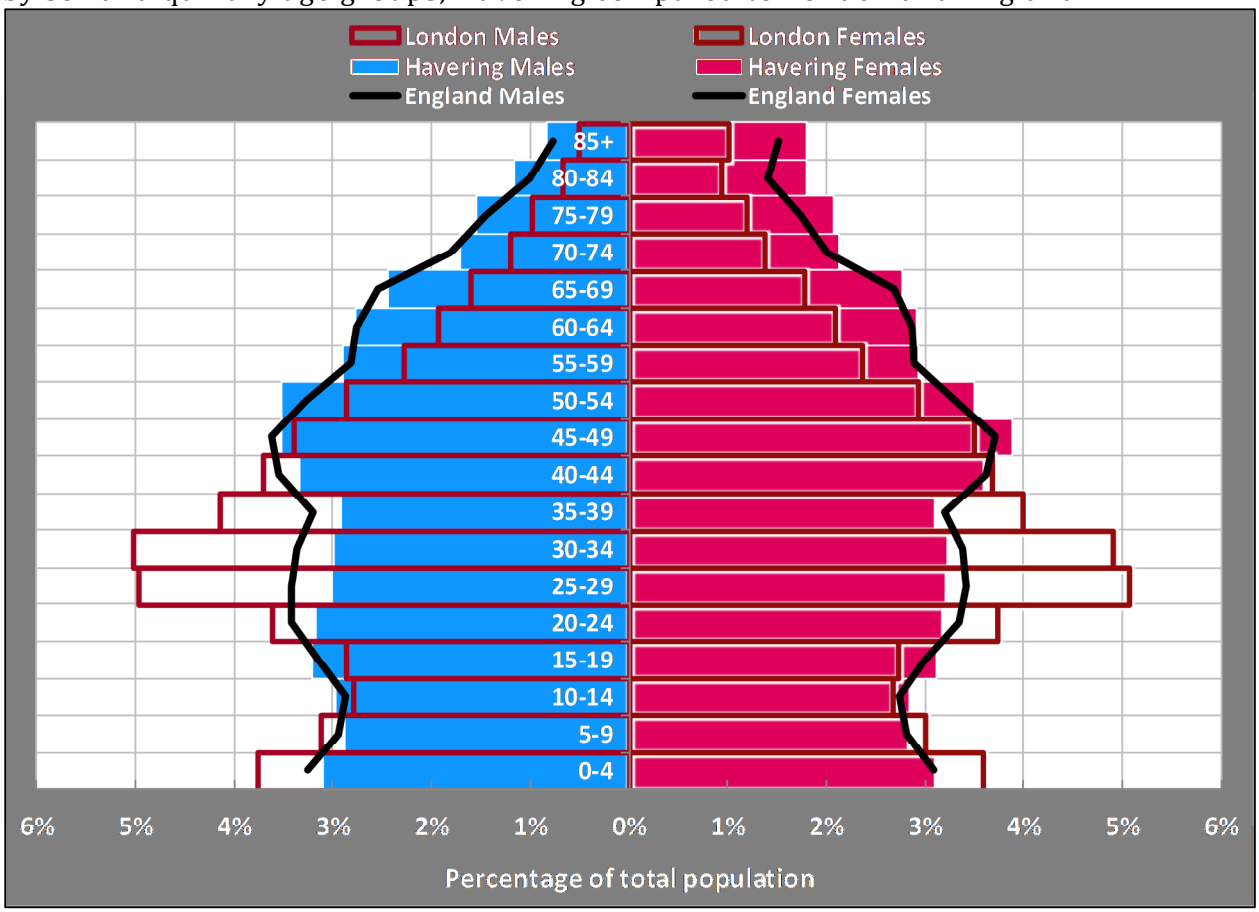
As Figure 6 illustrates, Havering's rates for all diagnosed STIs in 2012 were expectedly all lower than London rates. As described above, STIs are more prevalent in younger age groups and London is structurally younger than Havering (see Figure 7 and the Demographics Chapter for more information). When compared with the 2012 rates for diagnosed STIs in England (with a relatively more similar age structure), only Havering's rates for diagnosed Herpes and Warts were higher – rates for others (Syphilis, Gonorrhoea and Chlamydia) were either similar or lower (see Figure 6).

Figure 6: Rates (per 100,000) of sexually transmitted infections, Havering compared to London and England, 2012



Data Source: Public Health England (Table 3 – Number & rates of acute STI diagnoses in England, 2009 – 2012; Data type: residence data)

Figure 7: Population pyramid, showing the distribution of the total population in 2012, by sex and quinary age groups, Havering compared to London and England

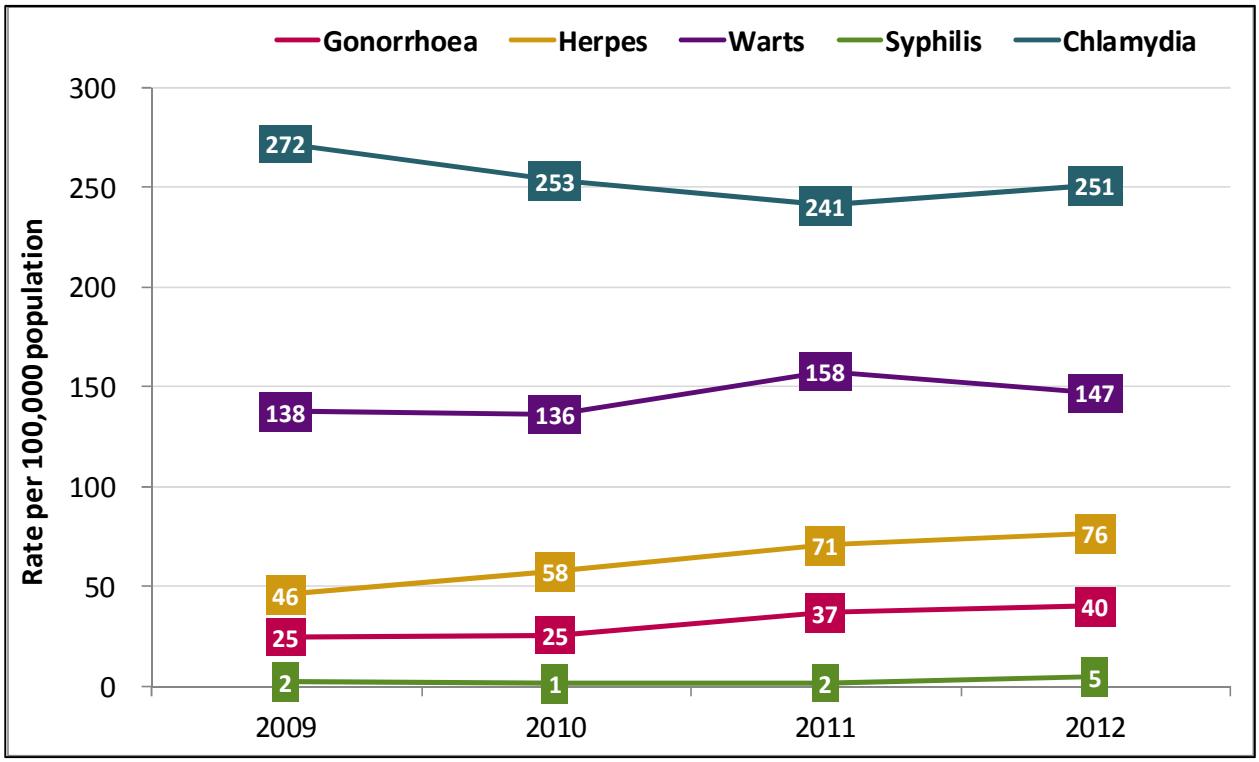


Data Source: ONS mid-2012 population estimates

Figure 8 suggests that (apart from chlamydia, which has been on a slight downward trend from 2009) the acute diagnoses rates (per 100,000 population) of STIs (syphilis, gonorrhoea, herpes, and genital

warts) have increased from 2009 to 2012 in Havering. It should be noted that the 2012 rate for chlamydia in Figure 8 cannot be compared with the rates for preceding years, because of changes made to the 2012 data processing methods.

Figure 8: Rates of acute STIs diagnoses, per 100,000 population, in Havering, 2009 – 2012



Chlamydia diagnoses from GUM services that were reported as 'previously diagnosed at another service' (C4X, C4OX & C4RX) have been excluded from 2012 data (only). These diagnoses have been reported via CTAD & are already included in the community services chlamydia data. As a result, GUM services chlamydia data from 2012 are not comparable to data from previous years

Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

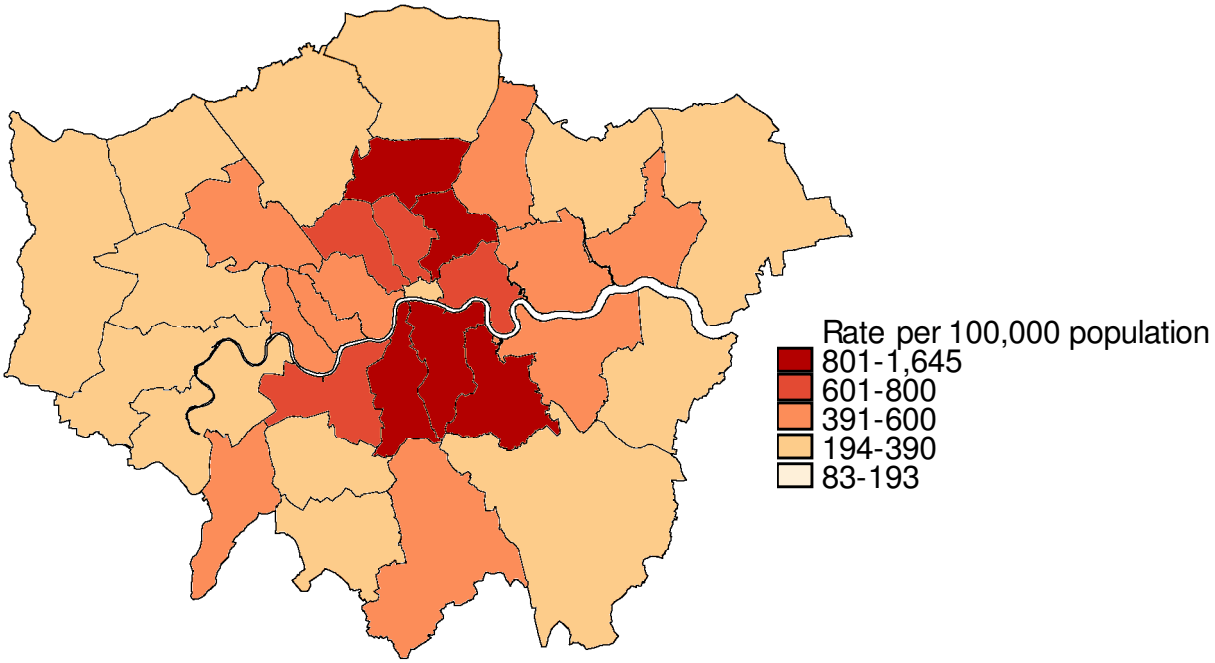
Chlamydia

Chlamydia (or Genital Chlamydia trachomatis) is the most commonly reported bacterial sexually transmitted infection (STI) in England. Most people who have chlamydia do not notice any symptoms; around 50% of men and 70-80% of women do not get symptoms with a chlamydia infection. Symptoms can appear one to three weeks after infection, many months later, or not until the infection has spread to other parts of the body, and include pain when passing urine, pelvic pain for women and pain in the testicles for men.

In 2012, there were approximately 450,000 STI diagnoses made in England and Chlamydia accounted for almost 46% of the diagnoses. Similarly in Havering, as illustrated in Figure 5, Chlamydia is the most common sexually transmitted infection (STI).

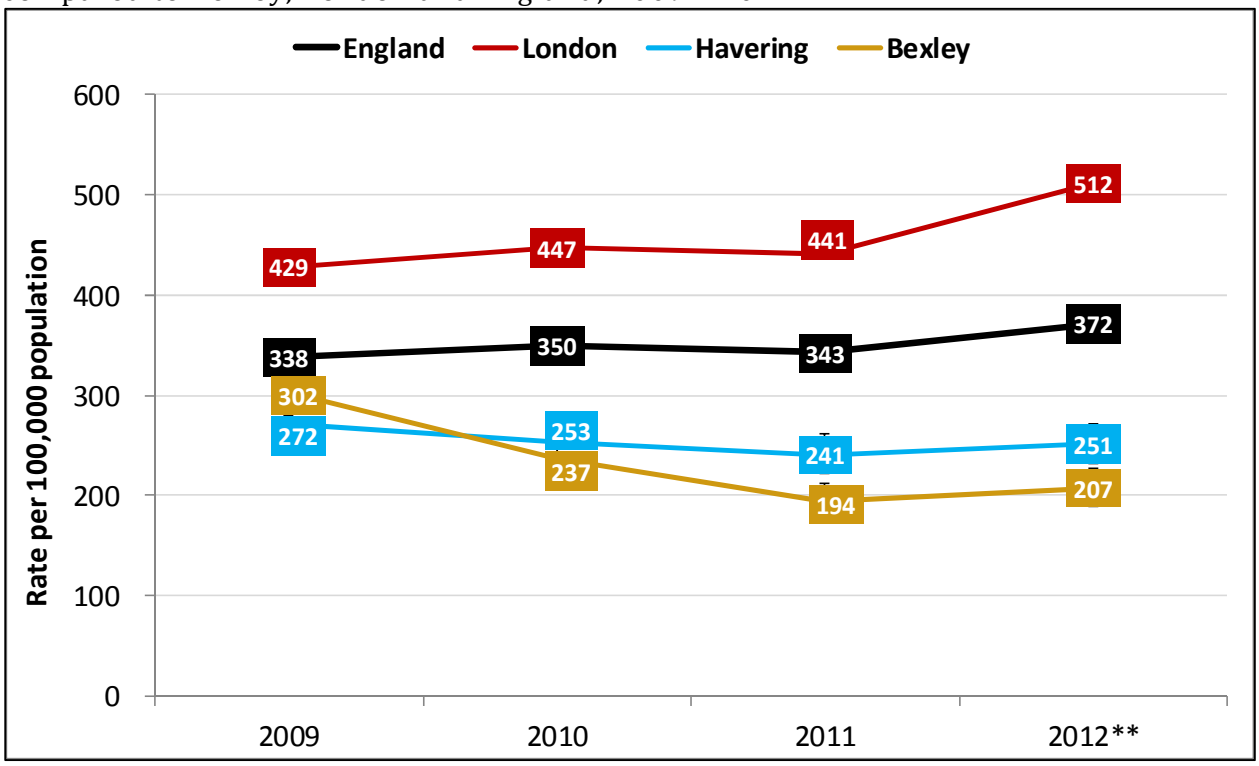
However, in 2012, the rate of chlamydia diagnoses in Havering was one of the lowest in London (see Figure 9). Havering's rates for diagnosed chlamydia have also consistently been significantly lower than both London and England rates from 2009 to 2012 (see Figure 10). While it is expected that Havering's Chlamydia rates will be lower than London (as previously discussed), it is unclear why Havering's Chlamydia rates have been consistently and significantly lower that England rates, particularly as the rates of infection for other STIs such as herpes and warts are higher than England rates.

Figure 9: Rates of chlamydia diagnoses by LA of residence in London, 2012



Data from routine GUM clinic returns; chlamydia data source includes community settings
Source: Public Health England

Figure 10: Rate (per 100,000 population) of total Chlamydia diagnosis, Havering compared to Bexley, London and England, 2009 – 2012



Chlamydia diagnoses from GUM services that were reported as 'previously diagnosed at another service' (C4X, C4OX & C4RX) have been excluded from 2012 data (only). These diagnoses have been reported via CTAD & are already included in the community services chlamydia data. As a result, GUM services chlamydia data from 2012 are not comparable to data from previous years
Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

However, there were still almost 3 diagnoses for every 1,000 people living in Havering in 2012. Therefore, Chlamydia remains a substantial public health problem and if left untreated, it can lead to a

wide range of complications, which could include pelvic inflammatory disease (PID), tubal factor infertility (TFI) and ectopic pregnancy (in women) and epididymitis (in men). These are important complications that can significantly impact people's reproductive health and wellbeing, particularly because Chlamydia is more prevalent among young people and much less common among people aged 25 years and above.

Diagnosed prevalence in the 15-24 year olds

The National Chlamydia Screening Programme was set up in 2003 by the Department of Health to test people aged 15-24 who are asymptomatic of chlamydia. The aim of the programme is to control chlamydia through early detection and treatment, so reduce the risk of onward transmission and consequences of untreated infection.

The underlying tenet of all screening programmes is to test non-symptomatic people. Therefore it is to be expected that a large number of those being screened will return a negative test for chlamydia. Public Health England recommends that a detection rate of 2,300 per 100,000 people aged 15-24 will lead to a drop in the prevalence of chlamydia infection. This is based on a national modelling exercise. Whilst Havering's chlamydia screening programme falls below the PHE recommended detection rate, nonetheless it does achieve similar detection rates to its statistical neighbours. It should be expected that there will be variance across England, and so whilst the chlamydia screening programme should continue to strive towards a high detection rate, local targets should be set that recognise a variance and also takes into account the trends in diagnoses of other sexually transmitted infections

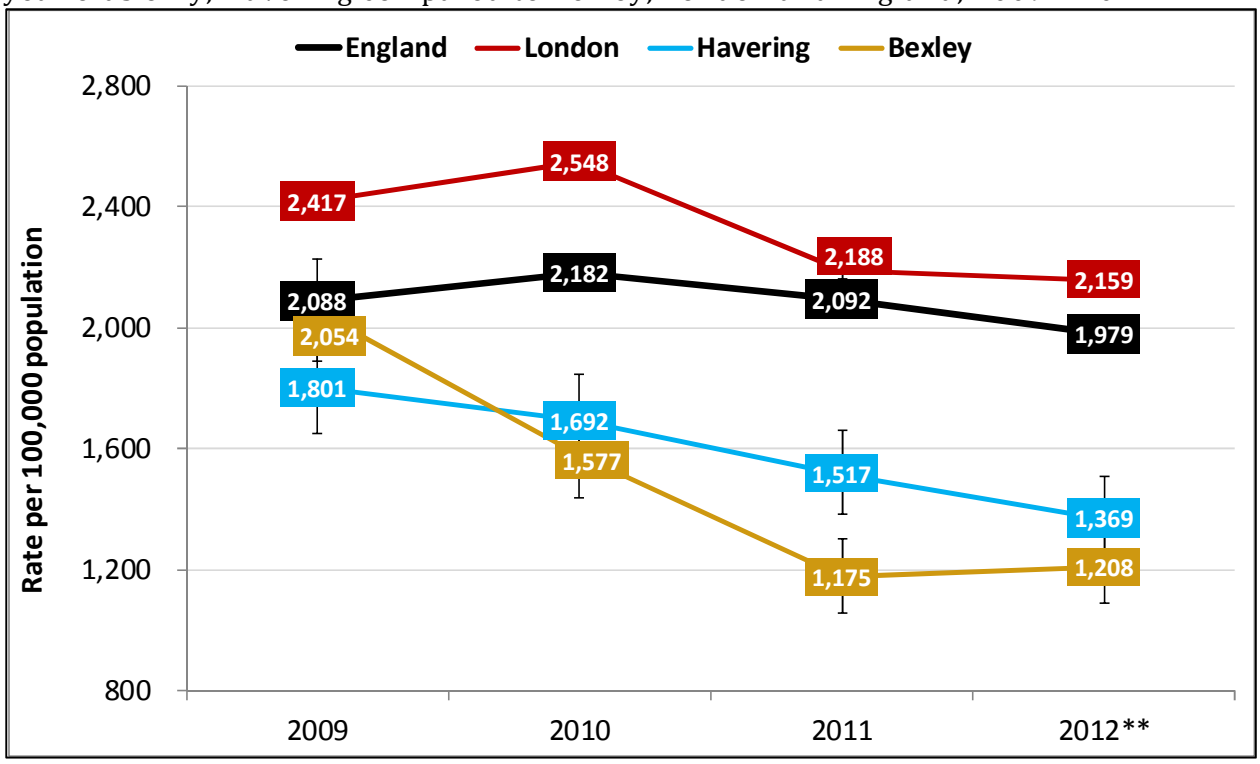
The rate of Chlamydia diagnoses among the target group in Havering is significantly lower than England's rate (see Figure 11 and Figure 12). However Figure 11 displays that the rate of Chlamydia diagnoses among people aged 15-24 years in Havering is similar to most other local authorities within the same national deprivation decile (the "third less deprived" deprivation decile), Figure 12 shows that this has been consistently and significantly lower than both London's and England's rates from 2009.

Figure 11: Chlamydia diagnoses (15-24 year olds) – CTAD (Persons)

Area	Lower / Similar / Higher	Rate per 100,000	Lower CI	Upper CI
England		1,979	1,969	1,990
Harrow		1,036	926	1,155
Bexley		1,208	1,088	1,337
Shropshire		1,250	1,137	1,371
Barnet		1,264	1,161	1,373
Havering		1,369	1,241	1,507
Suffolk		1,383	1,304	1,465
Poole		1,458	1,281	1,653
Worcestershire		1,520	1,427	1,617
Somerset		1,646	1,547	1,751
Staffordshire		1,654	1,576	1,734
Sutton		1,758	1,588	1,942
Solihull		1,876	1,710	2,054
Cheshire West and Chester		2,045	1,906	2,190
Milton Keynes		2,351	2,177	2,535
Swindon		2,413	2,226	2,613

Source: Public Health England (Public Health Outcomes Framework)

Figure 12: Rate of Chlamydia diagnoses per 100,000 population in age group, for 15-24 year olds only, Havering compared to Bexley, London and England, 2009 – 2012

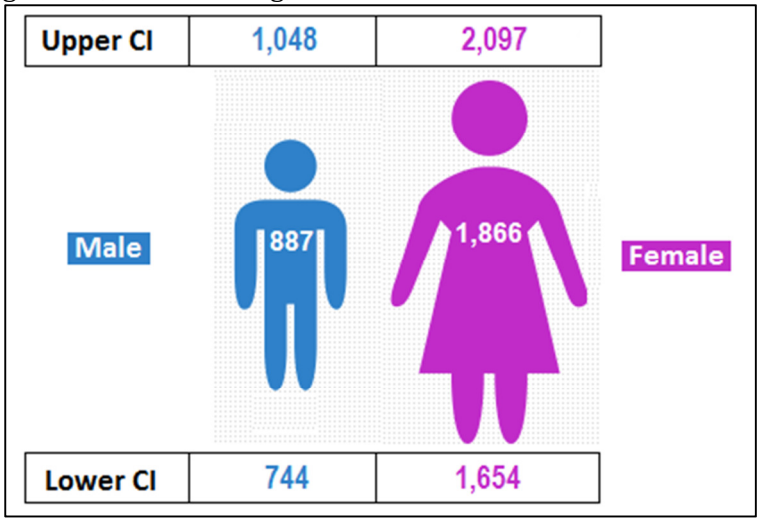


Chlamydia diagnoses from GUM services that were reported as 'previously diagnosed at another service' (C4X, C4OX & C4RX) have been excluded from 2012 data (only). These diagnoses have been reported via CTAD & are already included in the community services chlamydia data. As a result, GUM services chlamydia data from 2012 are not comparable to data from previous years

Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

A breakdown of Havering infection rates by gender shows that, in 2012, the rate of Chlamydia diagnoses among females was more than double the rate of males (see Figure 13). However, it is the case that females typically have older partners which frequently explains this variance in detection rates. If an individual aged under 25 is tested positive for chlamydia through the Chlamydia Screening programme, and their partner is aged 25 or older, then the partner is also treated as part of the programme.

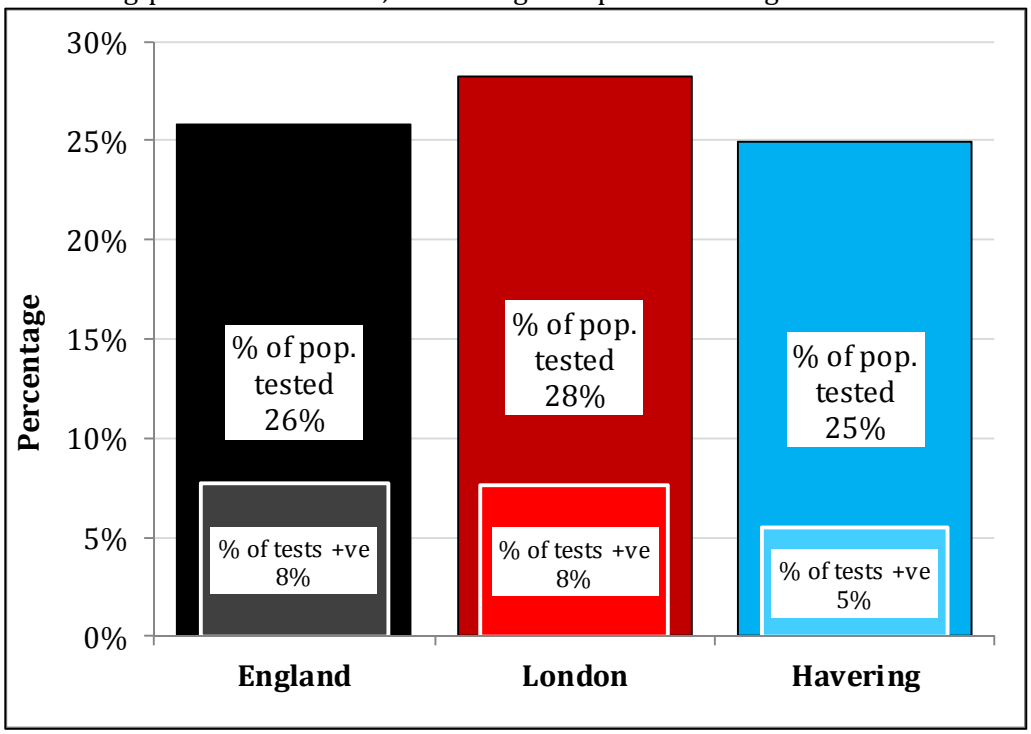
Figure 13: Rate per 100,000 of Chlamydia diagnoses population in 15-24 year olds, by gender, in Havering, 2012



Data source: Public Health England – Chlamydia Testing Activity Dataset (CTAD)

In 2012, 25% of 15-24 year olds in Havering (n=7,606) were screened for Chlamydia, which was marginally lower than the England and London coverage of 26% and 28% respectively (see Figure 14).

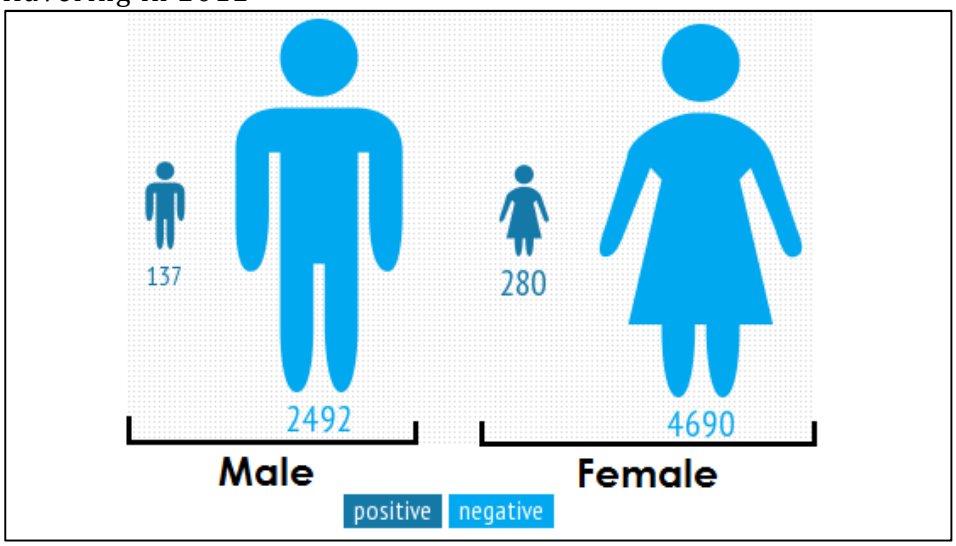
Figure 14: Percentage of 15-24 year old population tested and proportion of tests returning positive in 2012, Havering compared to England and London



Data source: Public Health England: Chlamydia testing data for 15-24 year olds in England, January to December 2012

While the rate of Chlamydia diagnoses among females was more than double the rate among males of Havering residents aged 15-24 years in 2012 (shown in Figure 13 and previously discussed), the proportion of positivity of chlamydia screens among females (6% - 280/4,690), as graphically illustrated in Figure 15, is similar to males' (5.5% - 137/2,492). Figure 15 also suggests that females are more readily coming forward for testing.

Figure 15: Outcome of total Chlamydia Screens by Gender for 15-24 year olds in Havering in 2012

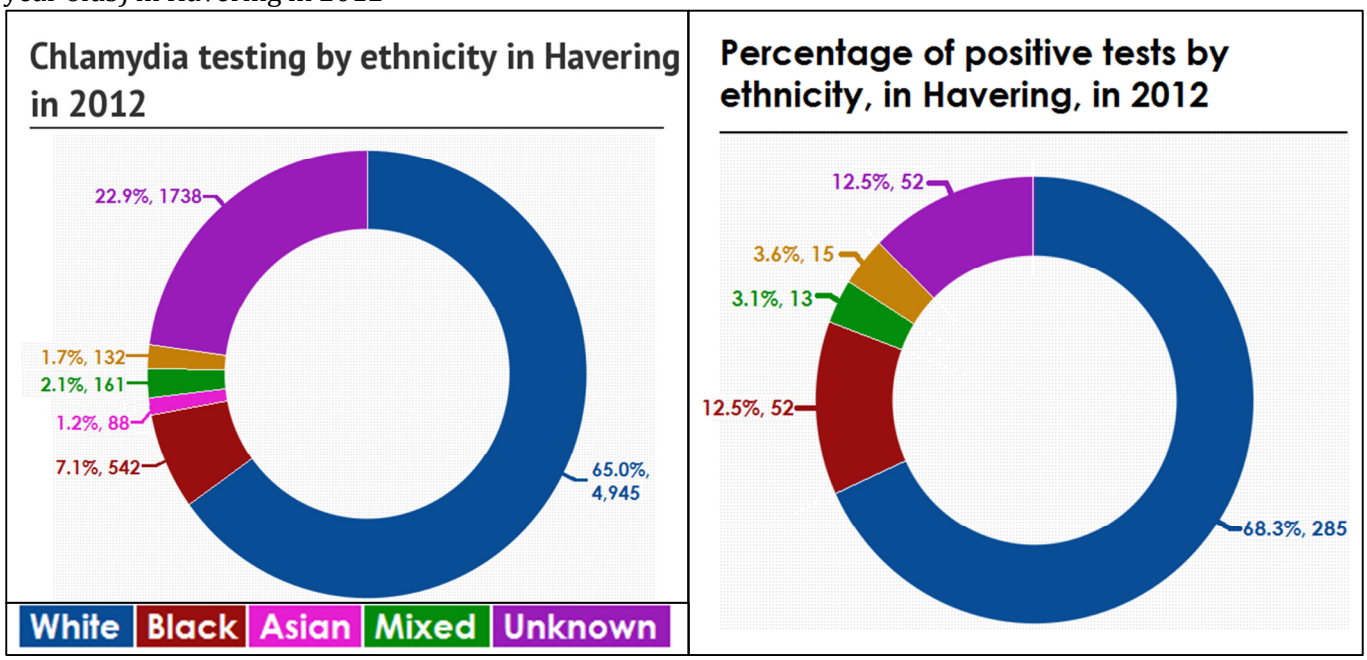


Data source: Public Health England

Figure 16 displays a breakdown of chlamydia screens (and positive tests) of Havering residents aged 15-24 year old by ethnicity. The large percentage of unknown and "other" ethnic group (25% of total -

1,860/7,606) in the chlamydia screening data limits the value of the analysis by ethnicity. However, Figure 16 shows that (in 2012) people of the "Black" ethnic group made up 7% of 15-24 year olds who were tested for chlamydia in Havering but accounted for about 13% of those with positive tests. One in every ten young persons identified as a "Black" person (10%) tested for chlamydia in 2012 was positive – the highest of all identified ethnic groups and double the overall percentage.

Figure 16: Chlamydia Screens by Ethnicity (15-24 year olds) and Positive tests by ethnicity (15-24 year olds) in Havering in 2012



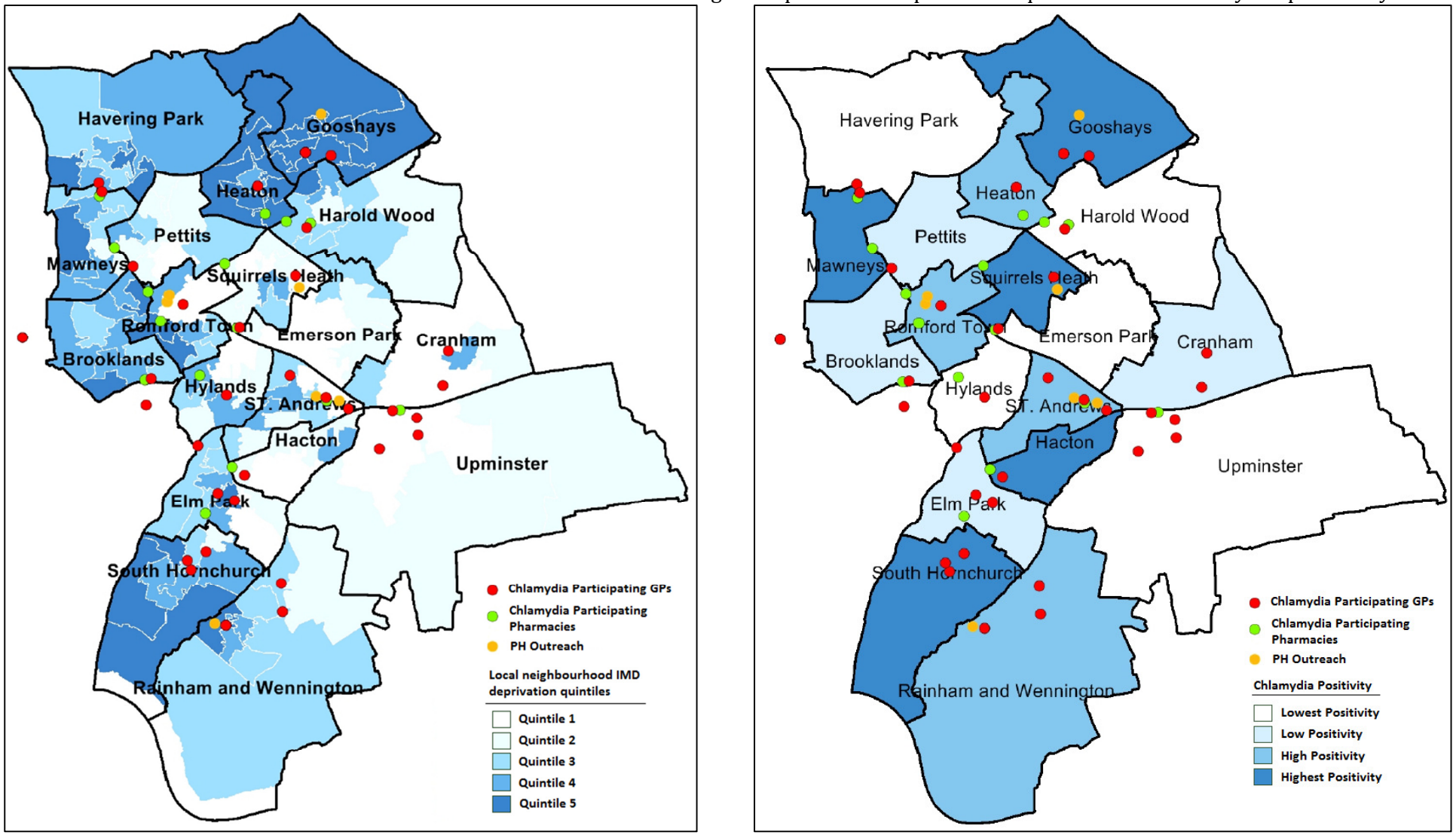
Data source: Public Health England

Deprivation, chlamydia and testing sites

A comparison of Figure 17's left map (showing local deprivation quintiles by LSOA, where "Quintile 5" is the most deprived) and the right map (showing the distribution of chlamydia positivity by ward) suggest an association with deprivation on chlamydia positivity. It is recognised that there is an association between disadvantage and poor sexual health, which his illustrated by the rates of chlamydia in the less advantaged neighbourhoods in the borough. Figure 17's left map suggests that there is a relatively lower number of chlamydia testing sites (the chlamydia participating GPs and pharmacies) in Havering's most deprived areas (Quintiles 4 and 5).

Although there are relatively lower number of chlamydia testing sites in areas of disadvantage, nonetheless, there are testing sites in places in Havering where young people gather, including for example, in Romford Town. Young people can access chlamydia screening from GP practices, pharmacists, and sexual health clinics. There are also non-clinical location outreach programmes located in non-clinical settings, such as children's centres, or pubs and clubs, which aim to encourage young people to screen.

Figure 17: Left map – Local deprivation quintiles and Chlamydia testing sites, 2012;
Right map – Local deprivation quintiles and chlamydia positivity in 2012



Data sources: Communities and Local Government, 2011 – for IMD (2010); Public Health England – for chlamydia data; and local data sources for others

Genital Warts

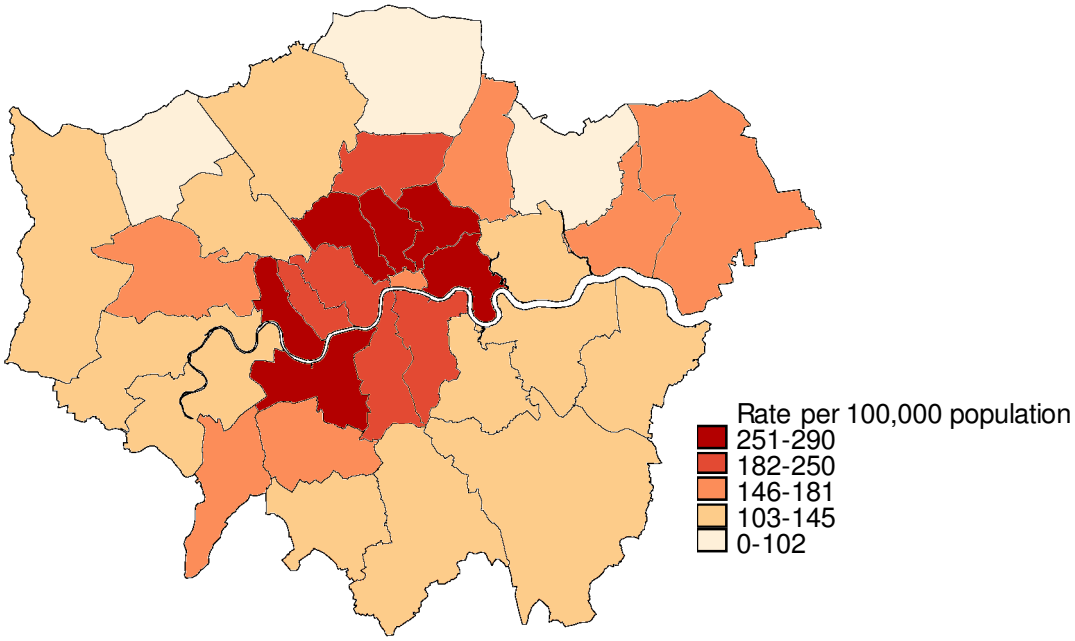
HPV (human papillomavirus) is a family of over 100 different strains of viruses, some of which can infect the genital tract and are sexually acquired. Most genital HPV infections do not have visible symptoms and so, many people can be infected without realising it. Some resolve without causing disease. However, certain HPV types (termed 'high risk') are associated with cancer (mainly cervical cancer) and HPV types that do not cause cancer are termed 'low risk'. Two of these 'low risk' types (type 6 and type 11) cause genital warts. HPV infections are extremely common in the sexually active population and are particularly common in the first few years after onset of sexual activity.

There are two main types of treatment for genital warts: (1) Topical treatment, where a cream, lotion or chemical is applied directly to the wart or warts; and (2) Physical ablation, where the tissue of the wart is destroyed using external forces, such as lasers or electricity. Different people respond to treatments for genital warts in different ways. However, topical treatments tend to work better on softer warts, and physical ablation tends to work better on harder and rougher feeling warts. Sometimes, a combination of topical treatment and physical ablation can be used. Either type of treatment can take several months to remove the warts.

As illustrated in Figure 5, genital warts is the second most common STI in Havering, with 147 diagnoses rate per 100,000 of the population in 2012 – insignificantly higher than the national average (135 per 100,000) but significantly lower than London's 168 diagnoses rate per 100,000 people (Figure 6). Furthermore, PHE's Sexual and Reproductive Health Profiles (as summarised in Table 1) reveals that, when compared to other local authorities in the same deprivation decile, Havering's rate of first episode genital warts diagnoses per 100,000 population is significantly higher.

The 2012 rate of first episode genital warts diagnoses in Havering was in the middle quintile and not one of the lowest among London boroughs (see Figure 18). In addition, though Havering's rates for genital warts diagnoses were similar to Bexley rates from 2009 to 2010, the local rates were significantly[6] higher than Bexley's in the following two years – 2011 and 2012 (see Figure 19). This seems to be due to the observed consistent downward trend in Bexley.

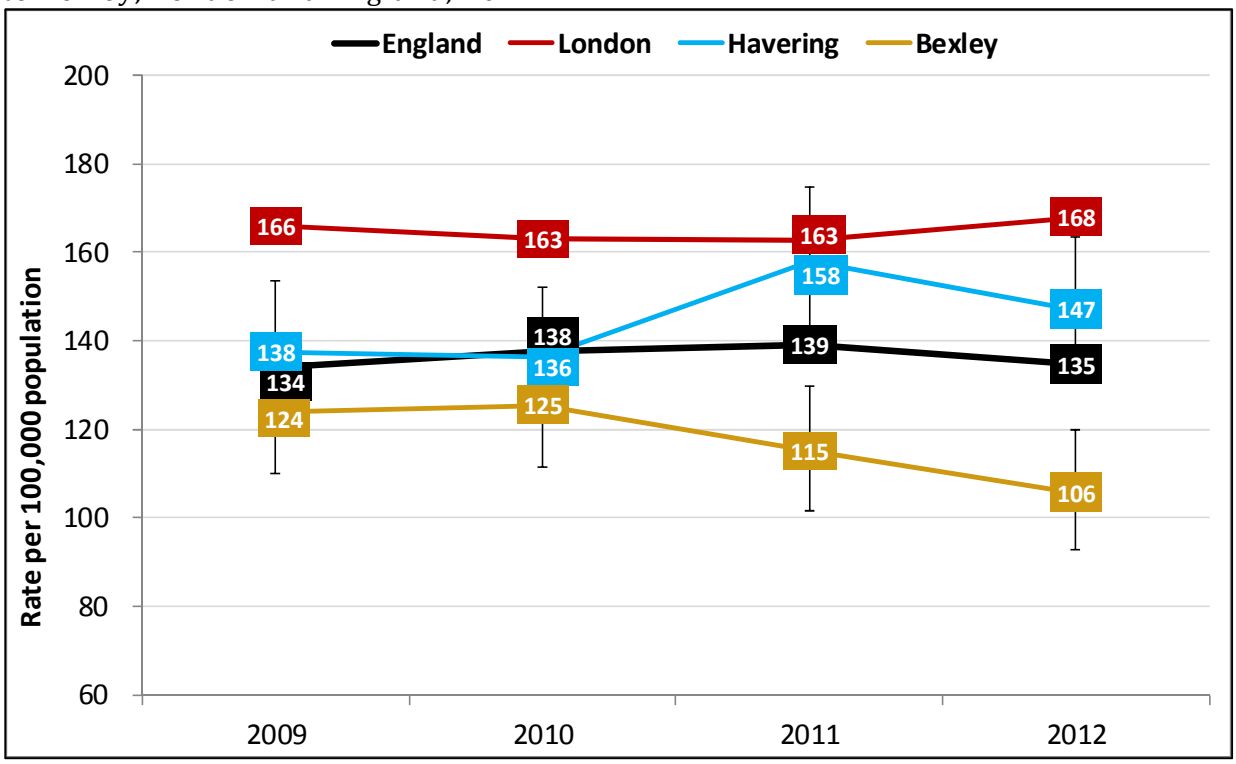
Figure 18: Rate of genital warts (first episode) diagnoses by local authority (LA) of residence in London, 2012



Data from routine GUM clinic returns
Source: Public Health England

[6] Note that wherever significance is described, this means "statistically significant"; an analytical term that shows that any differences are not as a result of chance.

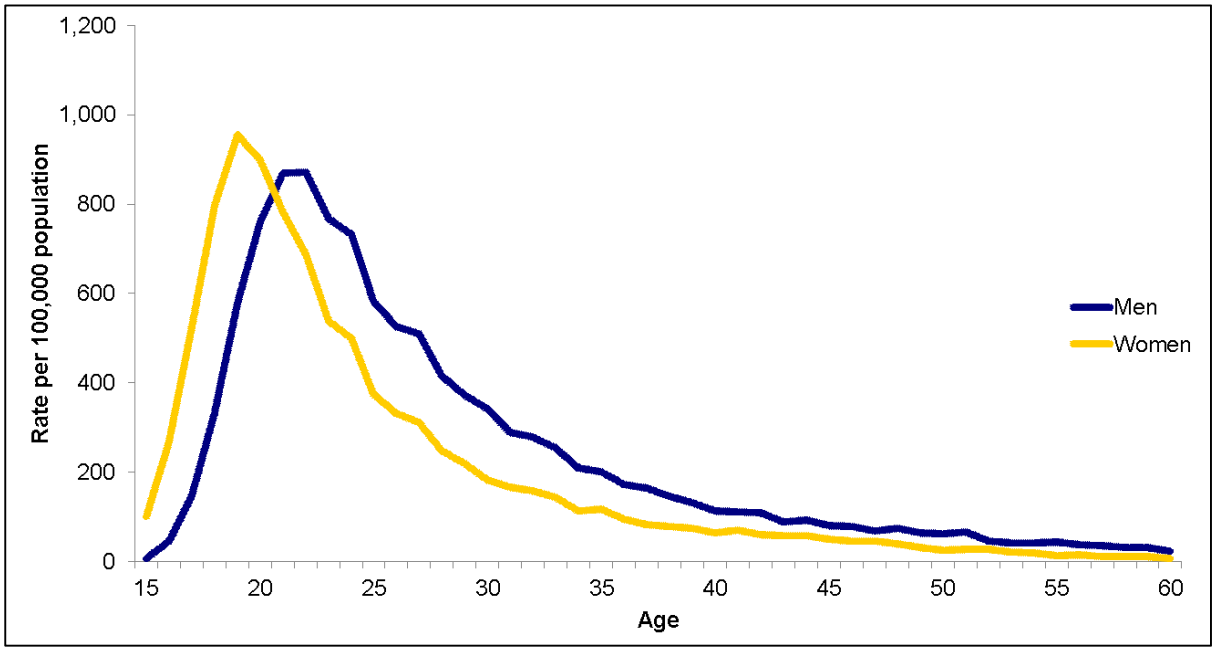
Figure 19: Rate of genital warts diagnoses per 100,000 population, Havering compared to Bexley, London and England, 2012



Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

Figure 20 indicates that the age at which genital warts' diagnoses rate is at its peak, for both males and females, falls within the 15-24 year olds target group.

Figure 20: Rate of genital warts (first episode) diagnoses by gender and age, England, 2012



Data from routine GUM clinic returns. Excludes diagnoses where gender was reported as unknown
Source: Public Health England

Cervical cancer

As previously described, HPV viruses classified as 'high-risk' are associated with cancer. Persistent infection by high-risk HPV types is detectable in more than 99% of cervical cancers. Of these high-risk

types, HPV16 is responsible for almost 60% and HPV18 for more than 15%, of all cervical cancers in Europe. In addition to cervical cancer, HPV is causally associated with less common cancers at other sites, including cancer of the vulva, vagina, penis and anus, and some cancers of the head and neck.

Cervical cancer is the second most common cancer of women worldwide. The introduction of a national cervical screening programme in the UK has made a major contribution to the fall in the incidence and death rate from cervical cancer. It has been estimated that mortality rates fell approximately 60% between 1974 and 2004 in the UK due to cervical screening.

According to national statistics, a total of 2,747 new cases of invasive cervical cancer were diagnosed in England in 2009. The peak incidence occurred in women in their 30s with a second smaller peak in women in their 70s-80s (i.e. women less likely to have benefited from cervical screening during their lifetimes; Figure 18a.1). In the UK, the lifetime risk of developing cervical cancer is estimated as 1 in 116. In the UK, approximately one third of women die within five years of the diagnosis of invasive cervical cancer.

Genital Herpes

Genital herpes are STIs caused by the genital herpes simplex virus (HSV) infection. There are two distinct subtypes of HSV: Type 1 causes oral herpes (or cold sores) but has increasingly been implicated in genital infections; and Type 2 is almost exclusively associated with genital infection.

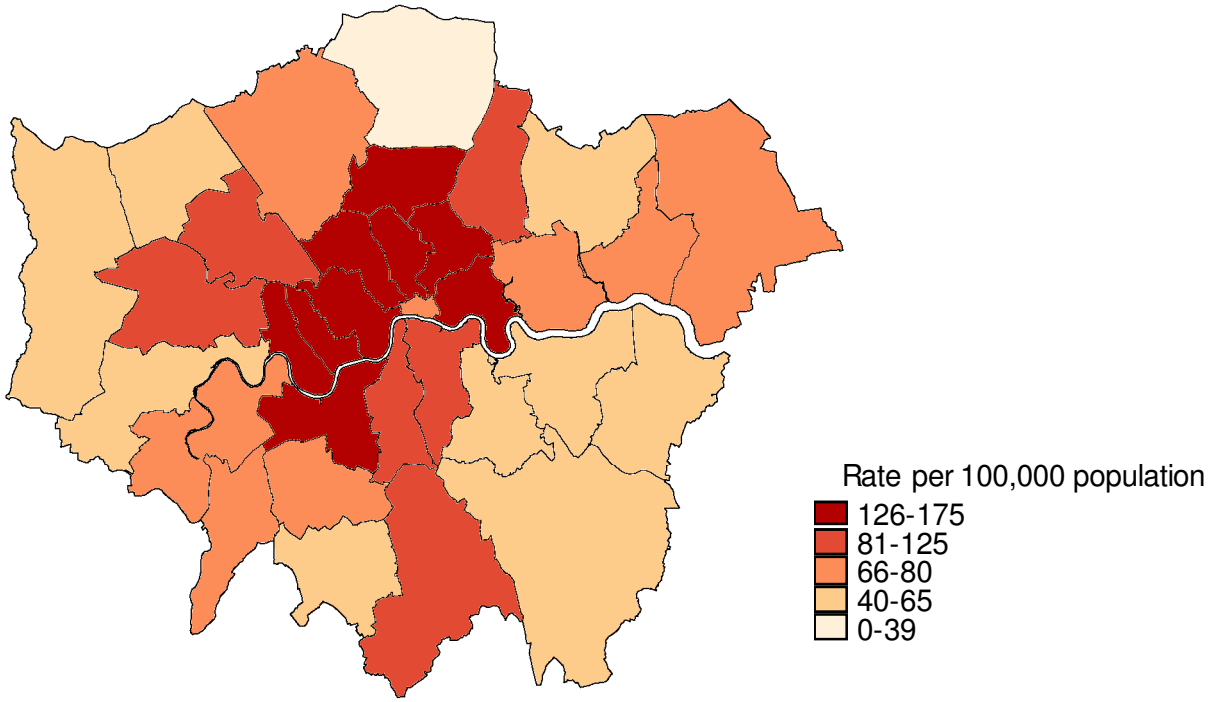
Because symptoms may not appear until months or years after being exposed to the virus, many people are unaware that they have been infected. Symptoms, when they do emerge, include painful blisters on the genitals and surrounding area which burst to leave open sores, a high temperature, and feeling of being unwell with aches and pains. Symptoms may last up to 20 days, and sores will eventually scab and heal without scarring.

Genital herpes is a long term condition. The virus remains in the body and can become active again. The average rate of recurrence is four to five times in the first two years after being infected. However, over time, it becomes active less frequently and each outbreak becomes less severe. The virus can cause severe systemic disease in new-born infants and the immunosuppressed. It may also facilitate HIV transmission. Genital herpes can cause problems during pregnancy and may be passed to the baby around the time of birth. If a woman develops genital herpes for the first time during early pregnancy (before week 26), she may be at risk of miscarriage. If a woman develops genital herpes during later pregnancy (from week 27 until birth), the risk of passing on the virus to the baby increases. Antiviral medication is often given to women during pregnancy where this is a risk of passing the infection on to the baby, to reduce the risk of transmission. Neonatal herpes (where the baby catches the herpes simplex virus around the time of the birth) is serious and sometimes fatal, but is rare in the UK.

Although there is no cure for genital herpes, the symptoms can usually be controlled using antiviral medicines. However, it is important to prevent the spread of genital herpes by avoiding sex until symptoms have cleared up and then continuing to use a condom afterwards.

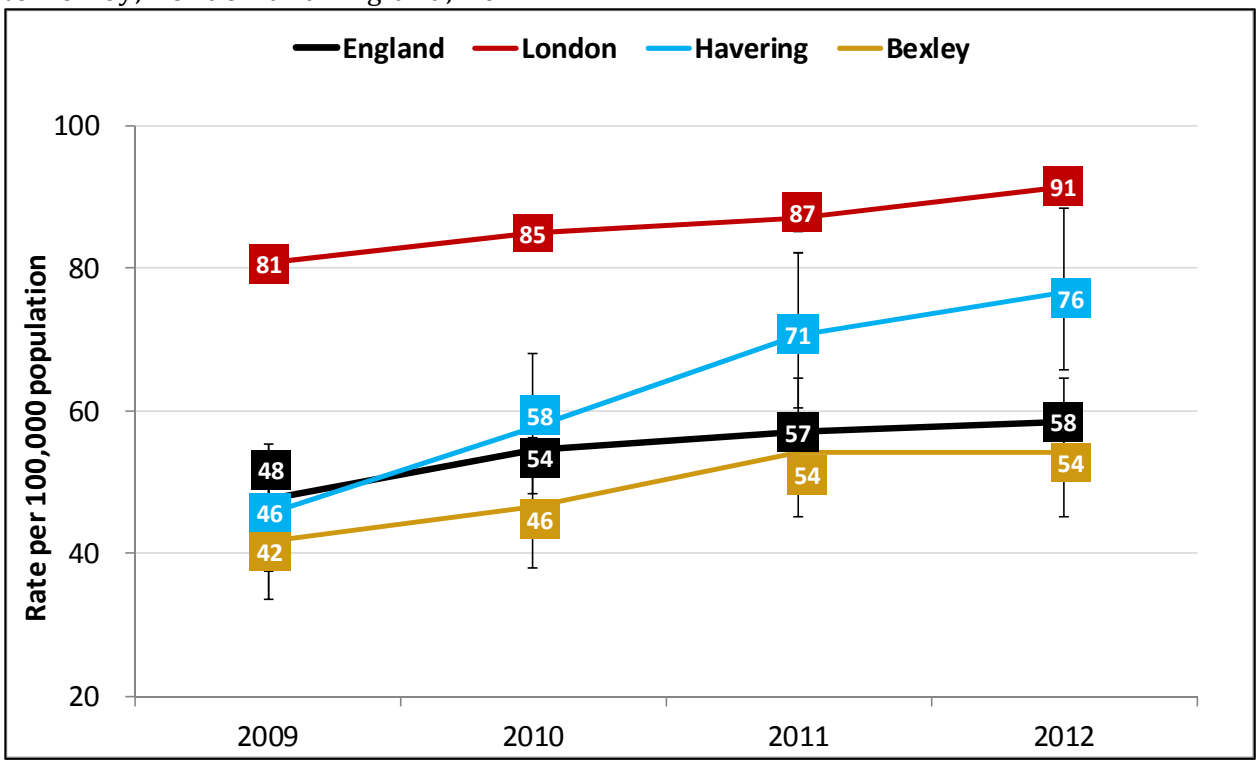
Genital herpes is the third most common STI in Havering, with 77 diagnoses rate per 100,000 of the population in 2012 (as illustrated in Figure 5). The 2012 rate of first episode genital herpes diagnoses in Havering was in the middle quintile – and not one of the lowest – among London boroughs (see Figure 21). Prior to 2012, the local rates between 2009 and 2011 were similar to the closest statistical neighbour (Bexley) and England, but expectedly significantly lower than London. However, there has been a consistent increase in the rate of genital herpes diagnoses in Havering from 2009 to 2012 (see Figure 22). The local rate increased by 65% from 2009 (46 per 100,000 population) to 2012 (76 per 100,000 population).
Consequently, in 2012, the rate for genital herpes diagnoses in Havering was significantly higher than Bexley's rate and the England average but still significantly lower than the average for London (see Figure 6 and Figure 22).

Figure 21: Rate of genital herpes (first episode) diagnoses by local authority (LA) of residence in London, 2012



Data from routine GUM clinic returns
Source: Public Health England

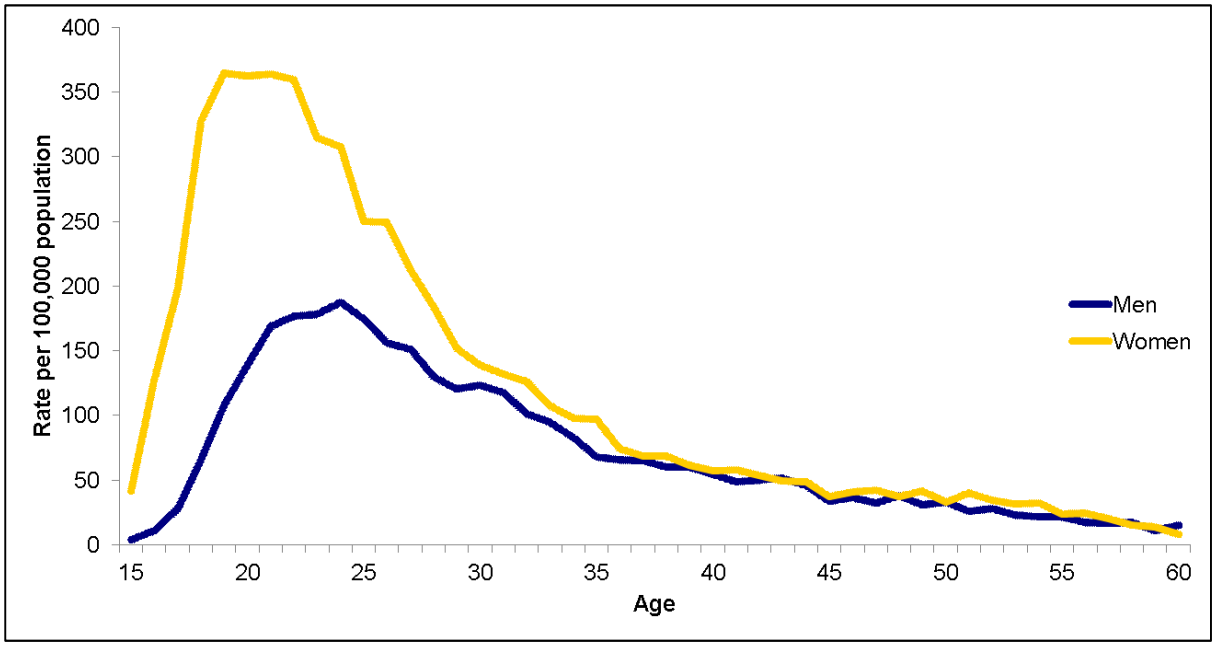
Figure 22: Rate of genital herpes diagnoses per 100,000 population, Havering compared to Bexley, London and England, 2012



Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

Figure 23 indicates that the age at which genital herpes' diagnoses rate is at its peak, for both males and females, falls within the 15-24 year olds target group. It also shows that the rate of genital herpes is higher among females than males.

