Walsall Council

Public Health Walsall: Sexual Health Needs Assessment Summary Report: May 2015

This needs assessment is part of the Walsall Joint Strategic Needs Assessment Process.

Key Summary findings

• In 2013, Walsall is ranked 55 (out of 326 local authorities in England; first in the rank has highest rates) for rates of new sexually transmitted infections (STIs). 2631 new STIs were diagnosed in residents of Walsall, a rate of 971.1 per 100,000 residents (compared to 810.9 per 100,000 in England).

• 57% of diagnoses of new STIs in Walsall were in young people aged 15-24 years (compared to 55% in England).

• In 2013, for cases in men where sexual orientation was known, 12.0% of new STIs in Walsall were among MSM.

• In 2013, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Walsall was 2447.3 (compared to 2015.6 per 100,000 in England).

• In 2013, Walsall is ranked 56 (out of 326 local authorities in England) for the rate of gonorrhoea, which is a marker of high levels of risky sexual activity. The rate of gonorrhea diagnoses per 100,000 in this local authority was 52.4 (compared to 52.9 per 100,000 in England).

• In 2013, among genitourinary medicine (GUM) clinic patients from Walsall who were eligible to be tested for HIV, 59.7% were tested (compared to 71.0% in England).

• In 2013, there were 13 new HIV diagnoses in Walsall and the diagnosed HIV prevalence was 1.6 per 1,000 population aged 15-59 years (compared to 2.1 per 1,000 in England).

• In Walsall, between 2011 and 2013, 58% (95% CI 42-72) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 45% (95% CI 44-46) in England.

• In 2013, in Walsall upper tier local authority, the total abortion rate was 18.6 per 1,000 female population aged 15-44 years, compared to 16.6 in England. Of those women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 35.5%, while in England the proportion was 26.9%.

• In 2012, the under 18 conception rate per 1,000 female aged 15 to 17 years in Walsall was 46.9, while in England the rate was 27.7.

• In 2013, the rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care in Walsall was 39.1, compared to 52.7 per 1,000 women in England.

Overarching recommendations

• Reducing the burden of HIV and STIs requires a sustained public health response based around early detection, successful treatment and partner notification, alongside promotion of safer sexual and health-care seeking behaviour.

• Local authorities are responsible for providing comprehensive, open access sexual health services. The prioritisation and provision of appropriate services can be shaped locally via Joint Strategic Needs Assessments (JSNAs), and guided by the Public Health Outcomes Framework and Framework for Sexual Health Improvement.

• Local epidemiological STI and HIV data can be employed to inform service commissioning and provision, and to make the case for prioritisation of sustained investment in prevention and control interventions, targeting populations most at risk.

• Every effort should be made to eliminate local barriers to testing, made available free and confidentially at easily accessible services. Alongside the effective clinical response, promoting safer sexual behaviour among individuals – including condom use and regular testing – remains crucial.

HIV

• The Public Health Outcomes Framework includes an indicator to assess progress in achieving earlier HIV diagnoses. Locally, JSNAs can be used to prioritise and inform the provision of appropriate HIV testing services, to deliver against this indicator.

• In local authorities with a diagnosed HIV prevalence greater than 2 per 1,000, implementation of routine HIV testing for all general medical admissions and for all new registrants in primary care is recommended.

Chlamydia

• The Public Health Outcomes Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults. This recommends local areas achieve an annual chlamydia diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population.

• The chlamydia diagnosis rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and genitourinary medicine services. Areas achieving or above the 2,300 diagnosis rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate.

Gonorrhoea

• Reducing gonorrhoea transmission, and ensuring treatment resistant strains of gonorrhoea do not persist and spread remains a public health priority. The Gonorrhoea Resistance Action Plan for England and Wales (April 2013) makes recommendations on ensuring prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission.

Sexual health messages for the general public

• Prevention messages should be promoted to all sexually active men and women, highlighting that individuals can significantly reduce their risk of catching or passing on HIV or an STI by:

  • Always using a condom correctly and consistently when having sex with casual or new partners, until all partners have had a sexual health screen.

  • Reducing their number of sexual partners and avoiding overlapping sexual relationships.

Engaging high risk groups

• Prevention programmes engaging specific groups at highest risk of HIV and STI infection should continue, including clinicians taking every opportunity to recommend that:

  • Sexually active under 25 year olds should be screened for chlamydia every year, and on change of sexual partner.

  • Men who have sex with men (MSM) having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly. MSM should also avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 18% of MSM are unaware of their HIV infection.

  • Black African and Caribbean men and women should have a HIV test, and a regular HIV and STI screen if having unprotected sex with new or casual partners.

Reproductive health

• Increasing access, choice and knowledge of all methods of contraception, including long-acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners can reduce unwanted pregnancies.

• Contraception should be available through general practice and a range of contraceptive, sexual health and young people's services. Contraception should be provided free from any prescription charges.

• Local authorities are mandated to commission open access contraception advice and treatment services that meet the needs of their local population.

• LARC methods are more effective at preventing pregnancy than other hormonal methods and condoms. There is also evidence LARC methods fitted by the abortion provider can reduce repeat abortions.

• For those women seeking an abortion, access to services at all gestations up to 24 weeks should be easily available and accessible.

Introduction

Information on STIs used in this report

For STIs this report has been compiled using routine STI data, the majority of which comes from genitourinary medicine (GUM) and HIV clinics. Chlamydia test and diagnosis data from community services are sourced from the National Chlamydia Screening Programme (NCSP) and 'Non-NCSP/Non-GUM' services for 2008-2011 and include only those aged 15-24 years. From 2012, chlamydia test and diagnosis data are sourced from the Chlamydia Testing Activity Dataset (CTAD) and include all ages. As a result, chlamydia data from community services from 2012 are not comparable to data from previous years. See link below for further details on chlamydia data from community services and for additional data on chlamydia testing coverage, positivity and diagnostic rates (for those aged 15-24 years) (http://www.chlamydiascreening.nhs.uk/ps/data.asp).

Diagnoses of all other STIs are reported from GUM clinics only i.e. information about STIs from non GUM clinics which has started to be collected as part of GUMCAD version 2, is not presented in this report.

The data are continually updated and this report uses STI data as of 08 April 2014. The information in this report may differ from other published data using data extracted at a different date, or using different population denominators.

Please also note that for some local authorities the number of some STIs e.g. syphilis, or the numbers of new STIs in certain ethnic groups may be small. Where this is the case please apply caution when interpreting comparisons to other local authorities, PHE Centre (PHEC) or national rates, trends in rates over time and when comparing the rates of STIs in different ethnic groups.

Appendix 1 describes the data sources.

Other sources of information

For more information on local sexual health data sources, please access the sexually transmitted infections page on the PHE website https://www.gov.uk/government/collections/sexually-transmitted-infections-stis-surveillance-data-screening-and-management/ .

For local information on a range of sexual health indicators including teenage pregnancy, please access the Sexual and Reproductive Health Profiles http://fingertips.phe.org.uk/profile/sexualhealth/ .

STIs

Burden and trend of new STIs

2631 new STIs were diagnosed in residents of Walsall in 2013 (1141 in males and 1484 in females), a rate of 971.1 per 100,000 residents (males 856.7 and females 1077.5) (gender was not specified or unknown for 6 episodes). The number of cases of each new STI diagnosed in Walsall from 2009-2013 can be found in Appendix 2. Please see Appendix 3 for diagnoses included in new STIs. It should be noted that if high rates of gonorrhoea and syphilis in a population are seen, this reflects high levels of risky sexual behavior.

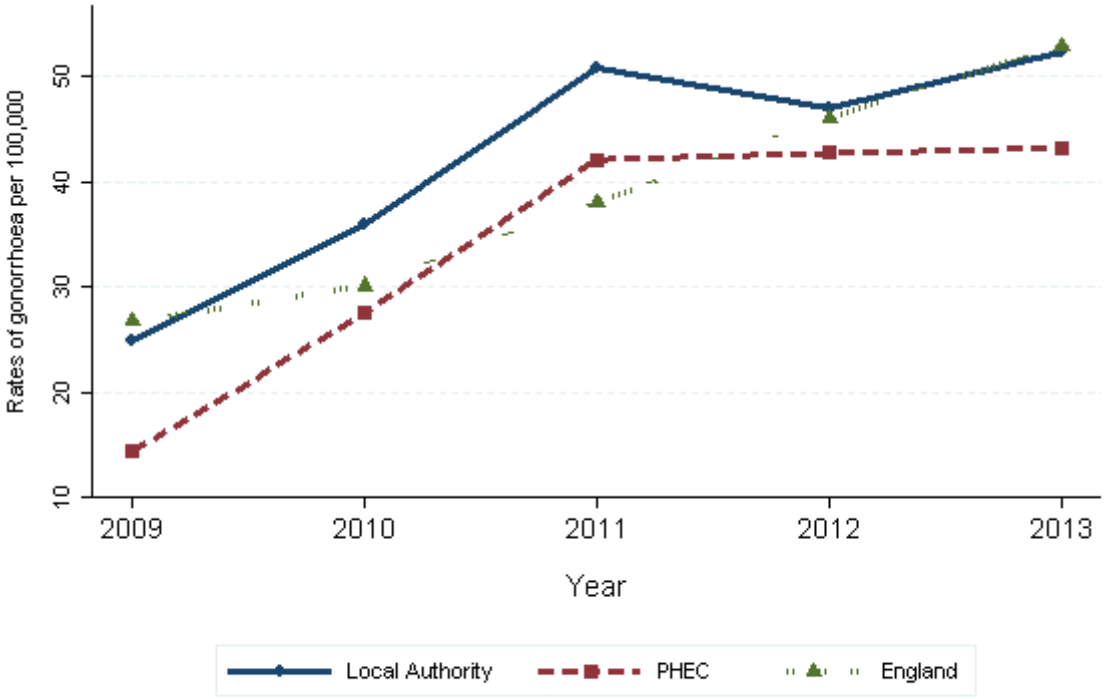
Table 1: Rates per 100,000 population of new STIs in Walsall and England: 2012-2013

Diagnoses	*Rate: 2012*	*Rate: 2013*	*% change 2012 to 2013**	*Rank within England: 2013***	*Rate in England residents: 2013*
New STIs	1150.5	971.1	-15.6	55	810.9
Chlamydia	725.3	444.4	-38.7	68	379.9
Gonorrhoea ¥	46.9	52.4	11.7	56	52.9
Syphilis	3.3	6.6	100.0	48	5.9
Genital Warts ‡	114.1	134.0	17.4	112	133.4
Genital Herpes ±	52.8	62.0	17.4	91	58.8

Rates are calculated using 2012 ONS population estimates
* % change not provided where rate per 100,000 population in 2012 was 0.0
** Out of 326 local authorities, 1st rank has the highest rates. Rank within England has been based on alphabetical order of local authority name where rate for local authority was 0.0 per 100,000 population
¥ Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM
‡ Any decrease in genital warts diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination
± Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs
Data Source: The Genitourinary Medicine Clinic Activity Dataset v2 (GUMCAD) and chlamydia test and diagnosis data are sourced from the Chlamydia Testing Activity Dataset (CTAD).

