Croydon joint strategic needs assessment 2010/11

Sexual health

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Sexually transmitted infections

The total number of new sexually transmitted infections diagnosed by the Croydon genitourinary medicine (GUM) clinic fell by 11% between 2008 and 2009 after having risen by 36% between 2007 and 2008.

Chlamydia is the most commonly diagnosed sexually transmitted infection at the Croydon University Hospital GUM clinic, with 1,161 new diagnoses in 2009. This is a 14% increase since 2008 which reflects, at least in part, improvements in screening and diagnostic tests. In 2009, the rate of chlamydia diagnoses in those aged 15 to 24 was 2,944.2 per 100,000 population, compared with a rate of 2,428.5 in London and 2,212.8 in England.

Croydon met the Department of Health chlamydia screening target in 2008/09 by screening 17% of those aged 15 to 24 years. In 2009/10, 9,810 young people aged 15 to 24 were screened, against a target of 11,000. In Croydon, 6.2% of tests were positive, higher than the average for London (5.0%). Young people aged 16 to 24 accounted for 68% of the diagnoses for chlamydia in the GUM clinic in 2009, with the highest number of diagnoses amongst women aged 16 to 19 years and men aged 20 to 24 years.

There were 305 cases of gonorrhoea diagnosed in Croydon University Hospital in 2009, which represents an overall increase of 3% since 2004. The rate of diagnosis in 2009 was 84 per 100,000 population, higher than the London (72.8) and England (29.7) averages. The increase in diagnoses is particularly noticeable in the 20 to 24 year age group. Nationally, men have higher rates of infection than women in all age groups.

Diagnoses of genital herpes at Croydon University Hospital have risen from 83 cases in 2004 to 314 cases in 2009. This is likely to reflect increased use of a more sensitive molecular test. The rate of diagnosis in 2009 was 79.3 per 100,000 population, the same as the London average but higher than the average for England (51.2). There were 419 cases of genital warts diagnosed in 2009, a 19% decrease from 2008. The rate of diagnosis in 2009 was 111.5 per 100,000 population, lower than both the London (163.6) and England (145.6) averages. There were less than 10 cases of syphilis diagnosed in the GUM clinic in 2009. This represents a rate of 6.1 cases per 100,000 population, compared with 14.1 in London and 5.5 in England. Across the UK, 49% of cases are found in men who have sex with men, of which almost a quarter are also infected with HIV.

In 2008, 953 Croydon residents accessed care for HIV, which represents a rate of 4.43 per 1,000 population aged 15 to 59 with HIV. Of patients accessing HIV care, 22% were men who have sex with men and 59% were of Black African ethnicity. The majority of those living with HIV in Croydon acquired the infection outside the UK. In 2008, 40% of HIV patients in Croydon were diagnosed late compared with a London average of 30%. Croydon has not been able to reduce the number of late diagnoses since 2004 and ranks 25th out of 31 primary care trusts in London in terms of performance.

Contraception

Recent data indicate that 19.8% of women in Croydon are using oral contraception and only 3.6% are using long acting reversible contraceptive methods. In 2007/08, 3,540 women were supplied with the emergency contraceptive pill through the emergency hormonal contraception scheme which is mainly accessed through pharmacies.

Abortions

In 2009, the abortion rate in Croydon was 29.7 per 1,000 women (aged 15 to 44), higher than the rate in both London (26.4) and England (17.7). In Croydon, 49% of all women having an abortion in 2009 had undergone one or more previous abortions, compared with 42% of women in London and 34% in England. Women of Black African ethnicity have the highest abortion rate. In 2009, 43.4% of women were not using any form of contraception prior to termination. This may indicate that in some cases abortion is being used as a form of birth control and that there are unmet contraceptive needs.

Infertility

The Croydon University Hospital fertility team see approximately 550 new patient referrals a year; of these, about a quarter require assisted conception with in vitro fertilisation (IVF). Intra uterine insemination (IUI) is recommended for couples with mild fertility problems and is now available for eligible patients at Shirley Oaks Hospital.

Teenage pregnancy

In 2008, there were 366 conceptions to women under 18 in Croydon. This is a conception rate of 55.5 per 1,000 girls aged 15 to 17 years, higher than the London (44.6) or England (40.4) averages. Of these conceptions, 59% led to abortion. Between 2005 and 2007, there was an average of 73 conceptions a year in girls under 16 years in Croydon. This represents a conception rate of 11.2 per 1,000 girls aged under 16, higher than the rates for London (8.7) and England (7.9). Of the conceptions to girls under 16 years, 67% led to abortion. In 2008, there were 145 live births to mothers under 18 years in Croydon. This is a rate of 23 births per 1,000 population, compared with 17 per 1,000 for London and 20 per 1,000 for England.

Vulnerable and high risk groups

There are over 80,000 children and young people aged under 18 and they comprise 23% of the total population. It is estimated that 55% of Croydon's young people are from Black and minority ethnic groups and 100 languages are spoken. National research shows that young people under 18 are more likely to partake in risky sexual behaviour and may be more susceptible to infection. The younger the age at which first intercourse occurs, the less likely it is that contraception will be used.

In March 2010, 1,008 young people in Croydon were being looked after by the local authority. These young people are recognised as being vulnerable to risk taking behaviour, including early and unprotected sexual activity. More than half of these children in Croydon are seeking asylum in the UK and so may be more vulnerable in terms of a lack of knowledge of sex and relationships, sexual exploitation or trafficking, for example.[1]

Young people leaving care and young people who are not in education, employment or training, are more likely than their peers to become teenage parents.

In 2008, 41% of the population in Croydon were from Black and minority ethnic groups and this is projected to be more than 50% by 2026. National data indicate that some Black and minority ethnic groups, especially younger Black Caribbean, Black African and other Black population groups are disproportionately affected by sexual ill health.

There is little research on sexual health needs and uptake of services among the homeless population. National anecdotal evidence suggests that there are significant gaps in access to sexual health services and that the homeless are more at risk of acquiring sexually transmitted infections than the general population.

People who use drugs and alcohol often take risks that endanger their health and the health of others. One of the most harmful is that of engaging in risky sexual activities, for example, not using contraception. Research by the Croydon drug and alcohol action team identified a continuing need for outreach services to engage groups at risk of both substance misuse and sexual ill health, for example sex workers and people from the lesbian, gay, bisexual and transgender population.

Little is known about the sexual health needs of people with mental health problems or people with learning disabilities in Croydon. People from both of these population groups may engage in high risk sexual behaviour which can lead to sexually transmitted infections and they may be vulnerable to abuse. In 2009, the number of adults with learning disabilities in Croydon was estimated to be 5,226. They may face restrictions in the availability of sex education.

1 A more detailed assessment of the needs of looked after children can be found as a chapter in the Croydon joint strategic needs assessment 2010/11.

A report by Croydon Community against Trafficking in 2009 showed that there were over 100 advertising brothels in the borough of Croydon. It has been estimated that up to 300 women are sex workers in such locations in the borough. There are strong links between on street prostitution and drugs and substance misuse. Male prostitution is less visible and mainly off street.

Men who have sex with men are a high risk group in terms of sexual ill health. Some of those who have sexually transmitted infections are also coinfected with HIV. There has been little research carried out at national level on the sexual health needs of lesbian and bisexual women as they are deemed to be in a low risk category when it comes to sexually transmitted infections and HIV.

Recommendations

Commissioning

1 Implement the five standards set out in the *London sexual health strategic framework* in Croydon.[2]

2 Implement the sexual health strategy for Croydon including the sexual health promotion plan and a workforce development plan.

3 Ensure sustainable commissioning arrangements for sexual health in Croydon and investigate the cost effectiveness of sexual health programmes in comparison with other areas and identify examples of best practice.

4 Include standards for the quality of data collected and robust outcome measures in the sexual health strategy and commissioning of services.

5 Improve the integration of sexual health promotion, contraception, testing and treatment of sexually transmitted infections including chlamydia into all existing provider services for sexual health.

6 Promote local and regional sexual health networks.

Sexually transmitted infections

7 Increase awareness of sexual health by integrating sexual health promotion into appropriate health and social services and programmes.

8 Improve awareness and uptake of sexual health services in Croydon.

9 Maintain access to Croydon University Hospital GUM clinic within 48 hours for 100% of patients.

10 Increase access to, and uptake of, condoms through the Croydon C-card scheme.

11 Increase the uptake of chlamydia screening by those at risk of infection and improve the outcome of chlamydia testing by ensuring treatment of positives and partner tracing. Develop the monitoring and evaluation of the quality of chlamydia screening, including reporting of positive tests, number of people treated as well as partners traced and treated.

12 Promote local, sector and pan London HIV prevention programmes for high risk groups.

13 Ensure that HIV prevention programmes for men who have sex with men increase the number of Croydon residents who benefit.

14 Deliver targeted HIV health promotion and testing through both outreach and integration into core services.

15 Deliver targeted HIV health promotion and testing to men who have sex with men through outreach.

16 Support routine HIV testing in acute settings.

17 Reassess HIV service provision taking into account the increase in numbers tested and diagnosed as well as improved treatment and management of HIV infection.

18 Improve patient outcomes by increasing early diagnosis and treatment through increased uptake of HIV testing.

2 London Sexual Health Programme. *London sexual health strategic framework*. London: London Specialised Commissioning Group; 2009.

Contraception and reproductive health

19 Agree a local plan to reduce the repeat abortion rate.

20 Increase the proportion of abortions in the first 10 weeks of gestation and maintain a level above the national target of 70%.

21 Increase awareness of, access to and uptake of all methods of contraception among all sexually active groups.

22 Increase access to long acting reversible contraceptive methods and agree a local target rate.

23 Increase access to free emergency hormonal contraception, through the local provision of enhanced sexual health services in pharmacies.

24 Agree arrangements to measure and increase post abortion contraception.

25 Improve access to specialised psychosexual medicine.

26 Review fertility services in Croydon and develop the provision of intrauterine insemination in line with National Institute for Health and Clinical Excellence (NICE) guidance.

Teenage pregnancy

27 Ensure adequate resources are available to implement the local teenage pregnancy strategy and action plan.

28 Improve targeting of relevant services to reach vulnerable groups of young people who are at greater risk of teenage pregnancy and prioritise those groups who are easily identifiable.

29 Improve the provision and quality of sex and relationship education in schools, colleges and non school settings and enhance advice and support for parents of teenagers.

Vulnerable and high risk groups

30 Target sexual health outreach at identified high risk and vulnerable groups.

31 Ensure integrated health and social care packages include consideration of sexual health for key vulnerable groups of young people, for example, looked after children and young people not in employment, education or training.

32 Further investigate the sexual health needs of people with mental health problems, people with physical disabilities or sensory impairment, people with learning disabilities, refugees and asylum seekers and sex workers.

Introduction

This chapter describes the current state of sexual health in Croydon. It identifies the distribution of sexual health and ill health in order to highlight where the greatest needs lie in terms of information, education and access to sexual health services. It identifies and summarises relevant sexual health policies and targets, presents local data and analyses how sexual health in Croydon compares with England, London and other boroughs. It assesses demographic and service use data. It also includes information from previous needs assessments, service reviews, user consultations, key informant interviews and local policy documents. It makes recommendations which will inform the first sexual health strategy for Croydon and the development of targeted, locally appropriate services.

The data on sexually transmitted infections other than HIV included in this chapter reflect those diagnosed in the GUM clinic at Croydon University Hospital. The GUM clinic and contraception services are open access and not all patients seen are Croydon residents. Data will therefore include information about patients from outside the Croydon area.

Care should be taken in interpreting changes in the numbers of sexually transmitted infections over time. Whilst this may be due to changes in the prevalence of disease, alternative explanations are possible, such as changes to diagnostic procedures including the introduction of screening programmes. There are also likely to be inaccuracies and missing data which could influence the conclusions that are drawn from service information. For example, data may contain double counting of test results where a confirmatory test has been performed.

Four broad areas of sexual health are examined: sexually transmitted infections, contraception and reproductive health, teenage pregnancy and the needs of vulnerable and high risk groups. The chapter also describes local sexual health services and workforce.

What is sexual health?

As described by the World Health Organisation:
Sexual health is a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[3]

Sexual ill health costs the NHS more than £700 million a year.[4] Appropriate investment in sexual health services can deliver significant savings. For every £1 spent on contraceptive services, £11 is saved in healthcare costs.[5]

The different elements of sexual health, such as family planning and genitourinary medicine, are often examined separately and the focus is on preventing disease and minimising the burden on health care. Although this chapter principally examines the magnitude of sexual ill health, it is important to move beyond a disease focused approach. A more holistic approach to sexual health seeks to normalise pleasurable and safe sexual experiences and relationships which are free from discrimination, coercion and violence. It explores the interactions between the different elements of sexual health in order to reduce inequalities and maximise health.

3 World Health Organization. *Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002,* Geneva. Geneva: World Health Organization; 2006.

4 Department of Health. *Health economics of sexual health: a guide for commissioning and planning.* London: Department of Health; 2005.

5 McGuire A and Hughes D. *The economics of family planning services.* London: Family Planning Association; 1995.

Policy context

In 2001, the government published a national strategy for sexual health and HIV.[6] This aimed to reduce the transmission of HIV and sexually transmitted infections (STIs); reduce the prevalence of undiagnosed HIV and STIs; reduce unintended pregnancy rates; improve health and social care for people living with HIV; and reduce the stigma associated with HIV and STIs. The national strategy also aimed to evaluate the benefits of more integrated sexual health services, including pilots of one stop clinics. An independent advisory group on sexual health published a mid term review of the national strategy in 2008.[7] The government response outlined the progress made in improving sexual health since 2001 and responded to each of the recommendations put forward by the independent advisory group.[8]

National goals for sexual health were restated in the 2004 public health white paper *Choosing health: making healthy choices easier.*[9] This included a new public service agreement target to reduce the under 18 conception rate by 50% by 2010 from the baseline rate in 1998. The white paper also set targets to ensure that all patients wanting to attend a GUM clinic were offered an appointment within 48 hours; to reduce the rate of new gonorrhoea diagnoses by 2008; and, increase the uptake of chlamydia screening for people between 15 and 24 years by 2008.

The 2010 public health white paper *Healthy lives, healthy people* describes the coalition government's long term vision for the future of public health in England.[10] The importance of sexual health is mentioned throughout the white paper. The publication of a further document on sexual health and teenage pregnancy is expected in spring 2011.

In 2008, the Medical Foundation for AIDS and Sexual Health, the London Health Observatory and the Health Protection Agency published *Sex and our city***.** This outlines the sexual health needs of Londoners and provides a map of the services available across the city.[11] The London sexual health strategic framework aims to inform the commissioning, development and delivery of sexual health services in London.[12] The London sexual health programme is funded by London's 31 primary care trusts to improve the sexual health of Londoners by leading and strengthening sexual health commissioning.

National standards for the management of sexually transmitted infections were published in January 2010 and help to define expectations for service provision.[13] Evidence and guidance on sexual health is published by NICE. A full list of NICE guidance relevant to sexual health can be found at the end of the chapter.

6 Department of Health. *Better prevention, better services, better sexual health: the national strategy for sexual health and HIV.* London: Department of Health; 2001.

7 Independent Advisory Group on Sexual Health. *Progress and priorities – working together for high quality sexual health: review of the national strategy for sexual health and HIV.* London: Medical Foundation for AIDS and Sexual Health; 2008.

8 Department of Health. *Moving forward: progress and priorities – working together for high-quality sexual health.* London: Department of Health; 2009.

9 Department of Health. *Choosing health: making healthier choices easier.* London: Department of Health; 2004.

10 Department of Health. *Healthy lives, healthy people: our vision for public health in England.* London: Department of Health; 2010.

11 Medical Foundation for AIDS & Sexual Health. *Sex and our city: achieving better sexual health services for London: project findings & recommendations.* London: Medical Foundation for AIDS & Sexual Health; 2008.

12 London Sexual Health Programme: *London Specialised Commissioning Group. London sexual health strategic framework.* London: London Specialised Commissioning Group; 2009. Available at www.londonsexualhealth.org.

13 British Association for Sexual Health and HIV & the Medical Foundation for AIDS & Sexual Health *Standards for the management of sexually transmitted infections (STIs).* London: British Association for Sexual Health and HIV & the Medical Foundation for AIDS & Sexual Health; 2010.

