Halton Joint Strategic Needs Assessment 2024

Sexual and Reproductive Health

Reader information	
Author	Adam Majors
Contributors	Katherine Woodcock, Grace Grange
Reviewer	Jennifer Oultram
Number of pages	66
Date release	January 2025
Contact	sharon.mcateer@halton.gov.uk
Related documents	

Version Control

Version Number	Date	Authors
1	January 2024	Katherine Woodcock, Adam Major, Grace Grange, Beth Milton – first draft commenced – adding relevant data, insight and information
2	March 2024	Adam Major - Draft
3	April 2024	Adam Major, Grace Grange – Final Draft
Final	August 2024	Adam Major – Final Report
Proof read	December 2024	Jennifer Oultram
Published	January 2025	

Contents

Table of Figures

Key findings and recommendations

Overall

Establish an appropriate multi-agency governance forum to oversee the delivery of sexual and reproductive health in Halton.

Ensuring that we have a workforce that is well trained and skilled to deliver a broad range of specialist and non-specialist sexual health services is critical. Workforce pressures have the potential to significantly impact on delivery of these services. Workforce planning, development and training needs to be prioritised at a local and regional level.

Sexually Transmitted Infections (STIs)

STI diagnoses were greatly impacted by the pandemic. Whilst recent indications show that STI diagnoses are returning to the pre-pandemic trend. Since the pandemic, large increases in rates of Gonorrhoea and Syphilis have been observed and may need specific attention. We need to continue to monitor STI diagnoses and action any observed rises accordingly.

Whilst Halton sexual health services appear to be well utilised, we need to continue to develop insight with our underserved and most at risk communities and work with these groups to understand how we can develop the STI testing and treatment offer locally.

Qualitative feedback indicates there is a need to improve knowledge on how to access services, both online and in clinic, ensuring they are discreet, non-judgemental and inclusive. There is also an identified need for improved education in schools, and also throughout the life course.

Partner notification is crucial to help contain the spread of STIs and is an integral role of sexual health services, but identifying and treating anonymous partners remains a challenge. Opportunities and innovations to increase partner notification within our local sexual health service needs to be fully explored.

It is important that people engaging in Chemsex are able to access the right support to minimise risk. Local intelligence around the use of Chemsex is limited; further insight and intelligence is needed to inform future service provision for both sexual health and substance misuse services and to raise the profile locally.

Chlamydia and the National Chlamydia Screening Programme (NCSP)

Achievement of the revised female-only detection rate target of 3,250 per 100,000 (aged 15 to 24yrs) is unlikely to be met in Halton without focussed activity to increase chlamydia screening, particularly within the community. A scaling up of the NCSP within community settings to increase chlamydia screening is needed, in particular settings such as outpatient departments, walk in centres, maternity and gynaecological services as well as settings specifically for young people such as colleges and youth services.

A guidance document to support the implementation of the NCSP outlines the minimum standards required to support an evidence-based and cost-effective approach. The local service should audit practice against the latest 2022 NCSP Standards to identify if any standards are not being met and possible areas for development.

HIV (Human Immunodeficiency Virus)

Halton is not an area of high HIV prevalence but increasing the number of people that are diagnosed promptly should be a priority.

We need to increase the number of people being tested for HIV in Halton. This includes those most at risk, (historically gay and bisexual men and other men who have sex with men (GBMSM)) but also amongst heterosexual men and women who nationally, make up a greater proportion of people diagnosed.

Opportunities to normalise HIV testing should be explored, including increasing provision of testing in primary care and emergency departments. Testing in a wider range of services such as drug and alcohol services, pharmacies and abortion services is also recommended.

There is a need for the continuation of outreach services to engage with high-risk communities such as people with multiple and overlapping sexual partners, to improve access to testing. Other innovative methods for engaging with underserved communities should be explored.

HIV postal testing has proved to be a highly acceptable route for testing. This should continue to be widely promoted and other options for discrete delivery to be explored, such as a click and collect services. Improved equality monitoring of the postal offer is recommended to help identify inequities in access and improve engagement with those that are digitally excluded.

Partner notification (PN) should remain a key part of sexual health service provision as an effective means to identify people with an undiagnosed HIV infection. There should be a consideration for alternative methods of PN including both digital and non-digital approaches.
Ensuring access to pre-exposure prophylaxis (PrEP) to all groups is important for all high-risk groups but in particular higher risk heterosexual men and heterosexual and bisexual women where uptake has been lower.

Unplanned Pregnancy

Halton has had a high abortion rate for some time. Women need good access to local contraception services with the full range of contraception options on offer. Engaging with underserved communities, including young women and women from deprived and disadvantaged communities in particular should be prioritised.

Sexual and reproductive health services should continue to deliver a comprehensive Long Acting Reversible Contraception (LARC) service, with outreach activity and enhanced provision for groups at greater risk of unplanned pregnancy. Or for those who historically are underserved by mainstream provision (e.g. people with a disability, or people from different minority ethnic backgrounds).

Focussed work is needed with primary care to improve availability of contraception, and to ensure that a full range of contraceptives is proactively offered by healthcare professionals.

Maximum uptake of the NHS Community Pharmacy Contraception Pilot needs to be ensured, encouraging more pharmacies in Halton to provide this service. This will help to improve accessibility to oral contraception and help to relieve the burden on sexual health services and primary care, creating more capacity for focused delivery of LARCs. This appears to be highly acceptable amongst women, with many stating they would be happy to get their contraceptive pill from non-traditional clinical settings such as pharmacies or online.

Ensure joined-up commissioning for gynaecological and reproductive health in line with the recommendations from the Women's Health Strategy. There should be a system-wide approach to women's reproductive health with partners within One Halton, so that women and girls can have more of their health needs met within integrated services.

Teenage Conceptions

Halton has a higher conception rate for both under 18s and under 16s when compared to England as a whole. System wide strategic leadership is required in order increase the profile locally and to enable a co-ordinated response across a range of stakeholders.

To help identify gaps and opportunities locally, and to support a co-ordinated response, a review of the Teenage Pregnancy Framework guidance is recommended including completion of the self-assessment checklist.

Introduction

About this Needs Assessment

The purpose of this Needs Assessment is to understand the Sexual and Reproductive Health (SRH) needs, demand and desires of the Halton population. This will be used to inform and shape the provision of Halton's SRH services in the future, to prioritise and identify key areas for development and ensure that any decisions are clearly based on the available evidence.

There is a wealth of intelligence that already exists on the topic of SRH so this needs assessment does not intend to repeat this and will signpost accordingly to the existing sources of information. Instead, this needs assessment will focus on specific topics where the latest intelligence tells us that improvement is required; we will scrutinise in more detail what, why and how improvements should be made in collaboration with our partners across the health and social care system.

The areas for improvement identified and explored in more detail are:

- Sexually Transmitted Infection (STI) testing
- Chlamydia Screening (young people aged 15-24yrs)
- HIV Late Diagnosis
- Teenage Conceptions
- Unplanned pregnancy

What is Sexual and Reproductive Health?

Good sexual and reproductive health is an important contributor to our overall wellbeing. The World Health Organisation (WHO) defines sexual health as a state of physical, mental and social wellbeing in relation to sexuality. This means being able to live within an environment that is respectful of an individual's sexuality encouraging safe sexual experiences free from coercion, discrimination and violence[1].

Most adults are sexually active, therefore good sexual and reproductive health is important to the overall health and wellbeing of individuals and society as a whole. SRH needs and behaviours will be impacted by a range of factors including age, gender, sexuality, ethnicity, mental wellbeing, education, literacy and cultural factors but there are core requirements common to all to ensure positive SRH. This includes good quality information and education to support people to make informed choices, being free from stigma, discrimination and coercion and access to high quality services, treatment and interventions[2].

Poor sexual and reproductive health manifests in, for example, sexually transmitted infections or unplanned pregnancies, with some population groups significantly more likely to experience poor sexual health. Therefore, this is an important area of focus for public health.

[1] WHO Sexual and Reproductive Health Research https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health

[2] OHID. Guidance: Sexual and Reproductive health and HIV: Applying All our Health. Updated 10 March 2022. Accessed: https://www.gov.uk/government/publications/sexual-and-reproductive-health-and-hiv-applying-all-our-health/sexual-and-reproductive-health-and-hiv-applying-all-our-health

National and local context

National Context

Women's Health Strategy for England

The Women's Health Strategy for England[3] published by the Department for Health & Social Care in August 2022 recognises that historically the health and care system has been designed by men for men, and not enough is known about issues that affect women only, such as endometriosis and the menopause. **It acknowledges that many women have to move from service to service to have their basic reproductive health needs met and women can struggle to access basic services such as contraception.**

Commitments include:

- Young people receiving high quality, evidence-based education on menstrual and gynaecological conditions, so that they are no longer taboo subjects.
- **All women and girls are able to access high-quality, personalised care within primary and community care, including access to contraception for the management of menstrual problems and gynaecological conditions.** Where more specialist care is needed, women and girls can access diagnostic and treatment procedures in a timely manner and disparities in access to care will be tackled.
- Healthcare professionals in primary care are well informed and trained in menstrual and gynaecological health and can offer women and girls evidence-based advice and treatment.
- Women can access high-quality, personalised menopause care within primary care and, if needed, specialist care in a timely manner, and disparities in access to menopause treatment are reduced. **Women are able to access the full range of treatment options, including contraception for the management of menopause symptoms.**
- **There is a system-wide approach to women's reproductive health –** as set out in the reproductive health consensus statement – based on reproductive wellbeing and supporting individual choice. This means national and local policies and services are centred on women and girl's needs, and reflect the life course approach, rather than being organised around a specific health issue or the needs of commissioners.
- **Women and girls have more of their health needs met at one time and in one place, through the development of local pathways that bring together and improve access to services** – for example, into women's health hubs. Achieving this ambition will require partnership working across all policy, commissioning, and delivery partners.
- Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making. This enables women to plan any subsequent pregnancy and reduce short inter-pregnancy intervals, which are associated with poorer pregnancy outcomes. **Contraception in maternity settings is actively encouraged** with a case study provided on how this is being achieved in North-West London.

Sexual and Reproductive Health Action Plan

This national action plan is yet to be published but this is referenced in the Women's Health Strategy and will include a focus on increasing access and choice for all women who want contraception. This includes Long Acting Reversible Contraception (LARC), and improving women's experiences, including during fitting and removal of an Intrauterine Device (IUD) or (Intrauterine system (IUS)

[3] DHSC (2022). Policy Paper. Women's Health Strategy for England. 30 August 2022. https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

The Hatfield Vision

Developed by the Faculty of Sexual & Reproductive Healthcare (FSRH), The Hatfield Vision outlines priority goals and actions (endorsed by 28 organisations) in areas such as access to contraception, reproductive rights, menopause, menstrual health, cervical screening and maternal health outcomes in black women and women of colour[4].

The Hatfield Vision aims to connect the Government's Women's Health and Sexual and Reproductive Health (SRH) Strategies and Action Plans in England, driving meaningful transformation across different parts of the system and enabling women and girls to experience high quality reproductive health at every stage of their lives. At the heart of The Hatfield Vision is an ambitious target, which advocates that by 2030, reproductive health inequalities will have significantly improved for all women and girls, enabling them to live well and pursue their ambitions in every aspect of their lives. This target will be reached and can be measured by success in achieving 16 goals in different areas of women and girls' SRH, including addressing unplanned pregnancies and improving access to chosen methods of contraception.

Breaking point: Securing the future of sexual health services

The Local Government Association (LGA) and English HIV and Sexual Health Commissioners' Group (EHSHCG) produced this report in November 2022, focusing on demand and funding pressures. The report reviews the trends since local authorities took responsibility for sexual health services in 2013, looking at the social and economic context in which they occurred[5].

Key messages include:

- Significant increase in the number of consultations at Sexual Health Services over the last 10 years.
- Number of screens and the overall number of services offered has increased, public awareness of Sexually Transmitted Infections (STIs) and contraception has grown.
- Local councils have been engaged in one of the biggest modernisation exercises in the history of public health, such as a rapid channel shift to online consultations, mobile phone apps, home testing and home sampling.
- Evidence from across the sector shows the capacity of councils to further innovate and create greater efficiencies is now limited.
- Unless greater recognition and funding is given to councils to invest in prevention services, a reversal in the encouraging and continuing fall in some STIs and more unwanted pregnancies is now a real risk, as is their ability to respond to unforeseen challenges such as Mpox.
- Behavioural change has increased demand.
- Equitable access to contraception remains a problem.

Joint United Nations Programme on HIV/AIDS (UNAIDS) (UNAIDS 90-90-90 Target)

The Joint United Nations Programme on HIV/AIDs (UNAIDS) 90-90-90 aims to eliminate AIDS by 2030, by ensuring that in 2020:

- 90% of people living with HIV would know their status.
- 90% of people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART)
- 90% of people receiving ART will have viral suppression.

[4] FSRH (2022). Faculty of Sexual and reproductive Healthcare Hatfield Vision. A Framework to Improve Women and Girls' Reproductive Health Outcomes. July 2022. https://www.fsrh.org/documents/fsrh-hatfield-vision-july-2022/

[5] Local Government Association (2022). Breaking point: Securing the future of sexual health services. 15 Nov 2022. https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services

In 2017, the UK was one of the first countries to meet this target[6]. In 2019, an estimated 94% of people living with HIV had been diagnosed, 98% of those diagnosed were on treatment and 97% of those on treatment had an undetectable viral load – meaning they cannot pass on the infection[7].

Towards Zero – An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England 2022 – 2025[8]

This national plan published in December 2021 by the Department for Health and Social Care sets out how an 80% reduction in new HIV infections will be achieved by 2030 with a focus on four key themes – prevent, test, treat and retain. **The overarching ambition is to achieve zero new infections, AIDS and HIV-related deaths in England by 2030**. The plan provides a framework for how this will be achieved via the following objectives:

1. **Ensure equitable access and uptake of HIV prevention programmes.**
   Evidence suggests that awareness, accessibility, availability and uptake of primary prevention initiatives is variable in different demographics and addressing this disparity is key to HIV prevention. There is also a need to make up any lost ground due to the impact of the COVID-19 pandemic and understand how it has affected HIV prevention.
2. **Scale up HIV testing in line with national guidelines.**
   HIV testing is essential so that everyone with an HIV infection can be offered lifesaving treatment, which also prevents onward HIV transmission by reducing viral load to undetectable and untransmittable levels. However, many people that would benefit from testing are still being missed. Testing must be made more accessible, particularly for those groups being under-diagnosed. We must tackle the stigma or other barriers which can stop someone taking up a test when offered.
3. **Optimise rapid access to treatment and retention in care.**
   Rapid access to and retention in HIV treatment can support those diagnosed with HIV to maintain an undetectable viral load, meaning they cannot transmit the infection to their sexual partners (Undetectable viral load = Untransmittable levels of virus (U=U).
   It is essential to ensure everyone who is diagnosed is referred to treatment rapidly and ensure that inequalities in access to and retention in treatment are tackled.
4. **Improve quality of life for people living with HIV and addressing stigma**
   Increasing retention in, and adherence to, care supports achieving good health outcomes and reduces HIV transmission but for some people living with HIV it can be challenging to prioritise their HIV care and adherence to treatment if they are experiencing personal, financial, housing, immigration, or mental health difficulties.

HIV Fast Track Cities

Fast-Track Cities is an international initiative to end new cases of HIV by 2030. Launched on World AIDS Day in 2014, over 300 cities across the world are part of this movement to get to zero new cases of HIV, zero preventable deaths, zero stigma and discrimination and a better quality of life for people living with HIV. Liverpool formally joined the Fast Track Cities Initiative on 1 December 2018 and is committed to extending the UNAIDS 90-90-90 target to 95-95-95 through accessible high-quality service delivery, support, information and choices to people

[6] https://www.gov.uk/government/news/hiv-diagnoses-continue-to-fall-as-uk-exceeds-unaids-target
[7] https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025#executive-summary
[8] DHSC (2021). Policy paper. Towards Zero: the HIV Action Plan for England – 2022 to 2025. Dec 2021. https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025

living with HIV and HCV[9]. Liverpool has since achieved 95-95-95 target, which means 95% of people living with HIV are aware of their status, 99.8% are in treatment and 98% are virally suppressed[10]

Syphilis Action Plan[11]

The Public Health England (PHE) action plan published in June 2019 focuses on the main affected populations in recognition that there is a **need to strengthen public health measures to reduce transmission of syphilis**. It focusses on 4 prevention pillars fundamental to syphilis control and prevention. These are:

- **Increase testing frequency of high-risk men who have sex with men (MSM)** and re-testing of syphilis cases after treatment.
- Deliver **partner notification** to British Association for Sexual Health and HIV (BASHH) standards.
- Maintain **high antenatal screening coverage** and vigilance for syphilis throughout antenatal care.
- Sustain **targeted health promotion.**

National Chlamydia Screening Programme (NCSP)[12]

Changes to the NCSP were announced in 2021 to focus on reducing reproductive harm of untreated infection in young women. Chlamydia screening in community settings such as GPs and pharmacies, will only be proactively offered to young women. Services provided by sexual health services remain unchanged.

Commissioning arrangements for Sexual and Reproductive Health

The commissioning responsibilities of local government and the NHS are set out in the Health and Social Care Act 2012. Local government responsibilities for commissioning sexual health services are further outlined in The Local Authorities Regulations 2013. The tables below summarise the key commissioning responsibilities of Local Authorities and NHS partners[13]

Local authorities commission:
Comprehensive sexual health services. These include: 1. **Contraception** (including the costs of LARC devices and other methods such as condoms) and advice on preventing unintended pregnancy – in specialist services and those commissioned from primary care (GP/community pharmacy) 2. **STI testing and treatment** in specialist services and primary care, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings and partner notification for STIs and HIV 3. **Sexual health** aspects of psychosexual counselling 4. **Any sexual health specialist services,** including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools' colleges and pharmacies. 5. **Relationship & Sex Education in Schools** **Social care services (which sit outside the Public Health ring fenced grant), including:** 1. **HIV social care** 2. **Wider support for teenage parents**

[9] https://fasttrackcities.london/cities/liverpool/
[10] UKHSA (2022). Restricted data source.
[11] PHE (2019). Syphilis: Public Health England Action Plan. June 2019. https://www.gov.uk/government/publications/syphilis-public-health-england-action-plan
[12] PHE (2021). Policy paper. Changes to the National Chlamydia Screening Programme. 24 June 2021. https://www.gov.uk/government/publications/changes-to-the-national-chlamydia-screening-programme-ncsp
[13] PHE (2014). Making it Work. A guide to whole system commissioning for sexual health, reproductive health and HIV. Revised March 2015. https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services

Integrated Care Boards (formerly Clinical Commissioning Groups) commission:

1. **Abortion services,** including STI and HIV testing and contraception provided as part of this abortion pathway (except abortion for foetal anomaly by specialist foetal medicine services – see NHS England commissions).
2. **Female sterilisation.**
3. **Vasectomy.**
4. **Non-sexual health elements of psychosexual health services.**
5. **Contraception primarily for gynaecological (non-contraceptive) purposes.**
6. **HIV testing** when clinically indicated in CCG-commissioned services (including A&E and other hospital departments).

NHS England commission:

1. **Contraceptive services** provided as an additional service under the GP contract.
2. **HIV treatment and care services** for adults and children, and cost of all antiretroviral treatment.
3. **Testing and treatment for STIs (**including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of 'essential services' under the GP contract (i.e.**,** not public health commissioned services but relating to the individual's care).
4. **HIV testing** when clinically indicated in other NHS England-commissioned services.
5. **All sexual health elements of healthcare in secure and detained settings.**
6. **Sexual assault referral centres.**
7. **Cervical screening** in a range of settings.
8. **HPV immunisation programme.**
9. **Specialist foetal medicine services,** including late surgical termination of pregnancy for foetal anomaly between 13-24 gestational weeks.
10. **NHS Infectious Diseases** in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B

Local Context

One Halton's Health & Wellbeing Strategy was agreed in 2022. It sets out ambitions under life-course headings of Start Well, Live Well and Age Well along with the cross cutting theme of addressing the wider determinants of health. The strategy set outs a vision for *"Improving access to services for people and groups most at risk…"* while ensuring *"…that the…services delivered meet people's needs, are safe and effective"*[14]. While there is no specific reference to sexual health, some of the priorities will be supported by positive action in this area, such as:

- **Support our community in Starting Well**: sometimes linked to unplanned pregnancies or first-time young parents. The Family Nurse Partnership (FNP) is aimed to support all first-time pregnant mothers aged 18 and under, to promote a healthy pregnancy, positive parenting and attachment.
- **Targeted action on inequalities**: Poor sexual and reproductive health outcomes are often experienced by minority, vulnerable and underserved groups, including Black ethnic minorities, gay/bisexual men and people from deprived communities.
- **Preventing ill health:** Prevention is a critical part of good SRH services. We need to ensure accessible treatment but also promote good sexual health by education, making different contraception pathways accessible and promoting HIV prevention.

The strategy also aims to uphold the 'Marmot Principles' set out in detail in 'All Together Fairer', Cheshire and Merseyside's approach to tackling inequalities. These principles are:

[14] One Halton H&WB Strategy 2022-2027, https://onehalton.uk/wp-content/uploads/2022/12/One-Halton-strategy.pdf

1) Give every child the best start in life.
2) Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3) Create fair employment and good work for all.
4) Ensure a healthy standard of living for all.
5) Create and develop healthy and sustainable places and communities.
6) Strengthen the role and impact of ill-health prevention.
7) Tackle racism, discrimination and their outcomes.
8) Pursue environmental sustainability and health equity together.

In 2022 Halton was chosen as one of 12 local authorities awarded up to £1 million from the Government's Family Hubs Transformation Fund.

Support for families is key to delivering good SRH outcomes, as children are given the best start in life and parents supported through uncertain times. A good start in childhood can help avoid many risk-taking behaviours linked to adverse childhood experiences (ACEs), including risky sexual behaviour into adulthood.