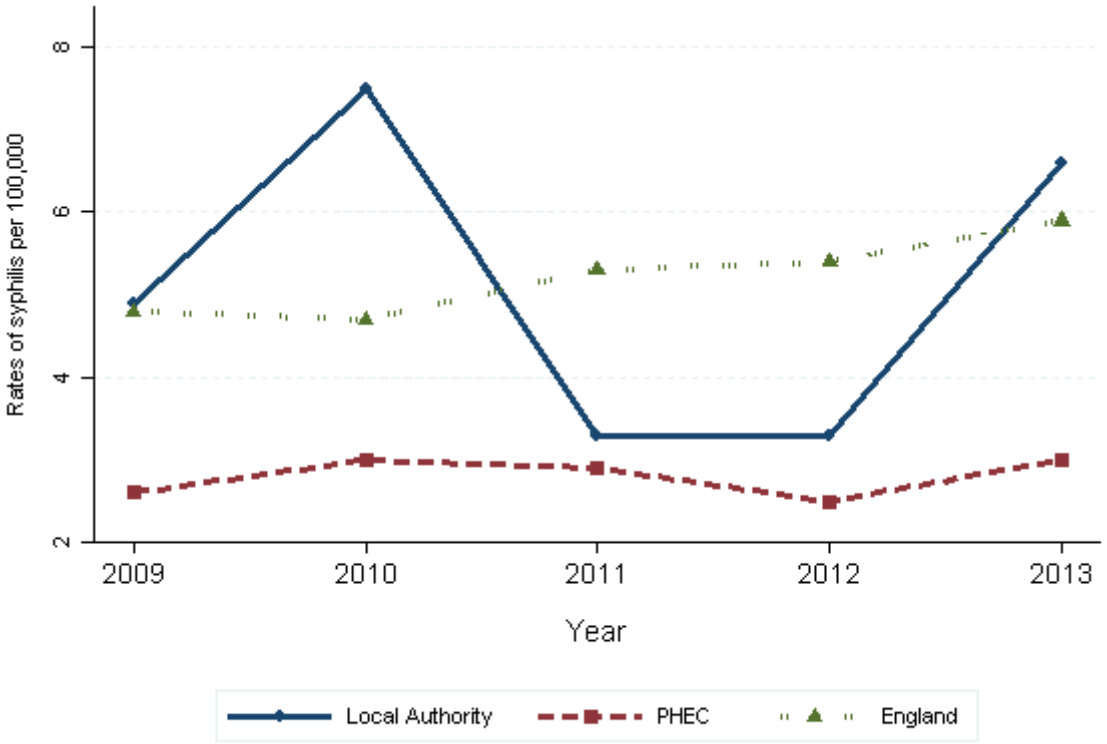
Figures 1a to 1d show the rates per 100,000 population of diagnoses of gonorrhoea, syphilis, genital warts and genital herpes by year in Walsall compared to rates in areas of West Midlands PHE Centre (PHEC) and England: 2009-2013. *(Please note different scales and that scales may not start at 0).*

1a. Rates of gonorrhoea*



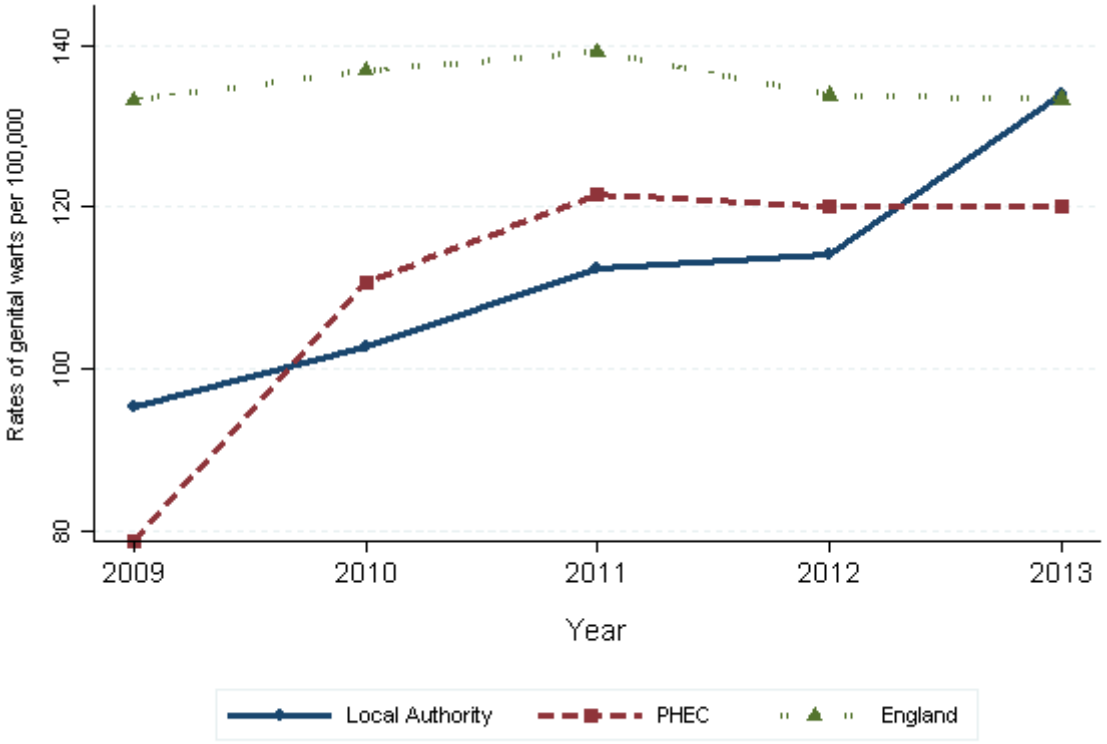
Source: Data from Genitourinary Medicine Clinics
*Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive Nucleic Acid Amplification Tests (NAATs) and additional screening of extra-genital sites in MSM
Rates are calculated using ONS population estimates

1b. Rates of syphilis



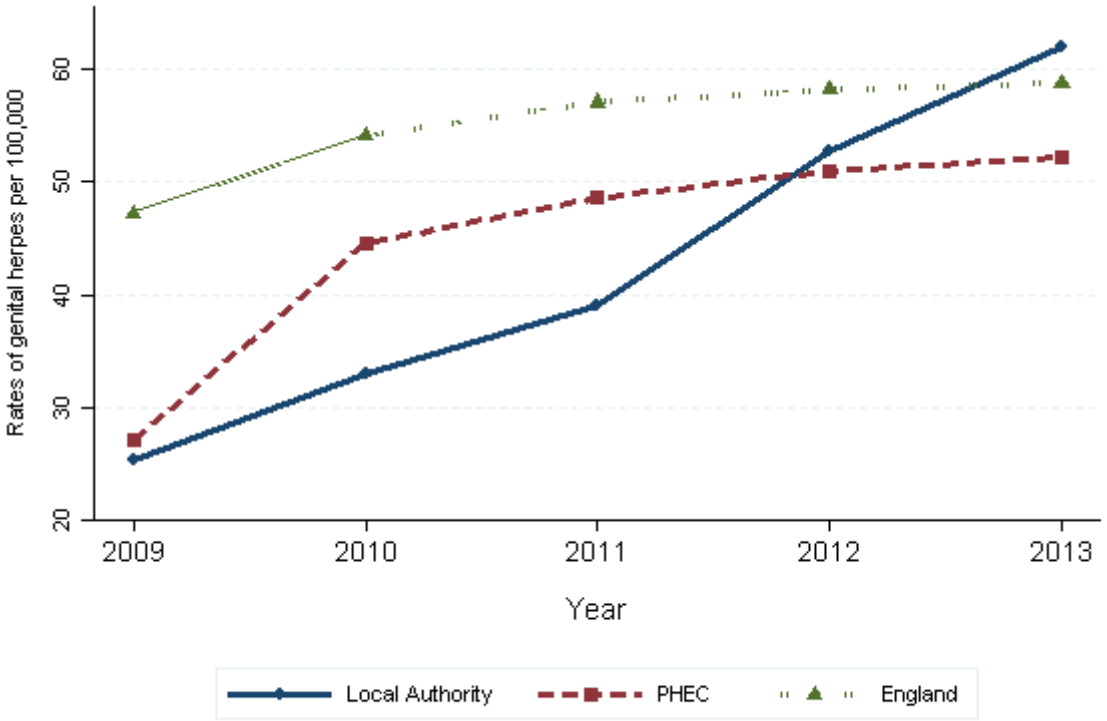
Source: Data from Genitourinary Medicine Clinics
Rates are calculated using ONS population estimates

