Sexual health

# Summary

## Introduction

The health and economic wellbeing of any population and the wellbeing of individuals can be critically influenced by sexual health. The financial case for sexual health services has been made repeatedly; effective sexual health services and the prevention of sexually transmitted infections (STI) and unplanned conceptions are cost-saving.

Total new STI diagnosis rates have fallen in England since 2012. Chlamydia infection is the most common followed by genital warts, non-specific genital infection (NSGI), gonorrhoea, herpes and syphilis (PHE, 2017). Chlamydia detection among 15-24 year olds had increased in Medway as screening in GPs and pharmacies was extensively promoted but has recently seen a slight downward trend. Late diagnosis of HIV is above the England average and remains a priority area.

This chapter does not include teenage pregnancy specifically as this is addressed in the teenage pregnancy chapter.

## Key issues and gaps

* Sexual ill health is not equally distributed among the population with the highest levels seen in men-who-have-sex-with-men (MSM), teenagers, young adults and some black and minority ethnic groups. It is therefore a necessary to promote sexual health in a multifaceted manner as it is influenced by a number of issues including socio-economic and cultural issues.
* There is some correlation between deprivation and STI rates, with Chatham town centre having the highest concentration of GUM diagnoses per 100,000 population. The National Chlamydia Screening Programme (NCSP) has identified the highest rates of positivity in Strood North, Luton and Wayfield, and the Rochester wards; it should be noted that the Young Offenders Institution and the Secure Training Unit skew the data for Rochester West.
* The highest HIV prevalence rates are shown in Chatham with lower prevalence in rural areas.
* The Pelvic Inflammatory Disease rate is significantly higher in Medway than the England average.
* Although reducing, the total abortion rate in Medway is significantly above England average.

## Recommendations for Commissioning

* A needs assessment should be conducted to identify existing or new gaps in service provision.
* HIV is of particular concern with late diagnosis of HIV posing serious problems at individual and community level. This increases the risk of onward transmission and ultimately treatment costs. There is a need to improve HIV awareness training amongst secondary care medical disciplines to improve early diagnosis.
* As a large proportion of those affected by HIV in Medway are of black-African origin, it is important to review services to ensure that they are accessible to this population.
* Improve sexual health services delivered by GPs, in particular access to Long Acting Reversible Contraception ( LARC), Chlamydia screening and referral for full STI screening.
* Improve chlamydia screening rates through core services to achieve the 2400/100,000 diagnosis rate.
* Reduce the number of women who have repeat abortions to the south East England average rate of 25.2%.
* Increase the uptake of LARC to achieve the South East average of 54/1,000.

# Who’s at risk and why?

All people who engage in sexual activity are at risk of sexual ill-health or unplanned pregnancy; however risk is not distributed evenly.

## People from some Black and Ethnic Minority Communities

In the UK 34% of those receiving treatment for HIV are black African [1], due, in part, to the higher incidence of HIV infection in sub-Saharan Africa. Efforts to tackle HIV among high risk groups should be supported with work to reduce stigma.

Undiagnosed HIV, and therefore late diagnosis, is of concern among black Africans and in particular black African women [2]. People living with HIV who live outside London are at a higher risk of being undiagnosed than those living inside London. Black and black British ethnic groups are at higher risk of being diagnosed with an STI than the general population [3].

## Men who have sex with men

Men-who-have-sex-with-men (MSM) face a range of health inequalities, including HIV and issues related to mental health and wellbeing, alcohol, drugs and tobacco [4].

It is estimated that 7% of the population are lesbian, gay or bisexual, but in England MSM accounts for 11% of all new STI diagnoses (81% of syphilis and 55% of new HIV diagnoses) [5].

While not relevant to all MSM, lifestyle factors including HIV sero-sorting, condomless sex, multi-partnering, chemsex, public sex environments all contribute to the risks of STI and HIV transmission. Increased extra-genital testing alongside improved laboratory testing are likely to have contributed to the increase in STI detection among MSM.

