Cornwall Council

Sexual Health Needs Assessment 2013-2016

Produced as part of the Joint Strategic Needs Assessment for Cornwall

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Executive Summary

- The population of Cornwall is approximately half a million people and has an older age profile than average in the UK. However, the proportion of young people in the population is growing.

- Cornwall is geographically dispersed, making the provision of timely access to sexual health services a challenge. In addition large numbers of visitors in summer months present a challenge to providing sexual health services to people regardless of their area of residence.

- The population of Cornwall generally experience good sexual health outcomes, with low rates of sexually transmitted infections and good coverage of Chlamydia screening in young people.

- However, there are still certain groups of people, such as those living in deprived communities who consistently experience poorer outcomes and services should continue to seek to identify and work with these groups.

- The Isles of Scilly have the lowest rate of STI’s in England and low rates of teenage conceptions, but due to its remote geographic location, there are still issues around providing access to timely sexual health services when needed.

- In Cornwall, although rates of HIV are low, there is a higher rate of late diagnosis than nationally, giving poorer outcomes and making spread of the infection more likely. This is an important indicator and as such on the PHOF.

- Rates of under 18 conceptions have decreased both locally and nationally over the past 15 years and rates of repeat abortions in this age group are low.

- There is little local data about sexual health knowledge and behaviour such as contraception use, this hinders our ability to fully understand issues in sexual health at a local level.

- There is some indication that some BME ethnic groups have lower rates of STI’s than white British groups. Services should seek to ensure that this is not due to lack of use of services.

- Uptake of the HPV vaccine in 2012/13 was the lowest in the South West at 64%.

- In Cornwall, as in other places, many sexual health promotion programmes are age targeted to specific age groups having higher levels of need, however, for some of these programmes, outcomes remain poor after the age cut off and as such, consideration should be given to extending programmes to reach a wider age group where evidence suggests this is appropriate, for example:
  - Prevention of pregnancy programmes target under 18’s but the highest numbers of abortions are in 20-24 year olds.
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This document

This is a refresh of the sexual health needs assessment, last conducted in 2006. Step 1 of the commissioning cycle is assessment of needs, followed by mapping service provision and conducting gap analysis to assess how services are meeting the needs. This document is only intended to cover the first of these and further work is needed to map service provision and conduct gap analysis/prioritisation.
1. Introduction

Sexual health is a fundamental aspect of individual and social wellbeing. The World Health Organisation (WHO) proposes the following definition of sexual health:

“Sexual health is a state of physical, emotional, mental and social well-being in relation 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.”

Sexual health services therefore should not only treat the poor sexual health outcomes but promote good sexual health to prevent problems occurring. Good sexual health services contribute to reducing inequalities and have economic benefits, both to the NHS and wider society. Economic evaluations of sexual health services show that they have been highly cost effective and many services are actually cost-saving. Estimates suggest that for every £1 spent on contraceptive services, the net gain to the NHS is £11.

1.1. National Context

England still has some of the highest rates of poor sexual and reproductive health in Europe. The National strategy: a framework for Sexual Health Improvement in England (2013) sets out the governments ambitions for good sexual health, including:

- a fall in the number of unwanted pregnancies, especially those that result in terminations;
- more people in high-risk groups being offered and accepting HIV tests;
- to ensure that people have access to free condoms and know how to prevent sexually transmitted infections;
- to continue to make progress in protecting our children from sexual abuse and exploitation;
- to continue to eradicate prejudice based on sexual orientation; and
- To help people to have the confidence and ability to say ‘no’ as well as ‘yes’.

**NICE Guidance**

Ensure that sexual health services, including contraceptive and abortion services, are in place to meet local needs. All services should include arrangements for the notification, testing, treatment and follow-up of partners of people who have a sexually transmitted infection (STI).

Define the role and responsibility of each service in relation to partner notification (including referral pathways).

As a part of this staff must be are trained in the provision of sexual health and commissioners should ensure there is an audit and monitoring framework in place.
The 2013 transfer of public health from NHS run primary care trusts into local authorities has seen a transformation of how sexual health services are commissioned. Local authorities have a mandated responsibility for commissioning comprehensive, open access, accessible and confidential contraception and sexually transmitted infections (STIs) testing & treatment services, for the benefit of all persons, of all ages present in the area. The mandate also includes sexual health promotion and disease prevention.

Sexual health commissioning is now split between the Local Authority, Clinical Commissioning Groups and the NHS Commissioning Board Local area Teams.

**Local Authorities**
- HIV Prevention – including testing in non-clinical settings
- Sexual health promotion
- Open access genitourinary medicine
- Contraception services; e.g. Locally Enhanced Services (LES) commissioned from local primary care providers e.g. LARC, Chlamydia screening, emergency contraception etc. The whole costs of these services; incl. the cost of drugs is borne by the LA.
- Health and Wellbeing board should have strategic overview of sexual health services
- HIV social/emotional support – e.g. voluntary organisations.
- Sexual Health Education (PSHE) including school nurses

**Clinical Commissioning Groups (CCG’s)**
- Community Gynaecology
- Vasectomy and sterilisation
- Abortion services.
- HIV testing in certain clinical settings

**NHS Commissioning Boards (LATs)**
- HIV Treatment and care,
- Health services for prisoners
- Sexual assault referral centres
- Cervical screening
- General Practitioners (Standard contraception services under standard GP contract)
- HIV testing in certain clinical settings
- HIV post exposure prophylaxis

These services are intrinsically related and so maintaining open channels of influence and communication will be essential to design a comprehensive sexual health service that is tailored to the local population. It is possible to commission some of these services jointly (and integrate budgets), and collaborative commissioning may indeed be the best solution to the problem of having preventative and treatment services commissioned by different providers; for example HIV and abortion services. In particular it is recommended that a collaborative approach is taken to HIV testing strategies in an area.
1.1.2. Public Health Outcomes Framework