Sexually transmitted infections

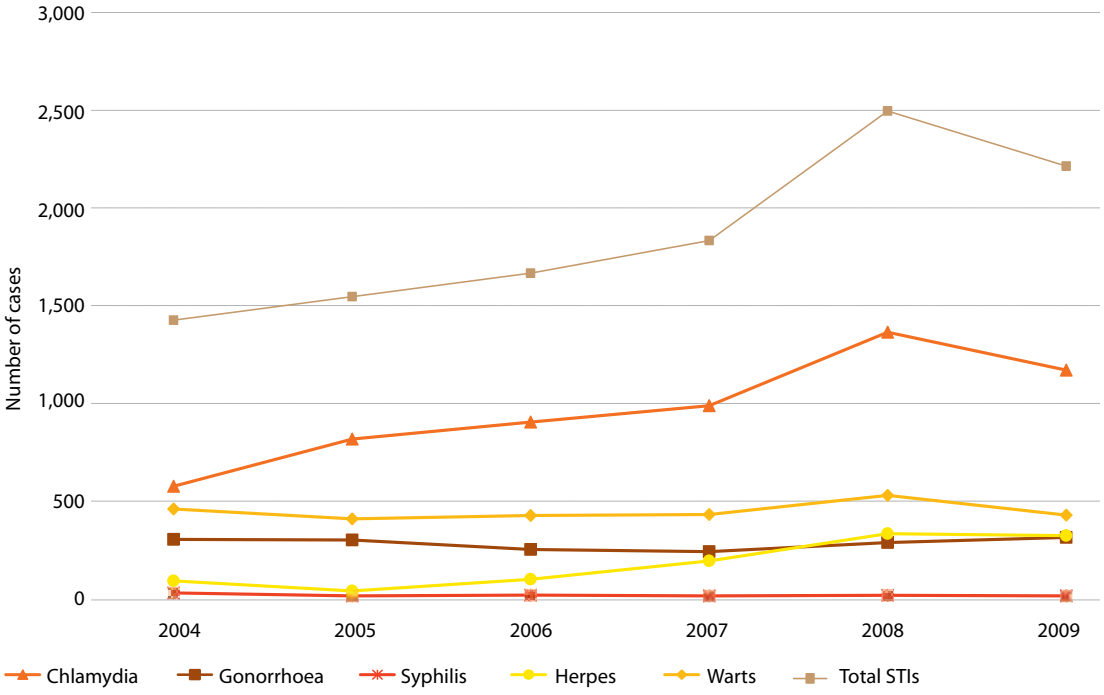
Introduction

Sexually transmitted infections (STIs) are diseases transmitted through sexual contact. They can be passed on during vaginal, anal and oral sex with an infected partner.

Data from genotourinary medicine (GUM) clinics in the UK indicate that the upward trend in new diagnoses of sexually transmitted infections may be abating.[14] The total number of new STI diagnoses reported by the GUM clinic in Croydon fell by 11% between 2008 and 2009 after having risen by 36% between 2007 and 2008 (figure 1).

However, this information only uses data from GUM as no information on sexually transmitted infections diagnosed in community settings is available. Caution should be taken in interpreting these figures since GUM is open access and therefore the diagnoses do not solely represent the needs of Croydon residents. In 2009, 82% of new attendees at the Croydon University Hospital GUM clinic were Croydon residents.[15] Repeated diagnoses in the same individual are also included in this data.

Figure 1 | number of sexually transmitted infections diagnosed at Croydon University Hospital GUM clinic, all ages, 2004-2009



Source: HPA STI annual data tables: data from genito urinary medicine (GUM) clinics, 2009

Chlamydia

Chlamydia is caused by the bacterium *chlamydia trachomatis* and is the most common bacterial sexually transmitted infection in the UK.[16] It is transmitted by oral, vaginal and anal sex and from mother to baby during vaginal delivery. In 70% of female infections and 50% of male infections, the patient shows no symptoms.[17]

14 Health Protection Agency. Health protection report: trends in diagnoses of *sexually transmitted infections in the UK*. London: Health Protection Agency; 2008.

15 Croydon University Hospital. GUM attendance data. 2009.

16 National Audit Office. *Department of Health: young people's sexual health: the National chlamydia screening programme.* London: The Stationary Office; 2009.

17 Health Protection Agency. Health protection report: trends in diagnoses of sexually transmitted infections in the UK. London: Health Protection Agency; 2008.

If left untreated in women, chlamydia is associated with pelvic inflammatory disease, which can lead to ectopic pregnancy and infertility. More than one third of babies born to infected women develop eye or lung infections and there is some evidence which shows that untreated chlamydia infections in pregnant women can lead to premature delivery. In men it can cause inflammation of the epididymis (a structure at the back of the testicle in which sperm matures and is stored). It can cause inflammation of the urethra in both men and women, which may lead to painful or difficult urination. It can also cause arthritis.

Chlamydia can be diagnosed by a simple urine test and is easily cleared from the individual with a course of antibiotics (although this does not protect against reinfection). The infection can be prevented through the use of condoms. The 1998 Chief Medical Officer's expert advisory committee reported that chlamydia costs the NHS £100 million annually.[18]

There were over 174,500 clamydia diagnoses made in England in 2008, 62% of which were made in GUM clinics.[19] In London, cases of chlamydia have increased by 110% in men and 59% in women since 1999.[20]

Nationally there is a particular burden of infection amongst young people with most cases being diagnosed in 20 to 24 year old men (1,163 per 100,000 population in 2008) and 16 to 19 year old women (1,406 per 100,000 population in 2008).[21] It is estimated that five to 10% of sexually active women under 24 years and men between 20 to 24 years may be currently infected with chlamydia.[22]

A review of national evidence indicates that a higher prevalence of chlamydia is recorded in studies based in certain healthcare settings, such as GP surgeries and sexual health clinics, than in studies which tested people in the general population or non healthcare settings.[23] This emphasises the need to ensure effective methods for finding cases in existing healthcare settings since they may be reaching a more sexually active population than those tested in non healthcare settings.

Since the introduction of the national chlamydia screening programme in 2003, diagnoses have been made in settings other than GUM clinics. However, in 2008 GUM still represented the principal route of diagnosis amongst 15 to 24 year olds, particularly amongst men.

A survey of 2,000 young adults and parents published in January 2010 found that 78% of young people are aware that chlamydia is the most commonly diagnosed sexually transmitted infection in England. However, 65% do not use a condom when they have sex with a new partner for the first time and 90% are not tested for sexually transmitted infections before starting a new relationship.[24]

In Croydon, the number of chlamydia diagnoses in the GUM clinic at Croydon University Hospital rose to 1,355 in 2008. This was a 38% increase from 2007 and the highest number of cases for any GUM clinic in south west London. In 2009, the number of diagnoses decreased by 14% to 1,161 new diagnoses of chlamydia, which constituted just under 10% of new attendances at Croydon University Hospital GUM clinic. Chlamydia diagnoses account for more than half of all sexually transmitted infections diagnosed at Croydon University Hospital GUM clinic since 2005.[25] In 2009, the rate of chlamydia diagnosis in those aged 15 to 24 was 2,944.2 per 100,000 population compared with a rate of 2,428.5 in London and 2,212.8 in England (figure 2).

18 Department of Health. *Chlamydia trachomatis: summary and conclusions of chief medical officer's expert advisory group.* London: Department of Health; 1998.

19 Health Protection Agency. *Chlamydia diagnoses reported in the UK and England.* London: Health Protection Agency; 2008.

20 London Sexual Health Programme. *London sexual health strategic framework.* London: London Specialised Commissioning Group; 2009.

21 Health Protection Agency. *STI annual data tables: data from genito-urinary medicine* (GUM) *clinics.* London: Health Protection Agency; 2009.

22 British Association for Sexual Health and HIV (BASHH). *UK national guideline for the management of genital tract infection with chlamydia trachomatis.* London: BASHH; 2006.

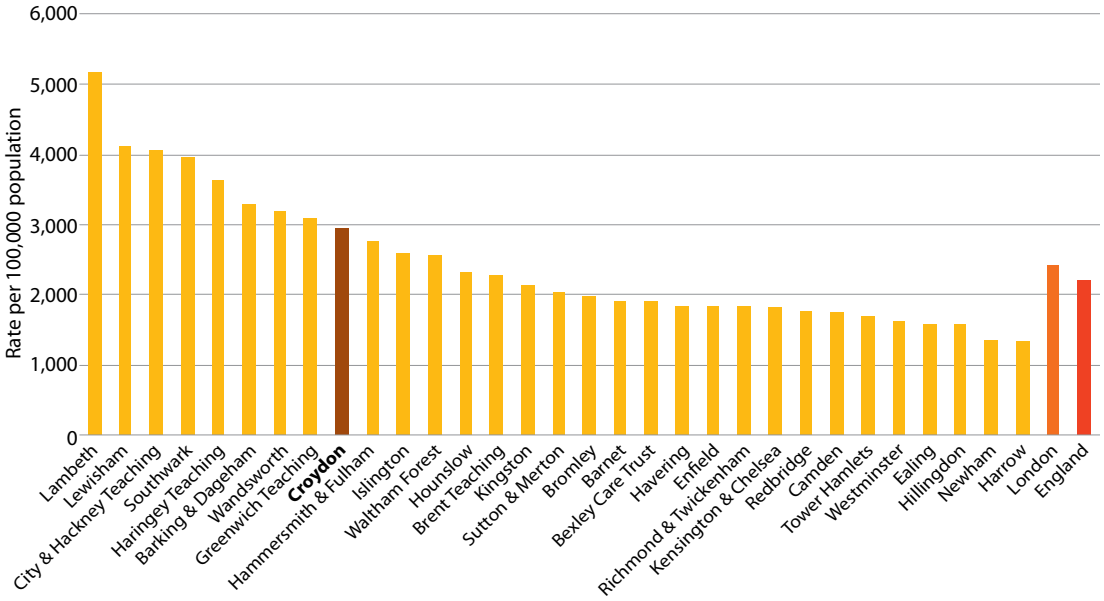
23 Adams EJ, Charlett A, Edmunds WJ, Hughes G. Chlamydia trachomatis in the United Kingdom: a systematic review and analysis of prevalence studies. Sexually Transmitted Infections. 2004 Oct;80(5):354-62.

24 http://www.dh.gov.uk/en/News/Recentstories/DH_11083525 Croydon University Hospital, KC60 data, Health Protection Agency.

25 Croydon University Hospital, KC60 data, Health Protection Agency.

The increase of chlamydia diagnoses over time could be due to increased awareness and testing rather than an increase in numbers of people with the infection.

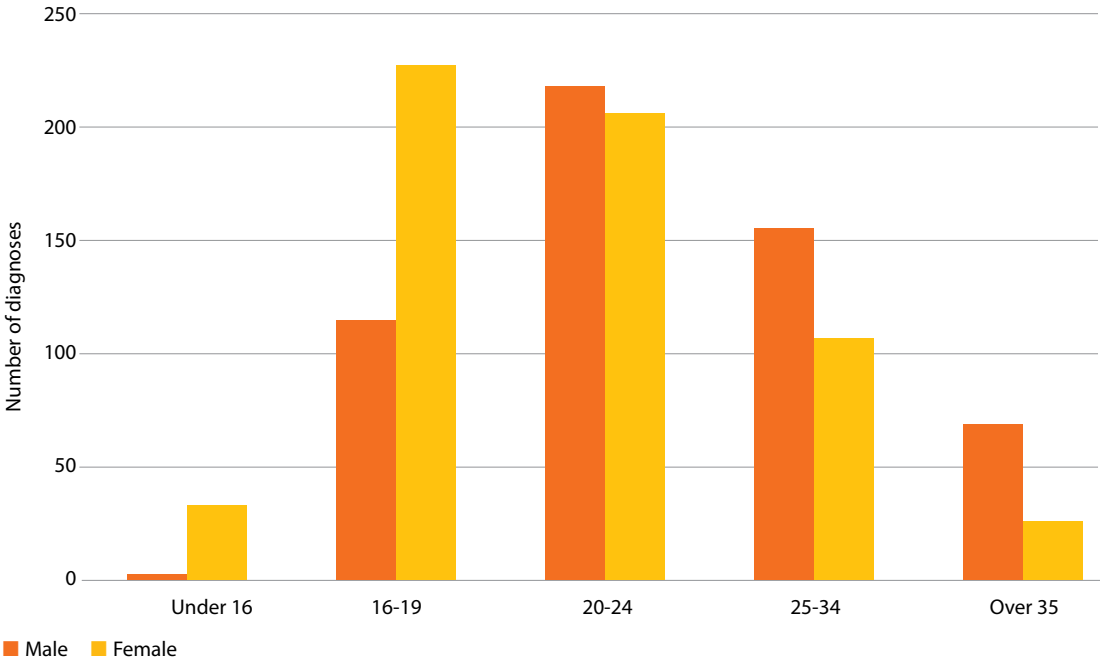
Figure 2 | chlamydia diagnosis rates per 100,000 population, London PCTs 2009



Source: Health Protection Agency, 2009

Young people aged 16 to 24 accounted for 68% of chlamydia diagnoses at Croydon University Hospital GUM clinic in 2009. The age and sex distribution is similar to the national picture with the highest number of diagnoses among women aged 16 to 19 years and men aged 20 to 24 years (figure 3).

Figure 3 | number of new cases of chlamydia diagnosed at Croydon University Hospital GUM clinic by age and gender, 2009



Source: Croydon University Hospital GUM clinic KC60 data, Health Protection Agency, 2009

National chlamydia screening programme

The national chlamydia screening programme was introduced in 2003 to identify and treat infection early, reduce transmission and promote sexual health. The programme provides screening to asymptomatic people aged 15 to 24 years in healthcare and non healthcare settings across England including GP practices, community sexual health services, schools and colleges. The programme, overseen by the Health Protection Agency, uses a case finding approach rather than systematically inviting a register of individuals to take the test at regular intervals.

Modelling by the Health Protection Agency indicated that testing between 26 to 43% of 16 to 24 year olds and carefully tracing and treating the sexual partners of those infected would have a significant impact on the prevalence of chlamydia.[26] In 2008/09, the Department of Health established chlamydia screening as a national priority. Primary care trusts were required to screen 17% of under 25s in 2008/09, 25% in 2009/10 and 35% in 2010/11. These figures exclude all testing activity in GUM clinics. The National Audit Office recently published an evaluation of the national chlamydia screening programme. The report concluded that the programme is not delivering value for money. It also expressed particular concern about the lack of robust scientific evidence on the level of chlamydia infection in the population and the probability that it leads to potentially severe complications.[27]

There are an estimated 44,400 people aged 15 to 24 years old in Croydon.[28] Croydon met the Department of Health target in 2008/09 by screening 17% of those aged 15 to 24 years. In 2009/10, 9,810 young people aged 15 to 24 were screened as part of the national chlamydia screening programme, against a target of 11,000. This missed the target of screening 25% of young people aged 15 to 24 by 2.6%.[29] In comparison, London exceeded the target for 2009/10 with 26% of young people tested.

The target for 2010/11 is to screen 35% (15,540) of young people aged 15 to 24 in Croydon. In order to achieve this target, NHS Croydon is providing additional support to primary care services and has set up new partnership arrangements with testing sites as well as commissioned outreach services targeting young people in the community.

According to a calculation of cost per chlamydia screen by the National Audit Commission, Croydon was spending £60.43 per screen in 2008/09 compared with an average cost across PCTs of £56.[30] Ways of reducing the cost per screen will have to be explored by evaluating commissioning arrangements and exploiting opportunities to work more closely with partners in the region.

In Croydon, 6.2% of tests were positive in 2009/10. This is the highest proportion of positive tests achieved in the south west London sector and is higher than the average for London (5.0%).[31] Possible reasons for this could be that the prevalence of chlamydia infection is particularly high in Croydon or that we are appropriately targeting the service to reach groups of young people at risk of infection.

Chlamydia testing coverage in Croydon is highest in the 16 to 18 age group, whereas the highest proportion of people testing positive for chlamydia infection is found among 19 and 20 year olds, as figure 4 shows.

26 Health Protection Agency. *New frontiers - national chlamydia screening programme annual report 2005/6.* London: Health Protection Agency; 2006.

27 National Audit Office. *Department of Health: young people's sexual health: the national chlamydia screening programme.* London: The Stationary Office; 2009.

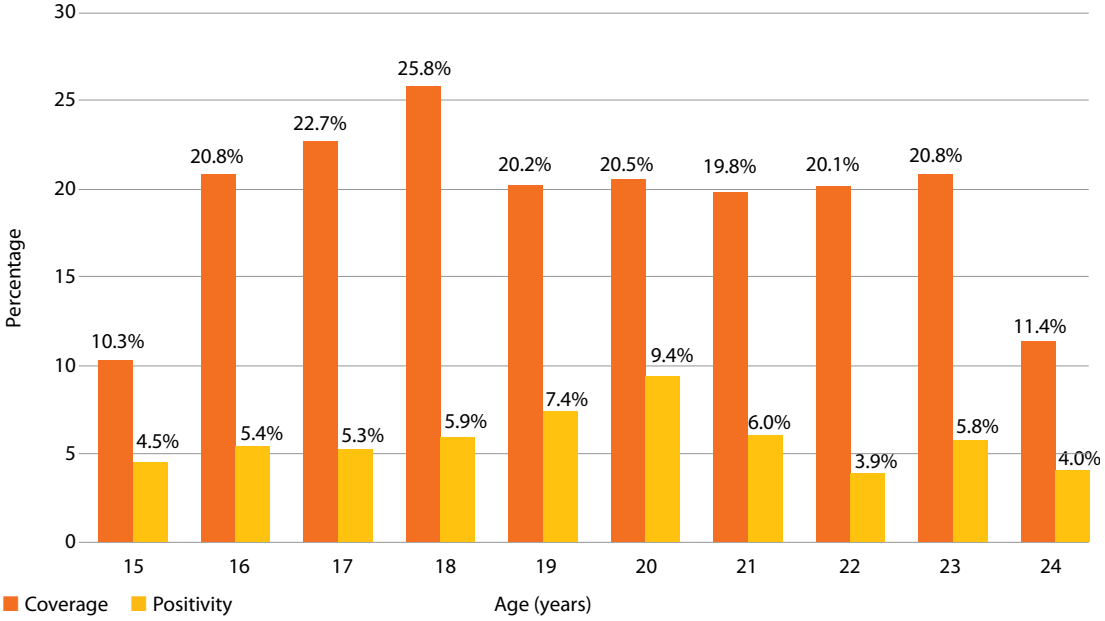
28 Office for National Statistics, 2009.