Figure 23: Rate of genital herpes (first episode) diagnoses by gender and age, England, 2012



Data from routine GUM clinic returns. Excludes diagnoses where gender was reported as unknown
Source: Public Health England

Gonorrhoea

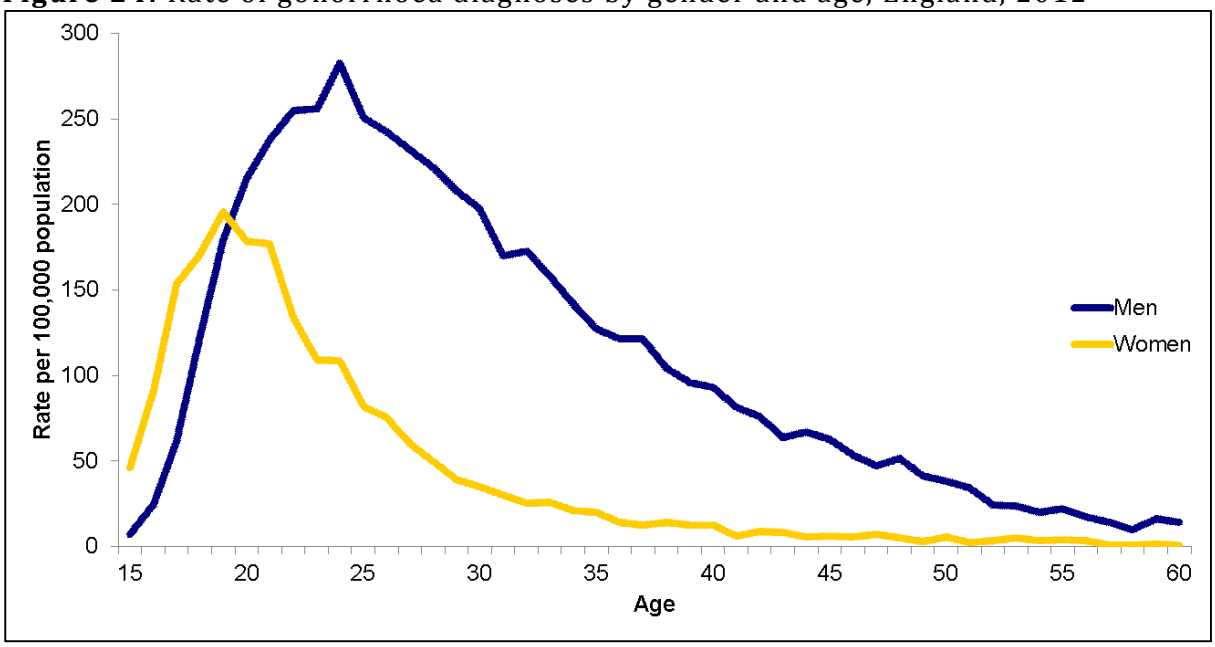
Gonorrhoea is a serious infection caused by the bacteria Neisseria gonorrhoeae, and is spread by sexual contact. There is concern that gonorrhoea is becoming drug resistant, and there are now limited antibiotics available for treatment. In 2012, there was a large rise of new gonorrhoea diagnoses in England and Wales, and there is concern about the high infection rates amongst men who have sex with men, and young adults in some urban areas.

In February 2013, the first Gonorrhoea Resistance Action Plan for England and Wales was published, which provides a strategic framework for a national response to gonorrhoea treatment resistance. It is important that information about prevention of gonorrhoea is promoted in Havering, especially amongst higher risk groups, including MSM and black African populations. The highest rates of gonorrhoea are seen in women aged 16-19 and in men aged 20-24 years (see Figure 24).

Symptoms in young women can include a painful and burning sensation when passing urine and discharge from the vagina that is yellow or bloody. Young men more frequently show signs of infection than young women. Typical symptoms include a discharge from the penis and a severe burning when passing urine. Men and women with rectal infections may experience discharge from the anus, anal discomfort and pain on anal intercourse. However, an infected person may have no symptoms, but still transmit the infection (caught through unprotected vaginal, oral or anal intercourse or genital contact) without knowing. A pregnant woman can also pass infection onto her new-born baby during delivery.

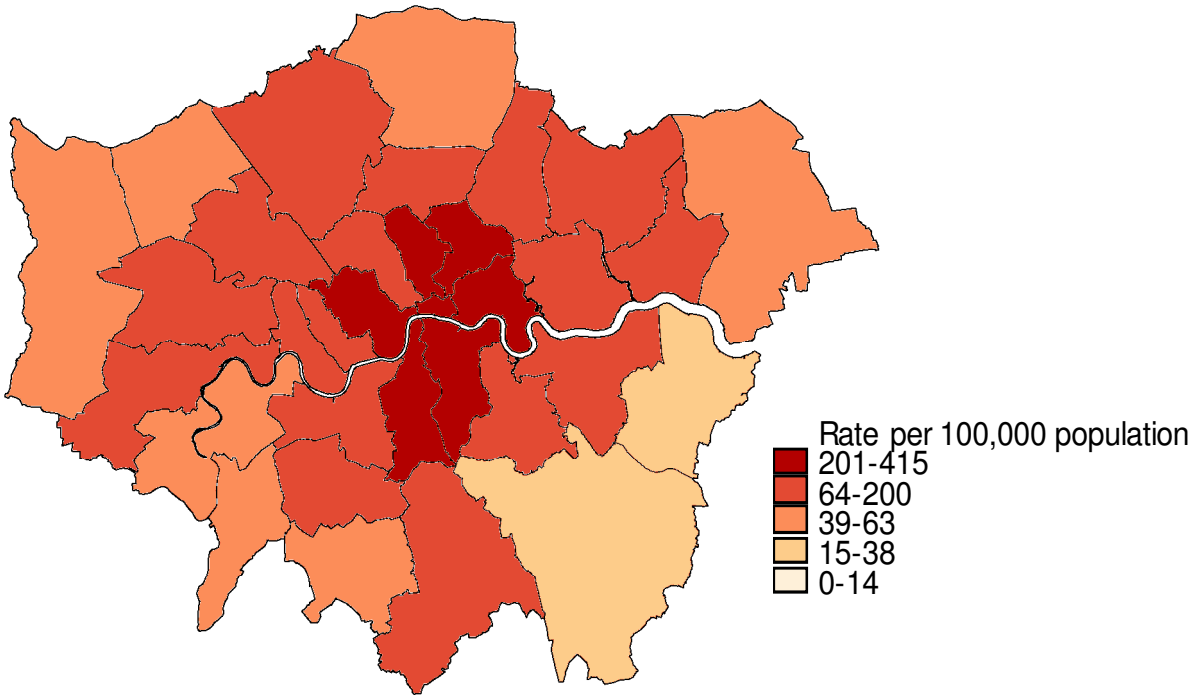
Gonorrhoea is the second least common STI in Havering, with 40 diagnoses rate per 100,000 of the population in 2012 (as illustrated in Figure 5). However, the 2012 rate of gonorrhoea diagnoses in Havering was in the middle quintile – and not one of the lowest – among London boroughs (see Figure 25). Public Health England's Sexual and Reproductive Health Profiles (as summarised in Table 1) further reveals that, when compared to other local authorities in the same deprivation decile, Havering's rate of gonorrhoea diagnoses per 100,000 population is significantly higher.

Figure 24: Rate of gonorrhoea diagnoses by gender and age, England, 2012



Data from routine GUM clinic returns. Excludes diagnoses where gender was reported as unknown
Source: Public Health England

Figure 25: Rate of gonorrhoea diagnoses by local authority (LA) of residence in London, 2012



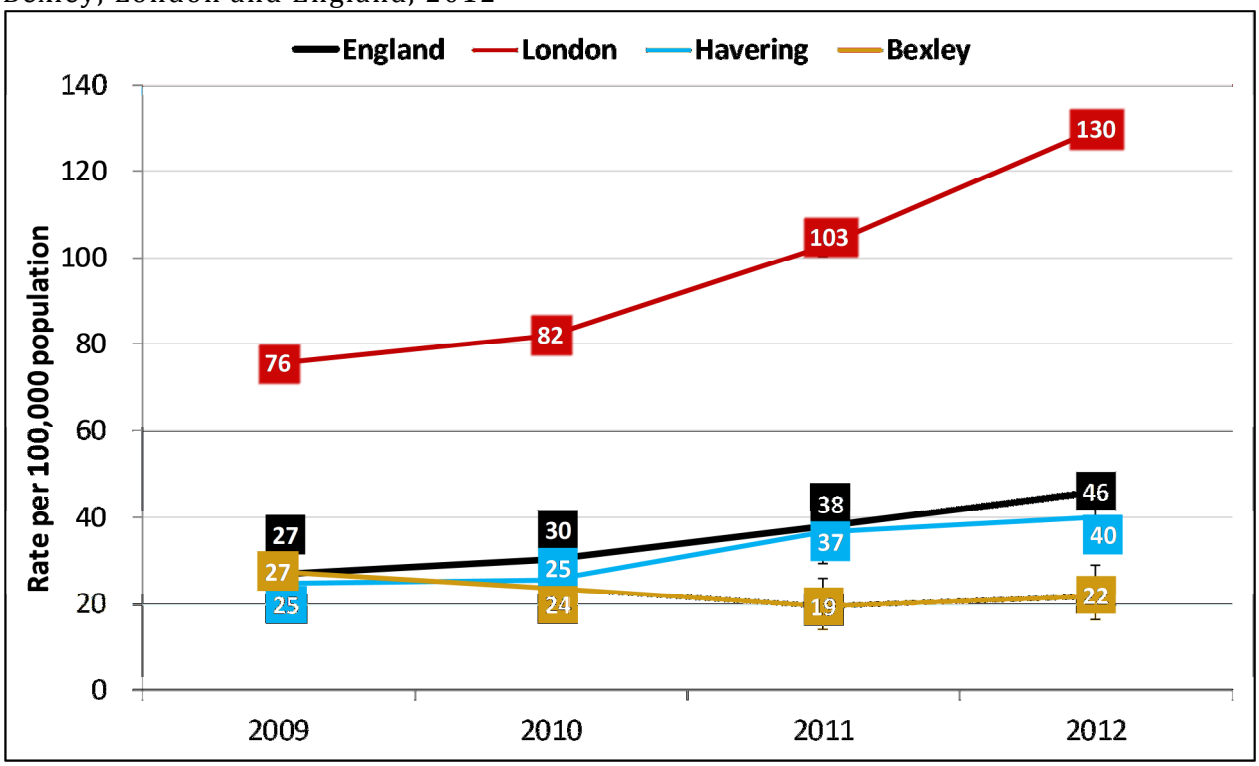
Data from routine GUM clinic returns
Source: Public Health England

In addition, though Havering's rates of gonorrhoea diagnoses were similar to Bexley rates from 2009 to 2010, the local rates were significantly higher than Bexley's in the following two years – 2011 and 2012 (see Figure 26). Unlike Bexley (but in similarity with London and England), the rate of diagnosed gonorrhoea in Havering has been on an increasing trend from 2009 to 2012. The yearly rate of gonorrhoea diagnoses in Havering increased by 60% from 2009 (25 per 100,000 population) to 2012 (40 per 100,000 population).

Gonorrhoea can usually be treated with an antibiotic. However, there are many strains of gonorrhoea and some are now resistant to the commonly used antibiotics. This makes it important for anyone with suspected gonorrhoea to be properly investigated. Surveillance of antimicrobial resistance is critical in guiding national treatment guidelines to ensure appropriate patient management.

The Gonococcal Resistance to Antimicrobial Surveillance Programme (GRASP) – a national sentinel surveillance programme – was established in 2000 to monitor trends and drifts in susceptibility to antimicrobial agents used for the treatment of gonorrhoea in England and Wales. The latest GRASP report describes the latest data on trends in and epidemiology of antimicrobial resistance and decreased susceptibility in gonococcal infection in England and Wales using data collected through GRASP in 2012 (see online at: www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317140152190).

Figure 26: Rate of gonorrhoea diagnoses per 100,000 population, Havering compared to Bexley, London and England, 2012



Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

The report shows, from the 2012 data, increasing and sustained prescribing of ceftriaxone and azithromycin (the recommended first line treatment for gonorrhoea infection in the UK) and a concomitant decrease in prescribing of cefixime. This coincided with a decline in cefixime decreased susceptibility at MIC ≥0.125mg/L. However, there is currently no accessible data to use for local insight.

The following are the key points of the latest GRASP report:

- In 2012, a new protocol was introduced based on all gonorrhoea diagnoses reported in 25 participating clinics in England and Wales between July and September.
- There were a total of 3,177 gonorrhoea diagnoses in England and Wales of which 3,103 were from England and 74 from Wales during the sampling period.
- A total of 1,518 patients diagnosed with gonorrhoea could be matched with a gonococcal isolate referred for susceptibility testing with 1659 gonorrhoea diagnoses that had no matched isolate.
- There is evidence of selection bias with symptomatic patients being more likely to be sampled than asymptomatic patients.
- There is evidence of isolates exhibiting decreased susceptibility to ceftriaxone (MIC≥0.125mg/L) for the first time since it was last reported in 2009.

- There has been a continued decline in the proportion of isolates exhibiting decreased susceptibility to cefixime (MIC≥0.125mg/L), particularly in isolates infecting MSM and women.
- Overall prevalence of azithromycin resistance (MIC≥1mg/L) increased slightly to 0.7% in 2012, with two isolates showing very high azithromycin MICs of ≥256mg/L for the first time since 2007.
- There is evidence that isolates from younger patients (13-19 years) are more susceptible to cefixime, azithromycin and penicillin than isolates from older patients.
- The previously observed bi-modal MIC distribution to cefixime among MSM has now changed to a normal distribution, although there is evidence that a bi-modal MIC distribution to cefixime is emerging in heterosexuals.
- Between 2011 and 2012, dual prescribing of doxycycline and ceftriaxone for MSM declined and dual prescribing of azithromycin and ceftriaxone increased, in line with treatment guidelines.
- Compliance with recommended treatment guidelines continued to increase in all regions of England and Wales.
- No spectinomycin resistance was observed.

Syphilis

Syphilis is a serious infection caused by the bacteria Treponema pallidum. It is mainly spread by sexual contact but it is possible to catch syphilis through sharing needles for injecting drugs with someone who is infected. If diagnosed early, syphilis can be treated with antibiotics. If not treated, syphilis can progress to a more dangerous form of the disease and cause serious conditions such as stroke, paralysis and blindness. Pregnant women can pass the condition on to the unborn child, which can cause stillbirth or the death of the baby shortly after labour. All women are offered an antenatal screen for syphilis.

People with syphilis are three to five times more likely to catch HIV. This is because the sores caused by syphilis make it easier for the HIV virus to enter the body. Nationally, syphilis is a less common infection than gonorrhoea, herpes, warts and chlamydia, although numbers of diagnoses have been rising in the UK over the past decade.

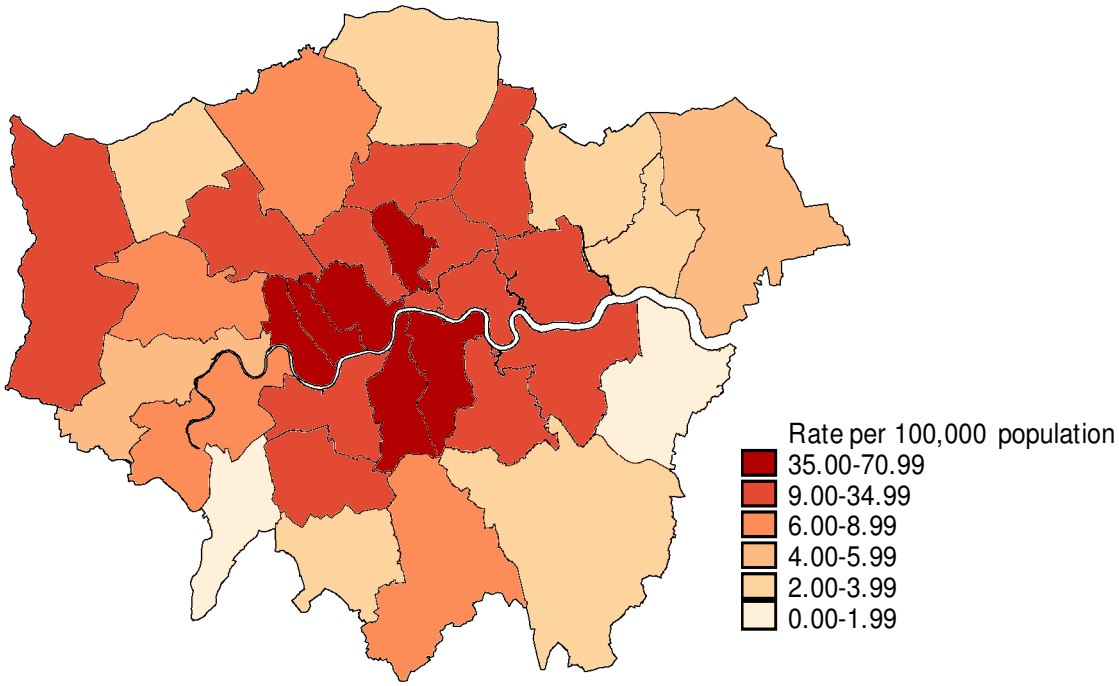
With the least rate of acute diagnoses (5) per 100,000 of the population in 2012, Syphilis is the least common acute sexually transmitted infection (STI) in Havering (see Figure 5). In addition, the 2012 rate of syphilis diagnoses in Havering was lower than all Inner London boroughs and similar to – or higher than – most of the boroughs in Outer London (see Figure 27).

Figure 28 shows that from 2009 to 2011, the local rates were steady between 1 and 2 per 100,000 population. This is similar to the closest statistical neighbour (Bexley) but significantly lower and higher than London and England respectively. However, in 2012, the rate of syphilis diagnoses in Havering became significantly higher than Bexley's and similar to England but it remains significantly lower than London.

Figure 29 indicates that syphilis diagnoses rate is high across a wider age range than the typical STI target group (15-24 year olds) and it also shows that syphilis diagnoses rate is far higher among males than females. This may be linked to findings that the majority of infectious syphilis and Lymphogranuloma venereum (LGV) is accounted for by MSM and HIV co-infection is common in those diagnosed with syphilis and LGV[7]. In 2012, there were between 10 and 19 syphilis diagnoses among MSM in Havering (see Figure 30).

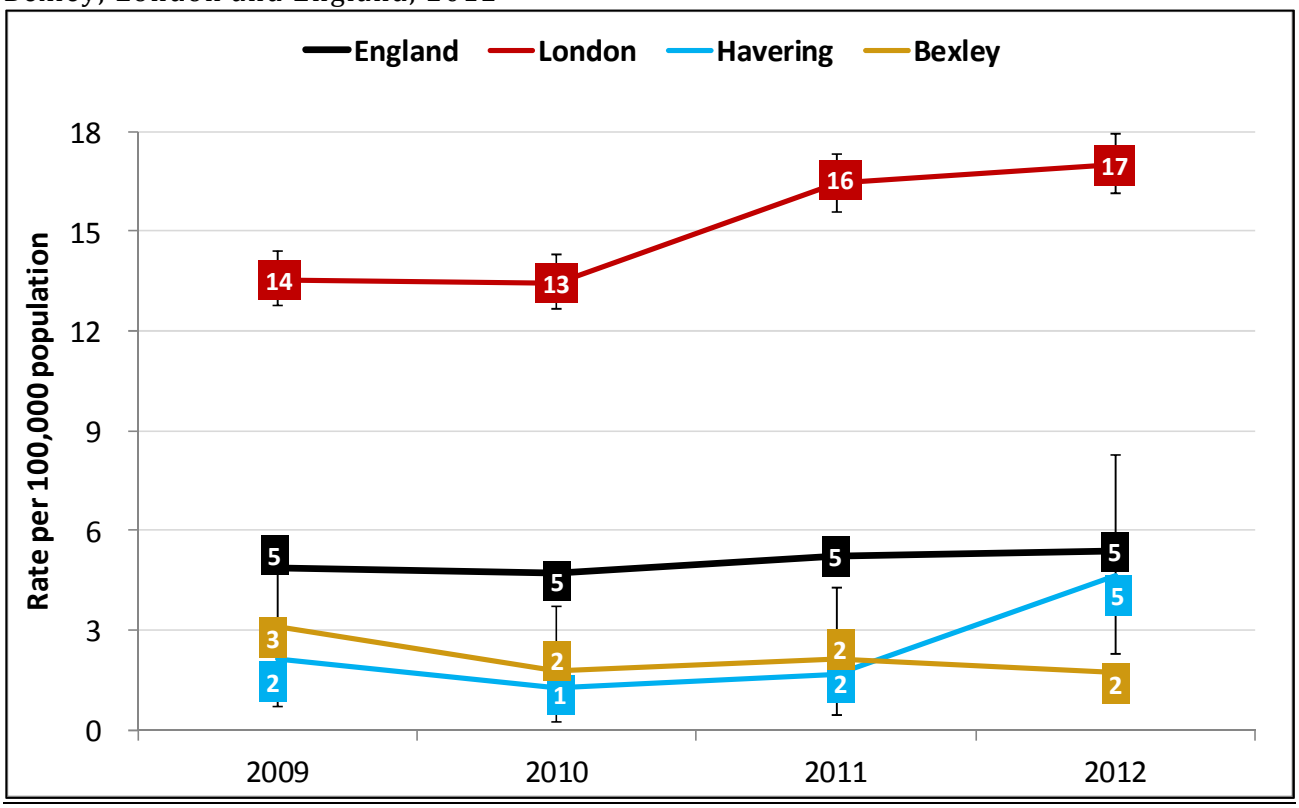
[7] *HPA (2009). Syphilis and Lymphogranuloma Venereum: Resurgent Sexually Transmitted Infections in the UK. Health Protection Agency (now part of Public Health England), June 2009. (Accessible online: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1245581513523).*

Figure 27: Rate of syphilis diagnoses by local authority (LA) of residence in London, 2012



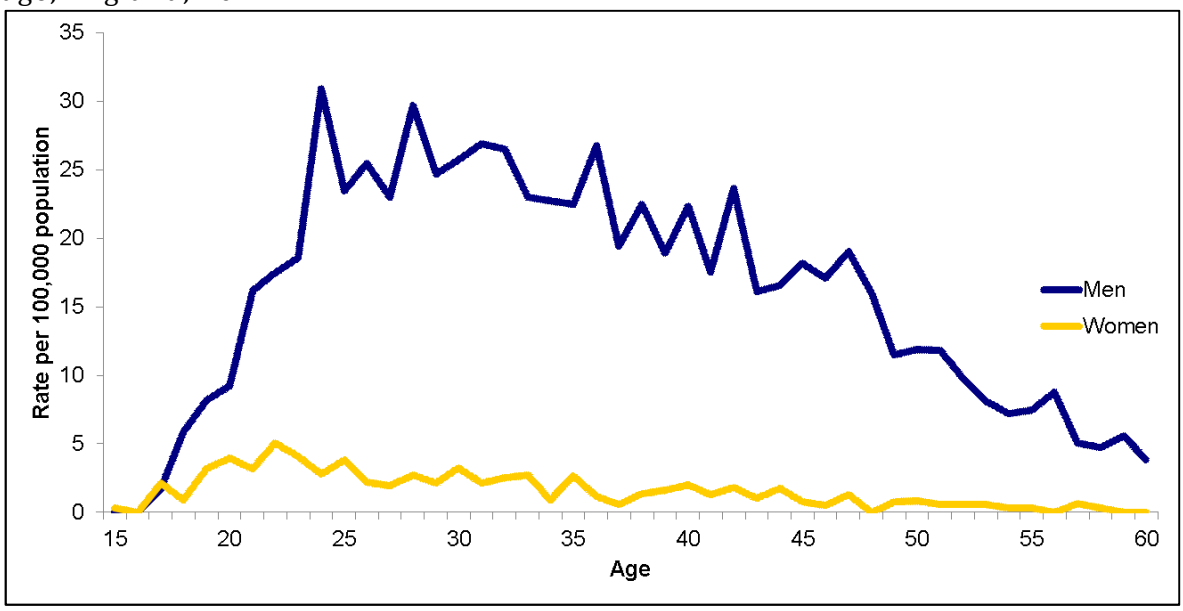
Data from routine GUM clinic returns. Includes diagnoses of primary, secondary and early latent syphilis
Source: Public Health England

Figure 28: Rate of syphilis diagnoses per 100,000 population, Havering compared to Bexley, London and England, 2012



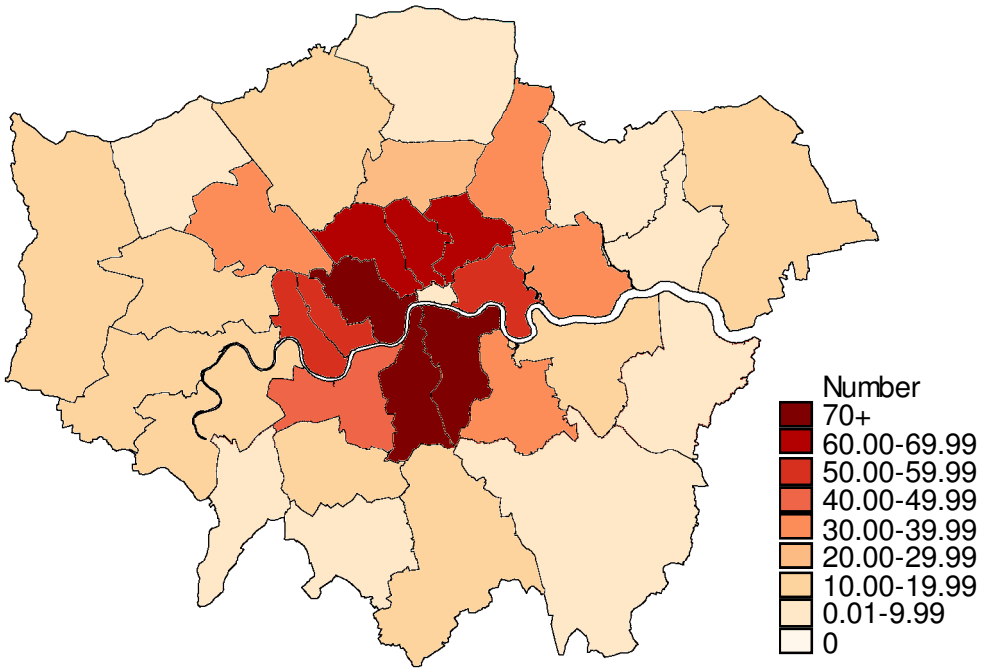
Data source: Public Health England – Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD); National Chlamydia Screening Programme (NCSP); Chlamydia Testing Activity Dataset (CTAD)

Figure 29: Rate of syphilis (primary, secondary & early latent) diagnoses by gender and age, England, 2012



Data from routine GUM clinic returns. Excludes diagnoses where gender was reported as 'unknown'
Source: Public Health England

Figure 30: Number of syphilis* diagnoses (including diagnoses of primary, secondary and early latent syphilis) among MSM by LA of residence in London, 2012



Data from routine GUM clinic returns
Source: Public Health England

At Risk Groups

Some groups in the population have an increased risk for one or more sexually transmitted infections (STIs). The increased risk is due to a number of factors:

- If part of a community where there is a higher prevalence of STIs – this means that each sexual contact carries a higher risk of infection – this is the case for MSM and some ethnic groups
- Substance misuse – which leads to riskier sexual behaviours, such as sex without a condom, or taking part in sexual activity that wouldn't have otherwise have happened
- Injecting drug use, in particular, is associated with increased risk of blood-borne viruses – or having sex with someone who injects drugs

- Multiple partners, either concurrently or successively
- If already infected with an STI

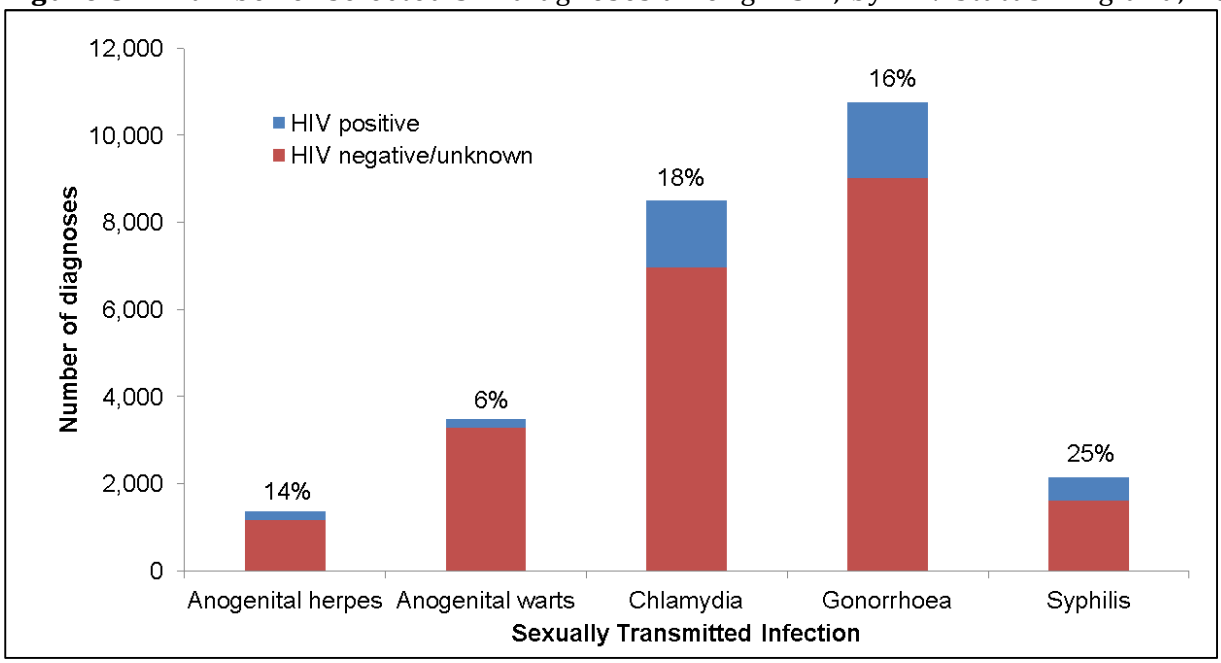
Apart from young people (discussed earlier and which cuts across all other groups), groups that are at highest risk of HIV and STIs in Havering are men who have sex with men (MSM); black Africans; black Caribbeans; intravenous drug users (IDUs); street or commercial sex worker, and prisoners.

Men who have sex with men (MSM)

Gay, bisexual and other MSM constitute an estimated 5.5% of the male population in the UK. This is a diverse population that includes people from different faith groups and ethnicities and people with disabilities. Notwithstanding this diversity, MSM bear a disproportionate burden of ill-health in three distinct but overlapping areas; sexual health and HIV, mental health, and the use of alcohol, drugs and tobacco. Whilst this section is focusing on MSM sexual health, nonetheless these associations should be considered for any response to improve sexual health in this group.

Gonorrhoea accounted for the highest count of STIs among MSM in England in 2012 (see Figure 31). In addition, 16% of MSM diagnosed with gonorrhoea are also HIV positive. The highest co-infection (of HIV and an acute STI) occurred with those diagnosed with syphilis (25%) – this is informative because syphilis is usually regarded as a tracker for risky sexual behaviour.

Figure 31: Number of selected STI diagnoses among MSM, by HIV status: England, 2012



Data from routine GUM clinic returns. For each STI, the percentage shown represents the proportion of total diagnoses that were among those HIV positive
Source: Public Health England

Emerging STIs among MSM

Shigella

Public Health England (PHE) reported that, in 2013, there was a surge in Shigella cases likely to have been sexually-acquired in men with no or unknown travel history and London is most affected. This led to a Public Health England health promotion campaign in January 2014 in partnership with Terrence Higgins Trust (THT), to warn MSM about the risk of Shigella dysentery.

Shigella is a serious gut infection which causes severe, prolonged diarrhoea and stomach cramps. Infected people can spread the infection to others by direct physical contact or indirectly by contaminating food. Among gay and bisexual men, Shigella is usually passed on through the faecal-oral route, either directly or indirectly via unwashed hands. Only a tiny amount of bacteria can spread the infection. Symptoms, which often develop around 1-3 days after sex, include frequent and explosive

diarrhoea lasting more than 48 hours; stomach cramps; feeling feverish with flu like symptoms; vomiting; and feeling weak and tired (accompanying the gastrointestinal symptoms).

Sexual orientation is not routinely collected for cases of Shigella in England and Wales. PHE extrapolated possible numbers of gay and bisexual men that acquired *Shigella flexneri* sexually in England and Wales by comparing the number of adult male cases with no or unknown travel with the number of adult females with no or unknown travel. In 2009, there was an excess of 43 adult males cases in England and Wales with no or unknown travel, by 2012 this had risen to 172 and to date in 2013 there have already been 224 cases. Although the number of known cases of Shigella is quite small, there is concern that not all cases are being reported – men with symptoms but who are unaware of Shigella might assume that it is a terrible case of food poisoning.

There is currently no local data to provide insight on this STI in Havering. However, this may need to be closely monitored, especially because the infection can be particularly dangerous for those already living with HIV or Hepatitis C. This can also have important links to the use of drugs such as Mephedrone, ketamine, crystal metamphetamine, and γ-butyrolactone[8].

As with HIV and other STIs, gay and bisexual men can reduce the risk of getting Shigella by:
- Always using a condom when having sex with casual and new partners.
- Avoiding overlapping and reducing the number of sexual partners.
- If having unprotected sex with casual or new partners, getting an HIV/STI screen at least annually, and every three months if changing partners regularly.

Lymphogranuloma Venereum

Lymphogranuloma Venereum (LGV) is a sexually transmitted infection caused by a type of chlamydia bacteria. The bacteria are different from the one which causes genital chlamydia. In the UK, it is mostly found in men who have sex with men, especially if they are HIV positive.

LGV is a common heterosexual sexually transmitted infection in other parts of the world, such as African and south Asian countries. It is transmitted through anal or vaginal sex, and possibly through the use of sex toys if they are not washed or a new condom used for each partner. The symptoms of LGV can start a few days to a month after coming into contact with the infection, including a small painless ulcer on the genitals, swelling and redness of the skin in the groin area. The infection can cause diarrhoea and lower abdominal pain.

LGV is associated with high risk sexual behaviour, including meeting partners on the internet, at parties or in saunas; dense sexual networks; simultaneous contacts (parties, saunas); unprotected rectal contact (insertive and receptive), intercourse and fisting; and poly drug use.

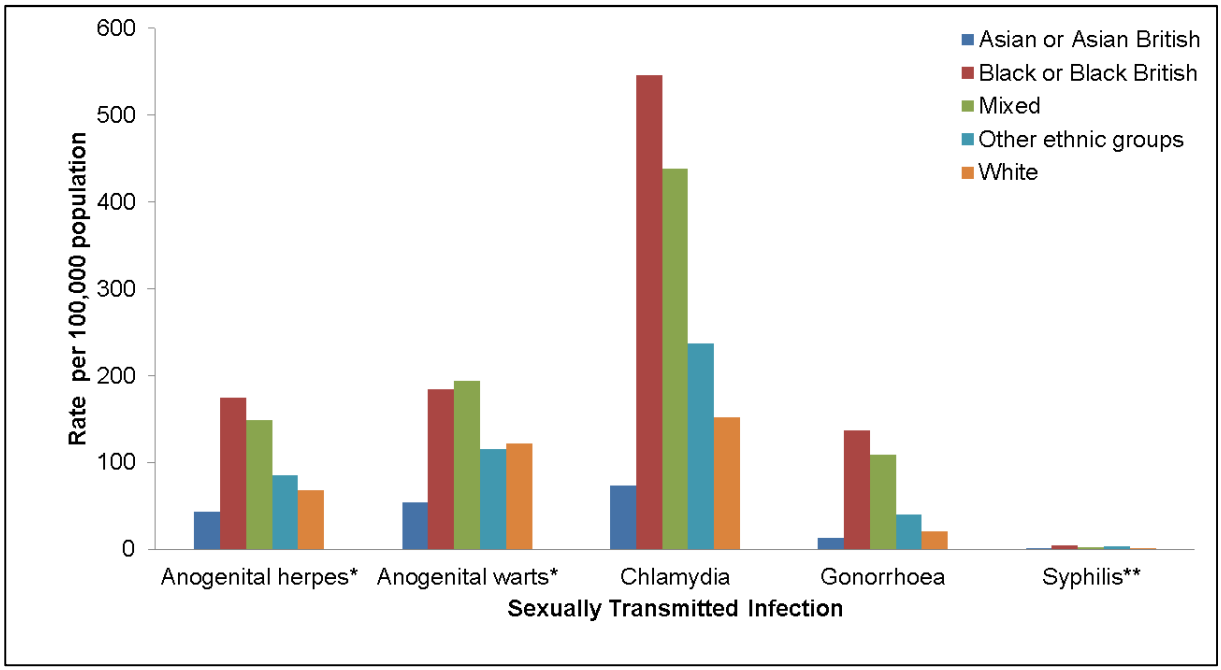
Before 2003, LGV was considered rare in the UK. But the PHE has reported an on-going and increasing numbers of cases of LGV, with 99% of cases being among MSM. Nine out of 10 people with LGV (90%) are white and 9 out of 10 of them (90%) have acquired their infection in the UK. In addition,
- two out of three are aged 35 or older,
- four out of five cases are co-infected with HIV,
- one-fifth test positive for Hepatitis C antibody,
- one-third are co-infected with another STI, e.g. gonorrhoea.

[8] Gilbart VL, Simms I, Gobin M, Oliver I, Hughes G (2013). High-risk drug practices in men who have sex with men. The Lancet, Volume 381, Issue 9875, Pages 1358 - 1359, 20 April 2013
Kirby T & Thornber-Dunwell M (2013). High-risk drug practices tighten grip on London gay scene. *Lancet* 2013; 381: 101-102**.** Full Text |PDF(161KB) |
Daskalakis DC & Blaser MJ (2007). Another perfect storm: *Shigella*, men who have sex with men and HIV. *Clin Infect Dis* 2007; 44: 335-337.
Borg ML, Modi A, Tostmann A, et al (2012). Ongoing outbreak of *Shigella flexneri* serotype 3a in men who have sex with men in England and Wales, data from 2009—2011. *Euro Surveill* 2012; 17. pii=20137.

Black Africans and Black Caribbean

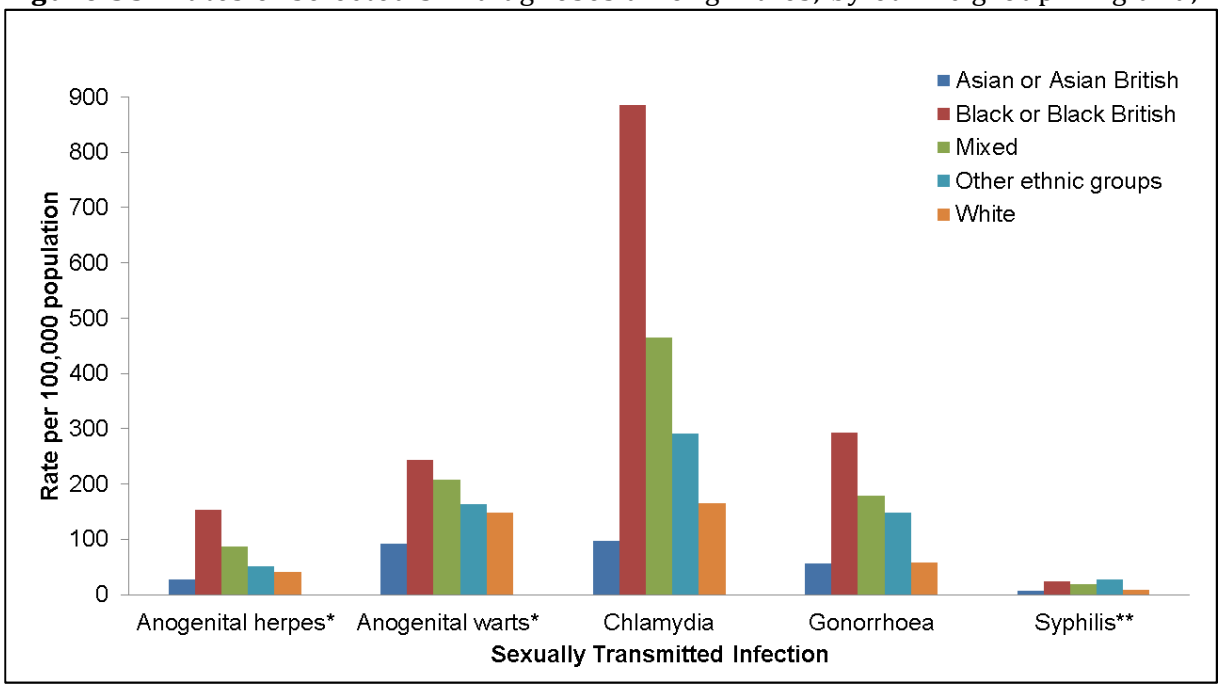
The rates of almost all common acute STI diagnoses among Black or Black British ethnic group are higher than all other ethnic groups. This is so among both females (Figure 32) and males (Figure 33).

Figure 32: Rates of selected STI diagnoses among females, by ethnic group: England, 2012



Data from routine GUM clinic returns
** First episode; **Includes diagnoses of primary, secondary and early latent syphilis*
Source: Public Health England

Figure 33: Rates of selected STI diagnoses among males, by ethnic group: England, 2012



Data from routine GUM clinic returns
** First episode; **Includes diagnoses of primary, secondary and early latent syphilis*
Source: Public Health England

Also see the "Most-at-risk groups" subsection of the "Human Immunodeficiency Virus (HIV)" section of this document for more relevant information.

Intravenous drug users (IDUs)

People who inject drugs are vulnerable to a diverse range of infectious and blood borne communicable disease, including hepatitis C and HIV. Both infections can be spread through sexual contact.

Hepatitis C

Hepatitis C is a blood borne virus and is usually asymptomatic in the early years. The majority of infected individuals are unable to clear hepatitis C naturally, and without successful treatment chronic infection can span several decades and can be life-long. Persistent infection can lead to end stage liver disease and hepatocellular carcinoma.

London has a higher rate of laboratory confirmed hepatitis C diagnoses than any other region. There were 2,747 new laboratory reports of confirmed hepatitis C diagnoses in London in 2012, a rise of 38% since 2011. This rise is likely to reflect improvements in reporting, as laboratory reporting became a statutory requirement in 2010, as opposed to an increase in underlying detection of infections. The number of new infections of hepatitis C per year appears to be stable or declining

In 2012 nearly 2,000 people in London were admitted to hospital with a diagnosis of hepatitis C. Hepatitis C was the primary indication for just under a quarter of first liver transplants in London.

Injecting drug use remains the major risk factor. It is estimated that over half of people who inject drugs have hepatitis C (59%). In the past 10 years men who have sex with men (MSM) has also emerged as an important route of transmission. Individuals originating from South Asia, where the prevalence of hepatitis C is high, are also particularly at risk. The number of diagnoses is highest in males, the peak age group being those aged 35 to 54 years.

If left untackled, hepatitis C infection will result in great costs, not only in terms of morbidity and mortality due to chronic disease, but also in financial costs due to treatment of the late complications of the infection. Hospital admissions and deaths from hepatitis C related end stage liver disease and hepatocellular carcinoma have risen three-fold in the UK since 1998

Hepatitis C is a major public health problem, with an estimated 60,000 people in London infected with hepatitis C, of whom an estimated 40% are undiagnosed. The PHE has reported that, between 2008 and 2012, 381 out of 403 (95%) of HCV (Hepatitis C Virus) positive MSM were also HIV positive. PHE further reported that:

About 1 in 3 of men infected with HCV reported more than 5 sexual partners in previous 3 months. In addition,

- Approximately 90% of men reported anal intercourse (3/5 unprotected).
- 4/5 reported sex under the influence of drugs.
- 30% of men reported IDU – most injected stimulants/opioids

Street or commercial sex workers

See section on Prostitution and trafficking.

Prisoners

Local and remand prisons are likely to have a high proportion of drug users and therefore a high prevalence of blood borne virus infections. Young Offender Institutions are likely to have a high prevalence of chlamydia and other sexually transmitted infection. Female prisons are likely to have a high proportion of drug users and commercial sex workers which will result in a high prevalence of blood borne viruses and sexually transmitted infections. Pregnancy, contraception and abuse will also be key issues.

Prevention

Prevention relies on a combination of factors, including access to information and provision of sexual health services including contraception (which is covered later in this chapter), and targeted interventions aimed at groups that are at higher risk of STIs.

HPV immunisation programme

The national HPV immunisation programme was introduced in September 2008, and is routinely recommended for all girls at 11 to 14 years of age with the first dose offered in school year 8 in England. When first introduced the HPV vaccination programme was offered to all girls in school year 8 in England (aged 12 to 13 years), and a 'catch-up' campaign for girls aged from 14 years to less than 18 years.

HPV vaccines are highly effective at preventing the infection of susceptible women with the HPV types covered by the vaccine. In clinical trials in young women with no evidence of previous infection, both vaccines are over 99% effective at preventing pre-cancerous lesions associated with HPV types 16 or 18 (Harper et al., 2006; Ault et al., 2007; Lu et al., 2011). Current studies suggest that protection is maintained for at least ten years. Based on the immune responses, it is expected that protection will be extended further; long-term follow-up studies are in place. Some other high-risk HPV types are closely related to those contained in the vaccines, and vaccination has been shown to provide some cross-protection against infection by these types (Brown et al., 2009; Lehtinen et al., 2012). Gardasil® is also 99% effective at preventing genital warts associated with vaccine types in young women (Barr et al., 2007)

Sex and Relationship Education for children and young people

Effective sex and relationship education is essential if young people are to make responsible and well informed decisions about their lives, and to be supported through their physical and emotional development, and to be equipped to understand and engage in healthy relationships.

All maintained secondary schools must provide sex and relationship education as part of the basic curriculum, and must meet the requirements of National Curriculum Science. In delivering sex education, schools are currently required to have regard to the Sex and Relationship Education Guidance (published 2000), and must have an up-to-date policy on SRE which is made available for inspection and to parents[9]. Currently, Academies and Free Schools do not have to follow the National Curriculum and so are not under the same statutory obligations as maintained schools. As such academies are not obliged to teach sex and relationship education.

In May 2013, Ofsted published a report on PSHE in primary and secondary schools in England, which raised concerns about the teaching of SRE. Furthermore, young people, when asked about their experiences of sex education at school, often complain about the focus on the physical aspects of reproduction, and the lack of any meaningful discussion about feelings, relationships and values. Research by the Children's Commissioner has found that far too many young people do not know what a good relationship looks like, and many did not even understand the concept of consent.

In the summer of 2014, the House of Commons Education Select Committee launched an inquiry into PSHE and SRE in schools which has led to plans to reform independent school standards regulations. It is not yet clear what impact the report and proposals will have, but ensuring that children and young people are provided with age-appropriate information and tools in order that they can make the right choices at the right time about sex and relationships is an important factor in preventing poor sexual health. Parents and carers of children and young people, schools, school nurses, the voluntary sector, faith groups, and community sector all contribute to supporting children and young people in ensuring that children and young people are equipped to engage in healthy relationships.

Risk-taking behaviours

There are key groups at higher risk of STIs including, men who have sex with men, and people who have come from or who have visited areas of high HIV prevalence, as well as behaviours that increase the risk of poor sexual health, including misuse of alcohol and/or substance abuse, early onset of sexual activity, and unprotected sex and frequent change of (and/or multiple sexual partners). Alcohol

[9] 2014, Long R, *Sex and Relationship Education in Schools SN/SP/6103*, House of Commons Library,

consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour, such as not using contraception or condoms.

Health professionals working in a range of settings can identify individuals at higher risk, and either have one to one structured discussions on the basis of behaviour change theories, or arrange for these discussions to take place with a trained practitioner in sexual health. Opportunities for risk assessment may arise during consultations on contraception, pregnancy or abortion, but also during routine care, or during new patient registration.
Preventing poor sexual health among vulnerable young people, including those from disadvantaged backgrounds, who are in (or leaving) care, or who have low educational attainment, or who are teenage parents, benefit from advice and support in both healthcare settings (such as primary care and pharmacies) and non-healthcare settings, such as schools, drug and alcohol misuse services.

Equip healthcare professionals and non-healthcare practitioners

Increasing awareness of sexual health among local healthcare professionals and relevant non-health practitioners (particularly those working with vulnerable groups) can contribute towards prevention of poor sexual health.

In taking forward "Every Contact Counts" there is an opportunity to appropriately raise issues related to sexual health, for example providing an HIV or chlamydia test as a part of routine healthcare, and to use these as opportunities to identify non-consensual sex and coercion, and domestic and sexual abuse and violence.

High quality, accurate information, whilst playing a crucial part in helping people to understand how to improve their sexual health, does not necessarily result in changes in attitudes and behaviour. Preventative interventions that focus on behaviour change theories can be effective in promoting good sexual health, by helping people to work through their own motivations and helping them to question and change their behaviour.

Clinical services

Open-access confidential sexual health services that are located and tailored to meet local needs are essential to test and treat infection and prevent onward transmission. Services should include arrangements for notification, testing, treatment and follow up of partners of people who have an STI.

Post Exposure Prophylaxis

Post exposure prophylaxis (PEP) is an anti-HIV medication that can help stop someone from becoming infected with HIV after the virus has entered their body. It is an emergency measure, that's used as a last resort, and must be taken within 72 hours of exposure, although the earlier that it is taken (ideally hours after coming into contact with HIV), the greater the chance of the treatment being successful.

PEP is not guaranteed to always work, but it does have a high success rate. It is made available free of charge but can only be prescribed by doctors and if certain criteria are met. Sexual health and HIV clinics can provide it, as can Accident and Emergency departments of hospitals. GPs do not give PEP.

PEP is a month long course of HIV drugs – and it must be taken every day for 28 days. The medication has serious side effects, and so are not a replacement for practising safer sex, and using condoms.
Before prescribing PEP the doctor will ask questions about the extent to which someone has been exposed to HIV, and will also carry out an HIV test. If someone already has HIV, then PEP would not be the right treatment. Three months after completing the course of treatment, another HIV test is undertaken.

Recommendations

Objective	Action
• Pay greater attention to the prevention of STIs among young people	• Schools to be supported to provide good quality sex and relationship education. Support for schools should be provided by school nurses, and where schools wish to include criteria on SRE as an element of their Healthy Schools award, there should be information available from the Council's public health team on where they can access information and training • Where young people are tested positive for an STI, they should receive advice on how to prevent further infections in the future. • There should be a focus on improving sexual health amongst the most vulnerable groups of young people, and specifically Looked After Children. This should take into account the association between use of alcohol, drugs, and poor sexual health. This should take into account influences of wider determinants on all aspects of LAC health by carrying out a health needs assessment for this group • Where there is evidence of very young teenagers having been exposed to risky sexual behaviours, such as having been infected by gonorrhoea, appropriate safeguarding procedures must be followed and there should be increased help, guidance, and support for these individuals • Ensure that chlamydia screening programme is effective and attains the greatest percentage of positive screens, and that the programme supports health promotion messages • The DPH, through the Health Protection Forum, should ensure that there is good coverage of the HPV vaccination programme, and appropriate measures are in place to address any inequalities in uptake
• Ensure that young people have the skills and knowledge to avoid early onset of sexual activity, and that they are confidence in deciding when hey are ready for a sexual relationship and if they want to continue in a sexual relationship	• Schools to provide good quality sex and relationship education, with support from the school nurse, including signposting to sources of evidence-based information • Schools and school nurses should provide parents with guidance and signpost to resources that support parents to be able to talk with their children about sex and relationships, and how to stay healthy.
• Reduce the risks to sexual health as a result of misuse of alcohol and/or substance abuse	• Commissioners of drugs/alcohol services should ensure that there are appropriate referral pathways in place for clients to be

Objective	Action

	referred/signposted to sexual health services, information and advice (including self-management)
	• Commissioners of drugs/alcohol services to monitor the following:
	  • how well trained are the frontline staff working in drugs alcohol services in all aspects of sexual health (unintended pregnancy, sexually transmitted infection and sexual exploitation and abuse)
	  • the numbers of clients referred to sexual health services
	  • the numbers of clients that are identified as at risk of sexual exploitation, and the actions that were taken as a result

• Greater attention to be paid to prevention of STIs among high risk groups, including
  • Men who have sex with men
  • Ethnic groups that are a high risk, including black Africans
  • Offenders
  • Looked After Children, and those leaving care
  • Young people (under 18) who are either parents, or are expectant parents
	• Ensure sexual health services are commissioned that focus on prevention as well as treatment
	• Ensure that a borough sexual health alliance is formed that brings together services in a way that best meets the needs of high risk groups
	• Develop a teenage pregnancy strategy, in consultation with stakeholders
	• Undertake further needs assessments for specific groups:
	  • Looked After Children, and those leaving care
	  • Offenders

• Healthcare professionals should use all appropriate opportunities to raise issues related to sexual health and make "Every Contact Count"	• Sexual health alliance to include representation by CCG, GPs, practice nurses, pharmacists in order to champion sexual health among healthcare professionals • Public health and CCG to raise awareness of sexual health among GPs and practice nurses by promoting national campaigns to general practice • Public health commissioners of pharmacy-provided sexual health services to ensure that pharmacists and counter staff promote good sexual health and signpost to sources of information
• Relevant non-healthcare practitioners, such as teachers and school support staff, children's centre staff and staff of alcohol outreach services to contribute towards prevention of poor sexual health	• Public health to provide training on sexual health to health champions in schools and children's centres

Human Immunodeficiency Virus (HIV)

HIV (Human Immunodeficiency Virus) is a virus that attacks the body's immune system – the body's defence against diseases. There is no cure for HIV but the introduction of anti-retroviral therapy (ART) has resulted in substantial reductions in AIDS incidence and deaths in the UK, and people diagnosed promptly with HIV can now anticipate a near normal life expectancy

Most people who are infected with HIV experience a short, flu-like illness that occurs two to six weeks after infection. After this, HIV often causes no symptoms for several years. The flu-like illness that often occurs a few weeks after HIV infection is also known as seroconversion illness. It is estimated that up to 80% of people who are infected with HIV experience this illness.

The most common symptoms are fever, sore throat, body rash, and can also include tiredness, joint pain, muscle pain, and swollen glands. The symptoms, which can last up to four weeks, are a sign that the body's immune system is attempting to fight off the virus. After the initial symptoms disappear, HIV will often not cause any further symptoms for many years. During this time, known as asymptomatic HIV infection, the virus continues to spread and damage the immune systems. This process can take about ten years, during which an individual will feel and appear well.

If left untreated, HIV will weaken the body's ability to fight infection, and thus become vulnerable to serious illnesses. This stage of infection is known as AIDS (Acquired Immune Deficiency Syndrome), although it is now more often described as late-stage HIV infection. At this stage, there is an increased risk of life-threatening illnesses such as tuberculosis, pneumonia and some cancers.

Whilst the main mode of transmission is through sexual intercourse, HIV can be passed on through infected blood and bodily fluids, including breast milk.

HIV is associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. Thousands of individuals are diagnosed with HIV each year but some living with the virus are unaware of their infection. Public Health England (2013) estimates that, in 2012, 98,400 people were living with HIV in the UK – with an overall prevalence of 1.5 per 1,000 population (1.0 in women and 2.1 in men). But an estimated 21,900 people (22%) living with HIV were unaware of their infection.

Public Health England (2013) reports that there were 490 deaths among people with an HIV infection in 2012, which is a continuation of the decline in mortality since the introduction of ART. But challenges remain, particularly with high rates of late HIV diagnoses. Those diagnosed with HIV late (CD4 count <350 cells/mm3) continued to have a ten-fold increased risk of death in the first year of diagnosis compared to those diagnosed early (Public Health England, 2013). Late diagnosis has a two-fold effect; the infected individual has poorer health outcomes, as treatment is started late, and also there is increased risk of passing on the infection to others if someone is unaware that they have the infection.

Despite HIV being now considered as a long-term condition, it is frequently regarded as stigmatising, and there remain many myths about HIV. For example, , there are concerns that HIV test results won't be kept confidential. Many believe that lengthy pre-test counselling is required prior to HIV testing, which is not the case. In fact, good clinical practice should encourage the 'normalisation' of HIV testing. Following a positive diagnosis, whether this is through diagnostic testing (where there are clinical indicators of disease), or opportunistic screening of populations (where non-symptomatic individuals are tested), it is imperative that any newly diagnosed individual is immediately linked into appropriate HIV treatment and care.

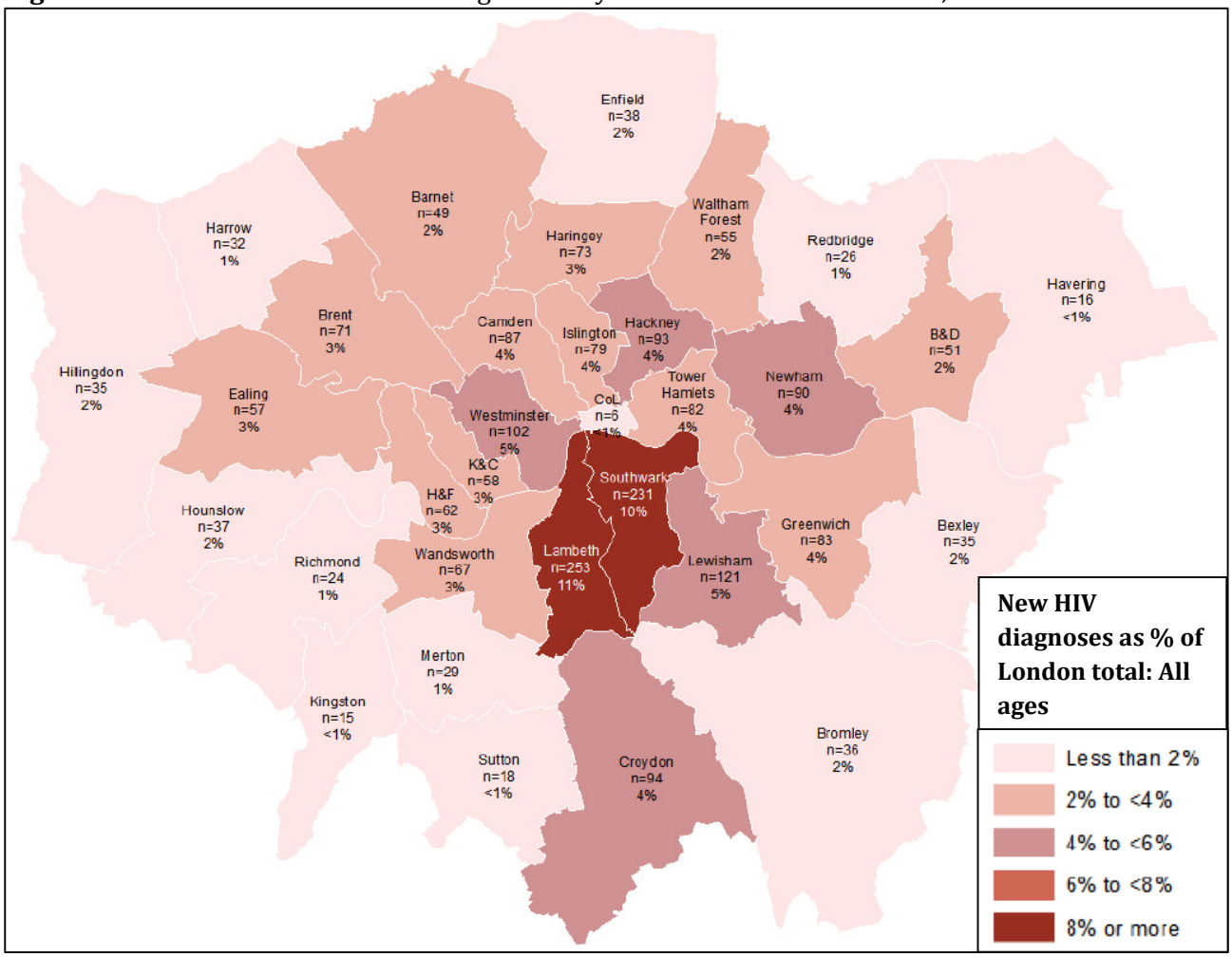
HIV prevention uses a number of methods to reduce or eliminate the risk of HIV infection. Condoms, when used consistently and correctly, are the only form of protection that can help stop transmission of STIs. Where people re-infected, it is important that they know their HIV status, so that they can prevent passing on the infection to others, including for women who may pass the infection on to their

unborn child. Treatment as prevention (TASP) uses antiretroviral treatment to decrease the amount of the virus in a person's bodily fluids (viral load), thus protecting their own health, and also reducing the likelihood of passing on the infection to others. Post exposure prophylaxis (PEP) can be prescribed for people who have potentially been exposed to the virus. PEP is particularly important for people who have been sexually assaulted, or exposed to blood through a needle stick injury, or other accident at work.

New HIV diagnoses

In 2011, 16 adult residents (aged between 15 and 59 years) of Havering were diagnosed with HIV (see Figure 34). HIV diagnoses among men who have sex with men (MSM) living in the borough and diagnosed at a London clinic totaled five – compared to less than five in 2010. For heterosexual men, the figure was less than five (as in 2010) and for heterosexual women it was 6 – compared to 7 in 2010 (see Figure 35).