Halton population and demographics

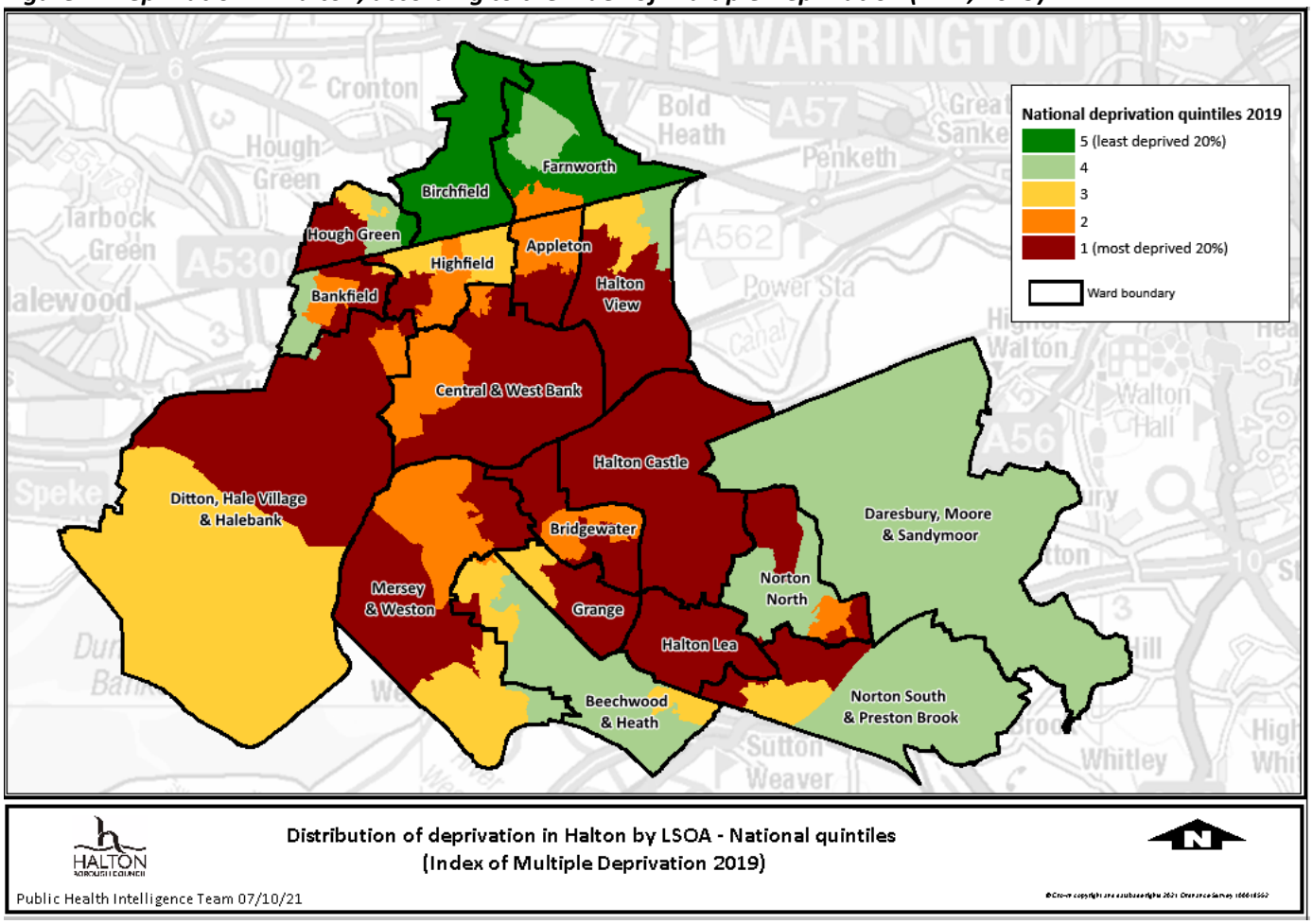
Overview of Halton

Halton covers the towns of Runcorn and Widnes and has a population of 128,500 (2021 Census). Demographically, Halton differs slightly to England as it has a lower proportion of younger adults in their 20s and 30s and a higher proportion of people aged 55 to 79. The local geography of the borough presents a specific challenge in having two distinct communities separated by the River Mersey and access between the two restricted to toll charging bridges. Although Halton residents do get the crossings for free.

Halton is a deprived borough, relative to England as a whole (27th most deprived of 326) The most recent Indices of Multiple Deprivation (IMD, 2019), showed that over one quarter of its population live in areas classified in the 10% most deprived in England, see

Figure 1. Life expectancy for both men and women is lower than the England average.

Figure 1: Deprivation in Halton, according to the Index of Multiple Deprivation (IMD, 2019)



The map above shows the distribution of deprivation across Halton, relative to England, with ward boundaries overlaid. Amongst the most deprived areas are Halton Castle, Halton Lea and around Widnes Town Centre. The least deprived areas relatively are Birchfield and Farnworth in Widnes, along with Daresbury in Runcorn. A more detailed map of the layout of individual neighbourhoods and their level of deprivation is provided in Appendix 1.

Protected characteristics

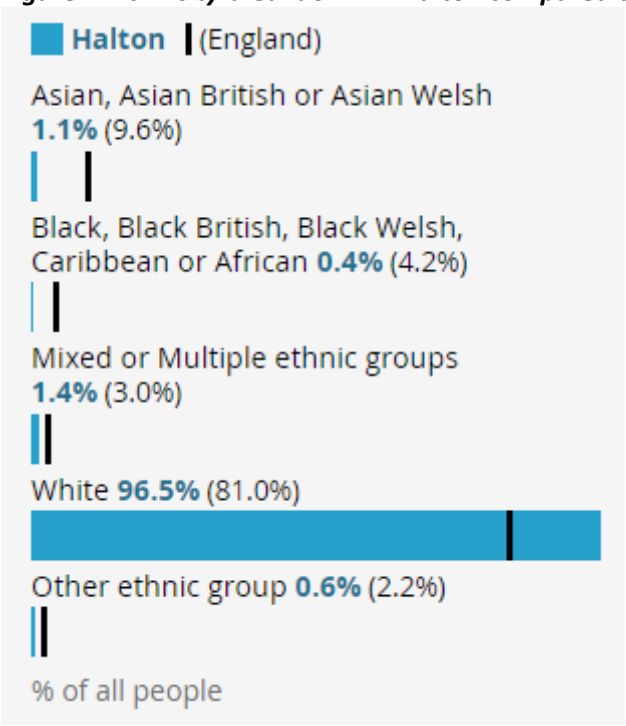
The 2021 census collected some new protected characteristics for the first time and the full results can be found in our latest JSNA summary https://www3.halton.gov.uk/Documents/public%20health/JSNA/JSNASummary.pdf. The data particularly relevant for this JSNA are outlined below.

Ethnicity

According to the 2021 Census, the majority of Halton's population were born in the UK (95%), compared to 83% across England as a whole.

Halton's population is predominantly white, with 96% of residents identifying in this group at the 2021 Census. There are lower proportions of minority ethnic groups than the England average; for example Black, Black British, Black Welsh, Caribbean or African made up just 0.4% of the population in Halton, compared to 4.2% in England.

Figure 2: Ethnicity breakdown in Halton compared to England, 2021 Census



Source: ONS Build a custom area profile

Sexual orientation

At the 2021 Census, 92% of Halton residents aged 16+ identified themselves as straight/heterosexual. This is a higher percentage than the North West (90.1%) and England (89.4%). 1.5% identified as gay or lesbian, which is the same as the England average and 0.9% as bisexual (England 1.3%).

The table below shows the breakdown in numbers and proportions by sex. The proportions are similar to all orientations other than bisexual where there are more females than males identifying as such.

Table 1: Sexual orientation of Halton residents by sex, 2021 Census

	Female	Male
Straight or Heterosexual	91.5%	92.3%
Gay or Lesbian	1.4%	1.6%
Bisexual	1.3%	0.5%
All other sexual orientations	0.2%	0.2%
Not answered	5.5%	5.5%

Source: Census 2021

Figure 3: Sexual orientation by age and sex, all usual residents aged 16 year and over, 2021 Census

FEMALES

Age	Total	Straight or Heterosexual	Lesbian, Gay, Bisexual, or Other (LGB+)	Not answered
Total	53,594	49,057	1,611	2,926
Aged 16 to 24 years	5,941	5,039	513	389
Aged 25 to 34 years	8,667	7,740	525	402
Aged 35 to 44 years	8,425	7,764	295	366
Aged 45 to 54 years	8,839	8,246	164	429
Aged 55 to 64 years	8,901	8,360	90	451
Aged 65 to 74 years	7,478	7,037	19	422
Aged 75 years and over	5,343	4,871	5	467

MALES

Age	Total	Straight or Heterosexual	Lesbian, Gay, Bisexual, or Other (LGB+)	Not answered
Total	50,352	46,472	1,130	2,750
Aged 16 to 24 years	6,292	5,626	266	400
Aged 25 to 34 years	7,811	7,010	347	454
Aged 35 to 44 years	8,108	7,523	214	371
Aged 45 to 54 years	8,575	8,062	154	359
Aged 55 to 64 years	8,428	7,889	97	442
Aged 65 to 74 years	6,880	6,424	43	413
Aged 75 years and over	4,258	3,938	9	311

Source: NOMIS

Learning disability and chronic illness

In 2022/23 there were 837 people registered with GPs in Halton with a learning disability, making up 0.6% of the registered population. This is the same proportion as the England average.

Groups most at risk

Risk factors

Poor sexual health varies by age, gender, deprivation, sexuality and ethnicity, nationally and in Halton. These are described in more detail in the succeeding chapters, but overall, the following groups are most at risk of poor sexual and reproductive health outcomes:

- Young people
- Women
- Gay and bisexual men and other men who have sex with men (GBMSM)
- Transgender, non-binary and gender diverse people
- Deprived populations
- Ethnic minority groups
- Those impacted by adverse childhood experiences (ACEs)

Young People

Younger people are more likely to be diagnosed with an STI, which is most likely linked to the higher rates of partner changes amongst this group.[15] Chlamydia diagnoses in particular are more marked in younger people under the age of 25 (hence the national chlamydia screening programme).

There are higher rates of unplanned pregnancies amongst younger people clearly evidenced by high termination rates [16]. In Halton, the teenage conception rate is higher than national and local comparators.

Women

Findings from a study using data from more than 13,000 people from Britain's third National Survey of Sexual Attitudes and Lifestyles (Natsal) found that nearly half of British women experience poor sexual and reproductive health (a considerably higher number than men). With issues ranging from risk of unplanned pregnancy, STIs and sexual function problems including, lack of interest in sex, painful sex and sexual coercion[17].

Research conducted by Public Health England found that symptoms associated with reproductive health had an important impact on women's wellbeing; 80% of the 7,500 women surveyed described experiencing unwanted reproductive health symptoms such as heavy menstrual bleeding, severe menopausal symptoms or postnatal symptoms[18].

Gay and bisexual men and other men who have sex with men (GBMSM)

GBMSM are more likely to be diagnosed with bacterial STIs than other men. Historically, GBMSM have also been disproportionately affected by HIV, although new diagnoses for HIV have seen the greatest reduction over recent years amongst this group.

Transgender, non-binary and gender diverse people

Globally, transgender people face higher rates of HIV, with risk of transmission up to 12 times greater than the general population. We do not know about STI rates in trans, non-binary and gender diverse people in England. The binary data system excludes anyone who is not cisgender, so the data is not available. Without relevant statistics, these communities are not able to be adequately included in planning for sexual and reproductive health services.[19]

Deprived Populations

Rates of STIs are strongly associated with socioeconomic deprivation, with the highest rates found among people living in the most deprived areas of England[20].

There is also a clear relationship between deprivation and the rate of abortion; as the rate of deprivation in an area increases, the abortion rate in that area also rises[21].

[15] UKHSA (2022). Official Statistics. Sexually transmitted infections and screening for chlamydia in England: 2021 report. 4 October 2022 https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2021-report#main-points

[16] All Party Parliamentary Group on Sexual and Reproductive health in the UK. *Women's Lives, Women's rights: strengthening Access to contraception beyond the pandemic.* s.l. : FSRH Policy and External Affairs, 2020.

[17] FSRH Statement: new study shows women disproportionately experience poor sexual and reproductive health. 10 January 2020. https://www.fsrh.org/news/fsrh-statement-study-half-women-poor-sexual-reproductive-health/

[18]PHE (2018). What do women say? Reproductive health is a Public Health issue. June 2018. https://www.gov.uk/government/publications/reproductive-health-what-women-say

[19] https://www.tht.org.uk/news/fight-better-sexual-health-must-not-exclude-trans-and-non-binary-people

[20] PHE (2019) Guidance. Health Matters: Preventing STIs. Published 21 August 2019. https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis

[21] L. Ewbank and D. Maguire (2021). Understanding trends in use of abortion services in England: an exploratory briefing. The Kings Fund. https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/Understanding%20trends%20in%20use%20of%20abortion%20services.pdf

Ethnic Minority Groups

Different minority ethnic groups are affected disproportionately by STIs. The diagnosis rates of STIs are particularly high in black ethnic communities. Black communities are also at a greater risk of contracting HIV [22]. Socio economic deprivation, as stated above is a known determinant of poor sexual health outcomes but other cultural influences on sexual behaviour are likely to contribute towards increased risk of STIs among ethnic groups[20].

Nationally, it has been reported that higher rates of emergency contraception have been observed amongst Black Caribbean communities and multiple terminations are also higher amongst women from Black ethnic groups[21].

Those impacted by adverse childhood experiences (ACEs)

Recent research has suggested strong connections between childhood trauma and poor sexual health outcomes in adult life, meaning it is critical to maintain a good quality relationships and sex education (RSE) curriculum. International literature suggests that adults exposed to four or more adverse childhood experiences (ACEs) are three times more likely to have sex before age 16, and six times more likely to report an STI in their lifetime.[23]

Other risk factors for poor sexual and reproductive health outcomes include:

- People with learning disabilities
  Evidence suggests that young people with a mild to moderate learning disability are more likely to practice unsafe sex and more likely to have been pregnant when compared to young people from the general population. Uptake of cervical screening is also lower for women with a learning disability[24].

- Substance misuse
  The use of drugs can lead to a loss of inhibition resulting in unplanned sexual activities, this is more likely to have a negative impact such as increasing the likelihood of contracting a STI, an unwanted pregnancy or experiencing regret, shame and mental anguish[25].

  Research indicates a strong link between binge drinking and/ or drug use and risky sexual behaviours amongst young people[26]. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use, multiple sexual partners, sexually transmitted infection and teenage pregnancy. Sexual assault is strongly correlated with alcohol use by both victim and perpetrator[27].

- Sex workers
  Sex workers are at an increased risk of poor physical and mental health. Many work in unsafe environments and the stigma associated with this work means they are marginalised and socially excluded. Whilst sex workers are predominantly women, there is a significant minority of male and trans sex workers; most

[22] PHE (2021). Variation in outcomes in sexual and reproductive health in England. A toolkit to explore inequalities at a local level. 12 May 2021. https://www.gov.uk/government/publications/sexual-health-variation-in-outcomes-and-inequalities
[23] Sara Wood et al., International Journal of Environmental Research and Public Health, Bangor University, July 2022: https://research.bangor.ac.uk/portal/files/48870267/ijerph_19_08869.pdf
[24] PHE. Health Inequalities: Sexual Health. https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjKpPDxhvX9AhWREMAKHaqvC1MQFnoECA4QAQ&url=https%3A%2F%2Ffingertips.phe.org.uk%2Fdocuments%2FHealth%2520Inequalities_Sexual%2520health.pdf&usg=AOvVaw2TScAlhTQKM_Ld6TsgHlcS
[25] European Monitoring Centre Drugs and Drug Addiction. Spotlight on……. Addressing sexual health issues associated with drug use. 21 October 2021. https://www.emcdda.europa.eu/spotlights/addressing-sexual-health-issues-associated-drug-use_en
[26] Khadr SN, Jones KG, Mann S*, et al* Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey.
BMJ Open 2016;**6:**e011961. doi: 10.1136/bmjopen-2016-011961
[27] Royal College of Physicians and BASHH (2011). Alcohol and sex: a cocktail for poor sexual health. https://www.ias.org.uk/uploads/pdf/Women/rcp_and_bashh_-_alcohol_and_sex_a_cocktail_for_poor_sexual_health.pdf

people using these services are men[28]. Street sex workers have often experienced extensive trauma including child abuse and domestic and sexual violence. Health issues generally in this population are further impacted by the experience of discrimination and stigma, leading to reduced health service seeking behaviour[29].

Other trends being observed include:

Age at first heterosexual intercourse has decreased, the number of sexual partners has increased and attitudes toward same-sex partnerships have become more tolerant (Mercer et al, 2013).[30] In recent years, progress has been made to teach SRH at younger ages, so young people have the skillset to maintain healthy relationships and good sexual health throughout adulthood. From 2020, primary schools have been required to teach relationships education, and in recent years, RSE curriculums have become more inclusive of LGBTQ+ young people.

Child Sexual Exploitation (CSE) is recognised nationally as one of the most important challenges facing agencies today. There is currently no local dataset available, so it is not possible at present to assess whether it is more of a problem in Halton than in other areas across the country. National data from the children in need census (an annual statutory census that collects data on children who are referred to local authority social care services in England), showed that in the year ending March 2023, of the total 508,360 episodes of children in need where a factor was identified; 15,020 identified child sexual exploitation (CSE) as a factor. In previous years, CSE was identified in around twice as many episodes of need for girls than boys[31].

Nationally there is an increase in the rate of some Sexually Transmitted Infections (STIs) emerging in older people who are embarking on new sexual relationships without considering the risks of unprotected sex.[32]

National rates of sexual offences and violent offences towards women have been rapidly increasing following the start of the COVID-19 pandemic; Refuge reported a 61% increase in calls per month to their helpline between April 2020 and February 2021.[33] Given that working from home has become normality for many to this day, the risk of domestic abuse remains higher than before home working arrangements were announced.

Sexual violence amongst the LGBT+ community is not widely discussed, but quantitative and qualitative research undertaken by Galop found that sexual violence was part of the lived experience of a significant proportion of people, seriously impacting on wellbeing whilst not being adequately served by the systems that are supposed to be providing protection and support.[34]

Sexual Health Services in Halton should always be targeted towards, and within easy reach, of people who are living with the 'vulnerabilities' listed above in order to strengthen preventative and reactive care.

[28] https://www.nihr.ac.uk/documents/2327-interventions-to-improve-health-outcomes-for-sex-workers/32727
[29] Potter, L. C. , Horwood, J., & Feder, G. S. (2022). Access to healthcare for street sex workers in the UK: perspectives and best practice guidance from a national cross-sectional survey of frontline workers. BMC Health Services Research, 22(1), [178]. https://doi.org/10.1186/s12913-022-07581-7
[30] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62035-8/fulltext
[31] Child victims of modern slavery in the UK - Office for National Statistics (ons.gov.uk)
[32] Local Government Association. 2022. Breaking point: Securing the future of sexual health services. https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services
[33] Refuge, March 2021, https://refuge.org.uk/news/a-year-of-lockdown/
[34] Galop (2022) LGBT+ People & Sexual Violence. https://galop.org.uk/wp-content/uploads/2022/04/Galop-LGBT-People-Sexual-Violence-April-2022.pdf

Sexual and Reproductive Health Profile
Sexually Transmitted Infection (STI) testing

Key Messages

In Halton:

- Despite generally increasing over the last 10 years, the rate of STI testing (excluding chlamydia aged under 25) in Halton is consistently lower (worse) than the England average; however it is better than the North West average.
- Chlamydia is the most common diagnosed STI in Halton and across England; in Halton it made up half (51% of diagnoses), the same as the national proportion.
- STI testing positivity (excluding chlamydia aged under 25) is higher than the England average.
- The STI new diagnosis rate (excluding chlamydia aged under 25) of 407 per 100k people is consistently significantly lower (better) than then England rate of 520 per 100k.
- The proportion of females aged 15 to 24 screened and detected for chlamydia is significantly lower in Halton than the England average. Detection rates are well below the UKHSA recommended level. The highest rates detected in females aged 15 to 24 in Halton were in those living around Widnes Town Centre.
- Rates of gonorrhoea, genital herpes, genital warts and syphilis were similar to or lower than the England average.

Who is affected?

- Nationally the burden of sexually transmitted infections (STIs) is greatest in young people aged 15-24 years, black ethnic minorities, GBMSM and areas of deprivation.
- The majority of STI diagnoses in Halton residents for the main infections are in those of white ethnicity (94%). Across England as a whole, Minority Ethnic populations are disproportionally affected by STIs.
- The majority of STI diagnoses in Halton residents for the main infections were in those who defined themselves as heterosexual or straight.
- There is a relationship nationally between STI diagnoses rate and deprivation, with more deprived areas seeing higher rates. This also appears to be true in Halton with the highest rate seen around Widnes Town Centre which falls into the most 20% of areas nationally.

What this means?

- Sexual health services were seriously impacted by the pandemic, so caution is needed when drawing conclusions from data during 2020 and 2021.
- It is difficult to determine whether an equitable service is being provided for ethnic minority groups and GBMSM, this is important as STI diagnoses are higher amongst these groups.

Recommendations

- Continue to monitor trends in STIs diagnoses, which were all greatly impacted during the pandemic.
- There should be ongoing work with underserved and high-risk communities in Halton to better understand and inform how to develop the STI testing and treatment offer locally and in line with best practice guidance (including Public Health England Guidance on promoting the sexual health and wellbeing of gay, bi sexual and other men who have sex with men[35]).

[35] PHE (2021). Sexually transmitted infections: promoting the sexual health and wellbeing of gay, bi sexual and other men who have sex with men. Published September 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1021121/HPRU1_MSM_PHE_UCL_Report__1_.pdf

- Improved recording of ethnicity, sexual orientation and gender identity within sexual health services so equity of access to services can be effectively monitored and services developed accordingly. Ensuring services are accessible and adapted appropriately for people with a disability, including learning disability is also essential.
- Consider opportunities and innovations to increase partner notification within sexual health services.
- Develop intelligence around the use of Chemsex in Halton to inform future service provision for both sexual health and substance misuse services and raise the profile locally.
- Qualitative feedback could identify any need to improve knowledge on how to access testing, both online and in clinic, ensuring services are discrete, non-judgemental and inclusive.
- Strengthen sexual health promotion, prevention and treatment efforts in non-clinical settings, including increased options for discrete and anonymous STI testing.
- Improve the education and access to information on sexual health and STIs, in schools, but also throughout the life course.

Overview

Sexually transmitted infections (STIs) are a major public health concern. If left undiagnosed (or untreated), common STIs may cause complications and long-term health problems, including:

- Pelvic inflammatory disease, ectopic pregnancy, postpartum endometriosis, infertility and chronic abdominal pain in women
- Adverse pregnancy outcomes including abortion, intrauterine death and premature delivery.
- Neonatal and infant infections and blindness
- Urethral strictures and epididymitis in men
- Genital malignancies, proctitis, colitis, and enteritis in men who have sex with men (MSM)
- Cardiovascular and neurological damage[36]

Increasing resistance and decreased susceptibility to antimicrobials used to treat STIs has reduced treatment options, so this is an area of emerging concern – most notably for gonorrhoea.

Prevention is critical to achieving good sexual health outcomes; education, condom use, diagnosis and treatment are key interventions for the prevention and control of STIs.
Partner notification is also crucial to help contain the spread of STIs. It is important that people diagnosed with an STI understand the importance and benefits of notifying their partners, this will help to prevent reinfection and reduce the transmission of STIs.