1c. Rates of genital warts



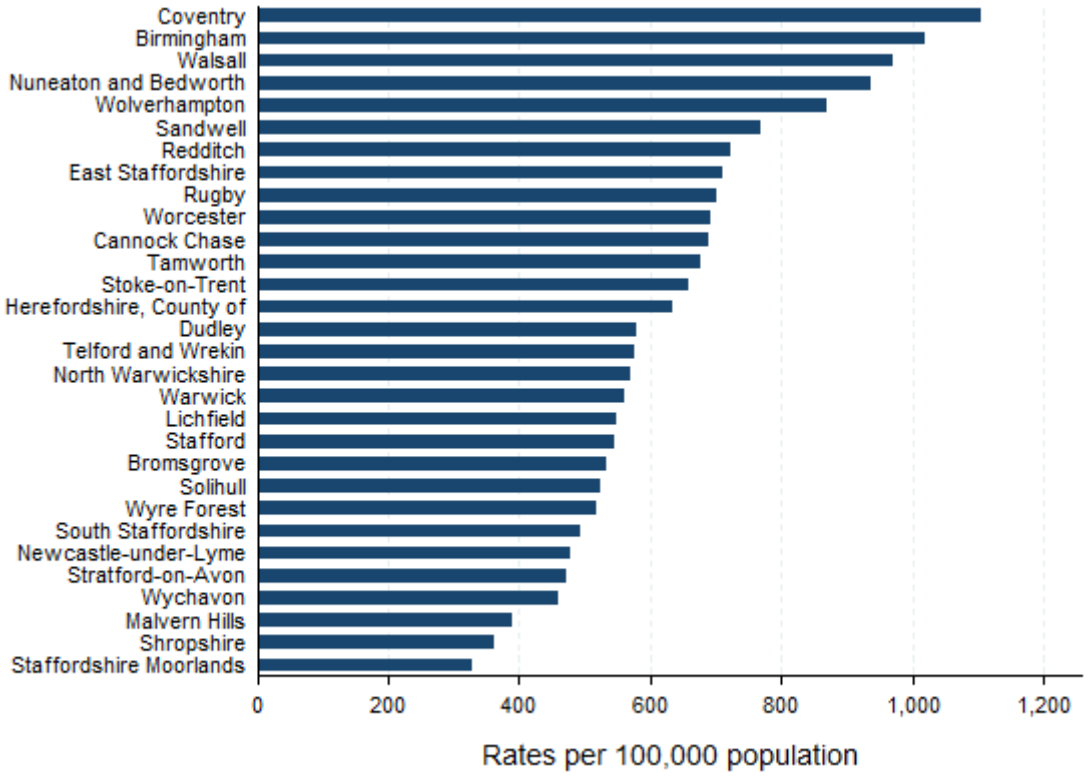
Source: Data from Genitourinary Medicine Clinics
Rates are calculated using ONS population estimates

1d. Rates of genital herpes*



Source: Data from Genitourinary Medicine Clinics
*Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs
Rates are calculated using ONS population estimates

Figure 2. Rates of new STIs in each local authority in West Midlands PHEC: 2013



Source: Data from Genitourinary Medicine clinics and community settings (for Chlamydia only)
Rates based on the 2012 ONS population estimates

Reinfection of STIs

Reinfection with an STI is a marker of persistent risky behaviour. In Walsall, an estimated 8.1% of women and 7.0% of men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became reinfected with a new STI within twelve months. Nationally, during the same period of time, an estimated 6.9% of women and 8.8% of men presenting with a new STI at a GUM clinic became reinfected with a new STI within twelve months.

In Walsall, an estimated 2.6% of women and 4.9% of men diagnosed with gonorrhoea at a GUM clinic between 2009 and 2013 became reinfected with gonorrhoea within twelve months. Nationally, an estimated 3.7% of women and 8.0% of men became reinfected with gonorrhoea within twelve months.

STI prevention groups

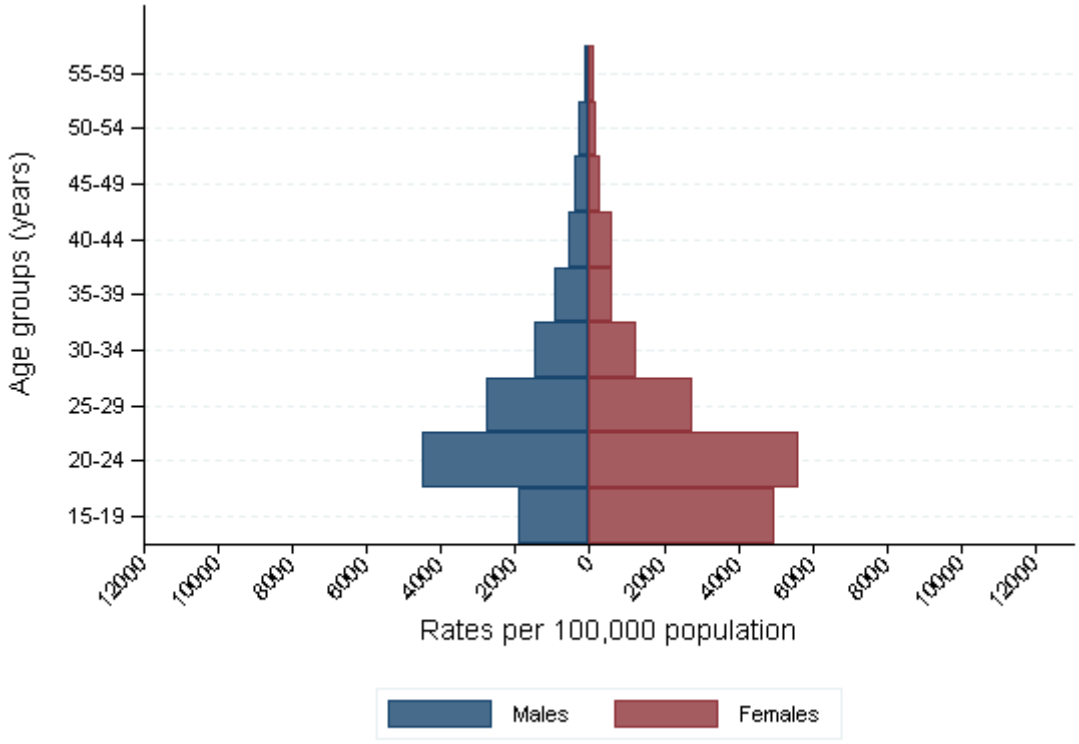
Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.

Overall, of all those diagnosed in 2013 with a new STI in Walsall, 43% were male and 56% were female (gender was not specified or unknown for 0% of episodes).

Young people

Young people between 15 and 24 years old experience the highest rates of new STIs. In Walsall, 57% of diagnoses of new STIs were in young people aged 15-24 years. The age profile is shown in Figure 3.

Figure 3. Rates of new STIs by age group and gender in Walsall: 2013



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)
Rates based on the 2012 ONS population estimates

Young people are also more likely to become reinfected with STIs, contributing to infection persistence and health service workload. In Walsall, an estimated 11.8% of 15-19 year old women and 8% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2009 to 2013 became reinfected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex.

The Public Health Outcome Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults under 25 years old: the annual diagnostic rate among the resident 15-24 year old population. The diagnosis rate reflects both coverage and the proportion testing positive at all sites, including GUM diagnoses as well as those made outside of GUM.

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it, other areas should work towards it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.

The chlamydia diagnosis rate in 15-24 year olds in Walsall was 2447.3 per 100,000 population. 32.4% of 15-24 year olds were tested for chlamydia with a 7.6% positivity rate. Nationally, 24.9% of 15-24 year olds were tested for chlamydia with a 8.1% positivity rate. The number of tests, annual coverage and positivity for Walsall are shown in table 2. The diagnosis rate per 100,000 and its rank in West Midlands PHEC and England are shown in table 3.

Table 2. Chlamydia testing data in 15-24 year olds in Walsall: 2013

Number of chlamydia tests in GUM	*Number of chlamydia tests in other settings*	*Total number of tests*	*Number of positives (all settings)*	*Percentage of population tested (all settings)**
2289	9020	11309	855	32.4

*Repeat tests are not excluded
Source: Data from Genitourinary Medicine Clinics and community settings

Table 3. Rates per 100,000 population of chlamydia diagnosis in 15-24 year olds in Walsall local authority, West Midlands PHE Centre and England: 2013

