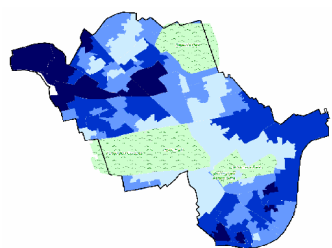


# Sexual Health Needs Assessment July 2010

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Westminster City Partnership

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*This document contributes to Westminster's JSNA*

## **Acknowledgements**

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# 1: Introduction

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Sexual health is often focused on sexually transmitted infections (STIs) and HIV as well as around conception, contraception and abortion. However, sexual health is much more than these issues; sexual health is the ability to enjoy sexual activity without causing personal harm or harm to others (Mayor of London, 2006). The World Health Organisation describes sexual health as:

‘the state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction and infirmity. Sexual health requires a positive, 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.’

The consequences of poor sexual health can be serious. Many sexual infections have long-term impacts on health such as:

- Pelvic inflammatory disease (which can cause ectopic pregnancies and infertility);
- Cervical and other genital cancers;
- Hepatitis, chronic liver disease and liver cancer;
- Recurrent genital herpes;
- Bacterial vaginosis and premature delivery;
- Psychological consequences of sexual coercion and abuse;
- Poor educational, social and economic opportunities for teenage mothers.

Furthermore, sexual health contributes to health inequalities – there is a clear link between social deprivation and poor sexual health. Women, gay men, young persons and persons from Black and Minority Ethnic (BME) groups are disproportionately affected by poor sexual health.

The financial impact of poor sexual health is also far reaching. The prevention of unplanned pregnancy by NHS contraception services is thought to save the NHS over £2.5 billion a year whilst the average lifetime treatment costs for an HIV positive individual is between £135,000 and £181,000. The monetary value of preventing a

single onward transmission is estimated to be between £1/2 and £1 million in terms of individuals health benefits and treatment costs (Department of Health, 2001).

The importance of sexual health and HIV was reflected in the 2001, National Strategy for Sexual Health and HIV. A number of key aims were set out, including:

- To reduce transmission of HIV and STIs;
- To reduce the prevalence of undiagnosed HIV and STIs;
- To reduce unintended pregnancy rates;
- To improve health and social care for people living with HIV;
- Reduce the stigma associated with HIV and STIs.

This needs assessment supports Westminster's Local Sexual Health and HIV Strategy and specifically aims to:

- Describe the picture of sexual health in Westminster, examining trends in STIs and HIV as well as teenage conception and abortion;
- Describe current service provision with regards to prevention, testing and management of sexual and reproductive health in Westminster – this will include services in primary care, the National Chlamydia Screening Programme, genitourinary medicine services and community contraceptive services;
- Determine whether existing services are meeting the needs of Westminster residents and identify gaps in services and areas of unmet need;
- Identify key prevention groups in greater need of services locally;
- Provide conclusions and recommendations for addressing gaps in services and current unmet need.

## **2: Westminster and its Population**

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### **Key Messages:**

- **An estimated 236,000 people live in Westminster, whilst nearly 244,700 people are registered with Westminster GPs;**
- **Westminster has a younger population structure than in most other parts of the country, with men and women aged 25-39 accounting for the largest proportion of the population;**
- **Westminster has a significant influx of both workers and visitors, swelling the daytime population to around one million;**
- **Westminster has an ethnically diverse population – an estimated 29% of the population belong to BME groups;**
- **The pattern of deprivation across Westminster is complex – affluent areas often lie adjacent to areas of multiple needs and areas of extreme wealth often lie next to areas of significant deprivation;**
- **Westminster has a large student population - 84,000 students are registered with Westminster based colleges and universities;**
- **Westminster also has a significant number of LGBT persons both living locally and visiting the borough.**

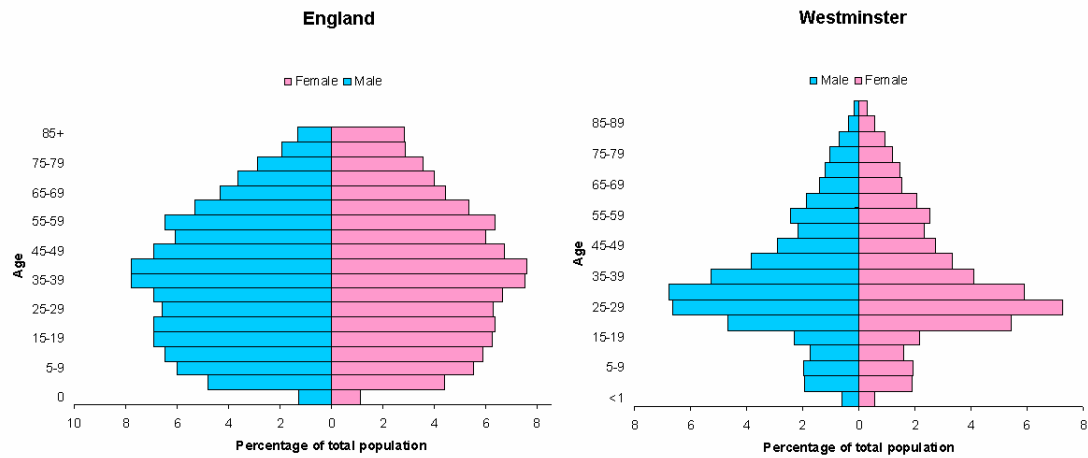
### **2.1 Overview of the Westminster population**

According to latest population estimates, 236,000 people are thought to live in Westminster (Office of National Statistics, 2008), although around 244,700 people are known to be registered with Westminster general practices (Exeter, 2010).

The population of Westminster, like many inner London boroughs, differs from the rest of England, with a higher proportion of the population in younger age groups. Men and women aged 25-39 account for the largest proportion of the population.

Westminster is a diverse borough; it is estimated that 29% of the population belong to black and minority ethnic (BME) groups, whilst 52% of the population were born outside of the UK – the highest proportion in the country.