The public health outcomes framework (PHOF)\textsuperscript{5} sets out indicators against which progress by local authorities is monitored. There are six indicators related to sexual health:

- Domain 1: Improving the wider determinants of health
  - Violent crime (including sexual violence)
  - Young people not in education, employment or training (NEET)
- Domain 2: Health Improvement:
  - Under 18 conceptions
- Domain 3: Health Protection:
  - Chlamydia diagnosis (15-24 year olds)
  - People presenting with HIV at a late stage of infection
  - HPV vaccination coverage (females 12-17 yrs old)

1.2. Local Context

The previous sexual health needs assessment, sexual health strategy and peer review were all conducted when sexual health commissioning arrangements were largely based in the Primary Care Trust (PCT) organisation.

1.2.1. Sexual health strategy

The Sexual Health Strategy for Cornwall was published in 2009 to cover the period 2010-2013 and took into account the recommendations from the needs assessment and peer review. It aims to promote, advance and support the improvement of sexual health and sexual health services in Cornwall and Isles of Scilly by meeting the following objectives via the provision of 3 levels of service:

1. To reduce transmission of HIV and STI’S and to reduce prevalence of undiagnosed HIV and STIs.
2. To ensure appropriate levels of service for all service users and service uptake for high risk and underserved groups.
3. To improve the health and social care for people living with/affected by HIV.
4. To reduce the stigma associated with HIV and STIs, and normalise access to sexual health services.
5. To reduce unintended pregnancy.
6. To improve the sexual health of young people.

The underlying principles of the strategy posit that at all stages services should provide:

- Confidentiality – Services should not only ensure confidentiality, but should make it very clear that they do so. GUM services have particular obligations regarding confidentiality.
- Equitable Access – There is a lack of equitable provision of services across the County. Following consultation of this strategy an implementation plan will be developed to address equity of service provision.
- Choice and Plurality – Patient choice is key to service improvement.
Service User Involvement – Cornwall & IOS aims to ensure that services are designed around the needs of people using them.

Equality and Diversity – The Strategy promotes the right that everyone has to be treated fairly and with dignity and respect.

There are links with other local strategies including the Teenage Pregnancy Strategy and the Health and Wellbeing Strategy.

1.2.2. Previous Sexual Health Needs Assessment 2006

In 2006 a comprehensive sexual health needs assessment with gap analysis was undertaken in the PCT and found that there were some key needs facing the population of Cornwall regarding sexual health.

Some of the key findings included

- Significantly smaller proportion of 20-24 year olds in the population than England
- Pockets of local deprivation that were not necessarily picked up by the index of multiple deprivation.
- Low rates of HIV, (although increasing), some groups disproportionately affected (MSM and Black African people).
- Increasing rates of chlamydia – due to introduction of chlamydia screening programme with considerable variation in rates across the county.
- Very high rates of chlamydia positivity in Isles of Scilly but need for re-examination due to very small numbers.
- Low levels of gonorrhoea with a suggestion of a downward trend.
- Teenage conceptions decreasing but not at the rate needed to achieve the 50% reduction target.
  - Consistently higher levels of teenage conceptions in Restormel.
2. Mapping Need

2.1. Population Summary

The population of Cornwall was 528,300 people at the last census (2011). This is an increase of just over 10,000 people or 2% since 2006, which reflects a slowdown of the greater than average growth in population that occurred in the early part of the century.

The population is 52% female and 48% male, this difference increases with age; 55% of over 65’s and 63% of over 80’s are female.

Figure 1 shows the population structure of Cornwall compared with England. This shows that Cornwall has a lower proportion of children (16% vs. 18%), young people (11% vs. 13%) and working age adults (51% vs. 53%) than England but a higher proportion of people of retirement age (16% vs. 12%) and older adults (6% vs. 4%). The age dependency ratio; the number of people who are considered not economically active (under 16’s and 65+) compared to the number who are economically active (16 to 64 years old), in Cornwall is 60%, significantly higher than the England dependency ratio of 52%, thus indicating more pressure on services.

Figure 1: If the population was 100 people: Cornwall compared to England (2011).
The Isles of Scilly

The population of the IoS is 2,203. Due to the small population, data is often suppressed and so it can be difficult to establish particular needs. Nevertheless, this population has very specific issues relating to access to services due to the islands geographical isolation and this can be particularly pertinent for sexual health services which need to be anonymous and may need to be accessed out of hours or urgently.

2.1.1 Population in Geographical Regions of Cornwall

Figure 2 shows the distribution of different age groups by old district regions in Cornwall. None of the regions have vastly different population structures but some have a higher proportion of particular age groups than others. Restormel and Kerrier have the highest populations and so have the highest absolute number of people in almost all of the population age groups.

Caradon has the highest proportion of older working age adults (45-64), Carrick has the highest proportion (and highest absolute number) of young people (15-24) and the lowest proportions of 45 to 79 year olds. Kerrier has the highest proportion of children (0-4) and the lowest proportion of over 80’s, North Cornwall has an average age distribution, Penwith has an older age structure, with a low proportion of people under 45 and a high proportion of people over 65 and Restormel has a high proportion of people aged 25 to 44.

Figure 2: The population by broad age groups of old district regions in Cornwall (2011)
2.1.2. Non Resident Population

The national sexual health strategy mandates that Sexual health services must be provided to anyone who needs them, regardless of their normal area of residence (although costs can be claimed back from the resident local authority if a valid postcode is given). Due to Cornwall’s location in the UK, surrounded on three sides by the sea and only bordered on one side by another local authority (Devon), this is less of an issue than some other areas; however, seasonal tourism has a large impact on the population of Cornwall.