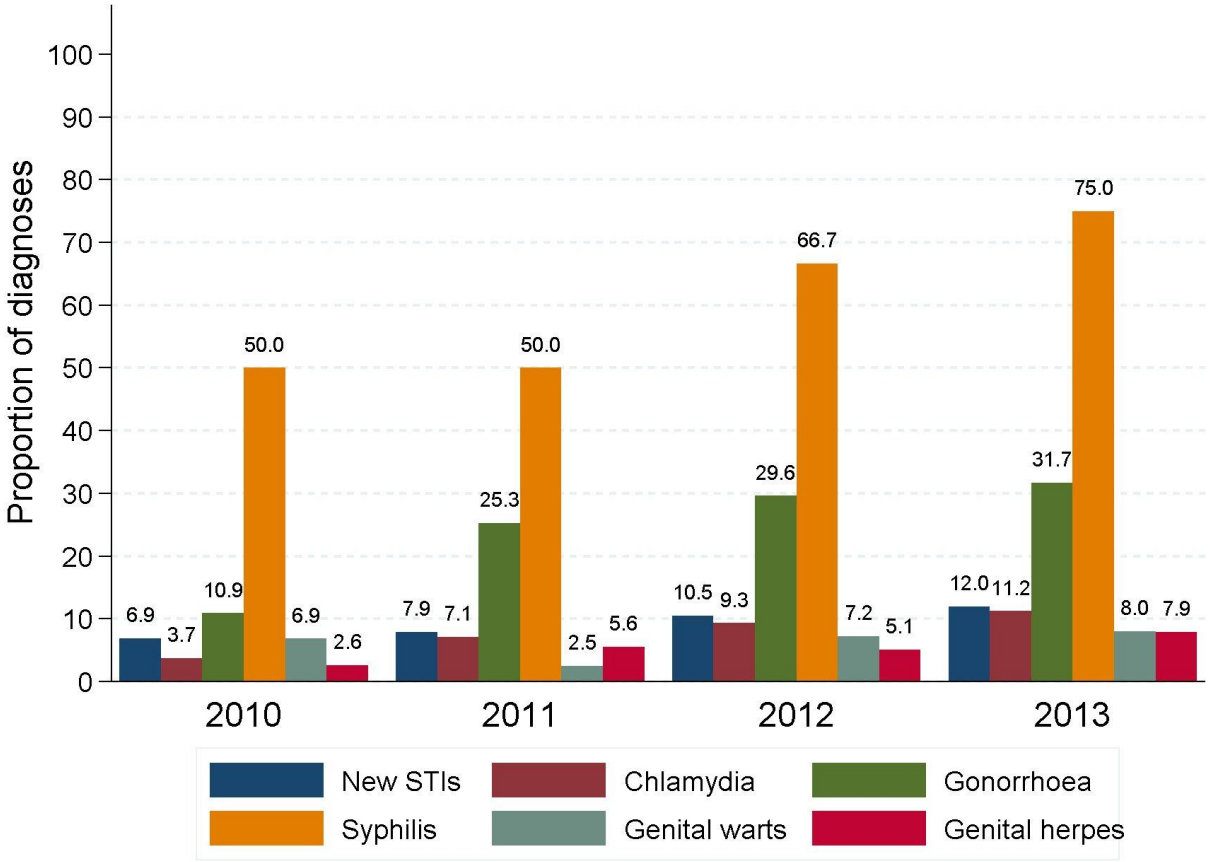
Rates of diagnosis	*Rate in the PHE Centre*	*Rate in England*	*Rank within PHE Centre†*	*Rank within England**
2447.3	1917.4	2015.6	2	54

Rates based on the 2012 ONS population estimates (15-24 year olds)
†Out of 30 local authorities in West Midlands PHEC, 1st rank has the highest rates
*Out of 326 local authorities in England, 1st rank has the highest rates
Source: Data from Genitourinary Medicine Clinics and community settings

Men who have sex with men (MSM)

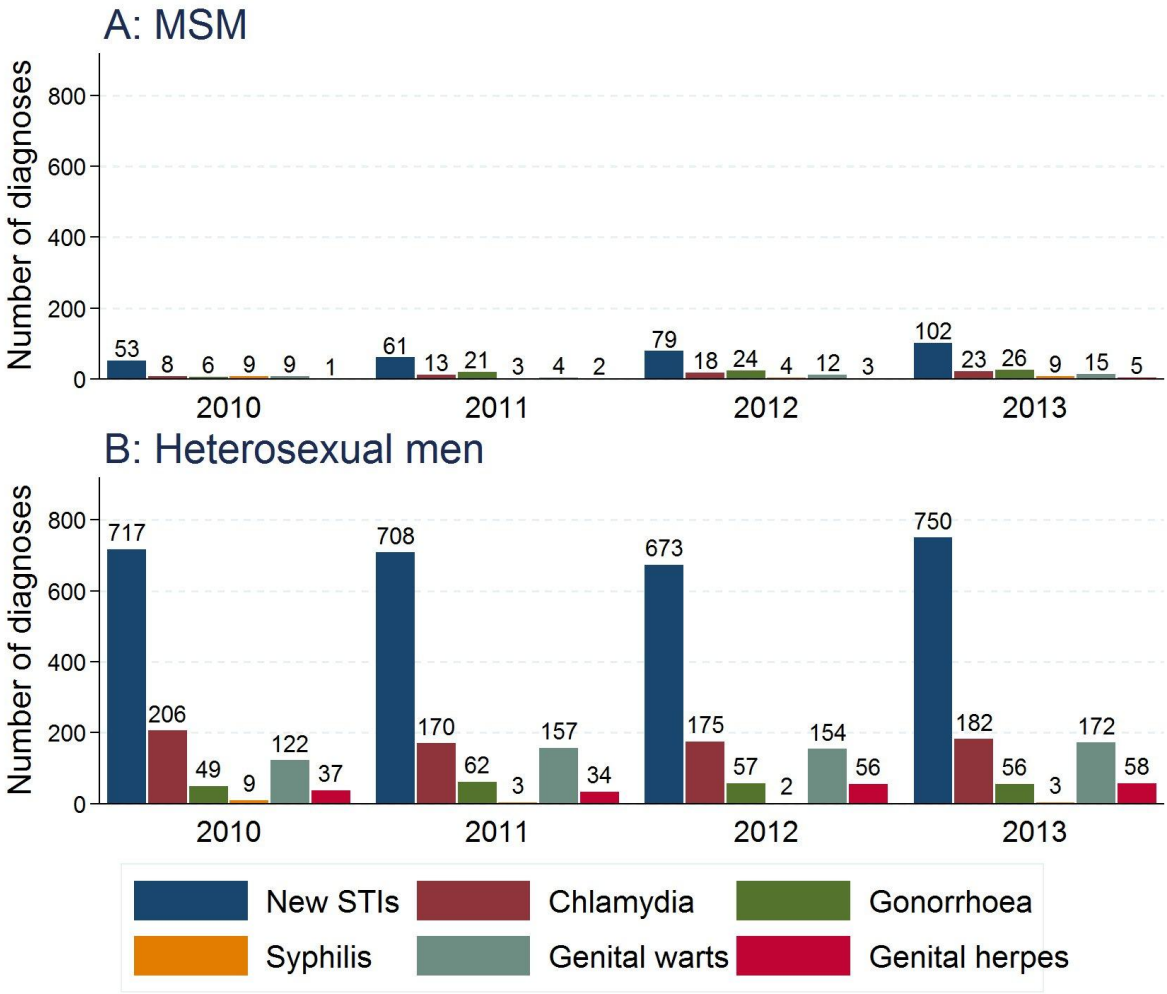
In Walsall in 2013, for cases in men where sexual orientation was known, 12.0% (n=102) of new STIs were among MSM. In 2010, the proportion of new STIs among MSM was 6.9% (n=53). Please note that the numbers for MSM presented in this report include homosexual and bisexual men.

Figure 4. Proportion of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM among men in Walsall (GUM diagnoses only): 2010-2013



Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM
For cases in men with known information on sexual orientation
See Figure 5 for denominator

Figure 5. Number of new STIs, chlamydia, gonorrhoea, syphilis, genital warts and genital herpes in MSM and in Heterosexual men in Walsall (GUM diagnoses only): 2010-2013



Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM

Ethnic group and country of birth

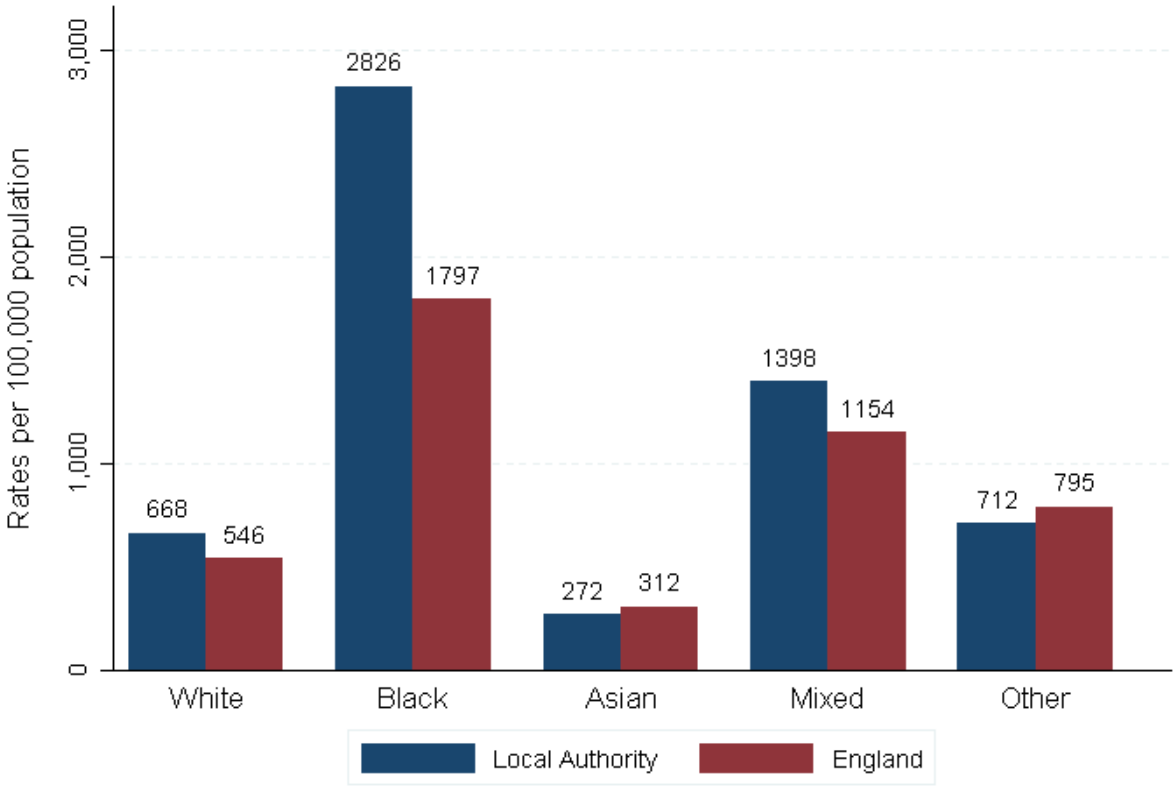
The proportion of new STIs diagnosed in GUM clinics by ethnic group is shown in table 4. Where recorded, 7.8% of new STIs diagnosed in Walsall were in people born overseas.