**Figure 1: ONS resident population structure for Westminster and England**



Source: ONS 2008 mid year population estimates

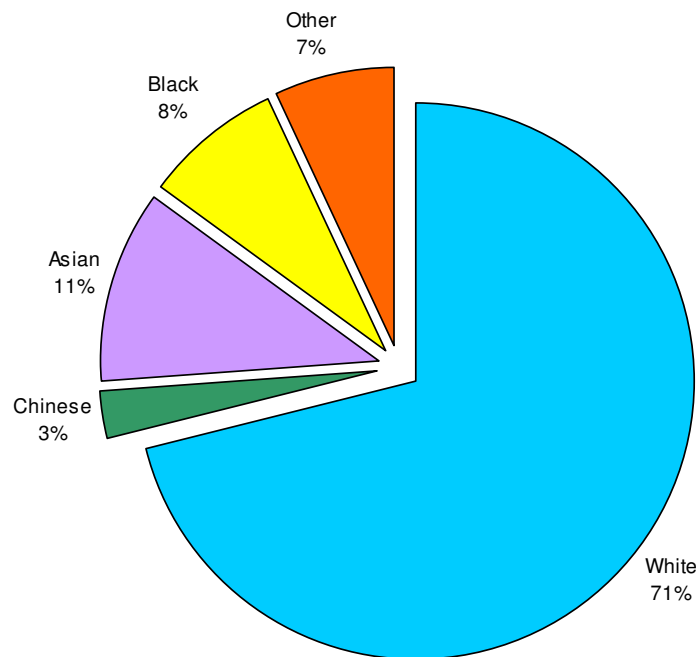
**Table 1: ONS resident population estimate for Westminster**

Age Group	Male	Female
<15	14,800	14,300
15-19	5,300	5,100
20-24	10,600	12,200
25-29	15,300	16,400
30-34	16,100	13,900
35-39	12,200	10,000
40-44	9,900	8,200
45-49	7,100	6,700
50+	27,000	31,000

Source: ONS 2008 mid year population estimates



**Figure 2: Ethnic composition of the Westminster population**



Source: GLA 2008 round population projections (low)

As well as being a residential area, Westminster is a centre for work, commerce, tourism, entertainment and government – this concentration of activity within the borough is thought to increase the population to around one million on working days, between 320,000 and 355,000 during evening and night time hours and between 390,000 and 434,000 at weekends (NHS Westminster, 2010).

According to the Index of Deprivation 2007 (IMD 2007) Westminster is the 72<sup>nd</sup> most deprived local authority out of 354 local authorities in England. The pattern of deprivation across Westminster is complex with areas of affluence and extreme wealth often lying adjacent to areas of significant deprivation. Much of the deprivation in Westminster is now concentrated in the North West and South of the City.

## **2.2 Key population groups in Westminster**

Given the inequalities in sexual health outlined in the introduction, it is also useful to look at those groups who are known to experience inequalities with regards to sexual health.

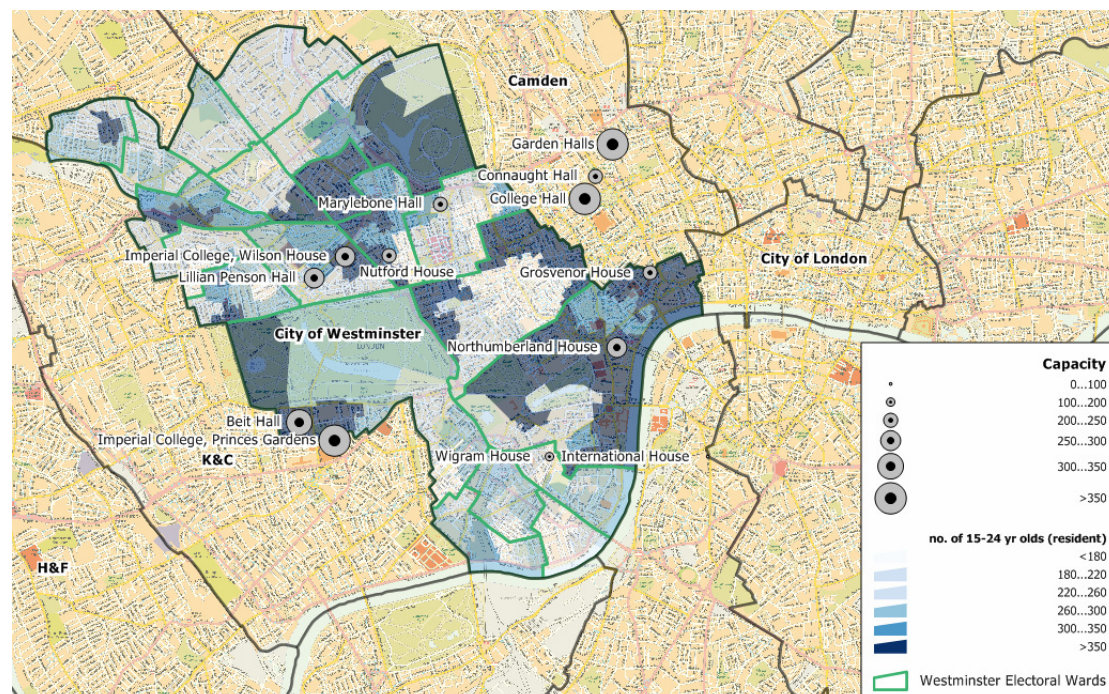
### (i) Young people in Westminster

There are an estimated 33,200 young people aged 15-24 resident in Westminster – a number which is expected to increase in the future. Overall, the Westminster population is highly mobile with the highest population turnover rate of any London borough and this is particularly true of the younger population aged 18 and above.

The 15-24 population is also extremely diverse; 34% of the population are from BME groups compared to 29% of the Westminster population as a whole and 11.8% of the England population as a whole (ONS, 2010). This diversity is expected to increase in the future.