In 2011, there were almost 4.5 million day visits to Cornwall and 22.5 million overnight stays. Peak months are June, July and August which see 2.1 million daytrips and 12.5 million overnight stays.¹⁹

North Cornwall and Restromel regions see almost 50% of these visitors between them but all district regions of Cornwall see a considerable influx of visitors in the summer months.

Sexual health services must therefore be able to cope with massive potential increases in demand in summer months; whether or not this spike in demand occurs, warrants further investigation.
2.1.3 Population Change (2006-2011)

Figure 3 shows how the age structure of the population of Cornwall has changed over the past 5 years. The solid blocks represent the population at the last census (2011) and the lines represent the population in 2006 (the numbers used in the last sexual health needs assessment).

Figure 3: The population of Cornwall in 2006 and 2011 by gender and 5 year age bands.

Figure 4 shows the percentage change between 2006 and 2011, for many groups the percentage change simply reflects the same cohort of people growing 5 years older. Some key changes include:

- The number of 0-4 year olds has increased by 11% (2,800) suggesting an increase in the birth rate.
- The proportion of the population aged 15-29 has increased since 2006. In particular, the number of 20-24 year olds has increased by 14% (1,500 people).
- The number of 35-39 year olds has decreased by 13% (4,500 people).
- The number of 60-69 year olds has increased by 17% (11,700 people) but this is likely to represent the aging of the baby boomer generation.
- Similarly to the rest of England, the numbers of people aged 85+ are also increasing.
Figure 4: Percentage change of population by age group between 2006 and 2011
3. Groups with Specific Sexual Health Needs

Some groups are known to be at higher risk of adverse sexual health outcomes or have different sexual health needs than others. The information box below lists some of these groups, although the list is not exhaustive and some people will fall into more than one of these groups. Data is not always available on these groups at a local level and sometimes inferences must be made from national or international rates.

- **Young People (esp. males)**
  - Not in Education Employment or Training (NEET)
  - Looked after children and care leavers
  - Teenage Parents
  - Young Offenders
- **Different BME groups (including Gypsies and Travellers)**
- **Deprived estates and neighbourhoods**
- **Lesbian Gay and Bisexual people (incl. men who have sex with men)**
- **Transgender people**
- **Prison Population (There are no prisons in Cornwall)**
- **Asylum seekers**
- **Homeless People**
- **Sex workers**
- **People with disabilities including learning disabilities**
- **People with drug and alcohol problems**
- **People with mental health problems**
- **People who are HIV positive**
- **Adults who are separated or divorced**

3.1. Young People

For the purpose of this report, young people have been grouped as 15-24 but there will also be some sexual health needs in younger ages. Young people have specific needs in relation to sexual health as it is the age when the majority of people will begin sexual relationships for the first time and so access to information and sexual health services are key for this age group. This is reflected in the high rates of sexually transmitted infections found in this age group and the target to reduce teenage conceptions in this population. In addition, young people may be reluctant to use services that they do not feel meet their needs and so services must be confidential and reflect the unique needs of young people. Transport is often an issue for young people as they may not have access to a car and opening hours need to allow young people to access services outside of school and college hours.

As shown in figure 1, Cornwall has a lower proportion of young people (15-24 years old) in the population than England, nevertheless, the population of young people and in particular the 20-24 age group has risen by almost 15% (see figure 4) since the last SHNA was conducted; from approximately 55,600 in 2006 to 60,200 in 2011. This increase of
approximately 5,000 young people is likely to be largely linked to the expansion of the Combined Universities of Cornwall, encouraging more young people to remain in the area for further and higher education. According to the 2011 census there are 26,900 full time students in Cornwall.  

This is reflected in the distribution of young people geographically, with the highest proportion of young people living in the Carrick area. However, sexual health services should not be limited to areas where there are high concentrations of young people, due to the geography of the region, many young people live in remote areas where access to services is difficult and the location of services should maximise access for all young people.

The Combined Universities in Cornwall is a collaboration of 5 universities and colleges to increase the further and higher education opportunities in Cornwall, enabling young people to continue learning without having to relocate outside of the county.

Young People Not in Education Employment or Training (NEET)
Young people who are not in education, employment or training (NEET) experience consistently worse sexual health outcomes than those who are in education employment or training (EET). For example, 15% of 16-18 year old NEETs are teenage mothers compared to 2% of 15-18 year olds in the general population. These outcomes can then contribute to maintaining their NEET status in the longer term.

There are approximately 910 (5.1%) 16-18 year old young people known not to be in education employment and training in Cornwall (NEET), these numbers have remained relatively consistent over the past three years and are consistently lower than rates in the South West (5.5%) and England (5.7%). This is particularly apparent if rates of young people with unknown NEET status are taken into account. There are a further 251 young people whose NEET status is unknown in Cornwall, taking the total potential rate of NEET to 6.5%, significantly lower than rates in England (16.6%) and the South West (15.5%). A low number of young people with unknown status suggests that most NEETs in Cornwall will be in contact with services.

Looked after children and care leavers
Sexual health outcomes are often worse for children in care or care leavers, and in particular these children are at significantly higher risk of becoming teenage parents.

In 2012 there were 480 children looked after by the local authority in Cornwall, a rate of 4.7 per 10,000 under 18 year olds. This is lower than the England rate (59 per 10,000) and the South West rate (51 per 10,000). (There are no looked after children in the isles of Scilly.) Rates of children in care have been increasing since 2008, in Cornwall, England and the South West.
3.2. Deprived Communities

Girls and young women from social class V are at approximately ten times the risk of becoming teenage parents as girls and young women from social class I. Young people with below average achievement levels at ages 7 and 16 have also been found to be at significantly higher risk of becoming teenage parents.\textsuperscript{16}

In the 2010 Indices of Deprivation, 33 (10%) of Cornwall’s LSOA’s fall into the most deprived 20% of England. In 2007 (the previous indices of deprivation) 36 LSOA’s were in the most deprived 20%, suggesting a slight reduction in deprivation, although this should be interpreted with caution, as the index is relative so it could also reflect deprivation increasing in other parts of the country.