Given that MSM are disproportionately affected by STIs, the emergence of antibacterial resistant gonnorhoea is likely to have greatest impact on this group.

## Young people

The [National Survey of Sexual Attitudes and Lifestyles (NATSAL) survey (2013)](https://www.natsal.ac.uk/sites/default/files/2021-04/Natsal-3%20infographics%20%281%29_0.pdf) indicates that just under a third of young people aged 16-24 at the time of the survey had had sex before age 16. Young people aged 16-24 are experimenting with a range of sexual practices: 71% have given or received oral sex, 19% males and 17% females have had anal sex. Anal sex among this group is higher than any other age range and unless participants observe safer sex messages this can increase health risks.

Young people are more likely to use contraception effectively if they are aware of the alternatives and are able to make their own choices. This group should be included in universal sexual health services, while acknowledging that those who are socially disadvantaged may require tailored support. Schools and other educational establishments have proven to be good sites to base contraceptive services. Due to the high prevalence of STIs condoms should be offered in addition to other forms of contraception [6].

## Looked-after children

Looked-after children are at high risk of teenage pregnancy and while there is much policy and guidance to reduce teenage pregnancy, little of the guidance is directly focused on this group’s needs. The limitations of school-based programmes with this group are well recognised.

Consultations with this group are key if targeted interventions are going to be effective [7].

## Sex workers

A literature review conducted by Balfour and Allen (2014) indicates that there are several factors that can adversely affect the health of sex workers [8]. The different types of sex work carry varying risk; for example, low risk activities such as stripping, web-casting and other forms of non-contact sex have significantly different impacts on health to on- or off-street sex work.

Even though some sex workers still engage in risky behaviour, research indicates that condom use among sex workers has increased over the last 30 years and incidence of HIV has decreased [8]. It should be noted that although potential for transmission is very high the actual rate of STI infection remains low. This may, in part, be due to the focus of support for sex workers being around sexual ill-health; prevention and support work should continue with this group.

## People subjected to sexual violence, abuse and exploitation

A needs assessment for the Sexual Assault Referral Centre (SARC) for Kent & Medway has been carried out. Details of the SARC are available online on the [Beech House webpage](http://www.beechhousesarc.org)

NATSAL, one of the largest scientific studies of sexual behaviour, indicated that 1 in 71 males and 1 in 10 females have had non-volitional sex ([Natsal-3 infographic](https://www.natsal.ac.uk/sites/default/files/2021-04/Natsal-3%20infographics%20%281%29_0.pdf)). The median age for this in males was 16 and for females 18 years.

Sexual violence is often linked to domestic violence. The long-term health effects of sexual violence are associated with depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide.

Violence in all its forms are common for many sex workers but reporting of violent crimes to authorities by commercial sex workers is low.

Although the effects of sexual abuse on people are well documented, detection and prevention of Child Sexual Exploitation is a developing field. Victims are likely to be at increased risk of HIV, STIs and pregnancy.

It is widely acknowledged that reliable information on the volume of sexual offences is difficult to obtain as a significant proportion of offences are not reported to the police, although the number of reported incidents is increasing.

# The level of need in the population

Local sexual health data is available through the [Public Health England Fingertips website](http://fingertips.phe.org.uk/profile/sexualhealth).

## Chlamydia Detection in young people

After several years of increasing the proportion of the population screened and increasing detection Medway has seen a decrease in both. This may be in part to upheaval caused by the recommissioning, redesign and changes of services; the situation is being monitored through the performance management cycle.