Eleven universities and colleges are based within Westminster and there are nine halls of residence, accommodating large numbers of students (figure 3). Latest available data from UCAS suggests that there are approximately 84,000 students registered with Westminster based colleges and universities (excluding the Royal College of Music).

**Figure 3: Distribution of halls of residence, Westminster**



There is some evidence to suggest that young persons who are not in education, employment or training (NEET) are more likely to experience poor sexual health than

other young people. Therefore, it is useful to identify locally how many young persons are not in education, employment or training. Unfortunately, NEET data for inner London boroughs is not available as it cannot be reliably estimated at borough level – however, overall data for Inner London suggests that 94% of 16-17 year olds participate in some form of education or learning – this compares to 92% in England (Department for Education, 2010).

### **(ii) Lesbian, gay, bisexual and transgender people in Westminster**

It is difficult to estimate the size of the LGBT population. Sigma research carried out a needs assessment of LGBT people in Lambeth, and to estimate the size of the population used a conservative estimate of 5% (Keogh *et al*, 2006). This took into account a national survey which found that 3.9% of women and 5.5% of men aged 16-44 and living in London had had a same gender sex partner in the previous 5 years. Other studies have found that the population proportion in inner London is higher than that of London in general, and that London has a greater representation than the UK as a whole. This demonstrates that in Westminster the consideration of the needs of LGBT people has to be greater than in the rest of the UK.

Using the 5% estimate and applying this to the population over 15 years old in Westminster, suggests that 10,165 LGBT people live in Westminster. This is likely to be a conservative estimate and does not consider the presumably large LGBT population who work or visit the Borough. This suggests that LGBT people represent a sizeable proportion of the resident and visiting population.

Overall very little is known about the LGBT population in Westminster. Further work is needed to better understand both the size of the LGBT population in Westminster (both residents and visitors to the borough) and also the characteristics of this population – for example, age, ethnicity and deprivation experienced.

### **(iii) BME people in Westminster**

Latest available data suggests that 29% of the Westminster resident population belong to BME groups – this is equivalent to 68,440 people (ONS, 2008). This number is expected to increase in the future.

The population of young people is much more ethnically diverse than the population of Westminster as a whole, suggesting that the population of Westminster is likely to

be more ethnically diverse in the future. Data from local schools shows that more than 150 different first languages were being spoken by pupils attending state schools in Westminster – Arabic, Bengali, Cantonese and Albanian being the most commonly spoken first language after English.

**(iv) Sex workers in Westminster**

There are significant numbers of men and women who either sell sex or who work in the sex industry living and/or working in Westminster. It is difficult to provide robust estimates of the numbers living/working locally, however, data from specialist sexual health services shows that in 2008/09, there were 3,040 contacts at the Praed Street Project and 1,178 contacts at the Working Mens Project.

## **Picture of Sexual Health in Westminster**

### 3: Epidemiology of Chlamydia

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#### Key Messages:

- Chlamydia is the most common bacterial STI in the UK and is associated with significant morbidity if untreated;
- Often infection is asymptomatic and so a significant proportion of those infected are undiagnosed;
- Young people are disproportionately affected by chlamydia;
- The profile of men diagnosed with chlamydia is slightly older than that of women.

Chlamydia trachomatis is the most common bacterial STI in the UK. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed (The UK Collaborative Group for HIV and STI Surveillance, 2007).

Untreated Chlamydia infection is associated with considerable reproductive mortality in women including pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility. In men complications include urethritis, epididymitis and Reiter's syndrome (The UK Collaborative Group for HIV and STI Surveillance, 2007).

#### 3.1 Overview of chlamydia in England

Estimates of chlamydia prevalence in the UK in the published literature varies considerably between studies, however, in a systematic review of the literature, the prevalence of chlamydia was shown to vary significantly depending on the setting.

**Table 2: Prevalence of chlamydia in the UK**

Age Group	GP Surgery	Population based	Family Planning Clinics	Antenatal Clinic	Termination of Pregnancy Clinic	GUM Clinic
<20	8.1%	4.8%	10%	12.6%	12.3%	17.3%
20-24	5.2%	3.2%	6.5%	8.3%	8.1%	11.6%
25-29	2.6%	1.5%	3%	4.1%	4%	5.9%
30+	1.4%	0.8%	1.8%	2.2%	2.2%	3.2%

Source: Adams *et al*, 2004

In all settings the prevalence of chlamydia varied according to age. Prevalence was highest amongst individuals aged <20 years old, ranging from 4.8% in the population based studies to 17.3% in GUM clinic attendees. The prevalence of chlamydia in all settings decreased with increasing age.

Overall the prevalence of chlamydia was higher in healthcare settings. This difference may be due to individuals at a higher risk of infection attending healthcare settings and also the presence of genital symptoms among healthcare setting attendees.

As a result of the variation in the prevalence of chlamydia between the studies reviewed, it is not possible to provide a robust estimate of the number of people in Westminster likely to be infected with chlamydia. However, all of the studies consistently showed that younger persons are disproportionately affected by chlamydia.

In England, rates of diagnosis of chlamydia have been increasing throughout the late 1990s and early 2000s, particularly amongst women aged 16-24 and men aged 16-34. In England the number of cases of chlamydia increased from 29,393 in 1997 to 107,804 in 2008.

### **3.2 Chlamydia in Westminster**

The main source of epidemiological data on STIs is KC60 data. KC60 data reports on all diagnoses of STIs made in GUM clinic settings. Data, however, is only available at clinic level (and not by PCT) and, therefore, represents all diagnoses made by a clinic regardless of the PCT of residence. Because GUM data is clinic based, local GUM data should not be used as a definitive number of cases of chlamydia diagnosed amongst Westminster residents, but instead serve as a guide to local trends.

In addition to KC60 data, some diagnosis data, specifically for persons with Westminster postcodes was requested from local GUM clinics to provide a more complete picture.