29 National Chlamydia Screening Office, 2010.

30 National Audit Office. 2009 op.*cit.*

31 National Chlamydia Screening Office, 2010.

Figure 4 | positive tests (positivity) compared to chlamydia screening coverage, Croydon residents aged 15 to 24 years, 2009/10

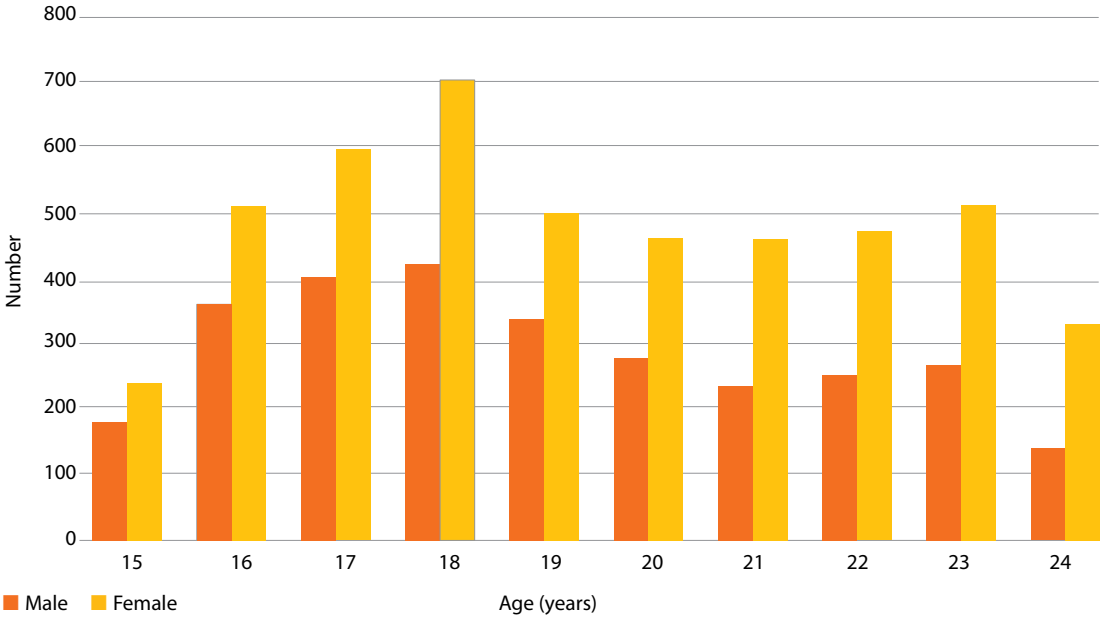


Source: National chlamydia screening programme data, 2009/10

Analysis of the rate of positive tests by screening site in Croydon showed that the Walk In Centre had the highest positivity rate of 13.5%, followed closely by pharmacies, 12.4%. Marie Stopes and Metro, the provider of outreach testing, presented the lowest rates of positivity, 3.3% and 2.9% respectively. It is particularly important that testing activities by outreach providers are targeting high risk groups. Outreach services in Croydon have been adjusted to direct testing at high risk groups of young people, for example through testing in pubs and clubs.

In Croydon, men are significantly less likely to be tested through the national screening programme than women (figure 5). The most successful methods to reach men in Croydon are outreach and remote methods such as the internet and mailouts.

Figure 5 | number of residents aged 15 to 24 years screened for chlamydia by age and gender, Croydon 2009/10



Source: National chlamydia screening programme data, 2009/10

Analysis of 2008/09 national chlamydia screening programme data by screening site reveals that 49% of tests in Croydon were conducted remotely through mailouts and the www.checkurself.org.uk website. This is compared with 18% for London and 13% nationally. Only 1% of tests in Croydon were from educational settings compared with 3.6% in London and 11.5% nationally.[32]

There is significant potential to increase the number of tests performed in core services. In 2009/10, only 34% of tests in Croydon were carried out in core services compared with 49% in London and 45% nationally. 10% of tests in Croydon were performed at GP surgeries (compared with 16% in London and 15% nationally), 2% in pharmacies, 20% in community contraceptive services and 1% in termination of pregnancy services.[33]

In 2009/10, a total of 623 tests were delivered through Croydon GPs, which constitutes an average of less than one test per month for every GP surgery. The total number of tests at pharmacies was 193, but 18 out of the 40 pharmacies that were able to screen for chlamydia did not perform any tests in the six months between April and September 2009.[34] This may be because pharmacies are only required to give information and not a chlamydia testing kit. In addition, tests require a urine sample and so the fact that not all pharmacists have a toilet for customer use may also present a difficulty.

Gonorrhoea

Gonorrhoea is caused by the bacterium *Neisseria gonorrhoea* and is the second most common bacterial sexually transmitted infection in the UK. Some infected women have no symptoms and if untreated, gonorrhoea has a significant impact on health. It may spread throughout the reproductive system and cause pelvic inflammatory disease, ectopic pregnancy, infertility and chronic pelvic pain in women. In men, untreated or recurrently infected gonorrhoea can lead to narrowing of the urethra, inflammation of the testes or prostate and chronic pelvic pain. The bacterium can also spread through the body and can lead to destruction of joints and heart valves.

Gonorrhoea is easily treated with appropriate (often single dose) antibiotics, which should eradicate 95% of uncomplicated infections within the community. However, the effective treatment of gonorrhea has been complicated by the ability of *Neisseria gonorrhoea* to develop resistance to antibiotics. It is very important that treatment guidelines for gonorrhoea are followed and regularly reviewed to reflect local patterns of antimicrobial resistance and also that the prevention of the disease is addressed. Gonorrhoea is preventable through safe sex practices including using condoms and reduced transmission through treatment and partner tracing.

Gonorrhoea infections tend to be geographically clustered in inner city areas and concentrated in specific population groups: GUM attendees, military personnel, prisoners and men who have sex with men have a higher prevalence of infection than the general population.[35]

Patients with gonorrhoea are also commonly infected with chlamydia (up to 20% of men and 40% of women with gonorrhoea are coinfected).[36] Therefore, all patients with gonorrhoea should be screened for chlamydia or receive presumptive treatment for it.

32 South west London Chlamydia Screening Office. 2010.

33 *ibid.*

34 *ibid.*

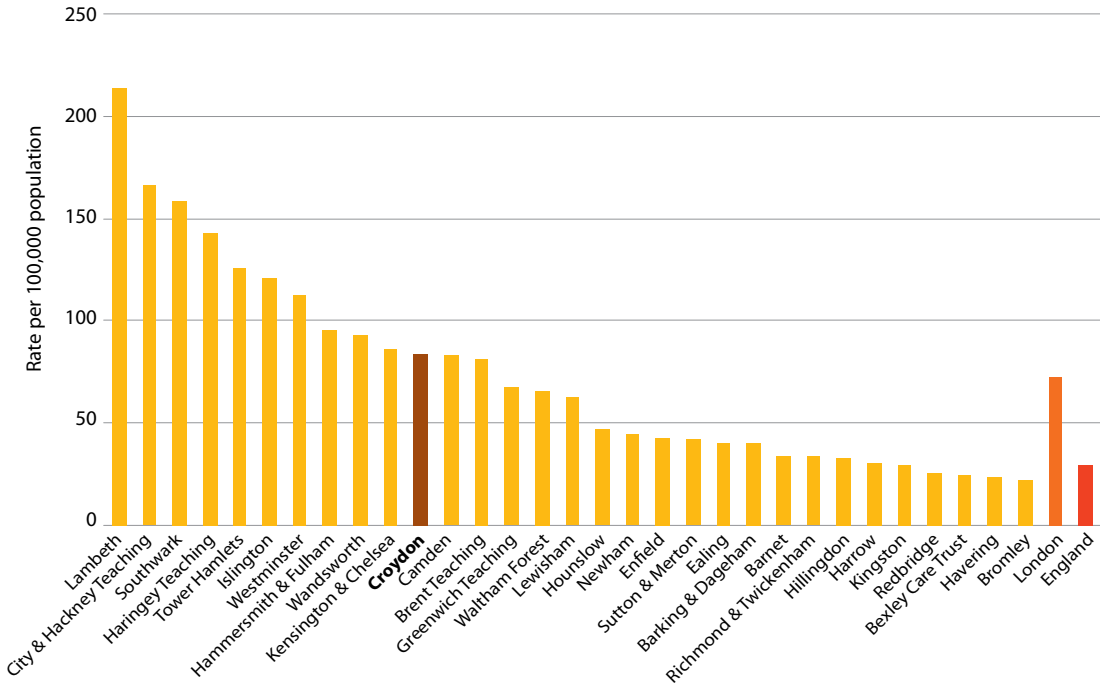
35 Delpech V, Martin IM, Hughes G, Nichols T, James L, Ison CA. Epidemiology and clinical presentation of gonorrhoea in England & Wales: findings from the gonococcal resistance to antimicrobials surveillance programme 2001-2006. Sexually Transmitted Infections. 2009;85:317-21.

36 British Association for Sexual Health and HIV (BASHH). *National guideline on the diagnosis and treatment of gonorrhoea in adults*. London: BASHH; 2005.

Nationally, there is a downward trend in diagnoses of gonorrhoea with an 11% drop since 2007.[37] Across all age groups, men have higher rates of gonorrhoea infection (59.5 per 100,000 population in 2008) than women (41.5 per 100,000 population in 2008). The highest rate of diagnosis in GUM clinics is among 20 to 24 year old men (152 per 100,000 population in 2008) and 16 to 19 year old women (135 per 100,000 women in 2008).[38] National data for 2008 shows that 30% of heterosexual men and 20% of women diagnosed were of Black Caribbean ethnicity, and 80% of those diagnosed were White.[39]

There were 305 cases of gonorrhoea diagnosed in Croydon University Hospital in 2009.[40] Croydon University Hospital has seen a 3% increase in cases of gonorrhoea since 2004, with the highest number of new diagnoses in 2009. There was a 20% increase in diagnoses between 2007 and 2008. The rate of diagnosis in 2009 was 84 per 100,000 population, higher than the London (72.8) and England (29.7) averages (figure 6). The increase in diagnoses in Croydon was particularly noticeable in the 20 to 24 year age group.[41] Overall, the highest rates of gonorrhoea in Croydon are seen in women aged 16 to 24 and men aged 20 to 34 years (figure 7).

Figure 6 | rate of gonorrhoea diagnoses per 100,000 population in London PCTs, 2009



Source: Health Protection Agency, 2009

37 Health Protection Agency. *STI annual data tables: data from genitourinary medicine clinics.* 24 July 2009.

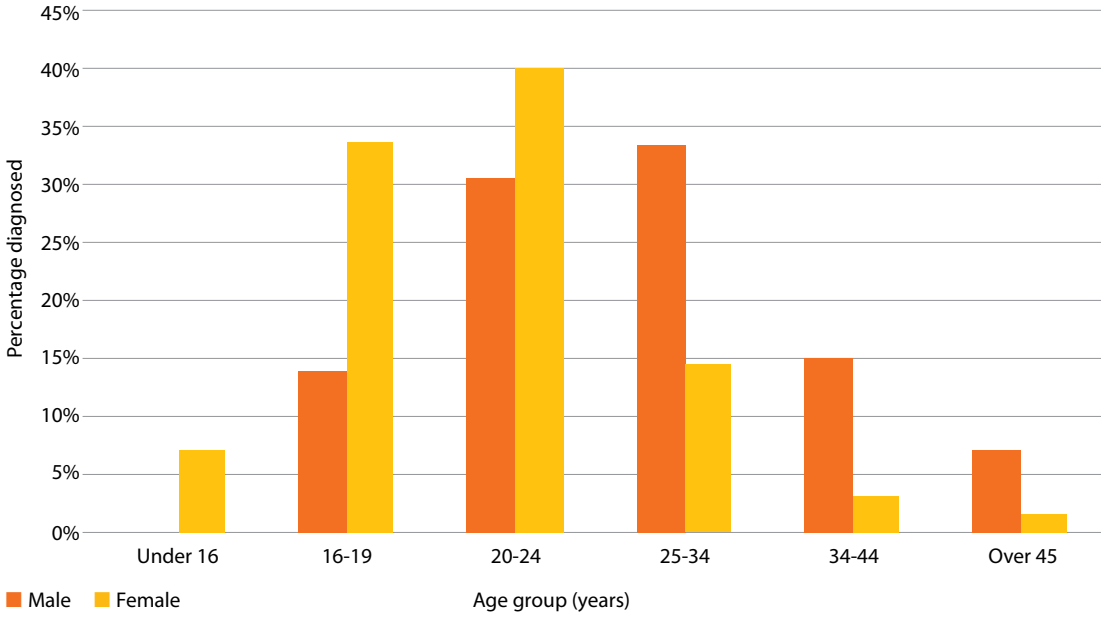
38 Health Protection Agency. *KC60 statistical returns from GUM clinics in England, Wales & Northern Ireland.* London: Health Protection Agency; 2008

39 Health Protection Agency. *STI annual data tables: data from genitourinary medicine clinics.* 2009.

40 *ibid.*

41 *ibid.*

Figure 7 | percentage new diagnoses of gonorrhoea at Croydon University Hospital GUM clinic by age and gender, 2009



Source: Health Protection Agency, 2009

Genital herpes

Genital herpes is caused by infection with the herpes simplex virus. Many genital herpes infections are asymptomatic but where it can be clinically diagnosed, recurrent painful, blisters on the genitals and surrounding area are characteristic. These ulcers are highly infectious. There are two distinct subtypes of herpes simplex virus. Type 2 is almost exclusively associated with genital infection. Type 1 causes oral herpes (or cold sores) but is increasingly implicated in about half of all genital infections. These changes illustrate how herpes simplex virus is readily transmissible via oral sex. Herpes simplex virus may be shed intermittently for many years even when no symptoms are apparent. As well as the presence of recurrent painful blisters, herpes is known to lead to significant psychological problems. Acquisition of herpes simplex virus during pregnancy risks infection between the mother and child, potentially leading to the death of the baby. Herpes simplex virus facilitates HIV transmission.

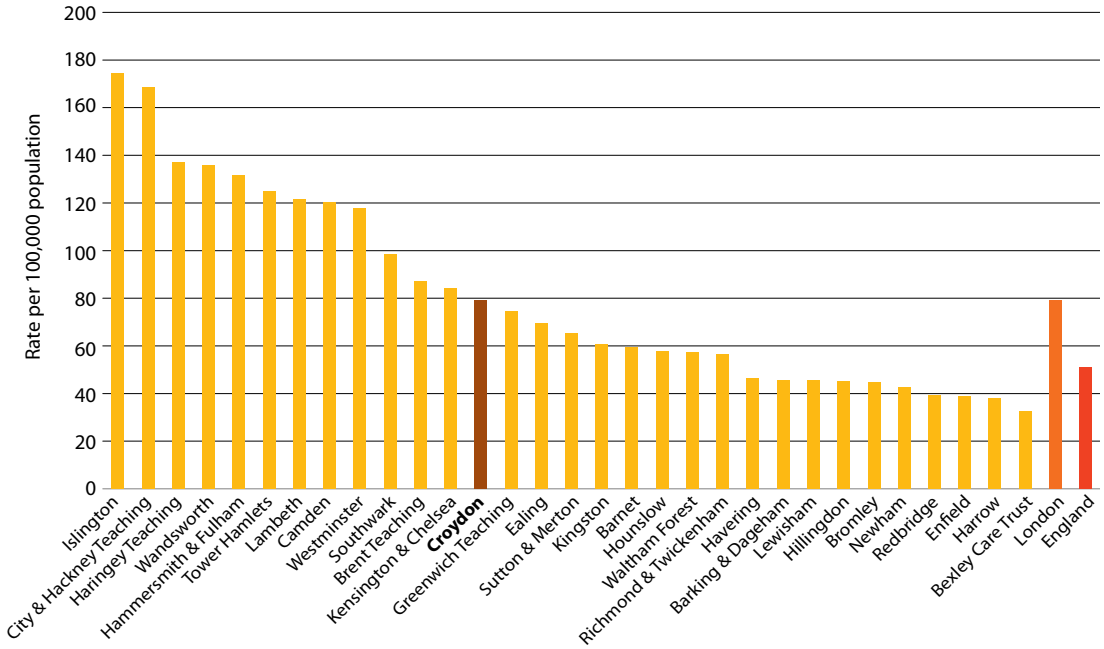
Between 2007 and 2008, the number of first time infections of genital herpes in the UK increased by 10% and those of recurrent herpes by 11%. Of first episode diagnoses, 97% were reported amongst heterosexuals. Rates are highest in women and men aged 20 to 24 years (251 per 100,000 population in women in 2008 and 133 per 100,000 population in men in 2008). Health Protection Agency data from UK GUM clinics up to 2007 indicates a continued increase in diagnosis of STIs.[42]

In south west London, the number of herpes diagnoses increased by 15% between 2007 and 2008 and is up by 26% since 2004. In Croydon, the number of cases diagnosed in Croydon University Hospital has risen from 83 in 2004 to 314 in 2009. This increase is likely to reflect the introduction of a more sensitive molecular test at the hospital.[43] The rate of diagnosis in 2009 was 79.3 per 100,000 population, the same as the London average but higher than the average for England (51.2) (figure 8).