Table 4. Number and proportion of new STIs by ethnic group (GUM diagnoses only): 2013

Ethnic group	*Number*	*%*
Asian or Asian British	109	5.7
Other ethnic groups	23	1.2
Not specified	87	4.5
Mixed	101	5.3
White	1420	74.0
Black or Black British	180	9.4

Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM

Figure 6. Rates of new STIs by ethnic group in Walsall and England (GUM diagnoses only): 2013



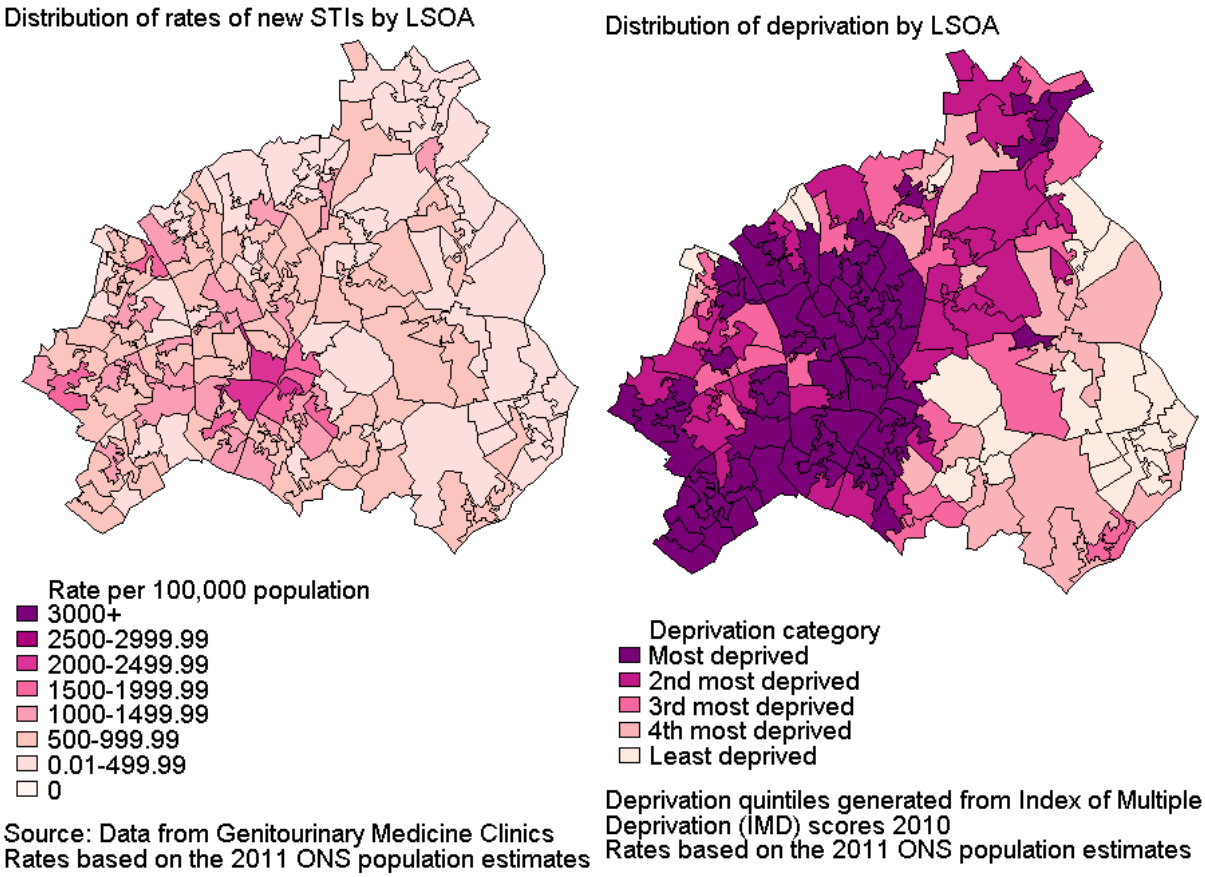
Source: Data from Genitourinary Medicine clinics
Excludes chlamydia diagnoses made outside GUM
Rates based on the 2011 ONS population estimates

Distribution of new STIs and deprivation

There is considerable geographic variation in the distribution of STIs and for Walsall, this is highlighted in Figure 7.

Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of new STIs and the index of multiple deprivation across England. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. The rates of new STIs by deprivation category are displayed in Figure 8.

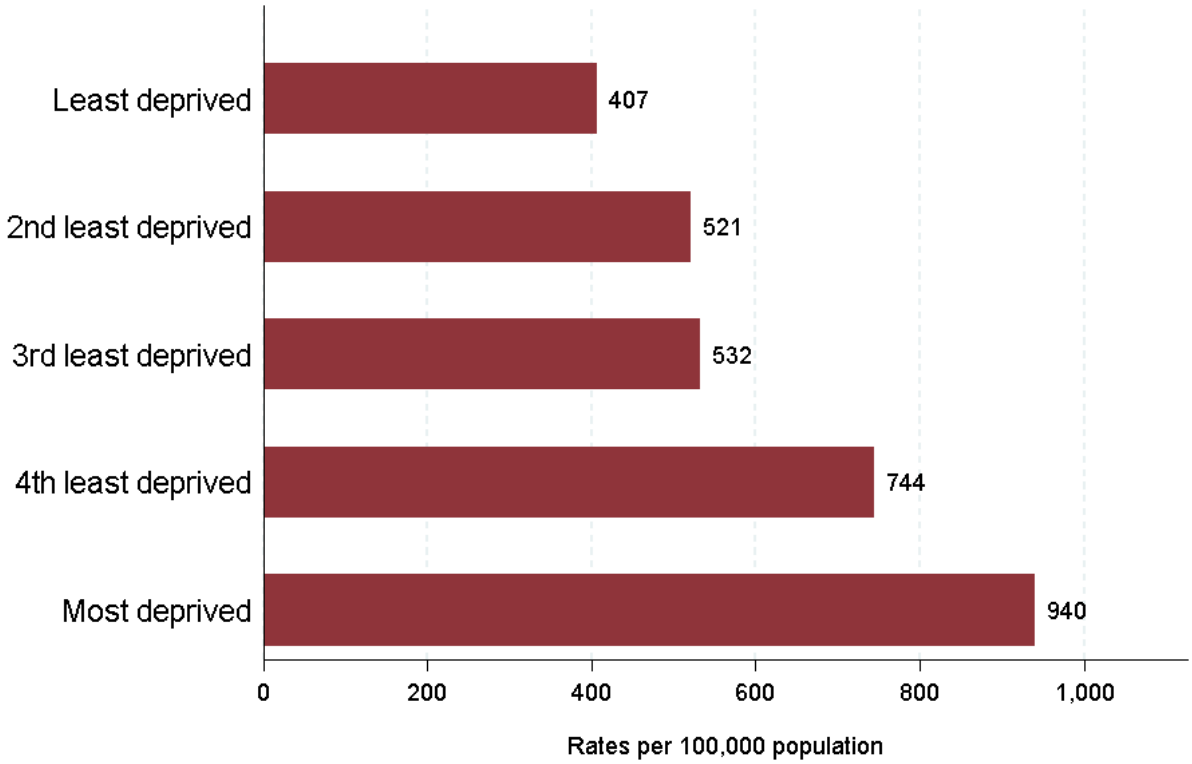
Figure 7. Rates of new STIs and deprivation by LSOA* in Walsall (GUM diagnoses only): 2013



Excludes chlamydia diagnoses made outside GUM.

* Lower Layer Super Output Areas (LSOA) are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1,000 and the mean is 1,500.

Figure 8. Rates of new STIs by deprivation category in Walsall (GUM diagnoses only): 2013



Source: Data from Genitourinary Medicine Clinics
Rates based on the 2011 ONS population estimates
Excludes chlamydia diagnoses made outside GUM

GUM clinic service use

Information on the clinics attended by residents of Walsall is shown in table 5. The table shows the list of GUM clinics with more than ten attendances by residents of Walsall.

Table 5. Percent of all attendances by Walsall residents at GUM clinics: 2013

Clinic name	*% of all attendances*
The Manor Hospital	82.0
Whittall Street Clinic	5.8
New Cross Hospital	5.1
Birmingham Heartlands Hospital	1.9
Sandwell General Hospital	1.5
Cannock Chase Hospital	1.0
Russells Hall Hospital	0.7
Sir Robert Peel Hospital	0.5