**Table 1:** Chlamydia detection and screening rates (PHE)

|  |  |  |
| --- | --- | --- |
| **Area** | **2016 detection rate aged 15-24 / 100,000 (PHOF indicator 3.02)** | **2016 Chlamydia proportion aged 15-24 screened** |
| Medway | 1754 | 20.50% |
| South East Region | 1500 | 19.20% |
| England | 1882 | 20.70% |

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## Other STI prevalence

Overall STI prevalence in Medway has fallen each year since 2012. In 2014 the most commonly diagnosed STI in Medway was chlamydia (333 per 100,000) followed by genital warts at 123.9 per 100,000; genital herpes 68.6 per 100,000; gonorrhoea 28.0 per 100,000 and syphilis 3.3 per 100,000. Although reducing, the prevalence of genital herpes is higher in Medway than both the South East and England. Chlamydia detection has increased since 2012. Syphilis is almost exclusively diagnosed among MSM. Although not specifically an STI, Pelvic Inflammatory Disease (PID) can be caused by bacterial infections such as chlamydia and gonorrhoea; Medway has admission rates to hospital well in excess of regional and England rates [9].

**Table 2:** Pelvic Inflammatory Disease rates (PHE)

|  |  |
| --- | --- |
| **Area** | **2015/16 Pelvic Inflammatory Disease (PID) rate / 100,000** |
| Medway | 365.0 |
| South East Region | 272.4 |
| England | 237.0 |

**Table 3:** Rates of all new STI diagnoses (PHE)

|  |  |
| --- | --- |
| **Area** | **2016 All new STI diagnoses (exc Chlamydia aged <25) / 100,000** |
| Medway | 652 |
| South East Region | 649 |
| England | 829 |

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## HIV

HIV prevalence in Medway has seen a slight decrease since 2014. However, late diagnosis is increasing, some of which may be attributable to increased testing opportunities. Across Medway the prevalence rate is 1.33/1,000 but that prevalence is not equally distributed. Data from the Survey of Prevalent HIV Infections Diagnosed (SOPHID) indicates that HIV diagnosis is highest in the ME4 and ME7 postcode areas. Adults aged 35-54 are more likely to be diagnosed with HIV in Medway than any other age group. The most common route of transmission was sex between men; the next more common was women who had heterosexual contact. Black Africans are the ethnic group at highest risk of HIV infection. However, the vast majority of UK HIV diagnoses are in people born in the UK as opposed to born overseas.

**Table 4:** HIV diagnosis rates (PHE)

|  |  |  |
| --- | --- | --- |
| **Area** | **2015 HIV diagnosed prevalence rate / 1,000 aged 15-59** | **HIV late diagnosis (%) (PHOF indicator 3.04)** |
| Medway | 1.33 | 50.00% |
| South East Region | 1.77 | 43.50% |

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## Unplanned pregnancy, Abortions and Repeat abortions

Not all unplanned pregnancies will lead to an abortion; outcomes for both mother and child are poorer than for a planned pregnancy [10]. Unplanned pregnancies are prevented by good access to all forms of contraception including long-acting reversible contraception (LARC). GPs are increasing the quantity of LARC they are prescribing but Medway is still below regional and England rates.

**Table 5:** Abortion rates (PHE)

|  |  |  |
| --- | --- | --- |
| **Area** | **2016 Total abortion rate / 1,000** | **2016 Under 25s repeat abortions (%)** |
| Medway | 18.0 | 29.4 |
| South East Region | 15.0 | 25.2 |
| England | 16.7 | 26.7 |

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## Other Needs

* Females aged 15-24 are at higher risk of STIs than males of the same age.[11](p31)
* Men-who-have-sex-with-other-men (MSM) are at greater risk of STIs than the general population and account of the majority of syphilis and gonorrhoea diagnoses in men. MSM are at higher risk of HIV. Diagnoses of chlamydia, syphilis and gonorrhoea are increasing among MSM.[11](p20, 21, 38)
* Individuals who are from the black and black British ethnic groups are disproportionately affected by STIs.[11](p44)
* Black Africans, and black African women, are disproportionately affected by HIV infections.[2]
* Heterosexuals are at far greater risk of a late HIV diagnosis than MSM.[2]
* There is insufficient data available to assess inequalities for those who have a physical or learning disability.