### **3.2.1 How many people are diagnosed with chlamydia?**

Local data from 56 Dean Street and the Jefferiss Wing shows that in 2009/10:

- 279 Westminster residents were diagnosed with chlamydia;
- 158 Westminster residents received epidemiological treatment because of suspected chlamydia.

The majority of cases were in younger persons; this is consistent with the published literature.

Analysis of KC60 data from the three main local GUM providers (Dean Street, Jefferiss Wing and Mortimer Market) provides a more detailed epidemiological picture and enables comparison with regional and national trends.

### **3.2.1 What are the characteristics of people diagnosed with chlamydia?**

#### **(i) age and sex**

Based on KC60 data from local GUM clinics, amongst men, the majority of cases of chlamydia diagnosed are aged 25-34 followed by men aged 20-24; this is similar to London and England. The levels of diagnosed chlamydia amongst men aged 16-19 is relatively low, similar to that observed in London and England. Amongst women, the majority of cases of chlamydia diagnosed in local GUM clinics are aged between 20 and 24 followed by women aged 25-34 (similar to men); this is not consistent with regional and national trends in which most cases diagnosed in GUM clinics are in women aged 16-19 and women aged 20-24.

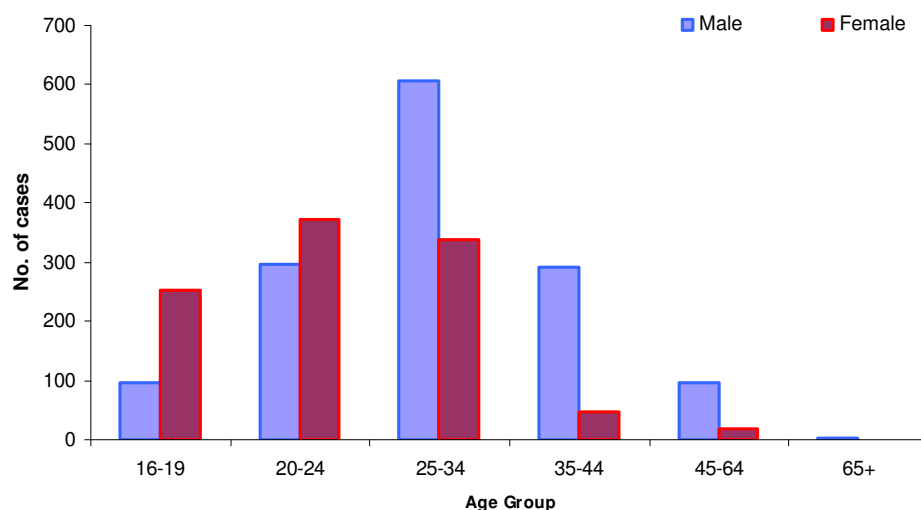
#### **(ii) time trends**

The number of chlamydia diagnoses in both men and women has fallen over the five year period 2003-2008 – this decrease is particularly marked between 2007 and 2008. The fall in the number of chlamydial cases diagnosed is consistent with a fall in the number of other STIs diagnosed (gonorrhoea, syphilis, anogenital warts and herpes also showed a clear fall in the number of diagnoses between 2007 and 2008).

The trends in Westminster are not consistent with regional and national trends. In both London and England as a whole the number of diagnosed cases of chlamydia has been rising, particularly in men. In England the number of cases in men and women are similar whereas in London and Westminster the number of cases is highest in men.