42 Health Protection Agency. *HIV/STIs. Health Protection Report [serial online].* 2008; 2(29).

43 *ibid.*

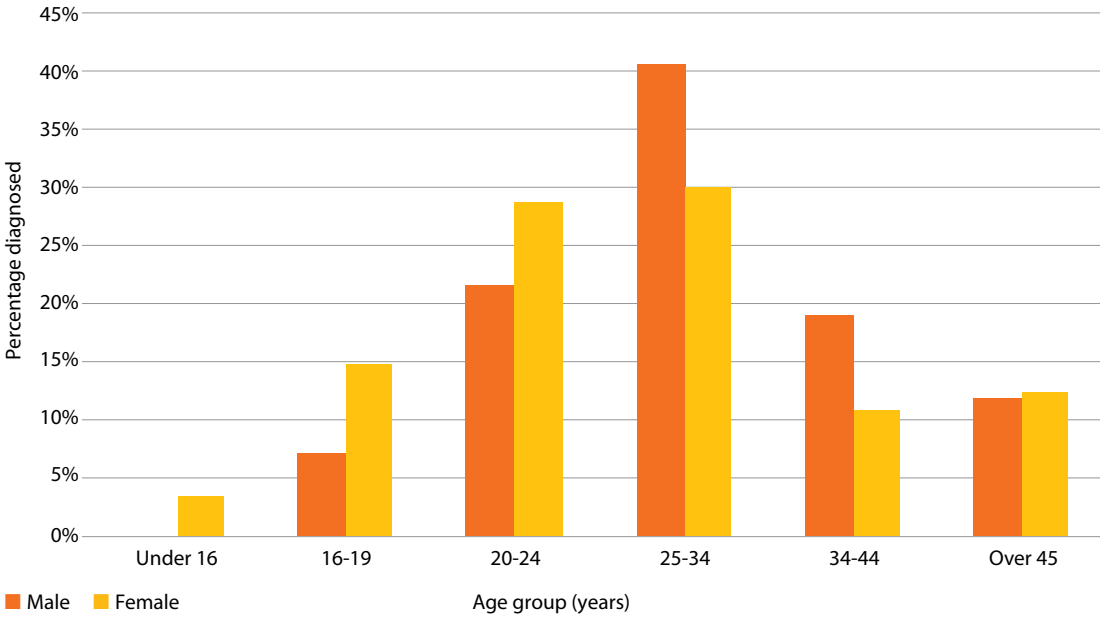
Figure 8 | rates of genital herpes diagnoses per 100,000 population in London PCTs, 2009



Source: Health Protection Agency, 2009

In 2009, new diagnoses for Croydon were highest in the 25 to 34 age group for both women and men (figure 9).

Figure 9 | percentage new diagnoses of herpes at Croydon University Hospital GUM clinic by age and gender, 2009



Source: Health Protection Agency, 2009

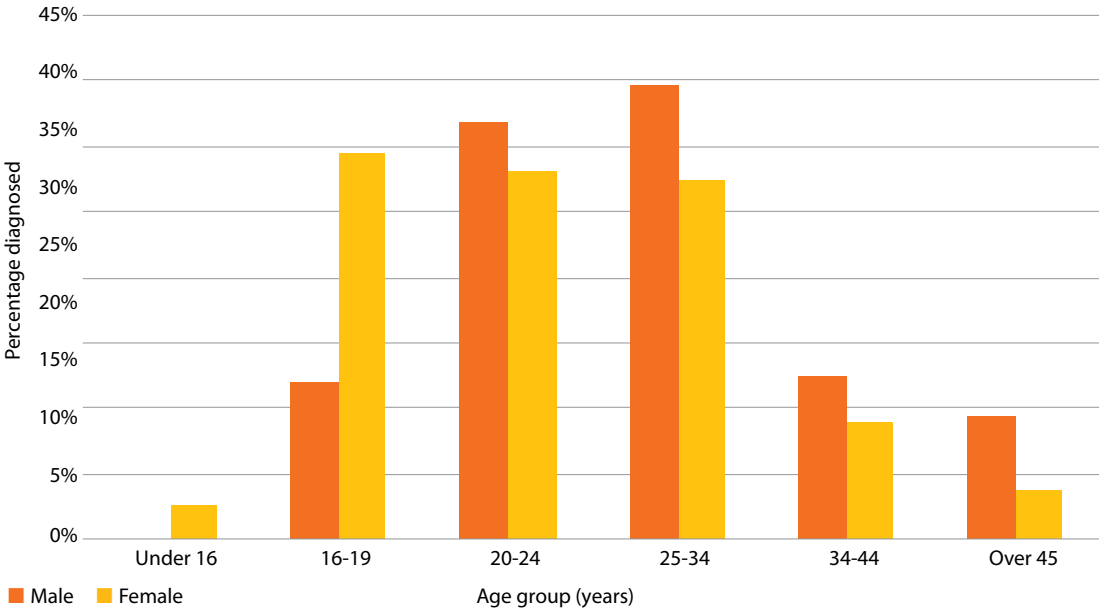
Genital warts

Genital warts are caused by human papillomavirus (HPV) usually type 6 or 11. They have a significant impact on health with considerable psychological and social consequences. Genital warts require lengthy treatment with cryotherapy (freezing) or creams. Genital warts are preventable with a vaccine that targets HPV 6 and 11.

At Croydon University Hospital GUM, there were 419 cases of genital warts diagnosed in 2009. This is 19% decrease from 2008. In London, diagnoses of warts increased by 10% between 2004 and 2008, and by 13% between 2007 and 2008. In 2009, the rate of diagnosis for genital warts in Croydon was 111.5 per 100,000 population, significantly less than both the London (163.6) and England (145.6) averages.[44]

Nationally, rates of diagnosis in GUM clinics in 2008 were highest in 16 to 19 year old women (850 per 100,000 population) and 20 to 24 year old men (816 per 100,000 population). The majority (97%) of diagnoses were reported amongst heterosexuals.[45] In Croydon, the age pattern differed slightly from the national pattern for males, in that the highest rate of new diagnoses was in the 25 to 34 year age group (figure 10).

Figure 10 | percentage new diagnoses of warts at Croydon University Hospital GUM clinic by age and gender, 2009



Source: Health Protection Agency, 2009

Syphilis

Syphilis is caused by the bacterium *Treponema pallidum*. Syphilis has a significant impact on health, particularly if it is not diagnosed until the later phase of the disease. It can cause a genital ulcer within a few months from infection (primary stage) but also spreads through the body with the potential to cause disease in any organ (secondary stage). Secondary stage symptoms can appear within a few months to two years from infection. These include fever, malaise, swollen lymph nodes and a rash that can affect the palm of the hand and soles of the feet. Primary and secondary stages are termed early syphilis and it is in these stages that syphilis is sexually infectious.

44 Health Protection Agency, Croydon University Hospital KC60 data.

45 Health Protection Agency. Trends in genital herpes and genital warts infections, United Kingdom: 1999 to 2008. Health Protection Report. 2009; 3(30).

Beyond two years (late stage) the bacterium can lay dormant for many years with the continuing potential to present as disease. This includes damage to the heart and large blood vessels or destruction of the nervous system resulting in sensory loss or dementia, at which point treatment is unlikely to be effective. The bacterium also readily crosses the placenta to a developing foetus resulting in congenital syphilis, with a range of clinical features that can present at birth and cause death of the baby.

Diagnoses of syphilis in the UK declined in the late 1980s and early 1990s as a result of behaviour change associated with the HIV pandemic. Between 1997 and 2007 however, annual diagnoses of infectious syphilis have risen twelvefold (from 301 to 3,789). Syphilis diagnoses overall are relatively rare, but outbreaks of infectious syphilis and lymphogranuloma venereum (caused by subtypes of the bacterium *chlamydia trachomatis*) are continuing especially among men who have sex with men who are known to be HIV infected. Men who have sex with men account for 73% of infectious syphilis and HIV coinfection is common in those diagnosed with syphilis (27%). In London, the number of syphilis diagnoses has been decreasing over time with a 47% decrease between 2004 and 2008. There were 47 cases diagnosed in south west London in 2008. [46]

In Croydon, there were only a very small number of cases of syphilis (<10) diagnosed in the GUM clinic at Croydon University Hospital in 2009. This represents a rate of 6.1 cases per 100,000 population, compared with 14.1 in London and 5.5 in England. For confidentiality reasons, further analysis of the data has not been possible. However, reflecting the national picture, these cases of syphilis were found in men who have sex with men and in people coinfected with HIV.[47]

HIV

The human immunodeficiency virus (HIV) destroys white blood cells (CD4 lymphocytes) resulting in suppression of the body's immune response. HIV is transmitted sexually and by infected blood or blood products, from mother to child during pregnancy, from maternal blood during childbirth or through breast milk.

Without treatment and a lowered immune response, the body is less able to defend itself against opportunistic infections and cancers. However, treatment with highly active antiretroviral therapy (HAART) is very effective, prolonging life expectancy of an HIV infected person to near normal levels. This treatment is costly, with average lifetime treatment costs for an HIV positive individual between £135,000 and £181,000. The monetary value of preventing a single onward transmission is between £500,000 and £1million in terms of individual health benefits and treatment costs.[48] Mother to child transmission can be virtually eliminated through effective antenatal testing and subsequent management.

Over the last decade or so, HIV infection has developed from a terminal illness into a treatable long term condition. If diagnosed and treated early, life expectancy is now near normal. However, HIV infection still carries a significant stigma, making discussion of the condition difficult and representing an important barrier to the uptake of testing and therefore access to early treatment.

The number of people diagnosed and living with HIV in the UK is increasing.[49] With rising numbers of people diagnosed with HIV, the need for comprehensive long term care and prevention of onward transmission is also increasing.

46 Health Protection Agency. *Syphilis and Lymphogranuloma Venereum: resurgent sexually transmitted infections in the UK: 2009 report*. London: Health Protection Agency; 2009.

47 Health Protection Agency. Croydon University Hospital KC60 data.

48 Department of Health. *Better prevention, better services, better sexual health: the national strategy for sexual health and HIV.* London: Department of Health; 2001.

49 Health Protection Agency. *England: new HIV diagnoses to end of June 2009.* London: Health Protection Agency; 2009.

There are an estimated 77,000 people in the UK living with HIV, diagnosed and undiagnosed.[50] The prevalence of HIV infection in 2008 was 4.2 per 1,000 for Croydon, 5.0 per 1,000 for London and 1.7 per 1,000 for England.[51] The British HIV Association recommends in its guidelines for HIV testing that more extensive HIV testing should be introduced if the prevalence is greater than two per 1,000 population.[52]

In 2007, there were 25,126 people with HIV accessing clinics in London.[53] Around 30% of those accessing services in south west London live in Croydon.[54] Over the last five years, the number of people accessing care in Croydon has increased by 50% and the continued rise in the number of cases in 2008 (953, an 8.5% increase from 2007) is a trend displayed in other London boroughs.[55]

In 2007, heterosexual sex was the most common route of transmission of HIV in south west London, followed by sex between men (20%).[56] People from Black African origin are significantly affected by HIV in Croydon. 59% of patients accessing HIV care in 2008 were of Black African ethnicity. The majority of those living with HIV in Croydon acquired the infection outside the UK.[57]

In south west London as a whole, there were more men than women accessing HIV services in 2007. However, in Croydon more women than men aged 16 to 45 access services particularly in the 16 to 24 year age group (76% women). In 2007, Croydon had the highest prevalence of HIV in pregnant women in south west London (0.55%).[58]

In 2008, most of those infected with HIV lived in the north of Croydon (figure 11), where the prevalence rate of eight or more per 1,000 in some areas is much higher than the average for Croydon (4.2 per 1000).[59] One reason for this could be because a higher concentration of the Black and minority ethnic communities affected by HIV live in these areas of Croydon.

50 Health Protection Agency. *Testing times - HIV and other sexually transmitted infections in the United Kingdom: 2007 2007.* London: Health Protection Agency; 2007.

51 Health Protection Agency. *Survey of prevalent HIV infections diagnosed.* London: Health Protection Agency; 2008.

52 British HIV Association. UK national guidelines for HIV testing. London: British HIV Association; 2008.53 Based on population aged 15-59 of 214,911. Office for National Statistics.

54 South west London Health Protection Unit (SWLHPU). *HIV Epidemiology in south west London in 2007.* London: SWLHPU; 2009.

55 Health Protection Agency. 2008 op. *cit.*

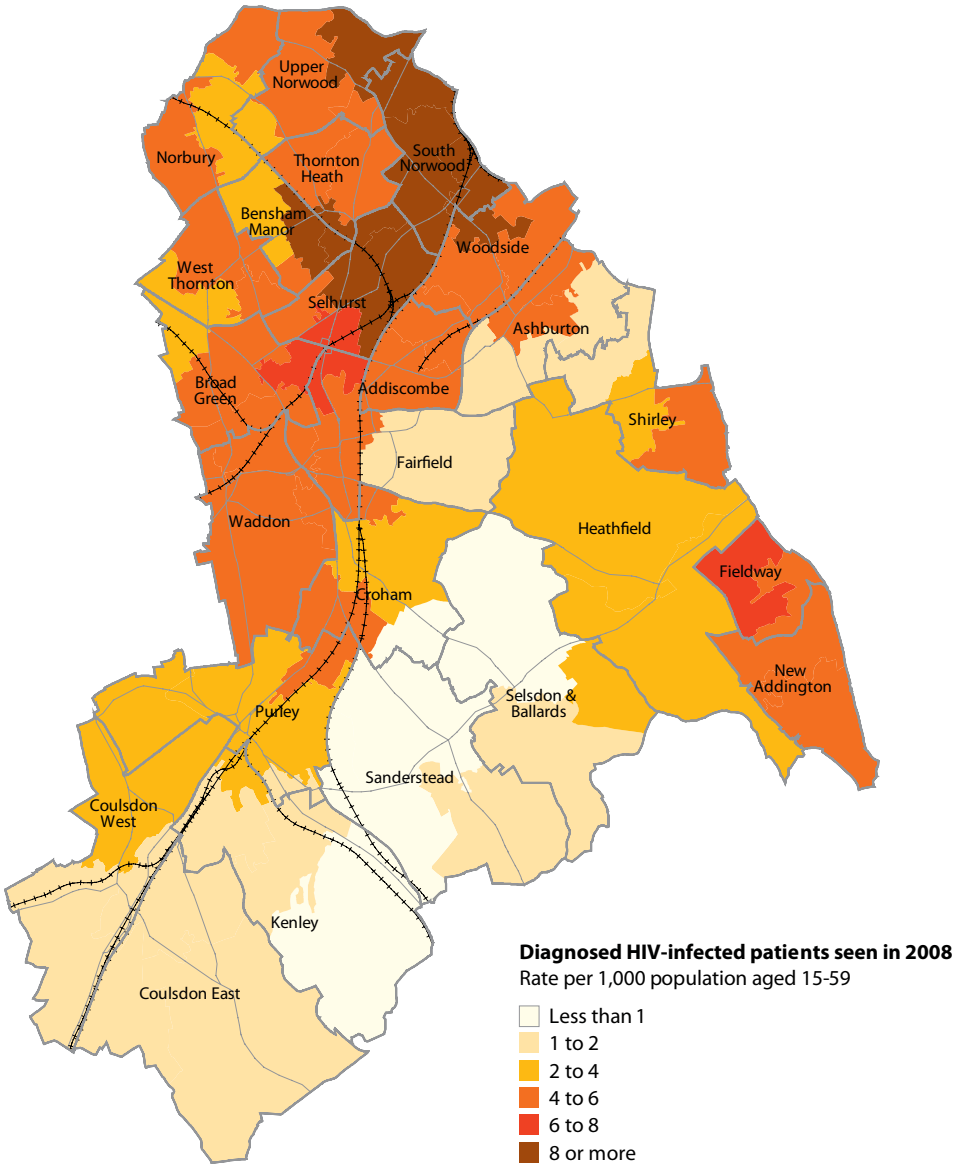
56 South west London Health Protection Unit. 2009 op. *cit.*

57 Health Protection Agency. 2008. op. *cit.*

58 South west London Health Protection Unit. 2009. op. *cit.*

59 Health Protection Agency. 2008. op. *cit.*

Figure 11 | patients diagnosed with HIV by middle super output area, Croydon 2008



Source: Health Protection Agency, 2008
Note: Middle super output areas are small areas defined following the 2001 Census. Each has a population of 7,000-8,000 people.