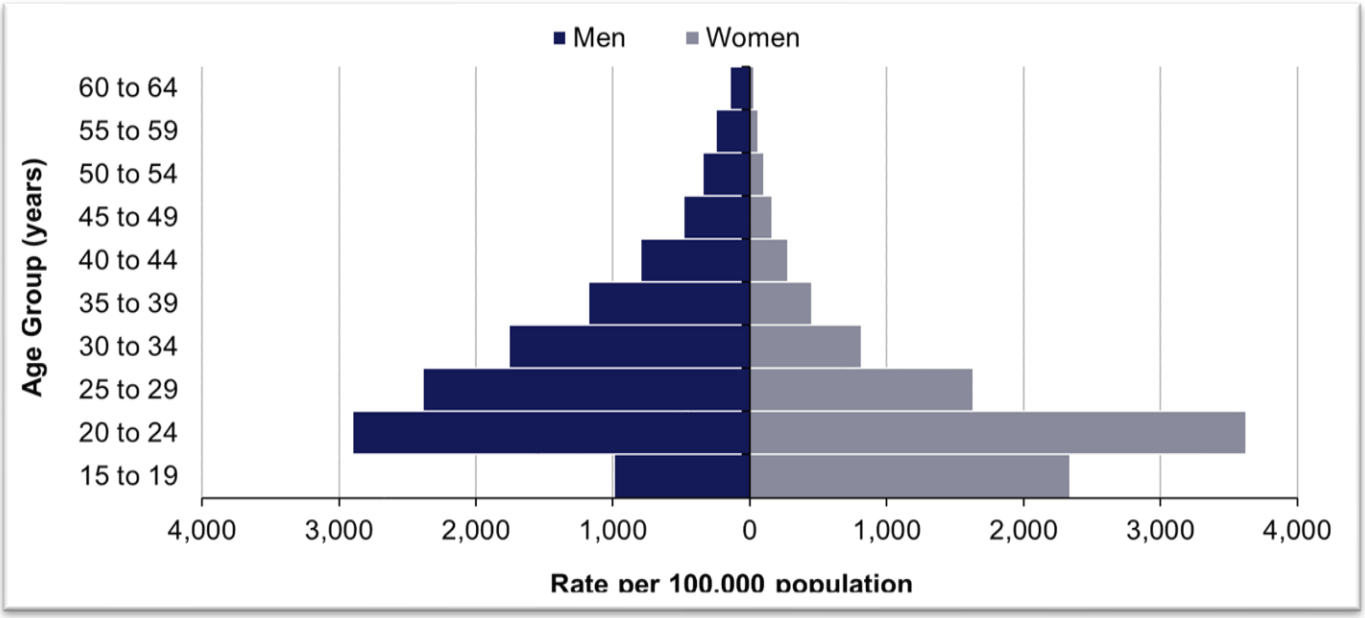
Sexual health service providers should ensure that processes are in place for discussions about partner notification with patients upon diagnosis. For some patients this could mean potentially difficult conversations with their partners; people should be made aware of the different partner notification methods available including the option to remain anonymous. In this instance, provider referral may be the most appropriate method[37]. Sex arranged using geospatial networking apps can make partner notification difficult, but there is also potential to use these apps for partner tracing and notification.

[36] PHE (2019). Health matters: Preventing STIs. https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis
[37] NICE Guideline (2022). Reducing sexually transmitted infections [NG221]

Groups most at risk

Young people are more likely to be diagnosed with an STI, which may be due to higher rates of partner change amongst this population group[38]. In 2019, it was reported nationally that heterosexual men and women aged 15-25 were three and half and seven times more likely (respectively) to be diagnosed with an STI than their older counterparts (aged 25 to 64yrs), most markedly chlamydia and gonorrhoea[39]. It is clear from the graph below that **young women aged 20-24yrs have the highest diagnosis rate for all STIs** (note: chlamydia accounts for the majority of these diagnoses), but this reduces considerably with age. See 5 below:

Figure 5: Rates of new STI diagnosis by age and sex: England, 2022



Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Men over the age of 25 have higher rates of diagnosis with an STI than their female counterparts. Rates of gonorrhoea, syphilis and genital warts are all higher amongst men than women. For women, chlamydia and genital herpes are higher.

Gay and bisexual men or other men that have sex with men (GBMSM) are more likely to be diagnosed with bacterial STIs than other men. The majority of syphilis and gonorrhoea diagnoses in men were in GBMSM accounting for 81% of syphilis cases and 66% gonorrhoea cases[39]. Furthermore, HIV–diagnosed GBMSM are three times more likely to be diagnosed with an acute bacterial STI than those that are HIV–negative or of unknown HIV status[39]. Repeat infection with gonorrhoea may contribute to infection persistence and onward transmission. In England, GBMSM are almost 4 times more likely to present with a repeat infect of gonorrhoea at a sexual health service within 12 months compared to women and heterosexual men[40].

Chemsex refers to sexual activity, mostly between men, while under the influence of drugs. People take part in chemsex for different reasons. Some people take part in chemsex to feel less inhibited and to enhance pleasure. Other reasons for taking part in chemsex are associated with feelings of stigma and issues around self-esteem.

[38] https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2021-report#main-points
[39] PHE 2021 toolkit for exploring inequalities in SRH at a local level: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf
[40] https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

The most common chemsex drugs are methamphetamine, mephedrone and GHB/GBL.

Chemsex is often associated with higher risk sexual behaviour and can also lead to drug addiction, as well as a higher risk of STIs and HIV.

It is important that people engaging in chemsex are able to access the right support to minimise their risk. This might include:

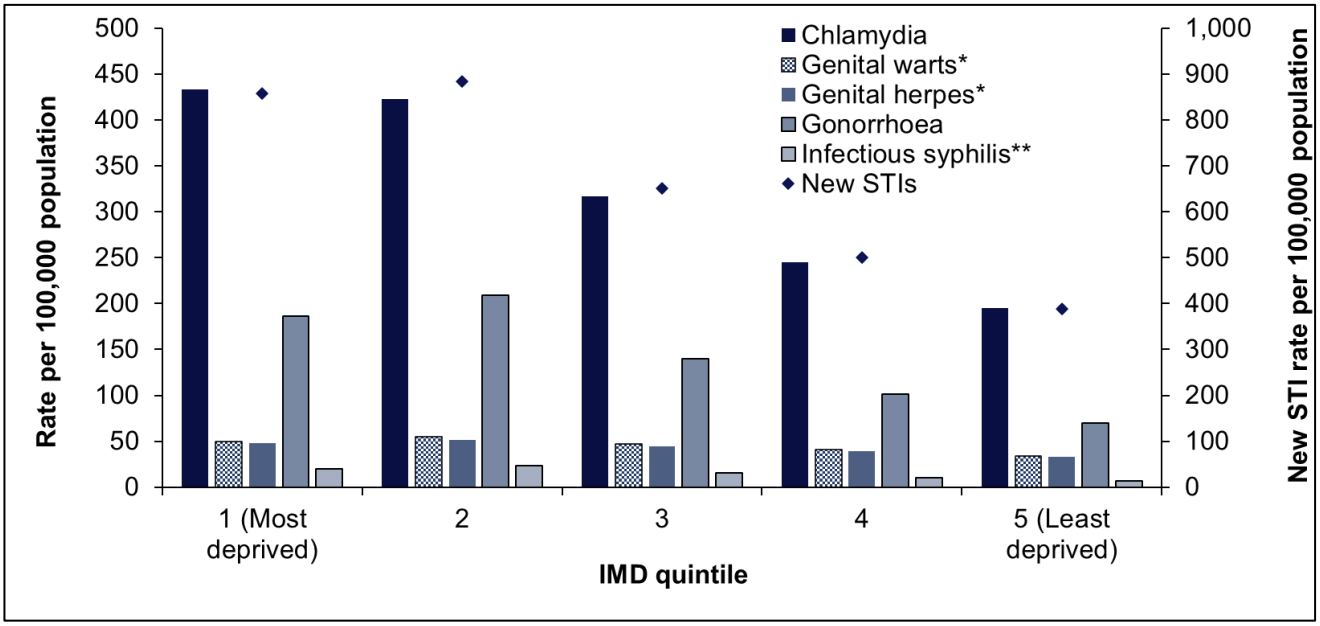
- Condoms and lube, and other barrier protection like dental dams
- Education around safer chemsex
- Needle exchange services
- PrEP/Post Exposure Prophylaxis (PEP) to protect against HIV.
- Regular testing for STIs/HIV[41]

There is limited STI epidemiological data available on trans and non-binary people and without data, the needs of these communities are invisible[42]. Without an adequate understanding of the potential inequalities that exist for trans and non-binary people, it is not possible to develop services to meet their needs.

Black and Asian Minority Ethnic populations are disproportionately affected by STIs, in particular for gonorrhoea (3.5 times higher diagnoses rate) and trichomoniasis (nine times higher diagnoses) compared to the general population [39]. It is likely that ethnic disparity in STIs is likely influenced by underlying socioeconomic factors rather than clinical or behavioural specific causes[43].

Rates of new STI diagnosis are shown to be consistently higher in more deprived populations. STI diagnoses data analysed by index of multiple deprivation (IMD) clearly demonstrates that rates of chlamydia, gonorrhoea and syphilis and all STIs are highest in most deprived areas and lowest in least deprived areas, as indicated in 6 below.

Figure 6: Rates of STI diagnoses by Index of Multiple Deprivation quintile, England, 2022



Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

[41] Change Grow Live. 2023. https://www.changegrowlive.org/advice-info/alcohol-drugs/chemsex-drugs
[42] THT, BASHH (2020). The State of the Nation – Sexually Transmitted Infections in England. https://www.tht.org.uk/our-work/our-campaigns/state-of-the-nation
[43] https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2021-report

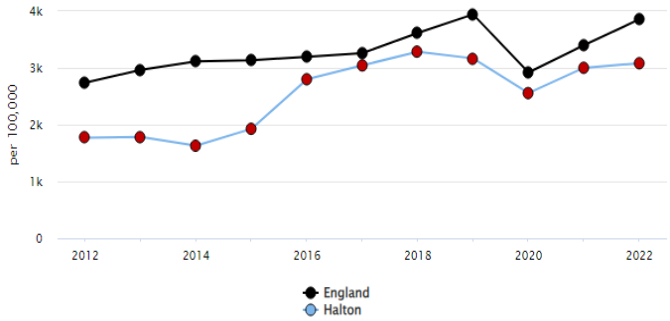
Data (current and trend)

Sexually Transmitted Infections (STI)

As STIs are often asymptomatic, frequent STI screening of groups with greater sexual health needs is important. Early detection and treatment can reduce long-term consequences, such as pelvic inflammatory disease, infertility and ectopic pregnancy. STI testing rates and diagnosis rates are closely linked. Low rates of testing will mask undetected, higher rates of STIs.

The STI testing rate and positivity rate in Figure 7 and Figure 8 below are for HIV, syphilis, gonorrhoea and chlamydia (aged 25 years and older) combined and include GUMCAD data only.

Figure 7: Trend in STI testing rate per 100,000 (excluding chlamydia aged under 25), 2012 to 2022, Halton and England



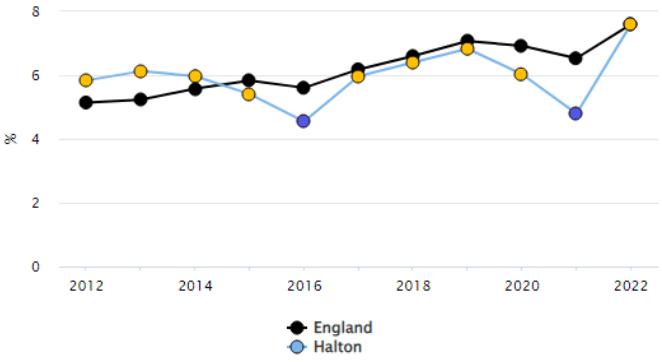
Recent trend: ➡ No significant change

Period		Halton Count	Halton Value	North West	England
2012	●	2,228	1,771.3	2,320.2	2,739.1
2013	●	2,253	1,787.0	2,649.2	2,966.0
2014	●	2,061	1,629.2	2,784.6	3,115.7
2015	●	2,442	1,927.1	2,663.7	3,136.2
2016	●	3,562	2,798.0	2,716.9	3,192.6
2017	●	3,884	3,044.0	2,655.1	3,259.4
2018	●	4,221	3,286.6	2,848.0	3,616.0
2019	●	4,099	3,167.5	3,058.8	3,942.6
2020	●	3,317	2,556.3*	2,007.6*	2,920.3
2021	●	3,860	3,002.1*	2,588.1*	3,399.5
2022	●	3,963	3,082.2*	2,646.2*	3,856.1

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

The rate of STI testing (excluding chlamydia aged under 25) in Halton is consistently lower (worse) than the England average but is better than the North West average. However, rates have generally increased since 2012. Unsurprisingly, the testing rate dipped, nationally and locally, in response to the COVID-19 pandemic but picked back up in 2021. This similarly impacted on testing positivity rates, as evidenced in Figure 8 below.

Figure 8: Trend in STI testing positivity (excluding chlamydia aged under 25), 2012 to 2022, Halton and England



Recent trend: ➡ No significant change

Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	North West	England
2012	●	130	5.8%	4.9%	6.9%	5.2%	5.1%
2013	●	138	6.1%	5.1%	7.2%	4.6%	5.2%
2014	●	123	6.0%	5.0%	7.1%	4.7%	5.6%
2015	●	132	5.4%	4.5%	6.4%	4.6%	5.8%
2016	●	162	4.5%	3.9%	5.3%	5.1%	5.6%
2017	●	232	6.0%	5.2%	6.8%	6.0%	6.2%
2018	●	270	6.4%	5.7%	7.2%	6.6%	6.6%
2019	●	280	6.8%	6.1%	7.7%	6.9%	7.1%
2020	●	200	6.0%*	5.2%	6.9%	6.8%*	6.9%
2021	●	185	4.8%*	4.1%	5.5%	6.0%*	6.5%
2022	●	301	7.6%*	6.8%	8.5%	9.2%*	7.6%

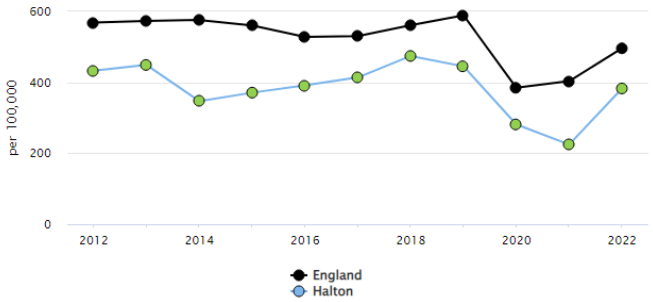
Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Halton has historically had a similar positivity rate to both England and the North West region.

Whilst a lower STI positivity rate is generally welcomed, recent years' figures showing a decrease were suspected to be showing the effects of the COVID 19 pandemic. **Figures given for Halton in 2022 have risen steeply from 2021, also mirrored in national and regional rates, and have returned to the overall upward trend over the last decade.**

New STI diagnoses (excluding chlamydia in under 25-year-olds) (Figure 9) among people accessing sexual health services is presented below. This includes all diagnoses so provides a more complete picture.

Figure 9: Trend in new STI diagnoses rate per 100,000 (excluding chlamydia aged under 25), 2012 to 2022, Halton and England



Recent trend: ⬇ Decreasing & getting better

Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	North West	England
2012	●	544	432	397	470	508	568
2013	●	566	449	413	487	514	573
2014	●	439	347	315	381	527	576
2015	●	470	371	338	406	483	560
2016	●	498	391	358	427	472	528
2017	●	528	414	379	451	461	530
2018	●	609	474	437	513	503	561
2019	●	576	445	409	483	500	589
2020	●	365	281*	253	312	309*	385
2021	●	289	225*	200	252	330*	403
2022	●	492	383*	350	418	446*	496

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Halton has a consistently lower rate for all STI diagnoses compared to England and the North West over the last 10 years and the overall trend is broadly flat. Rates in Halton fell between 2018 and 2021, but have seen a rise in 2022 (this has been mirrored across England and the North West). This may not reflect trends in individual infections.

Further analysis of chlamydia, gonorrhoea and syphilis infection rates are presented in more detail below. They all demonstrate a consistent picture; prior to the pandemic there was a steady increase in diagnoses for all of these STIs, which then appeared to drop off dramatically from 2020, returning to (near) pre-pandemic levels in 2022.

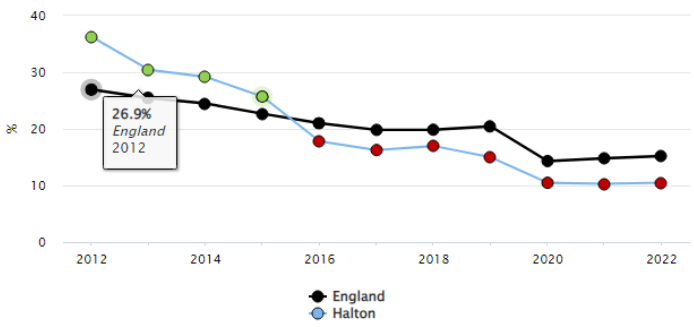
Chlamydia

Chlamydia causes avoidable sexual and reproductive ill-health. Chlamydia is the most common bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. While chlamydial infections are more commonly found among young adults aged <25 years, women and men aged 25 and over are also at-risk of chlamydia.

By diagnosing and treating asymptomatic chlamydia infections, chlamydia screening can reduce the duration of infection, which will reduce an individual's chance of developing chlamydia associated complications, and also reduce the amount of time someone is at risk of passing the infection on, which in turn will reduce the spread of chlamydia in the population.

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. The proportion screened in Halton has fallen since 2012 and stood at around 10.5% between 2020 and 2022; the proportion has been consistently lower than England and the North West since 2016.

Figure 10: Proportion screened for chlamydia aged 15 to 24, 2012 to 2022, Halton and England



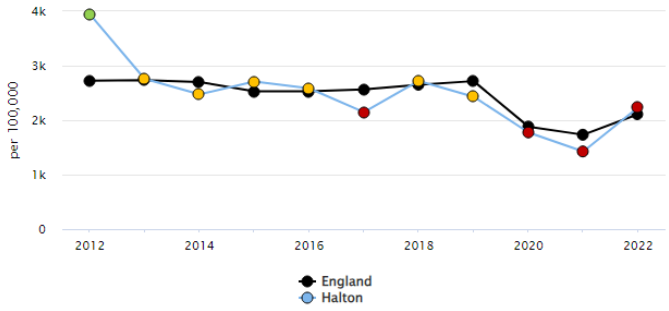
Recent trend: ⬇ Decreasing & getting worse

Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	North West	England
2012	●	5,599	36.3%	35.3%	37.2%	27.8%	26.9%
2013	●	4,639	30.5%	29.6%	31.4%	25.5%	25.5%
2014	●	4,407	29.2%	28.3%	30.1%	25.8%	24.5%
2015	●	3,828	25.7%	24.9%	26.5%	25.4%	22.7%
2016	●	2,608	17.8%	17.1%	18.5%	23.0%	21.0%
2017	●	2,309	16.3%	15.6%	16.9%	20.5%	19.8%
2018	●	2,392	17.0%	16.3%	17.7%	19.9%	19.9%
2019	●	2,094	15.0%	14.4%	15.6%	18.6%	20.4%
2020	●	1,461	10.5%	9.9%	11.0%	11.7%	14.3%
2021	●	1,436	10.3%	9.7%	10.8%	13.7%	14.8%
2022	●	1,476	10.5%	10.0%	11.1%	14.2%	15.2%

Source: [Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile]

The UK Health Security Agency (UKHSA) recommends that local authorities should be working towards achieving a detection rate of at least 3,250 per 100,000 female population aged 15 to 24.

Figure 11: Trend in chlamydia detection rate per 100,000 aged 15 to 24 (females), 2012 to 2022, Halton and England



Recent trend: ⬇ Decreasing & getting worse

Benchmarking against goal: <2,400 | 2,400 to 3,250 | ≥3,250

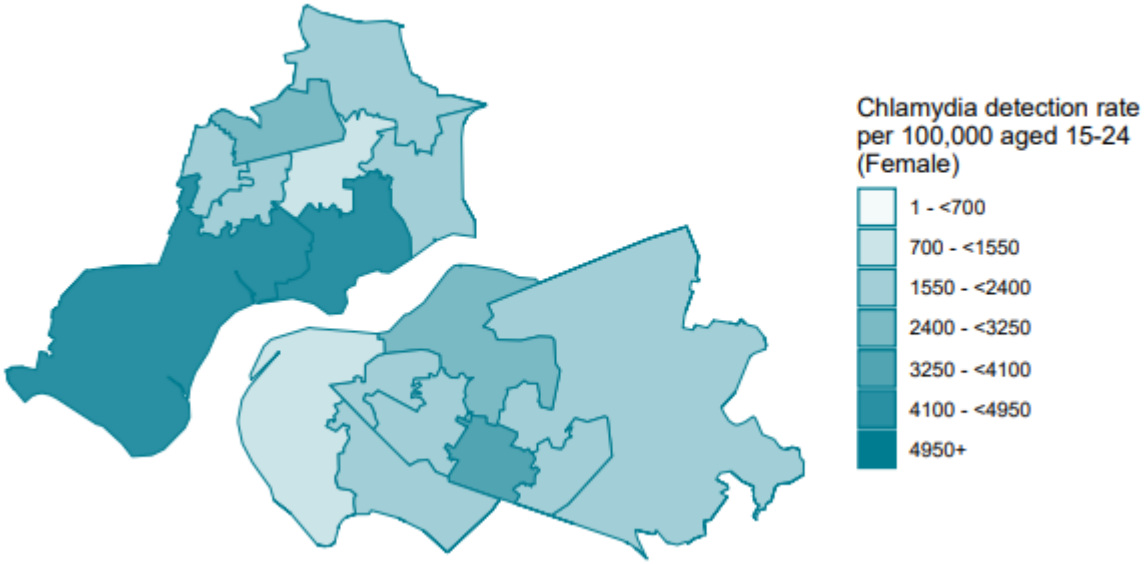
Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	North West	England
2012	●	301	3,949	3,515	4,421	3,091	2,723
2013	●	209	2,760	2,399	3,161	2,967	2,737
2014	●	185	2,474	2,130	2,857	3,179	2,701
2015	●	199	2,709	2,346	3,113	3,228	2,529
2016	●	187	2,585	2,228	2,984	3,075	2,529
2017	●	150	2,146	1,817	2,518	2,968	2,563
2018	●	189	2,721	2,347	3,138	2,951	2,651
2019	●	167	2,431	2,076	2,829	2,727	2,717
2020	●	121	1,775	1,473	2,121	1,717	1,882
2021	●	97	1,426	1,156	1,739	1,778	1,733
2022	●	152	2,234	1,893	2,619	2,262	2,110

Source: [Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile]

Figure 11 shows the trend in chlamydia diagnoses of females aged 15-24 attending sexual health services. Both Halton and England have been significantly below the goal of 3,250 per 100,000 since 2020. The trend is similar for males, with detection rates being below England since 2016.