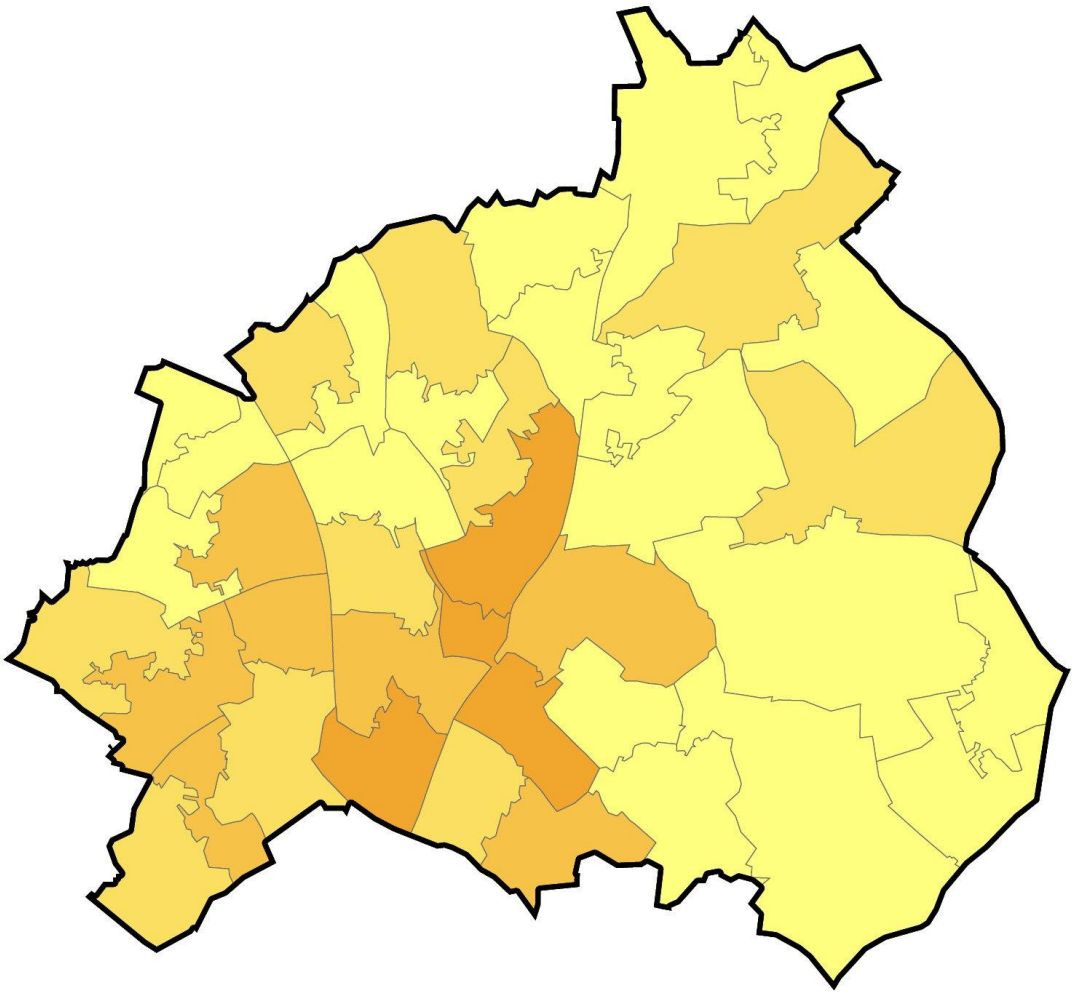
Robust epidemiological information to inform local commissioning is reliant on good quality data from GUM clinics. Appendix 4 has information on data quality from clinics that Walsall residents attended re. sexual orientation, ethnicity, country of birth, gender, age and LSOA. If this information is poorly collected, then this may result in artificially low STI rates/proportions in certain groups e.g. in MSM or ethnic groups.

HIV

Diagnosed HIV prevalence

In 2013, the diagnosed HIV prevalence rate in Walsall was 1.6 per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England. 26% of the MSOAs in this local authority had a prevalence rate higher than 2 per 1,000 (Figure 9).

Figure 9. Prevalence of diagnosed HIV in 15 to 59 year olds (per 1,000) by MSOA: 2013



Prevalence of diagnosed HIV infection
per 1,000 population aged 15-59

- 0 - 0.99
- 1 - 1.99
- 2 - 3.99
- 4 - 5.99
- 6 - 9.99
- 10 - 19.99
- 20+

People living with diagnosed HIV

In 2013, 273 adult residents (aged 15 years and older) in Walsall received HIV-related care: 152 males and 121 females. Among these, 39.6% were white, 49.1% black African and 5.5% black Caribbean. With regards to exposure, 30.8% probably acquired their infection through sex between men and 65.2% through sex between men and women (Table 6).

Table 6. Number of adults living with diagnosed HIV by ethnicity and exposure group in Walsall: 2009 and 2013

		2009	*% 2009*	*2013*	*% 2013*
Ethnicity	White	75	40.8	108	39.6
	Black Caribbean	6	3.3	15	5.5
	Black African	94	51.1	134	49.1
	Other	9	4.9	15	5.5
	Not known	0	0.0	1	0.4
Probable route of infection	Sex between men	57	31.0	84	30.8
	Sex between men and women	118	64.1	178	65.2
	Injecting drug use	5	2.7	6	2.2
	Other/Not known	4	2.2	5	1.8
Total	Total	184	100.0	273	100.0

Source: The Survey of Prevalent HIV Infections Diagnosed (SOPHID)

New HIV diagnoses

In England, of those diagnosed with HIV infection in 2013, 80% had residence information available through linkage with The Survey of Prevalent HIV Infections Diagnosed (SOPHID).

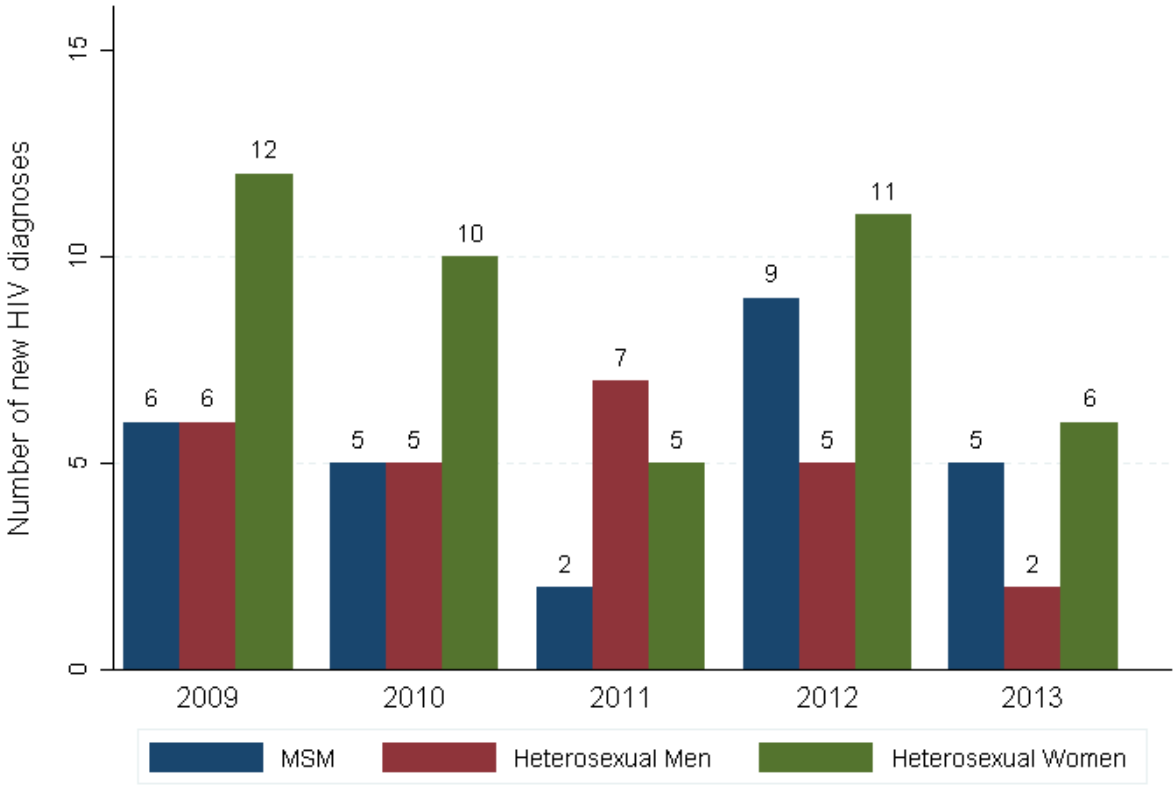
Where residence information was available in 2013, 13 adult residents of Walsall were newly diagnosed with HIV. Among those who acquired their HIV through sex, 5 new HIV diagnoses were among MSM, 2 among heterosexual men and 6 among heterosexual women (Figure 10).

HIV late diagnoses

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the Public Health Outcomes Framework and monitoring is essential to evaluate the success of expanded HIV testing.

In Walsall, between 2011 and 2013, 58% (95% CI 42-72) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm^3 within 3 months of diagnosis) compared to 45% (95% CI 44-46) in England. 36% (95% CI 13-65) of men who have sex with men (MSM) and 68% (95% CI 49-83) of heterosexuals were diagnosed late.

Figure 10. Number of adults newly diagnosed with HIV by route of sexual transmission, gender and year of diagnosis in Walsall: 2009-2013



Source:
HIV and AIDS new diagnoses and deaths
The Survey of Prevalent HIV Infections Diagnosed (SOPHID)

Offer and uptake of HIV testing at eligible* attendances in GUM clinics

In 2013, a HIV test was offered at 84.1% of eligible attendances at GUM clinics among residents of Walsall and, where offered, a HIV test was done in 64.9% of these attendances.

Nationally, a HIV test was offered at 79.4% of eligible attendances at GUM clinics and, where offered, a HIV test was done in 80.0% of these attendances.

Coverage of HIV testing among eligible* patients at GUM clinics

In 2013, among GUM clinic patients from Walsall who were eligible to be tested for HIV, 59.7% were tested.

Nationally, 71.0% of GUM clinic patients who were eligible to be tested for HIV were tested.

* When calculating these rates, eligibility for HIV testing is determined by reviewing previous HIV diagnosis and testing history for each patient. Those who are known to be HIV positive, based on their GUMCADv2 history, are not considered eligible for testing. Those who have been tested already are not considered eligible to be tested again until six weeks have passed (i.e. eligibility for testing occurs only once every six weeks).

Reproductive Health

Abortion

Abortion data is not available at lower tier local authority level so only upper tier information is presented in this section.

The total abortion rate, access to NHS funded abortions at less than 10 weeks gestation, and under and over 25 years repeat abortion rates are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

The National Survey of Sexual Attitudes and Lifestyles (NATSAL 2010) found that 16.2% of pregnancies in the year before the study interview were unplanned. This survey found that:

- pregnancies among 16 to 19 year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number were unplanned.
- the highest numbers of unplanned pregnancies occur in the 20 to 34 year age group.

Unplanned pregnancies can end in abortion or a maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children. Restricting access to contraceptive provision by age can therefore be counterproductive and ultimately increase costs.