Late diagnosis of HIV

It is estimated that a third of those infected with HIV are not diagnosed until the stage where their immune system is significantly compromised and can no longer protect against opportunistic infections or cancers. This is medically indicated by a white blood cell (CD4) count of lower than 200 per mm^3 of blood within three months of diagnosis. On average, people with a CD4 count lower than 200 will have been infected about eight years before their diagnosis. Nationally, 40% of HIV infected Black Africans and Black Caribbeans and 20% of those who acquired HIV infection through sex between men are diagnosed late.[60]

The Department of Health has set a national target to reduce the rate of late diagnosis of HIV to less than 15% by March 2011.[61] Early diagnosis and treatment is also cost effective, with direct care costs for late presenters estimated to be 200% higher than for early presenters.[62] A reduction in the rate of late diagnosis is seen as an indicator of a reduction of onward transmission.

60 Health Protection Agency. *Survey of prevalent HIV infections diagnosed.* London: Health Protection Agency; 2008.

61 Department of Health. *Better prevention, better services, better sexual health: the national strategy for sexual health and HIV.* London: Department of Health; 2001.

62 Bryce G. HIV testing in primary care. BMJ. 2009;338:b1085.

In 2008, 40% of HIV patients were diagnosed late in Croydon. This is an increase of 3% from 2007and is higher than the average for London at 31%. Croydon has not been able to reduce the number of late diagnoses since 2004 and ranks 25th out of 31 London PCTs in terms of performance.[63]

In Croydon, heterosexuals are diagnosed later than men who have sex with men. The fact that Croydon has a higher number of heterosexuals than men who have sex with men infected with HIV is one reason why Croydon has a particularly high rate of late diagnoses compared with neighbouring boroughs, such as Wandsworth (28%) which has a larger population of men infected with HIV through sex with men. The reasons why heterosexuals are diagnosed later in Croydon are not well understood as yet. Possible explanations include a fear of stigma, a lack of awareness of modern treatment options or that heterosexuals think they are less at risk of infection and so are less likely to be tested.

Interventions targeted at people of Black African origin and men who have sex with men are needed to ensure better health outcomes. Better systems need to be in place to facilitate early HIV diagnosis through community and primary care settings as well as in hospitals. The National Institute for Health and Clinical Excellence (NICE) is currently developing guidelines for increasing the uptake of HIV testing among these groups.[64] HIV testing in the community is currently available through the contraceptive and reproductive health service but only on appointment. The UK national guidelines for HIV testing recommend that people should be offered and encouraged to accept HIV testing in a wider range of settings than is currently the case.[65]

In March 2010, a focus group was held at The Junction in Croydon with 20 HIV positive service users. The main issues raised by participants were that counselling and support services need to be available at the time of diagnosis as well as beyond. Several participants said they felt abandoned after being told about their HIV status and they noted that the majority of voluntary support organisations for HIV positive people in south London have closed over the last few years. Some said they wanted a higher profile for HIV and for celebrities such as musicians to help to reduce stigma. Most said they preferred to be seen by one practitioner for health who could cover HIV as well as other needs but GPs were perceived as ill equipped and uncomfortable talking about HIV and sexual health in general. In contrast, consultants in GUM clinics were seen as engaged, reliable, competent and able to address HIV related issues comprehensively. For many the GUM consultant is the preferred healthcare professional.

Participants in the focus group said that long term health needs such as diabetes and hypertension need to be integrated in the care plan for those who are HIV positive and that routine HIV tests should be offered to increase early detection and prevent the spread of HIV.

Contraception and reproductive health

Contraception

Contraception services are essential to enable women and men to choose a form of contraception that suits them, be in control of their fertility and prevent unplanned pregnancy. A number of studies have found that contraceptive services result in substantial cost savings to healthcare systems by reducing the number of unintended and unwanted pregnancies.[66] One UK study found that for every £1 spent on contraceptive services, £11 is saved.[67] Condoms also offer the added benefit of protection against sexually transmitted infections which can result in significant ill health.

63 Health Protection Agency. *Survey of prevalent HIV infections diagnosed.* London: Health Protection Agency; 2008.

64 NICE guidance in development: *Increasing the uptake of HIV testing among Black Africans in England and Increasing the uptake of HIV testing among men who have sex with men* www.nice.org.uk/guidance.

65 British HIV Association. *UK national guidelines for HIV testing.* London: British HIV Association; 2008.

66 Mavranezouli I. Health economics of contraception. Best Practice and Research: Clinical Obstetrics and Gynaecology. 2009 Apr;23(2):187-98.

67 McGuire A and Hughes D. *The economics of family planning services.* London: Family Planning Association; 1995.

In July 2008 the Independent Advisory Group on sexual health and HIV published a review of the national strategy for sexual health and HIV.[68] The review identified contraceptive services and late abortions as two areas requiring further attention nationally.

There are currently 15 methods of contraception available.[69] Some, such as male and female sterilisation and long acting reversible contraception (intrauterine system, implant, injection and intrauterine device) avoid the risk of user error associated with some of the more traditional methods (the combined pill, contraceptive patch, contraceptive vaginal ring, progesterone only pill, natural family planning, male and female condoms, diaphragms and caps). There are also two methods of emergency contraception; the emergency hormonal contraceptive pill and the intrauterine device (IUD).

The Medical Foundation for AIDS and Sexual Health has set standards for contraceptive advice and provision which are endorsed by the Department of Health.[70] The recommendations state that women should be able to:

- Receive accurate information about the full range of contraceptive methods and have access to their free provision, including condoms.
- Access a contraceptive service within two working days with quick access to their chosen method and ongoing support.
- Access emergency hormonal contraception (EHC) or intrauterine (IUD) emergency contraception quickly and conveniently.

NICE published guidelines for long acting reversible contraception (LARC) in October 2005.[71] These provided evidence that LARC methods were more cost effective than the combined oral contraceptive pill (even at one year of use) and that intrauterine devices (IUD) and intrauterine systems (IUS) and implants were more cost effective than injectable contraceptives.

The guidelines include advice for particular groups, including women who have HIV, learning disabilities or physical disabilities, or are younger than 16 years.

NICE recommends:

- Providing information for women and offering a choice of all contraceptive methods including LARC methods.
- Provision of detailed information to women considering LARC methods tailored to their individual needs.
- Healthcare professionals should be competent to:
  - help women to consider and compare the risks and benefits of all methods relevant to their individual needs;
  - manage common side effects and problems.
- In services not providing LARC, mechanisms should be in place for referring women for LARC.
- Healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods.

68 Christophers H. Mann S. Lowbery R. *Progress and priorities - working together for high quality sexual health: review of the national strategy for sexual health and HIV.* London: Medical Foundation for AIDS and Sexual Health; 2008.

69 Department of Health. *The time is now: achieving world class contraceptive and abortion services.* London: Department of Health; 2009.

70 Medical Foundation for AIDS & Sexual Health. *Recommended standards for sexual health services.* London: Medical Foundation for AIDS & Sexual Health; 2005.

71 NICE. *Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception.* London: NICE; 2005.

UK trends in use of contraceptives and application in Croydon

A 2006/07 survey by the Office for National Statistics estimated that four million women use contraceptive services each year, with three quarters accessing services provided by their GP and one quarter accessing specialist community contraceptive services. The survey showed that 76% of all women under 50 were using at least one form of contraception, with just over half (56%) using either short acting or long acting reversible methods. Among women who attended NHS community contraceptive clinics in England, the 16 to 19 year old age group had the highest rate of attendances.[72]

Single women are more likely to use the contraceptive pill or condoms and married women are more likely to use LARC or other permanent methods.[73] Croydon has a higher proportion of single people and lower proportion of married people compared with England and Wales.[74] Data might therefore indicate higher use of short term methods of contraception in Croydon.

Another national survey showed that Black and minority ethnic groups are less likely than women from White ethnic groups to report using hormonal contraception and permanent methods of contraception and were more likely to use barrier methods. Married Pakistani and Indian women reported the lowest use of contraception overall. Among single women who reported being sexually active, Black African and Black Caribbean women reported the lowest contraceptive use of all methods.[75]

Use of contraception in Croydon

Recent analysis estimated that 19.8% of women accessing services in Croydon are using oral contraception and only 3.6% are using long acting reversible contraception (LARC).[76] This is likely to be an underestimate since the data only includes prescribing from general practice and the community contraceptive service. Data on LARC prescribing in 2007/08 shows that Croydon is performing well in relation to other London boroughs.[77] However there is likely to be considerable opportunity to encourage more women to use LARC, which is more cost effective than the contraceptive pill. It is estimated that if 15.2% of women used LARC, as recommended by NICE, then an annual saving of £200,000 could be realised.[78]

In increasing the uptake of LARC, consideration should be given to the full range of LARC methods. All GP practices in Croydon prescribe injectable contraceptives but not all GP practices prescribe IUD/IUS or implants. Two LARC GP champions for south west London have recently been appointed who will contribute to the development of provision of all LARC methods in primary care. It should be noted that potential side effects from different methods of contraception mean that adequate counselling should be given to enable women to choose the most suitable method.

The Croydon emergency hormonal contraception scheme forms part of Croydon's teenage pregnancy strategy and provides emergency hormonal contraception free of charge to women aged under 21. In 2007/08, there were a total of 3,540 women who were supplied with the emergency contraceptive pill through the emergency hormonal contraception scheme, making pharmacies the largest provider of emergency hormonal contraception in Croydon.[79] This is in addition to the emergency hormonal contraception pharmacies would have sold to women not on the scheme.

The majority of those supplied emergency hormonal contraception through the scheme are aged 16 to18 years. Since 2006/07, there has been an increase in the number of women using the scheme across most age groups and in 2007/08 the largest proportion (34%) of clients were from a White British background followed by those of Black Caribbean origin (31%).[80]

72 Lader D. *Contraception and sexual health (2006/7) Omnibus survey report no 33,* London: Office for National Statistics; 2007.

73 ibid.

74 Crayford T. *Annual report of the director of public health: Croydon decennial health atlas.* London: Croydon Primary Care Trust; 2004.

75 Saxena S, Copas AJ, Mercer C, Johnson AM, Fenton K, Erens B, et al. Ethnic variations in sexual activity and contraceptive use: national cross sectional survey. Contraception. 2006 Sep;74(3):224-33.

76 NICE. *Long acting reversible contraception: cost template.* London: NICE; 2006.

77 NHS Croydon. *Croydon contraceptive needs assessment.* London: NHS Croydon; 2008.

78 NICE. 2006. op. *cit.*

79 NHS Croydon. 2008. op. *cit.*

80 NHS Croydon. *Croydon emergency hormonal contraception scheme: activity report 2007-8.* London: NHS Croydon; 2008.

Abortions

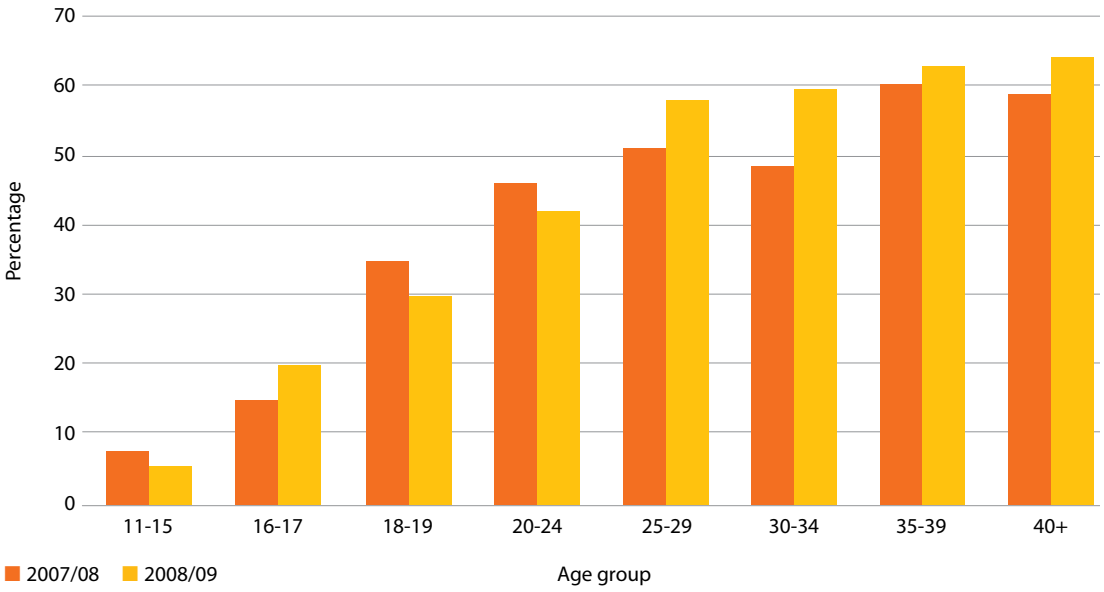
Marie Stopes and Croydon University Hospital are the two NHS Croydon providers for termination of pregnancy services. In 2009 Croydon had higher abortion rates across all ages than London or England. The overall abortion rate in Croydon was 29.7 per 1,000 women (aged 15 to 44) compared with 26.4 in London and 17.7 in England.[81]

An analysis of reasons for abortion in Croydon indicates that the majority (97%) of abortions in all age groups were carried out because the pregnancy had not exceeded its 24th week and continuance of the pregnancy would involve risk of injury to the woman's physical or mental health.

The abortion rate remained fairly stable in Croydon between 2002 and 2006 but the percentage of abortions being undertaken under 10 weeks' gestation has increased from 60.5% in 2002 to 81.2% in 2008.[82] This suggests that women are gaining access to abortion services at earlier stages of pregnancy.

The percentage of repeat terminations generally increases with age. In Croydon over 60% of terminations in 35 to 39 year olds were undertaken in women who have had at least one other termination (figure 12). Just under half (49%) of all women undergoing an abortion in 2009 had one or more previous abortions, compared with 42% of women in London and 34% in England. The proportions of repeat abortions in women aged under 25 in Croydon is 35.9%, higher than in London (32.2%) and England (24.7%).[83]

Figure 12 | percentage of terminations of pregnancy with one or more previous terminations, Croydon 2007/08 to 2008/09



Source: NHS Croydon. Termination of pregnancy analysis 2008/09

Although White British women comprise the largest proportion of all terminations in Croydon (31.1%), figure 13 shows that women of Black African ethnicity have the highest abortion rate (75.7 per 1,000 women aged 15 to 44).[84]

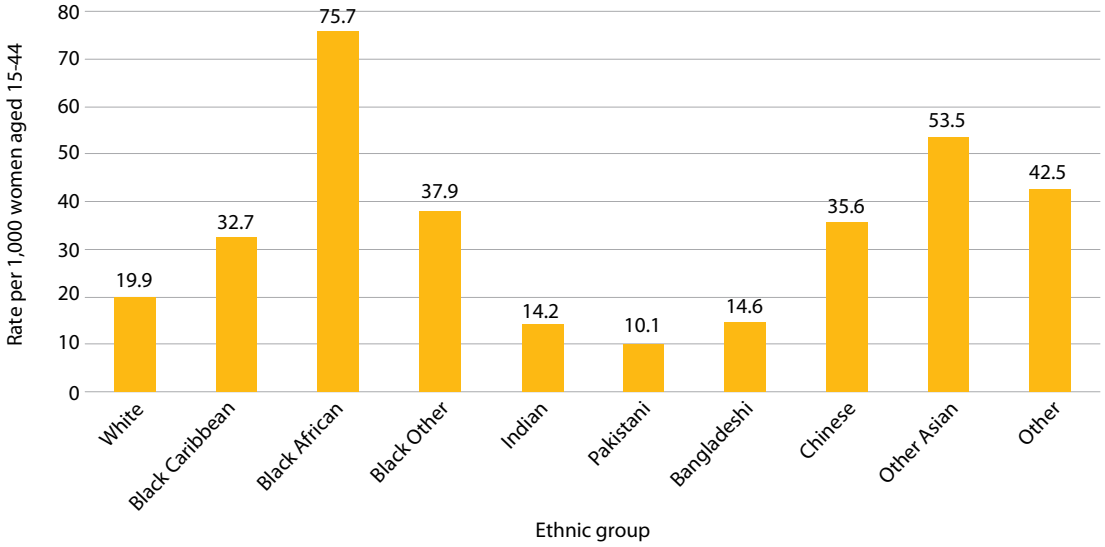
81 Department of Health. *Abortion statistics: England and Wales 2009.* London: Department of Health; 2010.

82 NHS Croydon. T*ermination of pregnancy analysis 2008/09.* London: NHS Croydon. 2009.

83 Department of Health. 2010. op. *cit.*

84 NHS Croydon. *Termination of pregnancy analysis 2008/09.* London: NHS Croydon. 2009.

Figure 13 | termination rate by ethnic group, Croydon 2009/10



Source: NHS Croydon. Termination of pregnancy analysis 2008/09

In 2009, an analysis of contraception methods used prior to termination of pregnancy showed that 43.4% of women were not using any form of contraception (Table 1).

Table 1 | contraception methods used prior to termination of pregnancy, Croydon 2009

Method	Percentage %
No contraception used	43.4
Condom	33.5
Contraceptive pill	17.8
Abstinence	2.8
Long acting reversible contraceptive methods	0.4
Unknown	0.7

Source: Marie Stopes, Croydon

Contraception counselling is important following an abortion, in order to enable women to be in control of their fertility and prevent further abortions due to unwanted pregnancies. These data suggest a lack of effective contraceptive methods being recommended or used in this group and it is possible that abortion is being used as a form of birth control in some cases, indicating some unmet contraceptive need across all age groups.

