Report to:	**Birmingham Health and Social Care Overview and Scrutiny Committee**
Date:	**18 February 2020**
TITLE:	**SEXUAL AND REPRODUCTIVE HEALTH, CONTEXTUAL DATA**
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Report Type:	**Information report**

1. Purpose:
To provide the Committee with a contextual briefing on sexual and reproductive health data.

2. Recommendation
The Health and Social Care Overview and Scrutiny Committee is asked to note the contents of this report.

3. Context

Sexually Transmitted Infections (STIs)

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

- pelvic inflammatory disease, ectopic pregnancy, postpartum endometriosis, infertility, and chronic abdominal pain in women;
- adverse pregnancy outcomes - including abortion, intrauterine death, and premature delivery;
- neonatal and infant infections and blindness;
- urethral strictures and epididymitis in men;
- genital malignancies, proctitis, colitis, and enteritis in men who have sex with men (MSM); and
- cardiovascular and neurological damage.

3.2 The most commonly diagnosed STIs are chlamydia, first episode genital warts, gonorrhoea and first episode genital herpes.

3.3 The diagnosis rates of STIs remains greatest in young heterosexuals aged 15 to 24 years, black minority ethnic (BME) populations, MSM, and people residing in the most deprived areas in England.

HIV

3.4 HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission.

3.5 Although HIV testing is increasing, the number of new HIV diagnoses has declined over the past decade, with a substantial decrease over the past 3 years. This recent reduction has been mostly driven by fewer HIV diagnoses among MSM, as a result of targeted HIV prevention, including:

- HIV testing - particularly repeat testing among higher-risk men
- improvements in the initiation of anti-retroviral therapy
- treatment as prevention (TasP)
- Pre-exposure prophylaxis (PrEP)

3.6 Late HIV diagnosis is the most important predictor of morbidity and mortality among those with a HIV infection. Those diagnosed late have a 10-fold risk of death compared to those diagnosed promptly.

3.7 Prompt treatment initiation of antiretroviral therapy (ART) reduces the risk of onward HIV infection to partners. Successful ART decreases a person's viral load and HIV transmission does not occur when the viral load is undetectable. UK British HIV Association (BHIVA) treatment guidelines recommend that all people living with a diagnosed HIV infection should be offered treatment as soon as possible after diagnosis.

3.8 Prevention is central to achieving good sexual health outcomes and entails changes that reduce the risk of poor sexual health outcomes and activities that encourage healthy behaviours. Education, condom use, diagnosis and treatment are key interventions for prevention and control.

Reproductive Health

3.9 Reproductive health is relevant for all populations regardless of gender, ethnicity, socioeconomic group or sexual preference. Public Health England's consensus statement on reproductive health aims for the population to have the ability and freedom to make choices about the aspects of their reproductive lives regardless of age, ethnicity, gender and sexuality. The consensus statement seeks for: reproductive health and access to reproductive healthcare to be free from stigma and embarrassment; the ability to make informed choices and exercise freedom of expression in all aspects of reproductive health; the ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation; the ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need; people to participate effectively and at every level in decisions that affect reproductive lives; and, the opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

3.10 Whilst there are many and varied reasons a woman may have an abortion, indicators such as total abortion rate and the proportion of repeat abortions may be used as proxy measures for lack of access to good quality contraception services and advice and of problems with individual use of

contraception. These indicators help identify maternity and contraception needs within the area.

3.11 The use of long acting reversible contraception (LARC) methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years depending on the type of product. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. It is important not to attribute 'worse'/'better' values to this indicator as the intention is to encourage choice rather than to promote LARC methods at the expense of other contraceptive methods.

Teenage Pregnancy

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

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

4. Birmingham Sexual Health data

4.1 Public Health England produces a sexual and reproductive health profile for local authority areas; this data provides useful context for sexual and reproductive health need and services within the City. Full details can be accessed via https://fingertips.phe.org.uk

4.2 Appendix A sets out local summary statistics for sexually transmitted infections; HIV; reproductive health; and, teenage pregnancy.

4.3 Appendix B provides background information on the indicators included in the tables, this provides the rationale for each indicator, how the indicator is defined, how it was calculated and any caveats that need to be observed when scrutinising the data. It also provides context to the Birmingham rates, showing how Birmingham compares to the national and regional averages and against our CIPFA nearest neighbours (similar local authority areas identified for

comparative and benchmarking exercises).