Figure 34: Number of new HIV diagnoses by London LA of residence, 2011



Source: Public Health England

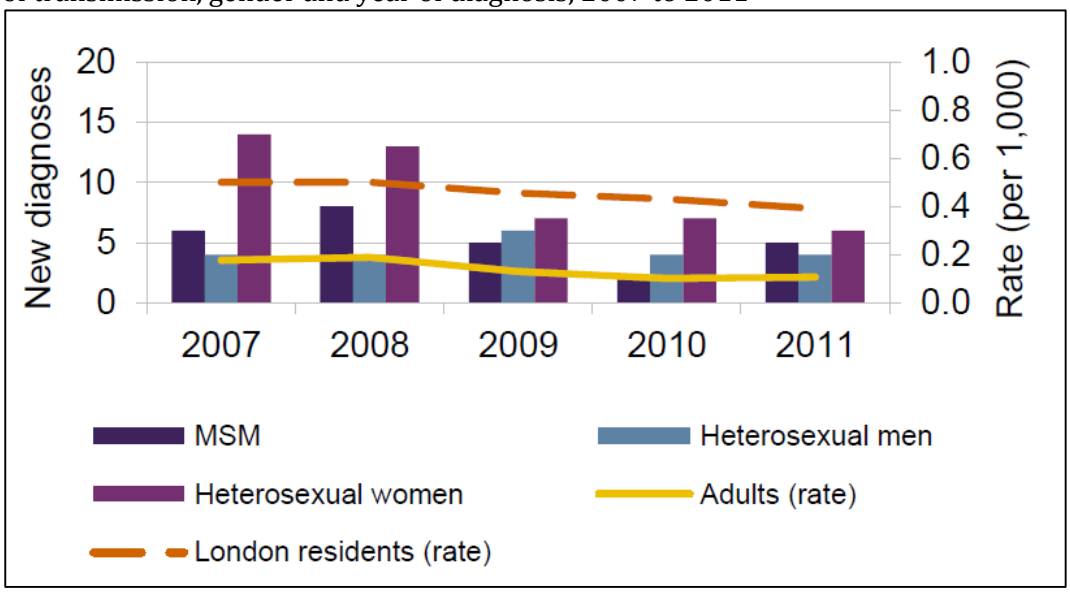
Because of the small number of new HIV diagnoses in Havering, there is very little analysis that can be done without breaching data protection and confidentiality rules. However, some of the following key features of new HIV diagnoses in London (according to Public Health England's report "HIV epidemiology in London: 2011 data") might be useful:

Gender: Almost three quarters of those diagnosed with HIV in 2011 were male (74%). However, in heterosexually acquired cases, it was females who predominated (58%).

Route of infection: The most common route of acquiring HIV in those diagnosed in 2011 was through sex between men. Sex between men and women was the second most common route of infection

accounting for 43% of new diagnoses of HIV in London. During the decade prior to 2010 sex between men and women had been the most common route of infection. However, numbers in this group have declined since 2003. In 2011, people who inject drugs (PWID) accounted for one percent of all diagnoses, a proportion which has remained relatively stable since 2000.

Figure 35: Number of adults newly diagnosed with HIV living in Havering and rate per 1,000, by route of transmission, gender and year of diagnosis, 2007 to 2011



Source: Public Health England

Ethnicity: In 2011, 50% (n=1,315)[10] of newly diagnosed cases of HIV were white, up from 1,233 in 2010; while 30% (n=787, adjusted) were black African. The proportion of newly diagnosed HIV cases who were black African has declined following a peak of 51% in 2002. In 2011, the proportion of those being newly diagnosed who were white men was 46% of new diagnoses. This is up from 40% in 2010 and is the highest proportion recorded over the past decade. In 2011, black African men made up 12% of new diagnoses, and black African women 18%. This is a large decrease in the proportions seen a decade previously when black African men accounted for 18% of new diagnoses and black African women 32%. Black Caribbeans have continued to account for around five percent of those newly diagnosed with HIV (n=129 in 2011). The proportion of cases who belong to other black and other minority ethnic (BME) groups seems to have remained steady in recent years and in 2011 they accounted for 15% of new HIV diagnoses.

World region of birth: Almost a third (31%) of people newly diagnosed with HIV in 2011 were born in the UK (where country of birth was reported). Among those born abroad, around half (32% of total) were born in Africa, with West Africa accounting for about half of these (15% of total). This is in contrast to earlier phases of the epidemic when Eastern and Southern Africa were more prominent. MSM were more much more likely to be UK-born than heterosexuals (45% of MSM with a known country of birth compared to 15% of heterosexuals with a known country of birth). One in five (19%) MSM was born in Western Europe (excluding the UK) and around one in eight (12%) was born in Latin America. Where reported, two-thirds (67%) of heterosexuals were African-born and 15% were born in the UK.

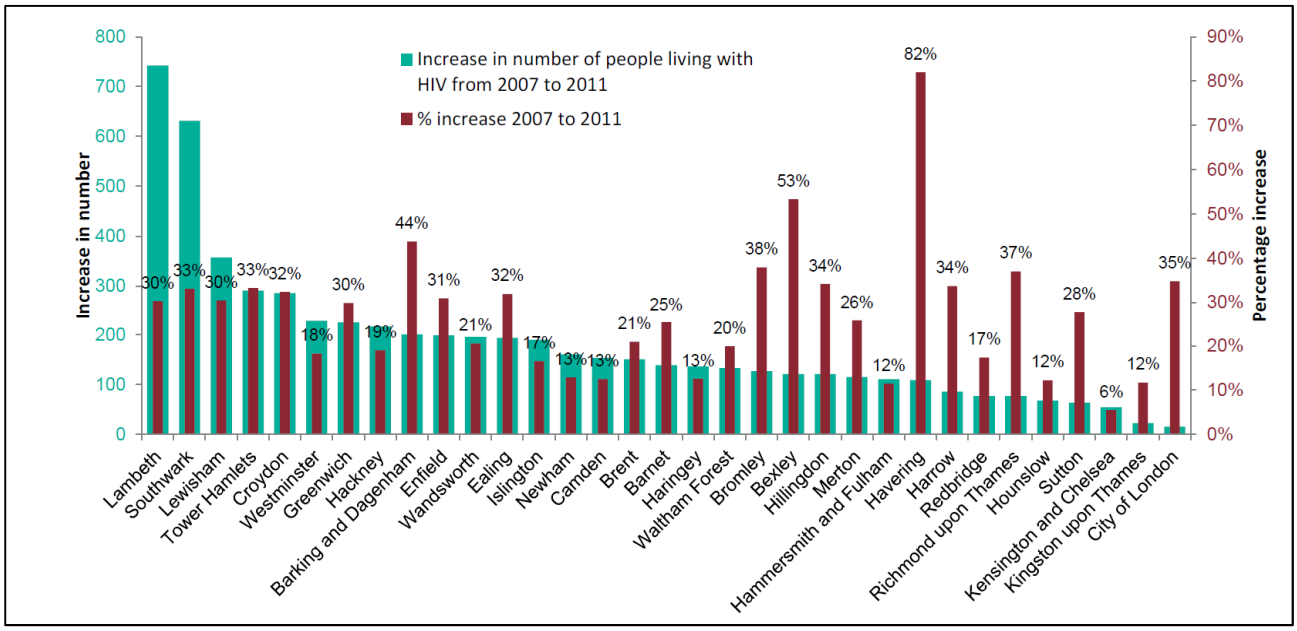
Age: In 2011 the median age at HIV diagnosis was 36 years (interquartile range (IQR): 29-44), the same as in 2010. Young people aged 15 to 24 years made up nine percent of those diagnosed with HIV in 2011, the same proportion (nine to 11%) as between 2002 and 2011. By contrast, the proportion of those aged 50 years or older at diagnosis more than doubled over the same period from six percent in 2002 to 13% in 2011.

[10] The description "n=" describes what this means in terms of numbers.

Local HIV Prevalence

The number of people living with HIV in Havering increased by 82% from 2007 to 2011 (see Figure 36), compared to 30% for England and by 10% from 2010 to 2011 (compared to 6% for England). However, the percentage increases were from relatively lower bases, and the actual numbers of people living with HIV in the borough are still low. As Figure 37 illustrates, in 2012 Havering still had the lowest prevalence of HIV of all London boroughs.

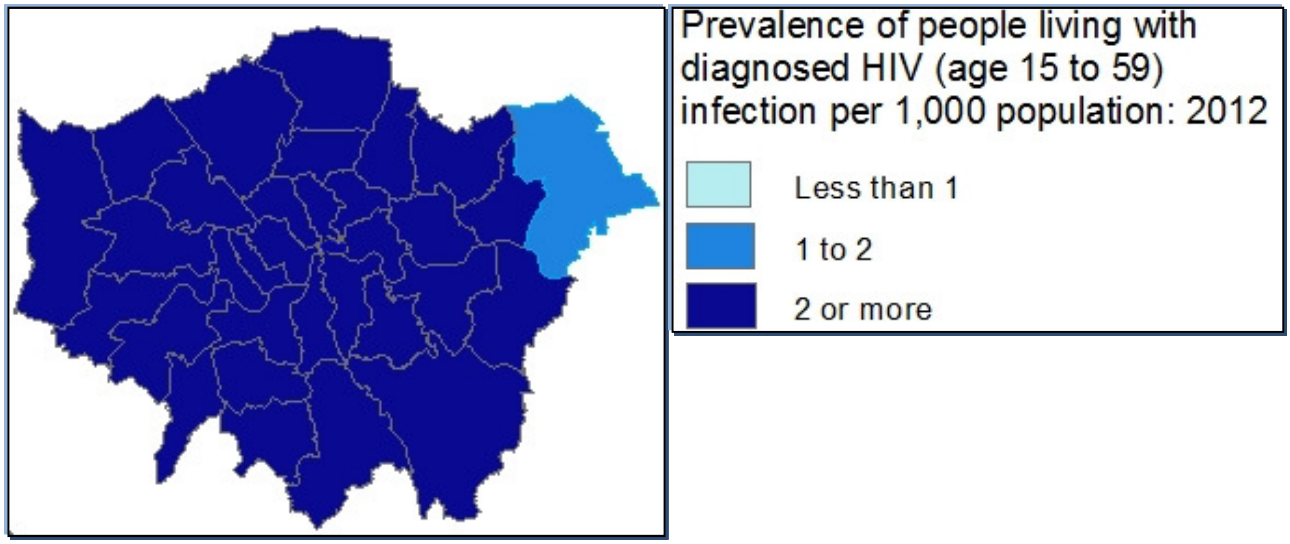
Figure 36: Increase in the number of people living with HIV and percentage increase by London PCT from 2007 to 2011



Source: Public Health England

In 2012, Havering's prevalence of diagnosed HIV was the lowest – and remains the only borough with less than 2 per 1,000 population aged 15-59 years – in London (see Figure 37).

Figure 37: Prevalence of people (aged 15 to 59 years) living with diagnosed HIV infection, per 1,000 persons, 2012

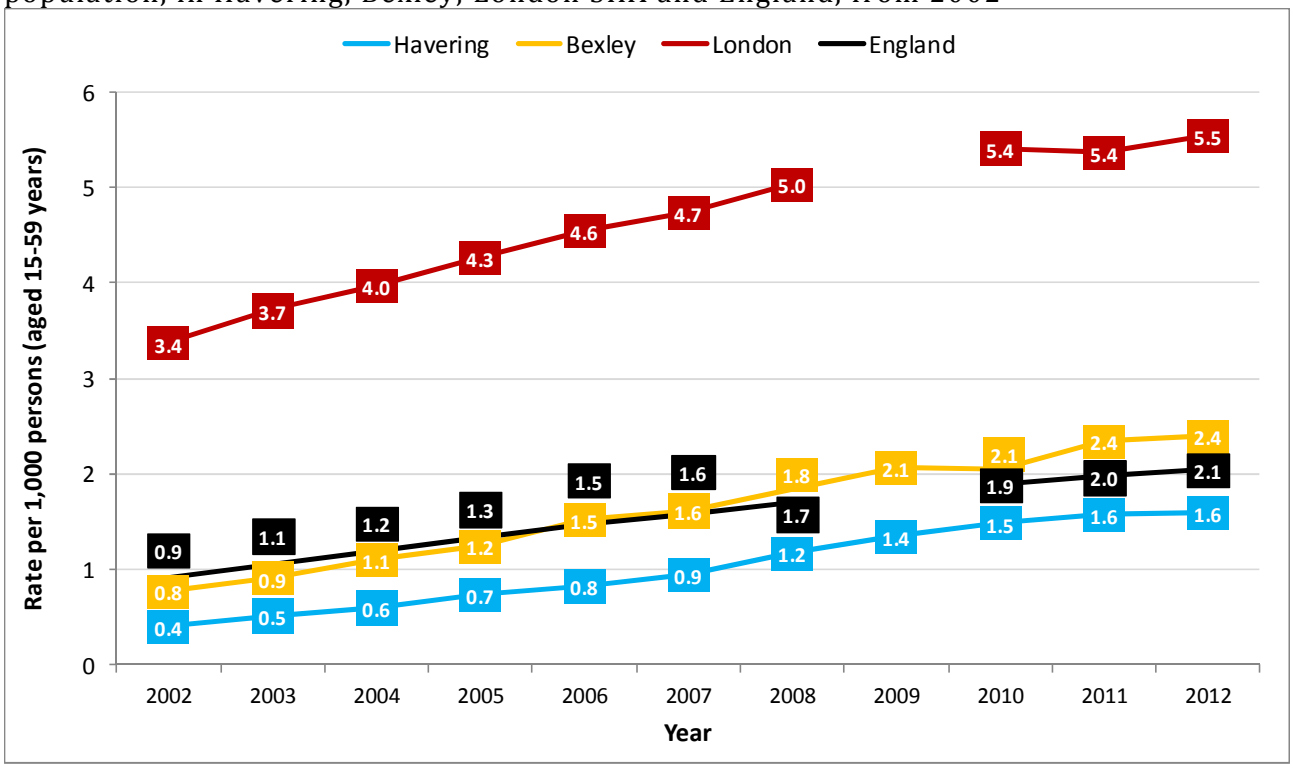


Source: Public Health England

In addition, Figure 38 shows that Havering's prevalence of diagnosed HIV was consistently lower than the closest statistical neighbour (Bexley), London and England throughout the preceding ten years.

However, there has been a fourfold increase in the local prevalence of diagnosed HIV from 2002 (0.4 per 1,000 population aged 15-59 years) to 2012 (1.6 per 1,000 population aged 15-59 years).

Figure 38: Prevalence of diagnosed HIV among persons aged 15 to 59 years, per 1000 population, in Havering, Bexley, London SHA and England, from 2002



Data source: Public Health England; Survey of Prevalent HIV Infections Diagnosed (SOPHID); Office for National Statistics mid-2012 population estimate

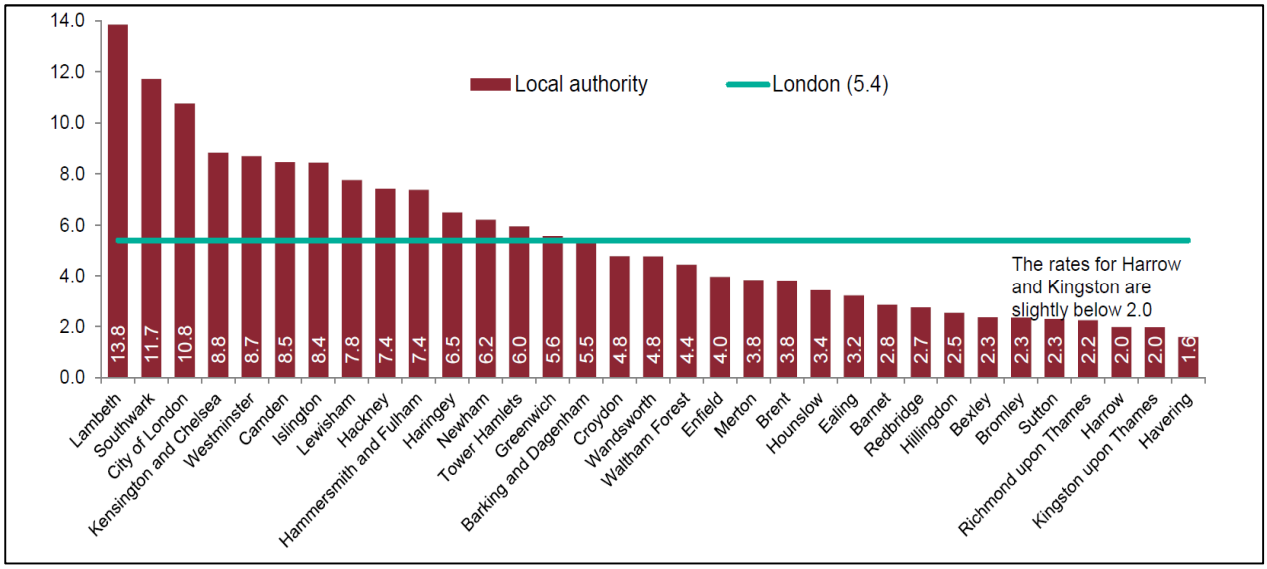
The total number of residents accessing HIV related care in 2011 (n=242) equated to a prevalence rate of 1.6 per 1,000 population aged 15-59, which is lower than the rates of both London (5.4 per 1,000) and England (2.0 per 1,000). Figure 39 shows the prevalence rate across all London Boroughs – there is a marked variation across local LAs, ranging from 1.6 per 1,000 in Havering to 13.8 per 1,000 in Lambeth (the highest in the country).

Diagnosed prevalence (rates per 1,000 population aged 15-59 years) in English Local Authorities is used to inform HIV testing policy. A diagnosed HIV prevalence that is higher than 2 per 1,000 indicates that HIV testing should be expanded beyond testing only in genito-urinary medicine settings. Despite Havering having the lowest prevalence rate of the London boroughs, 23% of middle super output areas (MSOAs) in Havering had prevalence rates higher than 2 per 1,000, with the highest rates found in the west of the borough.

In 2011, prevalence of diagnosed HIV over 2 per 1,000 was found in parts of Brooklands, Romford Town, Havering Park, South Hornchurch, and Mawneys wards (see Figure 40). These wards have been targeted as areas for interventions, and in 2014 a pilot HIV point-of-care testing programme was set up in Havering in three GP practices that are located in some of these higher prevalence wards, to assess the acceptability and level of uptake of HIV testing among newly registering patients. Evaluation of these pilots will inform about future roll-out of HIV Point of Care testing in Havering.

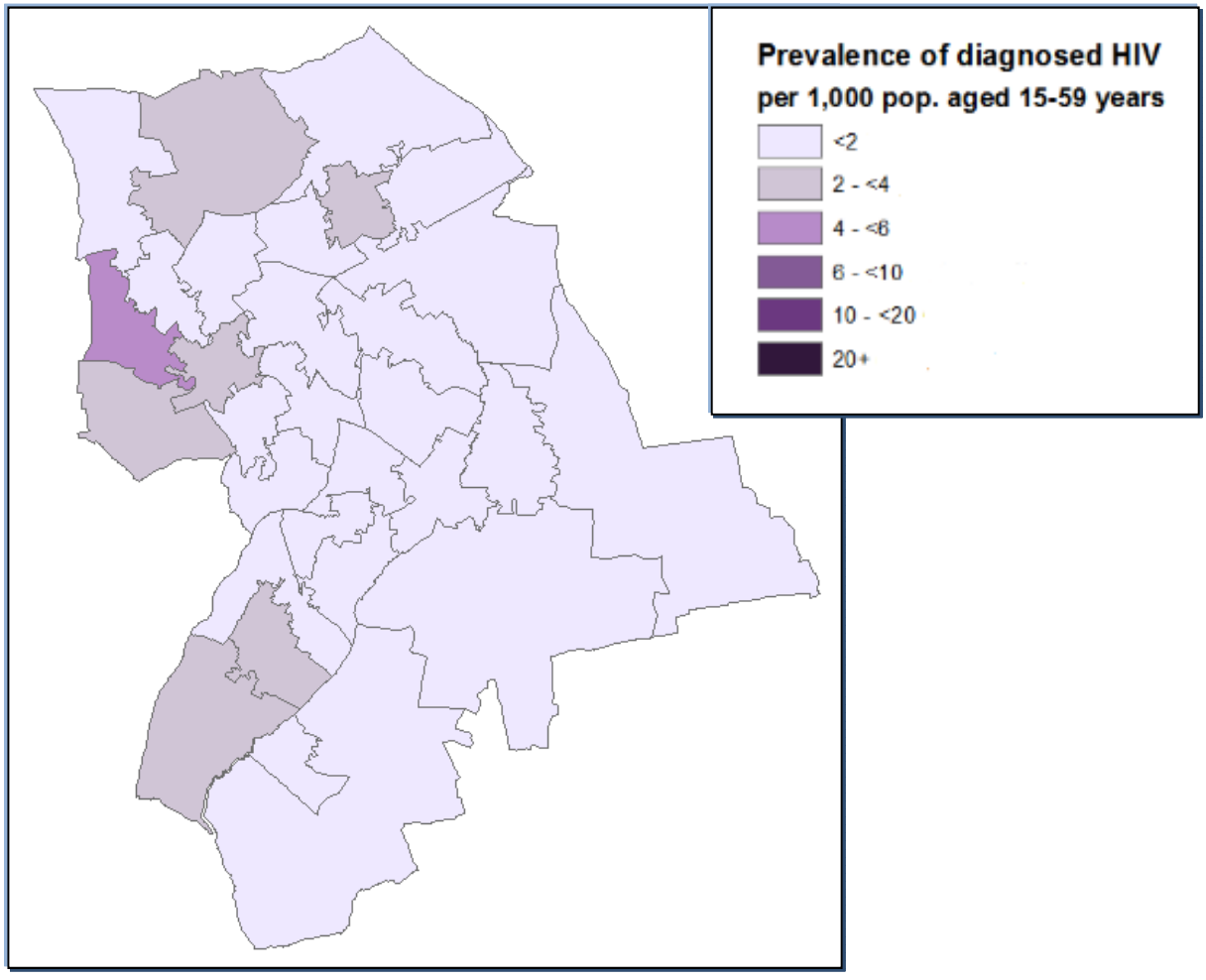
In addition, HIV prevention programmes are commissioned that aim to raise knowledge and awareness of HIV among high-risk groups in Havering.

Figure 39: Diagnosed prevalence rate of HIV (in those aged 15-59 years) by London LA, 2011



Source: Public Health England

Figure 40: Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA in Havering, 2011



Source: Survey of Prevalent HIV Infections Diagnosed (SOPHID)

Living with HIV

The development of effective treatment means that HIV is now considered a long term condition. People diagnosed with HIV today can expect a near normal life expectancy if they start treatment early

and take it correctly. However, living with HIV infection can affect all dimensions of a person's life: physical, psychological, social and spiritual. Counselling and social support can help people and their carers cope more effectively with each stage of the infection and enhance quality of life. With adequate support, people living with HIV are more likely to be able to respond adequately to the stress of being infected and are less likely to develop serious mental health problems. Assessment and interventions may be aimed at the acutely stressful phase following notification of HIV infection, the ensuing adjustment period, and the process of dealing with chronic symptomatic HIV infection and disease progression through to death.

HIV infection often can result in stigma and fear for those living with the infection, as well as for those caring for them, and may affect the entire family. Infection can result in loss of socio-economic status, employment, income, housing, health care and mobility. For both individuals and their partners and families, psychosocial support can assist people in making informed decisions, coping better with illness and dealing more effectively with discrimination. It improves the quality of their lives, and prevents further transmission of HIV infection.

For people with HIV/AIDS who must adhere to TB treatment, long-term prophylaxis or antiretroviral therapy, on-going counselling can be critical in enhancing adherence to treatment regimens.

The subject of the health and wellbeing of people living with HIV is too extensive to be covered by this JSNA chapter. It is therefore recommended that a future refresh of the JSNA Healthcare Chapter or a separate needs assessment consider the needs of people living with HIV and their families.

Late Diagnosis

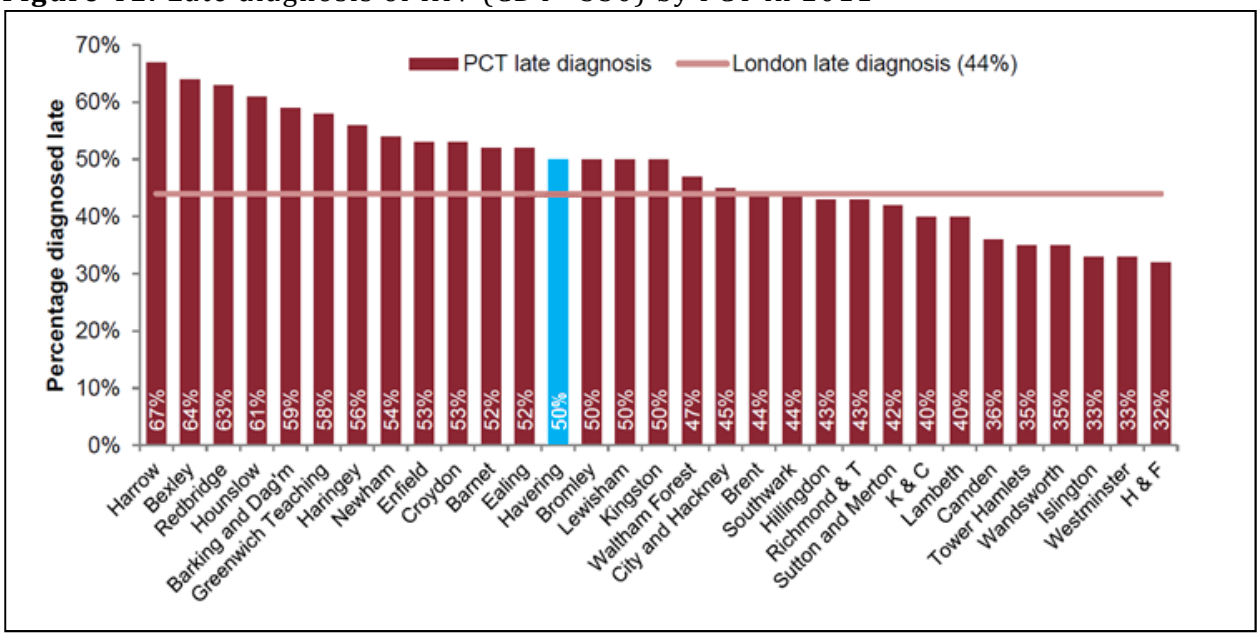
Reduction in late diagnosis is one of the three main public health outcome measures related to sexual health and is a key priority for Havering due to higher rates of late diagnosis. Late diagnosis is defined as patients with a CD4 cell count of less than 350 cells/mm3 within three months of diagnosis. Very late diagnosis is defined as patients with a CD4 cell count of fewer than 20 cells/mm3 within three months of diagnosis[11].

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services and a reduced response to anti-retroviral treatment. An earlier diagnosis can decrease onward transmission of HIV as an individual's knowledge of their HIV status has also been found to reduce their risk behaviour.

In Havering, one in every two people diagnosed with HIV in 2011 were diagnosed late. This is higher than London (44%) and 13th highest of the 31 London boroughs – see Figure 41. Within the MSM group, none (0%) was diagnosed late in Havering (compared to 31% in London). This strongly suggests that investing time and resources to target heterosexual at-risk groups (black African men and women) should reduce late diagnosis of HIV in the local population. So, although Havering has relatively low numbers of people living with HIV in the borough, compared to the rest of London, too many are being diagnosed late.

[11] HIV epidemiology in London: 2011 data. Published May 2013. PHE gateway number: 2013044

Figure 41: Late diagnosis of HIV (CD4 <350) by PCT in 2011



Source: Public Health England

Most-at-risk groups

In similarity with STIs, some groups in the population generally have an increased risk for HIV infection. They include: Men who have sex with men (MSM); Black Africans; Black Caribbeans; intravenous drug users (IDUs); street or commercial sex workers; people already living with an STI; young people; and prisoners. There is also risk of HIV transmission from infected pregnant women to baby.

In the UK, the HIV epidemic is largely concentrated among men who have sex with men (MSM) and black-African heterosexual men and women. Also important, albeit at a relatively lower level, is the prevalence of HIV among people who inject drugs (PWID). Public Health England (2013a) estimate that the prevalence of HIV among PWID and people who injected drugs for the first time in the preceding three years was respectively 13 per 1,000 (95% C.I. 9.4 to 17 per 1,000) and 10 per 1,000 (95% C.I. 2.9 to 27 per 1,000) in 2012.

However, among MSM, black-African men and black-African women, the overall prevalence of HIV was respectively estimated to be 47, 26, and 51 per 1,000 population. In the general population, it has been estimated that the prevalence of HIV in 2012 was 1.5 per 1,000 (1.5-1.6) population of all ages – 2.1 per 1,000 (1.9–2.2) in men and 1.0 per 1,000 (0.99-1.1) in women[12]. Therefore, in 2012, the prevalence of HIV was approximately 30 times higher for MSM and black-African men and women compared to the general population in England. Individual, societal and structural factors such as sexual behaviours, infections acquired abroad, migration and HIV-related stigma and discrimination contribute to this disparity[13].

In Havering, the largest proportion of residents accessing HIV related care in 2011 were infected as a result of heterosexual transmission (n=158, 65%). Infection via sex between men accounted for the next largest group (n=63, 26%) of residents receiving HIV care in Havering. The greatest number of

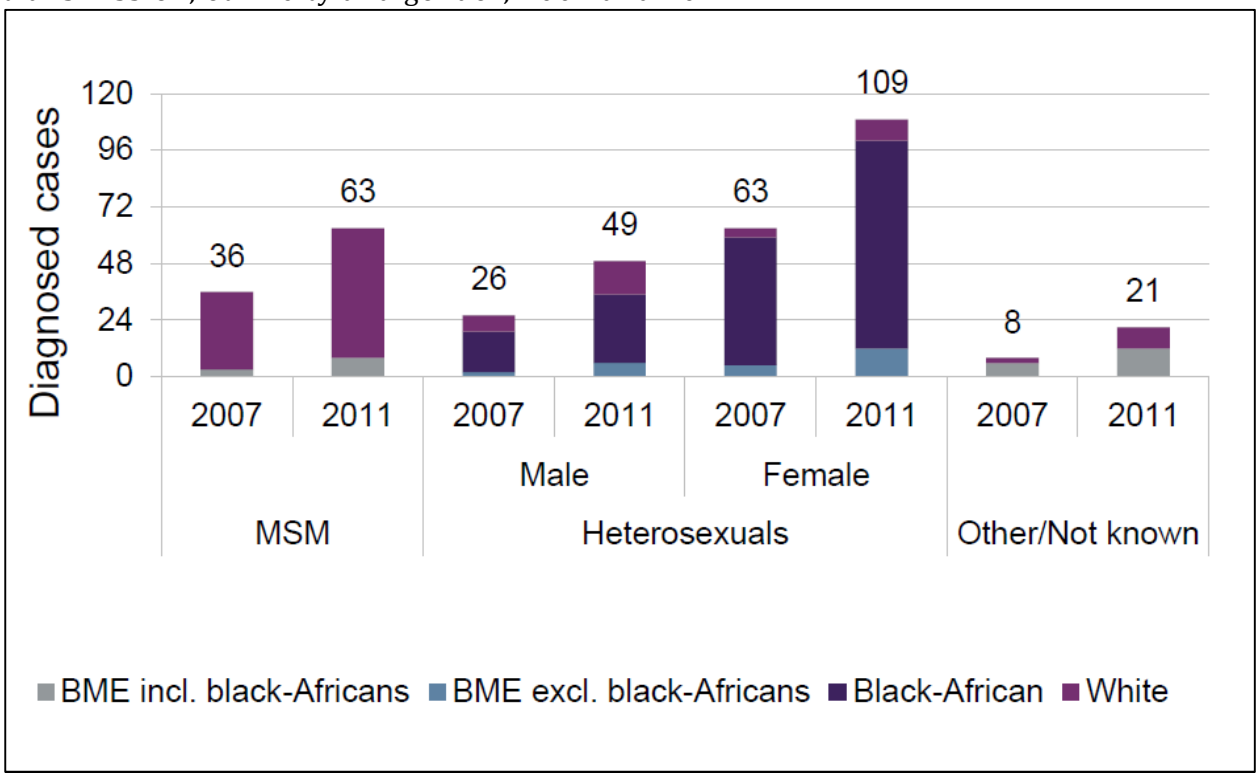
[12] *Public Health England (2013a). HIV in the United Kingdom: 2013 Report. Available online at: http://www.hpa.org.uk/Publications/InfectiousDiseases/HIVAndSTIs/1311HIVintheUk2013report/ (Accessed February 2014)*

[13] Rice BD, Elford J, Yin Z, Delpech VC (2012). A new method to assign country of HIV infection among heterosexuals born abroad and diagnosed with HIV. AIDS 2012 Sep 24;26(15):1961-6.
Fakoya I, Reynolds R, Caswell G, Shiripinda I (2008). Barriers to HIV testing for migrant black Africans in Western Europe. HIV Med 2008 Jul; 9 Suppl 2:23-5.

patients accessing care were in the black-African ethnic community, followed by the white ethnic group (n=87, 36%).

Figure 42 suggests that heterosexual women of black-African origin are at greatest risk of HIV in Havering, given their disproportionate representation in the diagnosed HIV population. It is likely that the disproportionate representation of heterosexual women of black-African origin in Havering's diagnosed HIV population may be due to testing for HIV in pregnancy, and possibly also because more women readily come forward to be tested and thus diagnosed, compared to men. However, there were more men (n=125) than women (n=117) in the 242 Havering residents that accessed HIV-related care in 2011, though some of the men were MSM.

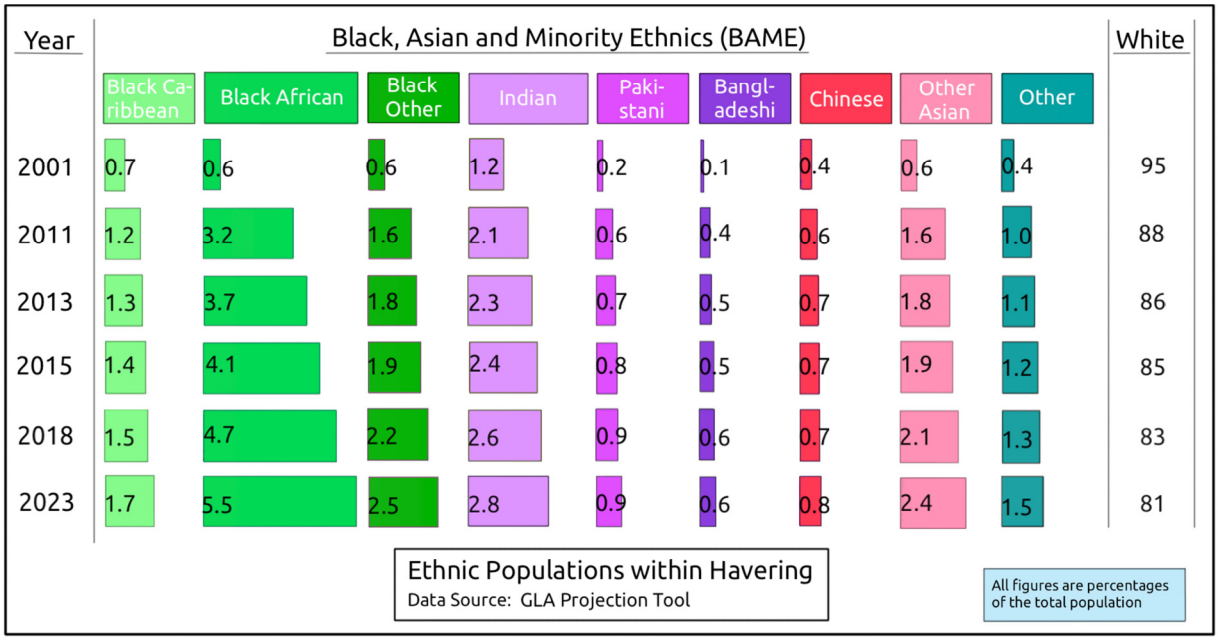
Figure 42: Number of adults with diagnosed HIV living in Havering by route of transmission, ethnicity and gender, 2007 and 2011



Source: Public Health England

It should be noted that, while the White ethnic group will continue to be over 80% of the total Havering population in the next decade, the Black African ethnic group is – and is forecast to continue to be – the fastest growing minority ethnic group in Havering (see Figure 43). Figure 43 shows that, while each of the other minority ethnic groups will still account for less than 3 in every 100 people in Havering, the Black African ethnic group will account for almost 6 in every 100 people in Havering by 2023 (see the JSNA Demographics Chapter for more information).

Figure 43: GLA Projection: Trends in Black, Asian and Minority Ethnic Populations, 2001 to 2023



Data source: Greater London Authority (GLA) Projections

Screening and testing for HIV in Havering

Screening is a process that tests asymptomatic people for a condition (such as the chlamydia screening programme for young people described earlier) whereas testing is a diagnostic tool for people who have some symptoms.

Screening and testing for HIV are both key tools in HIV prevention. As has been described above, HIV has a significant silent window before the onset of flu-like symptoms – at this stage there are insufficient antibodies for a test to infection, and this can be followed by a period of up to ten years when there are no symptoms. During both periods of time, infection can be passed on to others.

There are three types of tests for HIV:

- a blood test, in which a small amount of blood is taken and examined in a laboratory. These tests can provide a reliable result four weeks after exposure to HIV
- a saliva test, which is taken using a mouth swab. It can take up to three months after infection for the virus to show up in a saliva test
- a dried blood spot test, in which the finger is pricked and a spot of blood is blotted onto filter paper. It can take up to three months after being infected for the virus to show up in a blood spot test.

If a test appears positive, further blood tests will be undertaken to be completely sure before someone is given a positive result. Once someone is confirmed as infected with HIV, they will be referred to the specialist clinic for further tests to monitor the progress of infection and to work out when HIV treatment should be started. Anyone in Havering who suspects they may have been exposed to HIV is encouraged to undertake a test for HIV, either from their GP, or from one of the sexual health clinics in the Borough.

In early 2014, an HIV screening pilot was started in three GP practices in Havering; as part of their routine check for adults who are registering as new patients, when they are being offered the dried blood spot test. Havering is currently the only London borough where prevalence of HIV is below the level whereby all adults are routinely screened for HIV. The HIV screening pilot is being operated in Havering to prepare for any changes in local prevalence rates, when it may be advisable to roll out a screening programme across the whole, or parts, of the Borough.

Testing Uptake

Everyone who attends a sexual health clinic in Havering is offered an HIV test as part of the routine suite of STI tests. However, not everyone takes up the offer. As HIV testing should now be just a routine part of STI testing, GUM clinics (Genito-Urinary Medicine), will be changing the consent process for HIV testing, and making this an "opt out" test as is the case with all other STI tests. This will mean that patients will need to actively request for the test not to be undertaken, rather than give consent for the test to be carried out.

Sexual orientation was not reported with sufficient completeness by the clinics in this borough to allow MSM and heterosexual males to be reported separately. However, 70% of men (London average: 89%) and 74% of women (London average: 83%) offered an HIV test at the local clinic within the borough took up the offer. Making HIV testing an "opt out" test is expected to lead to higher levels of testing in GUM in the future. See more local information on HIV tests in Appendix 1 to Appendix 7.

Screening for HIV in pregnancy

In March 2013, Public Health England reported that the proportion of HIV-positive diagnosed women passing the infection on to their babies in the UK is now at its lowest ever level, having dropped four-fold in ten years. In 2000-2001 the percentage of women diagnosed with HIV who transferred the disease to their child stood at 2.1 per cent and by 2010-2011 it was down to 0.46 per cent

The NHS Infectious Diseases in Pregnancy Screening Programme is responsible for ensuring that all pregnant women are routinely offered screening for HIV, hepatitis B, syphilis and susceptibility to rubella infection. The aims of the programme are to ensure that women with these diseases are identified early in pregnancy and that strategies are put in place to prevent mother to child transmission. If a woman isn't aware of her HIV infection, her baby has about a 1 in 4 chance of being infected. Knowing they are HIV positive means women can receive treatment, and transmission of HIV from mother is child is almost entirely preventable through careful management during pregnancy (including ART), management of the birth, and avoidance of breastfeeding.

Pregnant women should be informed of their results (whether negative or positive), and those with positive screening test results for HIV are contacted and advised about the result at a face-to-face appointment. A test is will also be offered to the woman's partner, and any other children to determine if they have the infection and require treatment and care. See section on Maternity and Antenatal and Newborn Screening.

Post Exposure Prophylaxis

Post-exposure prophylaxis (PEP) is a month-long course of antiretroviral drugs taken very soon after sex which had a risk of HIV transmission or occupational exposure. The treatment must be started within 72 hours and continues for four week, and uses the same powerful drugs as used for HIV treatment.

Raising Awareness

In addition to screening, testing and post-exposure prophylaxis treatment, it is essential to raise awareness of HIV and how to reduce the risk of infection. Havering Council is a partner in London wide prevention programmes aimed at MSM, and also commissions voluntary sector organisations to target high risk groups with information about preventing HIV, and living with the infection. The voluntary sector organisations work in partnership with NHS and social care, and recruit and train people from the target groups to raise awareness in their own communities.

Recommendations

Based on the information presented above and relevant NICE guidance and recommendations[14] (on prevention of sexually transmitted infections and under 18 conceptions), specific recommendations for Havering stakeholders and partners are described below:

[14] http://www.nice.org.uk/guidance/ph33 and http://www.nice.org.uk/guidance/ph34

Objective	Action
Reduce discrimination, stigma and fear associated with HIV testing and normalise testing in all healthcare settings to reduce the level of undiagnosed HIV infection	• LBH public health to establish a sexual health alliance that includes representation by HIV prevention services • LBH to ensure that commissioned HIV prevention services raise awareness of HIV and HIV prevention, including information on where testing is available, and confidentiality of HIV results • Health professionals to routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus and all those attending at specialist health care settings • CCG to ensure that appropriate HIV testing is offered by acute service, including routine testing for all those from areas of high prevalence (2 per 1,000 diagnosed HIV) • LBH Public Health to recruit health champions from among the African and Caribbean communities to promote HIV testing as part of a wider health improvement programme • LBH commissioners to evaluate the Havering HIV Point of Care Testing pilot and commission services based on the findings • Providers of sexual health services to explain the confidentiality of HIV testing, and be able to discuss HIV symptoms and the implications of a positive or negative test
Healthcare providers to be knowledgeable about HIV, including matters of confidentiality, referral pathways, and trained in negotiation/behavioural change	• CCG / LBH Public Health to engage with primary care practitioners to ensure that GPs and practice nurses are aware of: o The symptoms that may signify primary HIV infection o The illnesses that co-exist with HIV o Referral pathways for HIV testing and treatment (and availability of online tests, etc) o Behaviour change theories to reduce risk-taking behaviours o Confidentiality o The advisability of offering HIV testing to all men who are at higher risk of HIV
HIV testing to be promoted among higher risk groups to ensure individuals are aware of their HIV status • MSM should have an HIV/STI screen at least annually, and every three months if having unprotected sex with new or casual partners. • Black Africans and Caribbeans should have an HIV test and should have regular HIV/STI screening if having unprotected sex with new or casual partners	• GPs should refer MSM to HIV testing at suitable intervals (at least annually or every three months where appropriate) • GPs should refer black Africans and Caribbeans for HIV testing at suitable intervals • Health champions from among the African and Caribbean communities to raise awareness of advisability and frequency of HIV testing among black Africans and Caribbeans

Objective	Action
	• LBH Public Health to commission remote access HIV testing kits, and ensure that availability of kits is promoted among target groups – ensuring that health promotion advice is given with orders/test results
Ensure that services are developed in line with patient need, including: locations and timings of services.	• Sexual health services to undertake surveys and community engagement to ensure that services are delivered effectively and cost-effectively in the right locations and at the right time, paying particular attention to those groups most at risk of poor sexual health; black African and Caribbean groups and MSM • The Director of Public Health, through the Health Protection Forum, should seek assurance that the referral pathways are effective, and in particular that men who test positive are seen by an HIV specialist within 48 hours
Increase knowledge of HIV and HIV prevention • MSM should to be made aware that serosorting (choosing sexual partners of the same HIV status as themselves) is unsafe. • MSM to be made aware of the risks of concurrent drug use, which has been identified as a risk factor for several STIs among HIV positive MSM. • promote consistent condom use, having fewer sexual partners and avoiding overlapping sexual relationships to reduce the risk of becoming infected.	• Schools to ensure that young people are aware of HIV and prevention, and school nurses to support schools to provide accurate information to staff, children and young people, and their parents • All providers of sexual health services and public health services (e.g. school nurses, health visitors) and health practitioners to promote consistent condom use, having fewer sexual partners and avoiding overlapping sexual relationships • Providers of sexual health services should advise MSM that serosorting is unsafe • Sexual health services and drug treatment services should make MSM aware of the risks of concurrent drug use as a risk factor for STIs among HIV positive MSM • Engagement to be undertaken with relevant groups such as faith and community groups (through the sexual health alliance) • Commissioned prevention services to undertake health promotion at venues and via on-line services visited by target groups – sexual health commissioners to monitor health promotion activities, including how well information materials are tailored to meet the needs of target groups • All stakeholders to raise awareness of HIV by supporting national prevention initiatives, including World Aids Day (healthcare and non-healthcare, to include schools, commissioned prevention services)
Ensure that local services are commissioned that meet nationally recognised standards	• Public health sexual health commissioners to ensure that services meet standards and

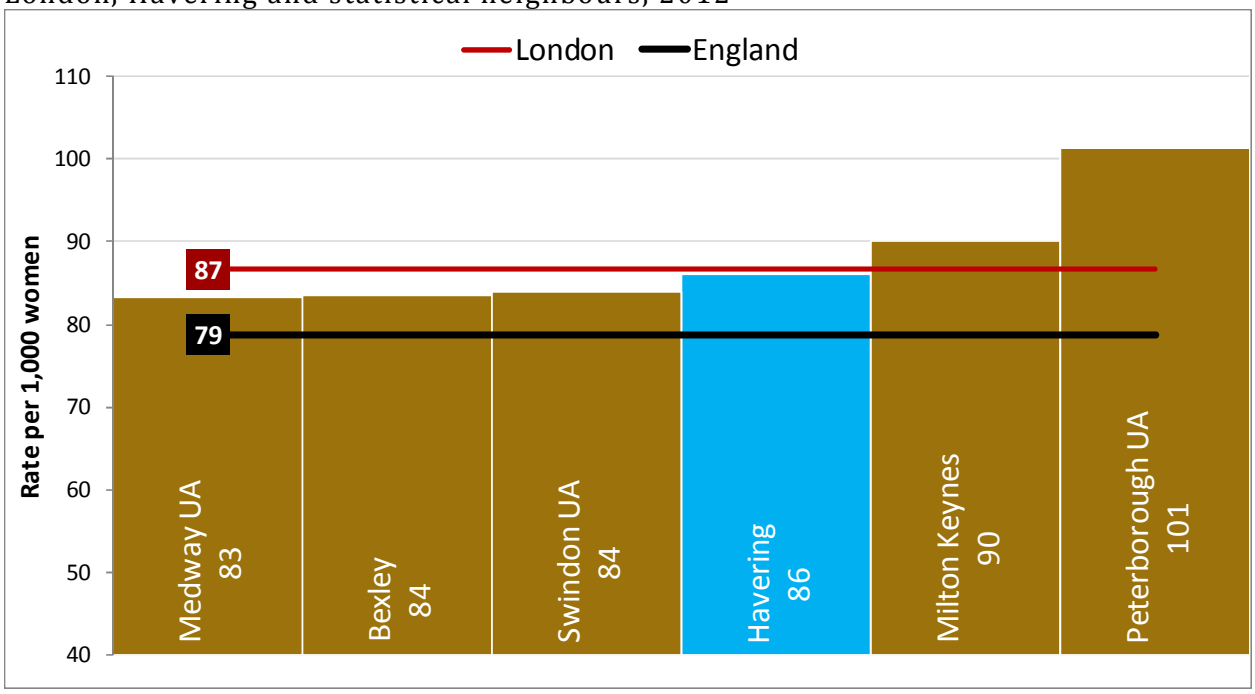
Objective	Action
	are monitored (including timeliness of results) • The Director of Public Health to ensure that there is a local strategy to increase uptake of HIV testing among target groups in accordance with NICE recommendations
Gain a greater understanding of the needs of people living with HIV and their families, including the effect on their physical, psychological, social and spiritual dimensions of their lives	• Undertake a health needs assessment of people living with HIV • Public health sexual health commissioners to ensure that information is collected on take up rates of HIV testing • Public health sexual health commissioners to obtain monitoring information from commissioned prevention services on effectiveness of local interventions that aim to increase the number of black Africans and MSM participating in HIV testing

Conception, abortion and maternity

Conception is a pregnancy of a woman which leads either to a maternity or an abortion. An abortion is the medical process of ending a pregnancy so it does not result in the birth of a baby. This is also described as a termination or termination of pregnancy. A miscarriage is where the pregnancy ends without medical intervention (although treatment may be needed after a miscarriage). Under UK law, an abortion can usually only be carried out during the first 24 weeks of pregnancy. After 24 weeks, abortions may only be carried out if it is necessary to save the woman's life, or to prevent grave permanent injury to the physical or mental health of the pregnant woman, or if there is substantial risk that if the child were born, s/he would have serious physical or mental disabilities.

The conception rate in Havering (86 per 1,000 women aged 15-44) is similar to the London average (87 per 1,000 women aged 15-44) but higher than England's (76 per 1,000 women aged 15-44) – this is similar to most of Havering's statistical neighbours (see Figure 44). The local conception rate is in the 2nd highest quartile among London boroughs (see Figure 45) but lower than the average for Outer London.

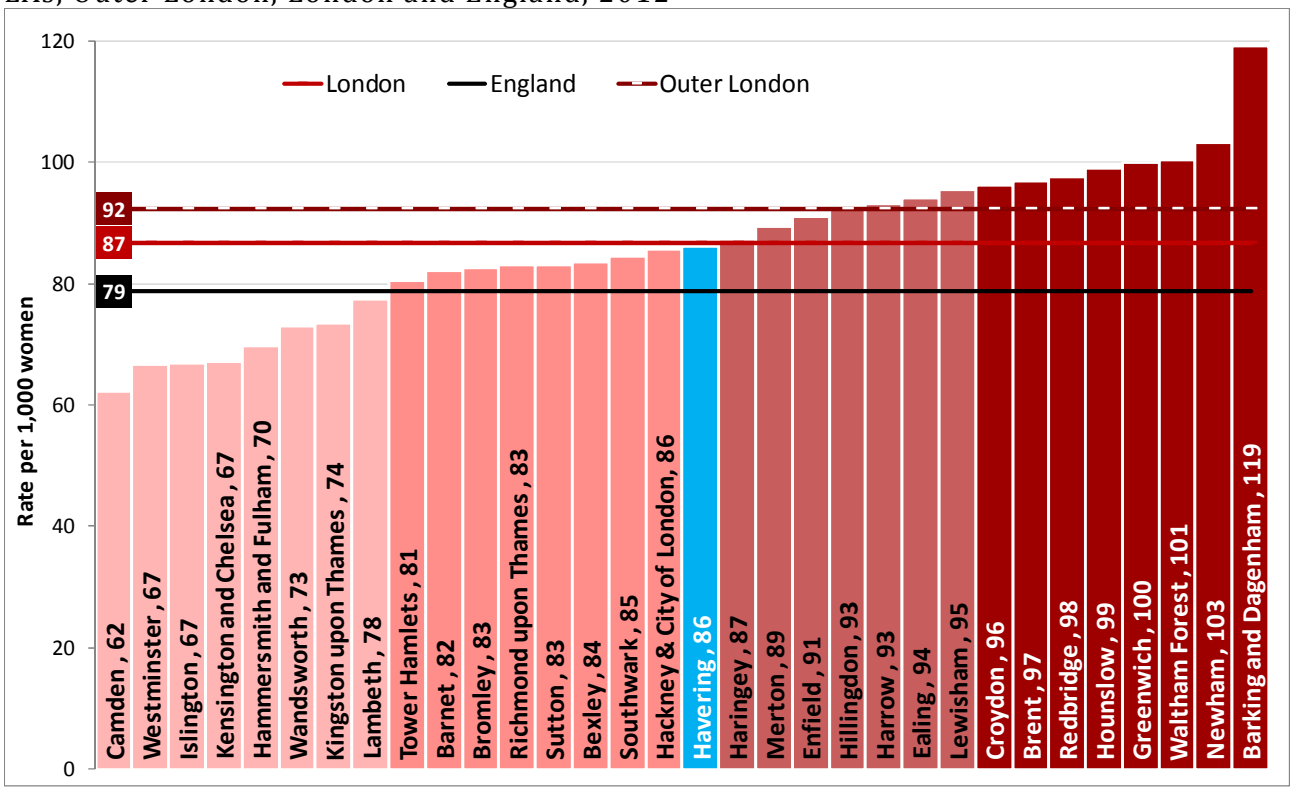
Figure 44: Conception rate per 1,000 women aged 15-44, for all conceptions in England, London, Havering and statistical neighbours, 2012



Data source: Office of National Statistics, 2012

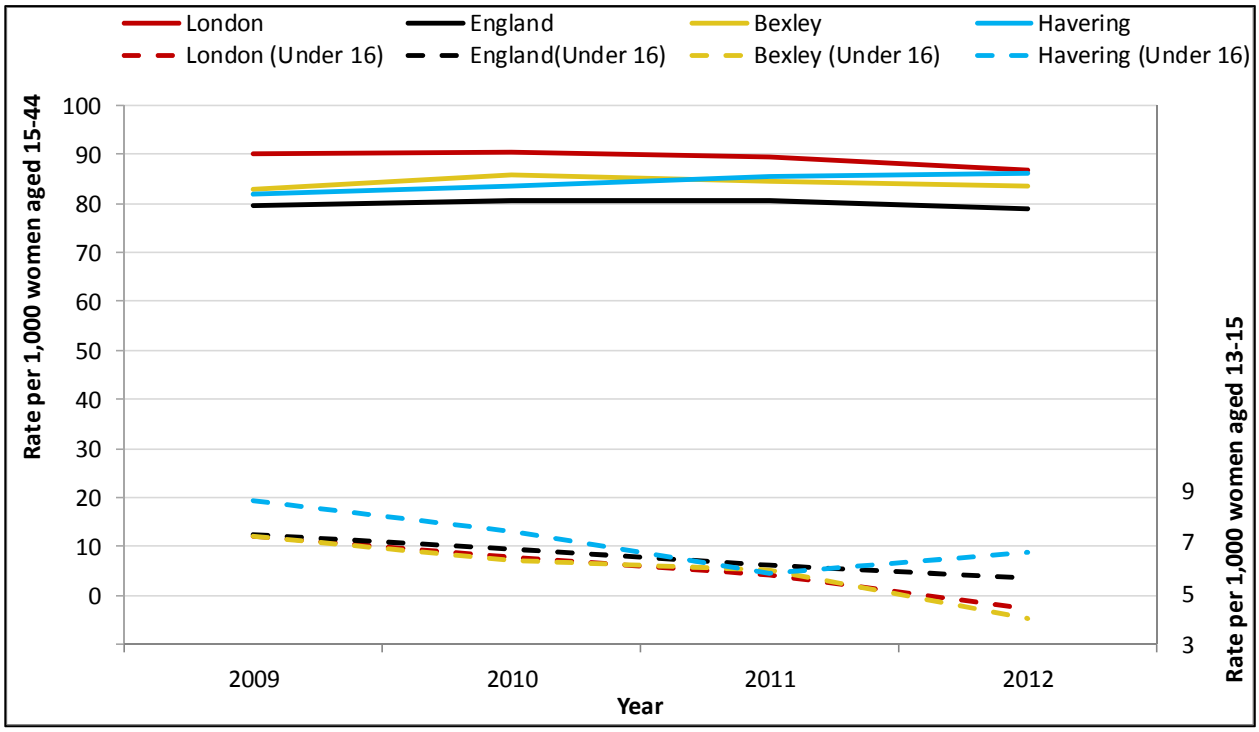
The conception rate in Havering has remained steady between 82 and 86 per 1,000 for the period 2009 to 2012 and broadly similar to comparators (see Figure 46). Similarly, as illustrated in Figure 47, the percentage of conceptions leading to abortion (for all conceptions) has been steady in Havering, as in England, London, Bexley (though marginally higher in Havering). However, the percentage of conceptions leading to abortion (for under 16 conceptions) has been on the increase in Havering, and higher than in England, London, Bexley (see Figure 47).

Figure 45: Conception rate per 1,000 women aged 15-44, for all conceptions, London LAs, Outer London, London and England, 2012



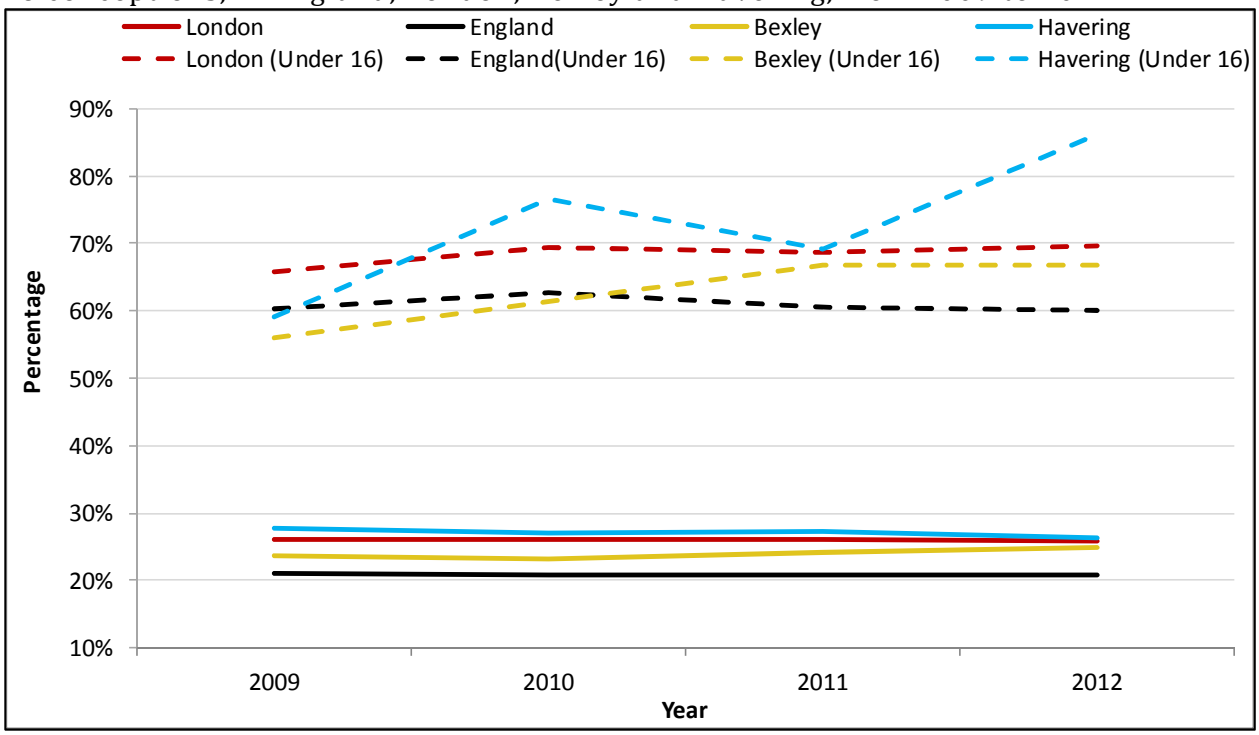
Data source: Office of National Statistics, 2012

Figure 46: Conception rates for women of all ages and under 16 (per 1,000 women aged 15-44 and 13-15 respectively), in England, London, Bexley and Havering, from 2009 to 2012



Rates for women of all ages and under 16 are expressed per 1,000 women aged 15-44, and 13-15 respectively.
Data source: Office of National Statistics, 2012

Figure 47: Percentage of conceptions leading to abortion in all conceptions and under 16 conceptions, in England, London, Bexley and Havering, from 2009 to 2012

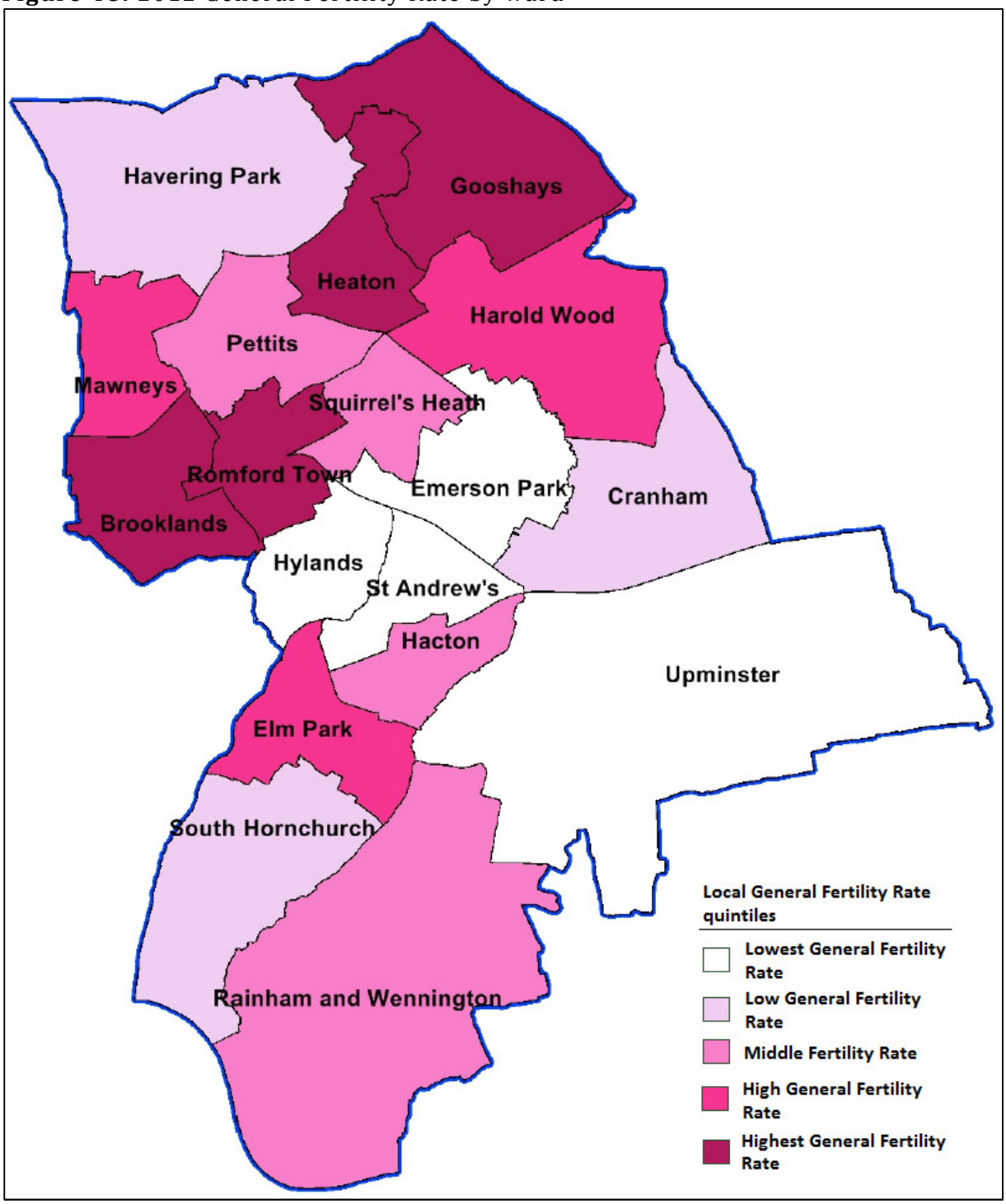


Rates for women of all ages and under 16 are expressed per 1,000 women aged 15-44, and 13-15 respectively.
Data source: Office of National Statistics, 2012

The general fertility rate (GFR) - the number of live births per 1,000 women aged 15–44 - is lower in comparison to London, England, and ONS comparators though Havering's GFR has been increasing at a greater rate than England and London (see the JSNA Demographics Chapter). Local fertility rates are highest in Gooshays, Heaton, Romford Town and Brooklands wards (see Figure 48).