Infertility

It is estimated that infertility affects one in seven couples in the UK.[85] Infertility is the failure to conceive after regular sexual intercourse for two years in the absence of known reproductive pathology. A cause of infertility is not identified in 30% of couples. It is estimated that in over 50% of cases, the cause of infertility lies in disorders in the man.[86]

There are three main types of fertility treatment:

- medical treatment such as use of drugs for ovulation induction
- surgical treatment, and
- assisted reproduction such as in vitro fertilisation (IVF) and intra uterine insemination (IUI).[87]

85 NICE. *Fertility: assessment and treatment for people with fertility problems.* London: NICE; 2004.

86 *ibid.*

87 *ibid.*

NICE guidance on the assessment and treatment of people with fertility problems provides recommendations on:

- Initial advice to people concerned about delays in conception
- Principles of care
- Investigation of fertility problems and management strategies
- Treatment for people who have problems getting pregnant
- Ways of treating people who have a known condition or reason for their fertility problems.[88]

Fertility services in Croydon are provided by Croydon University Hospital through their fertility team and Shirley Oaks Hospital for self funding patients.

NICE guidelines recommend up to six cycles of intra uterine insemination in couples with mild male factor fertility problems, unexplained fertility problems or mild endometriosis because this increases the chance of pregnancy. The most cost effective option seems to be to start with the least expensive treatment option (IUI), the costs of which are less than half those of in vitro fertilisation.[89] The Croydon University Hospital fertility team offers in vitro fertilisation but not intra uterine insemination, however some groups of patients with infertility can now be offered intra uterine insemination on the NHS at Shirley Oaks Hospital.

The waiting list for in vitro fertilisation at Croydon University Hospital is currently six months. Funding for in vitro fertilisation has to be approved by NHS Croydon in accordance with criteria developed by the south west London effective commissioning initiative. The fertility team see approximately 550 new patient referrals per year, 70% (approximately 385 patients) from Croydon, 25% from NHS Surrey and 5% self funding or from other PCTs. 25% (approximately 138 patients) require assisted conception with in vitro fertilisation. In 2008 the fertility team achieved an overall live birth rate per embryo transfer of 34%. This indicates that one in 50 live births in Croydon University Hospital were a direct result of fertility treatment.[90]

Teenage conceptions, terminations and births

The UK has the highest rates of teenage births in Europe.[91] The Social Exclusion Unit found that more UK children have had sex by the age of 15 than any other country surveyed.[92]

National research suggests that teenage pregnancy can have a negative impact on a young woman's academic achievement, employment, earning potential, mental health and living conditions and it can also have a negative impact on the child. It is associated with poor health outcomes for mother and child. The majority of teenage pregnancies in England and Wales are unplanned and half end in abortion.[93]

Conceptions

In 2008, there were 366 conceptions to women under 18 in Croydon. This is a rate of 55.5 per 1,000 young women under 18, higher than the London (44.6) or England (40.4) averages.[94]

Figure 14 shows that Croydon has experienced a slower rate of decline in teenage conceptions relative to the 1998 baseline, a 6.1% reduction between 1998 and 2008. This reduction is less than London (12.7%) or England (13.3%). The government target is to reduce teenage conceptions by 50% by 2010 which would require a reduction to a rate of 29.6 conceptions per 1,000 females aged 15 to 17, or 198 conceptions per year.

88 *ibid.*

89 NICE. *Fertility: assessment and treatment for people with fertility problems.* London: NICE; 2004.

90 Croydon Healthcare NHS Trust. *Croydon University Hospital: audit data 2008/09.* London: Croydon Healthcare NHS Trust; 2010.

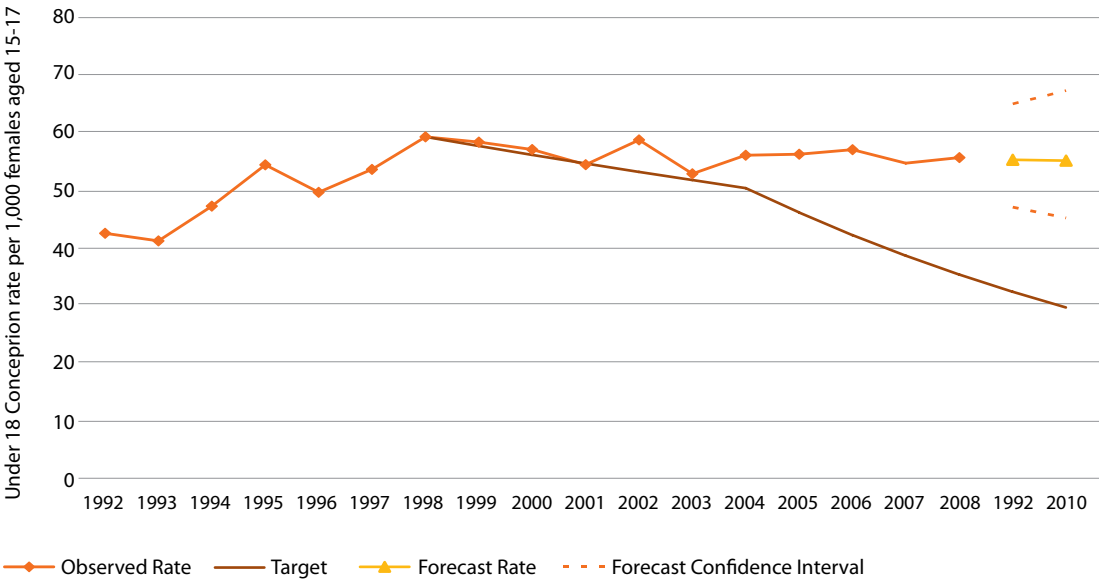
91 UNICEF. *A league table of teenage births in rich countries.* Florence: UNICEF; 2001.

92 Social Exclusion Unit. *Teenage pregnancy* London: The Stationary Office;1999.

93 Department for Education and Skills. *Teenage pregnancy next steps: guidance for local authorities and primary care trusts on effective delivery of local strategies.* London: Department for Education and Skills; 2006.

94 Office for National Statistics, 2010.

Figure 14 | under 18 conception rates, Croydon 1992 to 2008, and forecasted to 2010



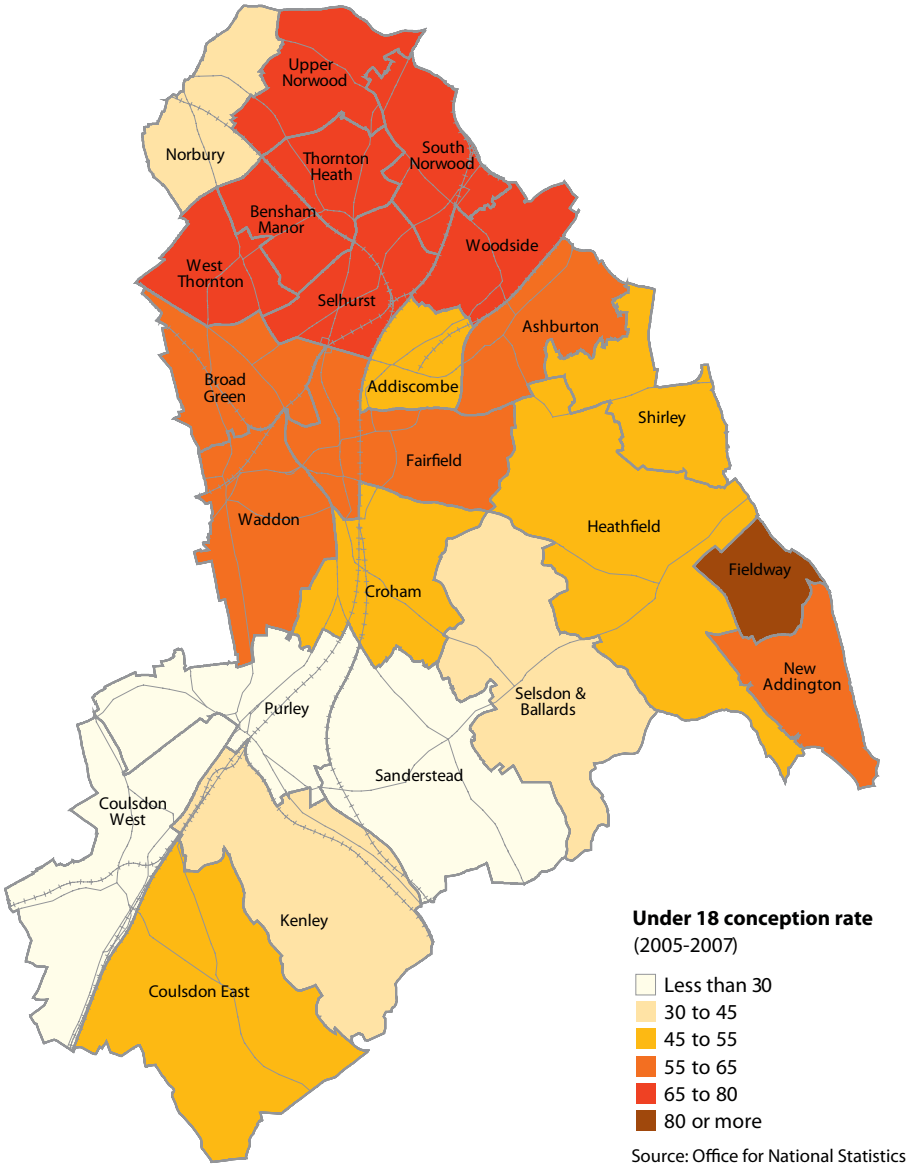
Source: Office for National Statistics data and Association of Public Health Observatories, 2010

Croydon has a higher rate of under 16 conceptions than London or England. For the period 2005 to 2007, there was an average of 73 conceptions per annum in girls under 16. This is a rate of 11.2 per 1,000, higher than the rates for London (8.7) and England (7.9). 67% of under 16 conceptions lead to abortion.[95]

Teenage pregnancy is a complex issue with many influencing factors, however there is an association between conception rate and deprivation. The highest rates of teenage conceptions in 2005- 2007 were recorded in Fieldway and South Norwood (figure 15).

95 Office for National Statistics, 2009.

Figure 15 | under 18 conception rate by ward, Croydon 2005-2007



Source: Office for National Statistics

Termination of pregnancy

In 2008, it is estimated that there were 216 conceptions leading to terminations in under 18 year olds, which constitutes 59% of all under 18 conceptions that year. Croydon has a higher rate of terminations in under 18 year olds (29.0 per 1,000) than the London (25 per 1,000) or England (19 per 1,000) average.[96]

Most terminations in under 18 year olds are performed on girls aged 16 to 17 years rather than younger age groups. One in five of Croydon teenagers having an abortion have had one before. In 2008/09 the number of repeat terminations increased amongst the 16 to 17 year old female population but decreased in 11 to 15 year old and 18 to 19 year old females.[97]

Over the last 10 years in Croydon there has been an increasing trend towards abortions as opposed to births in young people. However, Croydon has experienced a slower rate of increase in abortions in teenagers relative to the 1998 baseline (increase of 3.6% between 1998 and 2007) compared with the rate of increase in London (4.1%) and England (7.4%).[98]

96 Office for National Statistics, 2010.

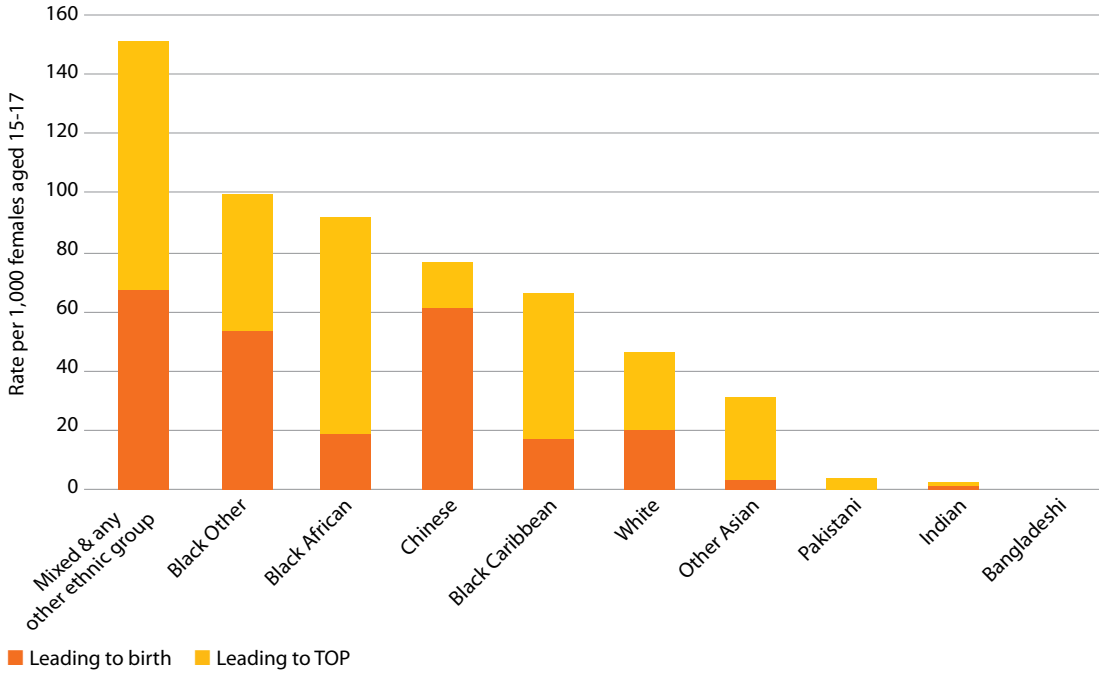
97 NHS Croydon. Termination of pregnancy analysis 2008/09. London: NHS Croydon. 2009

98 Office for National Statistics, 2010.

The number of terminations performed under 10 weeks in Croydon teenagers increased by 30% between April 1999 and January 2008, which indicates more teenagers are accessing termination services at an earlier point in their pregnancy.[99]

In Croydon white teenagers account for the majority of conceptions and terminations performed. However, standardised rates for population size indicate teenage conception rates are highest amongst those in mixed and Black ethnic groups and lowest amongst Asian groups (figure 16).

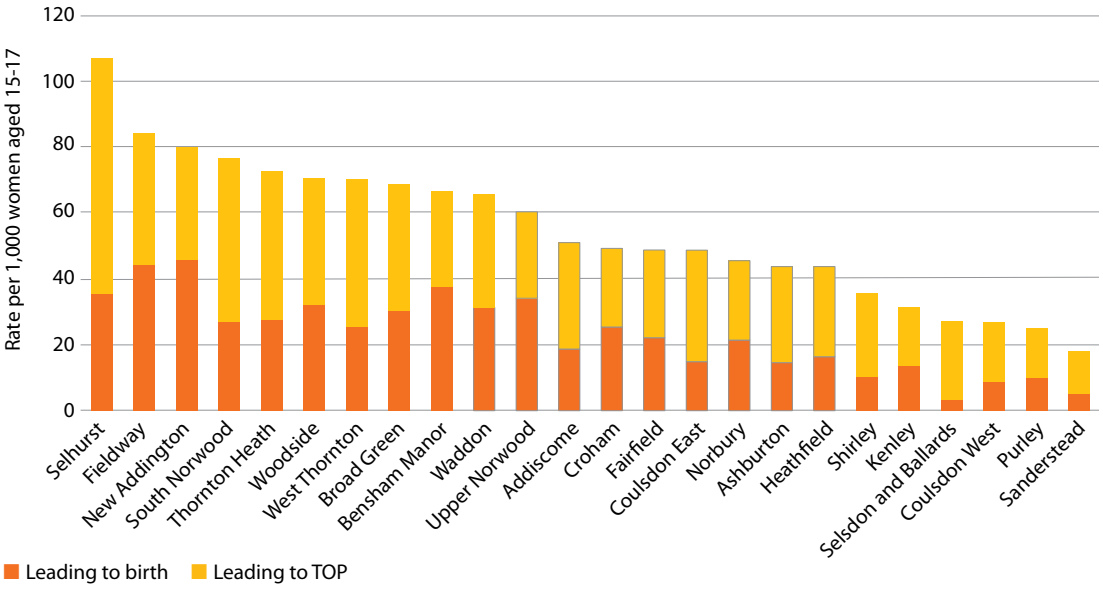
Figure 16 | rate of under 18 conceptions leading to birth and terminations by ethnic group, Croydon 2007/2008



Source: NHS Croydon: birth notifications and Marie Stopes data, 2007/2008

Numbers of terminations are noticeably higher in women living in the north and east of Croydon (figure 17), which is consistent with the higher conception rates in these areas.