![Deprivation category
Most deprived
2nd most deprived
3rd most deprived
4th most deprived
Least deprived](image)

Figure 5 shows the geographical distribution of deprivation in Cornwall

3.3 Lesbian, Gay and Bisexual People

It is difficult to estimate how many people in the population are LGB as it depends partially on the definition used and whether this is based on self-assignment to a category or based on sexual behaviour. These are often different, for example, a man may classify himself as heterosexual, and have long term partner who is a woman but may choose to occasionally (or regularly) have sex with men, alternatively, a man may classify himself as homosexual but not have sex with men at all; therefore, estimates of sexuality in the population tend to vary widely.

Research suggests that approximately 5-7% of the adult population in the UK are lesbian gay or bisexual. In Cornwall this would equate to approximately 26,000 adults. \textsuperscript{17} However, it is known that the proportion of the population of LGB people tends to be higher in cities and lower in rural areas. Public Health England uses 2.8% of the adult male population in
Cornwall as being MSM (Men who have sex with men) in the sexual health quarterly outcomes indicator report, which would give a significantly lower figure for males than the 5-7% above. This would have implications for local service provision in general and in particular for sexual health provision where some of the needs of LGB people are likely to be different to the needs of heterosexual people.

Lesbian, Gay and Bisexual people have specific needs relating to sexual health and some needs that are often overlooked. For example, the idea that lesbian women are not at risk of unwanted pregnancy or STI’s is a misconception as small scale studies in the UK have found that 61% of young lesbian and bisexual women had their first sexual experience with men. Indeed, several large-scale youth health risk surveys in the US have found that LGB youth were at least twice as likely as their peers to have conceived; suggesting that lesbian women need access to and advice on contraception at least as much as their heterosexual counterparts.

Research shows that men who have sex with men (MSM) are significantly more likely to have an STI than their heterosexual counterparts; including chlamydia, gonorrhoea, syphilis, Hepatitis B and HIV.

In addition, research suggests that gay men and lesbians are less likely to have routine screening tests than heterosexuals. This could be partially due to receiving mixed messages from the health community as 37% of lesbian and bisexual women had been told by a health professional that lesbian and bisexual women did not require a cervical screening test and 20% of health care professionals have admitted to being homophobic.

Transgender
Using a rate of approximately 20 per 100,000 adults, we can estimate that there are approximately 100 transgender adults living in Cornwall. Transgender adults will have unique sexual health needs and sexual health staff may need specific training relating to these needs.

3.4 Ethnicity
People from Minority Ethnic Groups are often found to have poorer health than the general population, although evidence suggests that the main underlying cause of this is the association between ethnicity and lower socioeconomic group (and so higher levels of deprivation). The 2006 SHNA found that this association between ethnicity and deprivation wasn’t apparent in Cornwall and more up to date data is yet to be available from the latest census to confirm whether this is still the case. Nevertheless, even if ethnicity is not necessarily associated with deprivation in Cornwall, people from different ethnic backgrounds may still have unique needs related to sexual health, and factors such as language difficulties or different cultural and religious beliefs may impact on use services.

Figure 6 illustrates the comparatively small proportion of Cornwall residents that are BME (5%). In England this figure is 20%.
Figure 6: Proportion of different ethnic groups in Cornwall, 2011

The proportion of the population that are BME in Cornwall has dropped slightly since 2006 which is contrary to the trend in England. In particular, numbers of Asian/Asian British, Black/Black British, other ethnic groups and white Irish have decreased, whilst people from some mixed race groups have increased in number (see figure 7). Nevertheless, the small percentage of BME people in Cornwall still accounts for almost 23,000 people living in Cornwall with a BME ethnicity.

Figure 7: Percentage change of different ethnic groups in population (2006-2011)

**Gypsy and Irish Travellers**
Research highlights gypsies and travellers as experiencing particularly poor health outcomes in general and related to sexual health, over and above the level normally experienced by
deprived populations. In addition, Gypsy and Traveller children often have poor attendance at school, indeed, at key stage 3, it is estimated that only 15-20% of children still attend school\textsuperscript{26}. These children might miss out on sex education and signposting delivered in a school setting.

The census identifies 635 Gypsy or Traveller individuals living in Cornwall but Cornwall Council estimates there are nearer to 1,000 on 76 registered pitches in Liskeard, Pool and St. Day. In addition there are a number of small, privately owned sites, temporary sites, and unauthorised sites and it is estimated that half to two thirds live in conventional housing.\textsuperscript{27}

Gypsies and Travellers are known to use health services less than other groups\textsuperscript{28} and this is likely to apply to sexual health services at least as much as other services. One of the factors affecting use of service may include discrimination from health personnel.

Interviews with Gypsy and Travellers in Kent\textsuperscript{29} found that most girls were not allowed to attend sex education classes at school. The people interviewed had little knowledge about STI’s and believed that sex education should be taught within the family but that the family didn’t have enough knowledge to teach it. There was a reluctance to attend sexual health services as they were seen as for ‘dirty’ people.

\textbf{3.5 Disabilities}\textsuperscript{30}

There are estimated to be 73,000 people in Cornwall with a disability, this is 23% of the working age population. The type and level of disability will vary considerably within this population and will affect their sexual health needs differently.

\textbf{Learning disabilities}

There are 15,000-20,000 people in Cornwall with mild to moderate learning disabilities and a further 4,000 with severe learning disabilities. This is a large but not a homogenous group and their needs regarding sexual health will vary considerably.