# Current services in relation to need

## Services

Medway moved to an integrated model of service delivery in October 2017. This included the introduction of an online STI self-sampling scheme. Services are delivered by Hub and Spoke clinics; the hub is at 4 Clover Street Chatham and the spokes include GP Practices, Healthy Living Centres and other community settings. In the first year there were approximately 22,000 contacts in clinical settings and home sampling has proved popular with 1,657 users during the first year.

The service consists of the following elements:

### 1. Hub and Spoke clinics offering a full level 1-3 service and Self-managed care

The aim is to:

* Provide integrated clinics for contraceptive and genitourinary medicine.
* Improve accessibility through extended opening hours.
* Develop a range of self-managed care interventions, including online self sampling.

### 2. Outreach

The aim of the outreach element is to:

* Provide immediate and necessary support to prevent sexual ill-health for those not accessing universal services.
* Identify and remove barriers to them accessing universal or targeted services.
* Promote universal services and encourage their use.

### 3. Psychosexual therapies

* Provide help for patients presenting with sexual health aspects of psychosexual/sexual dysfunction for short to medium term therapy.

### 4. National Chlamydia Screening Programme

The aim of the Chlamydia screening element is to target 15-24 year olds to:

* Prevent and control chlamydia through early detection and treatment of asymptomatic infection.
* Reduce where possible onward transmission to sexual partners.
* Prevent the consequences of untreated infection.
* Raise awareness and skills of health professionals to screen for chlamydia and provide the information young adults need to reduce the risk of infection and transmission.
* The scheme gives rapid access to chlamydia screening through a range of settings including GP, Pharmacy, online, grab-bins, educational establishments and clinical settings.

### 5. Get It condom scheme

The aim of the condom distribution scheme is to target 13-24 to:

* Reduce STI transmission and HIV in young people.
* Reduce teenage pregnancy, especially among those identified as being most at risk and vulnerable.
* Achieve an increase in the percentage of the population screened for chlamydia and an increase in chlamydia detection.

Young people can register online or through a number of other venues such as clinics, pharmacies and educational establishments.

### 6. LARC fitting and removal in primary care

The aim of the Long Acting Reversible Contraception (LARC) fitting and removal in primary care scheme is to:

* Provide women with a choice of where to have LARC fitted to increase availability and uptake.
* Reduce unplanned pregnancy among all women of child-bearing age.
* Reduce teenage conceptions.
* Reduce abortions.
* Provide value for money contraception.
* Increase average LARC usage times so that it is comparable between GPs and Sexual Health Clinics.

### 7. EHC in Pharmacies

The aim of the EHC in Pharmacies scheme is to:

* Reduce unplanned pregnancy among women aged under 30.
* Reduce abortions especially repeat abortions.
* Reduce teenage conceptions.

### 8. Community based Targeted HIV screening

The aim of Community based targeted HIV screening is to target identified high risk groups, currently men who have sex with men (MSM) and Black Africans, to:

* Reduce the number of those infected with HIV who are undiagnosed and not on treatment.
* Reduce late diagnosis of HIV.
* Contribute to the reduction of stigma surrounding HIV.

### 9. HIV Adult services

The HIV adult services provides treatment and support for people living with HIV and is commissioned by NHS England but delivered through the Integrated Sexual Health Service.

## Relationships and Sex Education

Medway Public Health supports Relationships and Sex Education (RSE) as part of Personal Health and Social Education (PHSE) by partnering with schools to ensure high quality delivery. RSE is operating in 12 of 18 secondary schools in Medway.

# Projected service use and outcomes

**Table 6:** Medway population projections 2012 - 2026 (ONS sub-national population projections). Note: Figures are in thousands

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **15 – 24 years** | **25 – 34****years** | **35 – 49****years** | **50 – 64****years** | **65 +****years** |
| 2018 | 36.4 | 40.7 | 55.3 | 53.0 | 45.4 |
| 2022 | 36.3 | 41.9 | 55.6 | 56.1 | 49.4 |
| 2026 | 38.2 | 41.0 | 59.0 | 56.1 | 54.5 |

Older age groups, who have less contraceptive- or STI- related sexual ill-health, (50-64 and 65+) are projected to grow at a faster rate than younger groups. This older group may experience other forms of sexual ill-health but these are more likely to be age-related.