Figure 17 | rate of under 18 conceptions leading to birth and terminations by electoral ward, Croydon 2006-2008



Source: NHS Croydon: *Birth notifications and Marie Stopes data,* 2006-2008

99 NHS Croydon. Termination of pregnancy analysis 2008/09. London: NHS Croydon. 2009

Teenage mothers

In Croydon in 2008 there were 145 births to mothers under 18 years old. Eighteen per cent of these teenage mothers had given birth to a child before. Croydon has a higher rate of births to under 18 year olds than London or England. In 2008 there were 23 births per 1,000 population aged 15 to 17 years compared with 17 per 1,000 in London and 20 per 1,000 in England.[100] Since 1998 the rate of those under 18 giving birth has decreased by 12.7%, however the London and England rates have declined by a greater degree (25% and 23% respectively).[101]

As of March 2010, 7.5% of those aged 16 to 19 years and not in education, employment or training are teenage mothers. This equates to approximately 47% of teenage mothers not being in education, employment or training.[102]

Teenage pregnancy strategy

Tackling teenage pregnancy has been a government priority since 1999. The national teenage pregnancy strategy set out by the Social Exclusion Unit in 1999 commits to halving the under 18 conception rate by 2010 (from 46 per 1,000 in 1998) and to setting a firm downward trend for under 16s conception rate by 2010.[103] It also aims to increase the number of teenage parents aged 16 to 19 in education, employment and training by 60% by 2010 and reduce their risk of long term social exclusion.[104]

Reducing teenage pregnancy is also a local priority for both NHS Croydon and Croydon Council. Reduction of the under 18 conception rate is included in Croydon's local area agreement as one of the children and young people's targets and is also one of the seven priorities of Croydon children's trust. It is one of the ten priority outcomes for NHS Croydon and included in NHS Croydon's strategic plan.

Croydon's teenage pregnancy strategy is overseen by the Croydon teenage pregnancy partnership board and is delivered through the children's trust. Key features of the strategy are to:

- provide sexual health and contraception services which are focused on young people
- ensure that schools and colleges deliver high quality sex and relationships education and personal health and social education
- target action at risk groups of young people, particularly looked after children
- ensure the provision of information
- support pregnant teenagers and teenage parents.

Despite delivering recognised good practice, teenage conception rates in Croydon have remained high. There are areas of particularly high prevalence. Key target groups include Black and minority ethnic groups, looked after children and young people not in education, employment and training.

Following a local review process, Croydon's teenage pregnancy action plan will focus on a number of key areas during 2010/11:

1 Young people focused contraception and sexual health services.
2 Strengthening sexual health work in schools and colleges and providing more challenge and support to schools and governing bodies.
3 Targeted work with at risk groups of young people especially looked after children.
4 Workforce development and training on teenage pregnancy and sex and relationship issues in mainstream children's service providers.

100 NHS Croydon: births notifications data.

101 Office for National Statistics, 2010.

102 Connexions South London sub regional unit. *NEET data analysis* (undated).

103 Social Exclusion Unit. *Teenage pregnancy* London: The Stationary Office;1999.

104 *ibid.*

5 A review of the family and parenting support strategy and its delivery programme.

6 Supporting youth services to address teenage pregnancy and young people's sexual health.

7 Strategic governance and accountability.

The Department of Health national support team also assessed Croydon's teenage pregnancy strategy in 2010. The key recommendations were:

- Ensure the agreed vision is owned by all partners and is translated into joined up action.
- The children's trust should work with NHS Croydon to maintain collaboration as the GP role in commissioning health services evolves.
- Share and analyse existing and future data collected by partners in order to commission services more effectively.
- Map the pathways for young people vulnerable to teenage pregnancy through the whole range of children's services to ensure that they are providing effective prevention and support.
- Scope current and future skills and competencies required in sexual health to enable better use of interactions between young people and school nurses, health visitors and midwives.
- Mandatory training in teenage pregnancy and sex and relationships education should be implemented for relevant staff in the local authority and NHS Croydon.

Vulnerable and high risk groups

Young people

Croydon has a relatively young population compared with other London boroughs. There are over 80,000 children and young people aged under 18 comprising 23% of the total population.[105] It is estimated that 55% of Croydon's young people are from Black and minority ethnic groups and around 100 languages are spoken by them.[106]

Most young people become sexually active aged 16 and over but between a quarter and a third of young people have intercourse for the first time before they are 16. National research shows that young people under 18 are more likely to take part in risky sexual behaviour and may be more susceptible to infection.[107] The younger the age at which first intercourse occurs the less likely it is that contraception will be used. About 20% of young people who report their first intercourse at 13 or 14 years old did not use contraception compared with about 10% of young people who had intercourse aged 16.[108]

In London, nearly half of all sexually transmitted infections diagnosed in hospital GUM clinics are in young people aged 16 to 24. Chlamydia, gonorrhoea, genital herpes and genital warts are the most common sexually transmitted infections amongst young people.[109]

Children and young people are increasingly exposed to sexualised images and messages. As children grow older, exposure to this imagery can result in body dissatisfaction, a recognised risk factor for poor self esteem, depression and eating disorders. The government commissioned a review in 2009 because of the emerging evidence highlighting the negative effects of early sexualisation on young people.[110] The review makes recommendations for creating safe and supportive environments for children to understand and explore relationships and sexuality at their own pace.

105 Office for National Statistics mid-2009 population estimates.

106 Greater London Authority. *Ethnic group population projection: London plan.* London: Greater London Authority; 2008.

107 Johnson AM, Mercer CH, Erens B, Copas AJ, McManus S, Wellings K, et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *The Lancet.* 2001;358(9296):1835-42.

108 Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer CH, et al. Sexual behaviour in Britain: early heterosexual experience. *The Lancet.* 2001;358(9296):1843-50.

109 Health Protection Agency. *Sexually transmitted infections and young people in the United Kingdom.* London: Health Protection Agency; 2008.

110 Papadopoulos L. *Sexualisation of young people: review.* London: Home Office; 2010.

In 2009, 64 young people aged between 16 and 19 living in north Croydon were asked about their views on sexual health, pregnancy and sexual health services in Croydon. A key finding was that young people's knowledge and use of sexual health services in the north of Croydon was poor. The most well known and most used sexual health services were the NHS Walk In Centre and the GUM clinic at Croydon University Hospital but both of these services were viewed as slow and uninviting. Young people wanted faster access, more friendly staff who were used to dealing with young people and opening times which were more convenient for them. Young people also wanted to see more services in non traditional health settings, for example youth centres and football clubs and more access to free condoms.

Some of the comments from the young people interviewed included:

'Young people don't really consider sexually transmitted infections. Young women are more preoccupied with getting or not getting pregnant, however, young men are more worried about sexually transmitted infections and don't feel pregnancy is really their problem.'

'I don't have a say if the woman decides to have a baby or not.'

'I think girls should have easier access to the contraceptive pill.'

'I arrived at 8 and was seen at 1. They make you wait forever', 'Waiting times are too long, NHS services need to be quicker'

'Not very welcoming and cold and clinical.'

'Staff look down on you if you want condoms – they think you are too young.'

'Most services are not young people friendly and shabby – you get in and out as soon as you can'

The young people's sexual health outreach and teenage pregnancy team provides preventative, targeted support to young people who are at greater risk of teenage pregnancy and poor sexual health. Weekly sexual health drop in sessions have been developed in each of Croydon's three further education colleges and in a number of other settings. The team is also involved in improving the capacity of local organisations through specialist sex and relationship education training and support. Teenage pregnancy prevention programmes are also delivered to young people at greater risk of teenage conception and poor sexual health.

Schools have an important role to play in educating young people about sex and preparing them to form healthy, respectful and emotionally fulfilling relationships. Sex and relationship education enables young people to take responsibility for their own and others' sexual health. It supports parents in giving their children the knowledge, skills and attitudes to make safe and responsible choices about relationships and sex. The teenage pregnancy and healthy schools teams work with primary and secondary schools to ensure sex and relationships education is delivered effectively. A sexual relationship education outreach worker has been appointed to support all schools in the development of their sex and relationships education.

Looked after children are defined as children in the care of a local authority through a care order made by a court or through a voluntary agreement with their parents. They may be looked after in a children's home, by foster carers, or other family members. All unaccompanied asylum seeking children are defined as looked after children. Some children enter care for short periods of time and move between carers. This creates particular challenges for assessing and meeting health needs.

Looked after children are a group of young people at increased risk of poor sexual health and teenage pregnancy.[111] Looked after young mothers are much less likely to have the support of a family and looked after young men are more likely to become young fathers than their peers who are not in care.[112] Support and intervention for vulnerable young people, including looked after children, is one of six strategic priorities of the Croydon teenage pregnancy action plan.

111 Social Care Institute for Excellence. *Preventing teenage pregnancy in looked after children*. London: Social Care Institute for Excellence; 2004.

112 Corlyon J, McGuire C. *Pregnancy and parenthood : the views and experiences of young people in public care.* London: National Children's Bureau; 1999.

In March 2010, 574 of the 1,008 looked after children placed in Croydon were unaccompanied asylum seeking children.[113] The sexual health needs of unaccompanied asylum seeking young people are likely to be similar to those growing up in the UK. Some however may be more vulnerable and may need additional information, guidance or support. English may not be their first language. They may lack knowledge of sex and relationships. They may have experienced or witnessed rape or sexual violence. They may live in places where they can be vulnerable to sexual exploitation, such as bed and breakfast accommodation and hostels. They may have been subject to harmful traditional practices such as female genital mutilation. They may also experience forced marriage, trafficking or involvement in the sex industry.[114]

Croydon offers a specialist assessment service to all new unaccompanied asylum seeking children, providing them with support on their arrival in the UK. The service is currently expanding to provide better assessments at an earlier point for all new unaccompanied asylum seeking children. It provides sexual health information, assesses needs and facilitates access to maternity services. In Croydon anecdotal evidence from practitioners suggests that many unaccompanied asylum seeking young people have very limited knowledge and awareness of sexual and reproductive health. Sex and relationships education programmes need to be developed for this group of young people.

Young people leaving local authority care aged between 16 and 25 are a particularly vulnerable group. Croydon Council has a leaving care and independence service which has a legal duty to ensure that all young people leaving care have their health needs assessed and a plan in place for meeting those needs. Nationally, young parents who are care leavers report wide variations in support and access to sexual health services before and after they became pregnant. They may fear involvement with services in case it leads to their child being taken into care.

Looked after children are more at risk of sexual exploitation and abuse through prostitution.[115] [116] When children and young people are abused through prostitution, alcohol and other drugs are often involved in the grooming and enticement process.[117] [118] One study found that 78% of sex workers who were also problematic drug users had been in care.[119] The Croydon Eclipse, based at Barnardos, is a multi agency project which works with young runaways and children at risk of sexual exploitation. During 2009, the team supported 39 individuals of whom 41% were looked after children.[120]

Child trafficking is usually for financial gain, resulting in exploitation including sexual exploitation, domestic servitude or slavery, criminal activity and benefit fraud. The covert nature of this criminal activity makes it difficult to identify the numbers of children involved and to prevent, detect and stop trafficking. It is only through partnership working across local and national agencies that this issue can be addressed. The trafficking sub group of the Croydon safeguarding children's board is developing local understanding and expertise about this issue. To support this programme a dedicated worker with expertise in preventing child trafficking is due to be appointed.

113 Croydon Council data; 2010

114 Wilson R, Sanders M, Dumper H. *Sexual health, asylum seekers and refugees: a handbook for people working with refugees and asylum seekers in England.* London: Family Planning Association; 2007.

115 Van Meeuwen A, Swann S, McNeish D. Edwards S. *Whose daughter next? Children abused through prostitution. B*arkingside, Essex: Barnardos: 1998.

116 Matthews P. *A review and a way forward: a report on the sexual exploitation of boys and young men.* Barkingside, Essex: Barnardos; 2000.

117 Palmer T. *No son of mine! Children abused through prostitution.* Barkingside, Essex: Barnardos; 2001.

118 Van Meeuwen A, Swann S, McNeish D, Edwards S. 1998. op. *cit.*

119 Cusick L, Martin A, May T. *Vulnerability and involvement in drug use and sex work.* London: Home Office; 2003.

120 Croydon Eclipse: *Invest to save evaluation: summary.* London: Croydon Eclipse; 2009.

Not being in education, employment or training between the ages of 16 and 18 is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health, including poor sexual health.[121] Reducing the proportion of 16 to 18 year olds not in education, employment or training is a priority for the government. In April 2010 there was a total of 620 young people aged 16 to 19 not in education, employment or training in Croydon; 481 were16 to18 year olds and 139 aged 19. Many organisations have a role to play in reducing the number of young people not in education, employment or training, including local authorities, schools, colleges, and employers. For example, the South London Connexions Consortium commission a range of information, advice and guidance services for young people including the Connexions shop in Croydon High Street.

Vulnerable adults

Homeless people

There is little research on the sexual health needs of homeless people or on their use of sexual health services. Anecdotal evidence suggests that there are significant gaps in access to sexual health promotion, testing and treatment of sexually transmitted infections, condom supply and use, contraceptive advice and cervical cytology. Research has shown that this group is at an increased risk of acquiring sexually transmitted infections and blood borne viruses compared with the general population.[122] In London 40% of homeless young women cite experience of sexual abuse.[123] Homeless people have particular difficulties in accessing primary care. They have unique and complex problems including high levels of drug and alcohol dependence, a high incidence of mental health problems, unstable domestic backgrounds and increased vulnerability to illness due to poor general health.[124] In Croydon, the homeless health team is providing homeless people with sexual health advice, condoms and chlamydia screening.

Drug and alcohol misusers

People who use drugs and alcohol often take risks that endanger their own health and the health of others. This includes risky sexual activities, for example, not using contraception.

All people are potentially vulnerable whilst under the influence of drugs or alcohol but problematic drug users are most at risk, particularly from the transmission of blood borne viruses such as HIV and hepatitis C. Croydon has an estimated 1,939 problematic drug users of which 1,303 have been estimated as being injecting drug users.[125] Many drug users are also involved in sex work and are therefore particularly vulnerable to HIV.

The Croydon Eclipse project works to prevent the sexual exploitation of young people. They report that all their cases in 2008/09 involved substance misuse, particularly alcohol.

Research by the Croydon drug and alcohol team identified a continuing need for outreach services to engage groups at risk of substance misuse and sexual ill health, for example, sex workers and people from the lesbian, gay, bisexual and transgender population.[126]

121 Payne J. Young people not in education, employment or training. London: Policy Studies Institute; 2000.

122 Ochnio JJ, Patrick D, Ho M, Talling DN, Dobson SR. Past infection with hepatitis A virus among Vancouver street youth, injection drug users and men who have sex with men: implications for vaccination programs. CMAJ. 2001 Aug 7;165(3):293-7.

123 Social Exclusion Unit. Rough sleeping: report by the Social Exclusion Unit. London: The Stationary Office; 1998.

124 Grenier P. Still dying for a home: an update of Crisis'1992 investigation into the links between homelessness, health and mortality. London: Crisis; 1996.

125 Home office data, 2010.

126 Croydon Drug and Alcohol Action Team Assessment of local need for adult substance misuse services. 2007 www.croydondaat.org.uk/plans/local_needs_assessment_dec2007.pdf. Accessed 19 January 2011.

People with mental health problems

Research into sexual risk behaviour among people with severe mental health problems suggests that they are likely to engage in high risk sexual behaviour, putting them at risk of sexually transmitted diseases.[127] For example, people with psychosis may have their decision making abilities impaired by their condition during a crisis period which raises the likelihood of risk taking. The risks are also higher for people with depression who may use sex as a coping mechanism. Little is known about the level of unmet need among people with mental health issues in Croydon and further investigation is required to identify needs and service gaps.

People with learning disabilities

In February 2009 the number of adults with learning disabilities in Croydon aged over 18 years was estimated to be 5,226 with 1,339 in contact with council learning disability services.[128] This does not include people placed in Croydon who are funded by another local authority but does include people funded by Croydon but living outside the borough.

People with learning disabilities face problems in terms of availability of appropriate sex education. In other areas of life, services are working towards normalisation for people with learning disabilities. This does not seem to be the case in the area of sexuality or sex education.[129] People with learning disabilities are also vulnerable to sexual abuse and exploitation. Learning disability health professionals and care workers often need to help and advise people with learning disabilities to make choices, conduct relationships and protect themselves from sexual abuse and unwanted pregnancy. The sexual health and sex education training needs of health professionals and care workers in contact with people with learning disabilities in Croydon is an area that should be reviewed.

Sex workers

In 2004 there were around 80,000 commercial sex workers in the UK. Approximately 85% of these were women working mainly off street.[130] Commercial sex workers are a group with diverse experiences, motivations and needs. Sex workers include men, women and transsexuals who may have entered sex work for different reasons and may work in very different environments. The differences between different groups of sex workers affect their vulnerability to sexually transmitted infections and ability to access sexual health services.[131]

In 2010, Croydon Community Against Trafficking identified over 100 advertising brothels in the borough of Croydon.[132] A mapping of commercial sex activity in London in 2004 located 730 flats, saunas and parlours where sex workers were operating.[133] Thirty nine sites were located in Croydon, one of which was fully licensed. This is likely to be an underestimation of commercial sex activity as the mapping focused on female sex workers and not all sites were identified in the mapping exercise. It was estimated between 2,972 and 5,861 women were working at these sites across London with estimates for Croydon put at between 100 and 350. The majority of women engaged in the off street sex industry across London were non British nationals with only 19% of women identified as coming from the United Kingdom. In Croydon the majority of sex workers identified their ethnicity as English although there was wide representation from other ethnic groups.

127 Higgins A, Barker P, Begley CM. Sexual health education for people with mental health problems: what can we learn from the literature? Journal of psychiatric and mental health nursing. 2006 Dec;13(6):687-97.

128 Information Centre for Health and Social Care, 2009.

129 Fraser S, Sim J. *The sexual health needs of young people with learning disabilities.* Edinburgh: NHS Health Scotland; 2007.