\textbf{3.6 Other vulnerable groups}

Estimates suggest that there are approximately 65 rough sleepers at any one time in Cornwall. This is the second highest number of all local authorities in England.\textsuperscript{31}

There are 191 households for asylum seekers in Plymouth, serving Devon and Cornwall.\textsuperscript{32}
4. Expressed Sexual Health Needs

4.1. Sexually Transmitted Infections

There is no data available on prevalence of sexually transmitted infections in the population and so prevalence is implied from diagnosis. However, this is heavily influenced by numbers and types of people taking sexual health screening tests and thus is not a true representation of prevalence in the population but is all that is available to inform decision making.

3570 acute STI’s were diagnosed in residents of Cornwall in 2012, a rate of 669 per 100,000 residents, making Cornwall 132\textsuperscript{nd} out of 326 local authorities (lower rank = higher rate). In the IoS this rate was 90 per 100,000; giving a rank of 326; the lowest in the country\textsuperscript{33}.

Nevertheless, within Cornwall, rates vary considerably, from 0 per 100,000 to over 3,000 per 100,000. This will partially be due to different population characteristics in each area, such as more young people but it will also partially be due to deprivation. Rates of acute STI’s in the most deprived areas of Cornwall and are higher than in less deprived areas.

A note about the data: Postcodes

Sexual health services do not require users to give their full names or addresses and some people may be inclined to omit this information due to concerns about anonymity. This can be problematic for analysis of Sexual Health data as there is not always a valid postcode to allocate a person to a local authority. In absence of a personal postcode, the GP postcode of the person using the service will be used, in absence of this, the testing centre postcode will be used and in absence of this, the laboratory postcode will be used. Inevitably this means that the data used here will never be a complete record of everyone using sexual health services in Cornwall.

Figure 8: STI rates per LSOA in Cornwall.
4.1.1 Chlamydia

Chlamydia is the most commonly diagnosed STI in the UK and is easily passed on during sex. Most people don’t experience any symptoms so are unaware they are infected, therefore a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. Public Health England (PHE) recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Rate of chlamydia diagnosis in 15-24 year olds is a PHOF indicator.

In 2012, 27% of the population of young people were tested for Chlamydia in Cornwall in 2012 and 26% of young people in the Isles of Scilly. There were 2194 diagnosis of Chlamydia per 100,000 15-24 year olds from Cornwall. This is 78th highest out of 326 local authorities in England. Nonetheless, this figure still falls slightly short of the 2,300 target set by PHE. In the Isles of Scilly, the positivity rate was 1198 per 100,000 15-24 year olds; 245th highest out of 326 local authorities. This is significantly lower than positivity rates in the IoS in the previous needs assessment, although this difference is more likely to be due to the increasing numbers of tests rather than a genuine drop in prevalence.

Trend data for chlamydia rates in 16 to 24 year olds over time are not available due to changes in reporting.

The rate of Chlamydia in people of all ages across Cornwall is 346 per 100,000; 104th highest of 346 local authorities in England. This rate has risen from 264 per 100,000 in 2011, an increase of 31%.

**Diagnosis of Chlamydia in different population groups**

In Cornwall, diagnosis of Chlamydia are most common in 20-24 year olds, and then 16-19 year olds. Between them, these two groups account for 67% of chlamydia diagnosis in Cornwall. This is similar to national percentages and reflects the core age group targeted by the national chlamydia screening programme. Nevertheless, a significant proportion (23%) of diagnosis are still found in the 25 to 34 age group although the rate of positivity in this group is lower; 665 per 100,000.

The majority of the population of Cornwall are White British but this group has been excluded from figure 10 to show differences between BME ethnic groups more clearly. The Cornwall population ethnicity proportions have been added to the graph to provide context but these represent all age groups in Cornwall and it is likely that the proportion of BME ethnicities in Cornwall will be higher in younger age groups; who are also more likely to experience higher rates of chlamydia (see figure 9).
Rates of chlamydia diagnosis by ethnicity are broadly in line with the Cornwall ethnicity profile, although there are lower numbers of females of a non-white-ethnicity and in particular, of Black ethnicities, testing positive than the population profile would suggest. This could be related to different cultural factors, influencing either sexual behaviour; and thus likelihood of contracting an STI or likelihood of completing a screening test; suggesting possible stigma associated with sexual health screening in some ethnic groups.

Approximately 60% of chlamydia is diagnosed in females. The majority of Chlamydia diagnosis are to heterosexual people in Cornwall, particularly for females. A representative minority of chlamydia diagnosis in males are to homosexual men.

**Pelvic Inflammatory Disease (PID)**
One of the common side effects of Chlamydia is PID, approximately 15% of cases of chlamydia in females will go on to develop PID and approximately 10% of these will be left infertile. In the UK, the bacteria that cause chlamydia (Chlamydia trachomatis) are responsible for 50-65% of cases of PID. The bacteria that cause gonorrhoea (Neisseria gonorrhoea) are responsible for about 14%.36

There were 275 hospital admissions where PID was a factor in 2010/11 in 15-44 year old women from Cornwall and IoS. This is a rate of 310 per 100,000 and is significantly higher than the national rate of 250 per 100,000. It is also significantly higher than the previous year’s rate of 247 per 100,00037.
4.1.2 Gonorrhoea

Gonorrhoea is a bacterial STI easily passed on during sex; the infection is easily treated with antibiotics, but can lead to serious long-term health problems if left untreated, including PID and infertility.\(^{38}\)

In 2012, there were 59 diagnosis of Gonorrhoea in Cornwall, a rate of 11.05 per 100,000 15+ population. This is significantly lower than rates in England, where the 2012 prevalence was 48.1 per 100,000 population\(^{39}\). It is likely that this lower rate may be caused by a lower proportion of MSM in the population.