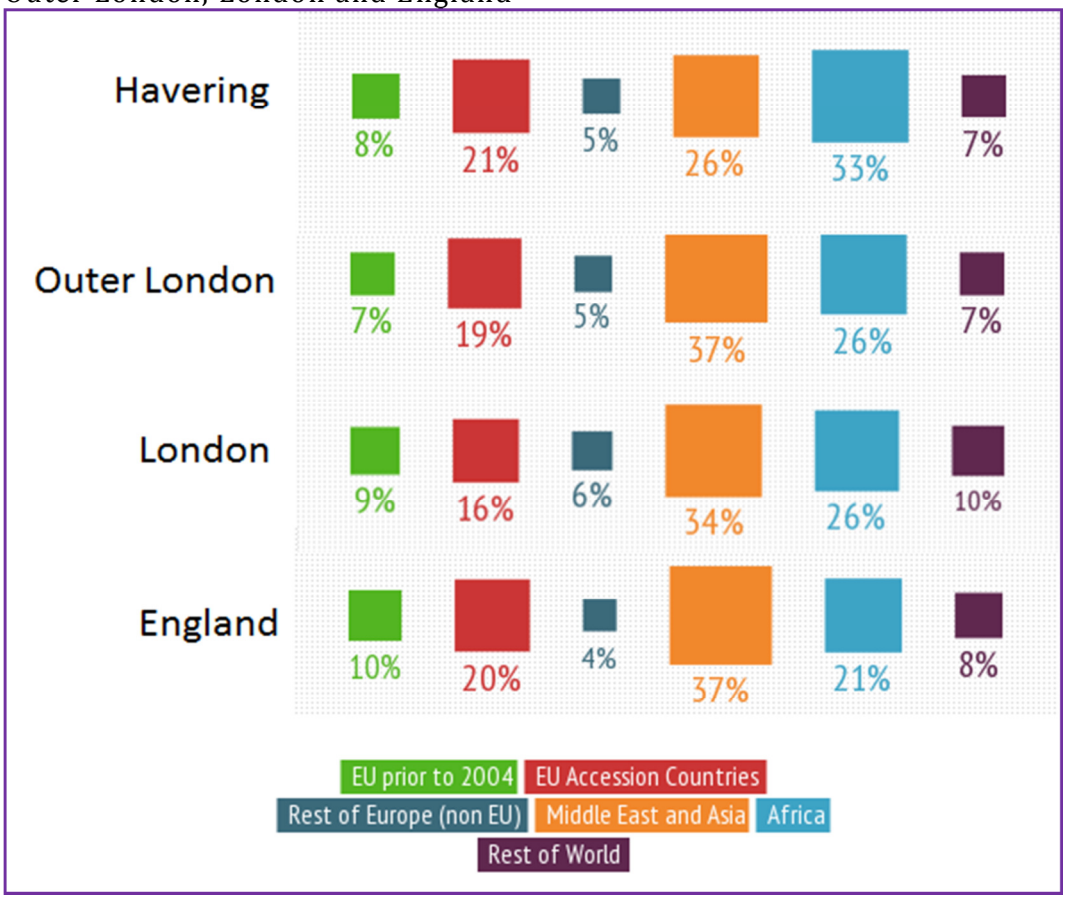
As described in the JSNA Demographics Chapter, fertility levels are on average higher among foreign born women. In particular, Figure 49 shows that in 2011, around a third of mothers who gave birth in Havering (33%) were born in Africa. In comparison, around one in five mothers (21%) and one in four mothers (26%) who gave birth in 2011 in London and England respectively were born in Africa. While Outer London's proportion of this group of mothers (26%) was the same as England's, Havering's was higher by 7 percentage points (and 12 percentage points higher than London). The implications of this in terms of risks during pregnancy are presented in the section on Antenatal and New-born Screening.

Figure 48: 2012 General Fertility Rate by ward



Data source: Office of National Statistics

Figure 49: Continent of birth of mothers with live births in 2011, Havering compared to Outer London, London and England



Data source: 2011 Census

Abortion

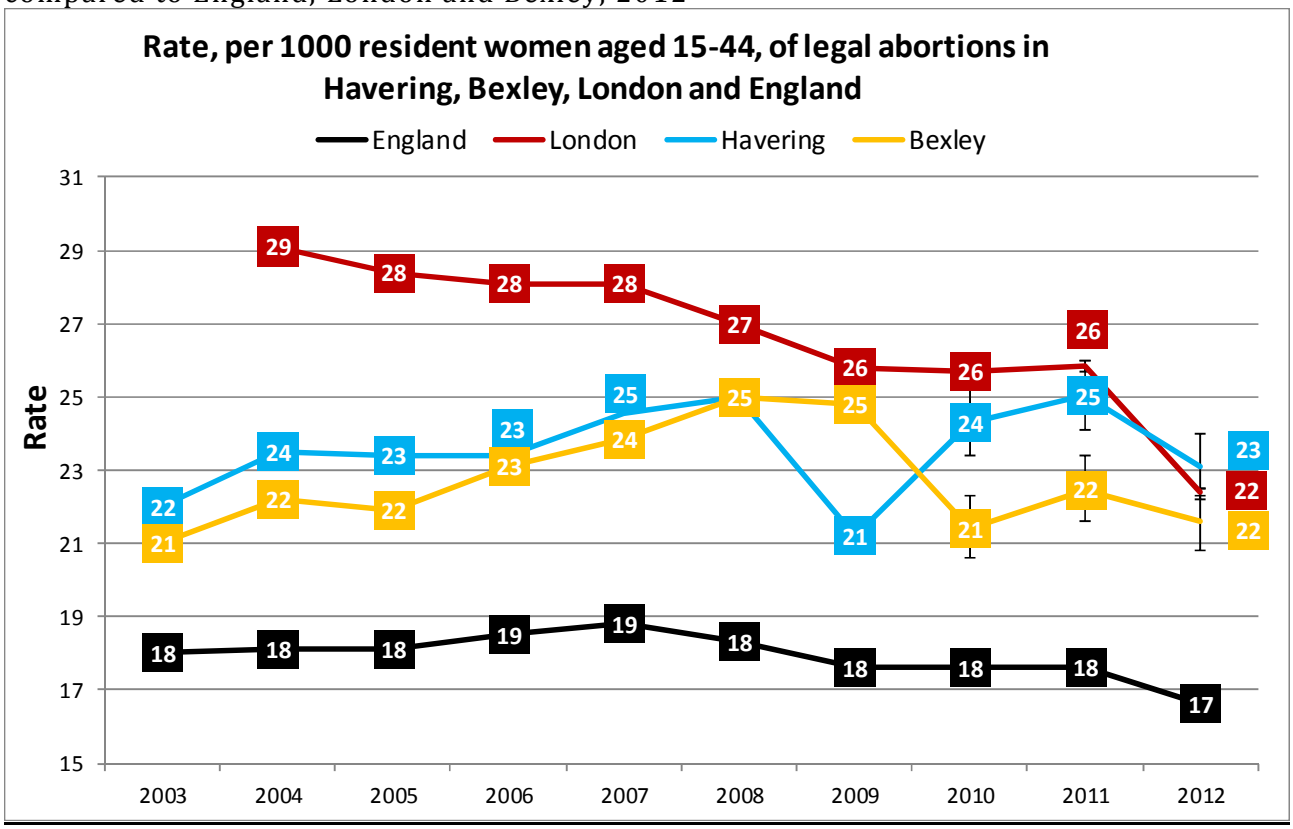
There were 1,041 abortions in Havering in 2012. As a rate, this is 23 (95% CI[15] 22.2 - 24.0) abortions per 1000 women aged 15-44 in Havering in 2012. The rate of abortions was steady over the previous decade to 2012 (see Figure 50) – during this time, the Havering rate was consistently and significantly higher than London's.

Furthermore, the 2012 rate of abortions in Havering is significantly higher than the rate of abortions (17 abortions per 1000 women aged 15-44) in England (see Figure 47). The rate of abortions in Havering is also higher than – but statistically similar to – the rate of abortions in London (22 abortions per 1000 women aged 15-44). In addition, in 2012, Havering has the highest rate of abortions when compared to similar health areas – former Primary Care Trusts (PCTs) – see Figure 51.

About 3 in every 10 women (29%) and 2 in every 10 women (22%) who had an abortion in Havering in 2012 were in the 20-24 and 25-29 age groups respectively. However, when put into the context of the distribution of Havering population, the highest rate of abortions remained the 20-24 age group but was followed closely by the 18-19 age group. The under 18 conception rate for Havering is higher than that of London and England.

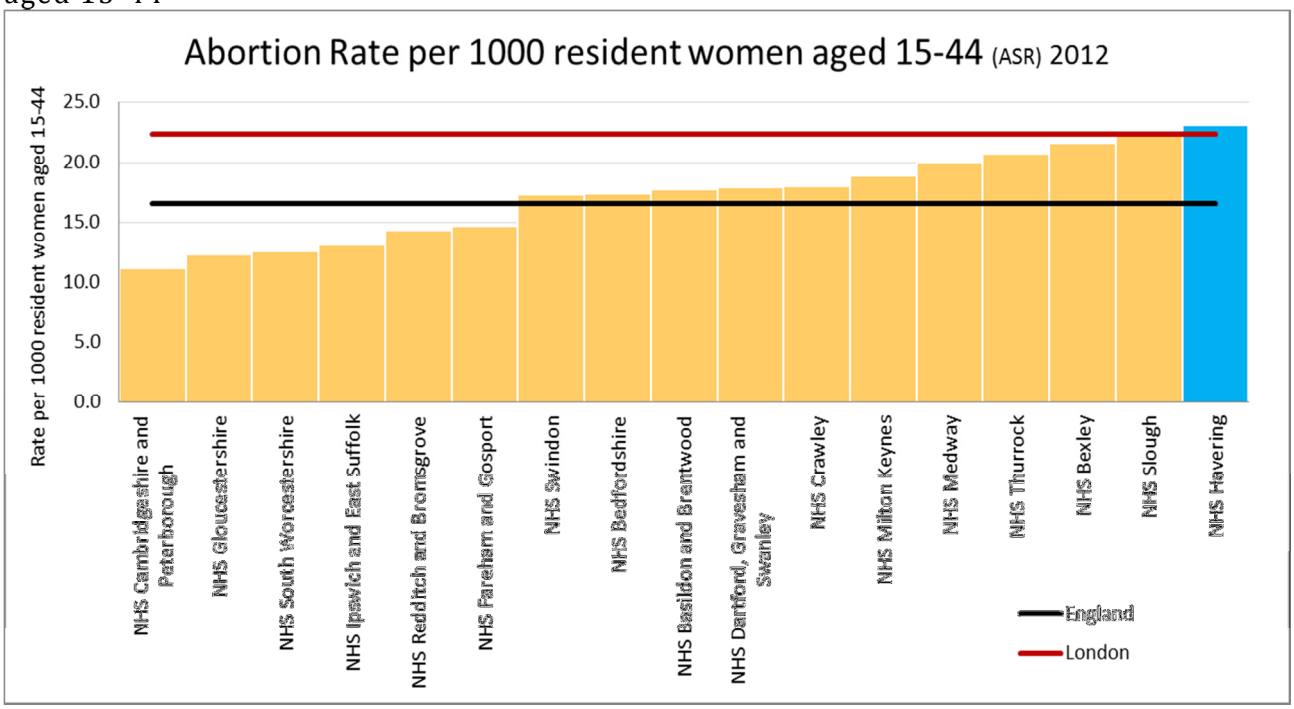
[15] CI means Confidence Interval. This is a statistical term that describes the level of certainty that the data represents.

Figure 50: Legal abortions, rates per 1000 resident women aged 15-44, Havering compared to England, London and Bexley, 2012



Data source: Abortion statistics for England and Wales, 2012 Department of Health

Figure 51: Legal abortions, rates by Havering by age, 2012 per 1000 resident women aged 15-44

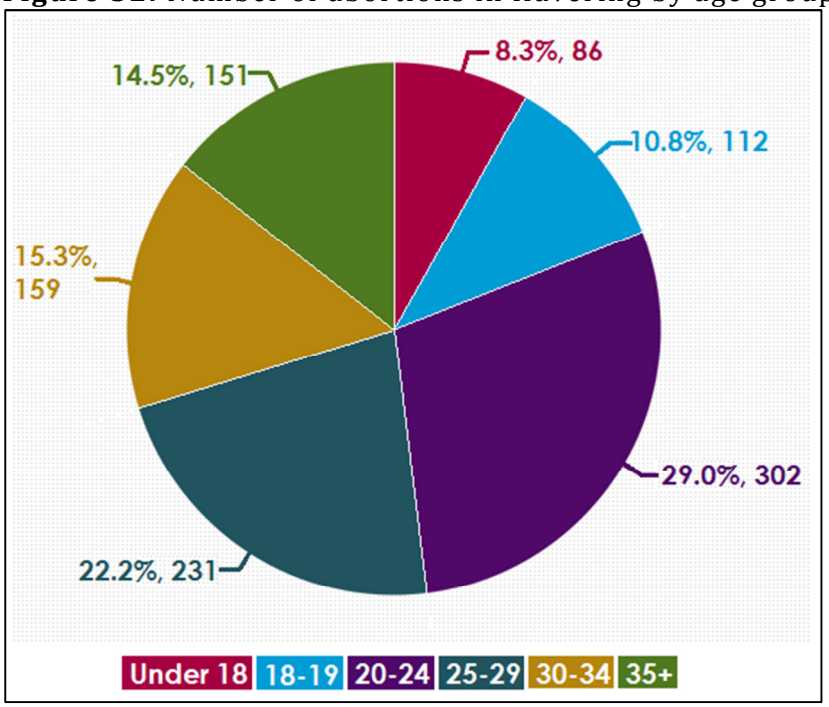


Data source: Abortion statistics for England and Wales, 2012 Department of Health

The number of abortions in 18-19 year olds is fewer than the number of abortions in 20-24 year olds (see Figure 52). However, if this were weighted to allow for this two year age group to be compared to a five year age group, this would indicate that the greatest numbers of abortions are among younger women (see Table 6). This has implications for commissioning and prevention, and particular

consideration should be given to the most vulnerable groups in the 18-19 year age bracket, including looked after children and young offenders.

Figure 52: Number of abortions in Havering by age group, 2012



Data source: Abortion statistics for England and Wales, 2012 Department of Health

Table 6: Rate Legal abortions: rates by Havering by age, 2012 per 1000 resident women aged 15-44

	Overall rate per 1000 resident women aged 15-44	Under 18	18-19	20-24	25-29	30-34	35+
Havering	23.1 (22.2 - 24.0)	18	39	41	31	21	9
London	22.4 (22.3 - 22.5)	15	34	39	28	22	12
England	16.6 (16.5 - 16.6)	13	26	29	22	17	7

Data source: Abortion statistics for England and Wales, 2012 Department of Health

In Havering the majority (80%) of abortions take place within 3-9 weeks of gestation, which is similar to London and England (see

Table 7).

Table 7: Proportion of legal abortions by gestation week 2012

Gestation weeks (%)	Week 3-9	Week 10-12	Week 13+
Havering	80	11	9
London	81	11	9
England	78	13	9

Data source: Abortion statistics for England and Wales, 2012 Department of Health

The majority 80% of abortions are funded by the NHS but provided by the independent sector. The proportion of abortions by purchaser in Havering shows a very different pattern to that of London and England (see Table 8). Fewer abortions took place within NHS hospitals than London and England,

which could indicate that, elsewhere, more late abortions are occurring, or it could simply be different commissioning arrangements.

Table 8: Legal abortions: by purchaser 2012

Purchaser (%)	NHS hospital	NHS funded (Independent sector)	Privately funded
Havering	4	94	2
London	18	76	6
England	33	64	3

Data source: Abortion statistics for England and Wales, 2012 Department of Health

The pattern of repeat abortions in Havering is similar to London and England (although there are very slight differences) – see Table 9:

- 44% of abortions in Havering were repeat abortion, which is slightly higher than the proportion of repeat abortions for London and England
- The proportion of abortions in Havering is higher in the over 25 age group. This is consistent with England and London

Table 9: Repeat abortions (%) Havering, England and London 2012

	Repeat all ages	Repeat in women aged <25	Repeat in women aged >25
Havering	44	32	55
London	43	33	49
England	36.9	27.1	45.4

Data source: Abortion statistics for England and Wales, 2012 Department of Health

Whilst Havering is not dissimilar from London and England, nonetheless little is known about why women are presenting for repeat abortions. Further investigations would be useful to understand how better to serve the needs of women who are representing for a termination of pregnancy.

Pregnancy and Health

This section is limited to brief descriptions of just four topics; infertility, pelvic inflammatory disease, ectopic pregnancy, and ante-natal and newborn screening. The subject matter of health in pregnancy, from pre-conception, during the pregnancy, and post-natally is too extensive and is mostly outside the scope of this chapter.

Whilst pregnancy and childbirth are normal human conditions, these can present risks for the health and wellbeing of the pregnant women, fetus and newborn child, and can have a lifelong impact on the health and wellbeing of her child. Some of the key factors that affect maternal health include social factors such as poverty, housing, domestic violence and levels of literacy; behavioural such as smoking, alcohol and substance misuse, levels of physical activity and body weight; pre-existing and pregnancy related conditions including diabetes, mental illness and high blood pressure; as well as timely access to antenatal care. These are cross-cutting themes that are considered in other chapters, but with the forthcoming changes in responsibility for commissioning the 0-5 health child programme, a JSNA chapter that specifically focuses on maternal health would be timely, and inform future commissioning of health visiting.

It is therefore recommended that a separate and dedicated JSNA chapter be developed on Maternal Health, paying specific attention to inequalities in health.

Infertility

Infertility is when a couple cannot conceive, despite having regular unprotected sex. Around one in seven couples may have difficulty conceiving. This is approximately 3.5 million people in the UK. About 84% of couples will conceive naturally within one year if they have regular unprotected sex. For

every 100 couples trying to conceive naturally, 84 will conceive within a year, 92 will conceive within two years, 93 will conceive within three years. For couples who have been trying to conceive for more than three years without success, the likelihood of pregnancy occurring within the next year is 25% or less.

There are many potential causes of infertility, and can affect both men and women. Common causes of infertility include lack of regular ovulation, blockage of the fallopian tubes, and endometriosis. In men, the most common causes are poor sperm counts, poor sperm quality, or both. Types of fertility treatment available include medical treatment for lack of regular ovulation, surgical procedures, such as treatment for endometriosis, and assisted conception (intrauterine insemination or in-vitro fertilisation)

More information is required on the causes and distribution of infertility in Havering, and access to infertility treatments.

Pelvic inflammatory disease

Pelvic inflammatory disease is an infection of the female upper genital tract, including the womb, fallopian tubes and ovaries. PID is a common condition, although it is not clear how many women are affected in the UK because it does not always have obvious symptoms. PID mostly affects sexually active women from the age of 15 to 24, and is mostly caused by a bacterial infection. About one in four cases of PID is caused by a sexually transmitted infection such as chlamydia or gonorrhoea. If affected by PID, the fallopian tubes can become scarred and narrowed, and increases the risk of having an ectopic pregnancy and of becoming infertile.

Ectopic pregnancy

The common risk factors for an ectopic pregnancy are pelvic inflammatory disease, if a woman has had a previous ectopic pregnancy, surgery involving the fallopian tubes, in-vitro fertilisation (a type of fertility treatment), if pregnancy occurs when using the contraceptive devices of IUD or IUS.[16]. Other risk factors include if the fallopian tube is abnormally shaped, smoking (smokers are twice as likely to have an ectopic pregnancy than non-smokers), and being over the age of 35. Havering has a significantly worse rate of ectopic pregnancies compared to London, and other areas in a similar deprivation decile.

More information is required on the causes of ectopic pregnancy in Havering, and it is recommended that a needs assessment on maternal health be undertaken that includes consideration of ectopic pregnancy.

Maternity and Antenatal and Newborn Screening

Maternity services provide advice, support and specialist care throughout pregnancy, during birth,and following delivery until the baby is 28 days old. One aspect of care given to the pregnant women and new born babies is the offer of antenatal and newborn screening, which includes screening for infectious diseases in pregnancy, including sexually transmitted infections.[17]

During pregnancy women are offered screening for HIV, hepatitis B, syphilis and rubella. Women are also offered tests for thalassaemia, and depending on the level of risk, may be offered a test for sickle cell.

Where women are identified with infections, their care is managed, and advice and treatment given. This reduces the risk to the baby, and can also improve the mothers own health. If identified as HIV positive during pregnancy, then interventions can reduce the risk of a mother passing on HIV to her baby from 25% (1 in 4) to less than 1% (1 in 100), as well as protecting the mother's own health. The

[16] Note that IUD and IUS are highly effective methods of contraception.

[17] The Antenatal and newborn screening programmes also screens for Downs syndrome, fetal anomaly, sickle cell and thalassaemia, and includes the newborn and infant physical examination, newborn blood spot testing, and newborn hearing screening.

risk of passing on hepatitis B from mother to baby can be reduced by vaccinating the baby, and the risk of a baby being born with syphilis can be reduced, by providing treatment for the mother.

Public Health England is responsible for all NHS screening programmes. National uptake of antenatal screening for hepatitis B, HIV, syphilis and rubella susceptibility was 98% in 2012. In 2012, 0.46% of pregnant women screened for hepatitis B were positive for hepatitis B surface antigen (a marker of current infection). The national percentage of pregnant women who tested positive for HIV was 0.19% in 2012 (highest in London at 0.39%). 0.15% of pregnant women tested positive for syphilis, with regional rates ranging from 0.06% in the South West and South Est to 0.34% in London.

The antenatal and newborn screening programme makes a vital contribution to identifying women with HIV who are unaware that they were infected. It is therefore important that Havering women, particularly those from ethnic groups that are at greatest risk agree to screening, and adhere to treatment and advice (including not breastfeeding).

Recommendations

Objective	Action
Reduce the percentage of repeat abortions among women aged 18 to 25	• Increase uptake of long acting reversible contraception, particularly among women who have had abortion previously • Audit the quality of pre and post-abortion contraceptive counselling and support given to women, and make improvements where identified • To ensure that women who identified as in need of more intensive support are identified by providers of abortion services, and are signposted to support services
Reduce the rates of ectopic pregnancies	• Increasing awareness and detection of pelvic inflammatory disease • Increasing identification of non-symptomatic chlamydia infection among young people • Reducing levels of smoking pre-conception • Understanding further the reasons for ectopic pregnancies in Havering
Women take up the offer of ante-natal screening, especially higher risk groups, such as African women	• The Director of Public Health, through the Health Protection Forum, should seek assurance that women in Havering are taking up the offer of ante-natal screening, especially higher risk groups, such as African women.
Gain an understanding of maternal health in Havering in order to plan and commission services that impact on maternal health and that of the child	• A JSNA chapter be developed on maternal health, to include pre-conception, pregnancy and post-birth

Teenage pregnancy

Teenage conceptions are measured as a rate per 1,000 in the relevant age group, and are published nationally as three combined years. This helps to even out yearly fluctuations which happen when there are small numbers of individuals that are being considered, and thus establish what the trends are.

Under 18 Conception, Maternity and Abortion

It is widely understood that teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation, and poverty. There is also a growing recognition that socio-economic disadvantage can be both a cause and a consequence of teenage parenthood.

The effects of teenage pregnancy on health and social outcomes that were highlighted in the 1999 Social Exclusion Unit Report on Teenage Pregnancy, and the high rates of teenage pregnancy in the UK relative to the rest of Europe preceded the launch of a national Teenage Pregnancy Strategy and the adoption of national targets to reduce teenage pregnancy by 50% by 2010. In Havering, a local three year teenage pregnancy reduction strategy was launched in 2010, which had a strong emphasis on preventing teenage conceptions.

Teenage pregnancy continues to be a national priority in:

- The Public Health Outcomes Framework
- Child Poverty Strategy
- Framework for Sexual Health Improvement in England (2013)

Tackling teenage pregnancy remains relevant to a number of other national and local priorities, including *Raising the Participation Age,* the *Troubled Families Programme,* the statutory duty to promote the educational achievement of looked after children, the local sexual exploitation action plan, and the *Havering Children and Young Peoples Plan 2011-14.*

As the data that follow show, yearly rates of under 18 conceptions have fluctuated considerably in Havering since 1998, with noticeable peaks between 1998 to 2000, and again in 2006 and 2008. Since 2008 there has been an overall and steep decline, leading to an all-time low in rates of conceptions in 2011 and 2012. Whilst the reduction in under 18 conceptions is good news, the percentage of conceptions leading to abortion in Havering has remained consistently high throughout the past thirteen years, and much higher than in England, London and Outer London. In England around half of under 18 conceptions result in abortion, whereas in Havering three-quarters of conceptions resulted in abortion in 2012. Havering had the fourth highest rate of under 18 conceptions leading to abortions among all London Boroughs.

The steep decline in under 18 conceptions in Havering is mostly attributed to reductions in rates of conceptions among 16 and 17 year olds. The under-16 conception rates, albeit involving low absolute numbers, showed a steady increase in the period 1998 to 2011, in contrast to the pattern in the rest of the country. The three year trends of under 16 conceptions show that Havering remains above the England, London, and even inner London rates. However, there has been a reduction in the year by year rates between 2009 and 2011 which is encouraging, but because of low absolute numbers it is not yet possible to determine if this is random fluctuation of whether an indication of a substantial and sustained change.

Girls who give birth as young teenagers are a particularly vulnerable group, and early child-bearing poses both physical and emotional risks for the young mother. National reports describe the risks to the children of young mothers that include low school attainment, antisocial behaviour, substance

abuse and early sexual activity[18]. Many young mothers drop out of school early[19], and more than half never resume their education, even though they are below the statutory school leaving age[20].

The rate of under 16 conception is the greatest contributor to the high rates of abortion described above; almost 90% of under 16 conceptions result in a termination. It would reasonable to assume that if the same progress could be made in reducing rates of under 16 conceptions as has been the case among 17 and 18 year olds, Havering under 18 abortion percentages would become much closer to that of England.

Because of the poor outcomes for both the young women who conceive before their 16th birthday and their babies, thus this sub-section of the JSNA chapter on sexual health will pay special attention to conceptions among under sixteens.

In 2013 a study was commissioned by the London Borough of Havering into teenage conceptions in the borough, and a report was received in September 2013. The study was carried out by a team of five consultants and involved both qualitative and quantitative research, including interviews with young people and practitioners from schools and a college, youth services, contraceptive and sexual health services, an abortion provider, midwifery and services providing targeted support to young people with risk factors for teenage pregnancy, and engagement with key services such as the school nursing service.

The study reported that there had been a large increase in absolute numbers of births to women who conceive before their 16th birthday: during the period 2001 to 2003, there were 12 births amongst this group, whereas between 2009 and 2011 there were 32 births.

Whilst conception data do not contain any information about fathers, national research[21] has shown that young men who were younger at age of fatherhood were more likely to be out of work and to have less money at age 30 years.

Research undertaken by North West Public Health Observatory found evidence that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risk sexual behaviour, such as not using contraception of condoms. Alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age, and alcohol misuse is linked to a greater number of sexual partners and more regretted or coerced sex. Alcohol also creases the risk of sexual aggression, sexual violence and sexual victimisation of women.

Conception

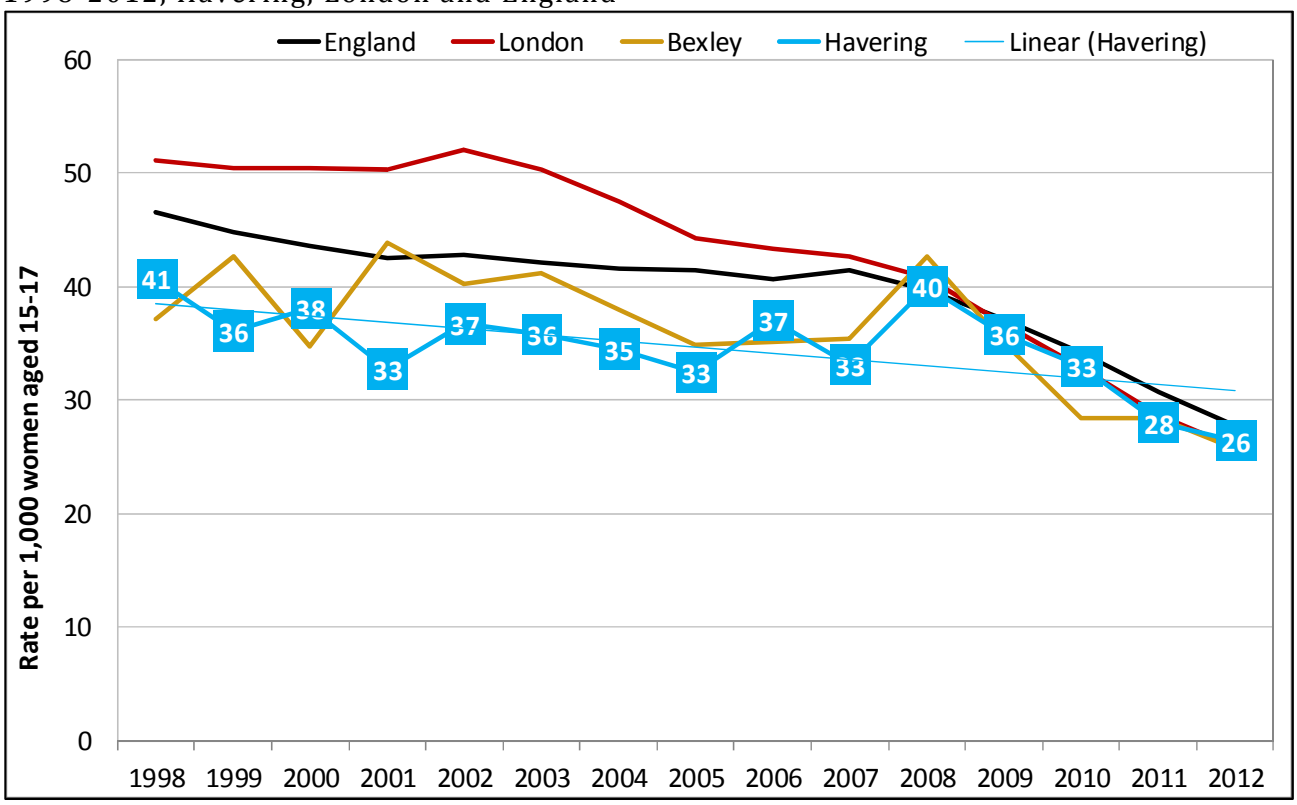
Figure 53 presents the trend in under 18 conceptions from 1998 to 2012 in Havering, London and England. In Havering in 2012 the under 18 conception rate was 26.4 per 1,000, which was below that of England (28.5 per 1,000), but above that of London (25.9 per 1,000). There has, however, been an overall reduction in teenage conceptions since the 1998 rate of 41 per 1,000. Between 1998 and 2012, the under 18 conception rate decreased by 35.1%.

Using a national forecasting model[22], it is possible to predict the likely rates of teenage conceptions at a local authority level until the year 2020. Figure 54 presents the trend for Havering by applying the forecasting model, which shows that the under 18 conception rate in Havering is predicted to stay between 28.0 and 44.6. However, in 2012 the actual rate fell below the lower limit of that forecast for 2012. If we assume that the rate remains stable (as the modelled figures suggest), and the number of

[18] Farrington, D *Understanding and preventing youth crime*, Joseph Rowntree Social Policy Research paper 93, April 1996. Also, see Gustavsson, N and Segal, E *Critical Issues in Child Welfare*, Sage Publications, 1994, page 26
[19] Gustavsson, N and Segal, E *Critical issues in child welfare*, Sage Publications, 1994, page 26
[20] *The needs and cares of adolescents*, British Paediatric Association, 1985, page 20
[21] Berrington et al
[22] The East Midlands public health observatory produce a forecasting model based on previous trends in teenage pregnancy, at 95% confidence interval

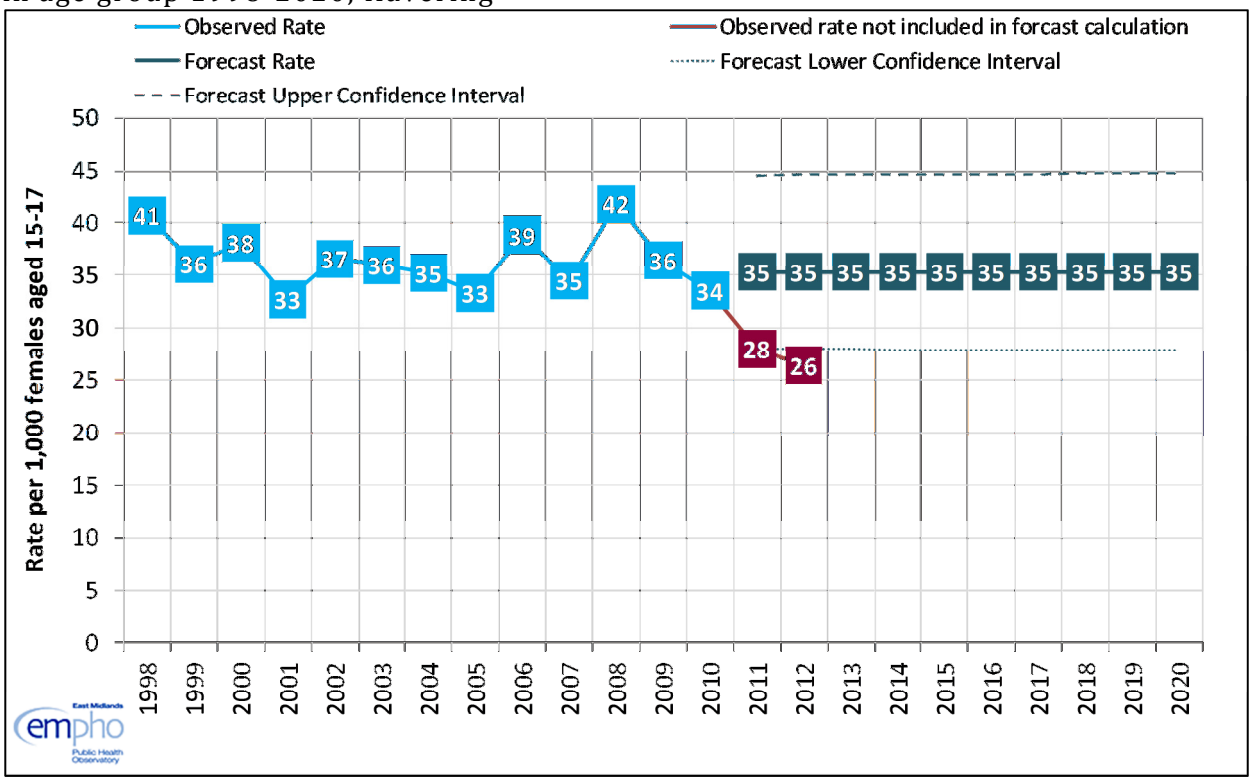
females aged 15-17 in Havering is projected to decrease from 2012 to 2020 (from 4,700 to 4,300) an absolute reduction of teenage conceptions of 8.5%.

Figure 53: Ten year trend in under 18 conception rate per 1,000 women in age group 1998-2012, Havering, London and England



Data source: Office of National Statistics, 2012

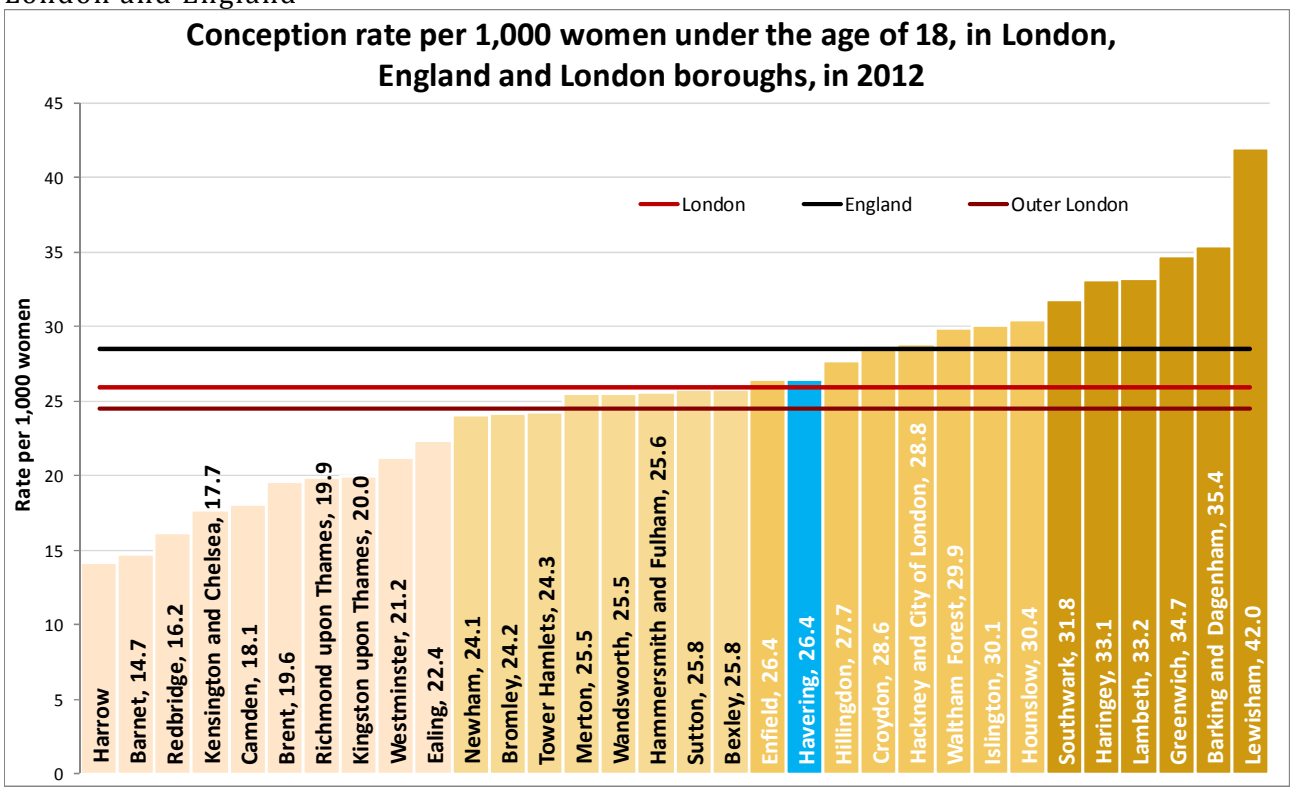
Figure 54: Ten year trend and projection in under 18 conception rate per 1,000 women in age group 1998-2020, Havering



Source: Office for National Statistics & Department for Education, East Midlands Public Health Observatory

Figure 55 presents the under 18 conception rate per 1,000 women under 18 across London boroughs in 2012. Havering ranks 13th highest (out of 32 boroughs) for teenage conception rates across London boroughs. Barking and Dagenham ranks the second highest in London which is to be expected, taking into account the borough's deprivation levels, and Redbridge amongst the lowest in London which, again, is to be expected because of the borough's demographics. Havering's closest statistical neighbour, Bexley, has a conception rate that is slightly lower than Havering. Bexley has a conception rate of 25.8 per 1,000, compared to Havering 26.4 per 1,000.

Figure 55: Under 18 conception rate per 1,000 women in age group 2012, London LAs, London and England



Data source: Office of National Statistics, 2012

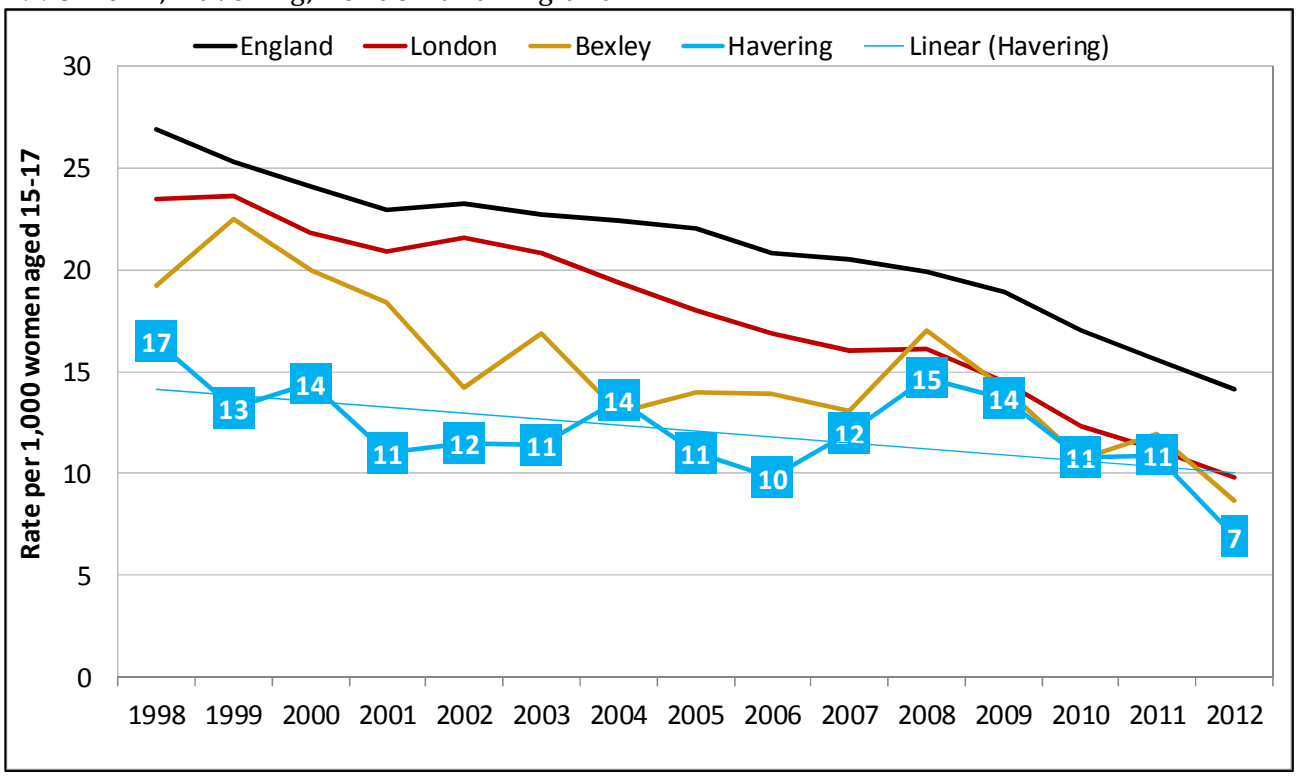
Maternity

Figure 55 presents the ten year trend in under 18 maternity rate per 1,000 women in the age group 15-17 from 1998 to 2012 in Havering, London and England. In 2012 the maternity rate per 1,000 women under 18 in 2012 in Havering was 6.9 per 1,000 resident women aged 15-17. This was lower than London, Outer London and England. This means that although teenage conceptions in Havering are comparatively higher than London, fewer teenage conceptions result in births to teenage mothers in Havering. This is due to a higher proportion of women aged 15-17 seeking termination of pregnancy.

As with teenage conception rate, the under 18 maternity rate in Havering has been falling overall over the last 10 years. Between 1998 and 2012, the under 18 Maternity rate has decreased by 58.2%. If the under 18 maternity rate in Havering was maintained at 6.9 per 1,000 women aged 15-17 Havering can expect fewer teenage pregnancies since the number of females aged 15 to 17 is expected to decrease.

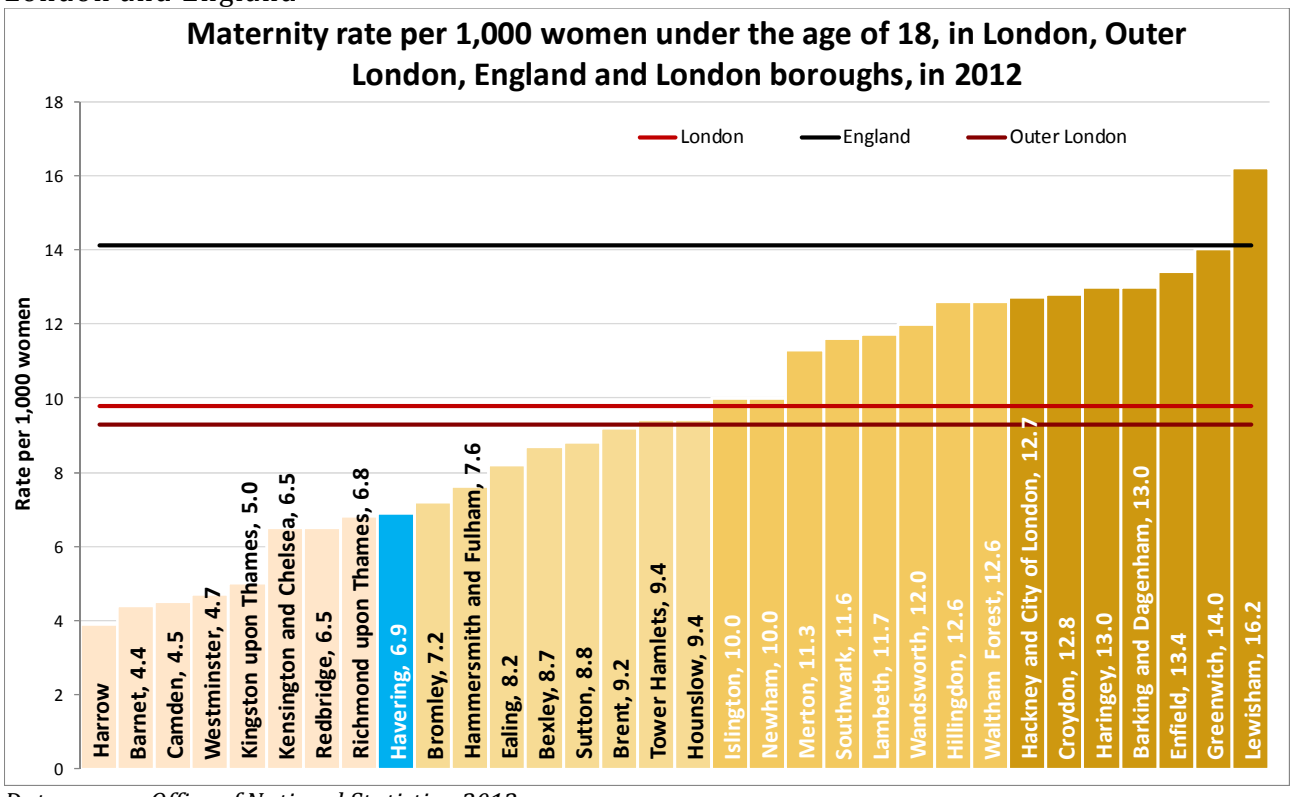
Figure 57 presents the under 18 maternity rate per 1,000 women aged 15 to 17 across London boroughs in 2012. Havering ranked amongst the lowest in London for teenage maternity rates, lower than England, London and the outer London average in 2012.

Figure 56: Ten year trend in under 18 maternity rate per 1,000 women in age group 1998-2012, Havering, London and England



Data source: Office of National Statistics, 1998-2012

Figure 57: Under 18 maternity rate per 1,000 women in age group 2012, London LAs, London and England

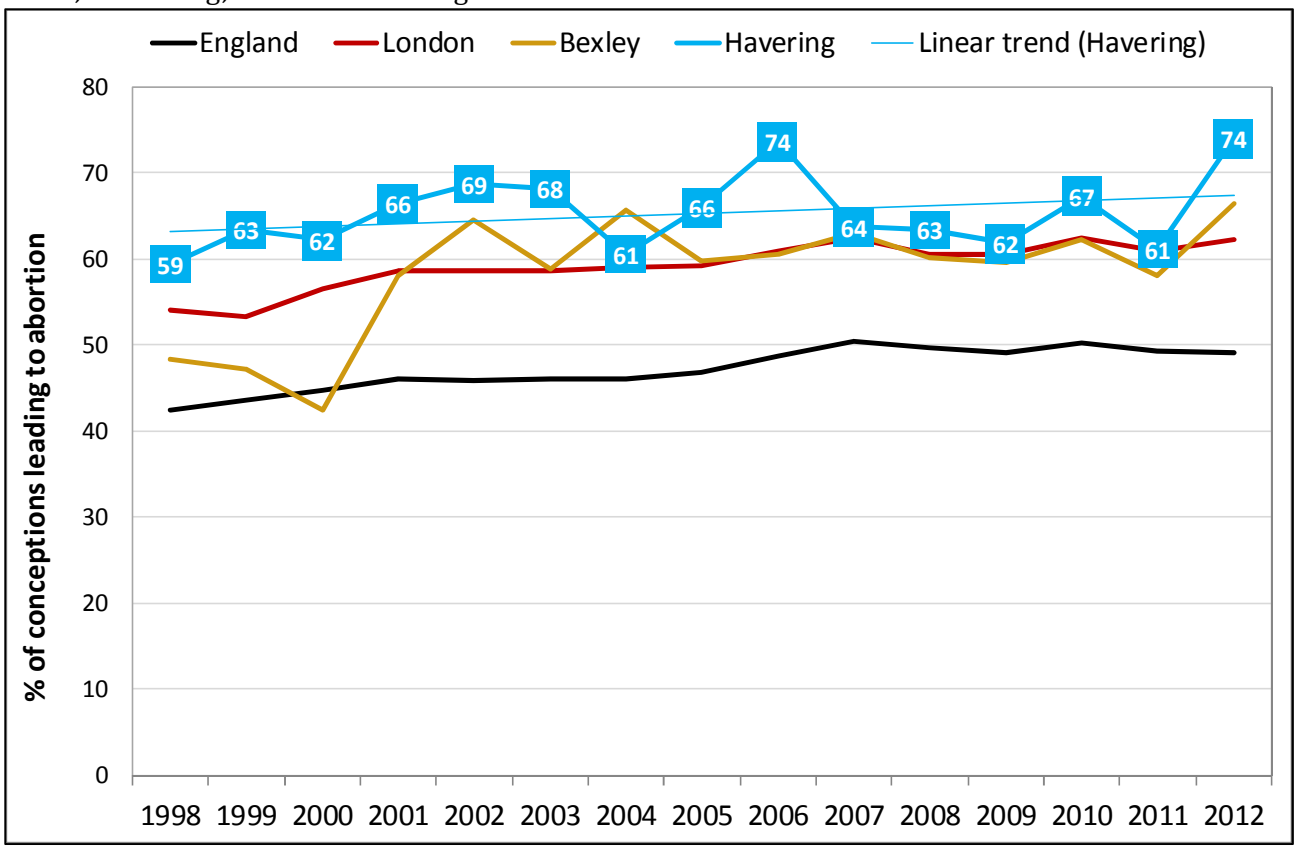


Data source: Office of National Statistics, 2012

Abortion

Figure 58 presents the proportion of under 18 conceptions resulting in abortion from 1998 to 2012 in Havering, London and England. In Havering in 2012, 74% of under 18 conceptions resulted in abortion. The proportion of under 18 conceptions leading to abortion in Havering has been increasing overall over the last 10 years. Between 1998 and 2012, the proportion of under 18 conceptions resulting in abortions increased by 24.6%.

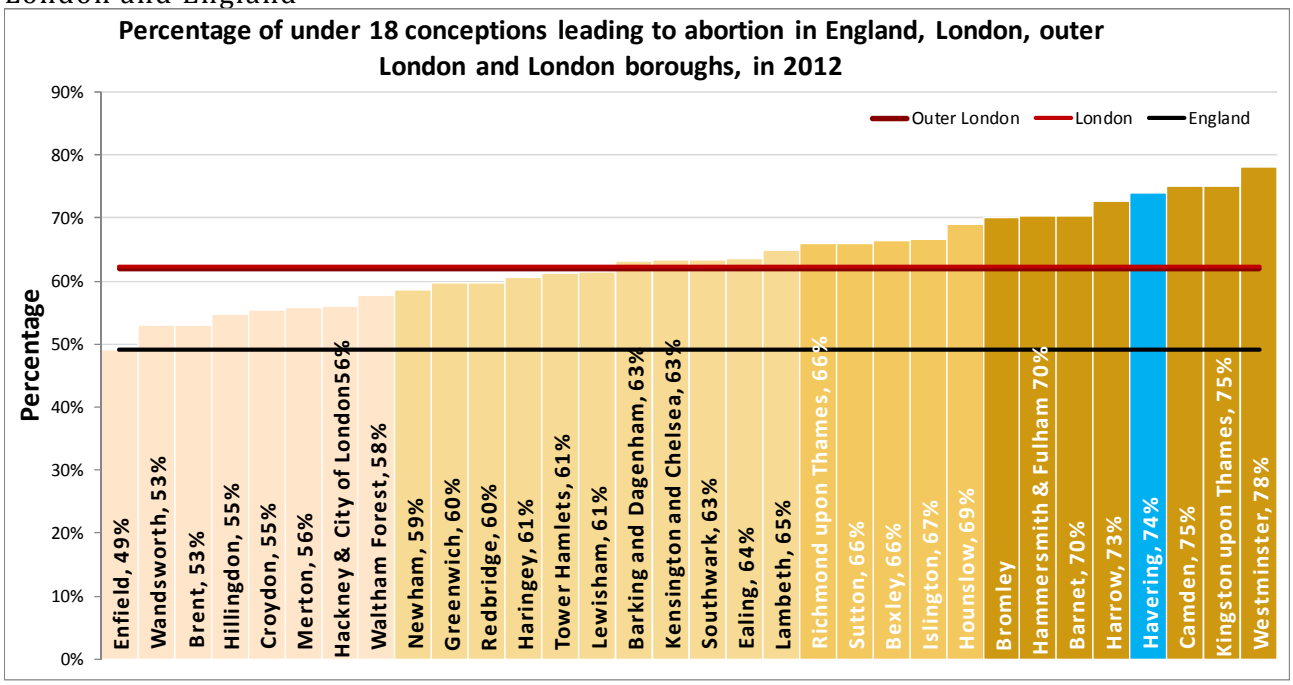
Figure 58: Trend in proportion of under 18 conceptions resulting in abortion 1998-2012, Havering, London and England



Data source: Office of National Statistics, 1998-2012

Figure 59 presents the proportion of under 18 conceptions resulting in abortion in 2012 across London boroughs compared to London overall and England. The proportion of under 18 conceptions leading to abortion in Havering was higher than the England, London, and Outer London in 2012. This in part explains the comparatively low teenage maternity rate despite the comparatively high teenage conception rate.

Figure 59: Proportion of under 18 conceptions resulting in abortion, 2012, London LAs, London and England

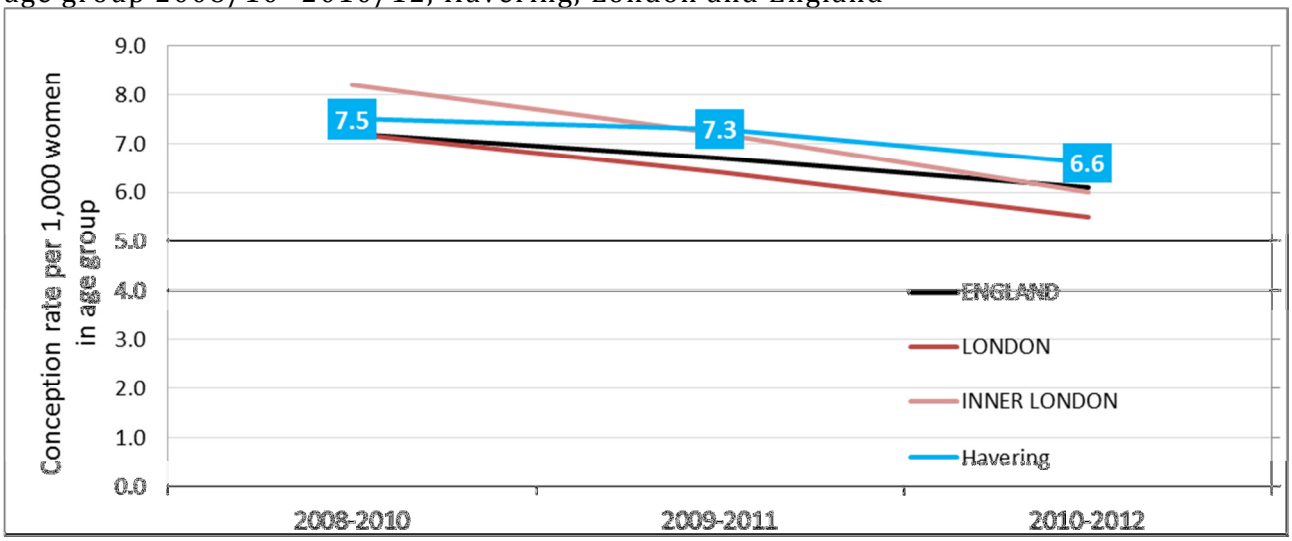


Data source: Office of National Statistics, 2012

Under 16 Conception, Maternity and Abortion

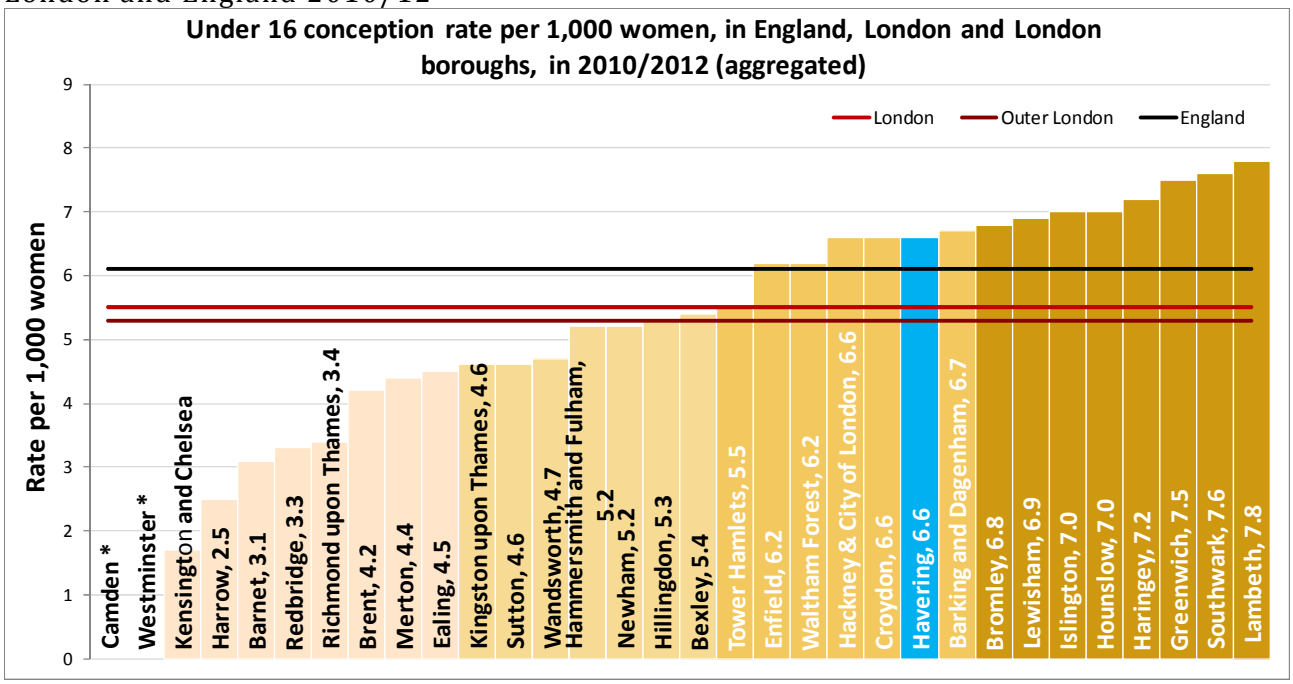
Figure 60 presents the trend in three year aggregated under 16 conception rate per 1,000 women in aged 13 to 15, from 2008/10 to 2010/12 in Havering, London and England. Figure 61 presents the conception rate per 1,000 women in age group for other London LA's, London and England 2010/12. In Havering, the 2012 the under 16 conception rate was 6.6 per 1,000 in 2010/12, which was above that of England (6.1 per 1,000), London (5.5 per 1,000) and Outer London (5.3 per 1,000). There has however, been and overall reduction in teenage conceptions since the 2008/10 rate of 7.5 per 1,000 to 6.6 per 1,000 in 2010/12. This is in line with the London and national trend.