ONS figures suggest that the population of 15-24 year olds in Medway will decrease over the next ten years and then gradually increase again. This dip may result in a decrease in sexual health and contraception needs short term but the need is likely to increase back to current levels.

The net international migration component of these figures is fixed at about 500-600 people per year. Data from the 2011 census indicates that 1,953 Medway residents reported living outside the UK one year previously. The impact of the current migration trends is unclear.

Factors that may contribute to a reduction in attendances:

* Change to integrated sexual health services; service users will attend fewer appointments as they will be treated holistically.
* Increase in home sampling/self-managed care; cost effective solutions will reduce physical attendances at clinics for regular testers and asymptomatic service users.
* Increased focus on prevention is likely to reduce ill-health but may lead to an increase in lower level interventions such as contraception/contra-infection services.
* Accessibility of purchased ‘over-the-counter’ and ‘over-the-internet’ screening at affordable prices; as screening becomes more accessible some potential service users may choose to access private health care to maintain anonymity.

Factors that may contribute to an increase in attendances:

* Gonorrhoea or chlamydia with antimicrobial resistance; STIs that do not respond to current treatment programmes will lead to an increase in follow-up visits and increased drug costs.
* Improved accessibility of services will remove a barrier to asymptomatic clients, any anticipated increase should be met with cost-effective solutions such as online services.

HIV Pre-Exposure Prophylaxis (PrEP) trials have indicated the effectiveness of PrEP; this may be viewed as a cost effective preventive intervention and may be rolled out nationally.

# Evidence of what works

Sexual health services should be viewed as a whole system and commissioned accordingly, across as many areas of responsibility as appropriate. [12][6]

A framework for sexual health improvement in England [13] sets out ten ambitions.

* Build knowledge and resilience among young people.
* Improve sexual health outcomes for young adults.
* All adults have access to high quality services and information.
* People remain healthy as they age.
* Prioritise prevention.
* Reduce rates of STIs among people of all ages.
* Reduce onward transmission of and avoidable deaths from HIV.
* Reduce unwanted pregnancies among women of fertile age.
* Counselling for all women requesting an abortion (CCG responsibility).
* Continue to reduce the rate of under-16 and under-18 conceptions.

Young person friendly services, including contraception and emergency contraception, need to be easily accessible.[6]

Information for young people should be communicated using a variety of means through a variety of outlets.[6]

Services should seek consent and ensure confidentiality.[6]

Services should be based on the principle of progressive or proportionate universalism and tailored to the socially disadvantaged.[6]

Contraceptive services should be provided after a pregnancy or an abortion.[6]

Sexual health services should be provided in educational settings.[6]

Condoms should be provided in addition to other forms of contraception.[6]

Workforce and wider workforce should be trained in areas relating to sexual health.[6]

# User Views

A programme of quantitative and qualitative primary research was conducted in April 2014 with over 300 respondents.

## Key messages

Sexual health promotion and education; it was widely reported that the internet would be used as the primary source of additional information. ‘Official’ sites from recognised, trusted health bodies, such as NHS Choices, were used.

A broad cross-section of qualitative participants and almost all the stakeholders expressed concern that there was insufficient promotion of the local sexual health services. Students indicated that they would like campaigns based on local data.

Attitudes, motivators and barriers towards accessing services:

* The surveys revealed that people were most likely to attend services if they had genital discomfort or if their partner had an STI.
* There were several emotional barriers that people said would deter them from attending services. The most common of these was anxiety about confidentiality. People in the focus group explained that they were worried that they would be ‘spotted’ walking in/out of a clinic or sitting in the waiting room. Some said they would overcome this by attending a clinic in another locality. Having sexual health services placed alongside other health services was seen to be one way of avoiding the ‘embarrassment’ of being seen using the service.
* A few people also spoke very strongly, stating that they would feel anxious and put off attending because they wouldn’t know what was expected of them. The most commonly noted practical barrier was the lack of evening or weekend opening hours.