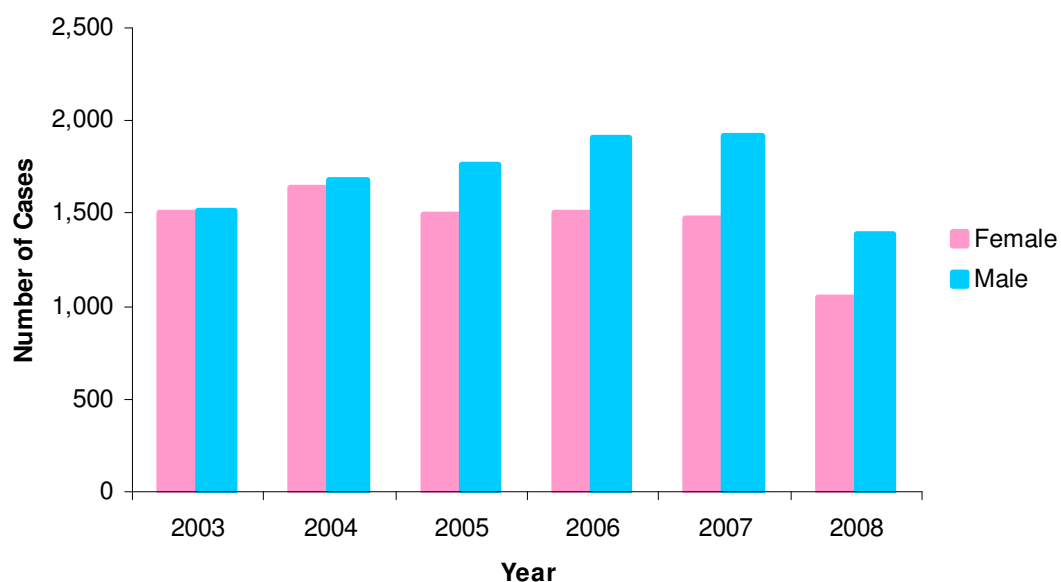


**Figure 4: Number of cases of uncomplicated genital chlamydial infection by age and sex, 2008**



Source, KC60, 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

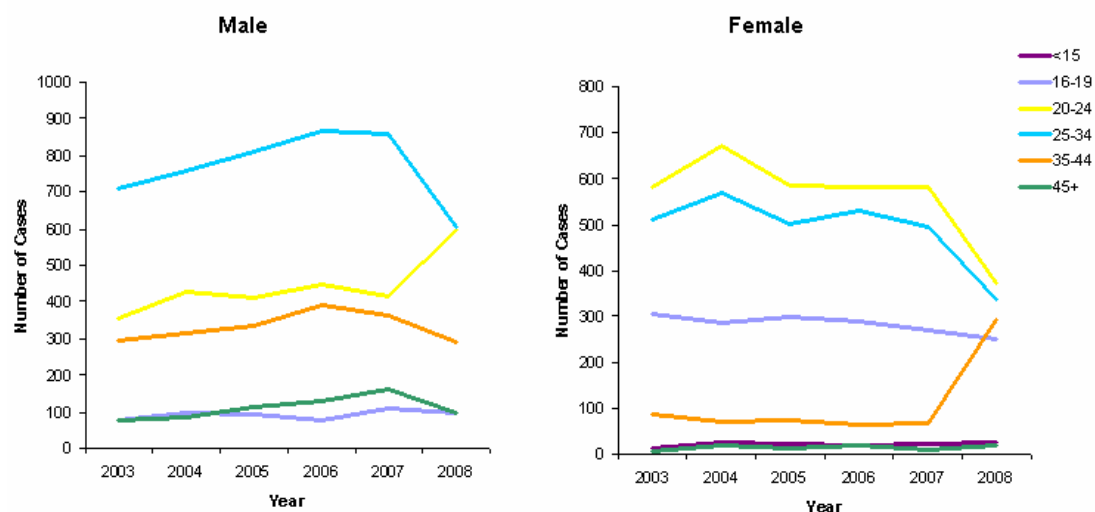
**Figure 5: Number of cases of uncomplicated genital chlamydial infection, 2003-2008**



Source, KC60, 2003-2008 (Dean Street, Jefferiss Wing and Mortimer Market)

In an attempt to better understand the time trends described, cases of chlamydia diagnosed in GUM clinics between 2003 and 2008 were stratified by age.

**Figure 6: Number of cases of uncomplicated genital chlamydial infection by sex and age group, 2003-2008**



Source, KC60, 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

The time trends observed in the diagnosis of uncomplicated chlamydial infection in Westminster vary significantly accordingly to age and sex. Amongst men the number of cases was increasing steadily, up until 2007 when the number of cases diagnosed in men aged 25-34 sharply decreased, whilst the number of cases amongst men aged 20-24 increased. This is in contrast to national trends in which the number of cases has been rising steadily.

Amongst women, the number of cases diagnosed was relatively steady (in some age groups declining slightly) up until 2007 when the number of cases diagnosed in women aged 20-34 sharply decreased whilst amongst women aged 20-34 the number of cases diagnosed decreased.

The trends observed between 2007 and 2008 are unusual and inconsistent with regional and national trends. The age trends observed do not appear to be explained by the introduction of the National Chlamydia Screening Programme. Further work is

needed to better understand the described trends and determine whether the trends observed represent real changes or are indeed artefact.

### **3.3 Conclusions**

Overall the number of chlamydia infections diagnosed in GUM clinic settings has decreased, particularly in females – this is in contrast to other STIs in which there has been little change year on year in the number of infections diagnosed (see section 4).

Chlamydia, however, remains an important public health problem in Westminster because many infections are asymptomatic. Therefore, there is likely to be a significant population with undiagnosed infection.

## 4: Epidemiology of other STIs

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### Key Messages:

- **STIs are an important public health problem in Westminster – an estimated 6,500 cases a year are diagnosed by local GUM clinics;**
- **Many STIs are asymptomatic, facilitating the spread of infection;**
- **Numbers of STIs diagnosed locally have remained constant over the last five years with the exception of 2007 in which there was an increase;**
- **Amongst men, the most common STIs diagnosed include chlamydia, anogenital warts and gonorrhoea, whilst in women the most common STIs diagnosed are chlamydia, anogenital warts and herpes simplex;**
- **Locally, STI infections are predominantly concentrated in men and young people, with the age profile of men affected slightly older than that of women;**
- **Men who have sex with men and Black African and Black Caribbean ethnic groups are also disproportionately affected by STIs, particularly gonorrhoea and syphilis;**

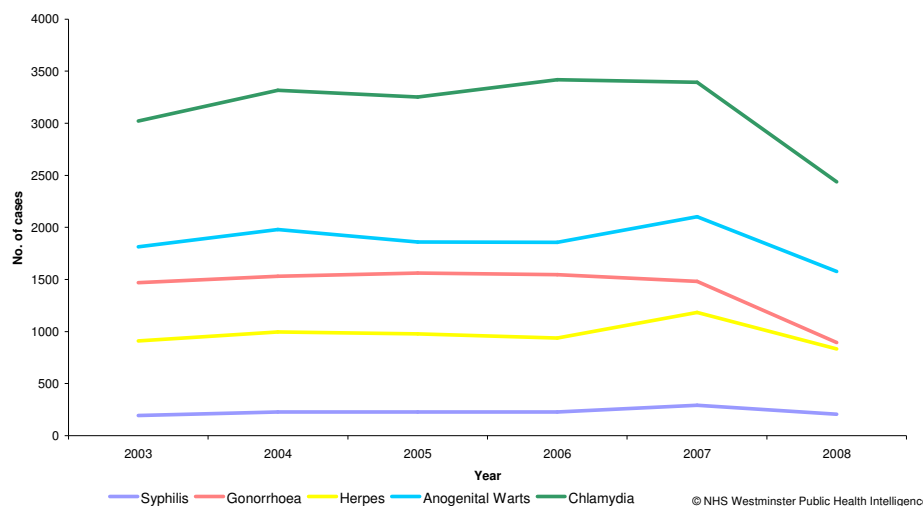
### 4.1 Overview

Sexually transmitted infections (STIs) are diseases that can be transmitted by unprotected sex between two people. Some STIs are symptomatic and may result in increased discharge, pain and ulcers, whilst others are asymptomatic and often remain undiagnosed. If STIs remain undiagnosed they can lead to serious complications and have long term health implications such as pelvic inflammatory disease and infertility.