Figure 60: Trend in three year aggregate under 16 conception rate per 1,000 women in age group 2008/10 -2010/12, Havering, London and England



Data source: Office of National Statistics, 2008-2012

Figure 61: Under 16 conception rate per 1,000 women in age group, London LA's, London and England 2010/12

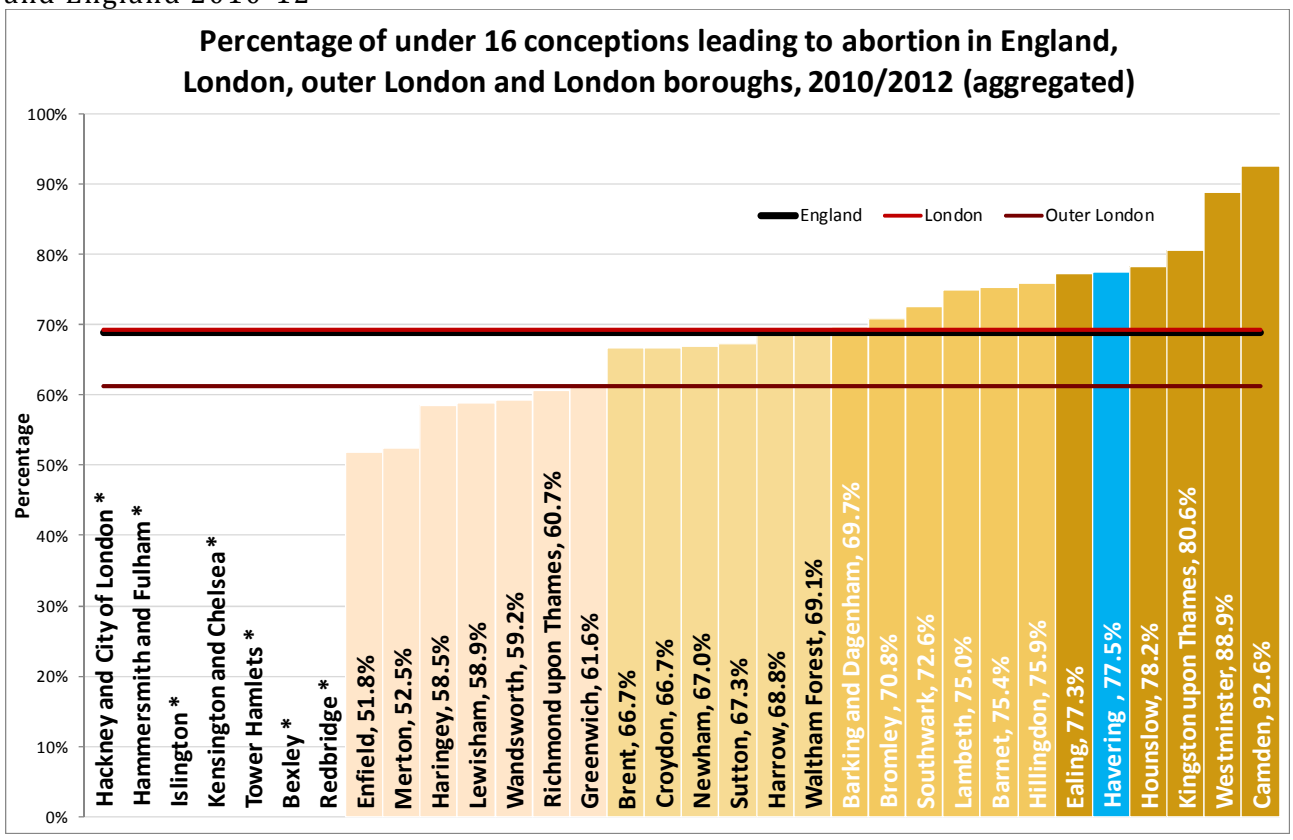


* denotes suppressed to protect confidentiality

Data source: Office of National Statistics, 2010-2012

Additionally, Figure 62 present the aggregated proportion of under 16 conception leading to abortion in Havering, London LA's, London and England in 2010-12. In 2010 to 2012, 77.5% of under 16 conceptions in Havering lead to an abortion. Compared to London, Outer London and England this is high.

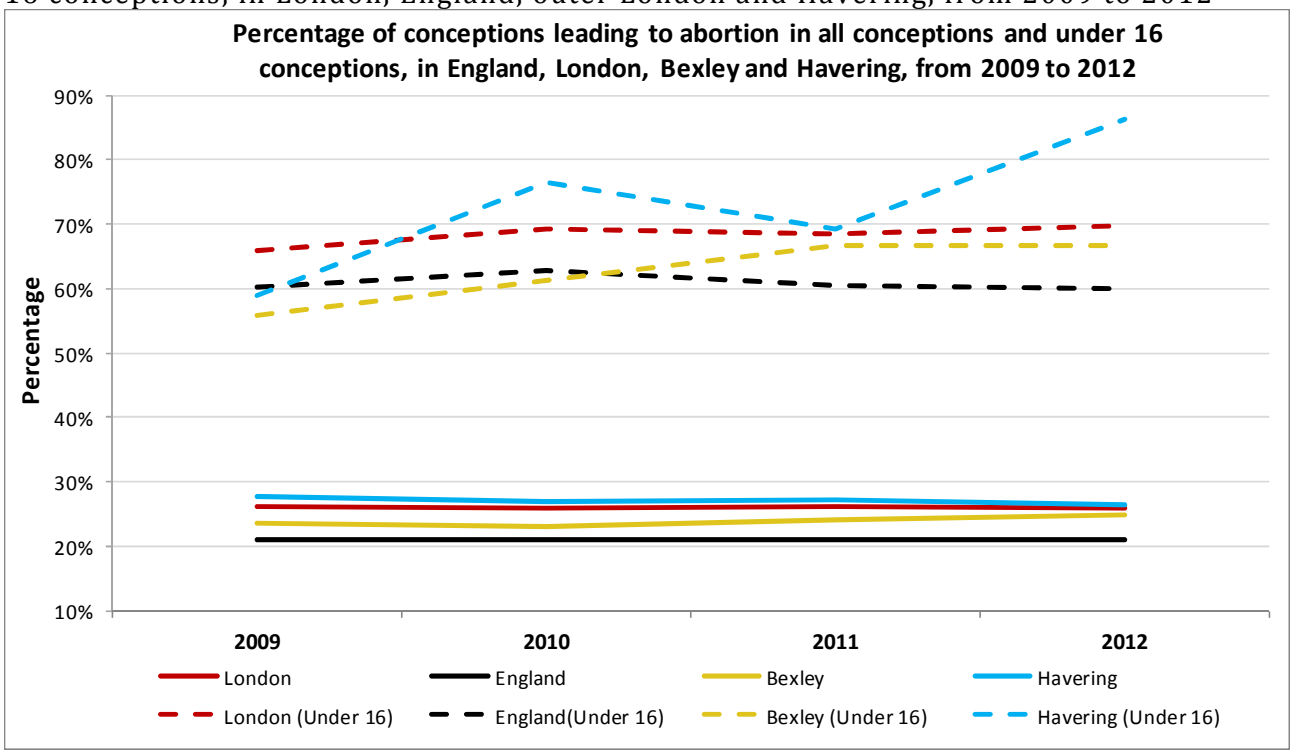
Figure 62: Proportion of under 16 conception leading to abortion, London LA's, London and England 2010-12



Data source: Office of National Statistics, 2012

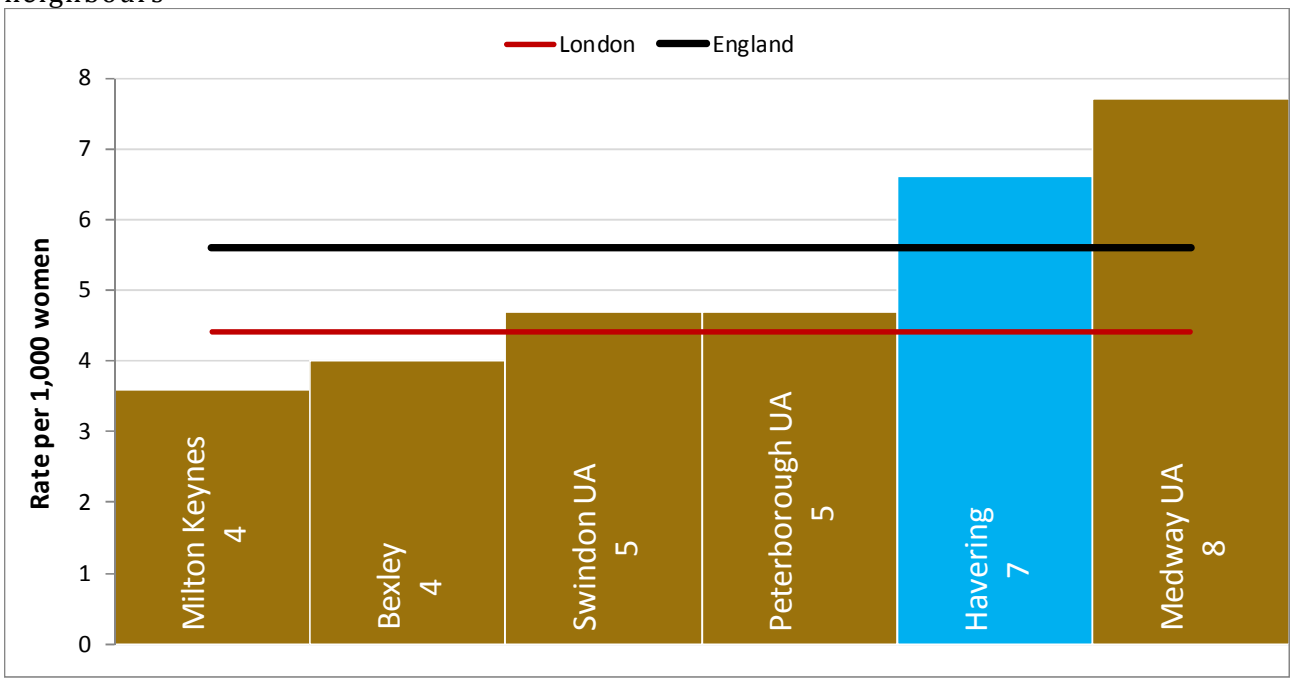
Whilst there is a substantial difference in the under 18 teenage pregnancy rate between Havering and Barking and Dagenham, which would be expected because of the level of deprivation in Barking and Dagenham, there is no really no difference at all between Havering and Barking and Dagenham for under 16 conception rates in the period 2010-2012 (6.6 per 1,000), It is the case that these rates represent small numbers (hence aggregated over three years), however every under 16 conception represents distinct challenges for the young mother, the young father, and their baby. Havering's ambition should be to reduce this rate at least to the level of Bexley, or an even more ambitious target.

Figure 63: Percentage of conceptions leading to abortion, in all conceptions and under 16 conceptions, in London, England, outer London and Havering, from 2009 to 2012



Data source: Office of National Statistics, 2012

Figure 64: Rate of under 16 conceptions in England, London, Havering and its statistical neighbours



Data source: Office of National Statistics, 2012

Support for young parents

Teenage pregnancy and early motherhood is associated with poor educational achievement, poor physical and mental health, social isolation, and poverty, with the impact being felt by both the mother and the child, and children born to teenage parents are more likely to have poor life outcomes. Rates of teenage conceptions, abortions and live births are monitored at a national level as described earlier, and whilst there are relatively low numbers of teenagers who become parents, this is a particularly vulnerable group that requires support and services to enable them to develop skills and confidence to live independently. In Havering, there are a number of programmes and initiatives to support young parents, including Mellow Babies, and the Strengthening Parenting Course. School nurses offer advice to schools on provision for young parents and can also signpost young parents to other support services.

It has been recommended elsewhere in this chapter that a further needs assessment be undertaken to consider maternal health. A maternal health needs assessment should pay particular attention to teenage mothers and, in anticipation of the transfer of health visiting commissioning to local authorities in 2015, should also consider the initiatives that have been delivered in other parts of the country for young mothers (such as Family Nurse Partnership), and support the development of a teenage pregnancy strategy.

Recommendations

Objective	Action

Ensure that the needs of teenage parents are met, and that there is a continuing reduction in the rates of teenage pregnancy, especially among under 16s	• Set up a sexual health alliance that include a specific focus on teenage pregnancy
	• Develop a teenage pregnancy strategy and associated actions, with progress integrated into the governance arrangements for broader children and young people's and health programmes and reported at the highest level.
	• The teenage pregnancy strategy should
	  ○ Include the development of a care pathway for teenage parents; from antenatal through to early years support, and which includes the role of general practice and health visitors
	  ○ Include consideration of support for young parents in continuing or returning to education and training as embedded in the Raising the Participation Age Programme.
	  ○ Clarify the referral pathway from pregnancy testing to abortion of maternity – this information should be disseminated to services working with young people
	  ○ Be informed by audits and training needs analyses that identify gaps relating to knowledge and skills in promoting healthy relationships, sexual health and safeguarding
	• The C Card scheme should be expanded further into GP surgeries and pharmacies, and be promoted by school nurses

Objective	Action
	• Undertake a needs assessment of maternal health, paying particular attention to the needs of young mothers
Ensure that there is high quality sex and relationship education in schools	• Havering Council to work in partnership with schools to support the delivery of SRE, including Pupil Referral Units and other alternative education providers • School nurses must support schools to deliver SRE • Public Health commissioners must ensure that there are strong links forged between contraceptive and sexual health services and young people's services, including schools. School nurses must facilitate visits to schools by contraceptive and sexual health services as appropriate, and ensure that services are made known to young people in advance of need. • Public Health commissioners must ensure that targeted sexual health support is made available to more young people, especially via schools to those at risk. This could include advice from school nurses.

Contraception

Condom Card (C-Card) Scheme

The C-card scheme is a London-wide initiative that was set up in April 2010 with the aim of providing easy access to sexual health advice and free condoms for young people.

Havering's C card scheme is a free and confidential service for any young person between the age of 13 and 24 who lives, studies or work in Havering. Havering's C card distribution outlets are located in many pharmacies, GPs, colleges and community settings (including Children's Centre). A young person can register for the scheme by visiting one of the outlets and asking to a member of staff about the C card scheme. The C Card worker has a discussion with the young person in private, and takes details of the young person's date of birth and part-postcode (for monitoring purposes). Thereafter, whenever the young person wishes to obtain condoms, they visit any C card outlet, show their C card and is then provided with a supply of condoms.

Young people can find out more about the C card scheme by visiting the Council website, speaking to their school nurse, or contacting the Council's Teen Pregnancy Prevention Worker.

On its launch in 2010, six London boroughs signed up to running the scheme. By April 2013, this had grown to 25 London boroughs. Since April 2010, Havering has been in the top quartile of best performing schemes in London in terms of numbers of registrations (6th) and revisits (3rd) with males accounting for 63% of users. Young people living in Harold Hill account for 14.4% of scheme users followed by Romford Town (10.8%), South Hornchurch (7.2%) and Rainham and Wennington (5.7%). Young people living outside Havering account for 15.4% of registered users. See more information on the local C-card data in Appendix 8 to Appendix 13.

Long-acting reversible contraception (LARC)

Long-acting reversible contraception (LARC) is a group of highly effective methods of contraception that require administration less than once per menstrual cycle or month. Whereas the effectiveness of barrier methods (such as condoms) and oral contraceptive pills depends on correct and consistent use, the effectiveness of LARC does not depend on daily concordance. Included in the category of LARC are:

- copper intrauterine devices
- progestogen-only intrauterine systems
- progestogen-only injectable contraceptives
- progestogen-only subdermal implants

LARC methods need to be inserted by a health professional, either into the uterus (IUD or IUS) or the arm (the implant).

It is estimated that between 30% and 50% of pregnancies are unplanned[23]. Expert clinical opinion is that increased uptake of LARC methods could help to reduce unintended pregnancy. See more analysis and information on LARC in Havering in Appendix 14 to Appendix 22.

Recommendations

Objective	Action
Ensure that women access the most appropriate and effective form of contraception that suits their needs	• LBH Public Health to commission sexual health services that increase uptake of LARC • LBH to ensure that school nurses provide information on reliable methods of contraception, including signposting to reliable website and apps

[23] According to NICE clinical guide 30 – 30% unplanned, according to NATSAL 1 in 6 are not planned and a further 2 out of 6 are "ambivalent", which means only 50% are planned.

Objective	Action
	• LBH Public Health to ensure that women are offered LARC, as the most effective form of contraception through a range of providers, and where LARC is wanted, this is to be provided at the earliest opportunity
Reduce the risk of unintended pregnancy following the birth of a baby	• CCG to ensure that maternity services have appropriately trained midwives who are knowledgeable of contraceptive methods, including LARC, and contraception when breastfeeding • CCG to ensure that maternity services audit advice given about contraception (pre and post birth), and that service user feedback is used to improve advice and information • LBH to ensure that advice given by health visitors is audited, and that service user feedback is used to improve advice and information • CCG to ensure that maternity services has a pathway into contraception services • CCG to consider options for contraception to be provided by the midwifery service • LBH Public Health to ensure that integrated sexual health service provider engages with GPs in order that good quality contraception advice is given to women at the 6-8 week check
Reduce the risk of unwanted/unintended pregnancy following a previous abortion	• LBH Public Health to commission sexual health services that provide/signpost to IUD as emergency contraception
Ensure that young people (men as well as women) are aware of condom use for both the prevention of infection and to prevent unintended pregnancy	• The C Card scheme should be expanded further into GP surgeries and pharmacies, and be promoted by school nurses • CCG to ensure that abortion providers discuss contraception during pre-abortion counselling and that there is a referral pathway into contraception services post-abortion using the most appropriate communication methods

See NICE guidance and recommendations for contraceptive services for under 25 years in Appendix 24

Sexual violence and exploitation

Sexual violence and exploitation (SVE) is a serious public health and human rights problem with both short-term and long-term consequences. Some definitions of sexual violence and exploitation are presented in Box 1.

SVE causes physical injury and it is related to an increased risk of various sexual and reproductive health problems, with both immediate and long-term consequences[24]. The impact of SVE on mental health can be as serious as its physical impact, and may be equally long lasting.

Deaths can also sometimes occur following SVE, which could be as a result of suicide, HIV infection[25] or murder – the latter occurring either during a sexual assault or subsequently, as a so-called "honour killing"[26]. The social wellbeing of victims can also be profoundly affected by SVE – for instance, individuals may be stigmatised and ostracised by their families and others as a consequence[27].

SVE is more prevalent against females than against males. For instance, the Ministry of Justice, Home Office & the Office for National Statistics[28] estimate that, based on data between 2009/10 and 2011/12, females are about 8 times more likely to be victims of the most serious sexual offences (including attempts) – see Figure 65.

[24] Jewkes R et al. Relationship dynamics and adolescent pregnancy in South Africa. Social Science and Medicine, 2001, 5:733–744.
Holmes MM et al. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. American Journal of Obstetrics and Gynecology, 1996, 175:320–324.
Eby K et al. Health effects of experiences of sexual violence for women with abusive partners. Health Care for Women International, 1995, 16:563–576.
Leserman J et al. Selected symptoms associated with sexual and physical abuse among female patients with gastrointestinal disorders: the impact on subsequent health care visits. Psychological Medicine, 1998, 28:417–425.
McCauley J et al. The ''battering syndrome'': prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. Annals of Internal Medicine, 1995, 123:737–746.
Coker AL et al. Physical health consequences of physical and psychological intimate partner violence. Archives of Family Medicine, 2000, 9:451–457.
Letourneau EJ, Holmes M, Chasendunn-Roark J. Gynecologic health consequences to victims of interpersonal violence. Women's Health Issues, 1999, 9:115–120.
Plichta SB, Abraham C. Violence and gynecologic health in women less than 50 years old. American Journal of Obstetrics and Gynecology, 1996, 174:903–907.
Campbell JC, Soeken K. Forced sex and intimate partner violence: effects on women's health. Violence Against Women, 1999, 5:1017–1035.
Collett BJ et al. A comparative study of women with chronic pelvic pain, chronic nonpelvic pain and those with no history of pain attending general practitioners. British Journal of Obstetrics and Gynaecology, 1998, 105:87–92.
Boyer D, Fine D. Sexual abuse as a factor in adolescent pregnancy. Family Planning Perspectives, 1992, 24:4–11.
[25] Miller M. A model to explain the relationship between sexual abuse and HIV risk among women. AIDS Care, 1999, 11:3–20.
[26] Mercy JA et al. Intentional injuries. In: Mashaly AY, Graitcer PH, Youssef ZM, eds. Injury in Egypt: an analysis of injuries as a health problem. Cairo, Rose El Youssef New Presses, 1993:65–84.
[27] Mollica RF, Son L. Cultural dimensions in the evaluation and treatment of sexual trauma: an overview. Psychiatric Clinics of North America, 1989, 12:363–379.
Omaar R, de Waal A. Crimes without punishment: sexual harassment and violence against female students in schools and universities in Africa. African Rights, July 1994 (Discussion Paper No. 4).
[28] Ministry of Justice, Home Office & the Office for National Statistics (2013). An Overview of Sexual Offending in England and Wales. Statistics bulletin. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf.

Box 1: Definitions of sexual violence and exploitation mostly directed against women and girls

Sexual violence and exploitation directed against women includes, but is not limited to, the following:

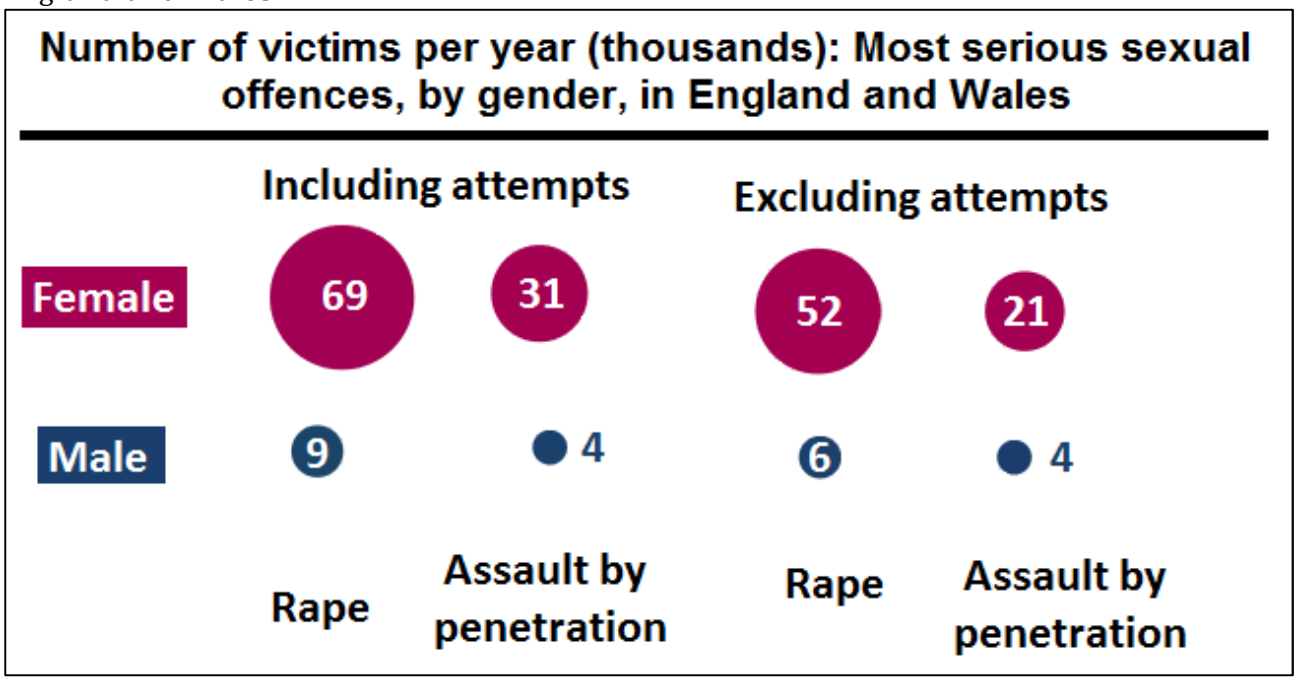
- *Female genital mutilation (FGM) – involves the complete or partial removal or alteration of external genitalia for non-medical reasons. It is mostly carried out on young girls at some time between infancy and the age of 15. Unlike male circumcision, which is legal in many countries, it is now illegal across much of the globe, and its extensive harmful health consequences are widely recognised.*
- *Forced marriage – a marriage conducted without valid consent of one or both parties, where duress is a factor.*
- *'Honour' based violence – violence committed to protect of defend the 'honour' of a family and/or community. Women, especially young women, are the most common targets, often where they have acted outside community boundaries of perceived acceptable feminine/sexual behaviour. In extreme cases the woman may be killed.*
- *Prostitution and trafficking – women and girls are forced, coerced or deceived to enter into prostitution and/or to keep them there. Trafficking involves the recruitment, transportation and exploitation of women and children for the purposes of prostitution and domestic servitude across international borders and within countries ('internal trafficking').*
- *Sexual violence including rape – sexual contact without the consent of the woman/girl. Perpetrators range from total strangers to relatives and intimate partners, but most are known in some way. It can happen anywhere – in the family/household, workplace, public spaces, social settings, during war/conflict situations.*
- *Sexual exploitation – involves exploitative situations, contexts and relationships where someone receives 'something' (e.g. food, drugs, alcohol, cigarettes, affection, protection money) as a result of them performing, and/or another or other performing on them, sexual activities. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the person's limited availability of choice resulting from their social/economic and/or emotional vulnerability. Young women and girls involved in or connected to gangs are at-risk of sexual exploitation by gang members.*
- *Sexual harassment – unwanted verbal or physical conduct of a sexual nature. It can take place anywhere, including the workplace, schools, streets, public transport and social situations. It includes flashing, obscene and threatening calls, and online harassment.*
- *Stalking – repeated (i.e. on at least two occasions) harassment causing fear, alarm or distress. It can include threatening phone calls, texts or letters; damaging property; spying on and following the victim.*

Source: The Way Forward – Taking Action to end Violence Against Women and Girls, Greater London Authority, 2010.

In addition, the prevalence of sexual offences committed against females, from 2004/05 to 2011/12, has ranged between 2.3 and 3.3 per cent with some statistically significant year-on-year changes, while the prevalence rates for male victims over the same period has ranged from 0.3 and 0.6 per cent per year with no statistically significant changes during this. Therefore, while it is acknowledged that sexual violence and exploitation (SVE) can be directed against both men and women, the main focus of this section is on the various forms of SVE against women and young girls.

For more information on this SVE section and other related topics (such as Domestic/intimate partner violence), read the "Violence Against Women & Girls Strategic Problem Profile" by the Havering Community Safety Partnership (available online).

Figure 65: Estimated numbers of victims of sexual offences in the last 12 months among adults aged 16 to 59, average of 2009/10, 2010/11 and 2011/12 Crime Statistics for England and Wales.



Data source: Ministry of Justice, Home Office & the Office for National Statistics

Female Genital Mutilation (FGM)

It was estimated in 2007 that as many as 66,000 women with FGM were living in England and Wales whilst 20,000 girls under the age of 15 were identified as potentially at-risk of FGM in England and Wales[29]. The largest population groups from practising countries in the United Kingdom were from Ghana, Kenya, Nigeria, Somalia and Uganda. The 2011 Census estimated that 1.4% of Havering residents were born in the aforementioned nations, this compares to an average of 3.8% in London. The largest group in Havering is Nigerian, accounting for 0.9%. Between 2001 and 2004 there were 47 maternities in Havering with identified FGM, this was the lowest total of all 32 London Boroughs[30].

The number of incidents reported to the police is unavailable nationally. The Metropolitan Police website states that there were 75 'incidents' reported between June 2009 and May 2011, of which just 2 were investigated as crimes. The Metropolitan Police 'Violence Against Women and Girls' report for December 2013 shows that there were 116 incidents of FGM between April and December 2013, an increase of 58.9% when compared with the same period the previous year. Of those incidents 24% (28) were recorded as criminal offences, and 14% (4) were substantiated. However, no prosecutions have been brought under the legislation prohibiting FGM which has been in place since 1985. This data is not broken down to an individual borough level.

There is very little reliable data on Female Genital Mutilation. However, some data on FGM was provided by NHS maternity services retrospectively. The exact methodology used to collect the data and hence their reliability as a guide to the true prevalence of FGM has still to be ascertained. Different NHS trusts have different methodology, but it seems the majority capture the information by direct enquiry via individual midwives and health professional reporting. Notwithstanding this, the data suggest that 4 of 435 women receiving NHS maternity services from May 2013 to Feb 2014 had evidence of FGM (Note: there are around 2,800 births to women resident in Havering each year). All 4 women recorded were from "Black/African" or "Any Other Black" ethnic groups.

[29] Dorkenoo, E.l Morison, L. and Macfarlane, A. (2007) A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales, FORWARD (Foundation for Women's Health, Research and Development).
[30] Ibid

The Department of Health announced that from April 2014 all NHS hospital trusts must record and report (from September 2014) on information about incidence of FGM and risks of FGM.

Forced marriage

There are no reliable estimates on the extent of forced marriage within the United Kingdom[31]. In 2012, the Forced Marriage Unit (FMU) which is a joint initiative between the Home Office and the Foreign and Commonwealth Office gave advice and support in 1,485 instances related to possible forced marriage. There has been an average of 1,630 reports per year nationally since 2008, with those aged 16-25 being identified as most at-risk[32].

The police Crime Recording Information System (CRIS) includes a crime flag to identify forced marriages (code entered is FM). In the past three years, there has been one crime recorded in Havering flagged as FM in November 2012. In this case two female teenage children (nationality not recorded, Black ethnic appearance) had fled their home because they believed they were going to be forced into marriage by their mother.

Honour based violence

There has been an average of 185-200 honour based violence crimes reported to and recorded by the Metropolitan Police annually since 2009. The police Crime Recording Information System (CRIS) includes a crime flag to identify honour based violence (code entered is HV). In the three years since August 2011 there had been less than five crimes in Havering. All victims were recorded as female, under the age of 21 and of Asian ethnic appearance and the suspects were male relatives (including brother, cousin and uncle). There were further offences which are described as HV but without the correct flag entered on the CRIS record.

According to the 2011 Census, 1.7% of Havering residents were born in southern Asian countries (compared to 7.7% in London) and 5.3% of residents self-defined as being Asian ethnicity (compared to 19.6% in London).

Prostitution and trafficking

In 2013 there were 2,808 calls to police regarding prostitution related anti-social behaviour (i.e. brothels, on-street prostitution, soliciting, and kerb crawling). This is based on the volume of calls received via the Metropolitan Police Metcalls/DARIS systems. Just 9 such calls were recorded in Havering throughout 2013. This was the 5th lowest volume in the Metropolitan Police force district. Conversely neighbouring and nearby boroughs Redbridge (254) and Newham (324) were the two highest boroughs. Whilst there are a low number of nuisance calls regarding prostitution in Havering, it was found that at least 27 brothels were being advertised locally in 2008, the 13th highest volume in London. This figure was guided solely by advertisements in local newspapers from research conducted by Eaves in 2008[33]. In 2011 SC&09 (the Metropolitan Police Human Exploitation and Organised Crime Command) undertook 73 brothel visits in 12 boroughs, of which 3 were in Havering[34]. An up to date figure on the number of brothels is currently unavailable.

Statistics on trafficking for sexual exploitation are unavailable at a borough level. The Metropolitan Police 'Violence Against Women and Girls' report for December 2013 shows that there were 33 offences in the last year compared to 22 for the same period the previous year. Furthermore, across

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[31] Strickland, P. (2013) Forced Marriage, Home Affairs Briefing 16th September 2013

[32] House of Commons debate http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120110/text/120110w0004.htm#12011076000484 and Family Law Week bulletin http://www.familylawweek.co.uk/site.aspx?i=ed112192 Both Accessed 07.02.2014

[33] Bindel, J. And Atkins, H. (2008). Big Brothel: A survey of the off-street sex industry in London, The POPPY Project, Eaves. See also Farley, M., Bindel, J. And Golding, J.M. (2009) Men who buy sex. Who they buy and what they know, Eaves, London.

[34] Bindel, J.; Breslin, R. and Brown, L. (2013) Capital Exploits: A Study of Prostitution and Trafficking in London, Eaves, London.

London in 2013 there were 2 offences of buying sexual services of a child; and 24 offences of causing, encouraging, arranging or facilitating child prostitution or pornography.

According to the Crown Prosecution Service, nationally there were 288 convictions for trafficking into the UK for sexual exploitation between 2005 and 2012. There were also 319 convictions for trafficking within the UK for sexual exploitation during the same period[35]. Internal trafficking may refer to the trafficking of persons for sexual exploitation within countries borders. There is evidence of this across London. The Enfield Violence Against Women and Girls Strategic Problem Profile (2012, 2013) identified that as few as half of on-street prostitution workers operating in Upper Edmonton were living in other London boroughs, including Newham, Barking and Dagenham, Waltham Forest and Havering. These females were entirely of Eastern European and Balkan backgrounds (i.e. Lithuania, Romania).

The number of persons involved in prostitution in Havering (including nationals and non-nationals) is currently unknown, however, it is important to note that more than half of women in prostitution have been raped and at least 75 per cent have been physically *"assaulted at the hands of the pimps and punters"*[36]. Furthermore, women in on-street prostitution are 12 times more likely to be murdered than the rate for all women in the UK[37].

The Modern Slavery Bill was published in June 2014, to specifically address slavery and trafficking in the 21st century in England and Wales. Courts will be given new powers to protect people who are trafficked into the UK, held against their will, and forced to work. This includes protecting from prosecution those men, women and children who are brought into the country from overseas and forced to work in illegal brothels. Maximum sentences for the most serious offenders will be increased from 14 years to life imprisonment. The Bill is expected to become law before the next General Election in 2015.

Women wanting to leave prostitution often face may barriers preventing them from exiting the industry. Obstacles range from problematic substance misuse, housing and accommodation, physical and mental health problems/experiences of violence as children, criminalisation, financial debt and loss of earnings, coercion from pimps to remain in prostitution, lack of education and training and often women enter prostitution at a very young and have no knowledge of any other way of life.

Eaves London Exiting Advocacy Service is a pan-London project to support women who are being exploited by the sex industry.

Women who have been trafficked for purposes of sexual exploitation can be identified through the National Referral Mechanism and will receive appropriate support and protection. To refer potential victims of human trafficking, including sexual exploitation, through the National Referral Mechanism referrals should be sent to the UK Human Trafficking Centre in the first instance. NRM referrals should be forwarded to the UK Border Agency if victims have been identified as part of the immigration process.

Poppy Project

Eaves offers two projects which assist women who have been trafficked and sexually exploited and those wanting to exit prostitution. The Poppy Project provides accommodation and holistic support to UK women who have been trafficked across borders or internally. The Poppy Acute Service provides women with accommodation in a shared safe house, financial support and support accessing health services and treatment, specialist counselling, education, criminal and immigration-related legal advice, parenting support and other support as needed. Poppy can accommodate nine women at any

[35] Crown Prosecution Service Freedom of Information request 3763 https://www.whatdotheyknow.com/cy/request/human_trafficking_statistics (Accessed 07.02.2014)
[36] Home Office (2004) Solutions and Strategies: Drug Problems and Street Sex Markets: London: UK Government.
[37] Home Office (2011) A review of effective practice in responding to prostitution.

one time. They have spaced for both foreign and British nationals. Bed spaces are located in London and referrals are accepted from services based in London.

The Poppy Outreach Service can provide short-term support and advocacy to trafficked women across England and Wales who do not require accommodation. Within the outreach team there is a Young Women's Worker who specialises in supporting trafficked women between the aged of 16-24 years, a Family Service specialising in working with trafficked women who have children and also provides reunification support, a Detention Centres and Prisons Worker who can provide advocacy and support to women in those hard to reach situations and the London Exiting Advocacy Service which provides specialist outreach support to women aged 18+ wishing to exit prostitution.

Poppy accepts women who meet the following criteria:

- Victim is over 16 years of age
- They have been trafficked to or escaped to the UK or have been trafficked within the UK and subsequently subjected to any form of exploitation such as: sexual exploitation, forced labour which includes domestic servitude, forced illicit activities such as cannabis farming, begging or pick-pocketing or organ harvesting.

Referrals to the Poppy Project can be made by telephone only. To make a referral or discuss whether a woman may have been trafficked agencies should call the helpline on: 0207 735 2062. The referral line is open between Monday-Friday, 9.30am-5.30pm.

The project is not able to accept referrals for children under 16 years of age. If professionals have concerns about a child who may have been trafficked call the NSPCC Child Trafficking Advice & Information Line on 0800 107 7057.

Salvation Army

The Salvation Army has responsibility for delivery the UK governments contract to manage support services for adult male and female victims of human trafficking.

The specialist support programme aims to care for victims in safe accommodation and provide access to confidential support services including:

- Legal advice
- Health care
- Counselling
- Educational opportunities

Professionals and victims of human trafficking can contact the 24-hour referral helpline on 0300 3038151 which is open seven days a week for assistance.

Sexual violence, sexual harassment and stalking

It is estimated that 1 in 5 women (20%) have been a victim of sexual abuse since the age of 16, whilst furthermore it's estimated that 0.5% of women were raped or sexually assaulted in the past year[38]. Of the 500,000 victims of sexual assault estimated annually, 85%-90% are women[39]. Survey data suggests that 90% of victims of serious sexual offences knew their perpetrator and 54% were committed by a current or former partner[40]. This contrasts significantly with offences reported to and recorded by police in Havering (65% of reports whereby victim knew suspect, and just 12% current or former partner). This would suggest locally that serious sexual assault and rape within intimate relationships is more severely underreported. Just 15% of all victims of serious sexual assault and

[38] Home Office, Office for National Statistics and Ministry of Justice (2013) An overview of sexual offending in England and Wales.
[39] Ibid
[40] Walby, S. and Allen, J. (2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey, Home Office: London.

rape reported offences to the police nationally. Of those offences which were reported to and recorded by police nationally 24% were 'detected' and just 7% resulted in a conviction[41].

Appendix 30 provides a breakdown of all sexual offences reported to police in Havering during the past five years, broken down to specific categories for the last three years. There is an average of 205 sexual offences reported to and recorded by police in Havering per year since 2009. Those which are rape and sexual assaults account for almost three-quarters of the total, of which there were 150 reported in 2013. Almost one in five of all reports are regarding sexual activity with consent involving people (almost entirely female) under the legal age of consent. One in ten of all reports were regarding sexual harassment, including stalking, of which 90% of reports related to indecent exposure.

The highest volume of rape and sexual assault reports are categorised in the table as 'Child victim inc. CSE'. Reports in this category increased +28.2% in the past three years, this group accounted for 33% of all rape and sexual assault in 2013. Within this category are offences of CSE (Child Sexual Exploitation), although the majority of offences are whereby young women have been raped or sexually assaulted by young men (i.e. people known to them from school, not in a relationship). The next highest category is 'Suspect known other – victim 17 and over' – this includes rape and sexual assaults perpetrated against victims through for example work colleagues or suspects they have met whilst out in social venues. There has been a reduction in this category of -42.9% compared to three years ago, with 16 offences in 2013 accounting for 11% of all rape and sexual assault.

Rape and sexual assaults which take place within intimate partner relationships or involving other family members (Child care case and Domestic Violence exc. IPV) account for 22% of all rape and sexual assaults reported to and recorded by police. The number of Child care cases (where a family member has raped or sexually assaulted a child) has decreased from 26 to 11 over the past three years (-57.7%). The number of IPV cases which are teenage IPV has also fallen to from 4 three years ago to just 1 in 2013. Conversely, the number of IPV cases involving victims aged 17 and over has increased for the last three consecutive years from 11 to 13 to 16. See more information and analysis of local data in Appendix 25 to Appendix 34.

Characteristics of female victims

As earlier sections of this chapter have shown, gender is a key factor related to the risk of sexual offence victimisation, with the majority of victims being female. In addition to this, risk of victimisation for females varied by other personal and household characteristics[42]. They include:

- Females aged between 16 and 19 were at the highest risk of being a victim of a sexual offence (8.2 per cent) and as age increased the risk of victimisation reduced.
- Single females (includes those in a relationship who are not cohabiting) and those who were separated (those who are married, but not living with their spouse) were more at risk than other females (5.3 per cent and 3.7 per cent respectively).
- Females from households in the lowest income bracket (under £10,000 per year) showed an increased risk of victimisation (3.8 per cent) as did full time students (6.8 per cent), and the unemployed (3.8 per cent).
- An increased risk of victimisation was apparent for females with limiting disabilities or illnesses (3.4 per cent) and those who were economically inactive at the time of interview due to long term illness (4.9 per cent).
- Factors relating to household location, and housing tenure were also related to risk of victimisation. For example, prevalence rates were higher among females in the 'City Living' Output Area Classification category (5.5 per cent), people living in flats or maisonettes (3.9 per cent), those living in an urban area (2.6 per cent) and in rented accommodation (3.4 per cent for social rented accommodation and 4.6 for private rented).

[41] Source: Home Office, Office of National Statistics and Ministry of Justice (2013) An overview of sexual offending in England and Wales

[42] Demographic characteristics deemed to be of greater risk of victimisation are ones with a statistically higher prevalence rate than the remainder of the female population (determined using a T-Test for statistical significance).

- Sexual victimisation rates were higher for females who reported visiting a pub at least once a week (4.3 per cent) or a night club one to three times a month (5.6 per cent). Those who visited a night club at least four times a month had the highest victimisation rate of any characteristic covered by the CSEW (9.2 per cent).

Many of these characteristics are closely associated and should not be viewed in isolation. Particular attention should be paid to the relationship between age and characteristics such as marital status, full-time student status and use of nightclubs and pubs; as should the relationship between household income and economic status, output area classification, tenure, occupation and residential characteristics. Previous reports in this area have used logistic regression to help identify factors which are independently associated with increased risk of victimisation. Previous analysis by the Home Office found that the characteristics which contributed most to explaining the risk of sexual offence were the respondent's sex, use of any drugs in the last year and age. However, other variables such as marital status, having a long-term illness or disability and frequency of visits to a nightclub were also important. The report also noted that although people who had used any drug in the last year were found to have higher odds of being a victim of sexual offence compared with those who hadn't, they could not conclude that there was a causal relationship between the two. Nor could they exclude the possibility that other lifestyle factors related to both drug use and victimisation, which were not included in the model, may be related[43].

Recommendations

These are partly based on NICE Public Health Guidance on Domestic Violence and abuse (NICE public health guidance 50) which is presented in Appendix 35 and Appendix 36.

Objective	Action
• Providers of all sexual health services to evidence that they are competent and trained to undertake motivational interviewing with young people to identify young people who are at risk of sexual exploitation.	• LBH to ensure that sexual health service providers undertake audits of training and effectiveness of motivational interviewing
• All children and young people understand consent, sexual consent and issues around abusive relationships.	• LBH-led Healthy Schools programme and school nursing service to contribute to SRE in schools to ensure children and young people understand sexual consent, and the different needs of boys and young men are acknowledged
• A free telephone helpline be available for vulnerable people at risk of sexual exploitation, and school nurses to be contactable via text messaging (children, young people and parents/carers)	• LBH to commission the integrated sexual health service to provide a helpline for young people to call • LBH to ensure that school nurses can be contacted by a range of methods, including text messaging
• Sex workers to be signposted / referred as appropriate, including to services that support exit from prostitution and for support for those who have been trafficked. Friends or relatives should not act as interpreters for people accessing sexual health services.	• LBH to ensure that sexual health providers have referral pathways in place. • LBH to ensure that all commissioned sexual health services specifically exclude friends or relatives acting as interpreters for clients/patients
• Services to be developed that prioritise the	• CCG and LBH Commissioners to ensure that

[43] Source: Home Office, Office of National Statistics and Ministry of Justice (2013) An overview of sexual offending in England and Wales

Objective	Action
importance of identifying violence and abuse	services are commissioned with trained staff, care pathways, and environments that are in accordance with NICE public health guidance on domestic violence, including monitoring that frontline staff are trained and equipped to recognise indicators of violence and abuse, especially staff in antenatal, postnatal, reproductive are, sexual health, mental health, children's and vulnerable adults services
• Local partners work together to prevent sexual abuse	• Establish a local sexual health alliance that takes into account sexual abuse and violence, including prevention of forced marriages, so-called "honour" violence, stalking, sexting • Develop protocols and methods for sharing information, within and between agencies

Assets

Morgan and Ziglio (2010)[44] define a 'health asset' as, *"any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain and sustain health and well-being and to help to reduce health inequities. These assets can operate at the level of the individual, group, community, and/or population as protective (or promoting) factors to buffer against life's stresses".* This JSNA chapter on sexual health largely focuses on ill-health, and the recommendations recognise the complexities presented by the new commissioning arrangements, the need to engage with many and varied service providers and stakeholders, and the impact of wider determinants and associated risk factors such s alcohol and drug misuse, domestic violence, low levels of education and poor mental health. However, in addition to the opportunities now available for commissioning to improve sexual health, there are a range of assets in Havering to support improved sexual health and resilience.

This section introduces just two examples of community assets; those of schools and health visitors but recognises that faith, voluntary and community sectors all have an essential role to play in influencing sexual health and wellbeing in the borough – which is reflected in earlier recommendations to include faith, voluntary and community representatives in the sexual health alliance described earlier.

Schools

Schools of course have a key role in educating children and young people around sex and relationship education (SRE). The objective of sex and relationship education is to help and support young people through their physical, emotional and moral development and will help young people learn to respect themselves and others and move with confidence from childhood through adolescence into adulthood. The Government's Education White Paper, The Importance of Teaching, published in November 2010 (1), stated:

> "Children need high-quality sex and relationships education so they can make wise and informed choices. We will work with teachers, parents, faith groups and campaign groups, such as Stonewall to make sure sex and relationships education encompasses an understanding of the ways in which humans love each other and stresses the importance of respecting individual autonomy"

All maintained secondary schools must provide SRE as part of the basic curriculum. The current statutory provisions on sex education are contained in sections 403 and 405 of the Education Act 1996 (2); and schools are currently required to utilise the Relationship Education Guidance. Academies and free schools do not have to follow the National Curriculum and thus are not under the same statutory obligations as maintained schools to provide SRE. Should they choose to provide SRE they must regard sections 403 and 405 of the Education Act 1996 (2).

Considering the wide remit of SRE with its focus on physical, emotional and moral development the Department for Education and Employment suggests that schools should utilise the national curriculum and Personal, Social, Health and Economic (PHSE) education. PSHE education is a planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives. As part of a whole school approach, PSHE develops the qualities and attributes pupils need to thrive as individuals, family members and members of society. Although PHSE is an integral element of education system it is currently not a statutory requirement of schools. A Government PHSE review in 2013 concluded that the subject would remain non statutory and that no new programmes of study would be published. A recent evaluation undertaken by the PHSE Association highlighted through a survey local authority members who work with over 4,500 schools that there was a 70% decrease in the amount of time dedicated to PHSE. The amount of time and breadth of PHSE remains a decision for school leaders and across the borough, as nationally, PHSE is likely to be delivered to different standards. A recent study by Stallard highlighted the difficulties in delivering PHSE due to busy time tables and a lack of value place on

[44] Morgan A, Davies M, Ziglio E. Health assets in a global context: Theory, methods, action: investing in assets of individuals, communities and organizations. London: Springer; 2010

PHSE, plus difficulties engaging children, young people and teachers especially in relation to cognitive behaviour therapy (CBT).

Health visitors

Health visitors provide advice and support to parents and families during the child's early years, through both universal service and, where needed, targeted interventions. Health visitors engage with prospective parents during the mother's pregnancy, and are ideally placed to offer advice on healthy relationships, including sexual health, and to signpost to appropriate sexual health services, including contraception services.

The responsibility for commissioning of health visiting services transfers to local authorities in 2015, and the Council has an opportunity to strengthen the role of health visitors in providing advice on sexual health and contraception to new parents, but especially to very young parents.

Service Users

Sexual attitudes and lifestyles

In 2013, the third national survey of sexual attitudes and lifestyles was undertaken in the UK (Natsal-3), with the results published in November 2013. Previous surveys were undertaken in 1990 and 2000. Over 15,000 adults aged 16-74 participated in interviews between September 2010 and August 2012, which was a representative sample of people living in Britain. A series of articles have been written that explore the changing patterns of sexual behaviour, attitudes, health and wellbeing across the population, and the findings have been considered in this JSNA chapter of sexual health alongside the data that are specific to Havering. The key points from the Natsal-3 survey are summarised in Box 2.

Box 2: Key points from the Natsal-3 survey

- *More people are having sexual intercourse before the age of 16: 29% of females and 31% of males aged 16-24 said that they had had sexual intercourse with someone of the opposite sex before age 16, which compares with older cohorts of: 26-34 (25% females, 26% males); 35-44 (18% females, 27% males.*
- *One in 10 women and one in 71 men said that they had experienced non-volitional sex since age 13. Although experiencing sex against their will could happen at any age, it was more common at younger ages. In most cases, the person responsible was someone known to the individual.*
- *An estimated one in six of pregnancies were unplanned, two in six were ambivalent. Just half of pregnancies were planned.*
- *The percentage of the population who have had a same-sex experience is growing.*
- *Anonymous STI testing from the sample of men and women aged 16-44 showed that HPV was the most common STI, followed by chlamydia. Around one in twenty women aged 18-19, and one in thirty men aged 20-24 had chlamydia.*
- *Since 1990, there has been an increase in access to sexual health services and STI/HIV testing; those having the greatest numbers of partners were those who were most likely to attend clinics and have an STI/HIV test.*
- *Although many aspects of health behaviour have strong social determinants, the study reported complex and inconsistent patterns, and noted that education is more strongly associated with sexual behaviours and attitudes than is individual socioeconomic status. Area-level deprivation was seldom associated with sexual behaviours.*

Source: Natsal-3 Survey

As the data elsewhere in this chapter show, rates of identified sexually transmitted infections in Havering have continued to rise, with the greatest burden of poor sexual health being borne by young people. As the Natsal-3 survey has found, use of sexual health services has also risen, and particularly among those at greatest risk of poor sexual health. The increased use of sexual health services makes it difficult to understand whether the rates of diagnosed sexually transmitted infections are as a result of a real increase of STIs, or whether we are simply better at finding the infection as a result of previous national strategies to increase attendance at sexual health services. Nevertheless, whatever

is the reason for the increased detection rate, it remains the case that the costs of responding to sexual ill-health is likely to create greater pressures on the public purse.

For most health services, waiting lists in effect act to limit the demand for health service and to some extent prioritise those that are most necessary. For STIs (as an infectious disease) rationing is ineffective and simply leads to either (a) increasing prevalence of illness, or (b) higher costs as residents attend services out of borough[45].

Clearly then, strategies that attempt either to ration services, or rely on unlimited response to demand, lead to greater health risks for the population and/or greater financial risks to commissioners. The Council, its partner sexual health commissioners, and broader stakeholders will need to invest energies in designing a strategy that relies on prevention in order to reduce the real demand for services, increase the knowledge and skills of the population in order to lessen the likelihood of first and repeat infections, and ensure that young people are empowered to make informed and safe decisions about sexual relationships.

Havering has a number of assets that can support such prevention strategies; schools and colleges that are engaged and interested in improving all aspects of children and young people's health, many of which are pursuing healthy school status, a network of services and individuals that are interested and willing to champion health improvement in the borough, and a wider population that is engaged in health and wellbeing activities through volunteering.

Existing service provisions for all the areas

There is very limited data resource on the experience of sexual health service users in Havering. Therefore, this section depends only and entirely on the NELNET (North East London HIV & Sexual Health Clinical Network) Sexual Health Service User Survey 2012.

In 2009, NELNET's Sexual Health sub-group developed a sexual health service user questionnaire to measure levels of satisfaction with services and to generate useful feedback which could be used to inform future service improvements. Results from the most recent survey, which was undertaken in October and November 2012, underpin this section of local sexual health service user experience. Some of the aims and objectives of the 2012 NELNET survey included:
- To gather feedback on current levels of satisfaction with service provision across the sector (acute and community).
- To enable targeted actions which maintain or support continued service improvement in these areas

It should be noted, however, that the NELNET survey was provider – rather than commissioner – focused. Therefore, there is focus on BHRT (Havering's main sexual health service provider) as a proxy for service users resident in Havering. In addition, GUM and CaSH were surveyed separately.

Ten 'services' in North East London participated in the survey and, as shown in Table 10, the attendance data from each service was used to determine sample sizes for required response rates from each service.

Table 10: Estimated service attendance data, 2012 NELNET sexual health service user survey 2012, as provided by service leads

Services	Service attendance data	% (against overall NEL attendances)	Sampling size	Number of forms
Homerton GU	26,154	13%	110	300
The Ivy / Homerton community services	13,668	7%	56	67
Barts	18,000	9%	74	71

[45] When commissioning responsibilities were changed in 2013, the implications of "open access services" provided by local authorities were that residents could access services anywhere in the country, with the borough of residence being charged for the service provided.

Services	Service attendance data	% (against overall NEL attendances)	Sampling size	Number of forms
AKC	30,000	15%	123	123
Tower Hamlets CaSH	24,000	12%	98	101
Whipps Cross DOSH	11,332	6%	46	55
Greenway Centre, Newham	16,076	8%	66	101
Newham Community Services	13,200	7%	54	57
BHRUT - GU attendances	21,000	11%	86	99
BHRUT - FP attendances	21,000	11%	86	78
TOTALS	**194,430**	**100%**	**800**	**1,052**

Data Source: NELNET, 2012

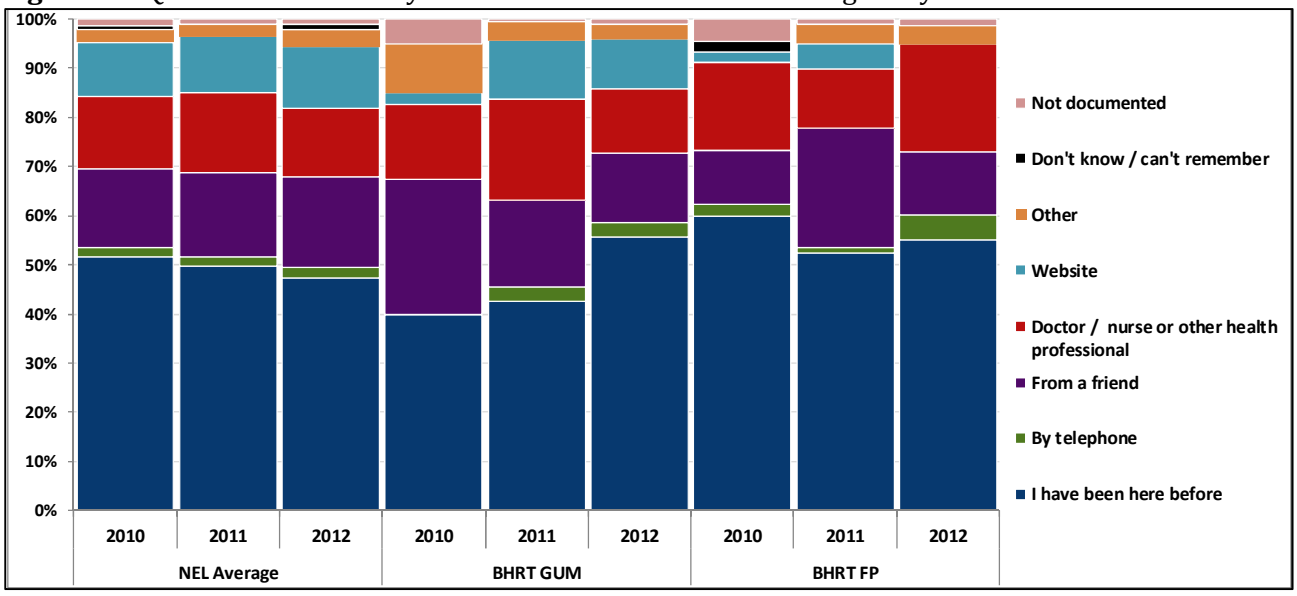
Summary for BHRT: service users' demographics

Question 1: How did you find out about us before coming today? (see Figure 67)

BHRT FP

- Over 55% of users were aware of the service having used it before; this is in line with the user feedback for the other providers included in this study.
- The second most common way of finding out about a service was being directed by a doctor/nurse or other health professional (22%), which is almost 10% higher than the previous year (12.8%). This may suggest that there may have been due to local interventions focused on improving referrals from GPs. For the majority of the other providers, the second most common way of finding out about a service was through a friend.
- BHRT FP was the only provider out of the 10 that had no users finding out about the service through their website. This is a drop compared to the previous year whereby 5% of users had become aware of the service through the website. There is need to improve engagement with potential service users using better web presence that is mobile and tablet friendly.

Figure 66: Question 1: How did you find out about us before coming today?



Data source: Summary for BHRUT: service user's opinions, NELNET

BHRT GUM

- Over 55% of users were aware of the service having used it before; this is in line with the user feedback for the other providers included in this study.
- The second most common way of finding out about a service was through a friend (14.1%), closely followed by being directed by a doctor/nurse or other health professional (13.1%).

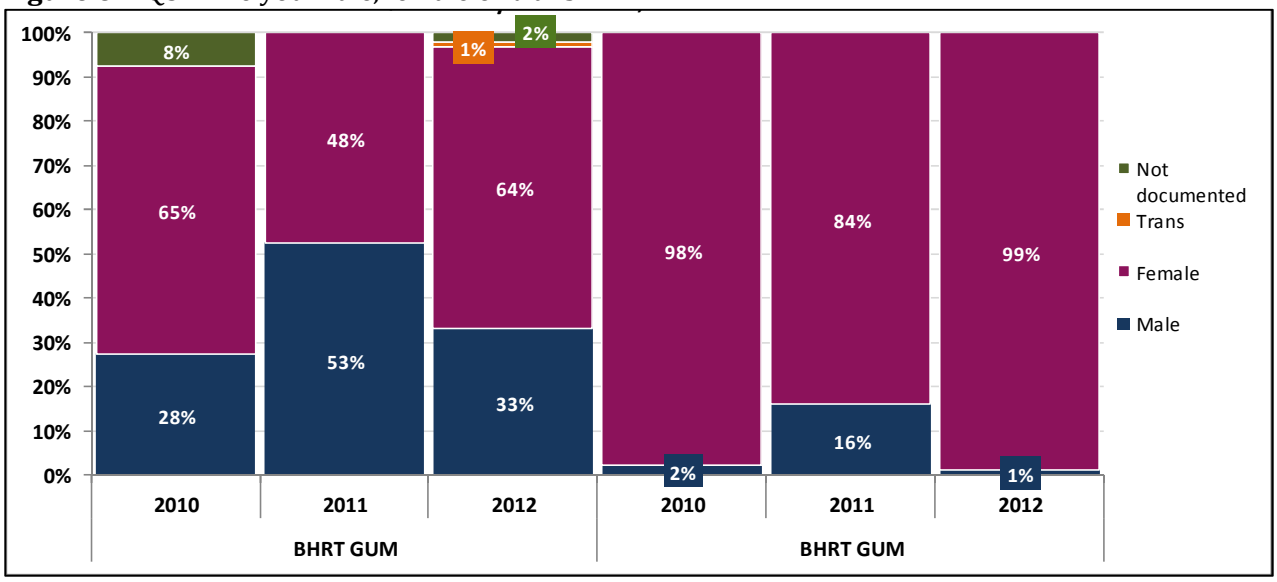
Question 2, 3 and 4 are summarised in Table 11, Figure 67 and Figure 68 respectively.