In response to the findings of the survey, the Integrated Sexual Health Service will provide services in the evenings and also on Saturday mornings. Webpages will be developed that will give service users an indication of what happens at the clinic and how testing is performed. Respondents wanted a degree of choice over the clinician they saw.

Of those surveyed 40% had sought information and support for sexual health issues from their GP. This was the most commonly used health service. Seventeen per cent had visited the chemist, 17% the CaSH service and 14% the Medway Maritime Hospital GUM service.

A smaller quantitative survey took place in youth settings in early 2015 that gave insight where the young people surveyed would prefer to attend services to improve their sexual health. Youth settings were popular for prevention and regular screening but for most other issues young people would prefer to access a Sexual Health Clinic.

Medway Sexual Health Network (MSHN) is open to all professional or voluntary organisations and is a forum to disseminate information and receive feedback from partner agencies in relation to sexual health. MSHN actively contributed to the writing of the integrated sexual health service specification.

# Unmet needs and service gaps

## HIV testing and diagnosis

Late diagnosis of HIV accounts for 39.5% of all diagnoses (CI 95% 23-63.3) which indicates individuals are not accessing regular testing. Heterosexual contact now accounts for a higher number of infections than among men who have sex with men; therefore the uptake of testing should be promoted and encouraged in all settings.

## Chlamydia screening

Increased screening through core services and targeted outreach is required to reach the proposed Public Health Outcome diagnosis range of 2,400 positives per 100,000 15-24 year old population. Medway achieved a detection rate of 1,754/ 100,000 in 2016.

## Easy access to STI screening

STI self-sampling kits have been made available through the Integrated Sexual Health Service. These have proved popular with younger adults and demand has outstripped supply, therefore additional resources should be made available to increase the number of tests taken by self-sampling.

## Young peoples sexual health services

Accessibility to services for young people has improved, with onsite services available in educational establishments and online self-sampling is popular with adolescents and young adults. Now that the integrated service has begun, young people should be asked for their views on the quality and accessibility of services.

## Local termination of pregnancy services

There has been a fall in women presenting at an early stage of pregnancy; this may have been in part to the disruption to the local Marie Stopes International clinic. A referral pathway has been developed to local SH services but the effectiveness of this pathway needs to be monitored.

## Provision of Long Acting Reversible Contraception (LARC)

Promotion and uptake of LARC still require improvement to achieve the South East Average of 54/1000 . Depo and oral contraception (which do not offer the same level of protection as a LARC method) still make up a large proportion of contraception issued through the clinical services.

## Sexual Assault Referral Centre (SARC)

Whilst there is a sexual assault referral service located at Beech House, Armstrong Road, Maidstone there remain issues for wrap around services including STI testing and treatment, particularly for pediatric clients.

# Recommendations for Commissioning

* A needs assessment should be conducted to identify existing or new gaps in service provision.
* HIV is of particular concern with late diagnosis of HIV posing serious problems at individual and community level. This increases the risk of onward transmission and ultimately treatment costs. There is a need to improve HIV awareness training amongst secondary care medical disciplines to improve early diagnosis.
* As a large proportion of those affected by HIV in Medway are of black-African origin, it is important to review services to ensure that they are accessible to this population.
* Improve sexual health services delivered by GPs, in particular access to LARC, Chlamydia screening and referral for full STI screening.
* Improve chlamydia screening rates through core services to achieve the 2400/100,000 diagnosis rate.
* Reduce the number of women who have repeat abortions to the south East England average rate of 25.2%.
* Increase the uptake of LARC to achieve the South East average of 54/1,000.

# Recommendations for needs assessment work

The last Service review was conducted in 2014. A review of the sexual health system should be planned for 2018.

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