The map below shows the distribution of chlamydia detection in 15-24 year olds by geography in Halton. Although the data on the map does not match exactly to electoral wards, the highest rates were seen in those living in central Widnes town (covering Central and West Bank ward) and in Ditton, Hale Village and Halebank ward to the west of Widnes town. These are both relatively deprived areas, Central and West Bank falling in the top 20% most deprived areas in England.

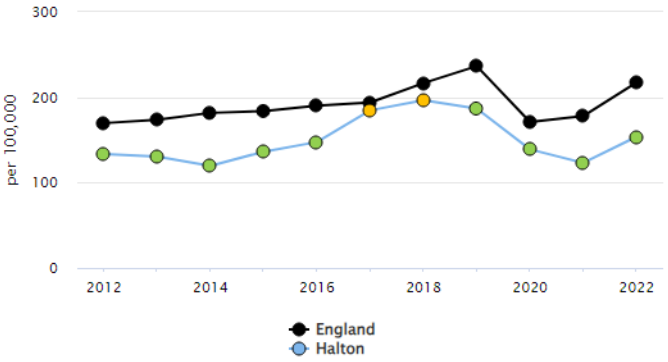
Figure 12: Chlamydia detection rate per 100,000 females aged 15 to 24 by Middle Super Output Area, Halton residents, 2022



Source: UKHSA SPLASH report (restricted access)

Those aged 25 and older are not opportunistically screened, and therefore lower rates are seen as better. In Halton, rates have been significantly lower (better) than England since 2012 (apart from 2017 and 2018), recent rates are also lower than the North West.

Figure 13: Trend in chlamydia diagnoses per 100,000 aged 25 and older, 2012 to 2022, Halton and England



Recent trend: ⬇ Decreasing & getting better

	Halton						
Period		Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	●	116	133	110	160	154	170
2013	●	114	131	108	157	154	174
2014	●	105	120	98	145	167	182
2015	●	120	136	113	163	175	184
2016	●	131	148	123	175	183	190
2017	●	165	185	158	215	179	194
2018	●	177	197	169	228	194	217
2019	●	170	187	160	217	192	236
2020	●	127	139	116	165	136	171
2021	●	113	123	102	148	153	178
2022	●	141	154	129	181	198	217

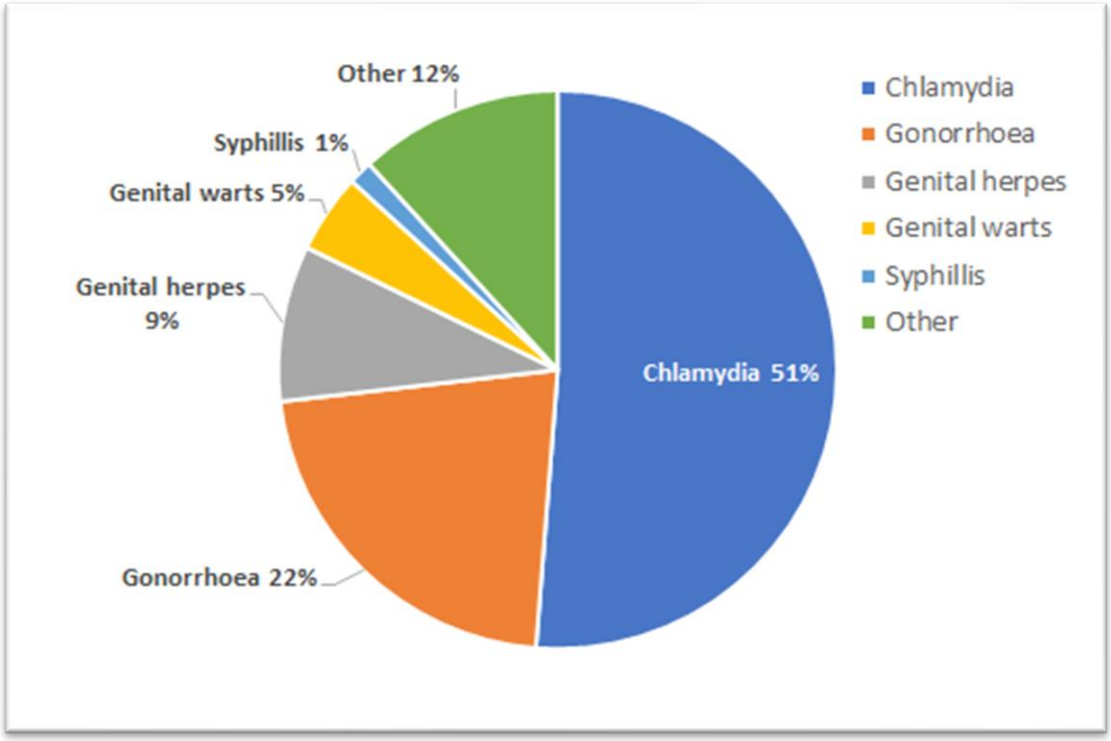
Source: [Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile]

Chlamydia diagnostic rates for those aged over 25+ have decreased over the last three years but we need to be cautious about the interpretation of this (Figure 13). During the pandemic there was reduced STI testing (nationally and locally), but this was also supported by changes in behaviour due to national lockdowns reducing opportunities for STI transmission.

Chlamydia was the most commonly diagnosed STI among all Halton residents during 2022, accounting for 51% of all diagnoses, followed by gonorrhoea and genital herpes as shown in

Figure 14 below. Chlamydia represented half of diagnoses while gonorrhoea made up just over 1 in 5 diagnoses (22%). These proportions are similar to the England average (51% and 21% respectively).

Figure 14: Proportion of STIs diagnosed in Halton, all persons, 2022

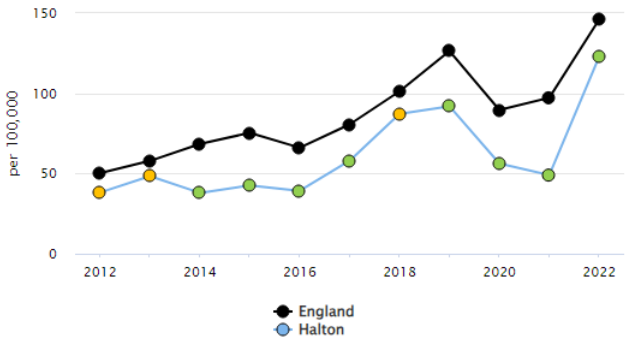


Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Gonorrhoea

Gonorrhoea diagnoses in Halton have followed a similar trend to the England average and seen a noticeable, threefold increase since 2016 (apart from in 2020 and 2021 during the Covid-19 pandemic). However rates are consistently significantly lower in Halton than the England average since 2019.

Figure 15: Trend in gonorrhoea diagnoses per 100,000 population, 2012 to 2022, Halton and England



Recent trend: ➡ No significant change

Period		Halton Count	Value	95% Lower CI	95% Upper CI	North West	England
2012	🟡	48	38	28	51	45	50
2013	🟡	61	48	37	62	43	58
2014	🟢	48	38	28	50	45	68
2015	🟢	54	43	32	56	45	75
2016	🟢	50	39	29	52	50	66
2017	🟢	74	58	46	73	64	81
2018	🟡	112	87	72	105	82	101
2019	🟢	119	92	76	110	98	126
2020	🟢	73	56*	44	71	59*	90
2021	🟢	63	49*	38	63	69*	97
2022	🟢	158	123*	104	144	133*	146

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

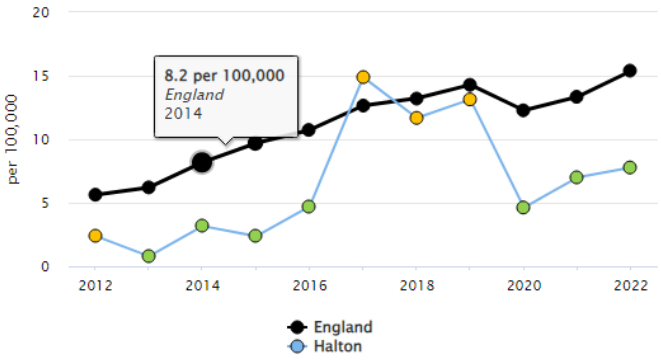
The majority of diagnoses were aged between 20 and 34 (66%) and there were approximately equal numbers of males and females (source: UKHSA GUMCAD Report).

Gonorrhoea cases have surged in England following the easing of COVID-19 restrictions, with case numbers now higher than they have ever been[44]. While the analysis suggests some of the increase is associated with increases in testing, the scale of the increase in diagnoses strongly suggests that there is more transmission of STIs within the population. This is true of both England and Halton.

Gonorrhoea is becoming increasingly resistant to antibiotics and at risk of becoming untreatable in the future, making it vital that people test early and diagnose the infection so that they can prevent passing it on. **Considering the sharp rise in cases, understanding reasons and potential mitigation should be a priority for both treatment and education services.**

Syphilis

Figure 16: Trend in syphilis diagnoses per 100,000 population, 2012 to 2022, Halton and England



Recent trend: No significant change

Period		Halton Count	Value	95% Lower CI	95% Upper CI	North West	England
2012		3	2.4	0.5	7.0	5.5	5.6
2013		1	0.8	0.0	4.4	4.4	6.2
2014		4	3.2	0.9	8.1	5.8	8.2
2015		3	2.4	0.5	6.9	6.3	9.7
2016		6	4.7	1.7	10.3	8.4	10.7
2017		19	14.9	9.0	23.3	10.9	12.7
2018		15	11.7	6.5	19.3	12.2	13.2
2019		17	13.1	7.7	21.0	13.6	14.3
2020		6	4.6	1.7	10.1	9.6	12.3
2021		9	7.0	3.2	13.3	11.1	13.3
2022		10	7.8	3.7	14.3	12.7	15.4

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

The trend in syphilis diagnoses in Halton has fluctuated since 2012 and been significantly lower than England between 2020 and 2022. Numbers of diagnoses have been 10 or less per year since 2020.

Whilst syphilis overall is not currently an STI of concern locally, this position should be monitored over time given the current high incidence nationally[44].

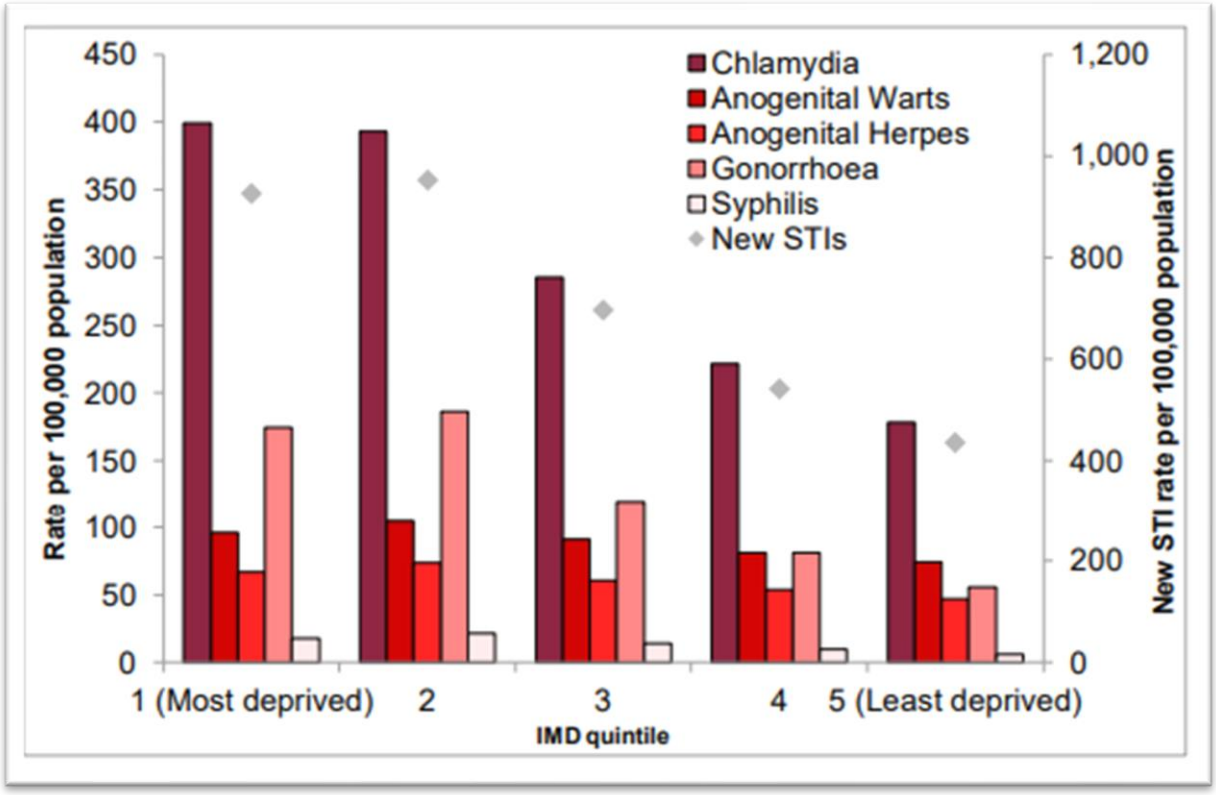
STI Testing Rates by Deprivation

When considering socio–economic status, rates of new STI diagnosis are shown to be consistently higher in more deprived populations (as measured by the Index of Multiple Deprivation [IMD]). The bar chart below shows that rates of chlamydia, anogenital warts, anogenital herpes, gonorrhoea and syphilis and all STIs are highest in most deprived areas and lowest in least deprived areas as measured using Index of Multiple Deprivation quintiles.

Understanding the reasons for this is important. It could be an indication of higher risk sexual behaviours (such as condomless sex with casual or multiple partners). This also reinforces the importance of ensuring accessible services in these areas; providing rapid treatment and partner notification can reduce the risk of STI complications and infection spread. Given that around half of Halton's neighbourhoods are in the lowest quintile[45], **services should be configured with specific reference to where these neighbourhoods are located (see Appendix 1).**

[44] Gonorrhoea and syphilis at record levels in 2022 - GOV.UK (www.gov.uk)
[45] Exploring local income deprivation (ons.gov.uk)

Figure 17: Rates of STI diagnoses by Index of Multiple Deprivation quintile, England 2019 [22]

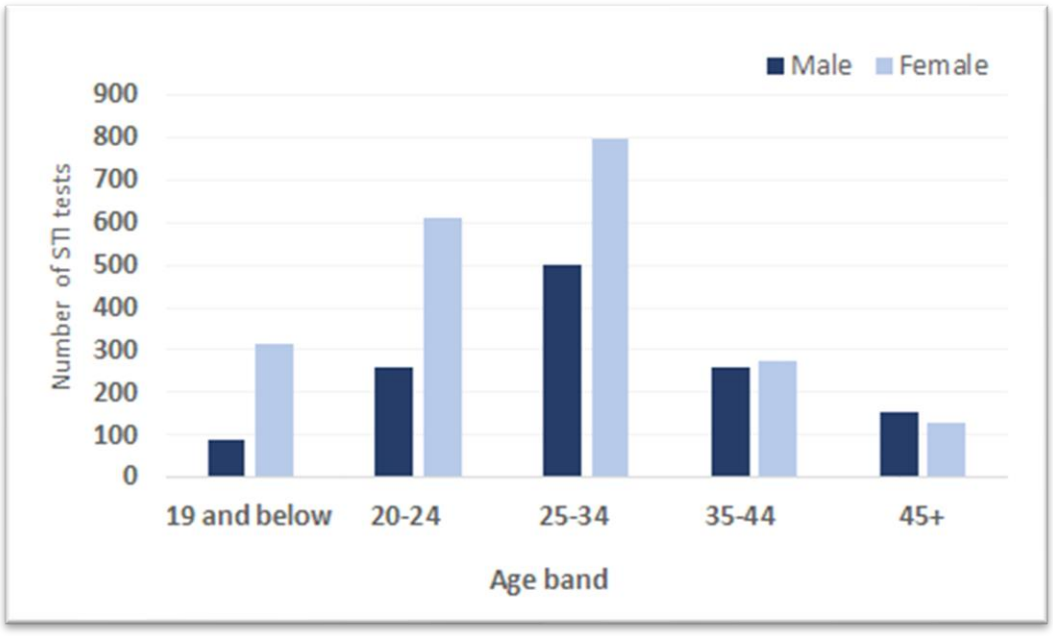


STI testing diagnoses by age and sex

(N.B. data covers all Halton residents, whether they attend services in Halton or outside.)

Females represented the majority of STI tests (for chlamydia, gonorrhoea, HIV and syphilis) in Halton residents during 2022 (62%). The most common age band for tests in both males and females was 25-34.

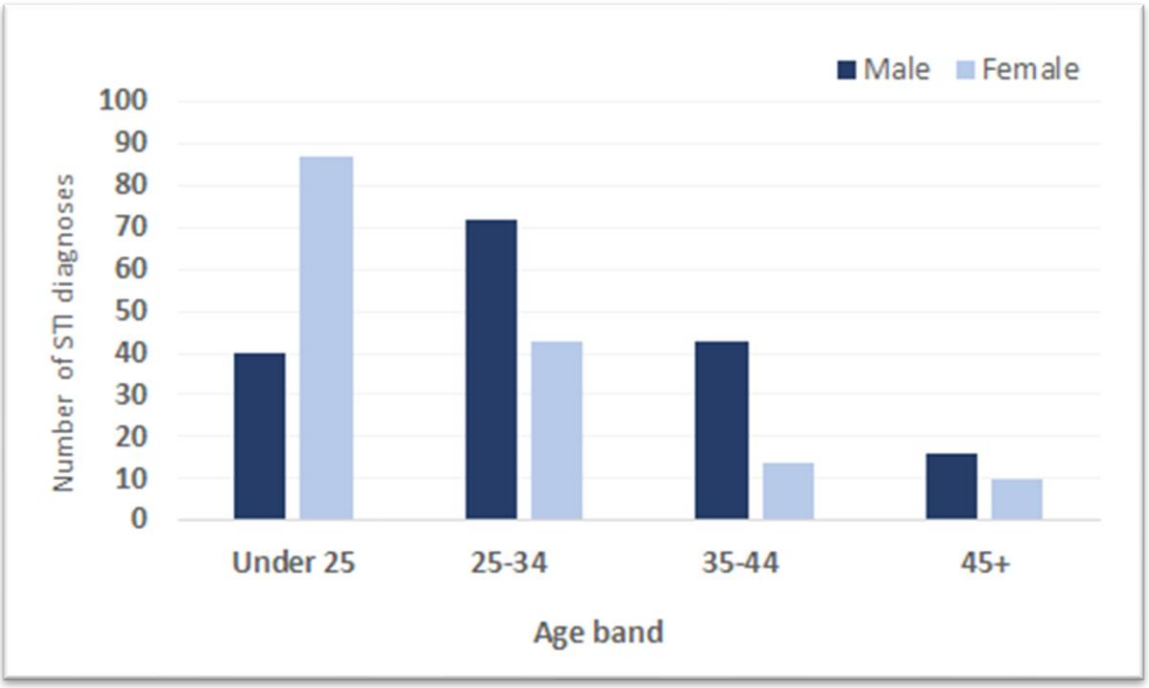
Figure 18: STI tests for chlamydia, gonorrhoea, HIV and syphilis by sex and age group, Halton residents, 2022



Source: UKHSA GUMCAD Report (restricted access)

In terms of overall STI diagnoses (excluding chlamydia), there is a fairly equal split overall between males (53%) and females. The most common age group for male diagnoses is 25-34, whereas for females it's under 25.

Figure 19: STI diagnoses (excluding chlamydia) by sex and age group, Halton residents, 2022



Source: UKHSA GUMCAD Report (restricted access)

The majority of chlamydia and genital herpes diagnoses are in females, but the majority of syphilis are in males; gonorrhoea and genital warts are roughly equal.

Table 2: Selected STI diagnoses by sex (where recorded; chlamydia, gonorrhoea, herpes, syphilis and warts), Halton residents, 2022

	Chlamydia	Gonorrhoea	Herpes	Syphilis	Warts
Male	39%	52%	34%	90%	57%
Female	61%	48%	66%	10%	43%

Source: UKHSA GUMCAD Report (restricted access)

The male-female split of diagnoses in Halton broadly mirrors the national picture, suggesting that there isn't specifically a local issue with access and/or acceptability .

STI diagnoses by ethnicity

The majority of STI diagnoses in Halton residents for the main infections (chlamydia, gonorrhoea, herpes, syphilis and warts) are in those of white ethnicity (94% in 2022; *Source: UKHSA GUMCAD Report*). The data is well completed, with less than 1% of records not having an ethnicity assigned.
Across England as a whole, Minority Ethnic populations are disproportionally affected by STIs. For example the rate of gonorrhoea is 3.5 times that of the general population and for trichomoniasis, the rate is 9 times[22].

STI diagnoses by Sexual Orientation

The majority of diagnoses of chlamydia, gonorrhoea, herpes, syphilis and warts in 2022 in Halton residents were in those who defined themselves as heterosexual or straight. The pattern is different between males and females,

where diagnoses in gay men make up 29% (almost 1 in 3) of diagnoses of these conditions in men. There are more diagnoses of gonorrhoea and syphilis in gay men than straight/heterosexual men.

Table 3: Selected STI diagnoses by sexual orientation (chlamydia, gonorrhoea, herpes, syphilis and warts), Halton residents, 2022

	Males	Females	Total*
Heterosexual or Straight	61%	95%	81%
Gay/Lesbian	29%	0%	12%
Bisexual	6%	3%	4%
Not known	4%	2%	3%

* total includes records where sex is not recorded

Source: UKHSA GUMCAD Report (restricted access)

Services

Specialist Sexual Health Service

Halton's specialist sexual health service, 'AXESS' is delivered by Liverpool University Hospitals NHS Foundation Trust (LUHFT). The service is currently commissioned by Warrington BC and Halton BC as a joint service. The current contract is due to run until October 2025.

Axess provides an integrated STI and contraception service offering free sexual health screens, treatment, results management and advice on STIs as well as delivering the full range of contraception (and contraception counselling) to men and women of all ages. The service also supports people who are having problems with their sexual health including psychosexual therapy. The service is delivered by a team of professionals including doctors, nurses, therapists and administrators.

The service operates clinics at limited times from Monday to Friday across two venues, Halton General Hospital (Monday 1-4pm, Wednesday 1-4pm, Thursday 1-2.30pm, Friday 1-4pm) and Widnes Health Care Resource Centre (Tuesdays 9am – 4pm). There is an option to book appointments in advance via telephone or online. 'Walk in and wait' (non-bookable appointments) are only available on one day a week for two hours at either venue (Runcorn, Weds 5-7pm; Widnes Tues 5-7pm). Telephone assessment and advice is available when clinics are not running.