Nationally, diagnosed rates of gonorrhoea in males have increased significantly since 2008, a threefold rise from 20 per 100,000 to almost 70 per 100,000*. Rates in males from Cornwall have increased over the same time period but much less steeply. It is important to remember that increases in rates of STI’s may not represent a rise in population prevalence of the disease but can be caused by increased testing and identification.

Diagnosis of Gonorrhoea in different population groups

The most common age for gonorrhoea diagnosis in Cornwall is 20-34 years old. This is similar for both males and females.

The majority of the population of Cornwall is White British but this group has been excluded from figure 14 to show differences between BME ethnic groups more clearly. The Cornwall
population ethnicity proportions have been added to the graph to provide context but these represent all age groups in Cornwall and it is likely that the proportion of BME ethnicities in Cornwall will be higher in younger age groups; who will also be more likely to experience higher rates of STI’s.

There are a higher proportion of ‘other ethnic groups’ with diagnosis of gonorrhoea than the proportion in Cornwall, there are also a higher proportion of males from a ‘white other’ background. There were no positive diagnoses of gonorrhoea in people from Asian or Black backgrounds in Cornwall.

Approximately 70% of cases of gonorrhoea are diagnosed in men and 30% in women. The sexuality of people with diagnosed gonorrhoea varies by gender, approximately 45% of males with gonorrhoea are homosexual but 90% of females with gonorrhoea are heterosexual.

Figure 14: Diagnosis of Gonorrhoea in Cornwall by Ethnicity 2008-2013 (Cornwall population ethnicity added for comparison).

Figure 15: Gonorrhoea cases by gender and sexual orientation in Cornwall (2008-2012).
4.1.3 Syphilis

Syphilis is a sexually transmitted infection that may also be transmitted from mother to foetus during pregnancy or at birth, resulting in congenital syphilis. It is more common in men than women, particularly men who have sex with men. If diagnosed early, syphilis can be treated with antibiotics, however, if it is not treated, syphilis can progress to a more dangerous form of the disease and cause serious conditions such as stroke, paralysis, blindness or death.

It is estimated that people with syphilis are three to five times more likely to catch HIV. This is because the genital sores caused by syphilis can bleed easily, making it easier for the HIV virus to enter the blood during sexual activity. Infection with both HIV and syphilis can be serious because syphilis can progress much more rapidly than normal.40

There were 7 diagnosed cases of syphilis amongst residents of Cornwall in 2012, a rate of 1.3 cases per 100,000 (solid purple line in figure 16). This is significantly lower than the national rate of 5.4 cases per 100,000 (dashed purple line in figure 16). Nationally, males (dashed green line) have significantly higher rates than females (dashed yellow line) and rates in males are having almost doubled between 2008 and 2012. However, whilst rates of syphilis in males in Cornwall are also higher than rates in females, rates have decreased significantly since 2008 when rates were 4.7 per 100,000 to 1.5 per 100,000 in 2012.

Figure 16: Rates of Syphilis diagnosis in Cornwall and England by Gender (2008-12)

Diagnosis of Syphilis in different population groups

Figure 17 shows the proportion of different age groups diagnosed with syphilis in Cornwall. The age profile of syphilis is older than some other STI’s, with the most common age for diagnosis being between 25 with 64 and no diagnosis to people under 20 years old.
The majority of the population of Cornwall is White British but this group has been excluded from figure 18 to show differences between BME ethnic groups more clearly. The Cornwall population ethnicity proportions have been added to the graph to provide context, these represent all age groups in Cornwall but it is likely that the proportion of BME ethnicities in Cornwall will be higher in younger age groups; who will also be more likely to experience higher rates of STI’s.

Figure 18 shows clear differences between the proportion of the population testing positive for syphilis by ethnic group, with the proportion of positive tests to ‘white other’ ethnicities far exceeding the proportion of ‘other white’ ethnicities in the population for both males and females. There were no diagnosis of syphilis in people from Asian, Black or Mixed backgrounds in Cornwall; this could just be due to small numbers of people from these ethnic groups combined with low numbers of syphilis diagnosis.

Figure 19: Syphilis cases by gender and sexual orientation in Cornwall (2008-2012).

Almost 80% of syphilis is diagnosed in males. Males and Females have very different profiles of syphilis diagnosis in terms of sexual orientation. Approximately 75% of males with syphilis were homosexual or bisexual, whereas over 80% of females with syphilis were heterosexual.
4.1.4 Anogenital Herpes

Genital herpes is a common infection caused by the herpes simplex virus (HSV), which is the same virus that causes cold sores.

There were 257 cases of Genital Herpes diagnosed in Cornwall in 2012, a rate of 48 per 100,000 population, slightly lower than the national rate of 58 per 100,000. Rates of anogenital herpes have been increasing in England since 2008 but rates in Cornwall have remained relatively flat in this time period and are now lower than national rates.

![Graph](image)

*Figure 20: Rates of Herpes diagnosis in Cornwall and England by Gender (2008-12)*

Most diagnosis of Herpes in Cornwall occur in the 20-34 age groups (see figure 21) Rates of Herpes are higher in women (65% of diagnosis) than men and rates for both genders in Cornwall have risen slightly since 2008 (See figure 20) but at a lower rate of increase than nationally. Most people being diagnosed with Herpes in Cornwall are heterosexual. There is a lower percentage of men of BME ethnicities being diagnosed with Herpes in Cornwall than would be representative of the BME population in general (see figure 22).

![Pie chart](image)

*Figure 21: Age distribution of anogenital herpes cases in Cornwall (2008-2012)*
4.1.5 Anogenital Warts and Human Papillovirus (HPV)

Anogenital warts are caused by the HPV virus, which also causes cervical cancer, and are spread by skin to skin contact.