Ascertaining the number of STIs diagnosed annually amongst Westminster residents is complex, as diagnoses occur in a range of settings. Most data on STIs is derived from Korner (KC60) activity reports from GUM clinics in England. However, such data is not available by place of residence (data is currently available at clinic level only which includes residents and non-residents). Therefore, local GUM data should not be used as a definitive number of cases of STIs diagnosed amongst Westminster residents, but instead serve as a guide to local trends.

Recent trends show that the number of STIs diagnosed in local GUM clinics has remained relatively constant over the last five years, with the exception of 2007 where there was an increase in the number of STIs diagnosed.

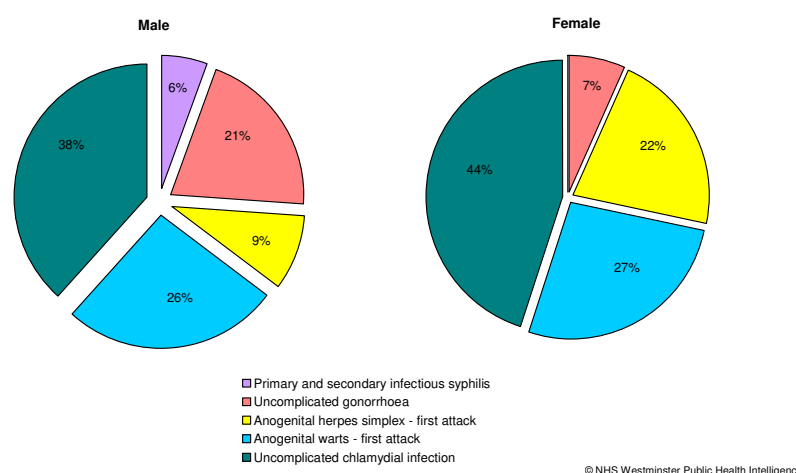
**Figure 7: Number of STI diagnoses, 2003-2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

In both men and women, chlamydia is the most common bacterial STI in Westminster, followed by anogenital warts. In men, gonorrhoea is the next most commonly diagnosed STI, whilst in women herpes simplex is the third most common STI diagnosed in Westminster.

**Figure 8: STIs diagnosed by type, 2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

## 4.2 Gonorrhoea

Gonorrhoea is a bacterial STI caused by the bacteria *Neisseria gonorrhoea* and is the second most common bacterial STI diagnosed in England. If infection is not treated, gonorrhoeal infection may lead to complications such as chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy and infertility in women. Furthermore, the effective treatment of gonorrhoea has been complicated by the development of antimicrobial resistance; the prevalence of ciprofloxacin resistance has risen significantly in recent years.

**In recent years there has been a decline in gonorrhoeal diagnoses in Westminster**

**In Westminster, MSM account for a significant number of gonorrhoeal infections**

**Men, young persons and Black ethnic groups are disproportionately represented amongst gonorrhoeal diagnoses**

### 4.2.1 Gonorrhoea in England

After increasing in the late 1990s and early 2000s, rates of diagnosis of gonorrhoea have been decreasing in recent years. In England the number of cases of gonorrhoea fell from 20,779 in 2004 to 15,177 in 2008, a reduction of 27%. This overall decline in the number of gonorrhoeal infections was largely due to a fall in heterosexually acquired infections. In contrast to the decline in heterosexual populations, the number of gonorrhoeal infections in MSM have continued to increase in recent years, and accordingly the proportion of all diagnoses of gonorrhoea attributable to MSM has increased; in 2004, MSM accounted for 25% of all gonorrhoeal infections diagnosed in GUM clinic settings, whilst in 2008 this proportion had increased to 29%.

Gonorrhoea diagnoses nationally are largely concentrated among specific population subgroups, namely young adults, MSM and black ethnic groups. Numbers and rates of gonorrhoeal diagnoses are higher in men than women; this is most likely a result of the fact that infection is more likely to be symptomatic in men and also because a significant proportion of cases are in MSM.

Data collected through the Gonococcal Resistance to Antimicrobials Surveillance Programme suggests that Black ethnic groups are disproportionately affected by gonorrhoea. In 2007, among heterosexuals diagnosed with gonorrhoea, 26% were Black Caribbean and 6% were Black African.

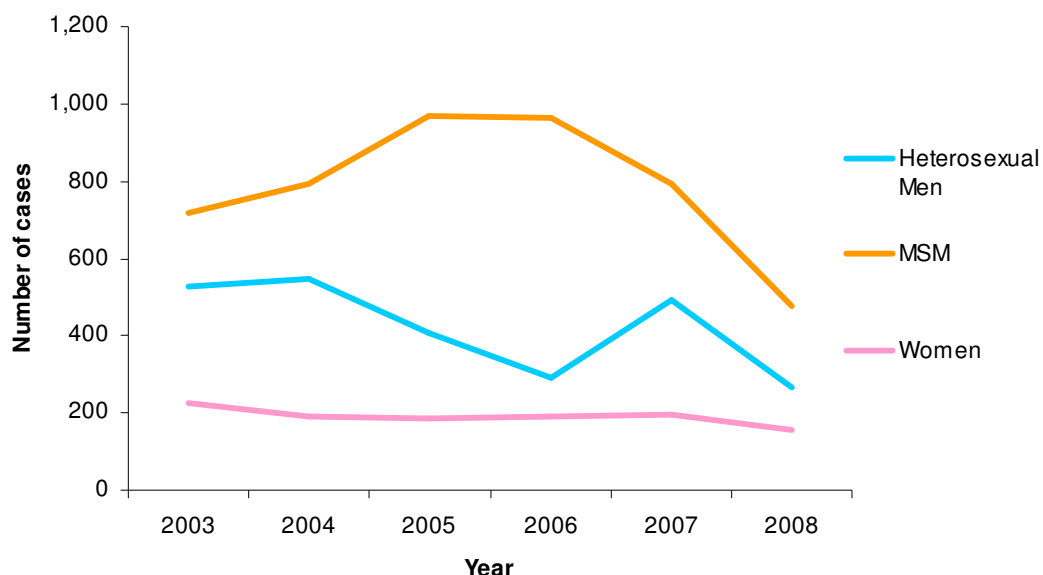
Nationally, gonorrhoeal infections are predominantly found in young adults. In women the majority of infections are in women aged <16 and 16-19, whilst in men infection is most common in men aged 20-24.