Sexually Transmitted Infections (STIs) (Table 1)

4.4 Table 1 shows that Birmingham is consistently performing well against the England average and against its CIPFA nearest neighbours for Syphilis and Genital warts diagnoses.

4.5 The chlamydia diagnostic rate in Birmingham is consistently higher than the Regional and England average (489 per 100,000 compared to 320 and 384 per 100,000 respectively); however it is similar to the rates observed in our CIPFA neighbours. Whilst Birmingham rates are high, this could represent an under reporting as the Birmingham and Women's laboratory did not submit any data for Q4 in 2018. It is also worth noting that as most chlamydia infections are asymptomatic and coverage of the National Chlamydia Screening Programme (NCSP) varies, the diagnostic rates identified nationally are very likely to underestimate the true prevalence of chlamydia in the population.

4.6 There is limited sexual and reproductive health data available at smaller geographical levels, however Public Health England has produced a map of chlamydia detection rates in the 15-24y population at a middle super output area (MSOA). Appendix C shows this information overlaid with Birmingham's ward boundaries. Chlamydia detection rates are highest in Newtown, Nechells, Stockland Green, Erdington, Glebe Farm and Tile Cross, Kings Norton South and Frankley Great Park; and are lowest in the South East of the City.

4.7 Diagnoses for gonorrhoea in Birmingham are significantly higher than the regional and national averages (149.1 per 100,000 compared to 79.0 and 98.5 per 100,000 respectively) and are higher than the CIPFA neighbours (119.7 per 100,000). The gonorrhoea rate in Birmingham has been increasing since 2013. Unlike chlamydia, people with a gonorrhoea infection are more likely to be symptomatic and may therefore be more likely to seek and access sexual health services.

HIV (Table 2)

4.8 Birmingham's HIV testing coverage is 70.9%; this means that 70.9% of patients accessing at least one specialist sexual health service in a calendar year accepted a HIV test. Birmingham's HIV testing rates are significantly better than the national, regional and CIPFA nearest neighbour averages (whose rates are 64.5%, 64.2% and 62.7% respectively).

4.9 Whilst Birmingham's late diagnosis rates are statistically lower than the England average when viewed over the whole population and in MSM in particular. It is interesting to note that late HIV diagnosis rates in both heterosexual men and women are relatively worse than for MSM. Late HIV diagnosis rates can give us an indication of the populations where HIV infections are being left undiagnosed.

4.10 Prevalence of HIV in those aged 15-59 in Birmingham is 2.84 per 1,000; this is higher than both the regional and national values (1.86/1,000 and 2.37/1,000). Appendix 2 shows the diagnosed HIV prevalence by MSOA for all ages in Birmingham; this indicates that prevalence is highest in the MSOA area that borders Edgbaston, Balsall Health West, Bordesley and Highgate and

Ladywood.

4.11 Birmingham's antiretroviral therapy (ART) rates in people who are newly diagnosed with HIV is significantly better than national, regional and CIPFA neighbour averages (86.5% compared to 79.1%, 82.5% and 79.1% respectively).

Reproductive Health (Table 3)

4.12 The abortion rate in Birmingham (19.3/1,000) is slightly higher than the national average (18.1/1,000) but remains similar to the regional average and CIPFA neighbour averages (19.0/1,000 and 19.3/1,000 respectively). Repeat abortions in the under 25 population are significantly higher in Birmingham (29.1%) than the national (26.8%) and CIPFA neighbour (27.6%) averages but are slightly lower than the regional average (29.5%).

4.13 The proportion of long acting reversible contraception methods (LARC) prescribed in Birmingham (44.4/1,000) is lower than the national average (49.5/1,000). Given the long acting nature of LARC this measure only gives an indication of the number of new prescriptions for LARC made each year – it is therefore likely to be an underestimate of LARC use in the population. LARC use is a choice and therefore it is not appropriate to attribute a better/worse value to this indicator.

4.14 Attendance of females under 25 years old in specialist contraception services remains relatively low in Birmingham. Rates in Birmingham are lower than the national and regional values at 92.4/1,000 compared to 140.4/1,000 and 103.7/1,000 respectively. Reporting data from the last five years shows that this rate has steadily reduced. This suggests that there is scope to increase access of specialist contraception services in this age group.