130 Hester M, Westmarland N. *Tackling street prostitution: towards an holistic approach.* London: Home Office; 2004.

131 Legros F. *A literature review of the sexual health needs of commercial sex workers and their clients.* Cambridge: DHIVERSE; 2005.

132 The Croydon Community against Trafficking. Annual report 2009/10. www.theccat.com. Accessed 19 January 2011.

133 Dickson S. Sex in the city: mapping commercial sex across London. London: The Poppy Project; 2004.

Sexual health outreach services have experienced increasing difficulty gaining access to these women and overall the industry seems more covert and exploitative which may indicate that high numbers of trafficked women are involved. Women trafficked for sexual exploitation are at a higher risk of sexually transmitted infections due to the existence of coercion and violence within the trafficking situation. They may have limited ability to negotiate how sex takes place and whether condoms are used.[134] In a study on trafficking that looked at the physical and psychological health of women and adolescents trafficked in Europe, 95% of the study sample reported being physically assaulted or coerced into a sexual act while trafficked.[135]

There is little specialist provision for people who have been trafficked. The women need accommodation, counselling, health services, education, training and legal advice, including advice on their immigration status, entitlement to service and the options if they choose to return to their country of origin.

Thornton Heath and Norwood have been highlighted as two of the areas in London where on street prostitution is common. There are strong links between on street prostitution and drugs and substance misuse. Women involved in on street prostitution in London were identified as mainly African Caribbean, British (both Black and White) and Irish. Women trafficked from outside the UK were rarely involved in on street prostitution.[136]

The Westminster Drug Project has a specialist women's outreach worker who engages with vulnerable women aged 17 and over in Croydon. This includes work with women engaged in the sex industry. Outreach work usually takes place in brothels and free condoms have been a key instrument in enabling engagement with this client group. A sex worker currently collects about 100 condoms a week from the project and distributes them to other sex workers. This enables the project to maintain contact with the group even if the brothel is moved to a different location. In 2009 the Croydon outreach team engaged with 28 brothels and distributed a total of 2,270 condoms.

Male prostitution is less visible and mainly off street. Many men are involved in work in pubs, saunas and escort agencies and do not usually have the same drug or coercion issues that might be the case for women. However higher levels of sexually transmitted infections have been found among this population and it is estimated that 11% of male sex workers are HIV positive.[137] They are often associated with high risk behaviours such as injecting drug use, high rates of anal sex and inconsistent condom use, with both clients and non paying partners.

Research evidence shows that sex workers face barriers to accessing sexual health services according to the environment and the context of their work. They experience discrimination because of their work and the continuing criminalisation of prostitution. Stigmatisation, reinforced by the spread of HIV, has created further barriers to sex workers in need of social and health services.[138]

Victims of sexual violence and abuse

Croydon's rape and sexual abuse support centre offers a helpline for victims of sexual violence as well as counselling and advocacy by appointment. The helpline responds to between 400 and 500 calls per month.[139]

Lesbian, gay, bisexual and transgender people

It has been estimated between five and 10% of the population could be classified as lesbian, gay, bisexual or transgender.[140] This would indicate a population in Croydon of between 15,000 and 30,000 people.

134 Legros F. *A literature review of the sexual health needs of commercial sex workers and their clients.* Cambridge: DHIVERSE; 2005.

135 Zimmerman C, Hossain M, Yun K, Roche B, Morison L, Watts C. *Stolen smiles: a summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe* London: London School of Hygiene & Tropical Medicine; 2006

136 Dickson, S. 2004. op. *cit.*

137 Legros F. *A literature review of the sexual health needs of commercial sex workers and their clients.* Cambridge: DHIVERSE; 2005.

138 *ibid.*

139 Rape and Sexual Abuse Support Centre data. Personal communication. 2010.

140 Croydon Council. *Equality and cohesion strategy: 2009–2012.* London: Croydon Council. 2009.

The national sexual health and HIV strategy highlights the fact that sexual ill health is not equally distributed among the population, with men who have sex with men as a high risk group in terms of sexual ill health.[141] This is supported by a study by Sigma Research which showed that of the men surveyed only 60% used a condom during their first experience of anal sex.[142] The survey also showed that of those who had anal intercourse in the last year, 48.8% had unprotected intercourse and 59.6% of those had both unprotected insertive and receptive intercourse. Evidence from the health trainer project delivered by the London HIV prevention programme also identifies high levels of sexual health needs for men who have sex with men.[143] Of the men reached by the project, 36.7% reported some unprotected anal intercourse with at least one non regular partner within the last 12 months and 4.7% reported unprotected anal intercourse with 10 or more partners in the last 12 months; 41.5% reported not having tested for HIV within the last 12 months and 14.6% reported testing very often, at least every four months. The project also found that 16.4% of men were diagnosed with either rectal chlamydia or gonorrhoea in the last 12 months. National surveillance indicates that a high proportion of men who have sex with men who had an acute sexually transmitted infection were also infected with HIV.[144] For example, 32% of those diagnosed with gonorrhoea, 40% of those with syphilis, 78% with lymphogranuloma venereum and 97% with hepatitis C, also had HIV.

There has been little research carried out at national level on the sexual health needs of lesbian and bisexual women as they are deemed to be in a low risk category when it comes to sexually transmitted infections and HIV. A 2002 report investigating lesbian and bisexual women's sexual health found that although lesbians and bisexual women may not be a high risk for sexually transmitted infections and HIV, one in eight respondents mentioned physical problems with sex and 4.1% reported having sex when they did not want to.[145] The authors emphasised that lesbians and bisexual women did not identify sexual health issues as a primary concern but also stressed that sexual health services should be equitable and sensitive to lesbians and bisexual women.

There are no dedicated GUM clinic sessions for patients who are lesbian, gay, bisexual or transgender in Croydon. A workshop held in April 2010 as part of the development of Croydon's sexual health strategy recommended the development of branding to make lesbian, gay, bisexual or transgender friendly services visible to those service users. It was noted at the workshop that transgender service users are not able to access some sexual assault support services as they are set up for women and do not recognize the needs of transgender service users. Further exploration regarding gaps in service provision for lesbian, gay, bisexual or transgender service users is required to ensure services meet their needs.

The London HIV prevention programme and south west London HIV prevention programme commission targeted outreach health promotion initiatives for men who have sex with men, for example condom distribution and health trainer outreach in clubs, saunas and pubs. The uptake of this service amongst Croydon residents has been very low and is currently being reviewed.

In 2008 Croydon's lesbian, gay, bisexual or transgender network (Crocus) reported anecdotal evidence of homophobic and transphobic crime and prejudice in Croydon which may prevent members of the lesbian, gay, bisexual or transgender communities from approaching services for support.[146]

141 Department of Health. *Better prevention, better services, better sexual health: the national strategy for sexual health and HIV.* London: Department of Health; 2001.

142 Hickson F, Wetherburn P, Reid D, and Stephens M. *Out and about: findings from the United Kingdom gay men's sex survey 2002.* London: Sigma Research; 2003.

143 GMI Partnership. *Health trainers Q4 and annual report.* London: GMI Partnership; 2009.

144 Health Protection Agency. *Sexually transmitted infections and men who have sex with men in the UK.* London: Health Protection Agency; 2008.

145 Henderson L, Reid D, Hickson F, McLean S, Cross J, Wetherburn, P. *First, service: relationships, sex and health among lesbian and bisexual women.* London: Sigma Research; 2002.

146 Crocus. Croydon LGBT Survey 2008. www.croydoncrocus.org.uk/survey.htm. Accessed 19 January 2011.

Black and minority ethnic groups

In 2008, 41%, of Croydon's population were from a Black and minority ethnic background and this is projected to be more than 50% by 2026.[147] National data indicate that some Black and minority ethnic groups especially younger Black Caribbean, Black African and other Black population groups are disproportionately affected by sexually transmitted infections and sexual ill health.[148]

There are particular barriers to accessing services for Black and minority ethnic communities, for example, language, cultural practices and stigma. Understanding and meeting the needs of these communities in Croydon is a challenge that needs to be met through better engagement with communities.

In January 2010 a consultation event involving 21 members of various Black and minority ethnic communities in Croydon gathered a range of views about sexual health services and how to target their communities. One key theme arising from the consultation was that sexual health promotion should use more creative methods for engaging with the community such as the use of peer educators and culturally sensitive activities. Some participants also said that the voluntary sector is central in disseminating information to communities and in delivering targeted projects. They also said that there needs to be more involvement of voluntary organisations in service development and more funding available to support them in promoting and communicating messages to their communities. Examples of good practice cited by participants included a sexual health clinic in Croydon College, health promotion techniques used by the teenage pregnancy team, sexual health training for members of the Black and minority ethnic community and the use of events such as the Croydon Mela for health promotion and distribution of chlamydia test kits.

Comments from participants included:

'There isn't enough involvement of key stakeholders, particularly in the community.'

'Parents and carers should be targeted to raise awareness in a family setting and community leaders should be involved with normalising sexual health.'

Refugees and asylum seekers

Refugees and asylum seekers experience issues which are also found in other groups in society, including rape, domestic violence and prostitution. Particular sensitivity is needed when addressing these issues with asylum seekers and refugees. In addition they may have low levels of knowledge about sexual health issues or have cultural differences and practices such as female genital mutilation. They can have difficulty in accessing services due to language, fear, persecution or stigma.[149] Further research is needed to identify the particular sexual health needs of the various groups of refugees and asylum seekers in Croydon.

147 Greater London Authority. Ethnic group population projections: 2008 round for London plan. www.london.gov.uk/who-runs-london/mayor/publications/society/facts-and-figures/diversity. Accessed 19 January 2011.

148 Health Protection Agency. *Sexually transmitted infections in Black African and Black Caribbean communities in the UK: 2008 report.* London: Health Protection Agency; 2008

149 Wilson R, Sanders M, Dumper H. *Sexual health, asylum seekers and refugees: a handbook for people working with refugees and asylum seekers in England.* London: FPA; 2007.

Sexual health services in Croydon

Croydon's strategic plan for sexual health and HIV 2010-2015 sets out a commitment to the development of integrated sexual health services. These will provide holistic intervention, streamline the care pathway and ensure efficient use of limited resources through better partnership work across all sectors.[150]

Community sexual health services in Croydon are currently being integrated with the aim that all sexual health services provide the basic elements of health promotion, screening, diagnosis and treatment of sexually transmitted infections, as well as contraception advice and access to all methods of contraception. The community sexual and reproductive health service is now managed by Croydon Healthcare NHS Trust. This provides the opportunity for further integration between the GUM clinic at Croydon University Hospital and community based reproductive and contraceptive services.

The strategic plan for sexual health in Croydon also aims to deliver more sexual health services in primary care settings. This includes rapid HIV testing by GPs and provision of oral contraceptives, emergency hormonal contraception, condoms and chlamydia screening and treatment by community pharmacies.

Planned changes to services have training implications for the local workforce. A workforce training needs assessment has been undertaken to inform a training plan. One aim is to enable staff from the community sexual and reproductive health service to deliver some of the basic services currently offered by the GUM clinic such as routine testing for sexually transmitted infections. In addition Croydon University Hospital GUM staff will need to be trained to be competent to deliver both sexual health and reproductive health services. Dual trained staff will increase the flexibility and capacity within GUM and sexual and reproductive health services to better meet local sexual health needs.

A clinical audit of intra uterine techniques across GPs providing this service was undertaken in March 2010.[151] The audit showed that training and updates required to ensure best practice are not routinely adhered to by all practitioners. The audit recommended more integrated working between the sexual and reproductive health services and primary care commissioning to ensure that the uptake of training by general practice is closely monitored. The audit report identified that lack of capacity among some general practitioners results in delivery of inflexible services which may limit access for patients. A referral system between GPs may resolve the capacity and access issues. The audit report action plan includes promoting practitioner to practitioner referral to increase access.

HIV service users involved in a focus group commissioned to inform this needs assessment raised concerns about the confidence of GPs to deal with issues regarding sexual health and HIV. The service users felt that GPs usually refer such queries to GUM services. GPs will need training to ensure they are confident and competent to roll out a planned rapid HIV testing programme in Croydon. GP practices participating in HIV testing in the primary care pilot programme in Croydon receive training on HIV testing and awareness of the needs of high risk groups.

There is a range of national, regional and local sexual health training available for both practitioners and lay people. The NHS Croydon public health department offer courses to health and social care professionals including courses on teenage pregnancy, condom awareness, chlamydia screening and HIV awareness.

A specialised sexual health training programme has been developed for community pharmacists offering enhanced sexual health services in Croydon. In 2009/10, 15 local pharmacists were trained and accredited to provide enhanced sexual health services including chlamydia treatment. Further training will be delivered on the provision of oral contraception. NHS Croydon is currently developing an on line training resource for new pharmacists who are accepted to provide enhanced sexual health services.

150 Document available from www.croydonobservatory.org/ihaw/

151 NHS Croydon. *Report on a clinical audit of intra uterine techniques (IUT)* London: NHS Croydon; 2010.

The SHARP programme is a three year project between NHS Croydon and Croydon Drop In, with funding from the King's Fund. SHARP's aim is to build capacity and deliver sex and relationship education training to local Black and minority ethnic communities, voluntary organisations and faith groups. So far 57 people have undertaken and completed the SHARP training programme.

Investment in sexual health

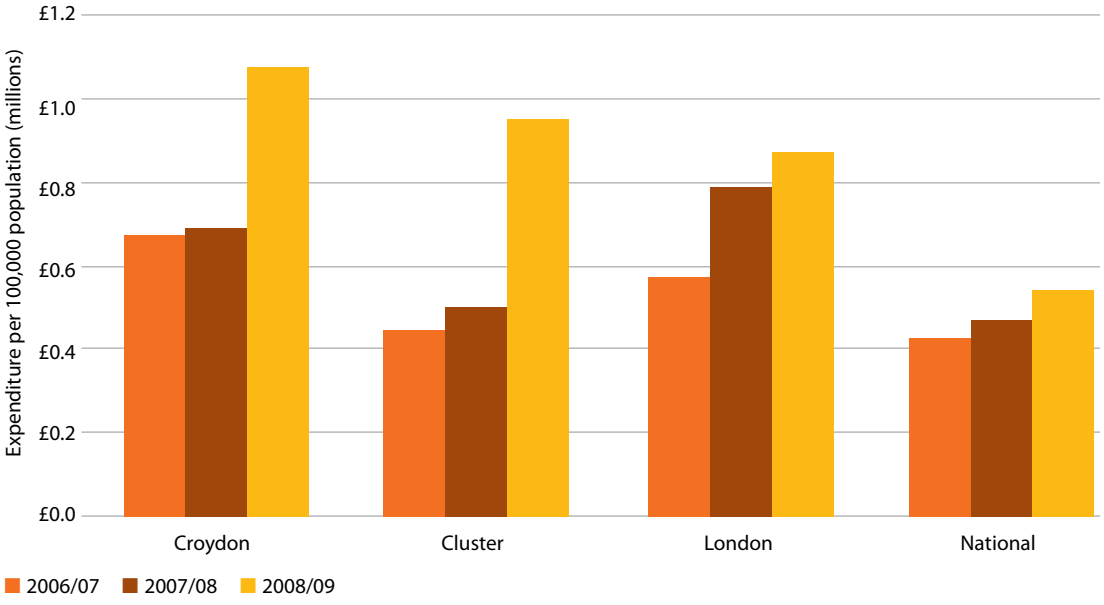
Programme budgeting is a technique for assessing investments in health programmes rather than health services, to allow comparisons in terms of spending and outcomes. Croydon's estimated programme budget spending for sexually transmitted diseases in 2008/09 was higher than the London Suburbs cluster of PCTs as well as the London and England averages (table 2). This is at least in part because of the concentration of high risk groups and the higher prevalence of sexually transmitted infections in parts of Croydon. NHS Croydon increased its spend on sexually transmitted infections by 56% between 2007 and 2009, compared with an increase of 90% by the London Suburb cluster PCTs and 11% in London overall (figure 18). Further work is needed to explore programme budget information for sexual health spending.

Table 2 | estimated expenditure on sexually transmitted diseases, per 100,000 population, 2008/09

NHS Croydon	£1,074,716
Cluster average	£951,459
London average	£871,204
England average	£542,810

Source: Department of Health, www.dh.gov.uk/programmebudgeting

Figure 18 | expenditure on sexually transmitted diseases, Croydon 2006/07 to 2008/09



Source: Department of Health www.dh.gov.uk/programmebudgeting

NICE guidance

Published NICE guidance:

NICE PH3, *prevention of sexually transmitted infections and under 18 conceptions*. February 2007

NICE PH6, *behaviour change*. October 2007

NICE CG30, *long action reversible contraception*. October 2005

NICE CG1, *fertility: assessment and treatment for people with fertility problems*. February 2004

NICE guidance in development:

Contraceptive services for socially disadvantaged young people. October 2010

Looked after children. October 2010

Personal, social and health education focusing on sex and relationships and alcohol education. January 2011

Increasing the uptake of HIV testing among Black Africans in England. March 2011

Increasing the uptake of HIV testing among men who have sex with men. March 2011

Testing with hepatitis B and C. December 2012

Preventing domestic violence. (publication date to be confirmed)