There are approximately 130 cases of genital warts per 100,000 15+ population in Cornwall, similar to the national rates. Rates of genital warts in Cornwall are slightly higher for males than females and have remained approximately level since 2008.
Diagnosis of Warts are most common in the 20-24 age group in Cornwall (see figure 24), which is similar to the national age distribution. Diagnosis of warts are approximately equal between the sexes.

There are lower numbers of females from BME ethnicities testing positive for anogenital warts in Cornwall than the population ethnicity would suggest (see figure 25). This suggests either lower rates in these populations or lower rates of testing.

**Figure 24: Age distribution of anogenital warts cases in Cornwall (2008-2012)**

**Figure 25: Diagnosis of Warts in Cornwall by BME Ethnicity 2008-2013 (Cornwall population ethnicity added for comparison).**
4.2 HIV (Human Immunodeficiency Virus)

HIV is associated with considerable morbidity and mortality and requires significant long-term care and treatment. Drug therapies have reduced the incidence of AIDS and HIV-related deaths but it remains a life-threatening infection.

Some groups in society are affected disproportionately by HIV, including MSM and some ethnic minority groups. 63% of HIV diagnoses where the infection was probably acquired in the UK are among MSM. Black African groups also experience higher than average HIV infection. The prevalence is thought to be 3.7% compared to 0.09% among white groups. In 2007, 40% of all new HIV diagnoses were in black Africans. Most had been infected heterosexually while in Africa.

In 2012 there were 19 new diagnosis of HIV in adult residents of Cornwall. There are 191 adult residents in Cornwall receiving on-going treatment for HIV (2011), a rate of 0.6 per 100,000, significantly lower than the England rate of 2 per 100,000, nevertheless, this represents a 50% increase from the number of residents receiving treatment for HIV in 2007. There were no residents of the IoS with recorded HIV.

Men in Cornwall are three times more likely to be diagnosed with HIV than women, and in particular men who have sex with men. 58% of HIV infections were through men having sex with men, and 35% through heterosexual sex and the remainder through injecting drug use or unknown routes.

In men the most common age for a new diagnosis was in 35 to 64 year olds. 93% of HIV infections in Cornwall were in White people, and 3% were in black Africans.

In Cornwall, 63% of people with HIV were diagnosed at a late stage of infection (when treatment is less effective and the virus is more likely to have been transmitted to others). This is worse than the national average of 50%. In particular, heterosexuals with HIV are more likely to be diagnosed late (79%) than MSM (55%).

In Cornwall, 74% of people attending GUM clinics were offered a HIV test which is slightly lower than the regional average of 79% in the same time period, although 66% of people attending GUM clinics in Cornwall had a HIV test which is higher than the regional average of 62%.
4.3. Teenage Conceptions

4.3.1. Under 18 Conceptions

Reasons for teenage pregnancy are diverse and complex but risk factors include lack of knowledge about sex and relationships, lack of access to information and services, low aspirations and educational attainment, peer, parental and cultural influences and poor emotional wellbeing. Teenage parenthood is associated with limited education and career prospects and increased poverty and disadvantage. In addition, children born to teenage parents are more likely to go on to become teenage parents themselves\(^{43}\).

In 2011 there were 279 conceptions to girls aged 15-17 years old in Cornwall and the Isles of Scilly. This is a rate of 30.3 per 1,000 young women. This is higher than the regional rate of 27.3 and similar to the national rate of 30.9 per 1,000.

Rates of Teenage (15-17 years old) conceptions have been falling in Cornwall since 1998, in line with the falls in England and the South West, although in recent years the rate of decrease seemed to be levelling off in Cornwall. However, early data from 2012 suggest that rates are likely to drop back in line with national and regional trends.

Figure 26: Rates of Teenage conceptions in Cornwall, the South West and England (1998-2012 (Q1-3))
Figure 27 shows the rates of teenage conceptions in the old district regions of Cornwall. Whilst Restormel is highest at 38.7 per 1000 and Caradon is lowest at 29.3 per 1000 15-17 year old females, the small numbers mean that the confidence intervals are large and as such overlap both with each other and the Cornwall & IoS rate. This means that there is no more variation than would expected naturally. Even if figures are aggregated to give three year averages, the differences are still not greater than would be expected by chance variation.

Nevertheless, long term trend data does show some consistent differences between the old district regions (see figure 28). Rates in Kerrier and Restormel are consistently higher than rates in other districts, which concurs with the findings of the previous needs assessment.
None of the areas however, have seen consistent and significant increases or decreases in rates, the rank of each district within Cornwall and IoS has remained relatively consistent.

4.3.2. Under 16 Conceptions

There were 160 conceptions to girls aged between 13 and 15 in Cornwall between 2008 and 2010, a rate of 5.8 per 1,000; lower than the English rate of 7.4 per 1,000.

Within Cornwall, rates are generally quite uniform, Penwith and the IoS had higher rates but not outside the variation that would naturally be expected due to small numbers.

4.3.3 Abortions

N.B. Abortion services are now commissioned by Kernow CCG although services to prevent pregnancy are commissioned by the council.

By the time they are 45, 1 in 3 women in the UK will have had an abortion. Whilst a small minority of abortions will be carried out due to problems with the pregnancy, most will be due to the pregnancy being unintended and thus are an indicator of contraception failure; whether this is failure to access contraception, failure to use contraception correctly, or the failure of the contraception itself.