The service has a well-developed remote offer, with availability of online STI postal kits through SH:24, a condom postal service and information available on common sexual health topics. There is a specific young peoples' service available for young people under the age of 19 years delivered under the name Axess4U available in Widnes on Thursdays 3.30-6pm.

Partner notification is an integral part of the service, and this is monitored by routine reporting to commissioners on several partner notification indicators in line with best practice. Identifying and treating anonymous partners however remains a challenge for services; they can only contact partners if the index case (patient documented with an STI) is able and willing to share partner contact details.
Axess also have a Link Team to support people with additional needs to access their services, as well as support for carers. The Link team can arrange clinic visits outside of regular opening hours for people if necessary. The service also has a dedicated member of staff to establish links with partners and identify how the service can engage with underserved communities. They have an outreach team and an education team. Outreach have worked with substance misuse providers and the Daresbury Asylum Seeker facility. They have further supported programmes such as PAUSE and the Family Nurse Partnership.

It is important to note that workforce pressures are a real concern for sexual health services. Nationally, morale amongst the sexual health workforce is reportedly low, attributed to a range of factors such as funding cuts, organisational changes, clinic closures and increased demand. Retention and recruitment are also challenging;

there is an aging workforce and there are difficulties in recruiting appropriate staff to replace the skills lost[46]. This is an issue faced by local services – both in Halton and across Cheshire and Merseyside.

STI Digital Service

Free STI postal kits are available to any residents living in Halton aged 16 years plus. These are particularly suitable for people without any symptoms and were more widely used during the pandemic when face to face appointments within the service were limited to nationally defined urgent criteria. The kits test for four key STIs – Chlamydia, Gonorrhoea, Syphilis and HIV.

This service is delivered by SH:24 with pathways to advise which kit is most suitable to individual need. Furthermore, SH:24 can provide free treatment by post for all reactive tests for Chlamydia. For all other reactive test results, the clinical team will facilitate access into an Axess clinic. Further information on the STI postal kits can be found on the Axess website.

STI Community Testing

Axess can provide healthcare partners with community testing kits that test for chlamydia and gonorrhoea. Kits are issued to service users for self-testing on the premises and the samples are returned by the partner organisation for laboratory analysis. All test results are returned to Axess and any reactive results are picked up directly by the team for either further testing or treatment.

Change, Grow, Live (CGL)

CGL (adult drug and alcohol treatment provider in Halton) work with Sahir House to promote their chemsex service provision, including at local Pride events and outreach through Sahir House's team. There are currently ongoing conversations around better integration of services such as needle exchange.

Data is not collated on chemsex in Halton, but UK level data suggests chemsex is widespread[47].

[46] House of Commons Health and Social Care Committee (2019). Sexual Health. Fourteenth Report of Session 2017-19 https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/full-report.html#heading-10

[47] https://www.sciencedirect.com/science/article/abs/pii/S095539591730378X?via%3Dihub

Qualitative Insights from Halton residents

Qualitative feedback indicates there is a need to improve knowledge on how to access services, both online and in clinic, ensuring they are discreet, non-judgemental and inclusive. There is also an identified need for improved education in schools, and also throughout the life course.

In April 2024, feedback was sought from a small sample of local women on their attitudes towards and experience of sexual health services. This study took a qualitative approach to gain in-depth perspectives from women living in Halton. Semi-structured interviews were conducted with 12 women aged between their 20s and 50s, representing both Widnes and Runcorn areas. Participants were recruited through the distribution of flyers and posters in public spaces such as family hubs, libraries, and supermarkets. An additional recruitment email was sent to women employed by Halton council. Participants received a £30 Love to Shop voucher as a token of appreciation for their time.

The full detailed report is available separately. The main recommendations from the insight gathered relevant to this section were as follows:

- **Ensure appointments can be booked online easily**
- **Increase access to online/postal STI testing**
- **Consider provision of self-testing kits at appropriate locations for pick up**
- **Increase awareness of the service and its offer**
- **In raising awareness, also make significant effort to demonstrate that the service is for all ages, not just young people**
- **Note that stigma is still perceived by most service users regarding STI/GUM concerns. Any communications to also address this**
- **Use social media, website and search engine optimisation to increase access to the service and relevant information**
- **Explore options for promotion in community or public settings**
- **Develop and deliver an enhanced education offer, universally applied, which deals with both contraception and STIs**

Chlamydia and the National Chlamydia Screening Programme (NCSP)

Key messages

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England. The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25.

How Halton performs?
Screening rates in Halton have reduced dramatically over the last decade from around 1 in 3 to around 1 in 10. Detection rates have broadly mirrored the national average but remain under the 3,250 per 100k national target.

Who is affected?
Women aged 15-24 are the most at-risk group for chlamydia diagnoses.

Overall, chlamydia detection is higher amongst young people from our more deprived areas.

What this means?
Achievement of the female-only detection rate target of 3,250 per 100,000 (aged 15 to 24yrs) is unlikely to be met in Halton without targeted activity to increase chlamydia screening, particularly within the community.

Recommendations

- Audit practice against the 2022 NCSP Standards to identify if there are any standards that are not currently being met.
- An overall focus on improving rates of chlamydia detection in our more deprived neighbourhoods.
- A scaling up of the NCSP within community settings particularly aimed at providing an enhanced service for groups likely to have higher rates of undetected infections.

Overview

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates highest in young adults. Left untreated, women, can bear more serious complications than men such as pelvic inflammatory disease, ectopic pregnancy and infertility. Transgender people and other people with a womb are also at risk[48]. Men who have chlamydia are at a much lower risk of harm; in asymptomatic individuals the infection can resolve without treatment[49].

A successful chlamydia control programme combines opportunistic screening with efforts to reduce the time between testing and treatment, strengthening partner notification and re-testing after treatment[50].

The National Chlamydia Screening Programme (NCSP) promotes opportunistic screening to sexually active young people aged under 25 years. The chlamydia detection rate among under 25-year-olds is a measure of chlamydia control activity, aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting

[48] Sarah C. Woodhall et al., BMJ, August 2015, https://sti.bmj.com/content/sextrans/92/3/218.full.pdf
[49] https://www.gov.uk/government/publications/ncsp-programme-overview/ncsp-programme-overview
[50] https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp

transmission. This indicator monitors the delivery of accessible, high volume chlamydia screening. A higher detection rate is indicative of increased control activity; the detection rate is not a good measure of the prevalence of disease.

In June 2021, the programme changed from a unisex approach, to focus on young women aged under 25 years. The focus was shifted to females as part of a targeted harm reduction approach because the most harmful effects of chlamydia are seen amongst people with a womb or ovaries. A review of the evidence indicated that screening of both sexes at realistic levels has not reduced chlamydia prevalence in the population[49].

Screening for chlamydia amongst younger people (under 25 years) in community settings, such as primary care will only be proactively offered to young women, men will not be proactively offered a test without an indication. Specialist sexual health service provision remains unchanged.

Local authorities were monitored against a detection rate target of at least 2,300 cases per 100,000 population aged 15 to 24. The recommendation was set as a level that would encourage high volume screening and diagnoses, be ambitious but achievable and high enough to encourage community screening, rather than specialist sexual health clinic, which would be likely to result in a continued chlamydia prevalence reduction.[51]

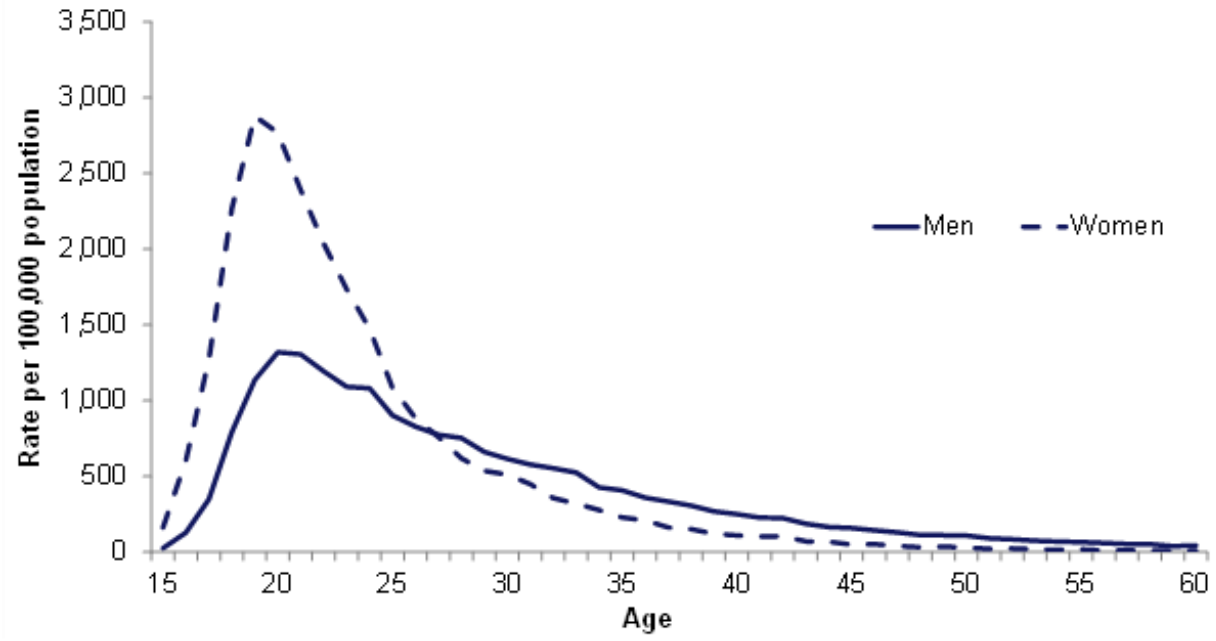
However, the shift in focus towards female targeted screening meant that the UK Health Security Agency (UKHSA) now recommends that local authorities should now be working towards a revised female-only benchmark detection rate of 3,250 per 100,000 aged 15 to 24 (female).

Groups most at risk

Nationally, women aged 15-24 are the most at-risk group for chlamydia diagnoses.

This is outlined in **Figure 20** below showing that diagnosis rate is highest in females around the age of 20. From the age of 27, chlamydia prevalence reverses and is higher amongst men albeit at a reduced rate.

Figure 20: Rates of chlamydia diagnosis by age and gender, England 2021



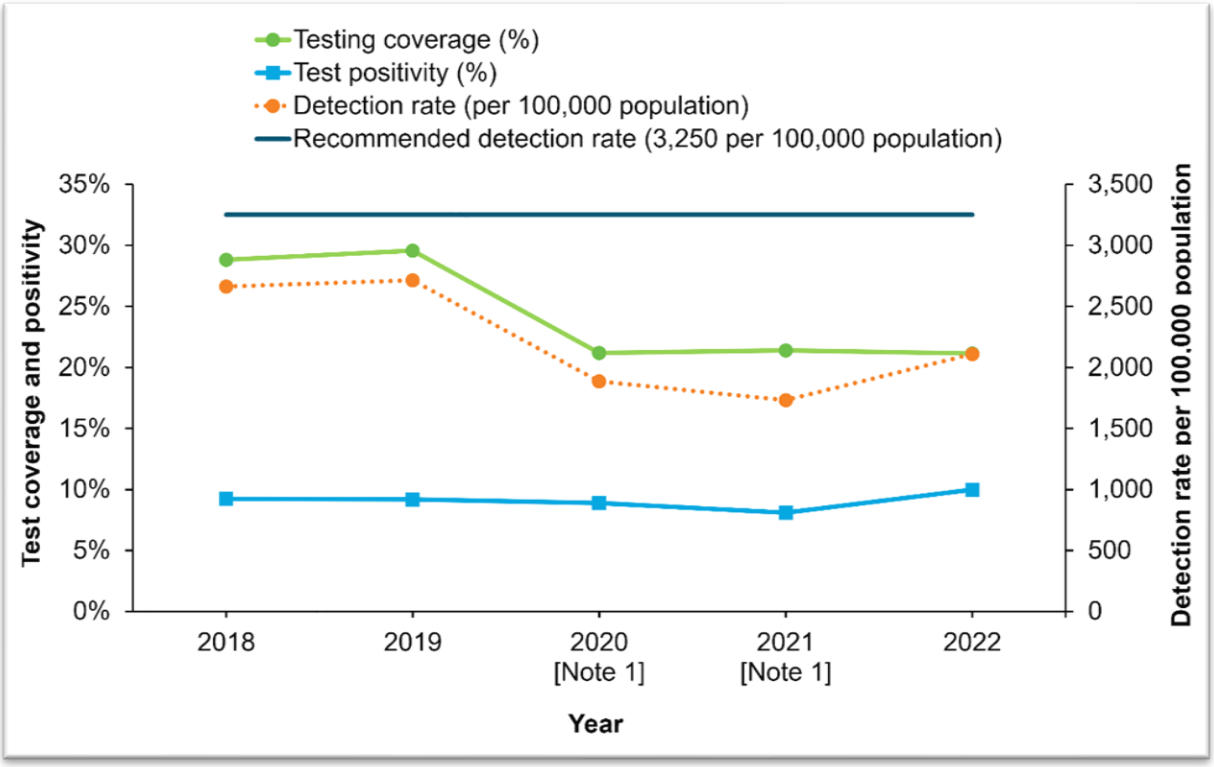
Source: UK Health Security Agency, 2022

[51] Public Health Outcomes Framework, 2022

In 2022, among young women aged 15 to 24 years screened through the National Chlamydia Screening Programme (NCSP)[52]:

- 690,531 chlamydia tests were carried out, a 1.2% decrease compared to 2021 (698,979)
- there were 68,882 chlamydia diagnoses, an increase of 21.8% compared to 2021 (56,562) – test positivity increased from 8.1% to 10.0% over the same period
- the detection rate also increased by 22.2% in 2022 (2,110 per 100,000 population) compared to 2021 (1,733 per 100,000 population)
- Test positivity also increased to 10.0% in 2022 compared to 8.1% in 2021

Figure 20: Chlamydia testing coverage, detection rates and test positivity among women aged 15 to 24 years, 2018 to 2022, England



Source: Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)

The majority of testing occurred among those of White ethnicity, accounting for 57.0% of all tests in 2022, and resulted in a higher proportion of diagnoses amongst this group (60.5% of diagnoses). Positivity was highest among those of Black 'Other' (non-African or -Caribbean) ethnicity (12.7%) followed by those of Black Caribbean ethnicity (12.0%) compared to those of White ethnicity (10.6%).

As with other STIs, chlamydia prevalence is associated with socioeconomic status. In 2022, chlamydia detection rates were highest among those living in the most deprived quintile in England, around 60% higher the rate of those living in the least deprived quintile.

[52] Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)

Data (current and trend)

For the current and trend data for Chlamydia, please see pages 29-31.

Services

Halton's Specialist Sexual Health Service (Axess) is the lead provider locally for the National Chlamydia Screening Programme.

Younger people under the age of 25 can also test for chlamydia using the postal kits as described in the earlier chapter (STI testing). Between April 2022 and December 2023, 67.6% of female service users under 25 were screened, although all were offered a test. 142 chlamydia tests for young women returned positive for chlamydia, resulting in a positivity rate of just over 2%, a detection rate of 2,083 per 100,000.

HIV (human immunodeficiency virus)

Headline: Although the prevalence in Halton is very low (91 in 2022), latest data available indicates that a greater proportion of people are diagnosed at a later stage of HIV infection compared to both England and the North West, with over 75% of cases diagnosed late. This is the highest rate in the region.

Key Messages

- Overall prevalence is very low in Halton (91 people in 2022) and is lower than the England and North West averages. It is also below the NICE definition of "high prevalence".
- Number of new cases of HIV are very low in Halton, averaging less than 10 per year; rates are either lower or similar to the England average.
- The proportion diagnosed with HIV at a late stage is significantly higher than the England and NW averages; it is the highest in the North West. Although the numbers are small.
- Pre-exposure prophylaxis (PrEP) need was lower than the North West and England averages. Of those identified, the majority (76%) started or continued with the drug, which is statistically similar to the England average. It is the highest in the North West.
- The coverage of ART in Halton exceeds the UNAIDS target of 95% of all people with diagnosed HIV infection to receive sustained treatment. Virological success is high in Halton at 100%.
- HIV testing coverage is significantly lower than the England average, particularly for women. In all men and men who have sex with men, it is similar to the England average. Repeat testing amongst gay, bisexual and other men who have sex with men is lower than the England and North West averages (this is a NICE guideline).
- Numbers of new cases of HIV are too small to analyse just for Halton, but across England as a whole in 2022, there are approximately equal numbers thought to have been infected through men having sex with men and women infected through having sex with men. This has changed over the last 10 years, as the probable route of exposure was predominantly sex between men.

Who is affected?

Historically, GBMSM and ethnic minority groups have been disproportionately affected by HIV. But since 2020, transmission via heterosexual contact for men and women combined has overtaken transmission by GBMSM.

What this means?

There is a need locally to increase and normalise HIV testing. This includes amongst those most at risk, which historically has been the GBMSM community but also amongst heterosexual men and women who nationally, make up a greater proportion of people diagnosed.

Recommendations

- Opportunities to normalise HIV testing should be explored, including increasing provision of testing in primary care and emergency departments. Testing in a wider range of services such as drug and alcohol services, pharmacies and abortion services is also recommended.

- There is a need for the continuation of outreach services to engage with high-risk communities such as people with multiple and overlapping sexual partners to improve access to testing. Other innovative methods for engaging with underserved communities should be explored.

- HIV postal testing has proved to be a highly acceptable route for testing. This should continue to be widely promoted and other options for discrete delivery to be explored, such as a click and collect services. Improved equality monitoring of the postal offer is recommended to help identify inequities in access and improve engagement with those that are digitally excluded.

- Ensuring access to PrEP to all groups is important for all groups but in particular heterosexual men and heterosexual and bisexual women where uptake has been lower.

- Consider how misinformation and stereotypes around HIV can be addressed in sexual health and drugs education, such as addressing people's perception of not being at risk.

- Partner notification (PN) should remain a key part of sexual health service provision. There should be a consideration for alternative methods of PN including both digital and non-digital approaches.

Overview

HIV (Human Immunodeficiency Virus) is a virus which attacks the immune system. **Whilst there is no cure for HIV, treatment can keep the virus under control and the immune system healthy so that a long and healthy life is attainable.** However, without medication people with HIV can develop AIDS (Acquired Immune Deficiency Syndrome), an advanced stage of infection when the immune system is seriously compromised.

Someone with AIDS has both HIV and at least one of a specific list of 'AIDS-defining' diseases, which include tuberculosis, pneumonia and some types of cancer [53]. If untreated, it is estimated that the time from HIV infection to AIDS and death is a decade[54]. Reducing the number of people unaware of their HIV infection is critical to ensure that they can access the necessary treatment to maintain their health and prevent onward transmission.

As people can live with HIV for many years without being aware of their status, it can be difficult to measure transmission of HIV. New HIV diagnoses is a useful proxy indicator to estimate transmission, although this will be influenced by testing patterns and reporting delays and will not indicate whether the infection was acquired within the UK[54].

[53] https://www.nat.org.uk/about-hiv/understanding-hiv

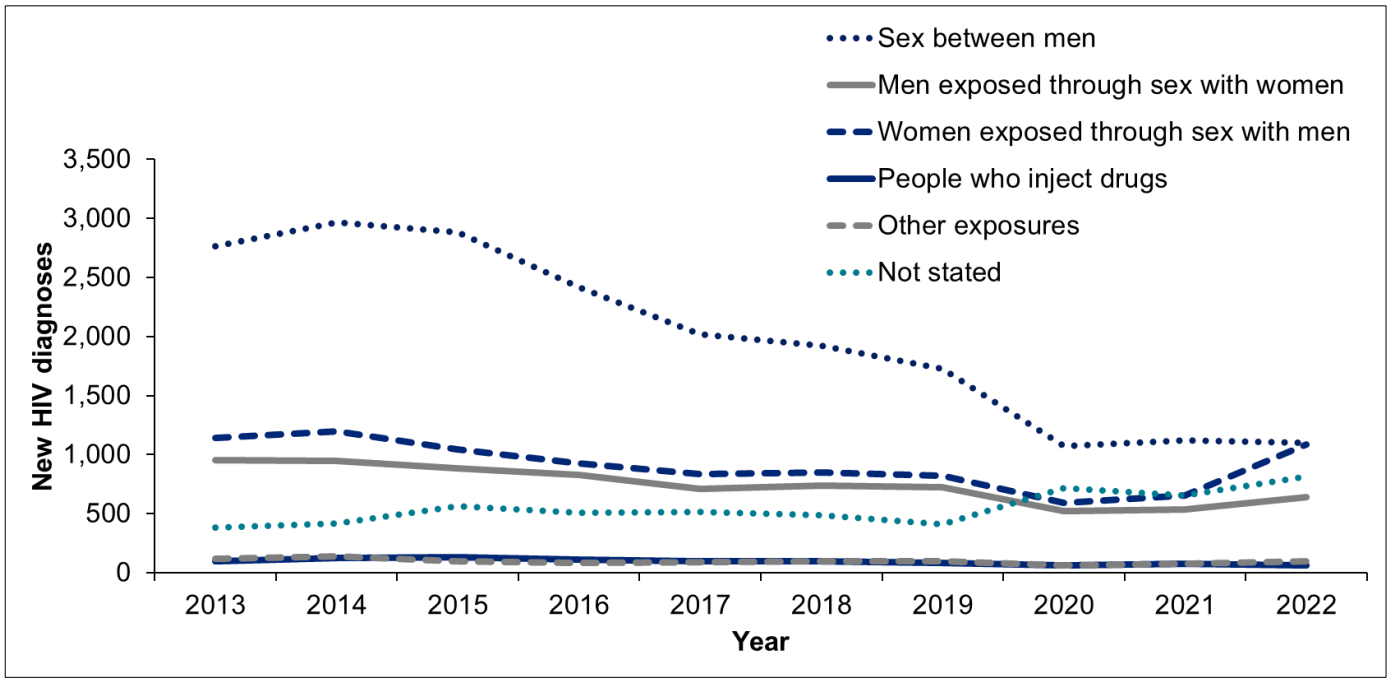
[54] https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/annex-a-background-document-to-support-the-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Measuring late diagnosis is therefore critical, helping to evaluate the success of expanded HIV testing and indirectly informs our understanding of the proportion of HIV infections undiagnosed.

Groups most at risk

Historically worldwide, GBMSM and ethnic minority groups have been disproportionately affected by HIV. Ten years ago, it was found that GBMSM acquire HIV at rates 44 times higher than other men and 40 times greater than women.[55] Nationally, the new HIV diagnosis rate has been greatest amongst GBMSM but this has declined considerably since 2019[56], as illustrated in Figure 21 below.