Table 11: Question 2: How old are you?

Age Groups	Percentage of Sample FP	Percentage of Sample GUM
18 and under	5%	13%
19-24	18%	29%
25-34	28	35%
35-44	30	13%
45-54	17	7%
55-64	1%	0%
Over 65	0%	1%
Not documented	1%	1%

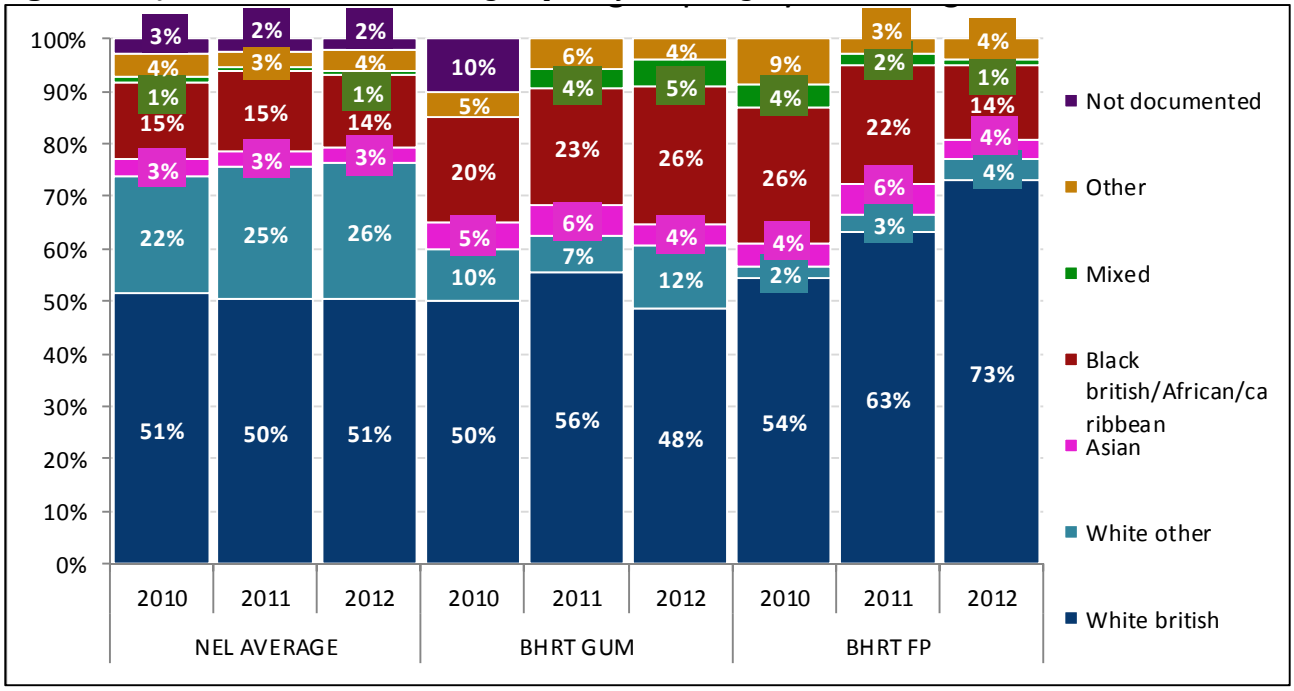
Data source: Summary for BHRUT: service user's opinions, NELNET

Figure 67: Q3 – Are you male, female or trans?



Data source: Summary for BHRUT: service user's opinions, NELNET

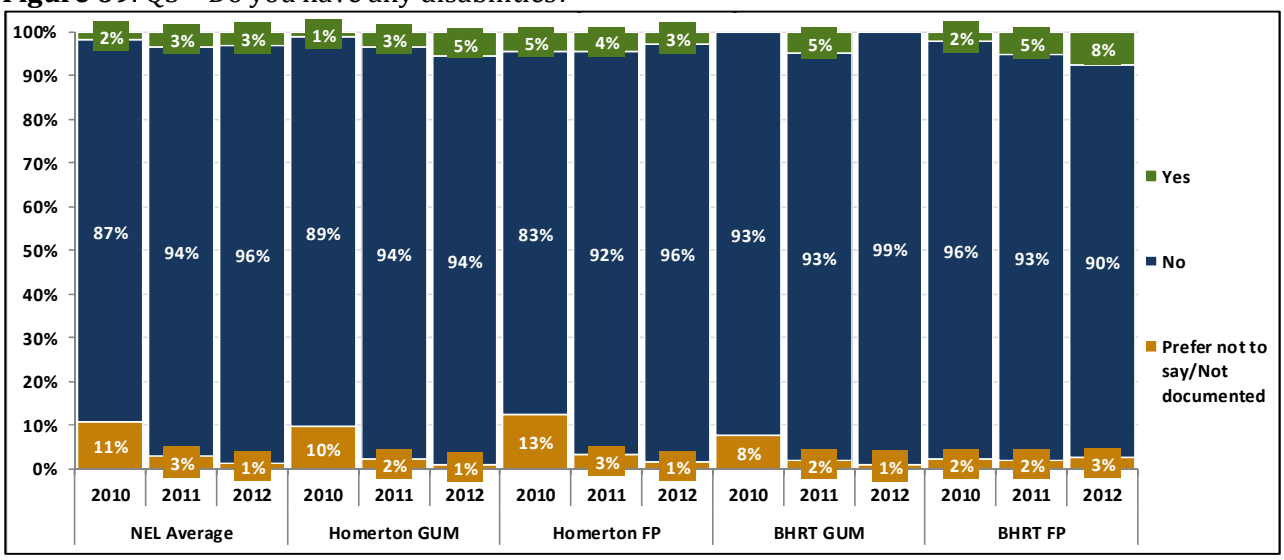
Figure 68: Q4 – Which of these ethnic groups do you belong to?



Data source: Summary for BHRUT: service user's opinions, NELNET

Question 5: Disabilities (see Figure 69)
Almost 8% (N=6) of users accessing the BHRT FP service considered themselves to have a disability, this is higher than the other 9 providers, which average 3% of users claiming to have a disability.

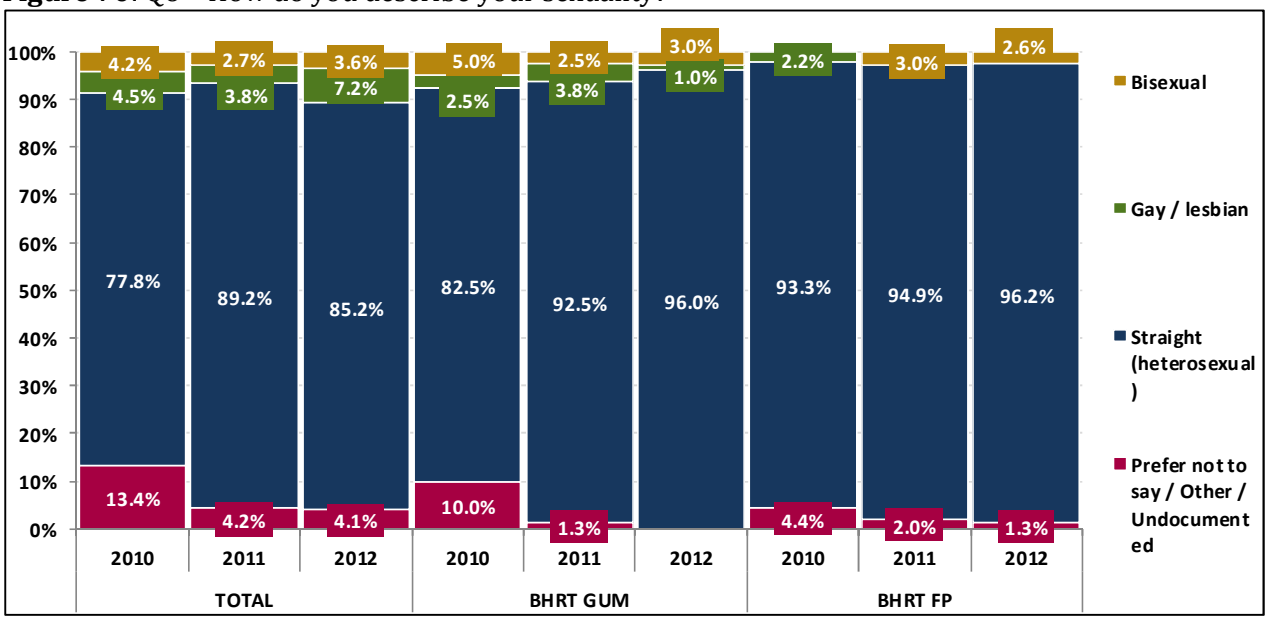
Figure 69: Q5 – Do you have any disabilities?



Data source: Summary for BHRUT: service user's opinions, NELNET

Question 6: Sexuality (see Figure 70)
The vast majority of users for both BHRT FP and GUM considered themselves heterosexual (96% in both cases. This is similar to the other providers, but the percentage of the sample describing themselves as Gay/Lesbian or bisexual does vary across the different providers. Despite variation, those considering themselves to be Gay/Lesbian or bisexual is still very much in the minority, with the highest being AKC users describing themselves as Gay/lesbian (18%).

Figure 70: Q6 – How do you describe your sexuality?



Data source: Summary for BHRUT: service user's opinions, NELNET

Summary for BHRT: service users' opinions

Question 7: Friendly Reception Staff
Users accessing a service from both BHRT GUM and FP reported positive feedback with both groups, with an average of 96% either agreeing or strongly agreeing that the reception staff were welcoming.

Question 8: Comfort, safety and cleanliness of the waiting area:

Users accessing a service from both BHRT GUM and FP reported positive feedback with both groups, with an average of 94% either agreeing or strongly agreeing that the waiting area(s) felt clean, safe and comfortable.

Question 9: Trust and confidence in the staff they met
Users accessing a service from both BHRT GUM and FP reported positive feedback with both groups, with an average of over 98% either agreeing or strongly agreeing that the users had trust and confidence in the staff they met. This is the highest percentage when compared with the other 9 providers.

Question 10: All staff treating a patient introduced themselves
Though the majority of staff did introduce themselves there has been a drop compared to the previous year, particularly from users accessing a service from the BHRT FP clinic, the previous year 96% whereas only 84%.

Question 11: Enough privacy during their visit
On average, 96% of users accessing a service at either BHRT FP or BHRT GUM felt they had enough privacy during their visit. This is slightly higher than the average for all 10 providers (93.5%). Though BHRT GUM still for the vast majority of users provided enough privacy, there has been a decrease for the past two years 2010 (100%), 2011 (96.9%) and 2012 (94.8%).

Question 12: Staff explained what they would be doing and why.
On average 98% of BHRT GUM or FP users felt the staff explained what they would be doing and the reasons why they would be doing it. There was little difference in positive response for BHRT GUM when comparing 2011 (98.8%) and 2012 (97%), but the FP clinic had an increase of more than 10% of users reporting positively on the way the staff communicated what was going to happen and why.

Question 13: Staff explained how they would get results of any tests taken.
On average 96% of users of BHRT FP or GUM reported they had been told how they would receive results of any tests taken during their visit. Again FP clinic had an increase of more than 10% (84.7% to 95.1%) of users reporting positively on the way the staff explain how they would receive results of any tests taken.

Question 14: Provided with clear information on their condition (diagnosis and treatment)
On average 94% of users of BHRT FP or GUM reported they had been provided with the necessary information on their diagnosis and how it can be treated. This is almost 4% higher than the average for all the providers' surveys in this research. Both BHRT GUM and FP have seen an increase since 2011 in the number of users feeling they have been provided with clear information (GUM 1% and FP 7%).

Q15: Provided clear information on contraception needs.
Both BHRT GUM and FP are performing much better compared to the other providers' survey. The average for all ten providers was 86% of users feeling they were given clear information on their contraception needs. For the users of the BHRT services on average 96% of users felt they were given clear information on contraception.

Q16: Users felt the staff treated them with dignity and respect.
For both BHRT providers the users reported positively on how they were treated with dignity and respect (GUM 99% and FP 100%). This is higher the average for all those surveyed (96.3%) but for the vast majority of providers their users reported positively on this area.

Q17: Satisfied with visit overall
On average 98% of users of BHRT FP or GUM reported they were satisfied with their visit to the service.

Q18: How would you rate your care received at the service?
On average 97% of users of BHRT FP or GUM reported the care they received as either 'good' or 'excellent' and there were no users for both clinics reporting the care as 'poor' or 'very poor.'

Q19: Would you recommend this service?
On average 99% of users of BHRT FP or GUM reported they would recommend the service to others, the BHRT services have performed well on this area for the past 3 years.
Quotes from users:
BHRT GUM
"I had a splendid experience today and was treated with so much care and respect that I've not seen in other hospitals I've visited."
"No matter how many times I come here, they see me and never make me feel I'm over the top with too many visits, I am always welcome."
"I am treated with respect and dignity and all the staff I came into contact with made me feel very relaxed. I didn't feel I was being judged and didn't feel any embarrassment due to the staff making me feel at ease."
Out of the 22 qualitative responses, 4 users stated waiting time was an issue.
BHRT FP
"Exceptional customer service, confidentiality skills, especially from reception staff. Receptionist understood the needs of both myself and other patients."
"Love that it's a walk-in and can come when it suits me."
"Drop in session good so don't have to book an appointment."

The vast majority of responses were positive though a couple of users felt that there was not enough privacy when a patient states the reason for their visit to reception. Analytical outputs for this subsection are presented in Appendix 37.

Recommendations

The key recommendations are summarised at part of the Executive Summary of this chapter. This section captures the full recommendations as described under each of the main sections of this chapter.

Recommendations on Sexually Transmitted Infections (STIs)

Objective	Action
• Pay greater attention to the prevention of STIs among young people	• Schools to be supported to provide good quality sex and relationship education. Support for schools should be provided by school nurses, and where schools wish to include criteria on SRE as an element of their Healthy Schools award, there should be information available from the Council's public health team on where they can access information and training • Where young people are tested positive for an STI, they should receive advice on how to prevent further infections in the future. • There should be a focus on improving sexual health amongst the most vulnerable groups of young people, and specifically Looked After Children. This should take into account the association between use of alcohol, drugs, and poor sexual health. This should take into account influences of wider determinants on all aspects of LAC health by carrying out a health needs assessment for this group • Where there is evidence of very young teenagers having been exposed to risky sexual behaviours, such as having been infected by gonorrhoea, appropriate safeguarding procedures must be followed and there should be increased help, guidance, and support for these individuals • Ensure that chlamydia screening programme is effective and attains the greatest percentage of positive screens, and that the programme supports health promotion messages • The DPH, through the Health Protection Forum, should ensure that there is good coverage of the HPV vaccination programme, and appropriate measures are in place to address any inequalities in uptake
• Ensure that young people have the skills and knowledge to avoid early onset of sexual activity, and that they are confidence in deciding when they are ready for a sexual relationship and if they want to continue in a sexual relationship.	• Schools to provide good quality sex and relationship education, with support from the school nurse, including signposting to sources of evidence-based information • Schools and school nurses should provide parents with guidance and signpost to resources that support parents to be able to

Objective	Action
	talk with their children about sex and relationships, and how to stay healthy

• Reduce the risks to sexual health as a result of misuse of alcohol and/or substance abuse.	• Commissioners of drugs/alcohol services should ensure that there are appropriate referral pathways in place for clients to be referred/signposted to sexual health services, information and advice (including self-management)
	• Commissioners of drugs/alcohol services to monitor the following:
	  • how well trained are the frontline staff working in drugs alcohol services in all aspects of sexual health (unintended pregnancy, sexually transmitted infection and sexual exploitation and abuse)
	  • the numbers of clients referred to sexual health services
	  • the numbers of clients that are identified as at risk of sexual exploitation, and the actions that were taken as a result

• Greater attention to be paid to prevention of STIs among high risk groups, including
  • Men who have sex with men
  • Ethnic groups that are a high risk, including black Africans
  • Offenders
  • Looked After Children, and those leaving care
  • Young people (under 18) who are either parents, or are expectant parents
	• Ensure sexual health services are commissioned that focus on prevention as well as treatment
	• Ensure that a borough sexual health alliance is formed that brings together services in a way that best meets the needs of high risk groups
	• Develop a teenage pregnancy strategy, in consultation with stakeholders
	• Undertake further needs assessments for specific groups:
	  • Looked After Children, and those leaving care
	  • Offenders

• Healthcare professionals should use all appropriate opportunities to raise issues related to sexual health and make "Every Contact Count"	• Sexual health alliance to include representation by CCG, GPs, practice nurses, pharmacists in order to champion sexual health among healthcare professionals • Public health and CCG to raise awareness of sexual health among GPs and practice nurses by promoting national campaigns to general practice • Public health commissioners of pharmacy-provided sexual health services to ensure that pharmacists and counter staff promote good sexual health and signpost to sources of information
• Relevant non-healthcare practitioners, such as teachers and school support staff, children's	• Public health to provide training on sexual health to health champions in schools and

Objective	Action
centre staff and staff of alcohol outreach services to contribute towards prevention of poor sexual health	children's centres

Recommendations on Human Immunodeficiency Virus (HIV)

Objective	Action
Reduce discrimination, stigma and fear associated with HIV testing and normalise testing in all healthcare settings to reduce the level of undiagnosed HIV infection	• LBH public health to establish a sexual health alliance that includes representation by HIV prevention services • LBH to ensure that commissioned HIV prevention services raise awareness of HIV and HIV prevention, including information on where testing is available, and confidentiality of HIV results • Health professionals to routinely offer and recommend an HIV test to all those who may be at risk of exposure to the virus and all those attending at specialist health care settings • CCG to ensure that appropriate HIV testing is offered by acute service, including routine testing for all those from areas of high prevalence (2 per 1,000 diagnosed HIV) • LBH Public Health to recruit health champions from among the African and Caribbean communities to promote HIV testing as part of a wider health improvement programme • LBH commissioners to evaluate the Havering HIV Point of Care Testing pilot and commission services based on the findings • Providers of sexual health services to explain the confidentiality of HIV testing, and be able to discuss HIV symptoms and the implications of a positive or negative test
Healthcare providers to be knowledge about HIV, including matters of confidentiality, referral pathways, and trained in negotiation/behavioural change	• CCG / LBH Public Health to engage with primary care practitioners to ensure that GPs and practice nurses are aware of: o The symptoms that may signify primary HIV infection o The illnesses that co-exist with HIV o Referral pathways for HIV testing and treatment (and availability of online tests, etc) o Behaviour change theories to reduce risk-taking behaviours o Confidentiality o The advisability of offering HIV testing to all men who are at higher risk of HIV
HIV testing to be promoted among higher risk groups to ensure individuals are aware of their HIV status	• GPs should refer MSM to HIV testing at suitable intervals (at least annually or every three months where appropriate)

Objective	Action
• MSM should have an HIV/STI screen at least annually, and every three months if having unprotected sex with new or casual partners. • Black Africans and Caribbeans should have an HIV test and should have regular HIV/STI screening if having unprotected sex with new or casual partners	• GPs should refer black Africans and Caribbeans for HIV testing at suitable intervals • Health champions from among the African and Caribbean communities to raise awareness of advisability and frequency of HIV testing among black Africans and Caribbeans • LBH Public Health to commission remote access HIV testing kits, and ensure that availability of kits is promoted among target groups – ensuring that health promotion advice is given with orders/test results
Ensure that services are developed in line with patient need, including: locations and timings of services.	• Sexual health services to undertake surveys and community engagement to ensure that services are delivered effectively and cost-effectively in the right locations and at the right time, paying particular attention to those groups most at risk of poor sexual health; black African and Caribbean groups and MSM • The Director of Public Health, through the Health Protection Forum, should seek assurance that the referral pathways are effective, and in particular that men who test positive are seen by an HIV specialist within 48 hours
Increase knowledge of HIV and HIV prevention • MSM should to be made aware that serosorting (choosing sexual partners of the same HIV status as themselves) is unsafe. • MSM to be made aware of the risks of concurrent drug use, which has been identified as a risk factor for several STIs among HIV positive MSM. • promote consistent condom use, having fewer sexual partners and avoiding overlapping sexual relationships to reduce the risk of becoming infected.	• Schools to ensure that young people are aware of HIV and prevention, and school nurses to support schools to provide accurate information to staff, children and young people, and their parents • All providers of sexual health services and public health services (e.g. school nurses, health visitors) and health practitioners to promote consistent condom use, having fewer sexual partners and avoiding overlapping sexual relationships • Providers of sexual health services should advise MSM that serosorting is unsafe • Sexual health services and drug treatment services should make MSM aware of the risks of concurrent drug use as a risk factor for STIs among HIV positive MSM • Engagement to be undertaken with relevant groups such as faith and community groups (through the sexual health alliance) • Commissioned prevention services to undertake health promotion at venues and via on-line services visited by target groups – sexual health commissioners to monitor health promotion activities, including how well information materials are tailored to

Objective	Action
	meet the needs of target groups • All stakeholders to raise awareness of HIV by supporting national prevention initiatives, including World Aids Day (healthcare and non-healthcare, to include schools, commissioned prevention services)
Ensure that local services are commissioned that meet nationally recognised standards	• Public health sexual health commissioners to ensure that services meet standards and are monitored (including timeliness of results) • The Director of Public Health to ensure that there is a local strategy to increase uptake of HIV testing among target groups in accordance with NICE recommendations
Gain a greater understanding of the needs of people living with HIV and their families, including the effect on their physical, psychological, social and spiritual dimensions of their lives	• Undertake a health needs assessment of people living with HIV • Public health sexual health commissioners to ensure that information is collected on take up rates of HIV testing • Public health sexual health commissioners to obtain monitoring information from commissioned prevention services on effectiveness of local interventions that aim to increase the number of black Africans and MSM participating in HIV testing

Recommendations on Conception, abortion and maternity

Objective	Action
Reduce the percentage of repeat abortions among women aged 18 to 25	• Increase uptake of long acting reversible contraception, particularly among women who have had abortion previously • Audit the quality of pre and post-abortion contraceptive counselling and support given to women, and make improvements where identified • To ensure that women who identified as in need of more intensive support are identified by providers of abortion services, and are signposted to support services
Reduce the rates of ectopic pregnancies	• Increasing awareness and detection of pelvic inflammatory disease • Increasing identification of non-symptomatic chlamydia infection among young people • Reducing levels of smoking pre-conception • Understanding further the reasons for ectopic pregnancies in Havering
Women take up the offer of ante-natal screening, especially higher risk groups, such as African	• The Director of Public Health, through the Health Protection Forum, should seek

Objective	Action
women	assurance that women in Havering are taking up the offer of ante-natal screening, especially higher risk groups, such as African women.
Gain an understanding of maternal health in Havering in order to plan and commission services that impact on maternal health and that of the child	• A JSNA chapter be developed on maternal health, to include pre-conception, pregnancy and post-birth

Recommendations on Teenage pregnancy

Objective	Action
Ensure that the needs of teenage parents are met, and that there is a continuing reduction in the rates of teenage pregnancy, especially among under 16s	• Set up a sexual health alliance that include a specific focus on teenage pregnancy • Develop a teenage pregnancy strategy and associated actions, with progress integrated into the governance arrangements for broader children and young people's and health programmes and reported at the highest level. • The teenage pregnancy strategy should o Include the development of a care pathway for teenage parents; from antenatal through to early years support, and which includes the role of general practice and health visitors o Include consideration of support for young parents in continuing or returning to education and training as embedded in the Raising the Participation Age Programme. o Clarify the referral pathway from pregnancy testing to abortion of maternity – this information should be disseminated to services working with young people o Be informed by audits and training needs analyses that identify gaps relating to knowledge and skills in promoting healthy relationships, sexual health and safeguarding • The C Card scheme should be expanded further into GP surgeries and pharmacies, and be promoted by school nurses • Undertake a needs assessment of maternal health, paying particular attention to the needs of young mothers
Ensure that there is high quality sex and relationship education in schools	• Havering Council to work in partnership with schools to support the delivery of SRE, including Pupil Referral Units and other alternative education providers • School nurses must support schools to

Objective	Action
	deliver SRE • Public Health commissioners must ensure that there are strong links forged between contraceptive and sexual health services and young people's services, including schools. School nurses must facilitate visits to schools by contraceptive and sexual health services as appropriate, and ensure that services are made known to young people in advance of need. • Public Health commissioners must ensure that targeted sexual health support is made available to more young people, especially via schools to those at risk. This could include advice from school nurses.

Recommendations on Contraception

Objective	Action
Ensure that women access the most appropriate and effective form of contraception that suits their needs	• LBH Public Health to commission sexual health services that increase uptake of LARC • LBH to ensure that school nurses provide information on reliable methods of contraception, including signposting to reliable website and apps • LBH Public Health to ensure that women are offered LARC, as the most effective form of contraception through a range of providers, and where LARC is wanted, this is to be provided at the earliest opportunity
Reduce the risk of unintended pregnancy following the birth of a baby	• CCG to ensure that maternity services have appropriately trained midwives who are knowledgeable of contraceptive methods, including LARC, and contraception when breastfeeding • CCG to ensure that maternity services audit advice given about contraception (pre and post birth), and that service user feedback is used to improve advice and information • LBH to ensure that advice given by health visitors is audited, and that service user feedback is used to improve advice and information • CCG to ensure that maternity services has a pathway into contraception services • CCG to consider options for contraception to be provided by the midwifery service • LBH Public Health to ensure that integrated sexual health service provider engages with GPs in order that good quality contraception advice is given to women at the 6-8 week check

Objective	Action
Reduce the risk of unwanted/unintended pregnancy following a previous abortion	• LBH Public Health to commission sexual health services that provide/signpost to IUD as emergency contraception
Ensure that young people (men as well as women) are aware of condom use for both the prevention of infection and to prevent unintended pregnancy	• The C Card scheme should be expanded further into GP surgeries and pharmacies, and be promoted by school nurses • CCG to ensure that abortion providers discuss contraception during pre-abortion counselling and that there is a referral pathway into contraception services post-abortion using the most appropriate communication methods

Recommendations on Sexual violence and exploitation

Objective	Action
• Providers of all sexual health services to evidence that they are competent and trained to undertake motivational interviewing with young people to identify young people who are at risk of sexual exploitation.	• LBH to ensure that sexual health service providers undertake audits of training and effectiveness of motivational interviewing
• All children and young people understand consent, sexual consent and issues around abusive relationships.	• LBH-led Healthy Schools programme and school nursing service to contribute to SRE in schools to ensure children and young people understand sexual consent, and the different needs of boys and young men are acknowledged
• A free telephone helpline be available for vulnerable people at risk of sexual exploitation, and school nurses to be contactable via text messaging (children, young people and parents/carers)	• LBH to commission the integrated sexual health service to provide a helpline for young people to call • LBH to ensure that school nurses can be contacted by a range of methods, including text messaging
• Sex workers to be signposted / referred as appropriate, including to services that support exit from prostitution and for support for those who have been trafficked. Friends or relatives should not act as interpreters for people accessing sexual health services.	• LBH to ensure that sexual health providers have referral pathways in place. • LBH to ensure that all commissioned sexual health services specifically exclude friends or relatives acting as interpreters for clients/patients
• Services to be developed that prioritise the importance of identifying violence and abuse	• CCG and LBH Commissioners to ensure that services are commissioned with trained staff, care pathways, and environments that are in accordance with NICE public health guidance on domestic violence, including monitoring that frontline staff are trained and equipped to recognise indicators of violence and abuse, especially staff in antenatal, postnatal, reproductive are, sexual health, mental health, children's and vulnerable adults

Objective	Action
	services
• Local partners work together to prevent sexual abuse	• Establish a local sexual health alliance that takes into account sexual abuse and violence, including prevention of forced marriages, so-called "honour" violence, stalking, sexting • Develop protocols and methods for sharing information, within and between agencies

Strategic recommendations on improving sexual health and reducing health inequalities

Objective	Action
• Increase uptake of long-acting reversible contraception (LARC), especially among 18-25 year old women	• LBH to commission sexual health services that increase uptake of LARC • LBH to ensure that school nurses provide information on reliable methods of contraception, including signposting to reliable websites and apps
• Increase uptake of intra-uterine devices (IUD) as emergency contraception	• LBH to commission sexual health services that provide/signpost to IUD as emergency contraception
• Ensure that midwives have appropriate knowledge of contraceptive methods, including LARC, and contraception when breastfeeding	• CCG to ensure that maternity services have appropriately trained midwives
• Ensure that appropriate advice on contraception is given by maternity services to pregnant women, that the midwife checks with the woman after birth that a method of contraception has been chosen	• CCG to ensure that maternity services audit advice given about contraception (pre and post birth), and that service user feedback is used to improve advice and information
• Ensure that health visitors discuss contraception with new mothers	• LBH to ensure that advice given by health visitors is audited, and that service user feedback is used to improve advice and information
• Ensure that there is a clear pathway for women to access contraception after birth, including options for contraception to be provided by the midwifery service, referrals into contraception services, and follow up at the 6-8 week check	• CCG to ensure that maternity services has a pathway into contraception services • CCG to consider options for contraception to be provided by the midwifery service • LBH to ensure that integrated sexual health service provider engages with GPs in order that good quality contraception advice is given to women at the 6-8 week check
• Ensure contraception is discussed before abortion (including LARC), and develop a referral pathway for follow up post abortion, including using communication methods most acceptable to the woman	• CCG to ensure that abortion providers discuss contraception during pre-abortion counselling and that there is a referral pathway into contraception services post-abortion using the most appropriate

Objective	Action
	communication methods
• Understand further the reasons for ectopic pregnancy	• LBH Public Health to support CCG and work with relevant services to investigate the reasons for ectopic pregnancies
• Reduce risks of ectopic pregnancy: reducing smoking pre-conception, increase identification of non-symptomatic chlamydia infection in young people, increase awareness and detection of pelvic inflammatory disease	• LBH to commission stop smoking services to engage with contraception services to ensure that women contemplating pregnancy are supported to stop smoking • LBH to ensure that commissioned chlamydia screening service improves detection rate
• Gain a greater understanding of infertility and miscarriage to inform commissioning plans and health improvement plans	• LBH Public Health to undertake a maternal health need assessment to include infertility and miscarriage
• Focus on prevention of STIs	• LBH to ensure that school nurses increase knowledge and awareness of STIs among young people • LBH to commission sexual health services that emphasise prevention, including using all available modern technology • LBH to ensure that all sexual health providers of STI testing include health promotion advice for those who test both positive and negative • LBH to increase registration with C-card scheme
• Ensure that ante-natal and newborn screening programme is being delivered locally so that babies are identified that are at risk as a consequence of maternal sexual health, including screening for HIV, and babies completing immunisation and serology testing for Hep B	• Director of Public Health, through the Health Protection Forum, to seek assurance of effectiveness of ante-natal and newborn screening
• Seek information on numbers of partners of women identified as HIV positive in pregnancy where partners have not been informed of HIV status	• Director of Public Health, through the Health Protection Forum, to seek information on partners of women identified as HIV positive in pregnancy where partners have not been informed of HIV status

Objective	Action
• Normalise and increase uptake of HIV testing, especially among high risk communities	• LBH health improvement network to train health champions from among the African community to promote HIV testing • LBH to commission HIV prevention programmes that target venues where at-risk communities congregate • CCG to ensure that A&E tests for HIV as part of the suite of blood testing, including auditing the uptake of HIV testing and responding to audit findings • CCG to promote to GPs the advisability and regularity of HIV testing among at-risk groups, including MSM • LBH to ensure that sexual health services engage in national promotion days, including World Aids Day and National HIV testing week with localised information • LBH to commission sexual health services that facilitates ease of access to HIV testing (i.e. remote testing/postal testing)
• For any late diagnoses of HIV, to identify where there were missed opportunities for diagnosis and reduce the likelihood of reoccurrence	• HIV services to undertake a look back of all people who are diagnosed late, to understand the lessons, and disseminate the learning as appropriate to primary, community, and secondary care providers • LBH to evaluate the effectiveness of new patient registration HIV point of care testing
• Gain a greater understanding of how people who are injecting drug users access sexual health services	• LBH to ensure that an audit is undertaken in drug treatment services
• Explore whether substance misuse services (drugs, alcohol, tobacco) engage with MSM on STI (and HIV) prevention	• LBH to explore how substance misuse services engage with MSM
• Providers of all sexual health services to evidence that they are competent and trained to undertake motivational interviewing with young people to identify young people who are at risk of sexual exploitation.	• LBH to ensure that sexual health service providers undertake audits of training and effectiveness of motivational interviewing
• All children and young people understand consent, sexual consent and issues around abusive relationships.	• LBH-led Healthy Schools programme and school nursing service to contribute to SRE in schools to ensure children and young people understand sexual consent, and the

Objective	Action
	different needs of boys and young men are acknowledged
• A free telephone helpline be available for vulnerable people at risk of sexual exploitation, and school nurses to be contactable via text messaging (children, young people and parents/carers)	• LBH to commission the integrated sexual health service to provide a helpline for young people to call • LBH to ensure that school nurses can be contacted by a range of methods, including text messaging
• Sex workers to be signposted / referred as appropriate, including to services that support exit from prostitution and for support for those who have been trafficked. Friends or relatives should not act as interpreters for people accessing sexual health services.	• LBH to ensure that sexual health providers have referral pathways in place. • LBH to ensure that all commissioned sexual health services specifically exclude friends or relatives acting as interpreters for clients/patients
• Develop a sexual health alliance that aims to improve sexual health amongst the population, and to include representation by services that can address associated risk factors (i.e. drugs and alcohol), and which engages with schools, parents, health professionals, pharmacists, social care professionals, substance misuse commissioners/providers, abortion and maternity services, community safety, and which includes representation on behalf of those that experience sexual health inequalities; appropriate community and faith leaders, young people, looked after young people, people with learning difficulties	• LBH to establish a sexual health alliance
• Develop a teenage pregnancy strategy, in consultation with stakeholders	• LBH Public Health to develop a teenage pregnancy strategy

• Consider undertaking further needs assessments for groups that experience poorer health outcomes including poor sexual health, including looked after children and those leaving care, people with learning difficulties, and people who are lesbian/gay/bisexual/transgender, and offenders (considering the different needs of male, female and young offenders)	• LBH/CCG to consider further needs assessments for specific groups:
	  • looked after children and those leaving care
	  • people with learning difficulties,
	  • people who are lesbian/ gay/ bisexual/ transgender, and
	  • offenders

Appendix: Supplementary Materials

Human Immunodeficiency Virus (HIV): Testing uptake & new diagnosis

Appendix 1: HIV testing offered and uptake in Havering, 2009 - 2012

	2009	2010	2011	2012
Eligible new GUM episodes	5,494	5,729	6,549	6,806
Offered	3,843	4,267	5,476	5,679
Tested	3,129	3,330	4,112	4,389

Data source: Public Health England- HIV test uptake and coverage in England, 2009 – 2012 (GUMCAD returns)

Appendix 2: Percentage of HIV tests offered, Havering compared to statistical neighbours, 2009-2012

	Year			
LA of residence	2009	2010	2011	2012
Stevenage	93%	93%	91%	92%
Worcester	89%	91%	85%	89%
Northampton	82%	84%	83%	84%
Rushmoor	84%	84%	85%	84%
Havering	70%	74%	84%	83%
Basildon	78%	77%	80%	81%
Gosport	75%	77%	76%	80%
Thurrock	79%	77%	81%	80%
Crawley	75%	69%	77%	79%
Bedford	77%	77%	73%	78%
Medway	81%	84%	84%	78%
Milton Keynes	75%	74%	72%	77%
Peterborough	78%	76%	74%	77%
Forest Heath	82%	80%	81%	76%
Swindon	93%	91%	84%	70%
Gravesham	65%	65%	68%	68%
Harlow	67%	68%	63%	65%

Legend: 63% – 93%

Data source: Public Health England- HIV test uptake and coverage in England, 2009 – 2012 (GUMCAD returns)

Appendix 3: Uptake of HIV tests offered, Havering compared to statistical neighbours, 2009-2012

	Year			
LA of residence	2009	2010	2011	2012
Gravesham	95%	97%	96%	97%
Northampton	92%	91%	92%	93%
Milton Keynes	85%	85%	89%	87%
Rushmoor	88%	86%	85%	87%
Medway	61%	74%	80%	86%
Crawley	79%	74%	81%	85%
Forest Heath	77%	81%	83%	84%
Peterborough	76%	79%	82%	84%
Gosport	73%	74%	79%	81%
Basildon	78%	79%	75%	80%
Thurrock	76%	78%	72%	79%
Havering	81%	78%	75%	77%
Bedford	61%	62%	70%	75%
Harlow	84%	80%	82%	75%
Swindon	52%	59%	65%	75%
Worcester	67%	66%	72%	72%
Stevenage	81%	77%	75%	71%

Legend: 52% – 97%

Data source: Public Health England- HIV test uptake and coverage in England, 2009 – 2012 (GUMCAD returns)

Appendix 4: HIV test coverage, Havering compared to statistical neighbours, 2009-2012

	Year			
LA of residence	2009	2010	2011	2012
Northampton	83%	85%	85%	86%
Rushmoor	81%	79%	80%	79%
Peterborough	71%	71%	71%	76%
Crawley	68%	58%	69%	75%
Forest Heath	71%	72%	75%	75%
Gravesham	70%	71%	74%	75%
Medway	58%	71%	75%	75%
Basildon	70%	69%	68%	72%
Gosport	61%	65%	70%	72%
Havering	64%	66%	70%	72%
Milton Keynes	72%	70%	71%	72%
Thurrock	68%	69%	66%	72%
Stevenage	82%	78%	74%	70%
Worcester	66%	67%	67%	70%
Bedford	54%	55%	59%	66%
Swindon	55%	62%	62%	63%
Harlow	66%	63%	60%	57%

Legend: 54% – 86%

Data source: Public Health England- HIV test uptake and coverage in England, 2009 – 2012 (GUMCAD returns)

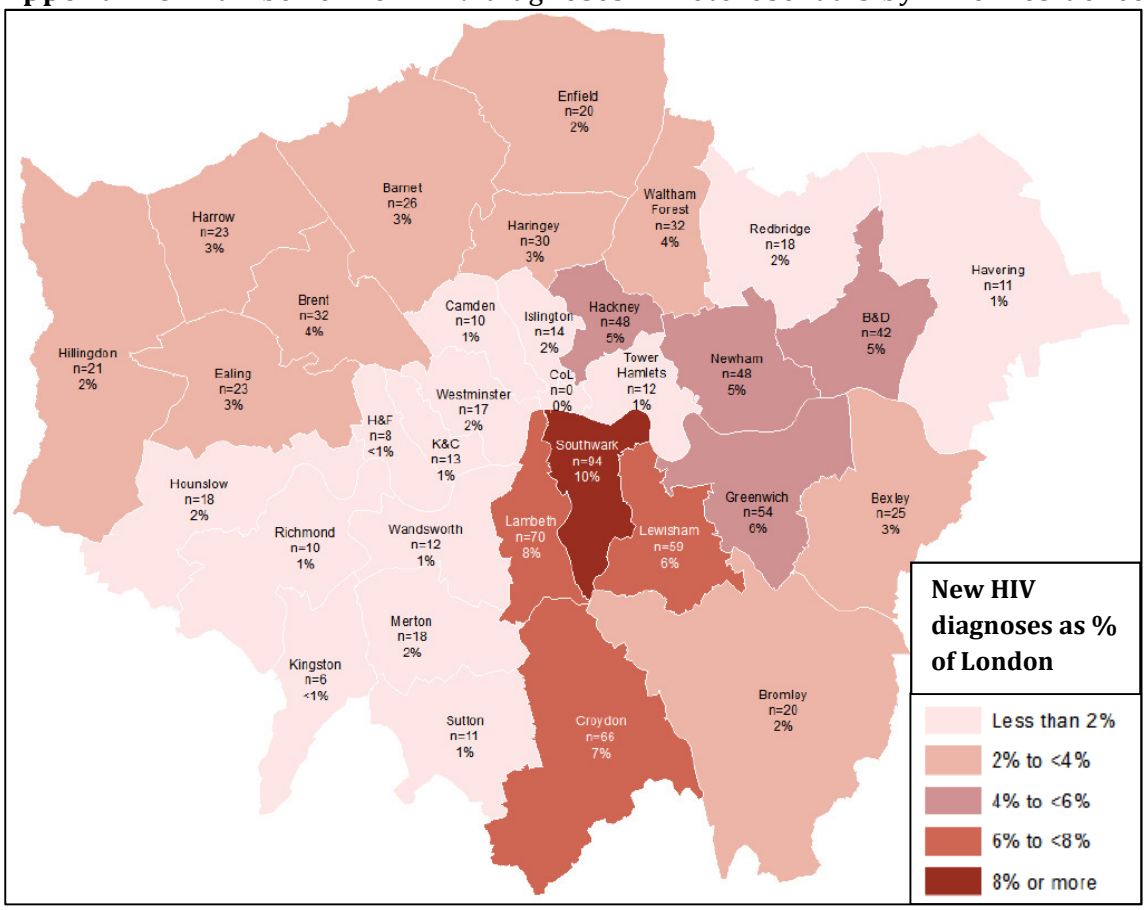
Appendix 5: HIV testing uptake in Havering and Statistical Neighbours, 2009-2012

LA of residence	Eligible new GUM episodes				Offered				Tested			
	2009	2010	2011	2012	2009	2010	2011	2012	2009	2010	2011	2012
Medway	6,272	6,451	6,989	7,886	5,100	5,448	5,841	6,141	3,088	4,032	4,693	5,291
Northampton	5,783	5,738	5,837	6,004	4,738	4,792	4,833	5,044	4,347	4,377	4,462	4,676
Havering	5,494	5,729	6,549	6,806	3,843	4,267	5,476	5,679	3,129	3,330	4,112	4,389
Swindon	6,731	7,245	7,283	7,720	6,233	6,616	6,095	5,436	3,252	3,880	3,969	4,098

LA of residence	Eligible new GUM episodes 2009	2010	2011	2012	Offered 2009	2010	2011	2012	Tested 2009	2010	2011	2012
Milton Keynes	5,031	4,431	5,207	4,951	3,783	3,286	3,735	3,828	3,211	2,799	3,336	3,333
Thurrock	4,369	4,675	4,918	4,992	3,448	3,595	3,976	3,977	2,617	2,804	2,865	3,152
Peterborough	4,577	4,268	4,491	4,708	3,571	3,246	3,308	3,642	2,713	2,565	2,728	3,063
Crawley	3,515	4,410	4,345	3,959	2,650	3,041	3,326	3,142	2,081	2,265	2,705	2,670
Basildon	4,064	4,038	4,345	4,094	3,159	3,114	3,465	3,304	2,457	2,451	2,593	2,641
Bedford	4,351	4,465	4,428	4,468	3,353	3,448	3,253	3,487	2,041	2,145	2,287	2,599
Rushmoor	2,349	2,390	2,543	2,711	1,971	1,998	2,167	2,269	1,733	1,716	1,852	1,974
Harlow	2,927	2,881	3,047	3,434	1,952	1,960	1,912	2,227	1,642	1,563	1,564	1,671
Stevenage	2,167	2,106	2,489	2,447	2,017	1,963	2,269	2,260	1,643	1,512	1,702	1,615
Worcester	2,129	2,257	2,307	2,217	1,899	2,061	1,965	1,979	1,278	1,350	1,405	1,433
Gravesham	1,879	1,914	2,007	1,963	1,218	1,241	1,370	1,343	1,155	1,198	1,311	1,300
Gosport	1,578	1,718	1,755	1,736	1,188	1,316	1,341	1,385	865	972	1,056	1,121
Wellingborough	1,516	1,565	1,605	1,458	1,349	1,408	1,353	1,232	987	1,067	1,119	1,094
Forest Heath	740	1,072	1,004	957	605	857	809	727	467	690	672	611

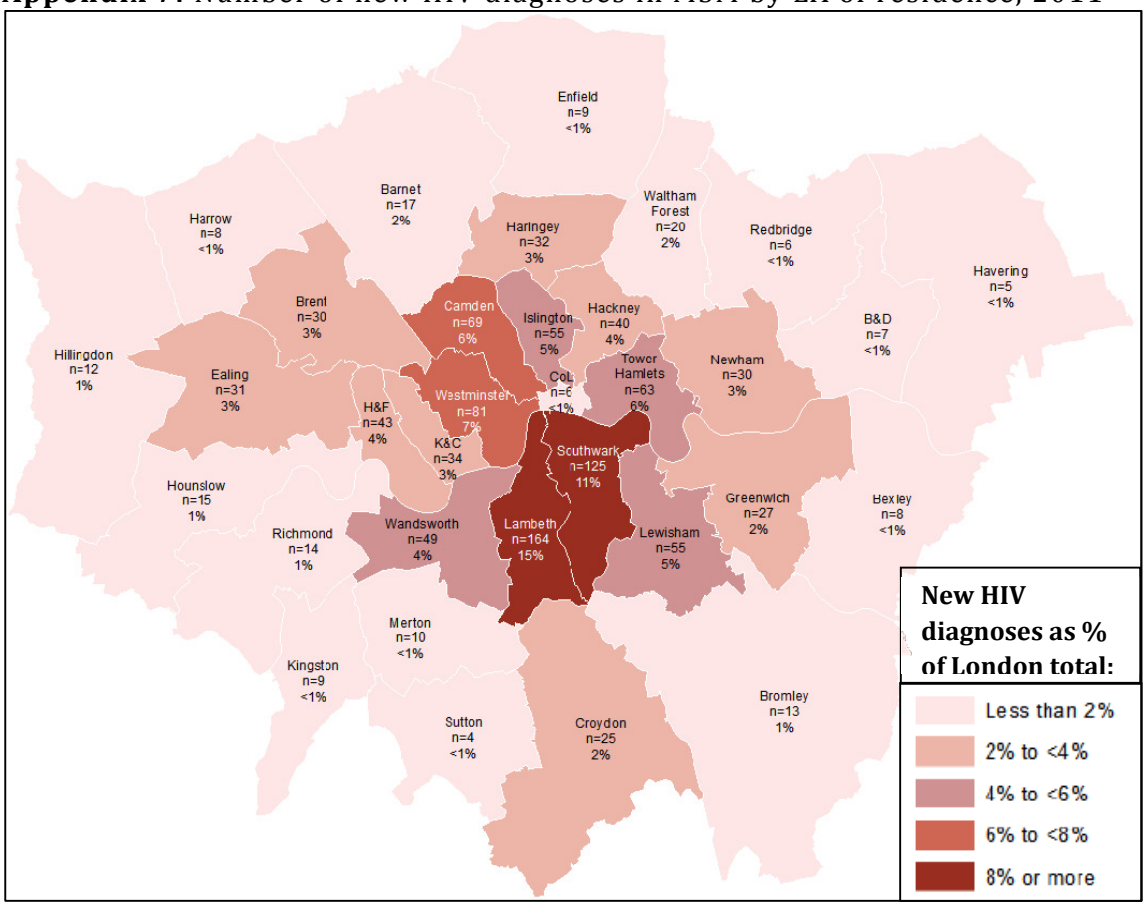
Data source: Public Health England- HIV test uptake and coverage in England, 2009 – 2012 (GUMCAD returns)

Appendix 6: Number of new HIV diagnoses in heterosexuals by LA of residence, 2011



Source: Public Health England

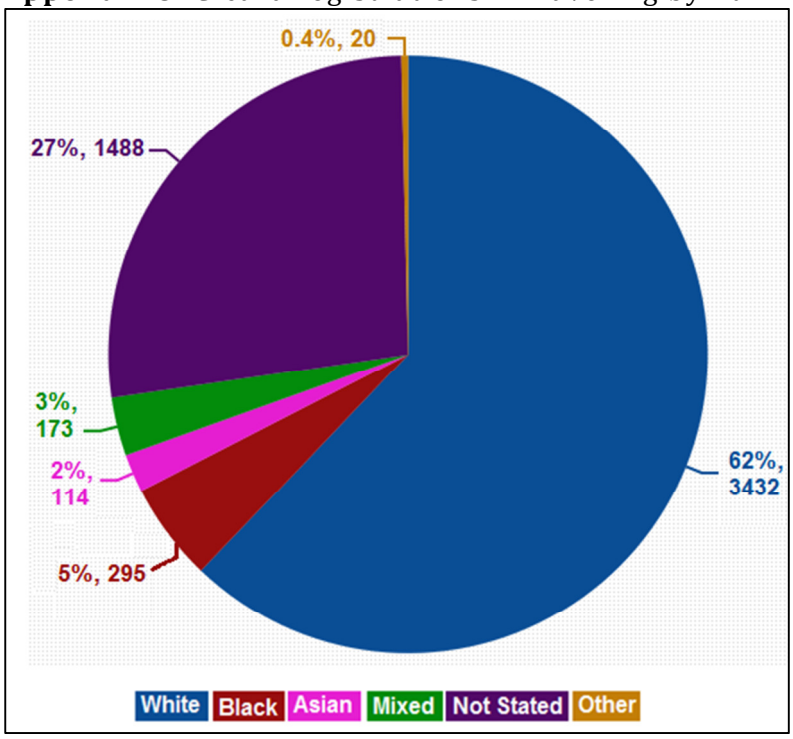
Appendix 7: Number of new HIV diagnoses in MSM by LA of residence, 2011



Source: Public Health England

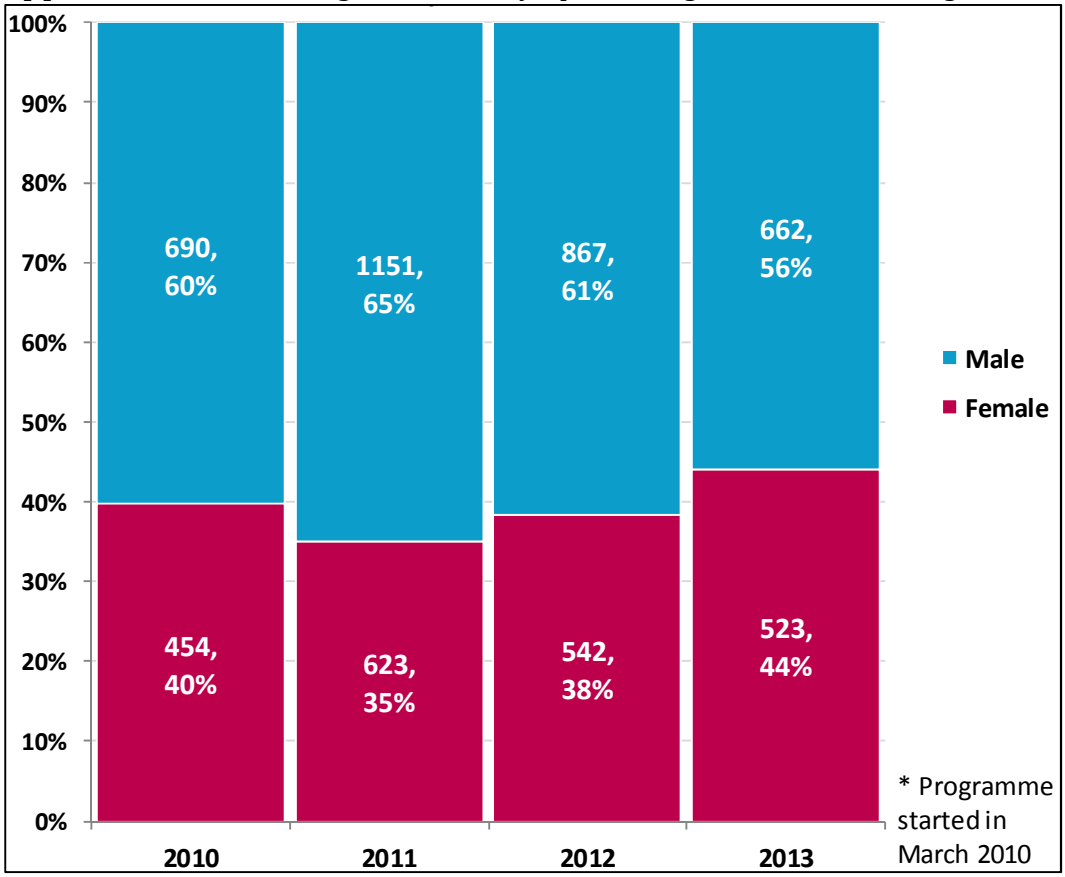
Contraception: Condom Card (C-Card) Scheme, Long-acting reversible Contraception (LARC) & NICE guidelines

Appendix 8: C-card registrations in Havering by Ethnicity, 2010-end of 2013



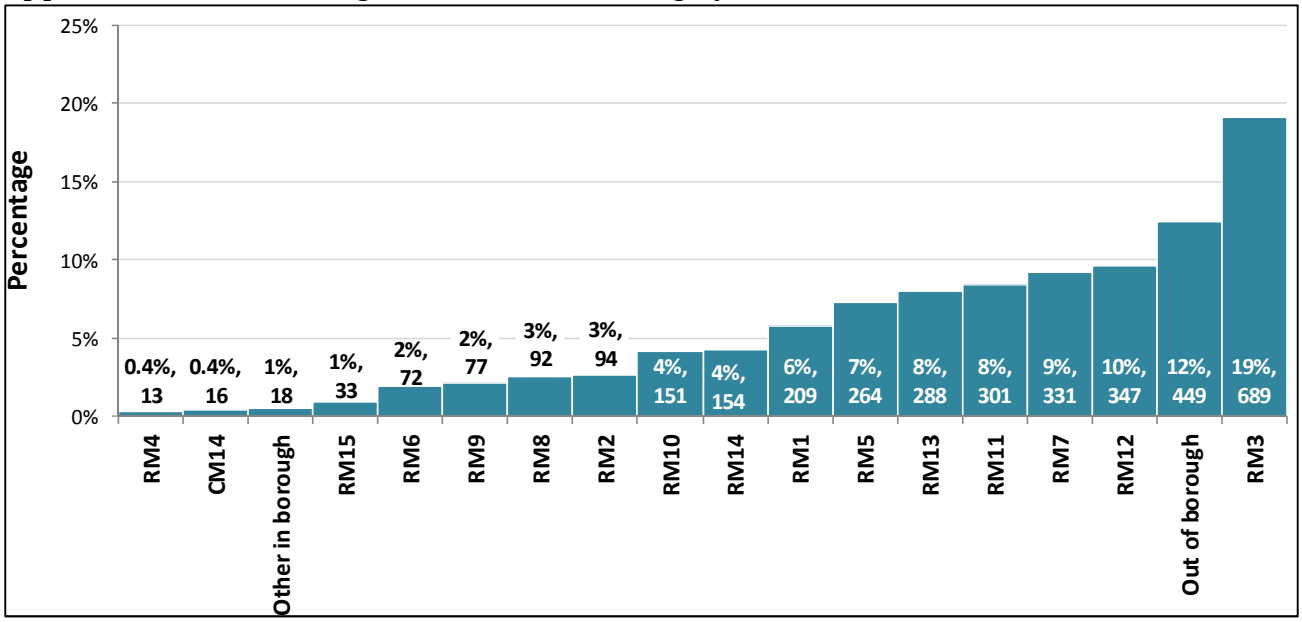
Data source: Havering C-card data, 2010-end of 2013

Appendix 9: C-Card Registrations by specified gender in Havering, 2010-end of 2013



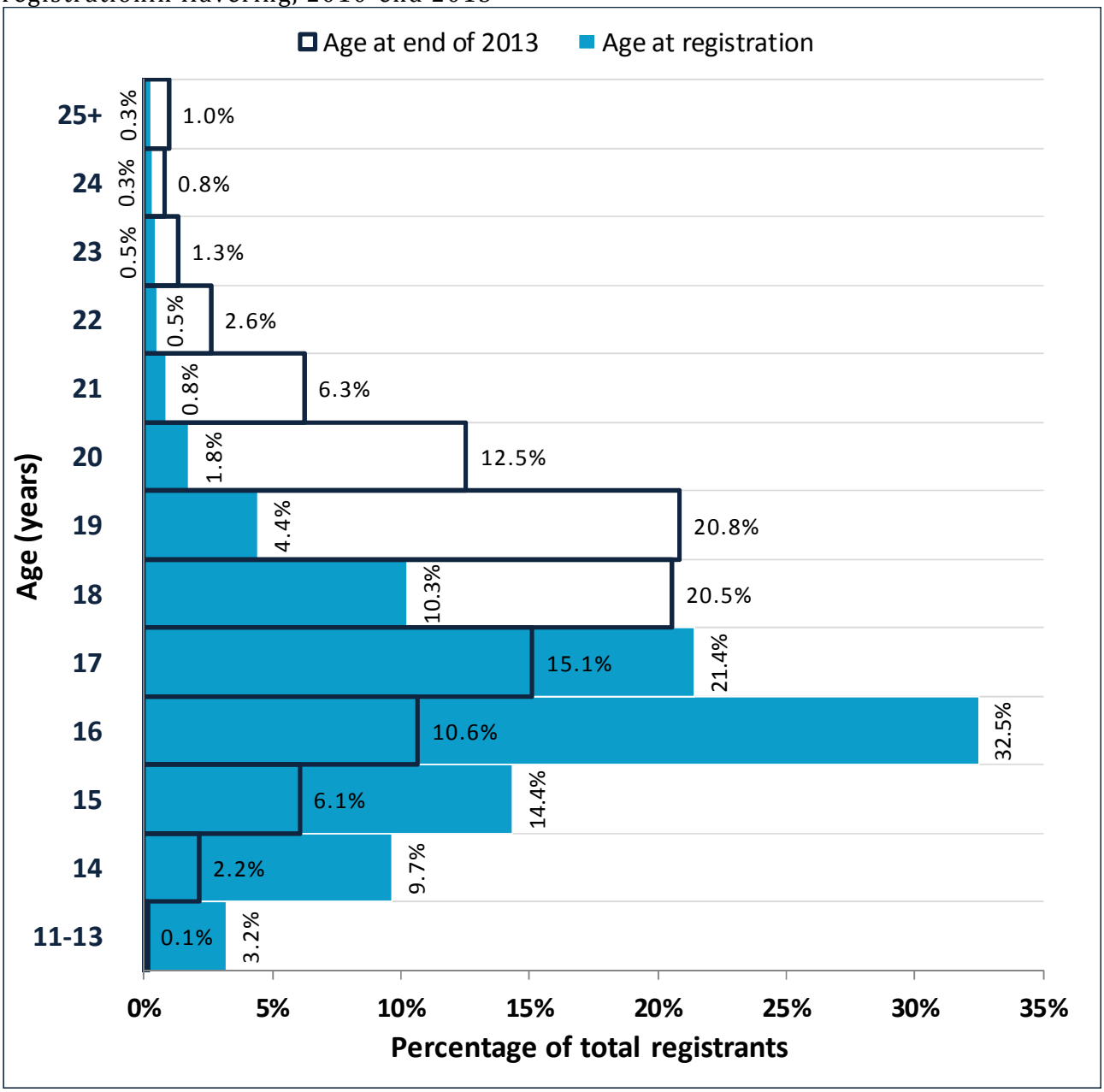
Data source: Havering C-card data, 2010 – end of 2013