#### 4.2.2 Gonorrhoea in Westminster

Locally gonorrhoea is the third most common STI diagnosed in men and the fourth most common in women. In 2008, 896 cases of gonorrhoea were diagnosed in local GUM clinics, the majority of which were in MSM (53% of cases). MSM account for a larger proportion of cases of gonorrhoea locally than they do regionally and nationally; in London 39% of gonorrhoeal infection diagnosed in GUM settings is amongst MSM, whilst in England MSM account for 29% of gonorrhoeal infections.

Overall, in recent years the number of cases of gonorrhoea diagnosed in GUM clinic settings has decreased in heterosexual men and women and in MSM (in which the decrease has been most marked – 33% between 2003 and 2008).

**Figure 9: Number of cases of gonorrhoea, Westminster 2003-2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

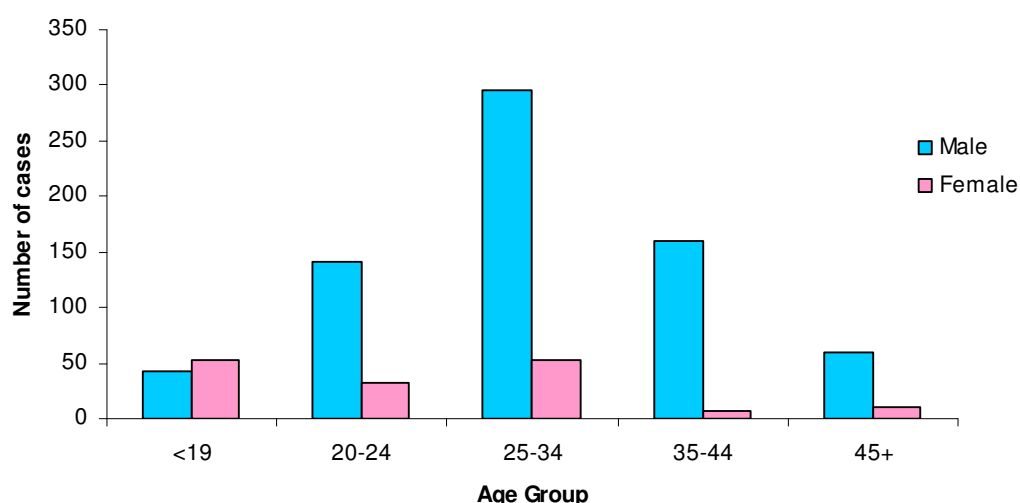
Whilst the decrease in diagnoses in heterosexual men and women is consistent with trends in London and England, the marked decline in cases among MSM is in

contrast to the increase in cases in England but is mirrored in London, but to a much lesser extent.

The majority of cases of gonorrhoea in Westminster are in men aged 25-34 and women aged 19 and under. This age profile is consistent with that in London and England.

Locally, it is not possible to describe gonorrhoeal diagnoses by ethnicity (data is not collected by GUM clinics), however, inferences can be drawn from national data derived from GRASP. Data from GRASP suggests that the proportion of diagnoses from Black Caribbean and Black African ethnic groups is higher than expected. Given the ethnic diversity of the Westminster population, the proportion of cases of gonorrhoea from BME groups is likely to be higher than that observed nationally.

**Figure 10: Number of cases of gonorrhoea in Westminster by age, 2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

### 4.3 Genital human papilloma virus

There is over 100 types of human papilloma virus (HPV) of which 40 are known to infect the genital tract and be acquired sexually. Most HPV infections are asymptomatic and resolve without causing disease, however types 6 and 11 are associated with genital warts. HPV

**With the exception of 2007, there has been little year on year change in the number of diagnoses of genital warts**

**Men account for the majority of HPV infections diagnosed locally**

**Infection is most commonly diagnosed in women aged 20-34 and men aged 25-34**



types 16 and 18 are associated with cervical cancer.

Genital warts are one of the most commonly diagnosed STIs in England and the lifetime risk of infection with genital HPV is high amongst sexually active people. HPV infections can often be difficult to treat and some patients may experience frequent reoccurrences.

#### **4.3.1 Genital warts in England**

The number of cases of first attack genital warts in GUM clinics in England has been increasing in recent years. In England the number of diagnoses of first attack genital warts increased from 61,157 in 1999 to 79,178 in 2008. This represents an increase of 23%. Cases of recurrent genital warts have also increased; in 1999 there were 34,434 cases identified in GUM clinics compared to 46,086 in 2008.

Between 1999 and 2008 the number of cases of first attack genital warts in heterosexual men and women increased by 23% and 22% respectively, however, the largest proportional increase was amongst MSM (36% increase).

National evidence suggests that a significant number of cases of genital warts are also identified in general practice. Rates of new diagnosis of genital warts in the registered general practice population in 2006 were 68 per 100,000 population in men and 58 per 100,000 in women.

Nationally, genital wart infections are predominantly found in young adults. Rates of newly diagnosed genital wart infections are highest among men aged 20-24 and among women aged 16-19.