Figure 21: New HIV diagnosis (all persons), by probable route of exposure and gender; England, 2012 to 2022



Source: HIV in England slide set, UKHSA October 2023[57]

Since 2020, HIV transmission via heterosexual contact for men and women combined has overtaken transmission by GBMSM, likely due to targeted interventions like PrEP pill availability and routine testing[58]. However, GBMSM continue to be a group at risk of HIV, and stigma surrounding HIV testing still exists. Following multiple anti-LGBTQ+ hate crimes in the Liverpool City Region in 2021, it is more important than ever to remove stigma surrounding HIV and testing.[59]

Among people who probably acquired HIV through injecting drug use, new HIV diagnoses remain stable and low at around 100 per year nationally. Other transmission routes remain rare in the UK.

[55] Halkitis PN. Discrimination and homophobia fuel the HIV epidemic in gay and bisexual men. Psychology and AIDS Exchange Newsletter. 2012. Apr

[56] UKHSA (2023). HIV in England 2023 slide set. https://www.gov.uk/government/statistics/hiv-annual-data-tables

[57] HIV in England 2023 Slide set: https://www.gov.uk/government/statistics/hiv-annual-data-tables

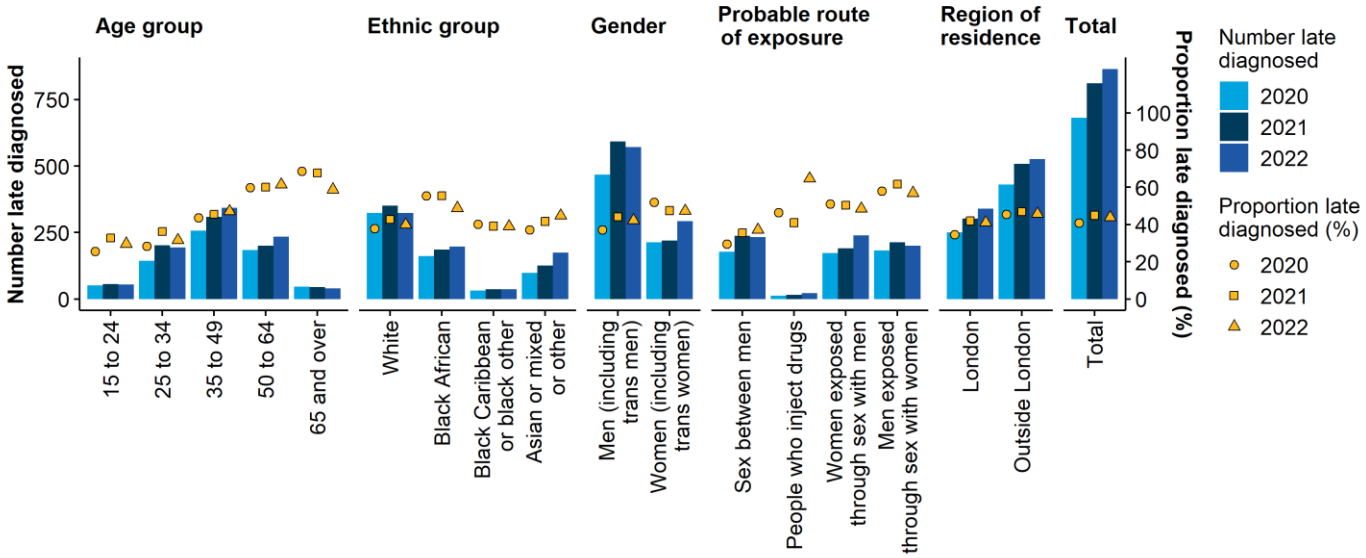
[58] Terrence Higgins Trust February 2022, https://www.tht.org.uk/news/heterosexual-hiv-diagnoses-overtake-those-gay-men-first-time-decade

[59] https://www.liverpoolecho.co.uk/news/liverpool-news/liverpool-charitys-future-uncertain-after-24660623

Black communities are also at a higher risk of contracting HIV.[60] Although Black African men and women made up only 1.8% of the UK population in 2018, they accounted for almost a third of those accessing HIV care[61].

Data for 2020-22 shows that people of Black African and Black Caribbean/Black Other ethnicity, as well as women and older age-groups (aged 50 and over) were more likely to be diagnosed at a late stage compared to men, younger age groups (aged 15 to 49) and people of white or other ethnicity. See Figure 22 below.

Figure 22: Proportion late diagnosed among adults newly diagnosed with HIV by demographics and probable route of exposure, England: 2020 to 2022



Source: HIV in England slide set, UKHSA December 2023

The graph shows that in 2022, 62% of men who were exposed through heterosexual contact and 49% of women exposed through heterosexual contact were diagnosed at a late stage, compared to 37% of men exposed through sex between men. This highlights the need to increase awareness and reduce stigma amongst heterosexual people.

Chemsex (use of mood and behaviour altering injectable and addictive drugs before or during sexual activity) can lead to higher sexual risk taking, increasing the risk of contracting HIV. GBMSM are more likely to engage in 'chemsex' than other groups[62].

Data (current & trend data)

HIV Diagnosis & Treatment

Prevalence rate per 1,000

In 2017, NICE HIV testing guidelines[63] defined high HIV prevalence local authorities as those with a diagnosed HIV prevalence of between 2 and 5 per 1,000 and extremely high prevalence local authorities as those with a diagnosed HIV prevalence of 5 or more per 1,000 people aged 15 to 59 years (see Figure 23).

[60] PHE Toolkit May 2021 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf

[61] Rachel Margaret Coyle, et al., 2018 https://sti.bmj.com/content/sextrans/94/5/384.full.pdf

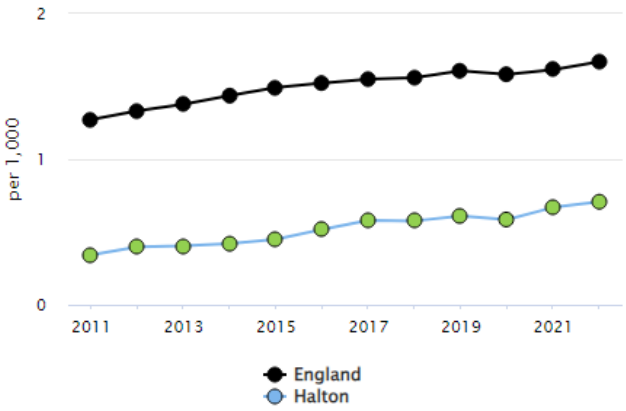
[62] Janey Sewell et al, June 2019, https://www.sciencedirect.com/science/article/pii/S0955395919300854

[63] https://www.nice.org.uk/guidance/NG60

Halton is not an area of high HIV prevalence.

Overall prevalence (total number of people living with HIV) is consistently low in Halton (91 people in 2022); this is a lower rate than the England and North West averages (0.71 per 1,000 compared to 1.67 in England and 1.37 in the North West). The majority of those living with HIV are aged between 15 and 59 (77 out of 91 in 2022).
The prevalence has been increasing slowly across both Halton and England over the last 10 years.

Figure 23: Trend in HIV diagnosed prevalence rate per 1,000, Halton and England, 2011 to 2022



Recent trend: ➡ No significant change
Benchmarking against goal: <2 | 2 to 5 | ≥5

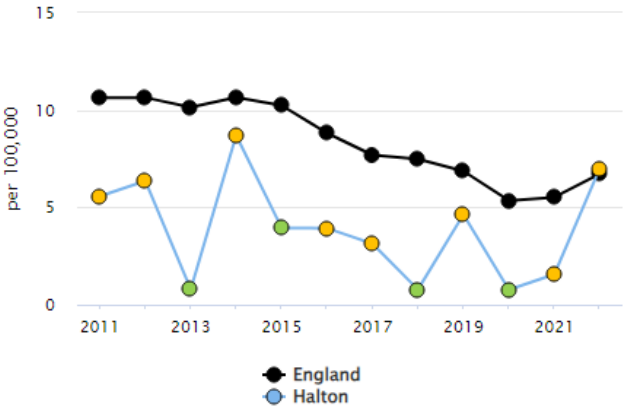
	Halton					
Period	Count	Value	95% Lower CI	95% Upper CI	North West	England
2011	43	0.34	0.25	0.46	0.96	1.27
2012	50	0.40	0.30	0.52	1.00	1.33
2013	51	0.40	0.30	0.53	1.04	1.38
2014	53	0.42	0.31	0.55	1.09	1.44
2015	57	0.45	0.34	0.58	1.15	1.49
2016	66	0.52	0.40	0.66	1.19	1.52
2017	74	0.58	0.46	0.73	1.22	1.55
2018	74	0.58	0.45	0.72	1.27	1.56
2019	79	0.61	0.48	0.76	1.33	1.61
2020	76	0.59	0.46	0.73	1.31	1.58
2021	86	0.67	0.54	0.83	1.37	1.62
2022	91	0.71	0.57	0.87	1.37	1.67

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

New HIV diagnosis rate per 100,000

The number of new cases of HIV is very low in Halton residents, averaging less than 10 per year. Taking into account the size of the population, rates are often slightly lower than the England and North West averages; however, in 2022 they were similar to the national average and higher than the North West.

Figure 24: Trend in new HIV diagnoses per 100,000 population, 2011 to 2022, Halton and England



Recent trend: ➡ No significant change

	Halton					
Period	Count	Value	95% Lower CI	95% Upper CI	North West	England
2011	7	5.6	2.2	11.5	7.5	10.6
2012	8	6.4	2.7	12.5	6.9	10.6
2013	1	0.8	0.0	4.4	7.5	10.1
2014	11	8.7	4.3	15.6	8.4	10.6
2015	5	3.9	1.3	9.2	7.1	10.2
2016	5	3.9	1.3	9.2	7.1	8.8
2017	4	3.1	0.9	8.0	6.8	7.7
2018	1	0.8	0.0	4.3	6.9	7.5
2019	6	4.6	1.7	10.1	5.5	6.9
2020	1	0.8	0.0	4.3	4.4	5.4
2021	2	1.6	0.2	5.6	5.0	5.5
2022	9	7.0	3.2	13.3	4.7	6.7

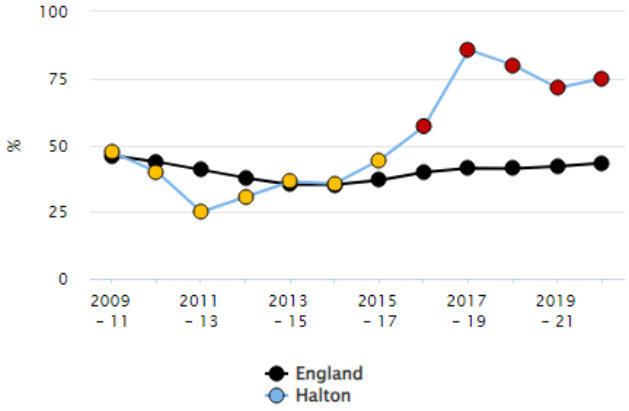
Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

A HIV key strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Among those diagnosed in England, those diagnosed late in 2021 were 5 times more likely to die within a year of diagnosis compared to those diagnosed promptly[64].

The number of residents in Halton newly diagnosed with HIV at a late stage of infection (defined as a CD4 count less than 350 cells per mm^3) is low so data is pooled for three years to account for these smaller numbers (See Figure 25).

Despite having relatively low rates of diagnosis, Halton has a significantly higher proportion of new cases diagnosed at a late stage: 75% compared to the England average of 43% and the North West average of 42%. Halton has the highest proportion in the North West. This noticeably increased during the period 2016-18. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection.

Figure 25: Trend in HIV late diagnosis in people first diagnosed in the UK per 100,000 population, 2009-11 to 2020-22, Halton and England (% with CD4 count less than 350 cells per mm^3 within 91 days of diagnosis)



Recent trend: Could not be calculated

Benchmarking against goal: <25% | 25% to 50% | ≥50%

Period		Halton Count	Value	95% Lower CI	95% Upper CI	North West	England
2009 - 11	●	9	47.4%	24.4%	71.1%	47.4%	46.1%
2010 - 12	●	6	40.0%	16.3%	67.7%	47.5%	43.8%
2011 - 13	●	3	25.0%	5.5%	57.2%	44.1%	40.8%
2012 - 14	●	4	30.8%	9.1%	61.4%	41.2%	37.8%
2013 - 15	●	4	36.4%	10.9%	69.2%	38.8%	35.3%
2014 - 16	●	5	35.7%	12.8%	64.9%	39.6%	35.2%
2015 - 17	●	4	44.4%	13.7%	78.8%	39.0%	36.9%
2016 - 18	●	4	57.1%	18.4%	90.1%	39.2%	39.9%
2017 - 19	●	6	85.7%	42.1%	99.6%	39.1%	41.4%
2018 - 20	●	4	80.0%	28.4%	99.5%	38.2%	41.3%
2019 - 21	●	5	71.4%	29.0%	96.3%	40.7%	42.1%
2020 - 22	●	6	75.0%	34.9%	96.8%	42.1%	43.3%

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Numbers in Halton are too small to analyse in detail by differential demographic.

As previously noted, HIV testing is integral to the treatment and management of HIV infection. Overall and particularly in women, HIV testing coverage (the proportion of people tested of those eligible when attending specialist sexual health services) is significantly lower than the England average; for all men and men who have sex with men, it is similar to the England average. Repeat testing in gay, bisexual and other men who have sex with men is lower than the national and regional averages (38% in Halton in 2022 compared to 47% in England and 44% in the North West). Repeat testing is a NICE testing guideline[65].

64 https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report#late-hiv-diagnoses

65 Quality and Outcomes Framework, 2022-23 - NHS England Digital

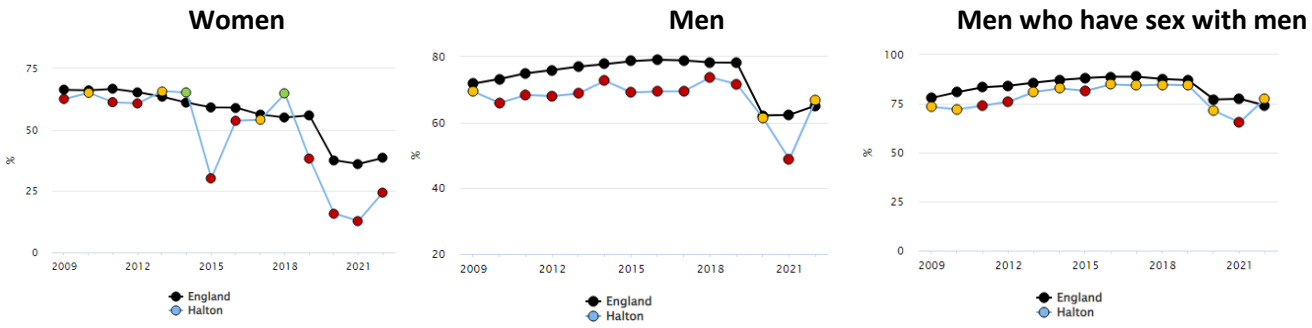
Figure 27: HIV testing data, Halton and England 2022

Indicator	Period	Halton			Region England	England			
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
HIV testing									
HIV testing coverage, total	2022	↓	1,123	36.2%	44.1%	48.2%	19.2%		76.3%
HIV testing coverage, gay, bisexual and other men who have sex with men	2022	→	128	77.6%	75.1%	74.1%	35.5%		92.5%
HIV testing coverage, men	2022	↓	475	66.9%	62.7%	65.1%	27.6%		85.6%
HIV testing coverage, women	2022	↓	470	24.5%	31.7%	38.5%	11.1%		73.1%
Repeat HIV testing in gay, bisexual and other men who have sex with men	2022	→	48	37.8%	43.5%	47.3%	11.7%		69.4%

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Numbers being tested dropped locally and nationally in 2020 due to clinics being closed during the COVID-19 pandemic and in 2022 were starting to return to pre-pandemic levels. However, the proportion of women taking a test was much lower in Halton and England overall in 2022 than it was in 2009 (63% in Halton in 2009, which dropped to 25% in 2022). This pattern is less marked for men and men who have sex with men.

Figure 28: Trend in HIV testing coverage in women, men and men who have sex with men, Halton and England 2009 to 2022



Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

HIV Treatment

While there is no cure for HIV, there are very effective treatments that enable many people to live a long and healthy life. However, without medication people with HIV can develop AIDS (Acquired Immune Deficiency Syndrome), which is an advanced stage of infection where the immune system is seriously compromised.

Pre-exposure prophylaxis (PrEP) is a drug taken by HIV-negative individuals before they have sex to stop them acquiring HIV. As part of a combination approach to HIV prevention, the roll out of routine PrEP commissioning began in England in the autumn of 2020. Specialist sexual health services (SHS) are responsible for the delivery of PrEP to those at higher risk of acquiring HIV66.

This indicator is used to determine PrEP need among people accessing specialist SHS. It assesses the proportion of all HIV negative people accessing specialist SHS who are at substantial HIV risk, and therefore could benefit from receiving PrEP. The indicator includes people who are having their need for PrEP met by receiving PrEP (met need)

[66] Office for Health Improvement and Disparities (2023) *Sexual and Reproductive Health Fingertips Profile (fingertips)*

as well as those with need who are not currently receiving PrEP (unmet need). This indicator does not relate to better or worse performance as it will vary between services depending on local populations 66. Halton's PrEP need was 4.4% in 2022, which was lower than the North West (7.5%) and the England average (9.7%). This is a slight increase from 2021 when it was 3.6%. Of those identified as needing PrEP, 76% started or continued with the drug; this was statistically similar to the England average and the highest in the North West.

Figure 29: HIV treatment data, Halton and England 2022

Indicator	Period	Halton			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Determining PrEP need	2022	–	149	4.4%	7.5%	9.7%	1.4%		31.9%
Initiation or continuation of PrEP among those with PrEP need	2022	–	113	75.8%	70.0%	71.0%	26.1%		86.2%
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV	2020 - 22	–	10	83.3%	83.5%	85.4%	0.0%		100%
Antiretroviral therapy (ART) coverage in people accessing HIV care ≤ 90% 90% to ≤ 95% > 95%	2022	–	89	97.8%	98.0%	98.1%	72.0%		100.0%
Virological success in adults accessing HIV care	2022	–	-	100%	97.5%	97.7%	89.8%		100%

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Antiretroviral therapy (ART) is a treatment for those with HIV, which works by stopping the virus replicating in the body. This allows the immune system to repair itself and prevent further damage. Successful ART decreases a person's viral load and HIV transmission does not occur when the viral load is undetectable. In Halton, 83% of people newly diagnosed with HIV were started on ART within 91 days, which is similar to the England (85%) and North West averages (84%).

To help end the HIV epidemic, UNAIDS set the target of 95-95-95 by 2025 (95% of all people living with HIV to know their HIV status, 95% of all people with diagnosed HIV infection to receive sustained treatment, and 95% of all people receiving treatment with viral load suppression)67. The coverage of ART in people accessing HIV care in Halton was 98% in 2022, which exceeded the UNAIDS target (as did the North West and England as a whole).

Virological success is the proportion of people accessing HIV care with an undetectable viral load (VL) (VL ≤200 copies/ml). HIV transmission does not occur when a patient's viral load is undetectable on ART, also known as Undetectable = Untransmittable (U=U). Success is high in Halton, at 100% of those diagnosed with undetectable load.

Services

Axess is the local provider commissioned to deliver services around HIV prevention and support. The service works innovatively taking a risk reduction approach to target high risk individuals, in particularly men that have sex with men (MSM). In other areas, services maintain trusted relationships with multiple sex on premise venues, those that regularly frequent sex parties and underground sex events, plus works across public sex environment sites. As there are no such premises in Halton, the need is more around hard to reach groups and work should focus on innovative ways to work with local areas that Halton residents will go to e.g. Liverpool, Manchester and Warrington. The service works to facilitate user access to sexual health testing and treatment services as well as providing HIV point of care testing to service users directly. The service also acts in an advisory capacity on LGBT sexual health and related issues across the health and social care economy.

[67] UNAIDS *2025 AIDS Targets*

The service also offers a non-clinical support service to Halton residents living with HIV to address health and social issues that impact on their health and wellbeing. The service offers time bound counselling and promotes a model of positive prevention and self-management. Sahir House also supports children and young people living with HIV in partnership with CHIVA, the Women's Hospital, Alder Hey Children's Hospital and Royal Liverpool University Hospital.

Axess offers HIV testing at all their clinics; all patients that attend for STI support should be offered a routine HIV test. Free STI postal kits can also be ordered online for residents over the age of 16 years so they can discreetly test for HIV at home.

National data indicates that in 2021, internet testing was the main route of access to HIV testing in England but was disproportionately accessed by GBMSM, especially outside London[64].

HIV partner notification (PN) is a process in which contacts of people with HIV are identified and offered HIV testing. PN is a highly effective HIV prevention strategy which is an extremely efficient way to find people with an undiagnosed HIV infection and provides the opportunity to maintain the HIV status of those partners who test negative. HIV PN is a critical function provided by Axess.

HIV testing is available within GP practices although testing in primary care is generally low and is not routinely offered. Testing will be provided if the patient presents with symptoms and/or signs consistent with an HIV indicator condition.

Opt-out HIV testing is also embedded in the care pathway at antenatal clinics so every pregnant woman should be routinely offered an HIV test.

National testing data[68] indicates that positive tests are more likely to be picked up in the following settings:

- Specialist HIV Services (5.7% positivity)
- Specialist Liver Service (1.0%)
- HIV self-sampling (OHID), UKHSA and LAs (0.7%)
- Sexual Health Services (0.9 %)
- Accident & Emergency (0.6%)
- Community outreach (0.5%)

Currently LUHFT (at the Royal Liverpool Hospital) is the HIV hub for all HIV services in Cheshire and Merseyside and deliver HIV treatment and care services in other clinics across the region, including Crewe, Chester, Halton, Macclesfield, Warrington, and Wirral. The service is commissioned by NHS England and is delivered in line with the service requirements outlined in the NHS England Specialised HIV Service Specification[69].

CGL Halton (Adult Substance Misuse Treatment Service) routinely offer HIV testing to all new entrants to service via a fingerprick test, along with other routine blood borne virus (BBV) testing. Anyone testing positive is referred to the sexual health service for confirmatory testing, and subsequent engagement with HIV services. Clients are routinely counselled as to the risks of BBVs throughout treatment.

[68] UKHSA. Research and analysis. Annual report from the sentinel surveillance of blood borne virus testing in England: data for January to December 2021. Published 7 March 2023

[69] https://www.england.nhs.uk/wp-content/uploads/2013/06/b06-spec-hiv-serv.pdf

Unplanned pregnancy

Headlines:
Halton has had a significantly higher abortion rate (27.9/100k) in comparison to England (19.2/100k) and the North West (23.0/100k).

Key messages

How Halton performs?
It is estimated that nationally half of all pregnancies are unplanned.