In 2013, in Walsall upper tier local authority:

- the total abortion rate per 1,000 female population aged 15-44 years was 18.6, while in England the rate was 16.6. The rank (out of 146) within England for the total abortion rate (1st has the highest rate) was 47.
- among women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 35.5%, while in England the proportion was 26.9%. The rank (out of 129) within England for the repeat abortion under 25 years (1st has the highest rate) was 6.
- among women aged 25 and over who had an abortion in that year, the proportion of those who had had a previous abortion was 44.1%, while in England the proportion was 45.3%. The rank (out of 146) within England for the repeat abortion carried out by women aged 25 and over (1st has the highest rate) was 75.
- among NHS funded abortions, the proportion of those under 10 weeks gestation was 81.8%, while in England the proportion was 79.4%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

Teenage pregnancy

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty.

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

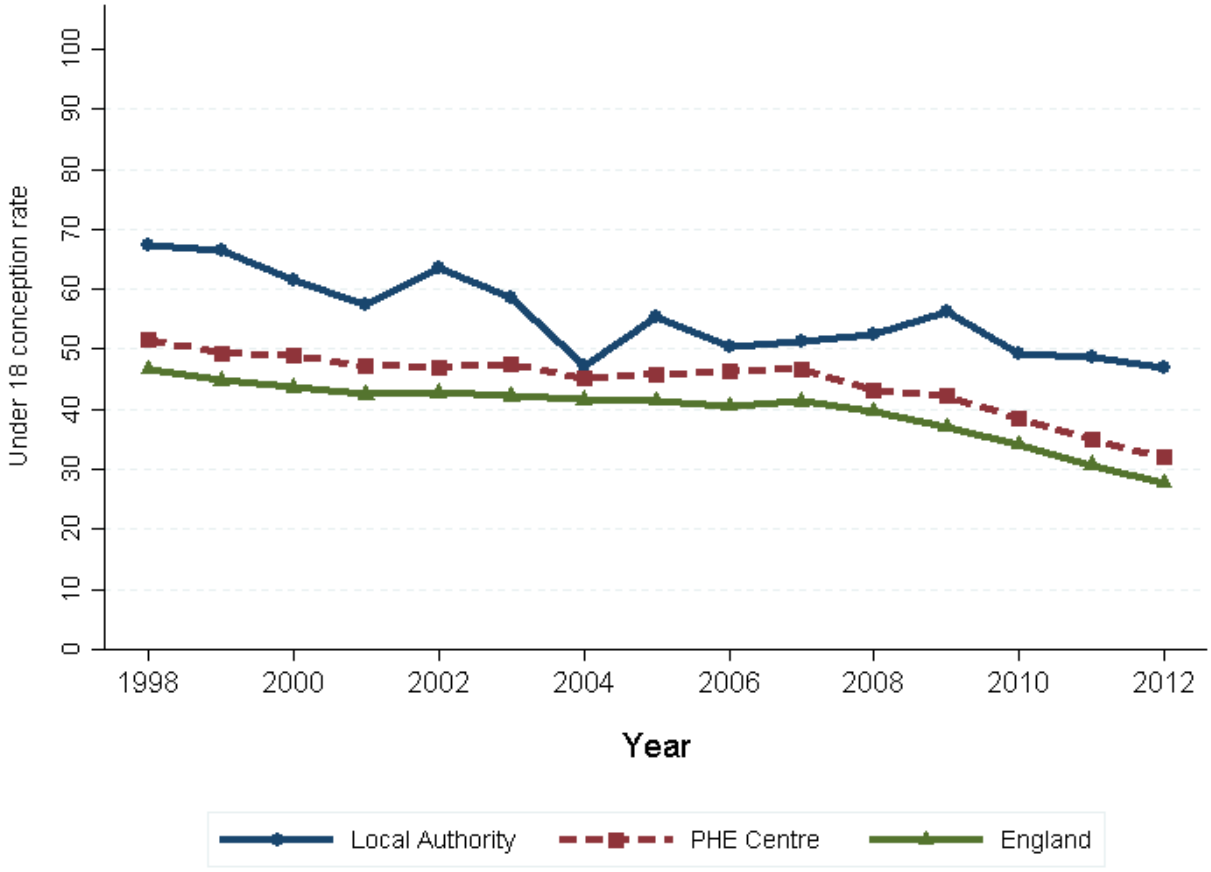
The rate of conceptions in under 18 year olds is an indicator in the Public Health Outcome Framework.

In 2012, in Walsall:

- the under 18 conception rate per 1,000 female aged 15 to 17 years was 46.9, while in England the rate was 27.7. The rank (out of 324) within England for the under 18 conception rate (1st has the highest rate) was 6. Between 1998 and 2012, Walsall achieved a 30.2% reduction in the under 18 conception rate, compared to a 40.5% reduction in England.

- among the under 18 conceptions, the proportion of those leading to abortion was 40.3%, while in England the proportion was 49.1%. The rank (out of 311) within England for the under 18 conceptions leading to abortion (1st has the highest percentage) was 271.

Figure 11. Under 18 conception rates per 1,000 females aged 15 to 17 years, in Walsall, West Midlands PHE Centre and England: 1998 to 2012



Contraception

The Department of Health's A Framework for Sexual Health Improvement in England indicated that up to 50% of pregnancies are unplanned. The government and the Faculty of Sexual and Reproductive Healthcare both highlight the importance of knowledge, access and choice for all women and men to all methods of contraception to aid in the reduction of unwanted pregnancies. Good contraception services have shown to lower rates of teenage conceptions, which is one of the indicators in the Public Health Outcomes Framework.

Contraception is widely available in the UK from a number of sources, and is provided free by the NHS for women and men of all ages. Contraception is available free of charge from: general practices, sexual and reproductive health (SRH) services, young person's clinics, NHS 'walk-in centres (emergency contraception only), some GUM clinics (emergency contraception and male condoms) and some pharmacists under a Patient Group Direction (emergency contraception).

Condoms are not prescribable on the NHS, and are therefore not available from prescription data from GPs. Condoms can also be purchased from pharmacies, supermarkets, and other retailers. Emergency hormonal contraception can also be bought over the counter at some pharmacies and private clinics.

Data on contraception is currently only collected from SRH services and some young person's clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care (see below section). Data from other providers are not available.

SRHAD is collected and collated by the Health and Social Care Information Centre. Reporting of the data is currently restricted under National Statistics rules, whereby disclosure of the data prior to the annual publication is prohibited. The NHS Contraceptive Services England, 2012/13 annual report will be published on 31 October 2014. SRHAD data for the LASERs will be released as a separate appendix after this date. This appendix will provide further analysis of the data from SRHAD and expand on the prescribing data on contraception provision section below.

Prescribing data on contraception provision

NHS Prescription Services, which is part of the NHS Business Services Authority (NHSBSA), uses NHS prescription forms to calculate how much pharmacists, GPs who dispense and appliance contractors should be paid as reimbursement and remuneration for medicines and medical devises dispersed to patients within primary care settings in England. This data is known as the Prescribing Analysis and CosT (PACT) data and is available to authorised users at Primary Care Organisations/Area Teams/Trusts and National users.

PACT data contains items that have been prescribed and dispensed, items that were not dispensed i.e prescriptions that were not collected are not included in the data. Please note data presented here is only from PACT, contraception prescribed or bought outside of PACT are not included (e.g. data from community sexual and reproductive health services, pharmacies and young people services etc).

The different methods of contraception prescribed within a primary care setting are presented in table 7. Care should be taken when interpreting this information as the total number of prescriptions is not representative of the number of women who have received each contraceptive method.

Long acting reversible contraception (LARCs) methods such as contraceptive injections, implants, intra-uterine system (IUS) or intrauterine device (IUD) are more effective as they do not depend on daily concordance. They are also considered to be more cost effective than User Dependent Methods (UDM), and their increased uptake could further help to reduce unintended pregnancy (NICE Clinical Guideline CG30 http://www.nice.org.uk/CG030). All currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use.

Table 7. Number of types of contraception and percentage of total contraception prescribed within a primary care setting: 2013

Choice	*Method*	*LA (n)*	*LA (%)*	*PHE Centre (n)*	*PHE Centre (%)*	*England (n)*	*England (%)*
LARCs	IU Device	141	0.4	4313	0.5	42466	0.5
	IU System	224	0.6	12656	1.5	132876	1.6
	Injectable Contraceptive¥	5630	15.9	109332	13.1	979573	11.4
	Implant	382	1.1	16899	2.0	158092	1.8
	TOTAL LARCs	6377	18.0	143200	17.2	1313007	15.3
UDM	Oral Contraceptives*	28729	80.9	680178	81.6	7150537	83.6
	Contraceptive Patch	382	1.1	8998	1.1	70407	0.8
	Other±	11	0.0	1325	0.2	24383	0.3
	TOTAL UDM	29122	82.0	690501	82.8	7245327	84.7
	TOTAL CONTRACEPTION	35499	100.0	833701	100.0	8558334	100.0