In 2012 there were 1161 abortions performed on women registered with GP practices in Cornwall, a rate of 13.3 per 1,000 women, lower than the national rate of 16.6 per 1,000 women. 166 of these abortions were to women under the age of 19. 44% of abortions in Cornwall were medical and 56% were surgical.
Age profile
The highest proportion of abortions nationally are to 20-24 year olds, but the highest rate of abortions as a percentage of all conceptions are in the youngest age groups where over 60% of pregnancies are terminated, the lowest rates arse in 30-34 year olds, but still over 10% of pregnancies are terminated in this age group (see figure 30).

![Figure 30: Number and rate of abortions in UK 2010](image)

Repeat abortions
Repeat abortions are of a particular concern as they may indicate fundamental problems with using or accessing contraception for an individual.

In Cornwall in 2012, 28% of abortions were to women who had already had a previous abortion (known as a repeat abortion); this is significantly lower than the 37% of abortions which are repeat abortions in England. In Cornwall, 19% of abortions were repeat abortions in under 25’s and 36% were repeat abortions in women over 25.46

Only 6% of abortions performed on under 19’s in Cornwall were repeat abortions, this is significantly lower than regional (9%) and national (10.5%) rates and is in the lowest quintile of rates nationally47.
5. Sexual Health Behaviours

5.1. Contraception Use
There is no local data regarding contraception use in young people although a survey has been commissioned, the results of which should be available in early 2014. A national survey found that amongst 16-19 year olds, only 57% used any type of contraception when they had sex*. In slightly older age groups rates were higher, 20-24 year olds used contraception 78% of the time. Of those using contraception, 65% of 19-19 year olds and 50% of 20-24 year olds were using condoms. It would be useful to have this information for Cornwall and IoS specifically, however, in its absence we have to conclude that rates would be similar to the national rates and acknowledge that there is still work to be done in both informing young people about their contraceptive choices and in making sure there is good provision of these services by young people when they are needed.

*LARC (Long Acting Reversible Contraception)

LARC are recommended by NICE as they provide safe, reliable contraception, which does not rely on user concordance and is more cost effective than oral contraceptive pills. LARC is offered at 85% of GP practices in Cornwall. 7.6% of the 15-44 female population in Cornwall and IoS use one of the methods of LARC, compared to 6.9% in the south west and 5.2% in England. LARC use has been particularly targeted towards young people; however, national research suggests that only 9% of 16-19 year olds are using a LARC method of contraception, whilst 18% of 25-29 year olds are. Please see the recent report for further details of LARC provision in Cornwall.

5.2. Sexual Violence
The community safety partnership strategic assessment reports that there were 539 recorded incidences of sexual offences and 7,440 incidents of domestic abuse in Cornwall in 2012/13. Both of these had remained stable compared to 2011/12 but reported incidence of domestic abuse and sexual violence is higher in Cornwall than the average for similar areas elsewhere in the country. Reported crime represents around a third of actual prevalence of domestic abuse and sexual violence, suggesting that in reality there will be approximately 1500 sexual offence and 22,500 incidents of domestic abuse in Cornwall per annum.

For more information about sexual or domestic violence please see the Strategic Assessment

5.3. HPV Vaccine uptake
The HPV (Human Papillomavirus Vaccine) is offered to all 12-13 year old girls as part of the routine vaccination schedule. Human Papillomavirus is known to cause almost all cases of cervical cancer and also to cause genital warts. The vaccine protects against types 16 and 18 which are responsible for over 70% of cases of cervical cancer.

In Cornwall, uptake of all 3 doses of HPV vaccine in 2012/13 was the lowest in the South West at 64%. This is comparable to a rate of 82% in the South West and 86% in England. It is likely that this is due to differences in the delivery method in Cornwall where the vaccine was delivered in GP Practices rather than schools as it was delivered in most other areas.
6. Summary and Next Steps

Whilst the population of Cornwall has an older than average age profile and is aging in line with national changes, the population of young people (15-24 year olds) in the population is has also grown between 2006 and 2012 which has implications for sexual health services, of which this age group are heavy users.

Sexual health in Cornwall is generally good with lower than average rates of sexually transmitted infections, particularly infections that are more common in men who have sex with men such as syphilis. Uptake of Chlamydia screening is good with diagnosis rates hitting recommended levels, although rates of hospital admission for Pelvic Inflammatory disease (of which sexually transmitted infectious are a key risk factor) are higher than national rates and rising. (STI’s are not the only risk factor for PID).

Rates of HIV are significantly lower than national rates although there is a high rate of late diagnosis in Cornwall compared to other areas. This is an important indicator as health outcomes are worse when HIV is diagnosed and treated later and contagion is more likely and as such is on the public health outcome framework.

Teenage conceptions in Cornwall and IoS have been decreasing since 1998 although, in recent years, the rate of decrease has been less than other areas in England but early data from 2012 show rates falling back in line with trends elsewhere. Rates of repeat abortions in under 19’s are significantly lower than regional and national rates, potentially suggesting good practice in post abortion counselling.

Some groups are known to be more at risk of adverse sexual health outcomes than others, however, data is often not available about these groups at a local level, so it is sometimes difficult to monitor whether services are reaching the right people. In addition, the data collected is often on outcomes and does not address the knowledge and behaviours that lead to these outcomes. This is important as many factors affect sexual health and so a better understanding of why poor outcomes occur is crucial. The SHEU (School Health Education Unit) survey is currently being conducted in Cornwall schools and so this should provide some good insight into knowledge and behaviours of school age children for the next needs assessment.

In addition, research suggests that there is a strong association between poor sexual health outcomes and drug and alcohol use, however, these subjects tend to be examined in isolation from each other. Thus there is a need to integrate findings about drug and alcohol misuse and sexual health in Cornwall to better understand the interactions between the two.

In terms of this needs assessment, the next step is to conduct a thorough review of sexual health service provision and to conduct gap analysis in order to attain where services are meeting needs and where they are not.
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