Halton consistently performs poorly on a range of abortion indicators, including overall abortion rate and abortions following a birth.

Who is affected?
Unplanned pregnancies are higher amongst vulnerable and socially disadvantaged groups, including women misusing drugs and alcohol, women with poor mental health, women experiencing domestic abuse, women with complex needs, young women and women from ethnic minority communities.

What this means?
There is a need for improving the uptake and utilisation of reliable contraception methods amongst women locally and potentially missed opportunities within healthcare services.
It is essential that women have good local access to contraception services with the full range of contraception options on offer, including LARC methods, which are the most and cost-effective contraception over other user dependent hormonal methods and condoms.
Engaging with underserved communities, including young women and women from deprived and disadvantaged communities in particular should be prioritised.

Recommendations

- Deliver a comprehensive LARC service via sexual and reproductive health services, with outreach activity and enhanced provision for groups at greater risk of unplanned pregnancy, or who historically are underserved by mainstream provision (e.g. people with a disability, or people from different minority ethnic backgrounds).

- Build on the women's health hub pilot to provide an enhanced LARC service in GP practices. Focussed work is needed with primary care to improve availability of contraception, and to ensure that a full range of contraceptives is proactively offered by healthcare professionals.

- Ensue maximum uptake of the NHS Community Pharmacy Contraception Pilot. This will help to improve accessibility to oral contraception and help to relieve the burden on sexual health services and primary care, creating more capacity for focused delivery of LARCs. This appears to be highly acceptable amongst women with many stating they would be happy to get their contraceptive pill from non-traditional clinical settings such as pharmacies or online.

- Improve the contraception offer post-termination and postnatally. All women should be offered contraception following a termination, with clear pathways for provision. Postnatal contraception needs to

be strengthened so that women are encouraged to consider their contraception preferences post-partum and are actively supported to take up their contraception of choice.

- Ensure joined-up commissioning for gynaecological and reproductive health in line with the recommendations from the Women's Health Strategy. There should be a system-wide approach to women's reproductive health with partners within One Halton so that women and girls can have more of their health needs met within integrated services.

Overview

More than 3 in 4 women at any one time want to either prevent or achieve pregnancy; contraception and pre-conception care are therefore a day-to-day reality for the majority of women for most of their reproductive years[70]. Choice and control over reproduction is important to ensure that as many pregnancies as possible are planned and wanted, health is optimised both before a first pregnancy and in the inter-pregnancy period, and women who do not wish to have children can effectively prevent becoming pregnant. **It is estimated that around 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence**[70]. Higher rates of unplanned pregnancies are evidenced amongst key vulnerable or socially disadvantaged groups[70].

There is clear evidence that **unplanned pregnancies are associated with poorer outcomes for women and their babies due to late presentations for antenatal care and a wide range of obstetric complications during the pregnancy, delivery and postnatal period**.
Mental health outcomes can also be impacted with increased incidence of antenatal and postnatal depression[70]. There are also psychological costs associated with termination of pregnancy. One large scale review of evidence estimated that around 20% of women will experience negative psychological effects ranging from anxiety to clinical depression, also highlighting that it was more likely to affect vulnerable groups[71].

Contraception is the single most cost-effective intervention in healthcare. Public Health England (PHE) estimated that every £1.00 invested in the provision of contraception achieves a £9.00 saving across the public sector[72]. The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use unlike the effectiveness of long-acting reversible contraceptive (LARC) methods, such as an intrauterine device/system (IUD/S) or implant, which are less likely to be impacted by user error[73]. It is widely agreed that LARC methods are more effective and cost-effective at preventing pregnancy than any other hormonal methods and condoms. **An increase in the provision of LARC will almost certainly lead to a reduction in rates of unintended pregnancy[74]**.

The Faculty of Sexual and Reproductive Health (FSRH) Clinical Guideline, Contraception after Pregnancy (2017, amended October 2020) states that **maternity services should provide Intrauterine contraception (IUC) and progestogen-only methods, including implant (IMP), injectable (POI) or pill (POP), to women before they are discharged from the service after childbirth**. Childbirth presents an opportunity for providing contraception at a time

[70] PHE (2018). Health matters: reproductive health and pregnancy planning. Accessed at: https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning
[71] Fine-Davis, Margaret. *Psychological Effects of Abortion on Women: A Review of the Literature.* Dublin : Crisis pregnancy agency report, 2007. 20.
[72] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730292/contraception_return_on_investment_report.pdf
[73] https://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-pdf-975379839685
[74] Exellence, National Institute for Clinical. Long Acting Reversible Contraception: Clinical Guideline. [Online] 2005. https://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-pdf-975379839685

when women are attending a service staffed by healthcare providers with the skills to offer a full range of methods and when women may be highly motivated to start using an effective method. **This also provides a great opportunity to engage with the most vulnerable and marginalised women who are at increased risk of an unplanned pregnancy and poor outcomes.**

The All-Party Parliamentary Group on Sexual and Reproductive Health (APPG - SRH) in the UK opened an enquiry in 2019 to look at access around contraception for women, this was in response to reports that women were unable to access contraception in a way that met their needs[75]. Evidence was re-submitted from May 2020 to account for the pandemic.
They found that:

- **Women in England are facing increasing difficulty in accessing contraception which suits their needs.**
- This is due to a combination of funding cuts and a fragmented commissioning system which means that care is not structured around women's needs.
- There is an **urgent need to structure care around the needs of women, especially underserved groups** such as ethnic minority groups, young women and women from poorer communities.

Groups most at risk

The evidence illustrates that **unplanned pregnancies is a health inequalities issue, resulting in disproportionately poorer physical and mental health outcomes for women and their babies from our most vulnerable groups**.
Higher rates of unplanned pregnancies are evidenced amongst the following groups:

- Teenagers
- Women using drugs and alcohol
- Women with poor mental health
- Women experiencing domestic abuse
- Women with multiple complex needs[70]

Abortion rates are also higher amongst some Black and Ethnic Minority groups, which suggests higher rates of total unplanned pregnancies and barriers to contraception. Similarly, there is inequality by deprivation with the abortion rate amongst the most deprived populations more than double the rate in the least deprived[76].

Abortion rates have been rising gradually over the last ten years, with rates at their highest (2019) since the Abortion Act 1967. Overall, abortion rates are highest amongst 20–24-year-olds, although they have been declining along with under 18s since 2007. The increase has been observed in women over the age of 30 indicating a rise in unplanned conceptions among this group[75].

In 2019, 40% of women receiving abortion care had one or more previous abortions, a proportion that has increased steadily from 34% in 2009[75]. This suggests a longstanding unmet need for contraception and missed opportunities within the healthcare system.

It is also **estimated that one in 13 women presenting for abortion or delivery conceive within 1 year of giving birth**[77]. Women underestimate the return of fertility post pregnancy, they also underestimate when they are likely

[75] All Party Parliamentary Group on Sexual and Reproductive health in the UK. *Women's Lives, Women's rights: strengthening Access to contraception beyond the pandemic.* s.l. : FSRH Policy and External Affairs, 2020.
[76] All Party Parliamentary Group on Sexual and Reproductive Health in the UK. Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic. 2020.
[77] *Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93–98.*

to resume sexual intercourse (50% resume intercourse within 6 weeks of birth[78], before they would routinely see their GP to discuss a contraceptive plan).

Women in the post-partum period need to be aware of the risks and supported to plan their contraception of choice following their pregnancy.

Another group which should be prioritised are women whose LARC fitting has expired or is due for replacement or removal. Some LARC fittings can safely be left in place past their expiry date, but this can lead to unplanned pregnancies if another contraception method is not used immediately following its expiry date (https://www.brook.org.uk/your-life/myths-about-long-acting-reversible-contraception-larc/).

Data (current & trend data)

Unplanned pregnancy key data

Contraception

During 2022/23, 1,425 females and 30 males living in Halton used NHS Sexual and Reproductive Health Services (aged 13 to 54). The majority of females accessing services were aged 25 to 34.

The majority of females access these services for contraception purposes (86%); again the most common age band was 25 to 34. The table below shows the number by age band and as a proportion of the female population, compared to England and the North West. A higher proportion of Halton female residents in the younger age groups (under 20) are accessing contraception services, compared to England and the North West, which is positive.

Table 4: Females using NHS Sexual and Reproductive Health Services for reasons of contraception, Halton residents, 2022/23

	Under 16	16-17	18-19	20-24	25-34	35-44	45-54	Total (age 13-54)
Halton (number)	60	135	120	215	390	215	90	1230
Halton (% of female population)	3%	9%	10%	7%	5%	3%	1%	4%
England (% of female population)	1%	5%	7%	7%	5%	3%	1%	4%
North West (% of female population)	2%	7%	8%	8%	6%	4%	1%	4%

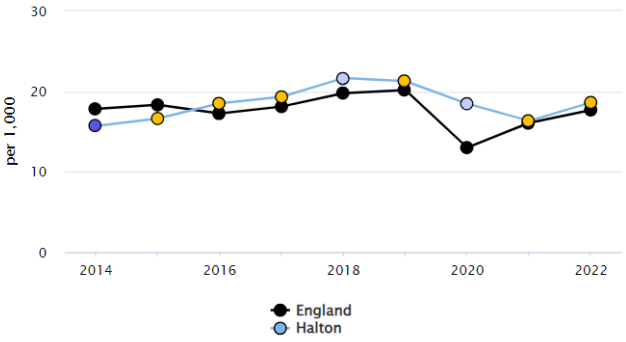
Source: NHS England Sexual and Reproductive Health Services (contraception) - Data tables 2022/23

Just over half (57%) of these females accessing services for contraception, were for long acting reversible contraception (LARC); the implant accounting for a third. This is similar to the England (55%) and North West (54%) averages. However there was a higher proportion choosing an injectable method in Halton than the national average (13% compared to 7%).

Total LARC prescriptions (excluding injections) in Halton is 27.9 per 1000 compared with an England rate of 41.8 per 1000 (Fingertips). With Halton being the 6th lowest in the North West region.

[78] McDonald EA, Brown SJ. Does method of birth make a difference to when women resume sex after childbirth? *BJOG* 2013;**120**:823–30

Figure 26: Sexual and Reproductive Health (SRH) services prescribed Long Acting Reversible Contraception (LARC) excluding injections rate per 1,000 population, Halton and England



Recent trend: ⬇ Decreasing

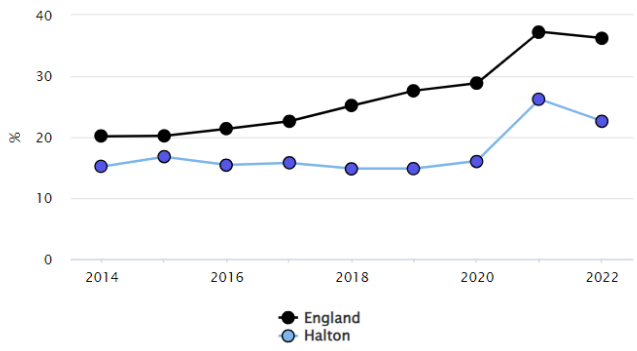
Period		Halton Count	Value	95% Lower CI	95% Upper CI	England
2014		379	15.7	14.2	17.4	17.8
2015		398	16.6	15.0	18.3	18.3
2016		440	18.5	16.8	20.3	17.3
2017		455	19.3	17.6	21.2	18.1
2018		510	21.7	19.9	23.7	19.8
2019		505	21.3	19.4	23.2	20.2
2020		440	18.5	16.9	20.4	13.0
2021		390	16.3	14.7	18.0	16.1
2022		445	18.6	17.0	20.5	17.7

Source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates

Source: Public Health Fingertips sexual health profile, 2022

From 2014, **the trend had been increasing in sexual health service LARC prescribing in Halton. However, in 2020 this trend dipped which again is attributed to the effects of the pandemic**. The trend is showing signs of returning to pre pandemic levels in 2022. Rates in Halton are broadly similar to national.

Figure 27: Under 25s choose Long Acting Reversible Contraception (LARC) excluding injections at Sexual and Reproductive Health Services (SRH), Halton and England



Recent trend: ⬆ Increasing

Period		Halton Count	Value	95% Lower CI	95% Upper CI	England
2014		223	15.2%	13.4%	17.1%	20.1%
2015		291	16.7%	15.1%	18.6%	20.2%
2016		305	15.4%	13.9%	17.1%	21.4%
2017		305	15.8%	14.1%	17.3%	22.6%
2018		285	14.8%	13.3%	16.5%	25.2%
2019		295	14.8%	13.2%	16.4%	27.6%
2020		165	16.1%	14.1%	18.6%	28.8%
2021		135	26.2%	22.8%	30.4%	37.3%
2022		155	22.6%	19.8%	26.1%	36.2%

Source: OHID based on NHS Digital SRHAD data

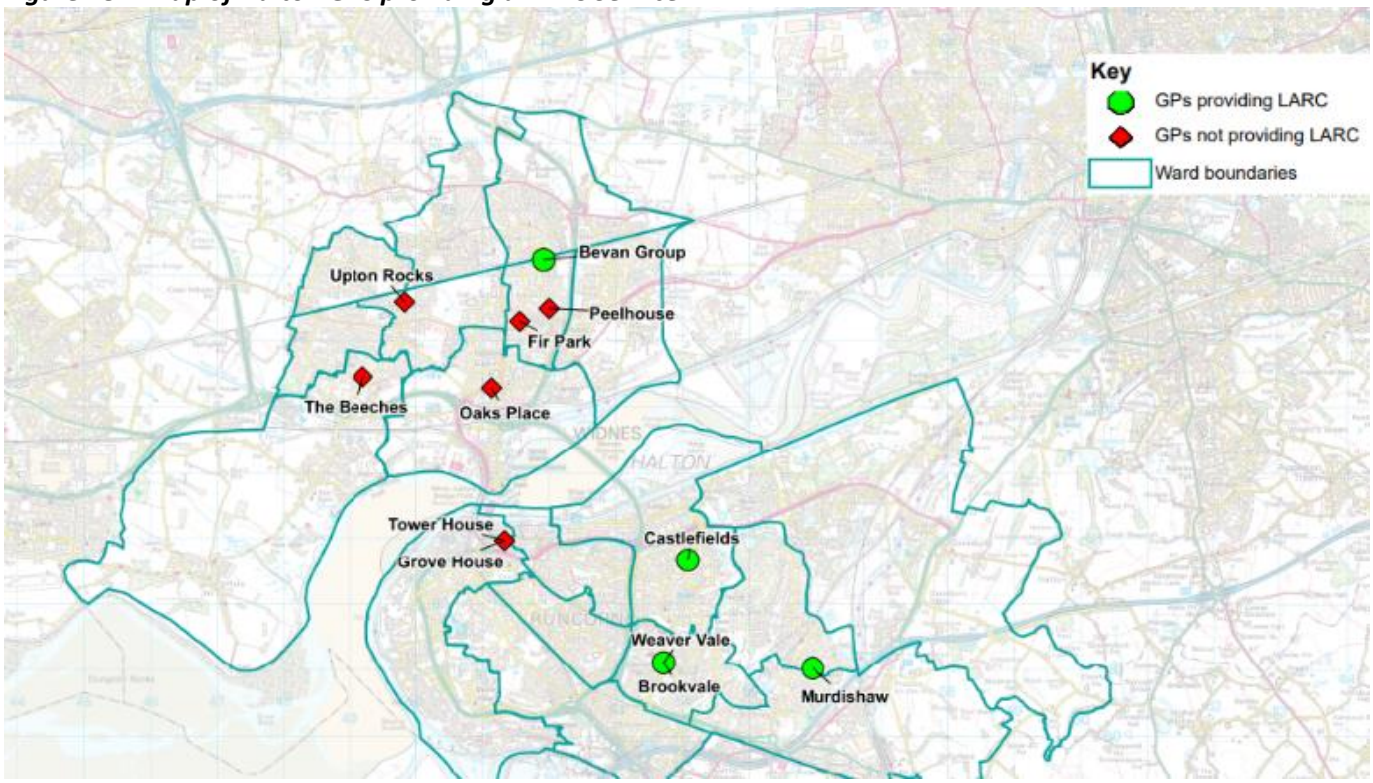
Source: Public Health Fingertips sexual health profile, 2022

Figure 27 above shows that **in Halton, since 2015, fewer 25 years olds choose LARC (excluding injections) at SRH services** than in England and the North West.

Under 25s (20-25s) are most at risk of a termination of pregnancy so increasing the number of LARC fits in primary care and the sexual health service amongst this cohort should be an area of focus in Halton.

Reviewing the location of practices providing LARC enables us to identify gaps in provision across Halton **see map below:**

Figure 28 – Map of Halton GPs providing a LARC Service



Ensuring all practices in Halton are able to provide an accessible LARC service will be key to reducing inequalities in unplanned pregnancy.

Conceptions and Termination of Pregnancy

Halton has a high total abortion rate of 27.9/100k compared with England (19.2/100k) and the North West (23.0/100k)[79].

Figure 29: U16 and U18 conception, abortion and birth data, Halton and England 2021

Indicator	Period	Halton			England			
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	Best/ Highest
Under 16s conception rate / 1,000 (Female, <16 yrs)	2021	–	9	3.8	2.1	7.0		0.6
Under 18s conception rate / 1,000 (Female, <18 yrs)	2021	–	50	22.1	13.1	31.5		2.7
Under 18s conceptions leading to abortion (%) (Female, <18 yrs)	2021	→	27	54.0%	53.4%	26.0%		87.5%
Under 18s abortions rate / 1,000 (Female, <18 yrs)	2021	→	26	11.9	6.5	2.0		14.6
Under 18s births rate / 1,000 (Female, <18 yrs)	2021	–	10	4.4	3.2	12.0		0.0

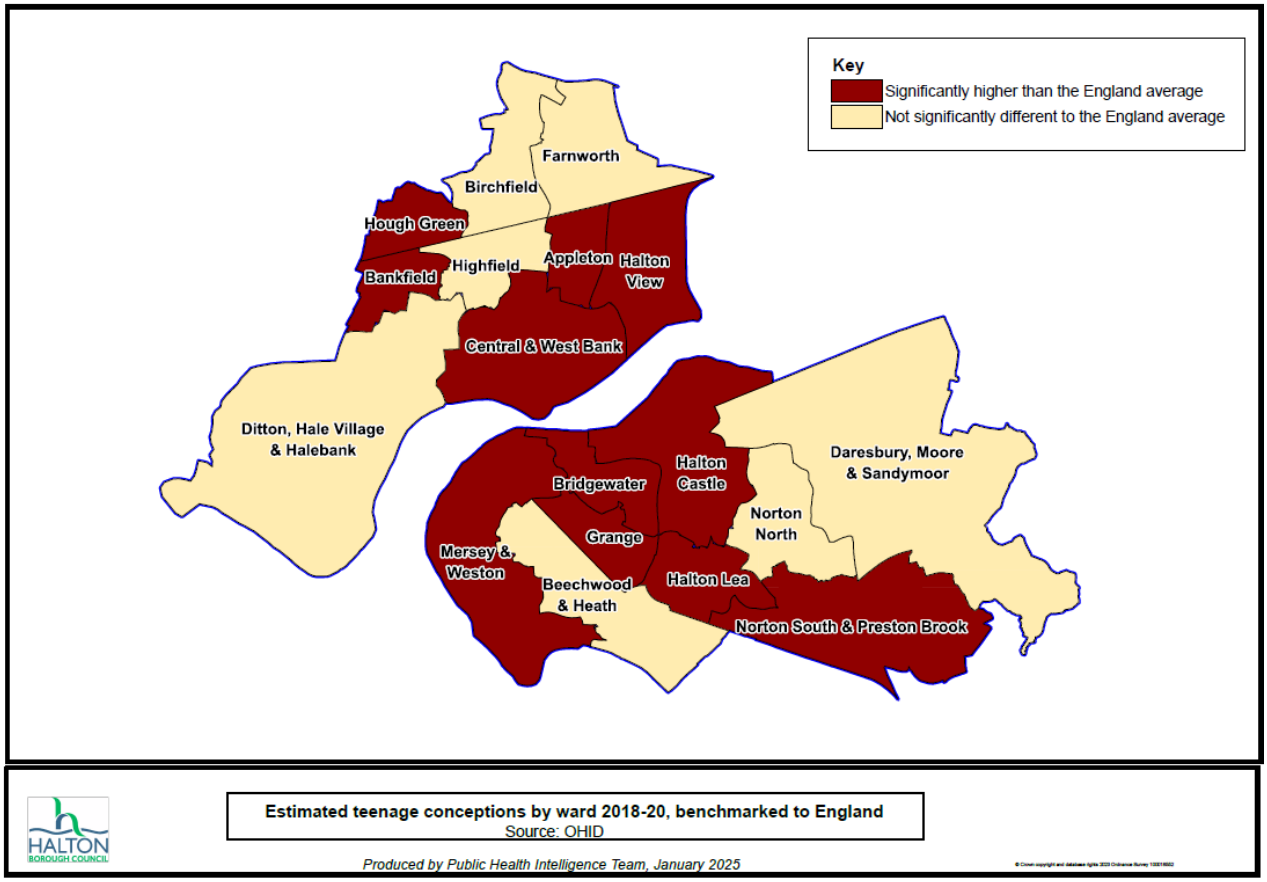
Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

The data above shows that even though the under 16 conception rate for Halton for 2021 was higher than the England average, it wasn't significantly so. However, the under 18 conception rate for Halton was significantly higher. There were 50 conceptions in females aged under 18 in 2021. Halton's rate was third highest in the North West in 2021.

The map below shows the wards with conception rates that were significantly higher than the England average (for 2018-20). These are mostly the more deprived areas, such as Bridgewater, Halton Castle and Central & West Bank.

[79] Abortion statistics for England and Wales: 2021 - GOV.UK (www.gov.uk)

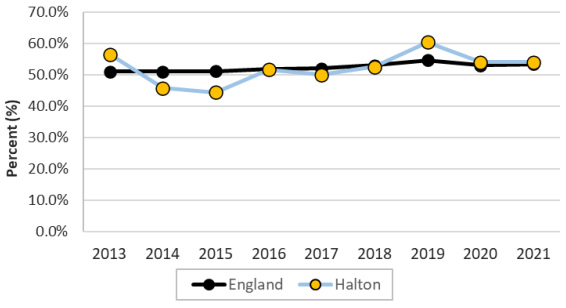
Figure 30: Estimated teenage conceptions by ward, benchmarked to England, 2018-20



The under 18 birth rate for Halton in 2021 was slightly higher than the national average, but not significantly higher.

The under 18 abortion rate for Halton was significantly higher than the England average in 2021 and has been consistently since 2016. In 2021 there were 26 abortions to females aged under 18. Halton's rate is third highest in the North West.