Appendix 10: C-Card Registrations in Havering by Postcode, 2010 – end of 2013



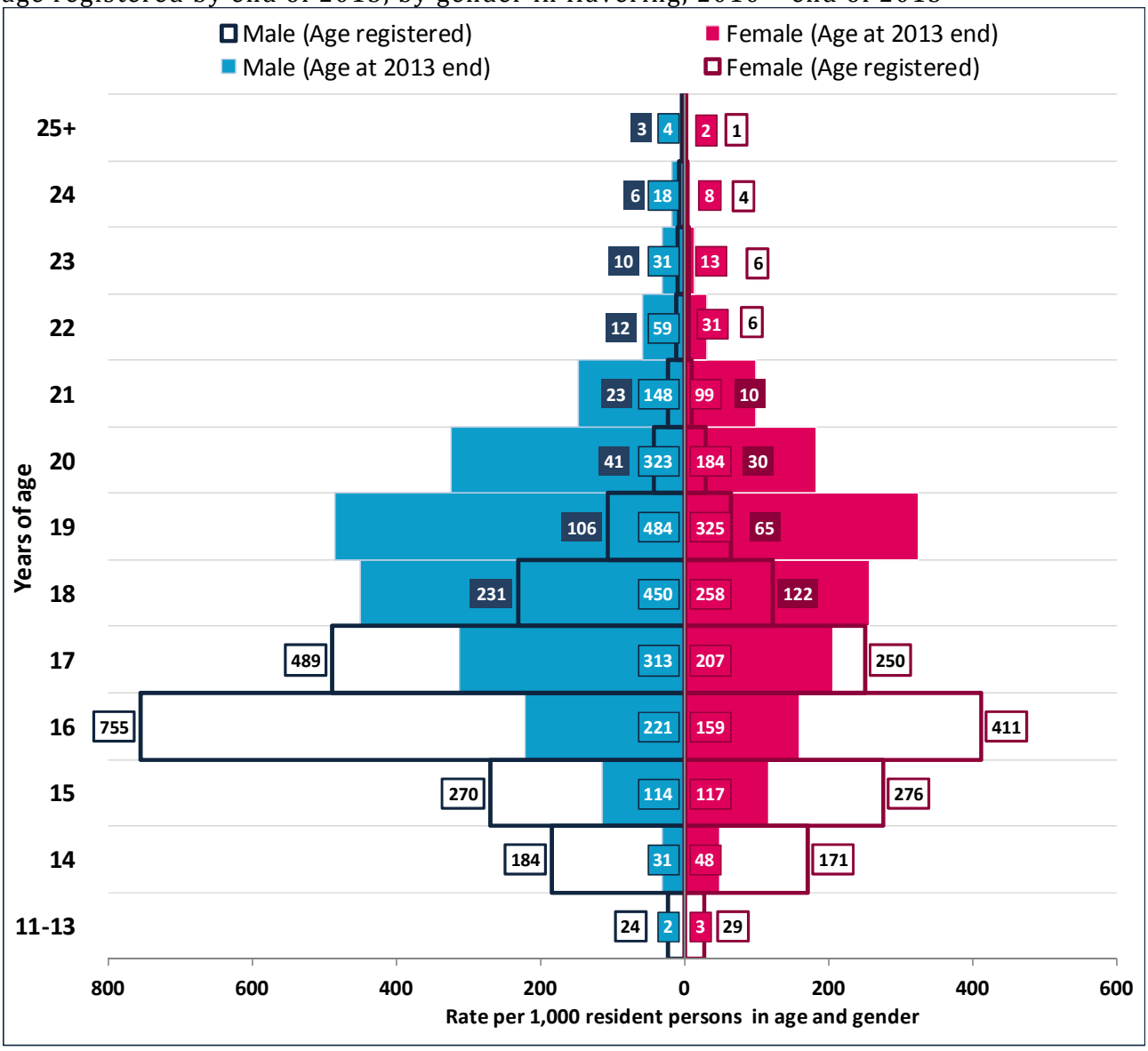
Data source: Havering C-card data, 2010-end of 2013

Appendix 11: Persons registered for C-card by age at end of 2013 and age at registrationin Havering, 2010-end 2013



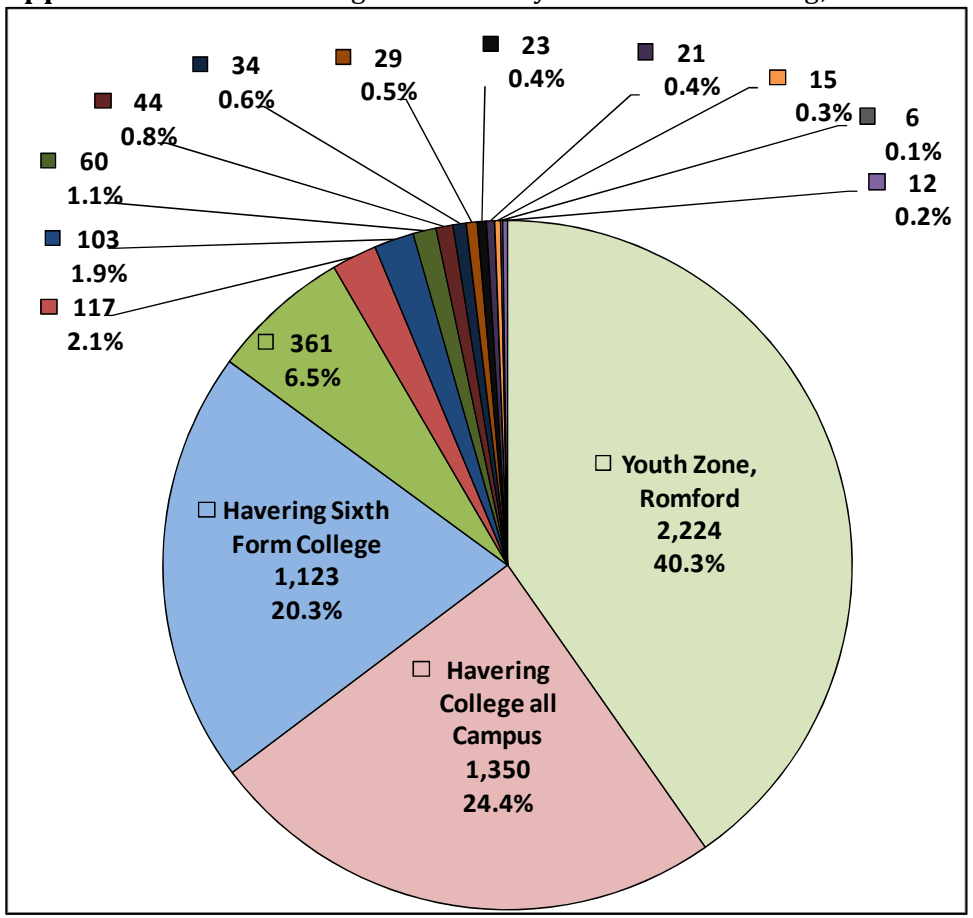
Data source: Havering C-card data, 2010-end of 2013

Appendix 12: Rate, per 1000 residents, C-card registrations by age at end of 2013 and age registered by end of 2013, by gender in Havering, 2010 – end of 2013



Data source: Havering C-card data, 2010-end of 2013

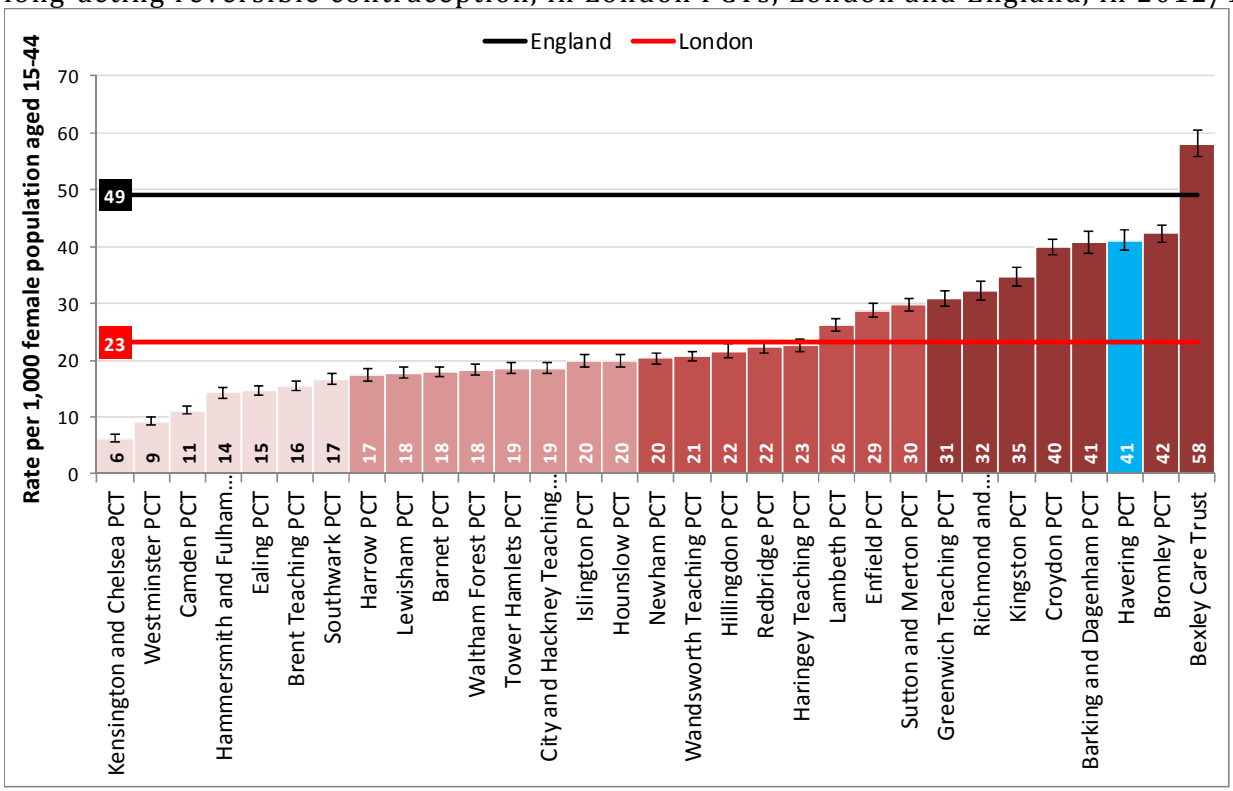
Appendix 13: C-Card registrations by outlet in Havering, 2010- end of 2013



Registration Outlet	Total	Percentage
Youth Zone, Romford	2,224	40.4%
Havering College all Campus	1,350	24.5%
Havering Sixth Form College	1,123	20.4%
Hilldene Information Shop	361	6.6%
My Place	117	2.1%
Young Addaction	103	1.9%
Robert Beard Youth House	60	1.1%
YMCA	44	0.8%
Leaving Care, Romford	34	0.6%
Lloyds Pharmacy	29	0.5%
MIM Pharmacy	23	0.4%
Chippenham Road Childrens Centre	21	0.4%
Royals Youth Centre, Rainham	15	0.3%
Century House	6	0.1%
Others	12	0.2%

Data source: Havering C-card data, 2010- end of 2013

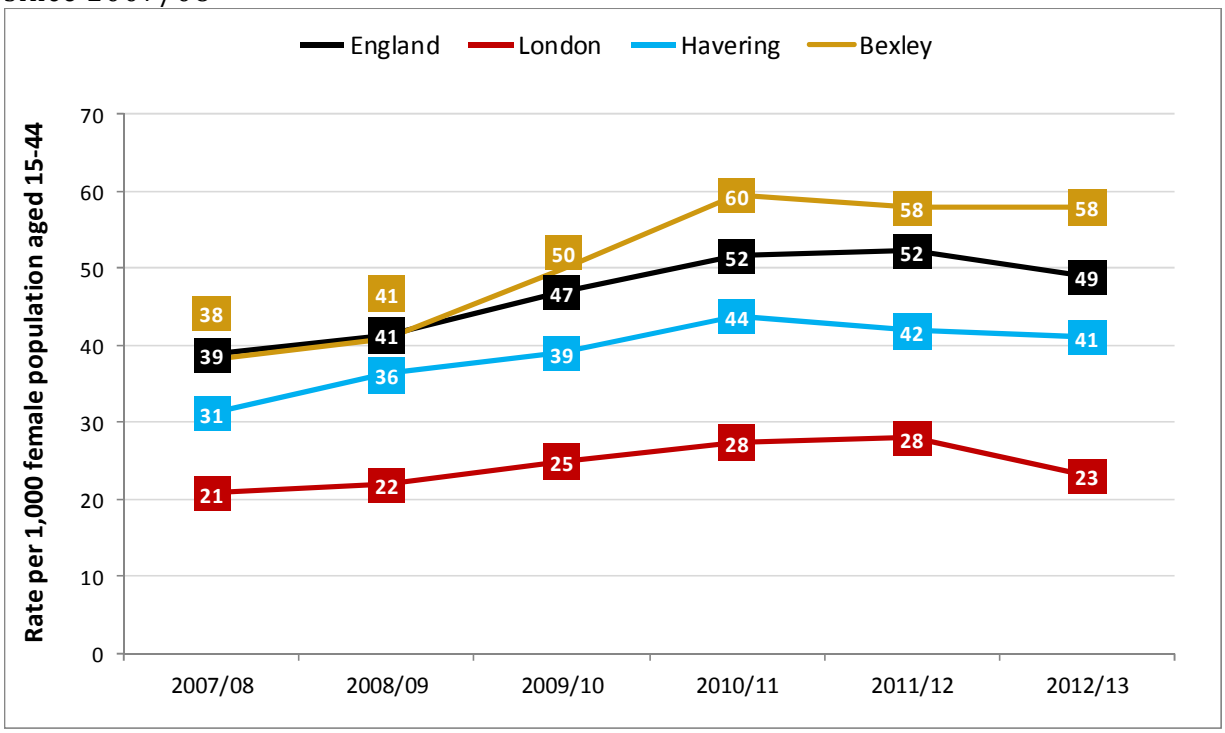
Appendix 14: Rate, per 1,000 relevant female population aged 15-44, of GP prescribed long-acting reversible contraception, in London PCTs, London and England, in 2012/13



Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

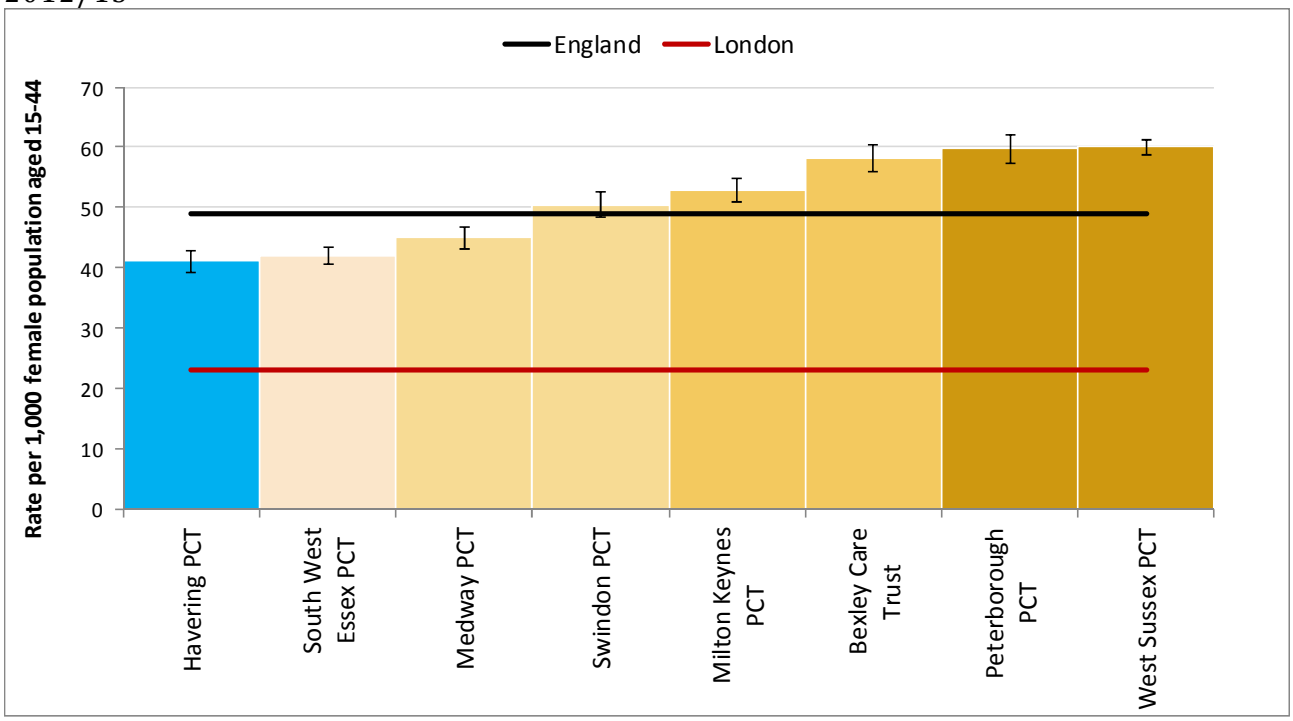
- The rate of prescribed LARC (per 1,000 women aged 15-44) has increased from 2007/08 to 2012/13 by 32%. But remains significantly lower than England rate, unlike a statistically similar neighbour (Bexley) that is significantly higher

Appendix 15: Rate, per 1,000 relevant female population aged 15-44, of GP prescribed long-acting reversible contraception, in Havering PCT, Bexley PCT, London and England, since 2007/08



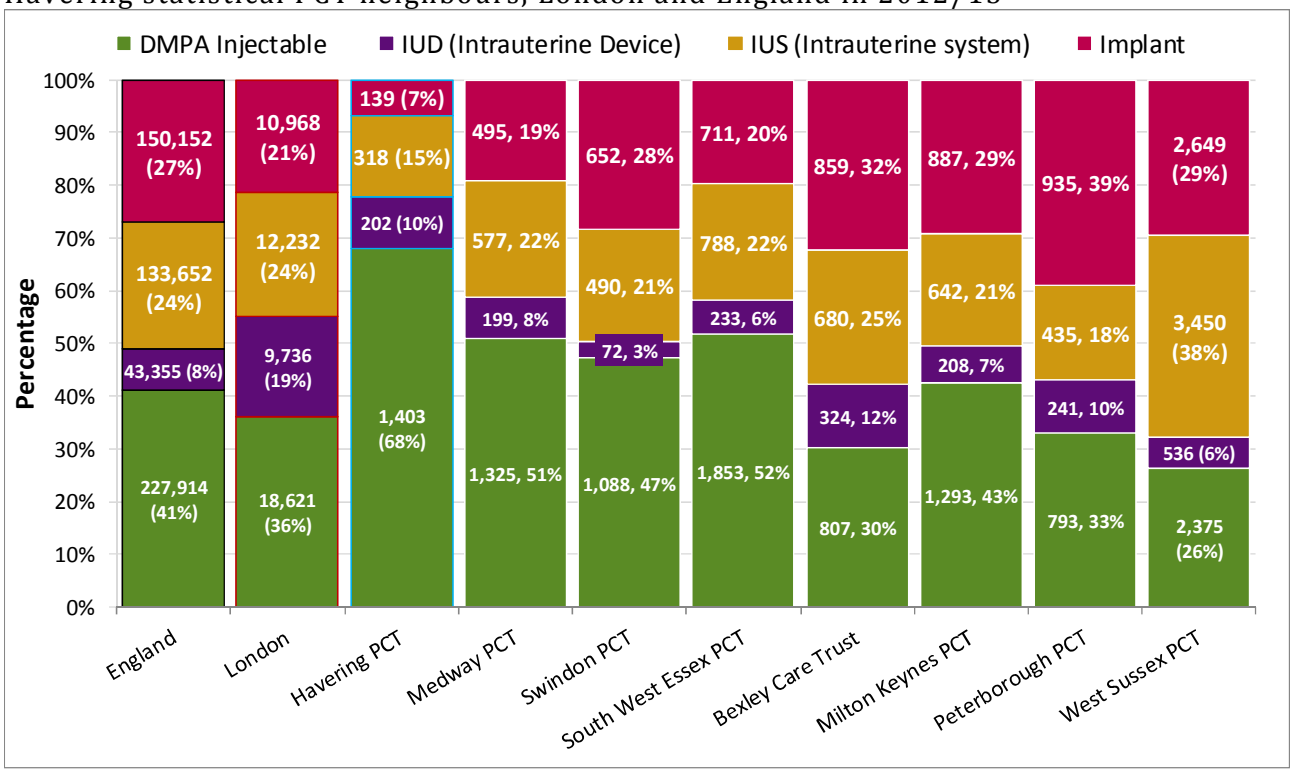
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 16: Rate, per 1,000 relevant female population aged 15-44, of GP prescribed long-acting reversible contraception, in Havering and statistical PCT neighbours, in 2012/13



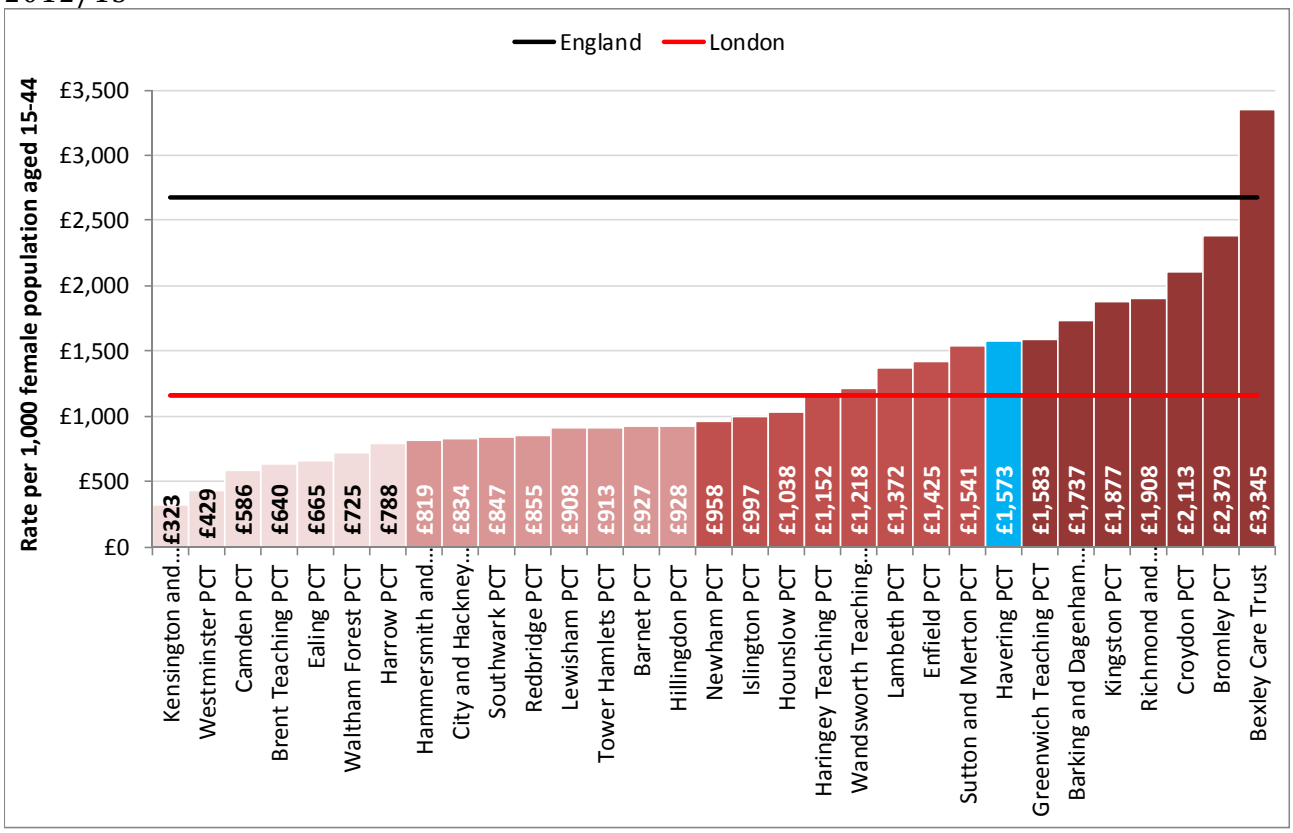
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 17: Count of GP prescribed long-acting reversible contraception by type, in Havering statistical PCT neighbours, London and England in 2012/13



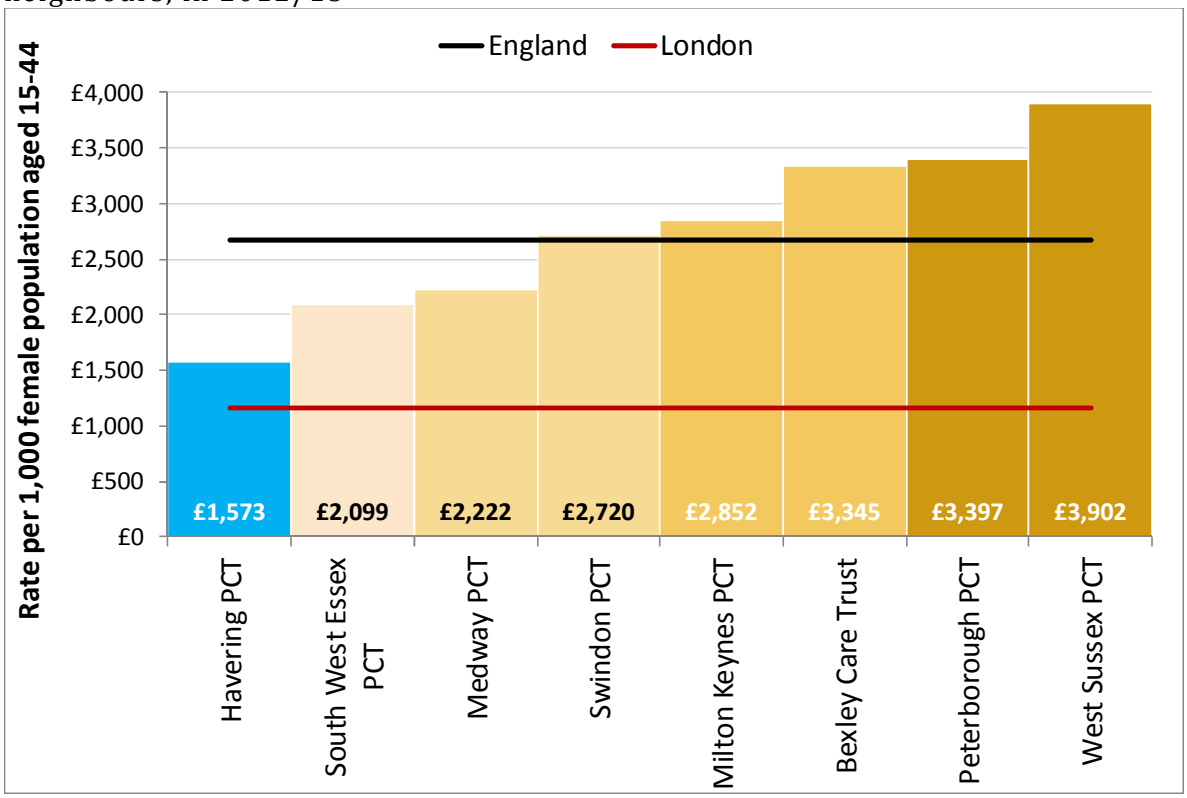
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 18: Rate, per 1000 registered female population aged 15-44, of cost of GP prescribed long-acting reversible contraception in London PCTs, London and England, in 2012/13



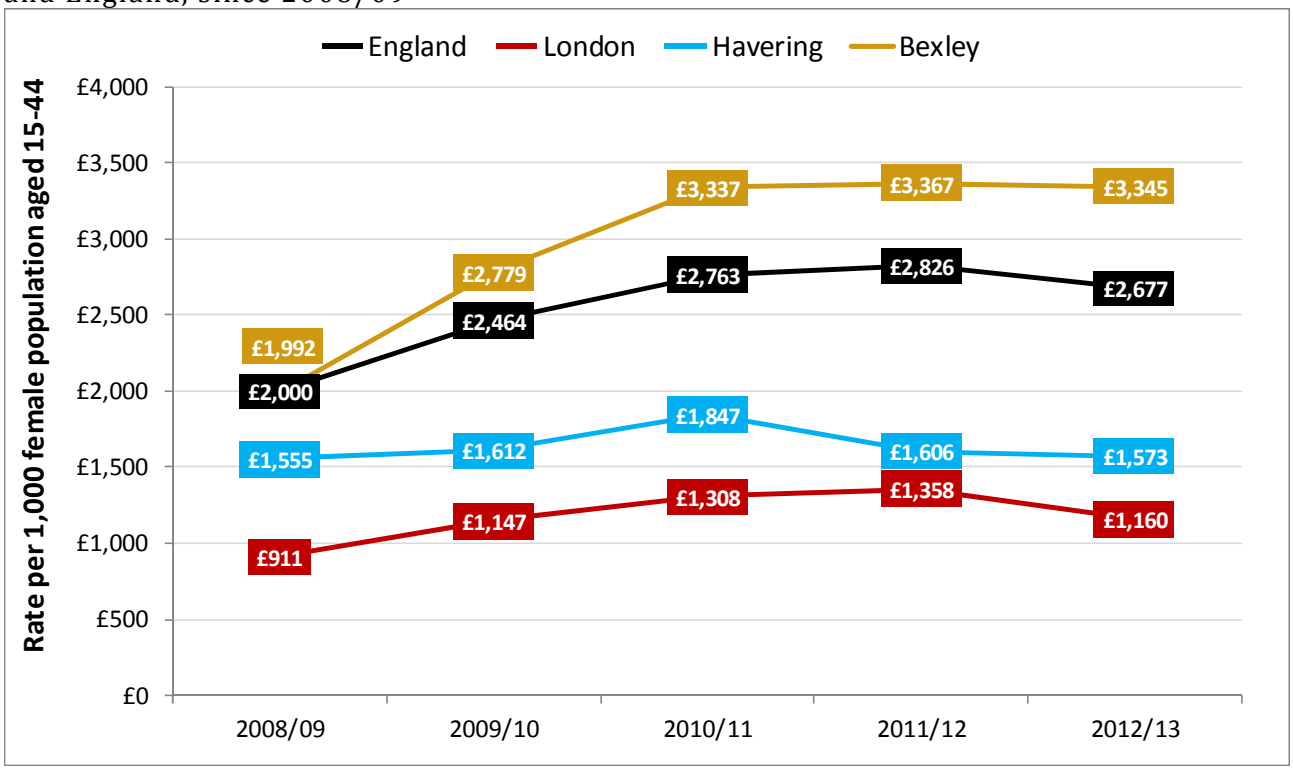
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 19: Rate, per 1000 registered female population aged 15-44, of cost of GP prescribed long-acting reversible contraception, in Havering and statistical PCT neighbours, in 2012/13



Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 20: Rate, per 1000 registered female population aged 15-44, of cost of GP prescribed long-acting reversible contraception, in Havering PCT, Bexley PCT, London and England, since 2008/09



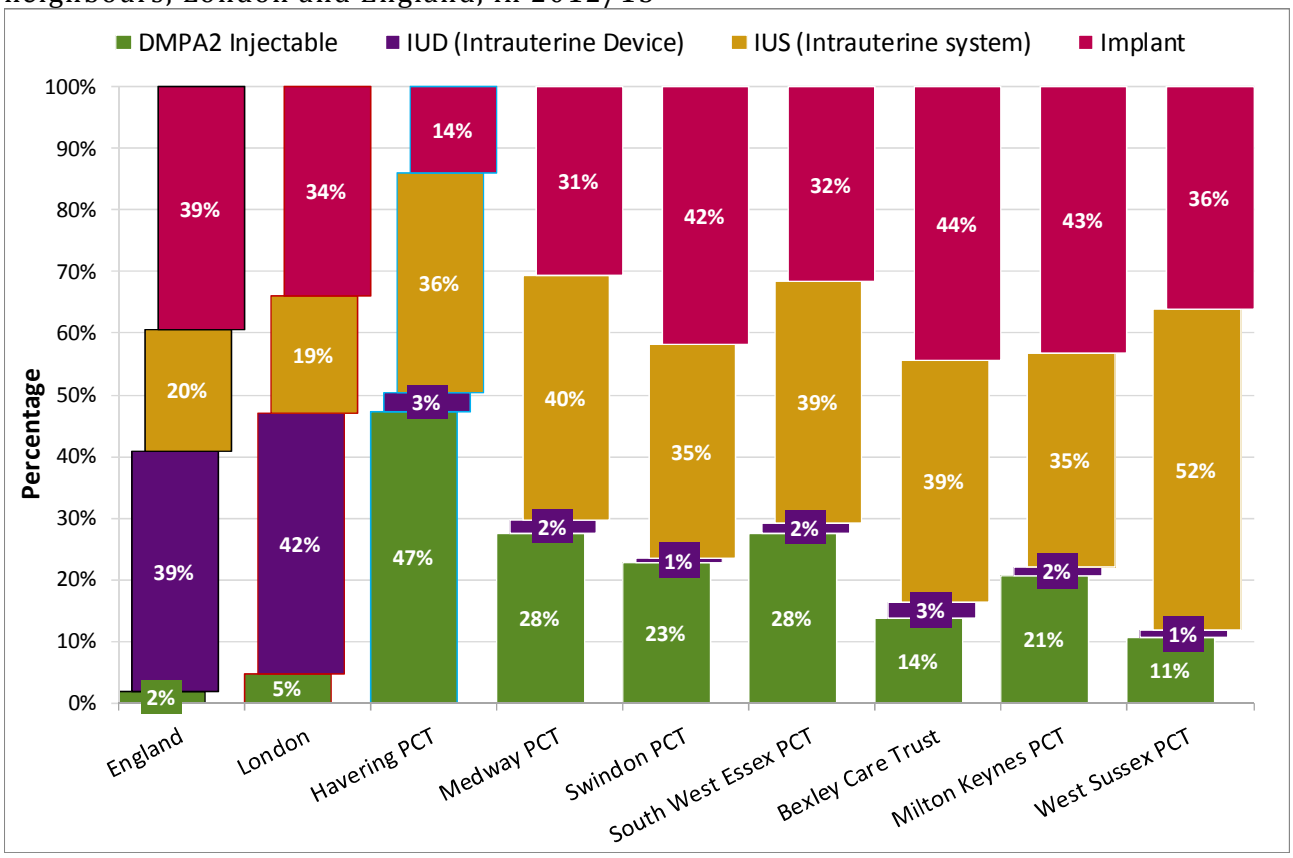
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 21: Rate, per 1000 registered female population aged 15-44, of cost of GP prescribed long-acting reversible contraception by type, in Havering, statistical PCT neighbours, London and England, in 2012/13

Area/Organisation	DMPA Injectable	IUD (Intrauterine Device)	IUS (Intrauterine system)	Implant	Total
England	£5,964,815	£527,209	£11,860,111	£11,945,936	£30,298,071
London	£495,572	£122,929	£1,088,559	£874,457	£2,581,518
Havering PCT	£37,382	£2,440	£28,160	£11,045	£79,027
Medway PCT	£35,333	£2,766	£50,864	£39,333	£128,296
Swindon PCT	£28,265	£803	£43,296	£51,887	£124,251
South West Essex PCT	£49,372	£3,027	£69,872	£56,576	£178,846
Bexley Care Trust	£20,993	£4,269	£60,280	£68,256	£153,798
Milton Keynes PCT	£33,686	£2,491	£56,672	£70,481	£163,330
West Sussex PCT	£62,378	£6,355	£306,152	£210,569	£585,454

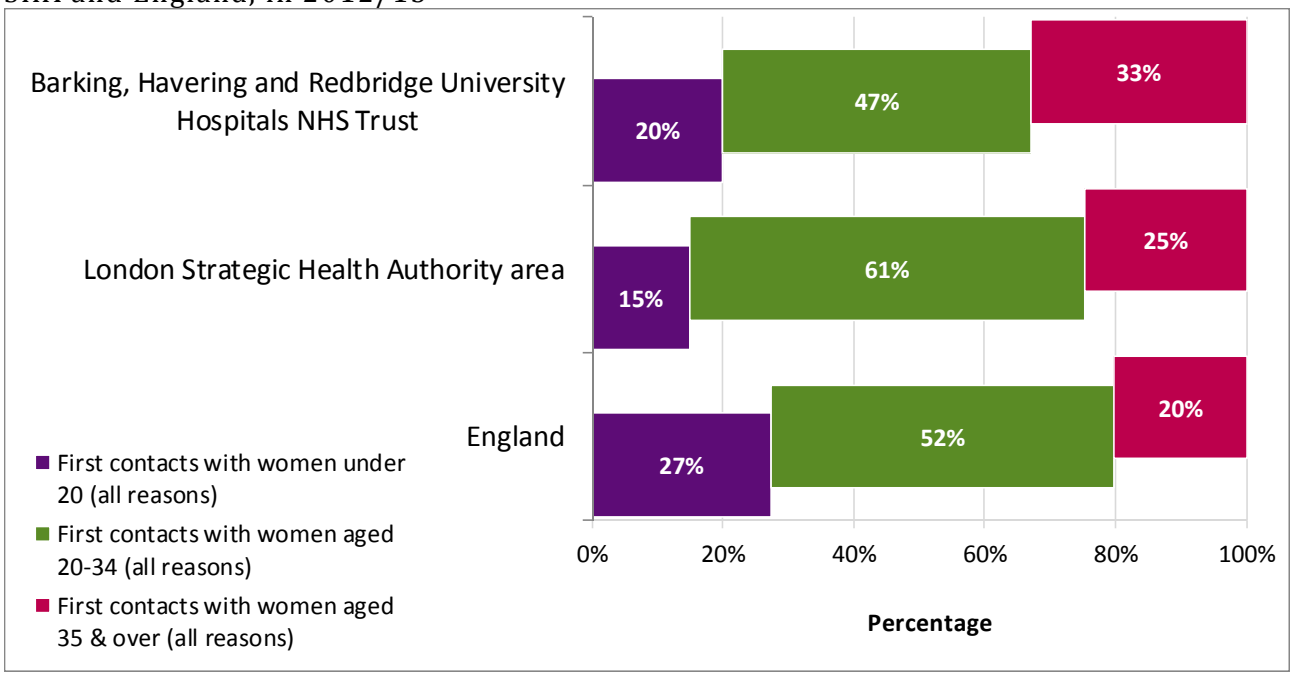
Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 22: Rate, per 1000 registered female population aged 15-44, of cost of GP prescribed long-acting reversible contraception by type, in Havering, statistical PCT neighbours, London and England, in 2012/13



Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 23: Percentage of total first contacts with women by age, in BHRUT, London SHA and England, in 2012/13



Data source: Sexual Health Scorecard/Fingertips Sexual and Reproductive Health Profiles, 2012/13

Appendix 24: NICE Guidance/Recommendations Contraceptive Services for under 25

Recommendations	Who to take action?	What action to be taken?
Assessing local need and capacity to target services	Health and wellbeing boards, local authority commissioners Directors of Public Health and children's services. JSNA lead and analytics team. Managers of contraceptive services in primary and acute care, the voluntary and private sectors. Public health practitioners with a responsibility for contraception and sexual health.	• Use evidence and intelligence to develop services to meet the demonstrated need. • Commissioners, with support from members of local public health networks, should use anonymised local health data and routinely collected surveillance data on. • Map the current range of local services, service activity levels and capacity across all contraceptive service providers. (Take account of services further afield that may be used by local young people, for example, large pharmacies in nearby town centres.) The mapping should include, but should not be limited to:
Commissioning coordinated and comprehensive services	Health and wellbeing boards and commissioners in local authorities and clinical commissioning groups with responsibility for hospital, community, education-based and primary care contraceptive services. Primary care, maternity and young people's services and pharmacies. Contraceptive services provided by NHS, voluntary and private sector organisations.	• Identify priorities and targets based on local need, using tools such as health equity audit and equality impact assessment. • Use Commissioning for Quality and Innovation (CQUIN) indicators and other arrangements and processes to improve the uptake of effective methods of contraception, as appropriate. • Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live. • Provide contraceptive services within genitourinary medicine and sexual health clinics, either as part of that clinic's services or by hosting contraceptive services provided by another organisation. • Ensure all contraceptive services (including those provided in general practice) meet, as a minimum requirement, the “You're welcome” quality criteria. They should also meet the Service standards for sexual and reproductive healthcare specified by the Faculty of Sexual and Reproductive Healthcare. In addition, services should follow clinical guidance on contraceptive choices for young people.

Recommendations	Who to take action?	What action to be taken?
		• Develop joint commissioning of needs-led contraceptive services for young people. This should include coordinated and managed service networks. It should also include comprehensive referral pathways that include abortion, maternity, genitourinary medicine, pharmacy and all other relevant health, social care and children's services. Referral pathways should also cover youth and community services, education, and services offered by the voluntary and private sectors. • Ensure pharmacies, walk-in centres and all organisations commissioned to provide contraceptive services (including those providing oral emergency contraception).
Providing contraceptive services for young people	Managers, doctors, midwives, nurses, pharmacists, receptionists and other staff working in contraceptive services, including those offered in education, GP services, pharmacies, maternity and postnatal care services, walk-in centres, acute and emergency care, and the voluntary and private sectors.	Doctors, nurses and pharmacists should: •offer culturally appropriate, confidential, non-judgmental, empathic advice and guidance according to the needs of each young person •set aside adequate consultation time to encourage young people to make an informed decision, according to their needs and circumstances •Provide information about the full range of contraceptives available, including emergency contraception (both oral and intrauterine) and long-acting reversible contraception (LARC). •Provide free and confidential pregnancy testing with same-day results and, if appropriate, offer counselling or information about where to obtain free counselling •Assess the risk of an STI, advise testing if appropriate, and provide information about local STI services. •Service managers, with the support of doctors, nurses and other staff, should offer services that: •are flexible, for example, offer out-of-hours services at weekends and in the late afternoon and evening •are available both without prior appointment (drop-in) and by appointment in any given area provide appointments within 2 working days •are open to young people aged under 16 who present for any service without a parent or carer. •working with school and college governors, head teachers, college principals and personal, social, health and economic (PSHE) education lead teachers.
Tailoring services for socially disadvantaged	Service managers and staff working in contraceptive services.	• Provide additional support for socially disadvantaged young people to help them gain immediate access to contraceptive services and to

Recommendations	Who to take action?	What action to be taken?
young people	This includes doctors, nurses and pharmacists.	support them, as necessary, to use the services. This could include providing access to trained interpreters or offering one-to-one sessions. It could also include introducing special facilities for those with physical and sensory disabilities and assistance for those with learning disabilities. • Encourage and help young mothers (including teenage mothers) to use contraceptive services, for example, by working with family nurse partnerships or children's centres. • Offer support and referral to specialist services (including counselling) to those who may need it. • Provide outreach contraceptive services that offer information, advice, and the full range of options. This includes provision for those living in rural areas who cannot reach existing clinics and services. • Offer culturally appropriate, confidential, non-judgmental, empathic advice and support tailored to the needs of the young person.
Seeking consent and ensuring confidentiality	Managers and staff, including receptionists and administrators, working in services that provide contraception and contraceptive advice to young people. This includes education, maternity services, pharmacies and voluntary and private sector organisations. Managers and staff in children's services, social care organisations and young people's advisory and support services. This includes guardians, chaperones, interpreters and advocates.	• Ensure staff are trained to understand the duty of confidentiality. • Ensure staff are familiar with best practice guidance on how to give young people aged under 16 years contraceptive advice and support. Ensure they are also familiar with local and national guidance on working with vulnerable young people. • Ensure those providing contraceptive services can assess the competence of young people aged under 16 to consent to receiving contraceptive advice and any treatment that may involve. They should also be able to assess the competence of other young people who may be vulnerable, for example, those with learning disabilities. • Ensure young people understand that their personal information and the reason why they are using the service will be confidential. Even if it is decided that a young person is not mature enough to consent to contraceptive advice and treatment, the discussion should remain confidential. • Reassure young people that they will not be discussed with others without their explicit consent. Explain that sharing information with another professional may be necessary if there are concerns, for example to protect a young person from possible harm or abuse. If this is the case, the young person should be told who needs to be informed and why. • Ensure the organisation's confidentiality and complaints policy is prominently displayed in

Recommendations	Who to take action?	What action to be taken?
		waiting and reception areas, and is in a format that is appropriate for all young people. • Ensure staff are adequately supported and supervised.
Providing contraceptive services after a pregnancy	Midwives, obstetricians and all those working in maternity and postnatal care services. GPs, health visitors, pharmacists, school nurses and other health professionals working in contraceptive services, primary and community services, family nurse partnerships and acute and emergency care.	• Midwives should discuss with pregnant women what type of contraception they intend to use after their pregnancy. • After pregnancy, midwives should check that women have chosen a method of contraception. If not, they should offer contraceptive advice on a range of effective methods tailored to the woman's circumstances and sensitive to any concerns she may have. This includes advice on contraception for women who are breastfeeding. • Midwives should provide women with the contraceptive they want before they are discharged from midwifery services. If this is not possible, they should offer a referral to contraceptive services. • Health visitors, family nurse practitioners and health professionals working with new mothers should check that women have been given advice on contraception and do have contraceptives. Where necessary, they should consider using outreach or home services to provide this support.
Providing contraceptive services after an abortion	GPs and other primary care practitioners. Contraceptive services Abortion services (including those providing early medical abortion). Counsellors working with abortion services.	• Before – and as soon as possible after – an abortion, discuss contraception and explain the full range of contraceptive methods available. Dispel any myths around fertility following an abortion. • Provide contraception to prevent another unintended pregnancy or refer them to contraceptive services for advice and contraception. If appropriate, offer counselling. • If the young woman does not want to be referred on, offer to contact her after her abortion to give advice on the most effective and suitable method of contraception for her, using a communication method of her choice.
Providing school and education-based contraceptive services	Nurses, doctors and counsellors and other professionals working in education-based settings.	• Involve young people in the design, implementation, promotion and review of on-site and outreach contraceptive services in and near schools, colleges and other education settings. • Ensure contraceptive advice, free and confidential pregnancy testing and the full range of contraceptive methods, including both LARC and emergency contraception, is easily available. • Ensure continuity of service, for example by making it clear to young people when and where local services are available during school, college or university holidays. • Ensure services not only provide contraceptives but are staffed by people trained to be respectful and non-judgmental.
Providing	Managers, doctors,	• Establish patient group directions (PGDs) and local

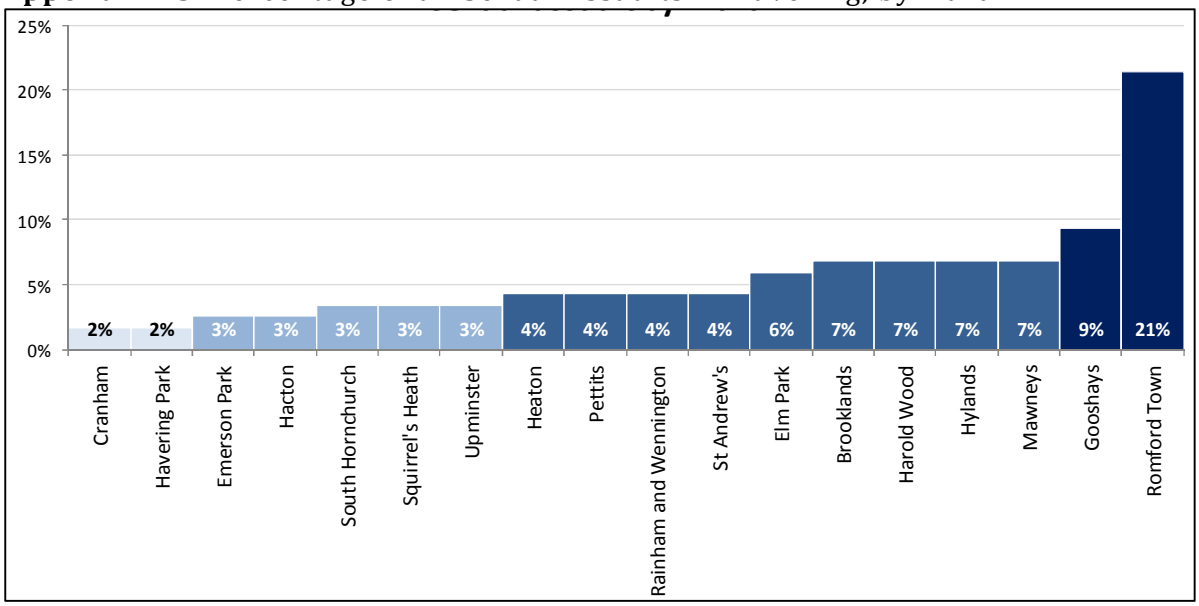
Recommendations	Who to take action?	What action to be taken?
emergency contraception	nurses (including school nurses), pharmacists and reception staff working in: contraceptive services, schools, primary and community care, acute and emergency services, pharmacies, maternity services, walk-in centres and voluntary and private sector health services.	arrangements to ensure all young women can easily obtain free oral emergency contraception. • Ensure young women (and young men) know where to obtain free emergency contraception. • Inform young women that an intrauterine device is a more effective form of emergency contraception than the oral method and can also be used on an ongoing basis. • Ensure young women have timely access to emergency contraception using an intrauterine device. • Ensure all health professionals providing oral emergency contraception are aware that they can provide this to young women aged under 16 without parental knowledge or consent, in accordance with best practice guidance. • Health professionals, including pharmacists, who are unwilling (or unable) to provide emergency contraception should give young women details of other local services where they can be seen urgently.
Providing condoms in addition to other methods of contraception	Managers and staff working in contraceptive services Practitioners with a responsibility for the health and wellbeing of young people in social care and children's services and the voluntary and private sector. Public health specialists, PSHE education and sex and relationships education teachers.	• Advise all young people to use condoms consistently and correctly in addition to other contraception. Condoms should always be provided along with other contraception because they help prevent the transmission of STIs. • Advise them to use a water-based lubricant with a condom if they want or need a lubricant. • Ensure free condoms (including female condoms) are readily accessible
Communicating with young people	Commissioners and providers of contraceptive services. Information service providers including, for example, libraries, job centres, schools, colleges and youth services.	• Use a range of methods, including the latest communication technologies, to provide young people, especially socially disadvantaged young people, with advice on sexual health and contraception. • This could include using: ○ bespoke websites or dedicated pages on social networking sites which enable young people to discuss sensitive issues anonymously ○ NHS websites such as NHS Choices and NHS Direct ○ websites provided by specialist service providers such as Brook or FPA that provide reliable, up-to-date, evidence-based health information and advice (schools and colleges should ensure their firewalls do not block these websites)

Recommendations	Who to take action?	What action to be taken?
		○ telephone helplines offering up-to-date and accurate information and details about local services – for example, 'Ask Brook'. These should, where possible, use local numbers that qualify for free calls as part of many mobile phone contracts. • Ensure information is available in a range of formats. Involve young people in the design of any media and distribution strategies.
Training and continuing professional development	Commissioners and managers of young people's contraceptive services. Primary and community care services, children's services, social services and young people's advisory and support services. Royal colleges and professional associations, further and higher education training boards, and organisations responsible for setting competencies and developing continuing professional development programmes for health professionals, healthcare assistants and support staff	• Managers should ensure all doctors, midwives, nurses, pharmacists and other health professionals working in contraceptive services have received the post-registration training required by their professional body. They should also have evidence to show that they are maintaining their skills and competencies. • Health professionals (including pharmacists) who advise young people about contraception should be competent to help them compare the risks and benefits of the different methods, according to their needs and circumstances. They should also be able to help them understand and manage any common side effects. • Colleges and training organisations should ensure doctors and nurses offering contraceptive services have easy, prompt access to pre- and post-registration theoretical and practical training in all methods of contraception. This includes intrauterine devices and systems and contraceptive implants. • Ensure all support staff who may come into contact with young people, particularly socially disadvantaged young people, are experienced in working with them. This includes being able to communicate with those who have physical or learning disabilities. It also includes being aware of and sensitive to, the needs of young people from different ethnic and faith communities in relation to contraception. • Ensure all support staff who work in contraceptive services with young people receive both formal and on-the-job training in how to offer basic information and advice about contraception. • Ensure all staff working for contraceptive services for young people, including administrative staff, know about the duty of confidentiality and child protection processes and legislation. • Ensure all staff are aware of local contraceptive service referral pathways so that they know how to direct young people to the services they need – whether it is for advice on, or the provision of, contraceptives (including condoms and emergency

Recommendations	Who to take action?	What action to be taken?
		contraception) or abortion services.

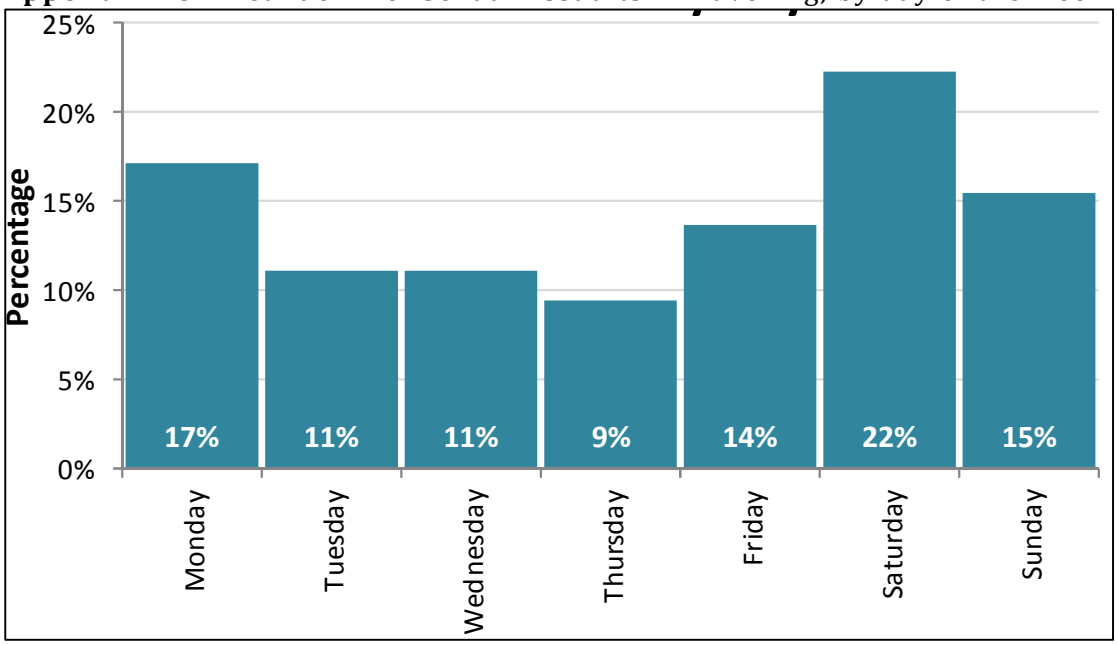
Sexual violence and exploitation: Data from London Ambulance Service & Metropolitan Police, and Nice Guidance

Appendix 25: Percentage of all Sexual Assaults in Havering, by ward



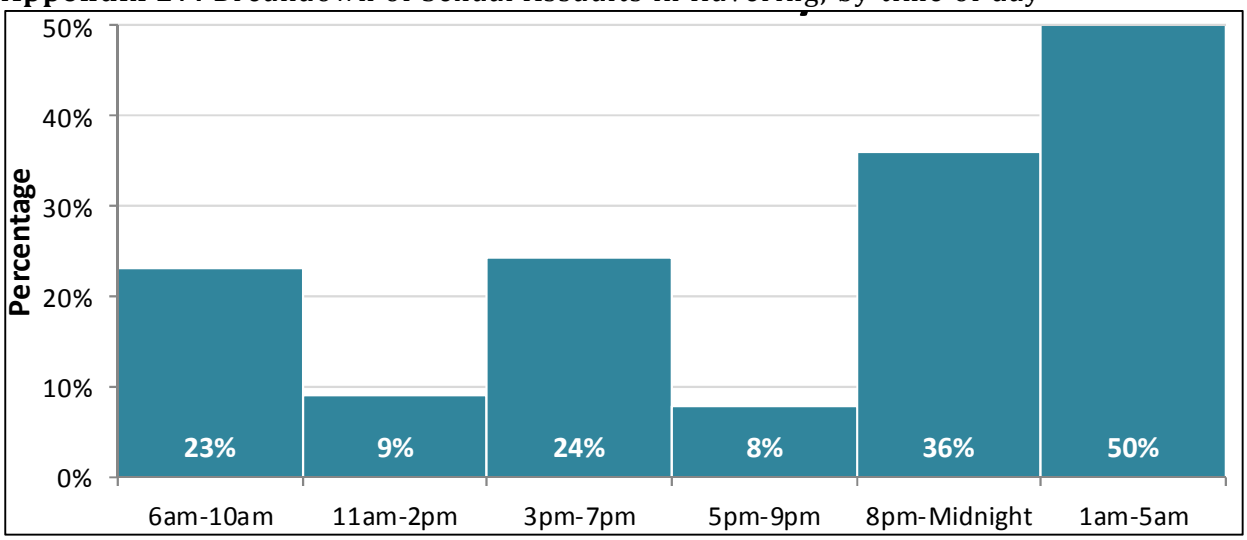
Data source: London Ambulance Service

Appendix 26: Breakdown of Sexual Assaults in Havering, by day of the week



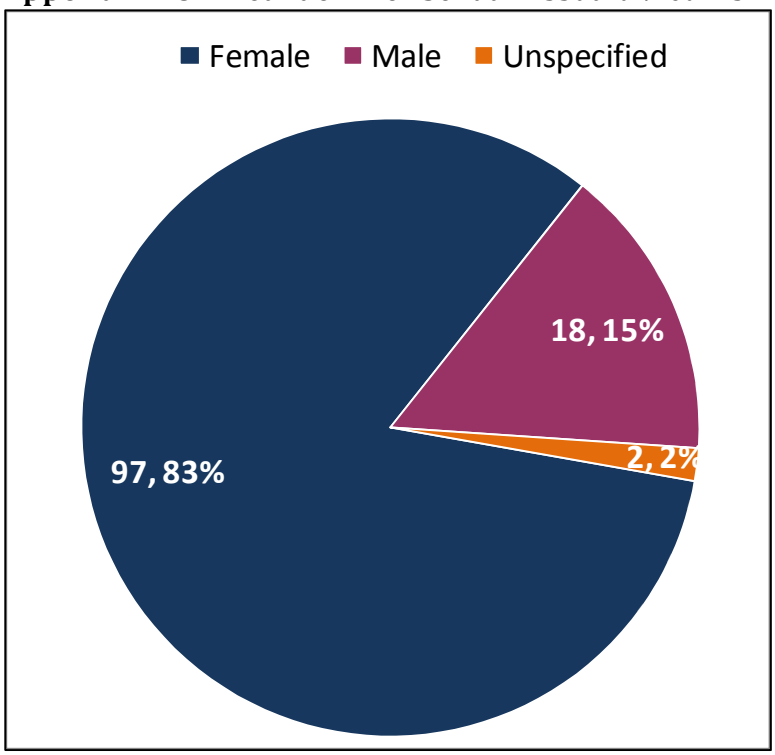
Data source: London Ambulance Service

Appendix 27: Breakdown of Sexual Assaults in Havering, by time of day



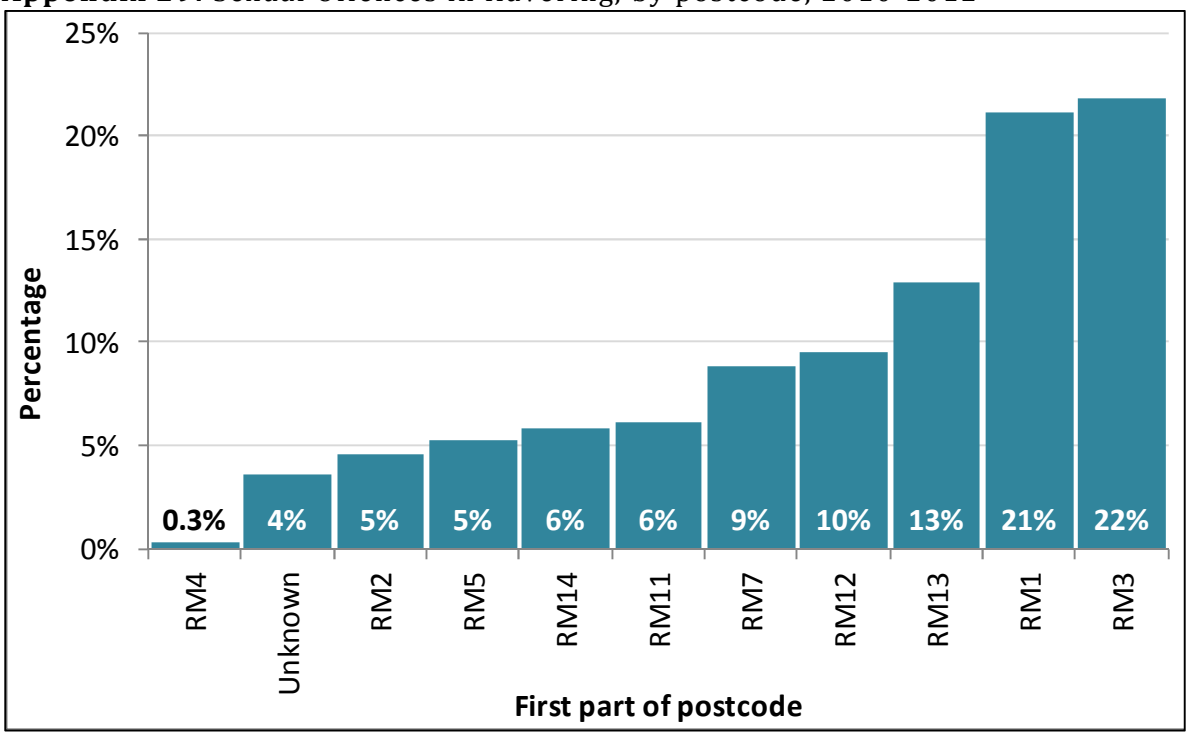
Data source: London Ambulance Service

Appendix 28: Breakdown of Sexual Assualt Victims in Havering, by gender



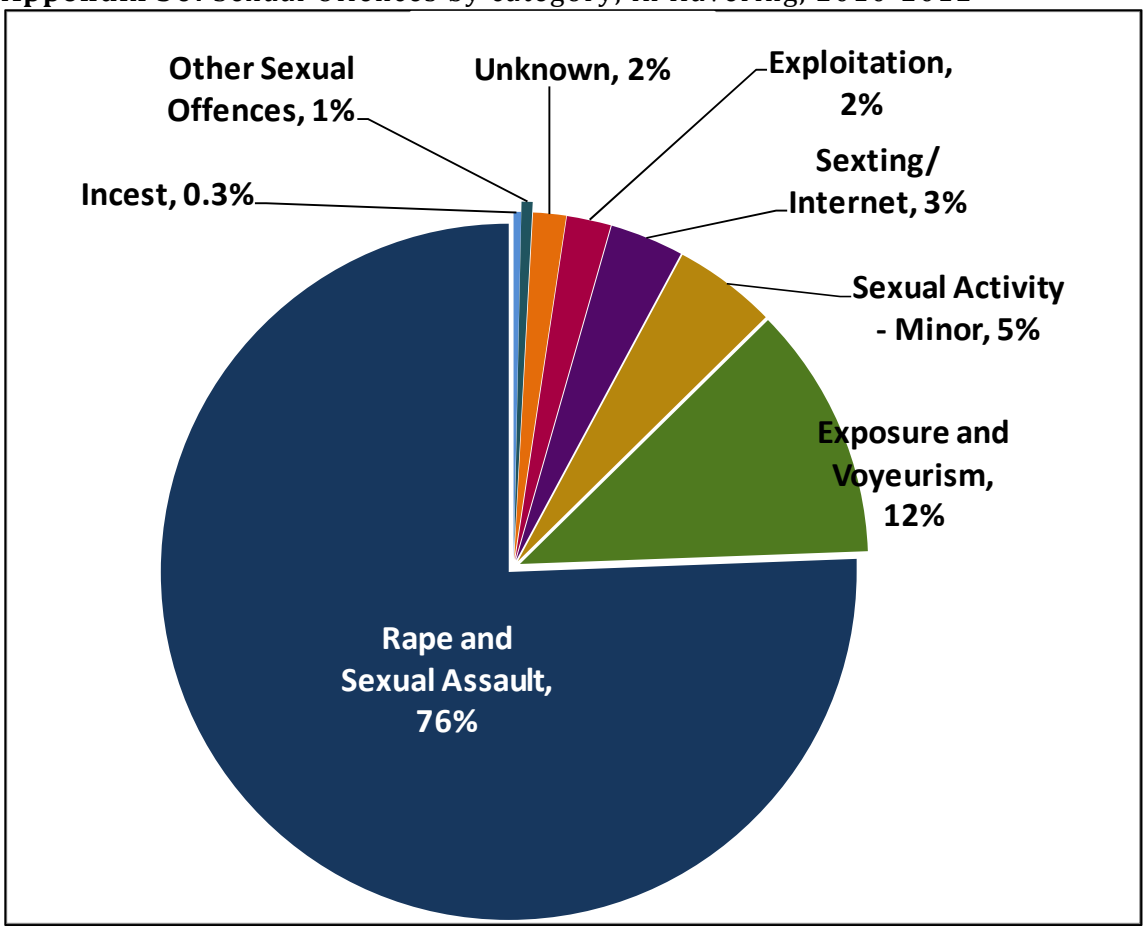
Data source: London Ambulance Service

Appendix 29: Sexual Offences in Havering, by postcode, 2010-2012



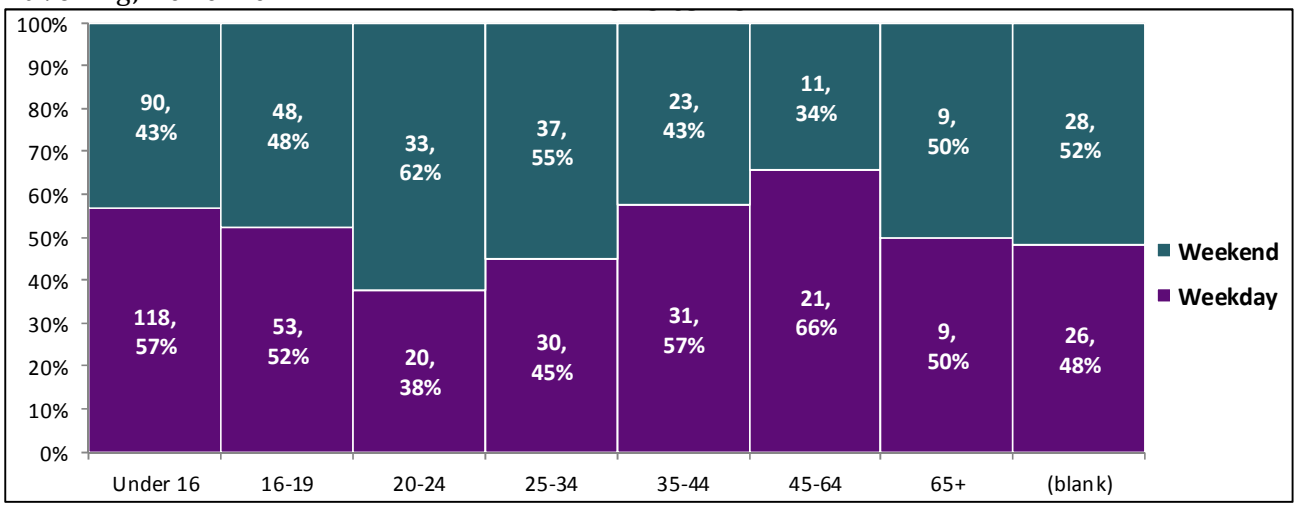
Data source: Metropolitan Police data 2010-2012