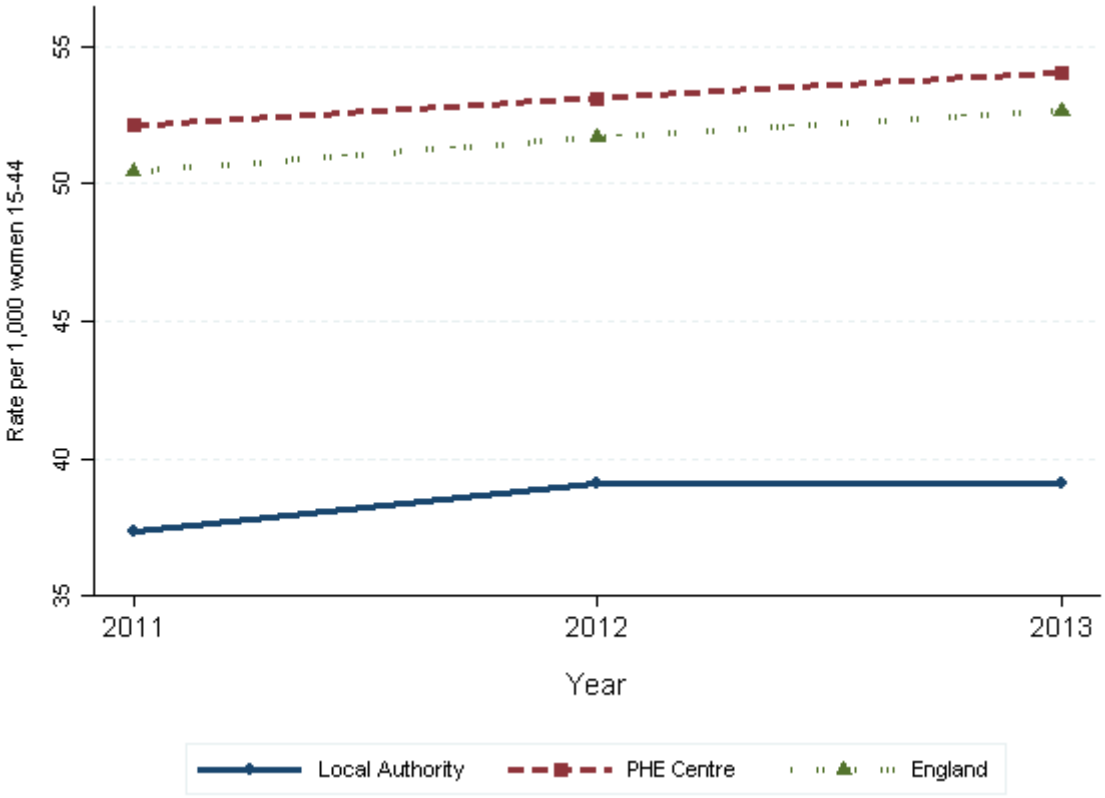
¥Excludes Norethisterone Enantate under LARC numbers but included under total contraception.
Number of individual DMPA doses prescribed reported, divided by 4.3 (estimated that to supply one woman with DMPA for one year requires 4.3 injections) for adjusted numerator (same as Sexual Health Profiles) – method adopted based on that undertaken for the London Sexual Health Needs Assessment mapping exercise 2008).
*Includes combined pill and progesterone only pill
±Includes vaginal ring, cap/diaphragm and spermicides
Source: NHS Prescription Services' Prescribing Database

The rate of LARCs prescribed in a primary care setting between 2011 and 2013 is shown in Figure 12. In 2013, Walsall is ranked 276 out of 326 local authorities in England for the rate of GP prescribed LARCs, with a rate of 39.1 per 1,000 women aged 15 to 44 years, compared to 52.7 in England.

The number of LARCs reported is not indicative of concordance as data on LARC removals are not available. Discontinuation is an important driver of relative cost effectiveness between LARC methods.

Please note only PACT data is included here and further data from SRH services will be presented in the contraception appendix, once SRHAD data is available.

Figure 12. Rates per 1,000 women aged 15 to 44* of LARCs prescribed in primary care for Walsall local authority, West Midlands PHE Centre and England: 2011 to 2013**



*Age not provided for PACT data
** Adjusted DMPA injectables reported (number of doses prescribed divided by 4.3. Estimated that to supply one woman with DMPA for one year requires 4.3 injections – method adopted based on that undertaken for the London Sexual Health Needs Assessment mapping exercise 2008).
Source: NHS Prescription Services' Prescribing Database
Rates based on the 2013 ONS population estimates (women aged 15-44 years)

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Martin Ewin
Public Health Intelligence Manager

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Appendix 1: Data sources

STIs

- Genitourinary Medicine Clinic Activity Dataset v2 (GUMCADv2)
- Chlamydia test & diagnosis data from community services are sourced from NCSP and 'Non-NCSP/Non-GUM' services for 2008-2011 and include only those aged 15-24 years. From 2012, chlamydia test and diagnosis data are sourced from CTAD and include all ages.

HIV

- The Survey of Prevalent HIV Infections Diagnosed (SOPHID)
- HIV and AIDS new diagnoses and deaths
- CD4 Surveillance Scheme
- Genitourinary Medicine Clinic Activity Dataset v2 (GUMCADv2)

Reproductive Health

- Abortion statistics, England and Wales: 2013, Department of Health
- Sexual and Reproductive Health Profiles, PHE

Contraception

- Electronic Prescribing Analysis and Cost (ePACT): 2013, NHS Prescription Services

Notes

1. STI data presented are compiled from a combination of sources and reflect diagnoses made in GUM clinics and include chlamydia diagnoses made in other community healthcare and non-healthcare settings such as general practice

2. STI data presented are the number of diagnoses reported and not the number of people diagnosed (except for data on coverage of offer and uptake of HIV tests)

3. Rates are calculated using ONS population estimates based upon the 2011 Census.

4. This report uses STI data as of 08 April 2014

Appendix 2 (Table 8): Number of cases of each new STI diagnosed in Walsall (including GUMCAD codes): 2009 - 2013

Please note that due to significant changes in the collection of chlamydia data in 2012 onwards, comparisons to numbers of new STIs and chlamydia infections in previous years are not robust.

Diagnoses	*Codes**	*2009*	*2010*	*2011*	*2012*	*2013*
New sexually transmitted infections (New STIs) †	All codes in this table	1833	2135	2247	3117	2631
Chancroid / LGV / Donovanosis	C1, C2, C3	4	3	0	1	1
Chlamydia ‡	C4, C4A, C4B, C4C	857	1070	991	1965	1204
Gonorrhoea	B, B1, B2, B5	66	96	137	127	142
Herpes: anogenital herpes (first episode)	C10A	67	88	105	143	168
HIV new diagnosis	E1A, E2A, E3A1, H1, H1A, H1B, H1X, H1AX, H1BX	20	16	12	20	19
Molluscum contagiosum	C12	53	62	56	53	50
Non-specific genital infection (NSGI)	C4H, C4N	282	268	463	381	458
Pelvic inflammatory disease (PID) & epididymitis: non-specific ¥	C5, C5A	187	191	137	60	119
Scabies / pediculosis pubis	C8, C9	8	8	0	8	14
Syphilis: primary, secondary & early latent	A1, A2, A3	13	20	9	9	18
Trichomoniasis	C6A	24	39	34	41	75
Warts: Anogenital warts (first episode)	C11A	252	274	303	309	363

* Please see Appendix 3 for information on codes
† Data from GUMCADv2 and community settings (for chlamydia diagnoses only)
‡ Chlamydia diagnoses data from GUMCADv2 and community settings
¥ Chlamydial and gonococcal PIDs are included in chlamydia and gonorrhoea totals
Data Source: The Genitourinary Medicine Clinic Activity Dataset v2(GUMCADv2) and community settings CTAD(for chlamydia diagnoses only)

Appendix 3: New sexually transmitted infections (STIs)

Suffixes of relevant SHHAPT codes* have been removed during the data cleaning procedure, but the base codes of suffixes have been included in the following list.

New STIs include:

A1 Primary syphilis
A2 Secondary syphilis
A3 Early latent syphilis
B Gonorrhoea
B1 Uncomplicated post-pubertal gonorrhoea
B2 Uncomplicated pre-pubertal gonorrhoea
B5 Complicated gonococcal infection – including PID and epididymitis
C1 Chancroid
C2 Lymphogranuloma venereum
C3 Donovanosis
C4 Chlamydial infection
C4A Uncomplicated chlamydial infection of the lower genital tract
C4B Complicated chlamydial infection – including PID and epididymitis
C4C Uncomplicated chlamydial infection, other sites
C4H Uncomplicated non-gonococcal/non-specific urethritis in males, or treatment of mucopurulent cervicitis in females
C4N Non-specific genital infection
C5 Complicated infection (non-chlamydial/non-gonococcal) – including PID and epididymitis
C5A Pelvic inflammatory disease and epididymitis (excluding C4 or B)
C6A Trichomoniasis
C8 Scabies
C9 Pediculosis pubis
C10A Anogenital herpes simplex - first episode
C11A Anogenital warts infection - first episode
C12 Molluscum contagiosum
E1A New HIV diagnosis - asymptomatic
E2A New HIV diagnosis - symptomatic
E3A1 New HIV diagnosis - late infection
H1 New HIV diagnosis
H1X New HIV diagnosis - diagnosed elsewhere
H1A HIV new diagnosis - acute infection
H1AX HIV new diagnosis - acute infection - diagnosed previously elsewhere
H1B New HIV diagnosis - late infection
H1BX New HIV diagnosis - late infection - diagnosed elsewhere

* SHHAPT codes: Sexual Health and HIV Activity Property Type (SHHAPT) codes, previously known as KC60 codes. These codes are used by clinic staff for coding data of GUMCADv2 extracts.

Appendix 4: Local clinics and data quality

Table 9 shows the list of clinics with more than ten attendances by residents of Walsall sorted by the number of attendances to clinics (highest to lowest).

Table 9. Percent of attendances to GUM clinics with "known" information on sexual orientation, ethnicity, country of birth, gender, age and patient LSOA by residents from Walsall: 2013

Clinic name	*Sexual orientation*	*Ethnicity*	*Country of birth*	*Gender*	*Age*	*LSOA*
The Manor Hospital	96.9	95.6	99.7	100	100	100
Whittall Street Clinic	99.4	97.6	98.7	99.4	100	100
New Cross Hospital	86.6	99.2	98	100	100	100
Birmingham Heartlands Hospital	53.7	97.2	91.7	100	100	100
Sandwell General Hospital	100	100	100	100	100	100
Cannock Chase Hospital	100	100	100	100	100	100
Russells Hall Hospital	100	100	96.1	100	100	100
Sir Robert Peel Hospital	88.9	98.4	100	100	100	100