Figure 31: Trend in U18 conceptions leading to abortion (%), Halton and England 2013 to 2021



Recent trend: ➡ No significant change

Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	North West	England
2013	○	43	56.6%	45.4%	67.1%	52.8%	51.1%
2014	○	33	45.8%	34.8%	57.3%	52.5%	51.1%
2015	○	36	44.4%	34.1%	55.3%	52.1%	51.2%
2016	○	30	51.7%	39.2%	64.1%	51.7%	51.8%
2017	○	38	50.0%	39.0%	61.0%	51.9%	52.0%
2018	○	42	52.5%	41.7%	63.1%	53.6%	53.0%
2019	○	32	60.4%	46.9%	72.4%	57.0%	54.7%
2020	○	34	54.0%	41.8%	65.7%	54.4%	53.0%
2021	○	27	54.0%	40.4%	67.0%	56.1%	53.4%

Source: Office for National Statistics (ONS)

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

In 2021 the percentage of under 18 teenage conceptions leading to abortion in Halton was very similar to the England average. The percentage has fluctuated slightly between 2013 and 2021, however, it has never been significantly different to the England average.

Figure 32: Under 25 and over 25 abortion data, Halton and England 2021

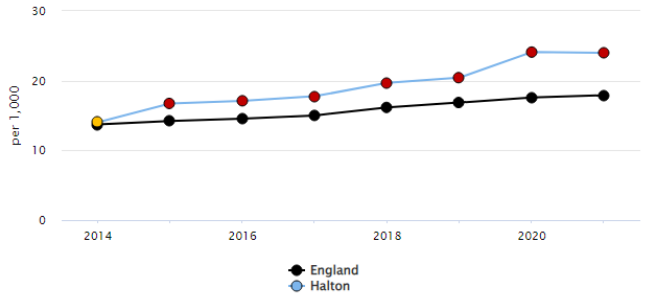
Indicator	Period	Halton			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Under 25s abortion after a birth (%) (Female, <25 yrs)	2021	→	69	26.8%	26.0%	47.2%		8.2%
Under 25s repeat abortions (%) (Female, 15-24 yrs)	2021	→	78	30.4%	29.7%	39.8%		17.3%
Over 25s abortion rate / 1000 (Female, 25+ yrs)	2021	↑	405	24.0	17.9	29.4		10.2

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

The percentage of under 25s in Halton having an abortion after birth is similar to the England average, as is the percentage of repeat abortions in females aged under 25. However, the over 25 abortion rate for Halton is significantly worse than the national average.

The chart below shows that the over 25 abortion rate in Halton has increased from 14 per 1,000 population in 2014 to 24 per 1,000 population in 2021. The rate in 2021 was significantly higher than the England average, and was the joint 13th highest in England (out of 151).

Figure 37: Trend in over 25 abortion rate/1,000, Halton and England 2014 to 2021



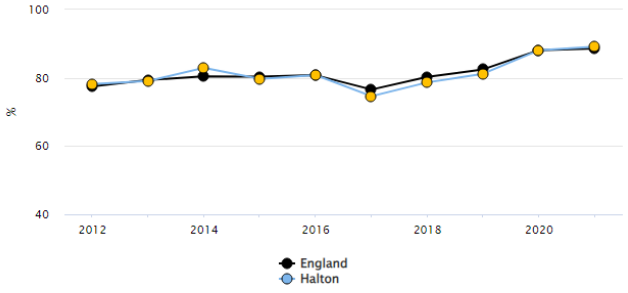
Recent trend: ↑ Increasing & getting worse

Period		Halton Count	Value	95% Lower CI	95% Upper CI	England
2014		234	14.0	12.3	15.9	13.7
2015		279	16.7	14.8	18.8	14.2
2016		284	17.1	15.2	19.2	14.5
2017		294	17.8	15.8	19.9	15.0
2018		326	19.7	17.6	22.0	16.2
2019		343	20.4	18.3	22.7	16.9
2020		407	24.1	21.8	26.5	17.6
2021		405	24.0	21.7	26.4	17.9

Source: Office for Health Improvement and Disparities, Department of Health and Social Care based on data from abortion clinics

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

Figure 38: Trend in abortions under 10 weeks (%), Halton and England 2012 to 2021



Recent trend: ↑ Increasing & getting better

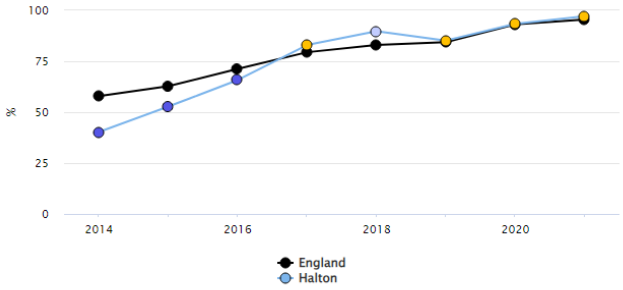
Period		Halton Count	Value	95% Lower CI	95% Upper CI	England
2012		422	78.1%	74.5%	81.4%	77.5%
2013		389	79.1%	75.3%	82.4%	79.4%
2014		398	82.9%	79.3%	86.0%	80.4%
2015		385	79.7%	75.9%	83.1%	80.3%
2016		412	80.8%	77.1%	84.0%	80.8%
2017		388	74.6%	70.7%	78.2%	76.6%
2018		435	78.7%	75.1%	81.9%	80.3%
2019		471	81.2%	77.8%	84.2%	82.5%
2020		602	88.1%	85.5%	90.4%	88.1%
2021		590	89.1%	86.5%	91.3%	88.6%

Source: Office for Health Improvement and Disparities, Department of Health and Social Care based on data from abortion clinics

Source: Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile

The percentage of abortions which took place under 10 weeks has, overall, increased in Halton since 2012. The 2021 figure (89.1%) is the highest it has been since 2012, and the percentage is similar to the England average of 88.6%.

Figure 39: Trend in abortions under 10 weeks that are medical (%), Halton and England 2012 to 2021



Recent trend: Increasing

Period		Halton Count	Halton Value	Halton 95% Lower CI	Halton 95% Upper CI	England
2014		161	40.3%	35.6%	45.1%	57.9%
2015		203	52.7%	47.7%	57.7%	62.7%
2016		271	65.8%	61.1%	70.2%	71.3%
2017		322	83.0%	78.9%	86.4%	79.4%
2018		390	89.7%	86.4%	92.2%	83.0%
2019		401	85.1%	81.6%	88.1%	84.3%
2020		562	93.4%	91.1%	95.1%	93.1%
2021		573	97.1%	95.4%	98.2%	95.5%

Source: Office for Health Improvement and Disparities, Department of Health and Social Care based on data from abortion clinics

Source: [Office for Health Improvement & Disparities Sexual and Reproductive Health Fingertips Profile]

Halton has seen a dramatic increase in the percentage of abortions under 10 weeks that are medical, from 40.3% in 2014 to 97.1% in 2021. The percentage was significantly lower than the England average in 2014, however, it was slightly higher than England in 2021 but not significantly so.

Qualitative Insights

In 2017/18, Public Health England undertook a comprehensive engagement exercise with women and stakeholders (through focus groups and an online survey) to gain a better understanding of women's experiences of and preferences for reproductive health and healthcare. Some of the headlines include:

- Knowledge of reproductive health was seen as a key factor in women being able to both manage unwanted symptoms and having a voice in making positive reproductive choices.

- For most women, preventing pregnancy was the most important reproductive issue throughout most of their lives. This priority was most marked for younger women who were also most likely to use the least reliable contraceptive methods such as pills and condoms. Older women tended to use more effective methods such as the IUD. One in 4 women who used condoms for contraception admitted that they did not use them regularly, significantly increasing their risk of unintended pregnancy.

- In general, women reported that General Practice (GP) was their preferred place to obtain their contraception including for the implant or IUD, although a significant minority preferred a sexual health setting. Women under 35 were more likely to receive their IUD in sexual health clinics compared with women over 35 receiving them in GP clinics. A total of 80% of women using pills received them from the GP although more than half would prefer to receive them elsewhere such as in pharmacy or online.

- Symptoms associated with reproductive health also had an important impact on women's wellbeing. 80% of women in the survey described experiencing unwanted reproductive health symptoms such as heavy menstrual bleeding, severe menopausal symptoms or postnatal symptoms. Menstrual problems were particularly common in women under 25.

The full report can be found on the Public Health pages of the Government website.

In the public survey, which supported the development of the Women's Health Strategy, gynaecological conditions were the most commonly reported topic for inclusion in the strategy, with menstrual health also a popular topic referenced for inclusion. It is important to note the role that hormonal contraception methods can have to support gynaecological health, having a range of benefits other than the primary purpose of pregnancy prevention.

The previously mentioned insight work with a small number of Halton residents also had valuable feedback around contraception services. Most felt that oral contraception was easy to access via their GP and had prior experience with this, however, respondents feedback was mixed for more involved procedures such implants or coils, with respondents who have used these methods reporting uncertainty among primary care services about necessary skills or capacity to provide them.

Where services were provided by Sexual Health services, in general, respondents felt that, while it can be difficult to access appointments quickly, they would usually become available and staff were skilled and service good. A number of respondents reported that the current available times for appointments were either a barrier to access or required flexibility with work or other commitments. This means that anyone limited by these factors may have trouble getting the services they need when they need them.

Respondents gave further insight on access to transport to attend appointments. In general, those with their own transport expressed no preference for the location of a service. Those limited to public transport, however, gave details of the challenges involved in accessing the site at the times available.

What the responses tell us is that there is no 'one size fits all' approach and options should be made available which suit different people. Those who prefer to see their GP would potentially benefit from outreach SH clinics based at GPs on a rotating basis. The proposed women's health hub might go some way toward this but there appeared a desire for the location to move to different practices. This would have the effect of making it easier for people to access the service closer to home, particularly for people without their own transport (a key wider determinant of inequality). Any future service should consider downscaling (but keeping) centralised clinic services and investigate to potential to provide outreach services at multiple locations or even mobile.

The key recommendations from the insight work relevant to this area were as follows:

- **Explore options for providing access to appointments during the evening and at weekends. All respondents expressed a preference for this**
- **Explore options for locating the service near to transport hubs for ease of access**
- **Explore options for provision of services in outreach locations, e.g. health centres, community settings and mobile**
- **Ensure appointments can be booked online easily**
- **Increase awareness of the service and its offer**
- **In raising awareness, also make significant effort to demonstrate that the service is for all ages, not just young people**
- **Use social media, website and search engine optimisation to increase access to the service and relevant information**
- **Explore options for promotion in community or public settings**
- **Note attitudes to hormonal contraception and possible implications for future demand**

Conclusions/next steps

This JSNA demonstrates that there is a lot of good work happening locally on the sexual and reproductive health agenda. Overall, local STI rates are comparable with national and regional rates. Halton is an area of low HIV prevalence and contraception activity in our specialist sexual health service is also in line England averages for:

- HIV testing coverage
- Total abortion rate
- LARC prescription rate
- Under 18s conception rate

But there is clearly more work that can be done. Our rates of STI testing are below the national target, and although activity is higher in our more deprived communities, it is not clear if this is proportionate to the level of need. Long Acting Reversible Contraception (LARC) prescribing in general lags behind the national rate, and there is work to be done to ensure women have better access to contraceptive options.

Recommendations are made at the beginning of the document and the evidence for these are weaved throughout the chapters but overall, key priorities can be summarised as:

- Programme of action to address high termination of pregnancy rates and under 18 conceptions in the borough.
- Develop the contraception offer within the community and wider healthcare settings, ensuring that contraception is accessible and minimise missed opportunities to prevent unplanned pregnancies.
- Prioritising prevention and access for vulnerable groups, including effective and clinically focused outreach that enables rapid support and identification of STIs and HIV in high-risk populations.
- Rebuild and scale up the delivery of the National Chlamydia Screening Programme, particularly within community settings that engage effectively with groups likely to have higher rates of undetected infections.
- Improve HIV awareness among the wider population in an attempt to change the trend of late diagnoses in Halton
- The sexual health workforce needs to be developed and nurtured locally (including both specialist and non-specialist provision)

Nationally there is a renewed focus on sexual and reproductive health. For example, the publication of the Women's Health Strategy with clear commitments on how women should expect to experience high quality reproductive health throughout the life course, and the HIV Action Plan with the ambition to achieve zero new infections, AIDS and HIV-related deaths in England by 2030. It is important that action is aligned with these national directives and they are embedded at a local level.

In order to facilitate delivery of the priorities and recommendations made within this JSNA, a Halton multi-agency governance SRH group should be established.

This will facilitate a much-needed system wide, co-ordinated action on sexual and reproductive health in Halton.

Key Resources

- UKHSA. Official Statistics: Sexually transmitted infections (STIs): annual data tables. Including 'England STI slide set 2022 for presentational use'. https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

- UKHSA (2023). HIV in England 2023 slide set. https://www.gov.uk/government/statistics/hiv-annual-data-tables

- UKHSA. Collection. Chlamydia: surveillance, data, screening and management. https://www.gov.uk/government/collections/chlamydia-surveillance-data-screening-and-management

- OHID open data source: https://fingertips.phe.org.uk/profile/sexualhealth

- UKHSA (2024). Summary profile of local authority sexual health. Halton. July 2024. https://fingertips.phe.org.uk/static-reports/sexualhealth-reports/2024%20update/E06000006.html?area-name=Halton

- PHE (2018). Health matters: reproductive health and pregnancy planning. Published 26 June 2018. https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning

Glossary

Adapted from BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, NHS Dumfries and Galloway Glossary (www.sexualhealthdg.co.uk), also Oxfordshire County Council Sexual Health Needs Assessment 2018 and Surrey Sexual Health Needs Assessment 2021

Abortion: Ending a pregnancy through medical intervention

ACEs: Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence

AIDS: (acquired immune deficiency syndrome) is the name used to describe a number of potentially life-threatening infections and illnesses that happen when your immune system has been severely damaged by the HIV virus.

Antiretroviral therapy (ART): This is the treatment of HIV infection using a combination of HIV medicines from different drug classes that suppress or stop the virus. It is also called highly active antiretroviral therapy (HAART) or combination therapy. HIV is a retrovirus that carries its genetic information in RNA and transcribes it into DNA5. ART reduces the likelihood of the virus developing resistance.

Bisexual: A person who is sexually attracted to both men and women. Can also be known as 'bi'

CCG: Clinical Commissioning Group - as an organisation it ceased to exist in July 2022 and has been replaced with Integrated Care Boards at Sub-Regional level and with One Halton at a local, Halton level who in turn share responsibility for local service commissioning.

CD4 count: CD4 count is a measure of immune function. By measuring someone's CD4 levels you can see how HIV has affected their immune system, showing how far the virus has progressed.

Census 2021: The census happens every 10 years and gives us a picture of all the people and households in England and Wales. Your answers to census questions help organisations make decisions on planning and funding public services in your area, including transport, education and healthcare

Chemsex: Chemsex means sexual activity, mostly between men, while under the influence of drugs.

Chlamydia: A sexually transmitted infection (STI) which is very common among men and women under 25. If untreated, Chlamydia can lead to infertility in women. Pregnant women can also pass it onto their babies. It is easily treated with antibiotics. Partners must be treated as well.

CIPFA nearest neighbours: The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. This is done by following the traditional 'distance' approach whereby a selection of variables (see below) is standardised (with a mean value of zero and a standard deviation of one) and the Euclidian distance between all possible pairs of local authorities is calculated[1]. These distances are then summed across every single subject and 'rebased' (by assigning a distance of 1 to the farthest neighbour meaning all overall distances will lie between zero and one) to calculate the final distance.

Coil: A contraceptive device usually made of plastic or copper, also known as an IUD or IUCD. It is inserted into the womb and stops fertilised eggs from settling and growing.

Community Pharmacy: This is a pharmacy that deals directly with people in the local area and provides pharmaceutical and cognitive services. It is one of the four pillars of the primary care system in England and has responsibilities including compounding, counselling, checking and dispensing of prescription drugs. It can operate out of big or small chain shops, grocery stores, or independent pharmacies. It may also be called retail pharmacy, drug outlet, or private pharmacy in some countries.

Condom: A thin, rubber sheath (cover) worn over the penis or placed inside the vagina to protect against unplanned pregnancies and sexually transmitted infections (STIs).

Consent: Another word for permission. It is against the law for anyone to have sex with another person without their consent. It is also against the law to have sex with a young person under 16 (17 in Northern Ireland) This is known as the age of consent.

Contraception: The word used to describe the prevention of conception (pregnancy) by artificial means. There are many different contraceptive methods and different methods suit people at different times of their lives.

CSE: Child Sexual Exploitation

Emergency Contraception: Pills that can be taken up to 120 hours after unprotected sex to prevent pregnancy. The earlier it is taken the more effective it is. Also known as Emergency Hormonal Contraception (EHC) and the morning after pill.

Fertility: When a woman or man has a healthy reproductive system and they are able to get pregnant or to produce healthy sperm, they are known as fertile, if not they are said to have FERTILITY PROBLEMS

FNP: Family Nurse Partnership

Gay: A word meaning homosexual or lesbian. Someone who fancies people of the same sex. Men who is sexually attracted to men and women who are sexually attracted to women.

Gender: Identifying a person as male or female.

Genital Warts: Small growths on or around the genitals caused by a virus.

Genitals: The sex organs that you find between your legs. In a woman these are the vagina and vulva and in a man, these are the penis and testicles. Also called genitalia.

GP: General Practitioner is name for your family or Practice Doctor

Gonorrhoea: This causes avoidable sexual and reproductive ill-health. Gonorrhoea is used as a marker for rates of unsafe sexual activity.

GUMCAD: Genitourinary Medicine Clinic Activity Dataset

Heterosexual: feelings involving sexual attraction to people of the opposite sex. Also known as straight.

HIV: Human Immunodeficiency Virus, - the virus that causes AIDS. HIV can be transmitted during unprotected sex as well as through blood and blood products. When the virus enters the blood stream it begins to destroy the body's defence system against infection. There is no cure but it can be treated. HOMOSEXUAL: Someone who is sexually attracted to people of the same sex.

Hormones: Naturally occurring chemicals that guide the changes that take place in the body. As well as causing physical changes, hormones cause emotional changes too. Hormones cause sexual developments such as puberty to start in men and puberty and periods in women.

Human papillomavirus (HPV): This is the name of a very common group of viruses. They do not cause any problems in most people, but some types can cause genital warts or cancer.

IMD: The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small areas (Lower Super Output Areas (LSOAs). It is a combined measure of deprivation based on a total of 37 separate indicators that have been grouped into seven domains, each of which reflects a different aspect of deprivation experienced by individuals living in an area.

Implants: A very reliable type of contraception where the hormone is in a small, plastic rod, which a specially trained doctor, or nurse inserts under the skin on a woman's arm. The implant works for 3 years and is over 99% effective at stopping pregnancy.

Infection: An illness caused by a bacteria or virus.

Intercourse: When the penis is put inside / penetrates the vagina or anus during sex

IUD: (Intrauterine Device) A very reliable type of contraception. The IUD is another name for the coil. It is a small device made of plastic and copper which is inserted into the womb to inactivate the sperm and stop fertilised eggs from settling and growing. Lasts up to ten years and is over 99% effective at stopping pregnancy. It can be used up to 5 days following unprotected sex to stop unwanted pregnancy.

IUS: (intrauterine system) A very reliable type of contraception similar to IUD. It is a small, plastic T-shaped device containing hormones. It sits in the womb and works for five years. It is more than 99% effective at stopping pregnancy.

Lesbian: A woman who is sexually attracted to another woman.

LGBTQ+ Lesbian, Gay, Bisexual, Trans, Queer plus is a generic term for individuals who do not identify as heterosexual

Long Acting Reversible Contraception (LARC): Contraceptive methods that require administration less than once per cycle or month, including copper intrauterine devices, progestogen-only intrauterine systems, progestogen-only injectable contraceptives and progestogen-only subdermal implants

LSOA: Lower Layer Super Output Areas (MSOA) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

Morning after pill: Proper name is emergency hormonal contraceptive pills. It can be taken up to 120 hours after unprotected sex to prevent pregnancy. However, the sooner it is taken the more effective it is.

MSM: Men who have Sex with Men

GBMSM: gay and bisexual men and other men who have sex with men

MSOA: Middle Layer Super Output Areas (MSOA) are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.

NATSAL National Survey of Sexual Attitudes and Lifestyles

NCSP: National Chlamydia Screening Programme

NICE: National Institute for Health and Care Excellence

Non-Binary: This is a term for individuals whose gender identity does not align with either of the binary categories of 'man,' 'woman' or 'male,' 'female.' Non-binary identities may be static, or fluid. Some non-binary people may include some aspects of male and female into their identities, others may reject them entirely. For some, 'non-binary' is an identity in itself, for others it is a way of describing or categorising their gender (or lack of) or distinguishing between binary and non-binary genders.

Oral Contraception: A hormonal form of contraception which is taken by the mouth in tablet form.

Period: Once a woman reaches puberty she will have a menstrual bleed, or period, each month. The bleeding happens when an egg is not fertilised and comes out of the vagina. Periods can start from 8-16 years old but it is usually between 12 -13 years old.
PHE: Public Health England

PHOF: Public Health Outcomes Framework

PrEP: PrEP, or pre-exposure prophylaxis, is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. PrEP can stop HIV from taking hold and spreading throughout your body

Primary Care Network: From 1 July 2019, all patients in England should be covered by a primary care network (PCN). PCNs are made up from groups of neighbouring general practices. The networks employ staff to deliver services to patients across the member practices.

Safe sex: Ways of having sex that lowers the risk of pregnancy and catching an STI e.g. kissing, mutual masturbation and using condoms

Sexual intercourse: The insertion of an erect penis into the vagina or anus. Also known as penetration

Sexual Orientation: Whether we prefer sexual relationships with opposite sex or same sex.

Sexuality: How we feel about ourselves as a sexual being and how others see us. Emotions, feelings, behaviour and culture can shape our sexuality and it develops throughout our lives.

Smear: A medical test to detect any changes in a woman's cervix

Sexually Transmitted Infection or STI: Sexually transmitted infections (STIs) are passed from one person to another through sexual contact. This includes anal, oral or vaginal sex. There are more than 30 different pathogens that cause STIs. These include bacteria like Chlamydia and viruses like HIV.

Straight: Common word for heterosexual.

Syphilis: A sexually transmitted infection which causes a painless sore. It may go unnoticed and can spread without either partner knowing. It is passed during sex or sexual activity and can be serious if left untreated.

Termination: Another word for abortion. Operation or procedure to end a pregnancy.

UK Health Security Agency (UKHSA): The UK Health Security Agency (UKHSA) is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation's health secure.

Unprotected Sex: Sex without a condom or contraception - carries the risk of pregnancy and catching an STI

WHO: World Health Organisation

Womb: Another name for the uterus

Appendix 1 – Detailed map of Halton Wards by Index of Multiple Deprivation (IMD)