Appendix 30: Sexual Offences by category, in Havering, 2010-2012



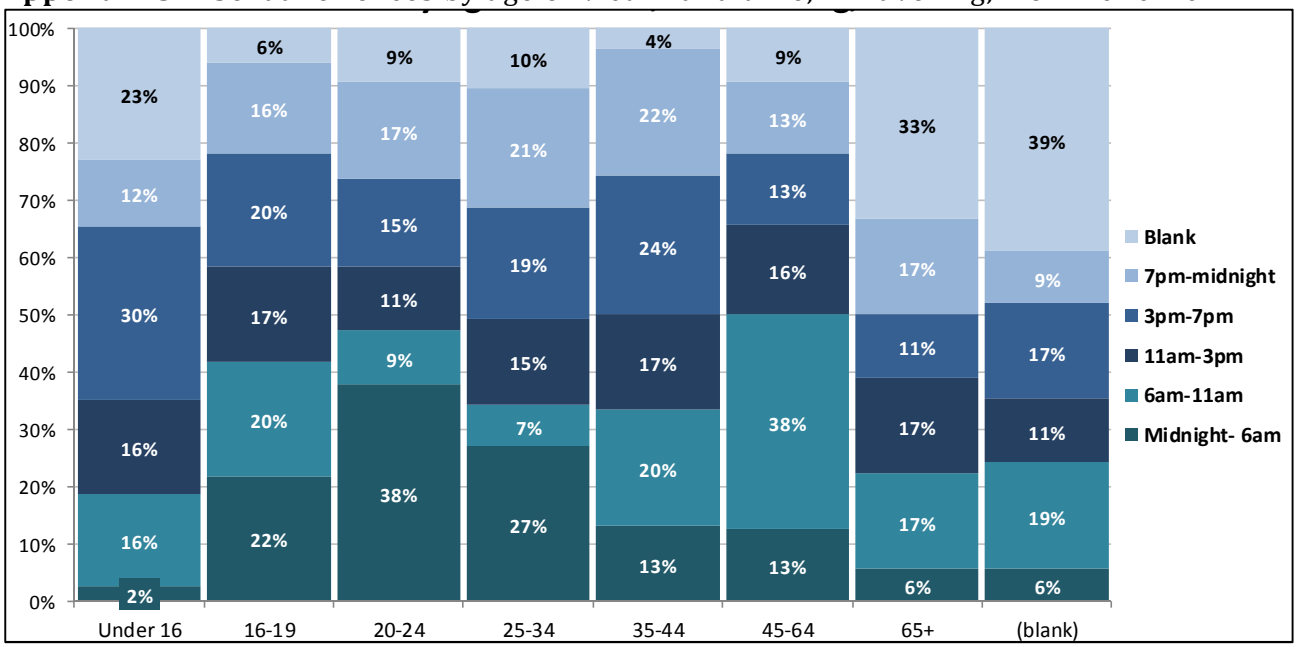
Data source: Metropolitan Police data 2010-2012

Appendix 31: Sexual Offences by age of victim and weekday/weekend distribution, in Havering, 2010-2012



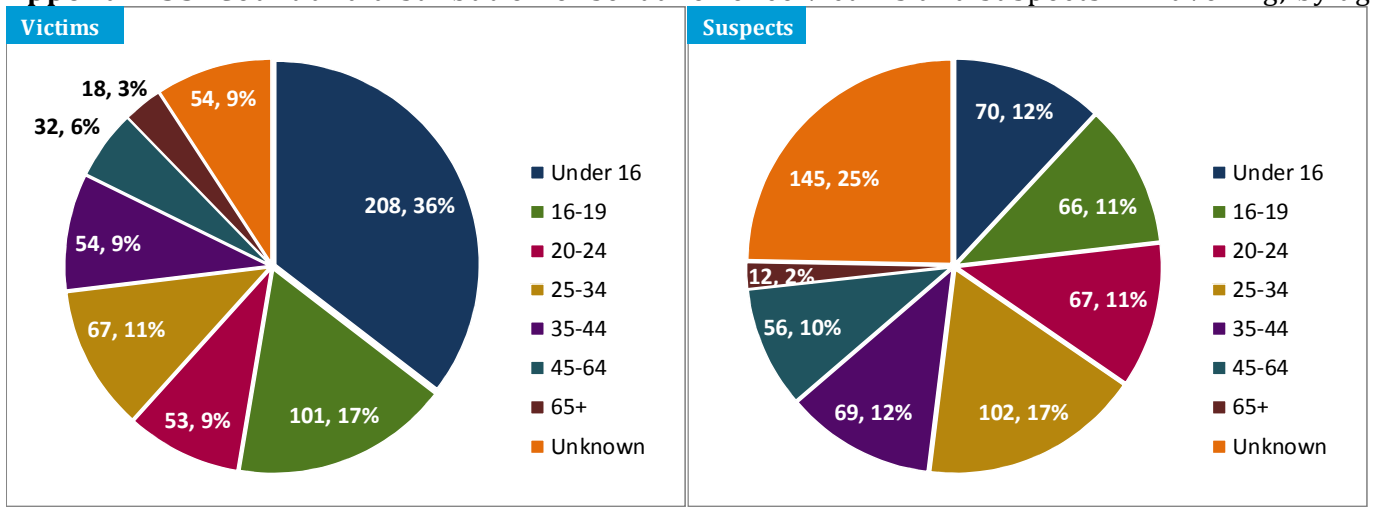
Data source: Metropolitan Police data 2010-2012

Appendix 32: Sexual offences by age of victim and time, in havering, from 2010-2012



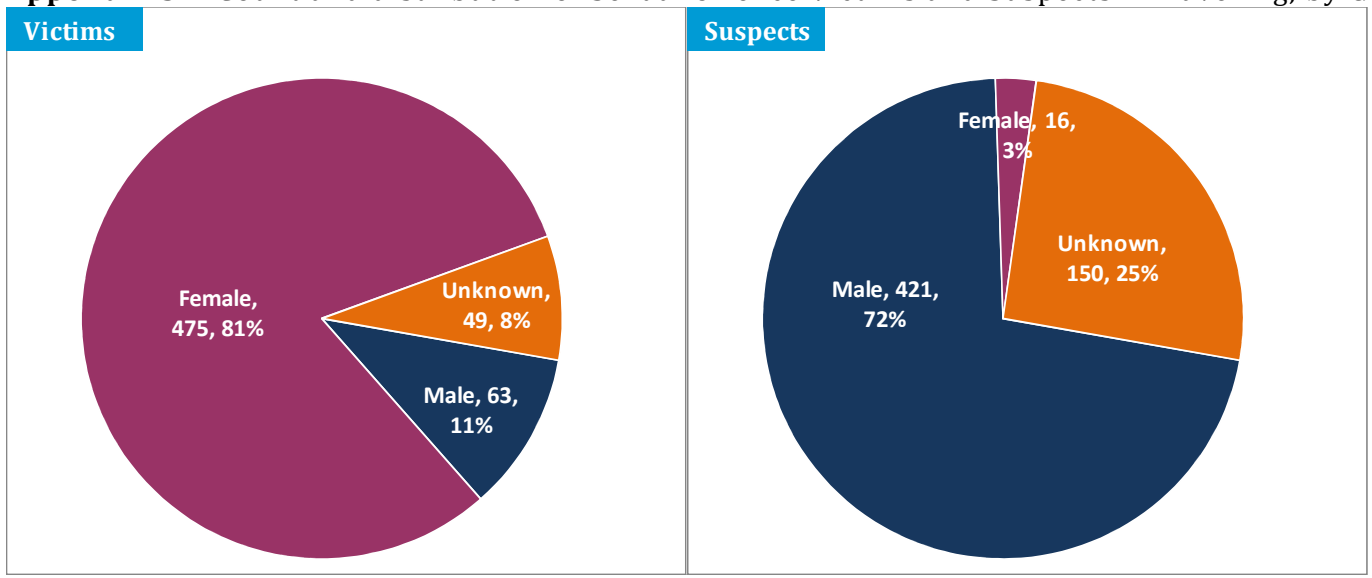
Data source: Metropolitan Police data 2010-2012

Appendix 33: Count and distribution of sexual offence victims and suspects in Havering, by age group, 2010-2012



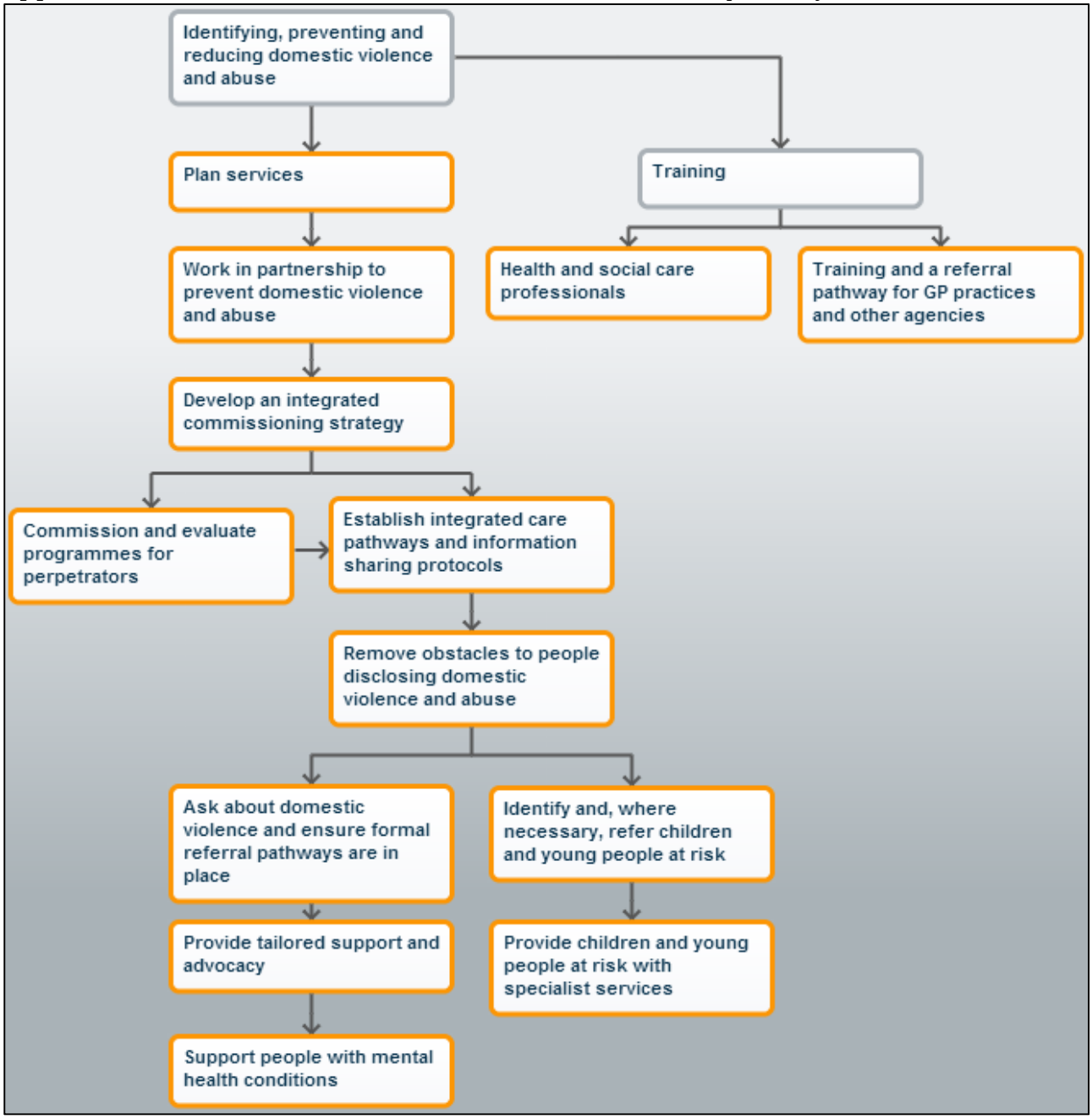
Data source: Metropolitan Police data 2010-2012

Appendix 34: Count and distribution of Sexual Offence Victims and Suspects in Havering, by Gender, 2010-2012



Data source: Metropolitan Police data 2010-2012

Appendix 35: NICE Domestic violence and abuse overview pathway



Appendix 36: NICE Public Health Guidance on Domestic Violence

Recommendations	Who to take action?	What action to be taken?
Plan services based on an assessment of need and service mapping	Local, regional and national commissioners of domestic violence and abuse services and related services; strategic partnerships, i.e. community safety partnerships	• Consult with women, men and young people who have experienced domestic violence and abuse as part of this assessment. • Local commissioners of related services should undertake a comprehensive mapping exercise to identify all local services and partnerships that work in domestic violence and abuse, such as drug and alcohol services. Map services against the Home Office- endorsed Coordinated Community Response Model and identify any gaps. • They should develop referral pathways that aim

Recommendations	Who to take action?	What action to be taken?
		to meet the health and social care needs of all those affected by domestic violence and abuse. This includes people with protected characteristics and those who face particular barriers trying to access domestic violence and abuse support services (see recommendations 4 and 9). • Regional and national commissioners of domestic violence and abuse services and related services should work with local commissioners to ensure service support extends across local authority boundaries, where necessary, for services such as prisons that cover broader geographical areas. • Regional and national commissioners (see above) should work with local commissioners to provide specialist services across local authority boundaries where there is not enough local need to justify setting them up within a particular local authority area. (This could include services to help prevent forced marriages, to help men, and lesbian, gay, bisexual or transpeople affected by domestic violence, or for people subjected to 'honour' violence or stalking.)

Participate in a local strategic multi-agency partnership to prevent domestic violence and abuse	Local authorities, health services and their strategic partners (including those in the voluntary and community sectors)	• Ensure senior officers from the following services participate in a local strategic partnership to prevent domestic violence and abuse.
		  • health services and the local authority (including the chairs of local safeguarding boards for adults and children)
		  • public health
		  • sexual violence services
		  • housing
		  • schools and colleges
		  • police and crime commissioners community safety partnerships
		  • criminal justice agencies (including probation)
		  • the Children and Family Court Advisory and Support Service specialist voluntary, community and private sector organization
		• Ensure health and social care practitioners are actively involved in both operational and strategic multi-agency
		• Regularly review membership of the partnership to ensure it is relevant and inclusive.

Develop an integrated commissioning strategy	Local strategic partnerships on domestic violence and abuse; commissioners, including clinical	• meet the health and social care needs of those who experience domestic violence and abuse • meet the needs of children and young people who are affected by domestic violence and abuse

Recommendations	Who to take action?	What action to be taken?

	commissioning groups and local authorities	• address the perpetrator's behaviour and health needs meet the needs of all local communities.
		• Ensure the strategy is based on the following principles:
		  • aligned or, where possible, integrated budgets and other resources
		  • one partner takes the strategic lead and oversees delivery on behalf of the local strategic partnership
		  • services address all levels of risk and all degrees of severity of domestic violence and abuse
		  • services are based on evidence-based commissioning principles and the local needs assessment and mapping exercise

Commission integrated care pathways	Commissioners of health and social care services	• Ensure there are integrated care pathways for identifying, referring (either externally or internally) and providing interventions to support people • Ensure people who misuse alcohol or drugs or who have mental health problems and are affected by domestic violence and abuse are referred to the relevant health, social care and domestic violence and abuse services. • Ensure all service pathways have consistent, robust mechanisms for assessing the risks facing adults who experience domestic violence and abuse and any children who may be affected.
Create an environment for disclosing domestic violence and abuse	Health and social care service managers in the statutory, voluntary, community and private sectors; specialist domestic violence and abuse services and related services. The latter includes: criminal justice, early years and youth services, housing, the police, prison and probation services, schools and colleges, and services for older people	• Display information in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse. Including contact details of relevant local and national helplines. It could also include information for groups who may find it more difficult to disclose that they are experiencing violence and abuse (see recommendation **9**). • Ensure the information on where to get support is available in a range of formats and locally used languages. • Take steps to ensure people who use the service are given maximum privacy • Establish a referral pathway to specialist domestic violence and abuse agencies (or the equivalent). This should include age-appropriate options and options for groups that may have difficulties accessing services, or are reluctant to do so. • Ensure frontline staff know about the services, policies and procedures of relevant local agencies in relation to domestic violence and abuse. • Provide ongoing training and regular

Recommendations	Who to take action?	What action to be taken?
		supervision for staff who may be asking people about domestic violence and abuse. This should aim to sustain and monitor good practice. • Establish clear policies and procedures for staff who have been affected by domestic violence and abuse.
Ensure trained staff ask people about domestic violence and abuse	Health and social care service managers and professionals	• Ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse. • Ensure people who may be experiencing domestic violence and abuse can be seen on their own. • Ensure trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. • Ensure staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse. • Ensure all services have formal referral pathways in place
Adopt clear protocols and methods for information sharing	Health, social care, education, criminal justice, probation and voluntary and community sector commissioners and service providers involved with those who experience or perpetrate domestic violence and abuse	• Take note of the Data Protection Act and professional guidelines that address confidentiality and information sharing in health services. This includes guidelines on how to apply the Caldicott guardian principles to domestic violence • Develop or adapt clear protocols and methods for sharing information, both within and between agencies. Clearly define the range of information that can be shared and with whom (this includes sharing information with health or children's services on a perpetrator's criminal history.) • Ensure protocols and methods encourage staff to: Remember their professional duty of confidentiality. • Determine when the duty of confidentiality might have to be breached: information should be shared only with the person's consent unless they are at serious risk, and within agreed multi-agency information-sharing protocols. • Note that information sharing without consent risks losing trust and may endanger a person's safety. • Weigh the risks of sharing information or not by determining whether you are sharing with the

Recommendations	Who to take action?	What action to be taken?
		aim of protecting someone. • Distinguish between anonymised data and personal data: the former does not need individual consent, but there should be a protocol in place for sharing such data. • Distinguish between situations that involve only adults and those where children are involved: information sharing without consent, or where consent is not given, is necessary when children's safety is at risk. • Ensure information-sharing methods are secure and will not put anyone involved at risk. Ensure the protocols and methods are regularly monitored. • Identify and train key contacts responsible for advising on the safe sharing of domestic violence and abuse-related information. • Ensure all staff who need to share information are trained to use the protocols so that they do not decline to cooperate because of being overcautious or for fear of reprisal. • Ensure any information shared is acknowledged by a person, rather than by an automatically generated response.
Tailor support to meet people's needs	Managers of domestic violence and abuse services; staff in all health and social care settings, including the public, voluntary and community sectors, and those they work with.	• Prioritise people's safety. • Refer people from general services to domestic violence and abuse (and other specialist) services if they need additional support. • Regularly assess what type of service someone needs • Think about referring someone to specialist domestic violence and abuse services if they need immediate support. This includes advocacy, floating support and outreach support and refuges. • Explore whether they would like to be referred to a local support group. • If there are indications that someone has alcohol or drug misuse or mental health problems refer them to the appropriate agency
Help people who find it difficult to access services	Health and social care commissioners and service providers in the public, voluntary and community sector	• Help people who may find domestic violence and abuse services inaccessible or difficult to use. • Identify any barriers people from these groups may face when trying to get help. • Introduce a strategy to overcome these barriers. • Train staff in direct contact with people affected by domestic violence and abuse to understand equality and diversity issues. • Ensure assumptions about people's beliefs and

Recommendations	Who to take action?	What action to be taken?
		values (for example, in relation to 'honour') do not stop staff identifying and responding to domestic violence and abuse. • Ensure staff know where to seek specialist advice. • Ensure interpreting services are confidential (often a concern in small communities where a minority language is spoken). • Ensure professional interpreters are used.
Identify and, where necessary, refer children and young people affected by domestic violence and abuse	Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children; providers of services where children and young people who are affected by domestic violence and abuse may be identified in the public, community and voluntary sectors.	• Ensure staff can recognise the indicators of domestic violence and abuse and understand how it affects children and young people. • Ensure staff are trained and confident to discuss domestic violence and abuse with children and young people who are affected by or experiencing it directly. • Put clear information-sharing protocols in place to ensure staff gather and share information • Develop or adapt and implement clear referral pathways to local services that can support children and young people. • Ensure staff know how to refer children and young people to child protection services. • Involve children and young people in developing and evaluating local policies and services dealing with domestic violence and abuse. • Monitor these policies and services with regard to children's and young people's needs.
Provide specialist domestic violence and abuse services for children and young people	Local safeguarding children boards and other local partnerships with a responsibility for safeguarding children; commissioners and providers of specialist services for children and young people who are affected by domestic violence and abuse in the public, community and voluntary sectors. The latter includes: child and adolescent mental health, health visiting, sexual health, social care and specialist paediatric services for child safeguarding and looked after children, and youth services	• Address the emotional, psychological and physical harms arising from a child or young person being affected by domestic violence • Provide a coordinated package of care and support that takes individual preferences and needs into account. • Ensure the support matches the child's developmental stage (for example, infant, pre-adolescent or adolescent). • Provide interventions that aim to strengthen the relationship between the child or young person and their non-abusive parent or carer. • Provide support and services for children and young people experiencing domestic violence and abuse in their own intimate relationships.
Provide specialist advice, advocacy and	Health and social care commissioners	• Provide all those currently (or recently) affected by domestic violence and abuse with

Recommendations	Who to take action?	What action to be taken?
support as part of a comprehensive referral pathway	(including clinical commissioning groups, local authority commissioners and police and crime commissioners); health and wellbeing boards; frontline practitioners in specialist domestic and sexual violence services (for example, domestic violence and abuse advisers, people working in refuges or outreach services)	**advocacy** and advice services tailored to their level of risk and specific needs. • Ensure practitioners are aware of how discrimination, prejudice and other issues, such as insecure immigration status, may have affected the risk that people using their services face. • Ensure specialist advice, advocacy and support forms part of a comprehensive referral pathway (see recommendation **4**). • Ensure the support is offered in settings where people may be identified or may disclose that domestic violence and abuse is occurring.
Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition	Clinical commissioning groups and specialist commissioners; police and crime commissioners; health and wellbeing boards; providers of primary care and mental health care services in the private, voluntary and community sectors.	• Where people who experience domestic violence and abuse have a mental health condition (either pre-existing or as a consequence of the violence and abuse), provide evidence- based treatment for the condition. • Ensure mental health interventions are provided by professionals trained in how to address domestic violence and abuse. • Ensure any treatment programme includes an ongoing assessment of the risk of further domestic violence and abuse.
Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse	Health and wellbeing boards; commissioners of tailored interventions for people who perpetrate domestic violence and abuse	• Commission robust evaluations of the interventions. • Identify, and link with, existing initiatives that work with people who perpetrate domestic violence and abuse. • Commission tailored interventions for people who perpetrate domestic violence and abuse. • Ensure interventions primarily aim to increase the safety of the perpetrator's partner and children. • In addition, staff should report on the perpetrators' attitudinal change, their understanding of violence and accountability, and their ability and willingness to seek help. • Link perpetrator services with services providing specialist support for those experiencing domestic violence and abuse (including children and young people). For example, link ongoing risk assessments of the perpetrator with safety planning and support provided by specialist services.
Provide specific training for health and social care professionals in how to respond to domestic violence	Royal colleges and professional organisations responsible for setting training and registration standards for clinical,	• Training to provide a universal response should give staff a basic understanding of the dynamics of domestic violence and abuse and its links to mental health and alcohol and drug misuse, along with their legal duties. • Level 1 Staff should be trained to respond

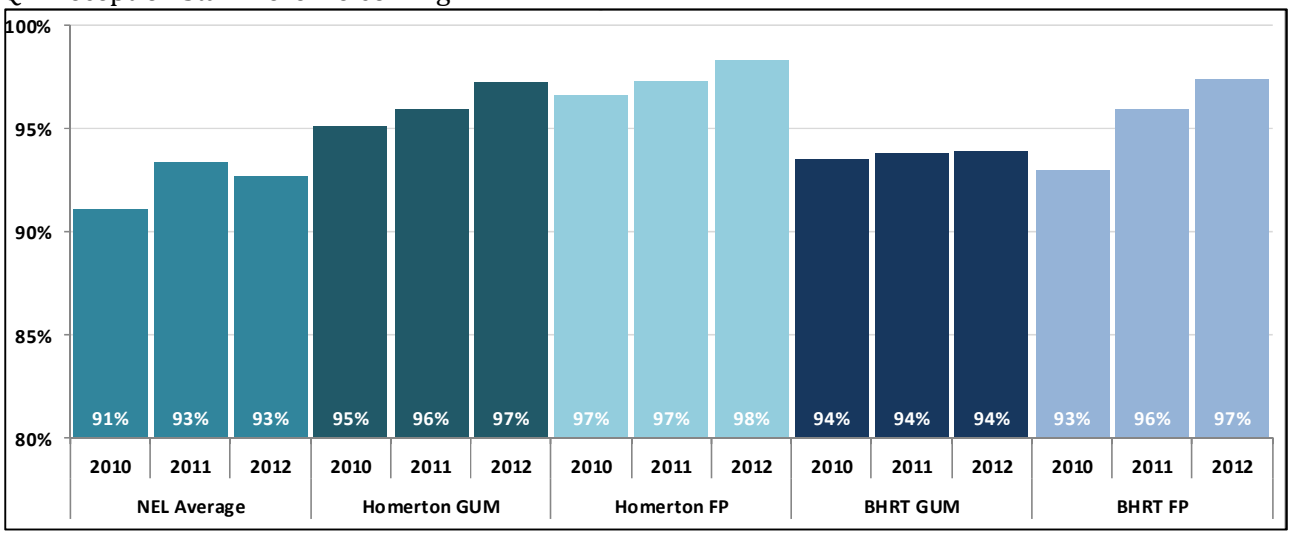
Recommendations	Who to take action?	What action to be taken?
and abuse	social workers and social care staff; commissioners; Health Education England; heads of health, social care and related services; universities and other providers of health and social care training, including interpreting	to a **disclosure** of domestic violence and abuse sensitively and in a way that ensures people's safety. They should also be able to direct people to specialist services. • Level 2 Staff should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Typically this level of training is for: nurses, accident and emergency doctors, adult social care staff, ambulance staff, children's centre staff, children and family social care staff, GPs, mental health professionals, midwives, health visitors, paediatricians, • Training to provide a specialist response should equip staff with a more detailed understanding of domestic violence and abuse and more specialist skills: • Level 3 Staff should be trained to provide an initial response that includes **risk identification and assessment**, safety planning and continued liaison with specialist support services. Typically this is for: child safeguarding social workers, safeguarding nurses, midwives and health visitors with additional domestic violence and abuse training, **multi-agency risk assessment conference** representatives and adult safeguarding staff. • Level 4 Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. • Other training to raise awareness of, and address misconceptions about, domestic violence and abuse issues and the skills, specialist services and training needed to provide people with effective support. • Organisations responsible for training and registration standards should: • The higher levels of training include increasing amounts of face-to-face interaction, although level 1 training can be delivered mostly online or by distance learning. • Face-to-face training covers the practicalities of enabling someone to disclose that they are affected by domestic violence and abuse and how to respond.

Recommendations	Who to take action?	What action to be taken?
GP practices and other agencies should include training on, and a referral pathway for, domestic violence and abuse	NHS England, commissioners and service managers working in specialist domestic violence and abuse services, GPs	• NHS England, commissioners and GPs should commission integrated training and referral pathways for domestic violence and abuse. This should include education for clinicians and administrative staff in GP practices on how to make it easier for people to disclose domestic violence and abuse.
Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse	Royal colleges and professional organisations responsible for setting training and registration standards for relevant clinical, social workers and social care staff; heads of health, social care and related services; universities and other providers of health and social care training for professionals who come into contact with service users, including interpreters	• Ensure training about domestic violence and abuse is part of the undergraduate or pre-qualifying curriculum, and part of the continuing professional development, for health and social care professionals who come into contact with service users. • be clear about the level of competency needed for each role • ensure the content on domestic violence and abuse is linked to child welfare, safeguarding and adult protection services, and vice versa

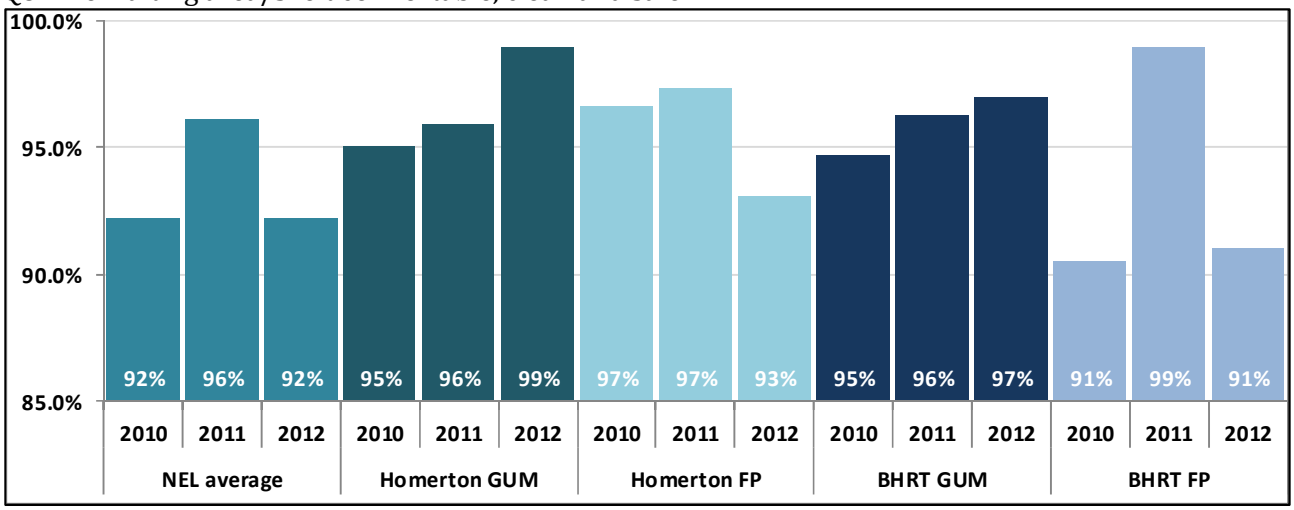
Service Users: Summary got BHRUT: service user's opinions

Appendix 37*:* Summary for BHRUT: service user's opinions – Q7 – Q20

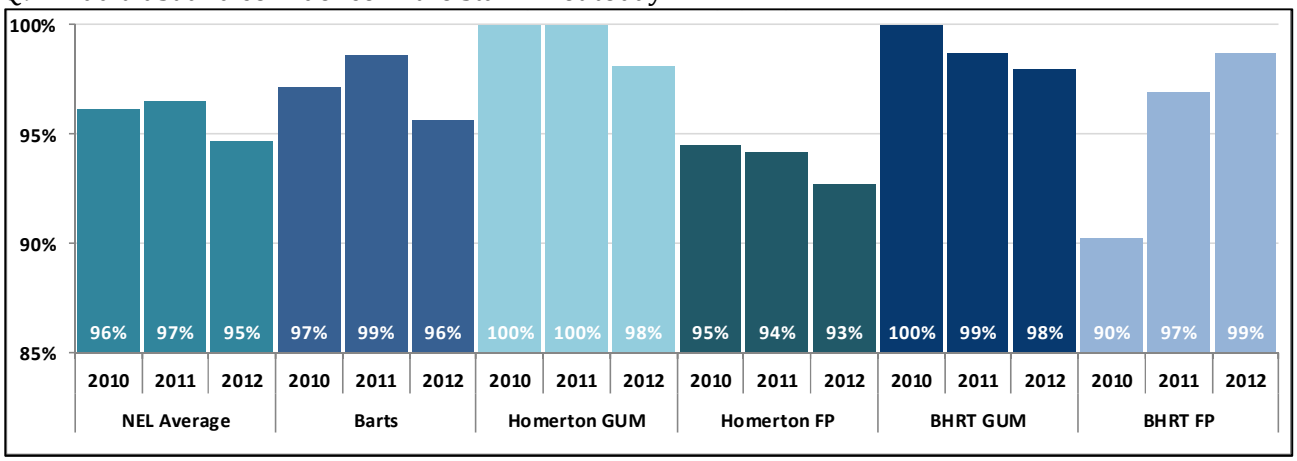
Q7. Reception staff were welcoming



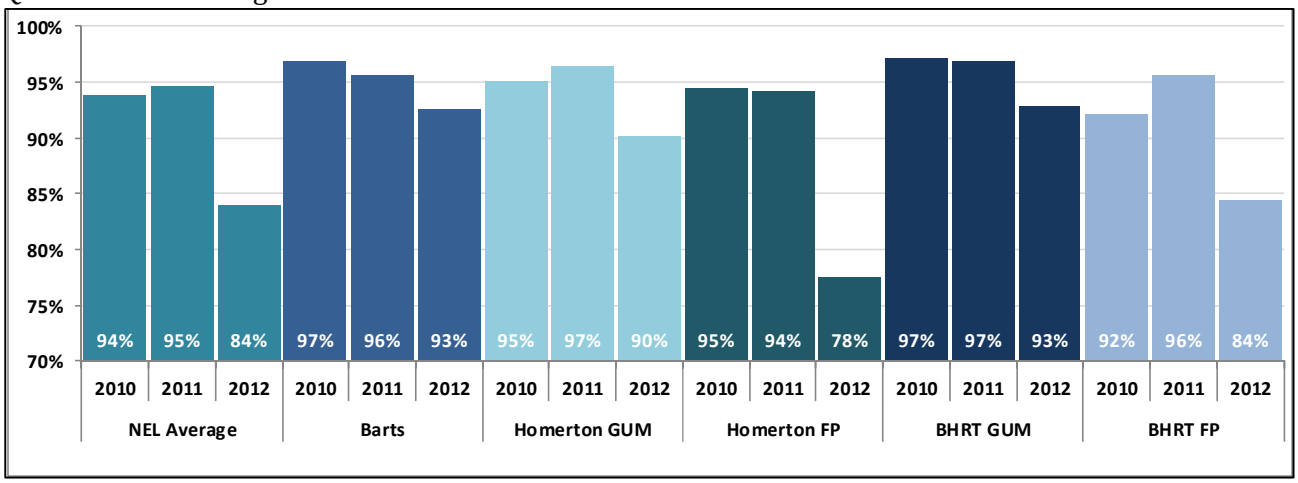
Q8. The waiting area/s felt comfortable, clean and safe.



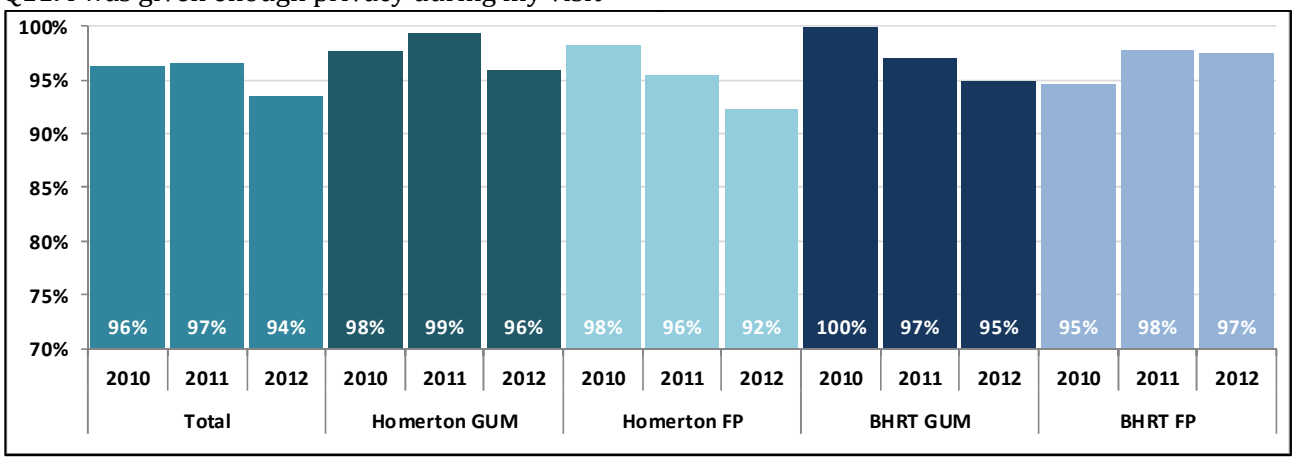
Q9. I had trust and confidence in the staff I met today



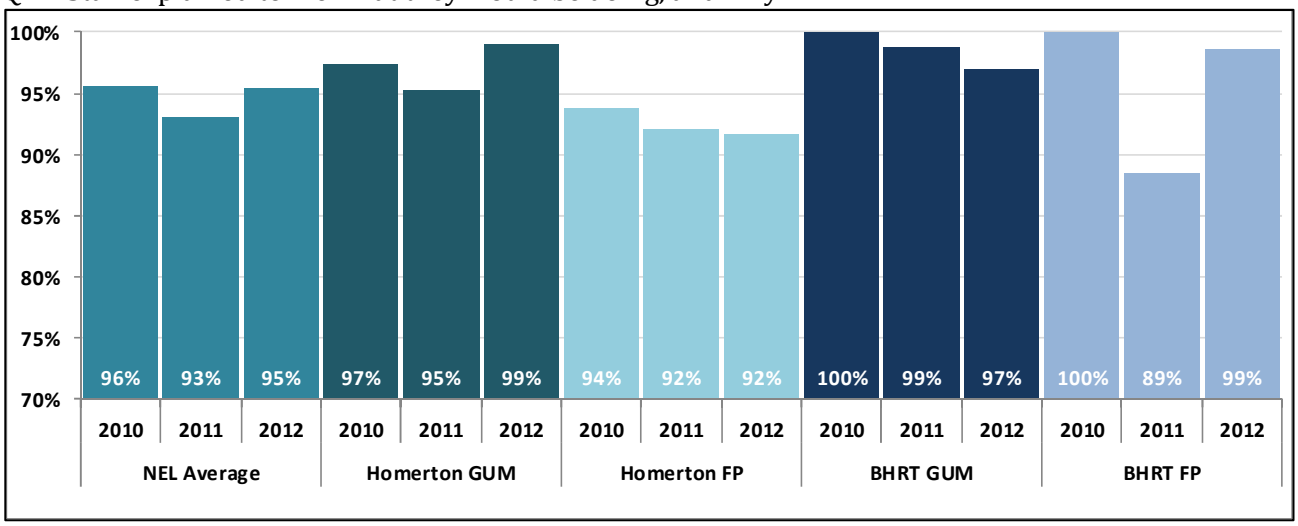
Q10. All staff treating me introduced themselves



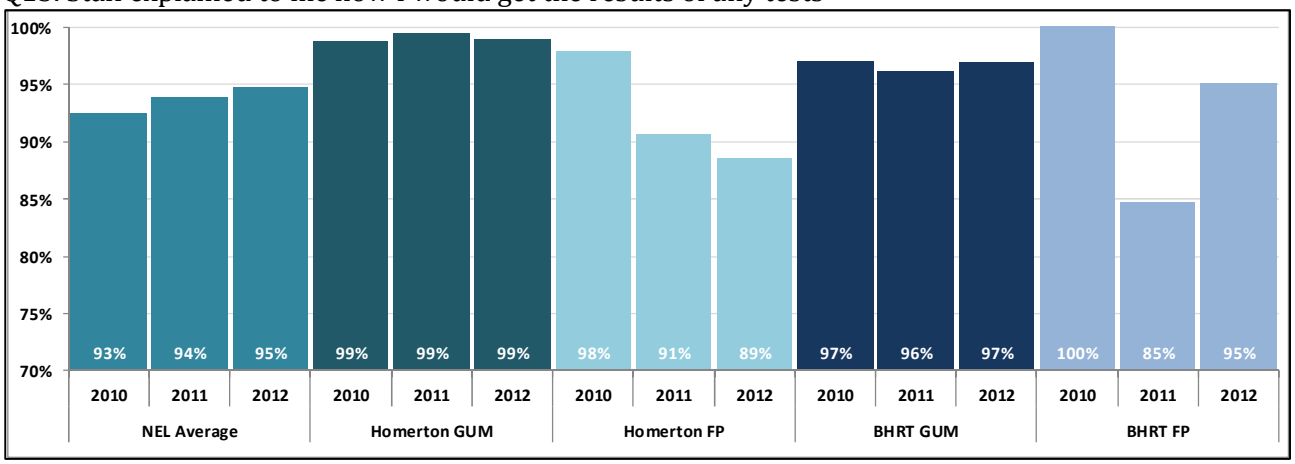
Q11. I was given enough privacy during my visit



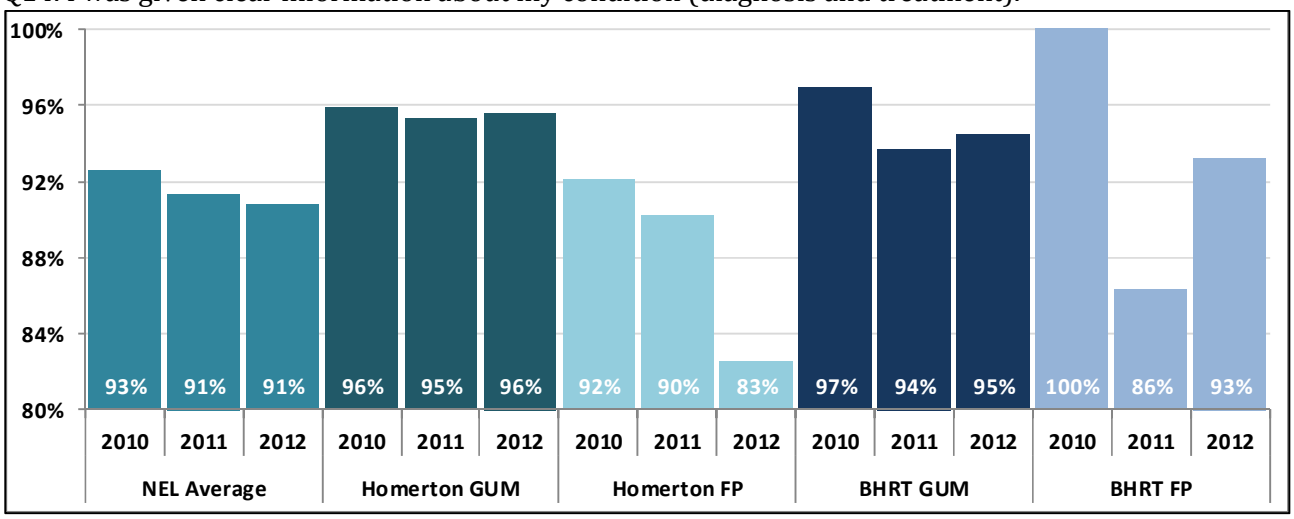
Q12. Staff explained to me what they would be doing, and why.



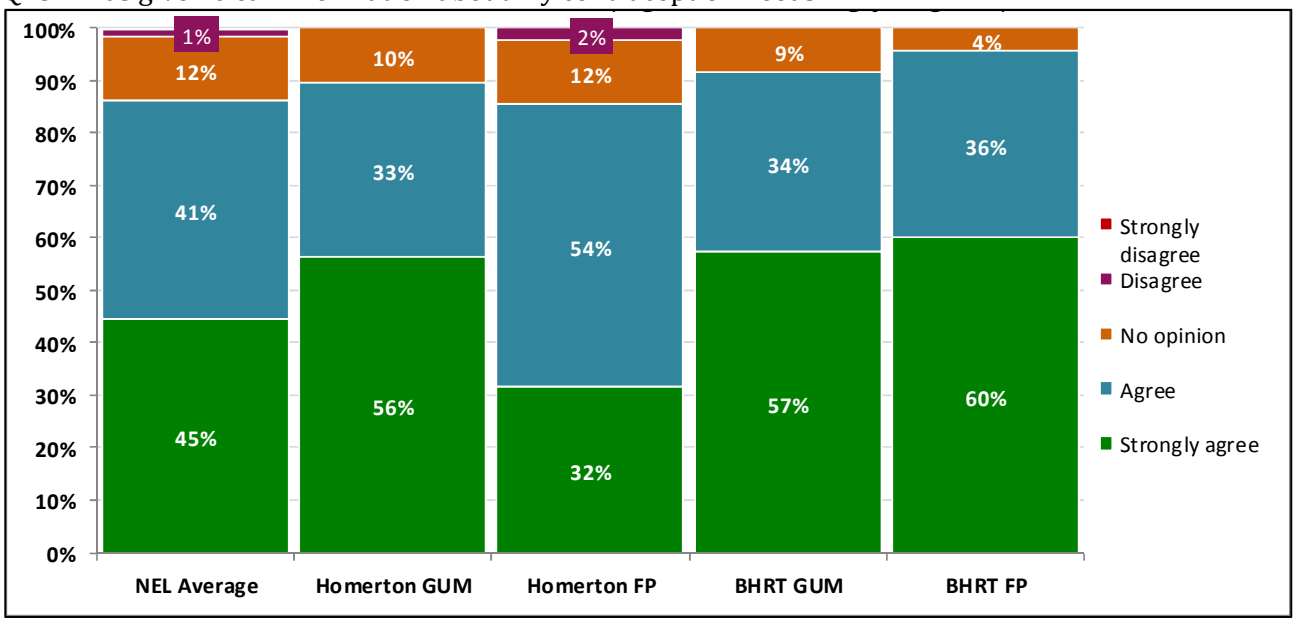
Q13. Staff explained to me how I would get the results of any tests



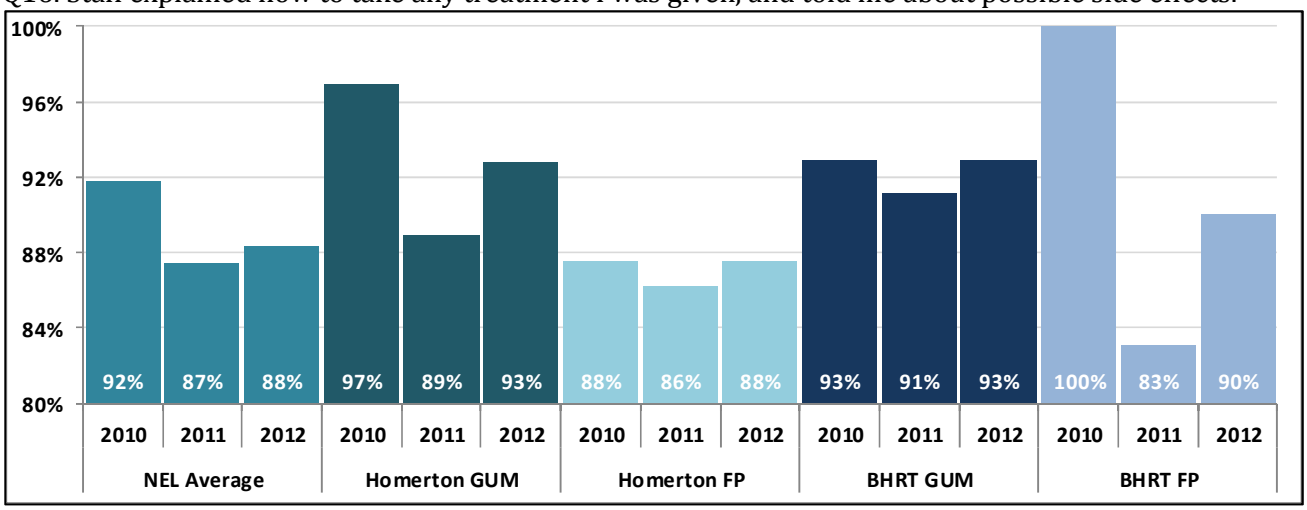
Q14. I was given clear information about my condition (diagnosis and treatment).



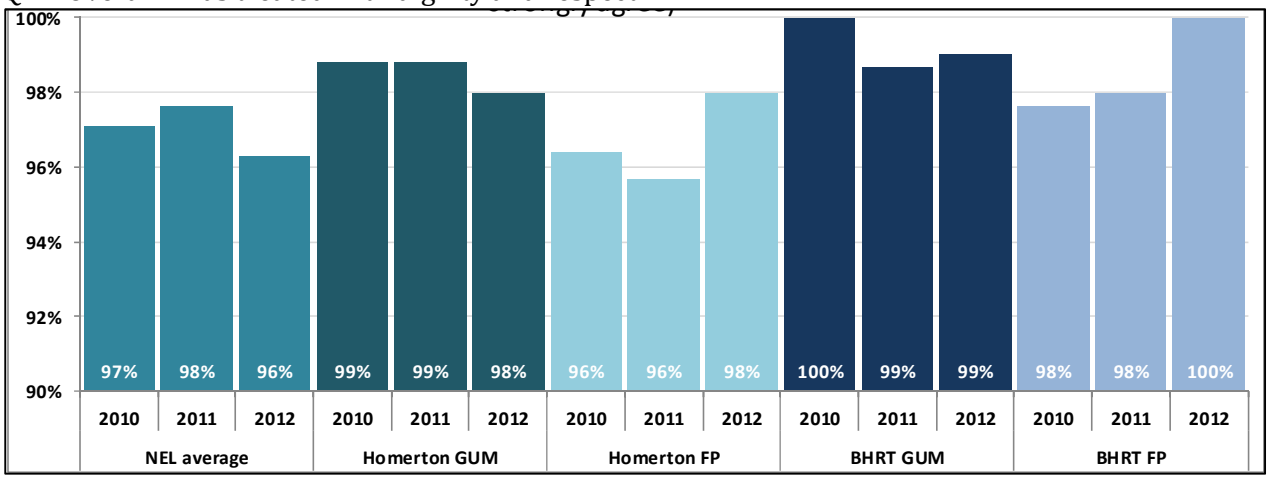
Q15. I was given clear information about my contraception needs



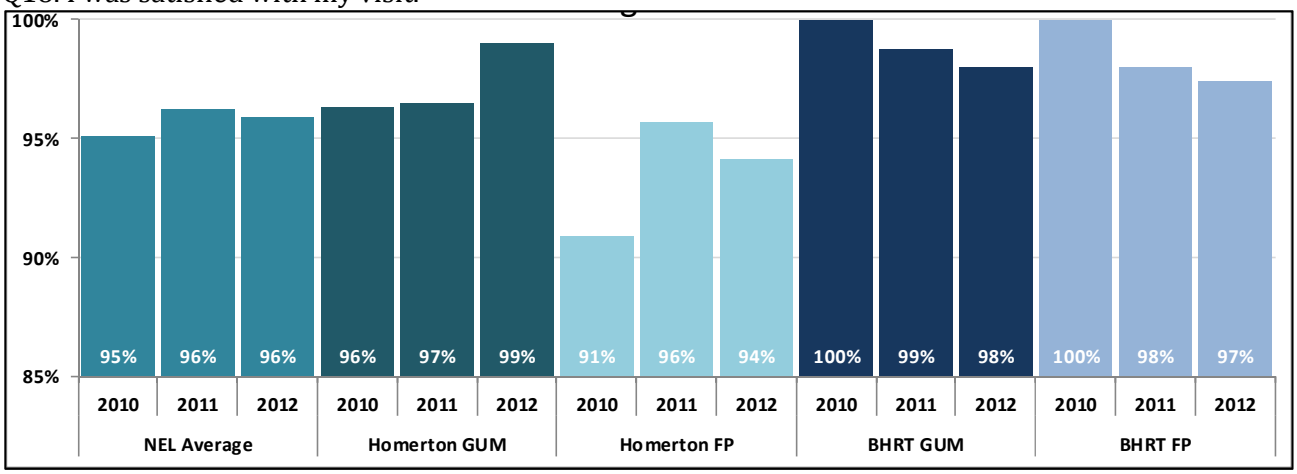
Q16. Staff explained how to take any treatment I was given, and told me about possible side effects.



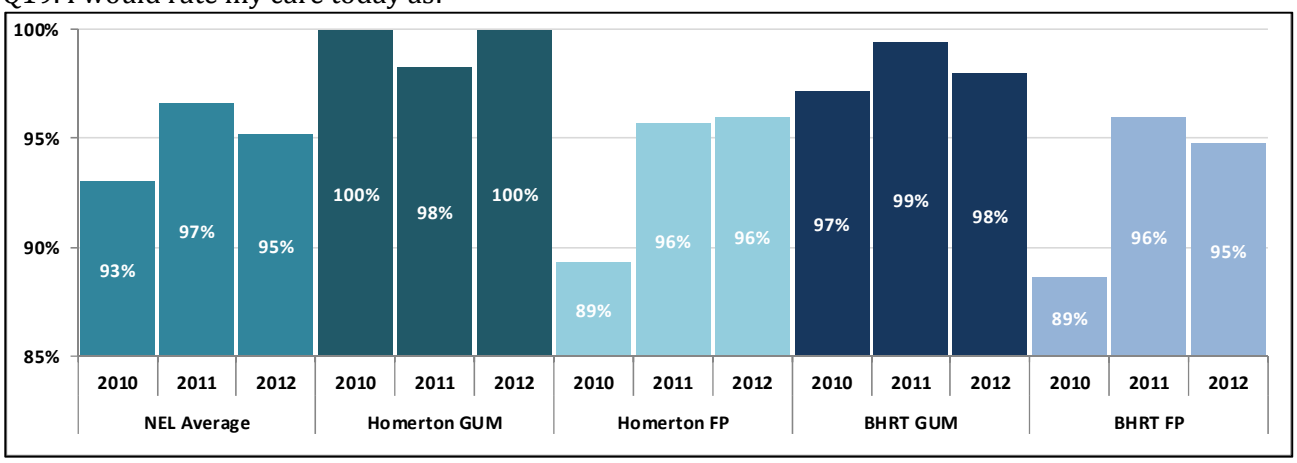
Q17. Overall I was treated with dignity and respect



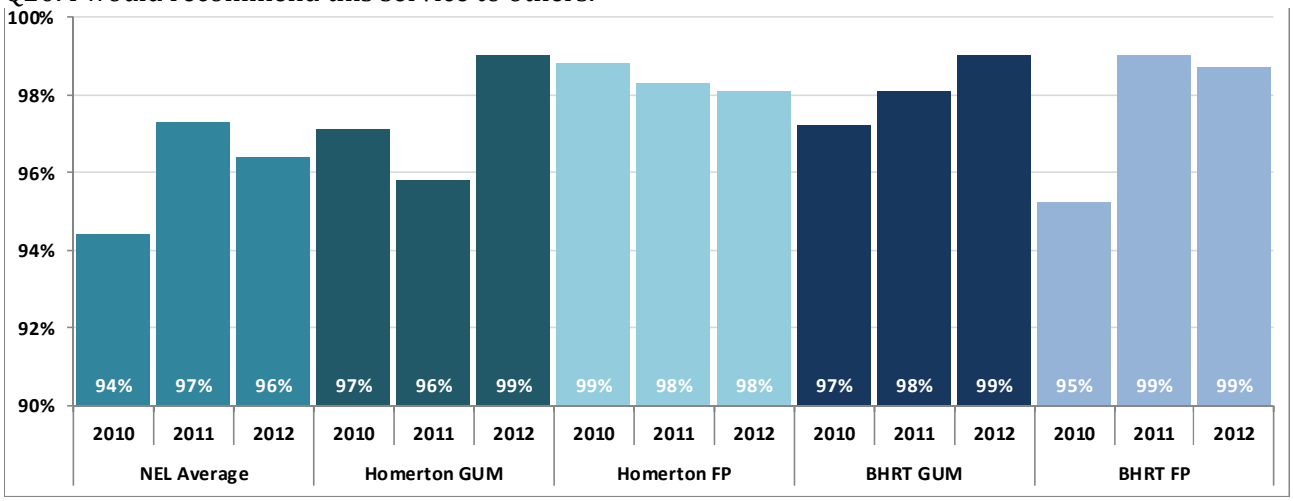
Q18. I was satisfied with my visit.



Q19. I would rate my care today as:



Q20. I would recommend this service to others.



Data Source: NELNET Sexual Health Service Users Survey 2012