Teenage pregnancy (Table 4)

4.15 In general conception rates for those under 16 and for those under 18 in Birmingham remain similar to the national and regional averages. Birmingham's under 16s conception rate is 3.0/1,000 compared to 3.1/1,000 in the West Midlands and 2.7/1,000 in England; this rises to 19.4/1,000 conceptions in under 18s in Birmingham, West Midlands (19.9/1,000) and England (17.8/1,000).

4.16 The number of births to women aged under 18 years and the proportion of teenage mothers in Birmingham is higher than the national and regional averages. 1.0% of mothers in Birmingham are aged between 12 and 17 compared to 0.9% in the West Midlands and 0.7% in England; this may be partially explained by the younger age profile of the City.

Appendices
Appendix A: Birmingham Sexual and Reproductive Health Outcomes Framework summary tables
Appendix B: Sexual and Reproductive Health Profile Indicator Definitions
Appendix C: Birmingham Chlamydia and HIV maps

Appendix A: Birmingham Sexual and Reproductive Health Profile summary tables

Key:

Significance compared to England average:

- Significantly worse
- Not significantly different
- Significantly better

Change from previous:

- No significant change
- Increasing / Getting better
- Increasing / Getting worse
- Decreasing / Getting better
- Decreasing / Getting worse

Table 1: Sexually Transmitted Infections (STI), Birmingham, West Midlands and England averages (Reporting Period 2018)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	England Value	Change from previous
Syphilis diagnostic rate per 100,000	All ages	2018	**8.7**	7.2	13.1	→
Gonorrhoea diagnostic rate / 100,000	All ages	2018	**149.1**	79.0	98.5	↑
Chlamydia diagnostic rate / 100,000	All ages	2018	**489**	320	384	→
Genital warts diagnostic rate / 100,000	All ages	2018	**93.4**	82.0	100.1	↓
Genital herpes rate / 100,000	All ages	2018	**56.1**	48.2	59.0	→

Source: Public Health England fingertips

Table 2: HIV testing, diagnoses, treatment and care, Birmingham, West Midlands and England averages (Reporting Period 2016-2018)

Indicator	Population	Reporting Period	Birmingham Value	Region Value	England Value	Change from previous
Testing						
HIV testing coverage, total (%)	All	2018	**70.9**	64.2	64.5	→
Diagnoses						↑
New HIV diagnosis rate / 100,000 aged 15+	Ages 15+	2018	**12.9**	6.8	8.7	↓
Late HIV diagnosis (%)		2016-18	**41.0**	46.0	42.5	N/A
Late HIV diagnosis in MSM (%)		2016-18	**31.6**	37.5	32.5	N/A
Late HIV diagnosis in heterosexual men (%)		2016-18	**57.1**	61.9	59.4	N/A
Late HIV diagnosis in heterosexual women (%)		2016-18	**42.7**	45.6	49.4	N/A
HIV diagnosed prevalence rate / 1,000 aged 15-59		2018	**2.84**	1.86	2.37	→
Treatment and care						
Prompt ART initiation in people newly diagnosed with HIV (%)		2016-18	**86.5**	82.5	79.1	N/A

Source: Public Health England fingertips

Table 3: Reproductive Health, Birmingham, West Midlands and England averages (Reporting Period 2018)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	England Value	Change from previous
Total abortion rate / 1000	15-44y	2018	**19.3**	19.0	18.1	↓
Under 25s repeat abortions (%)	<25y	2018	**29.1**	29.5	26.8	→
Total prescribed LARC excluding injections rate / 1,000		2018	**44.4**	43.2	49.5	→
Under 25s individuals attend specialist contraceptive services rate / 1000 - Females	<25y	2018	**92.4**	103.7	140.4	↓

Source: Public Health England fingertips

Table 4: Teenage pregnancy, Birmingham, West Midlands and England averages (Reporting Period 2016-2018)

Indicator	Age	Reporting Period	Birmingham Value	Region Value	England Value	Change from previous
Under 16s conception rate / 1,000	<16y	2017	**3.0**	3.1	2.7	↓
Under 18s conception rate / 1,000	<18y	2017	**19.4**	19.9	17.8	↓
Under 18s births rate / 1,000	<18y	2016	**7.0**	6.1	5.6	→
Teenage mothers (%)	12-17y	2017/18	**1.0**	0.9	0.7	→

Source: Public Health England fingertips

Public Health England. Public Health Profiles. [accessed 27/01/20] https://fingertips.phe.org.uk © Crown copyright 2020.