#### **4.3.2 Genital warts in Westminster**

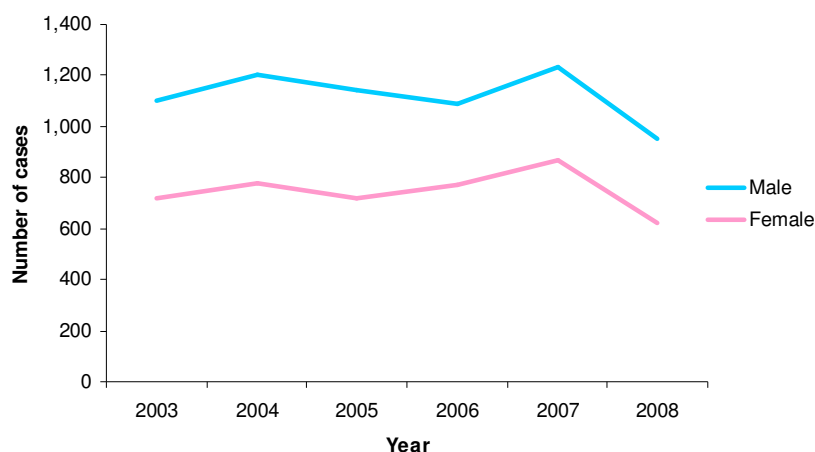
Analysis of data from Jefferiss Wing, Dean Street and Mortimer Market GUM clinics shows that the number of cases of first attack genital wart infections remained relatively stable between 2003 and 2008, with the exception of 2007 in which there was a peak in cases; this is consistent with other STIs diagnosed in GUM clinic settings in Westminster.

This pattern is not consistent with trends in London and England in which the number of cases of first attack genital wart infections is increasing.

Men account for the majority of infections in Westminster – this is similar to the picture both regionally and nationally.

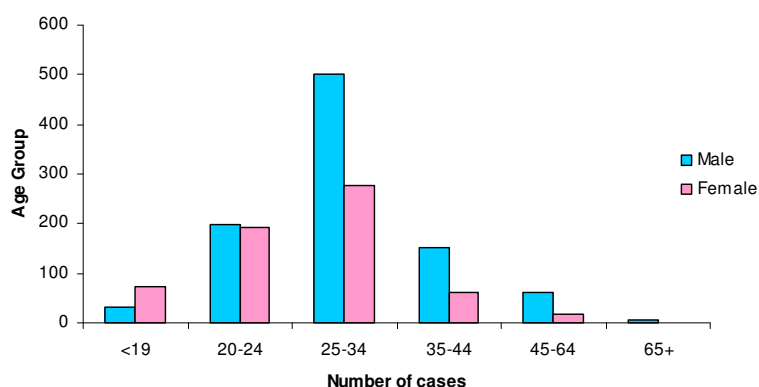
In terms of the age distribution, the majority of cases are in men and women aged 25-34, with smaller numbers in the younger and older age groups. This differs from the picture in England in which the majority of cases in men are aged 20-34 and in women aged 16-24, however, is similar to London as a whole.

**Figure 11: Number of cases of first attack genital wart infections, Westminster 2003-2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

**Figure 12: Number of cases of first attack genital wart infections by age, Westminster 2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

## 4.4 Syphilis

Syphilis is a relatively rare infection caused by the spirochete, *Treponema pallidum*. The disease has different stages: an early infectious stage (primary, secondary and early latent infection in the first two years of infection) and late non-infectious syphilis (late latent infection and tertiary syphilis). The clinical manifestations associated with syphilis are varied, but the primary and secondary stages are characterised by mucocutaneous lesions –almost any organ of the body can be affected. Furthermore, infection in pregnant women, syphilis may result in foetal death, prematurity or congenital syphilis.

**After increasing in the late 1990s, the number of diagnoses remains constant in Westminster**

**Predominantly diagnosed in men aged 25-44, particularly men who have sex with men**

**Amongst heterosexuals diagnosed, Black ethnic groups are overrepresented**

**Con-infection with HIV is common.**

### 4.4.1 Syphilis in the UK

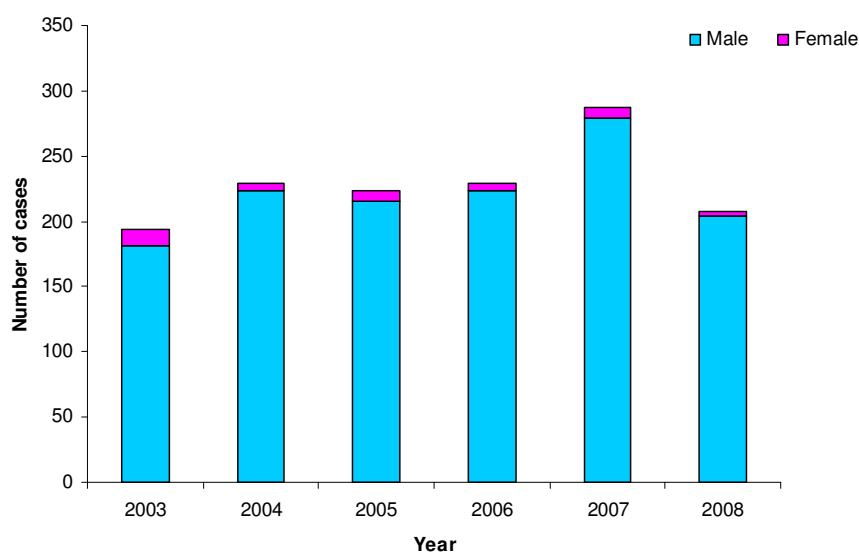
Although syphilis is a relatively rare infection the number of cases has been rising significantly over the last decade in the UK after falling during the eighties (coinciding with changes in sexual behaviour associated with HIV awareness campaigns). In the UK, the number of diagnoses of infectious syphilis increased from 301 in 1997 to 3,702 in 2006.

### 4.4.2 Syphilis in Westminster

Analysis of data from Jefferiss Wing, Dean Street and Mortimer Market GUM clinics shows that for the period 2003-2008, the number of cases of primary and secondary infectious syphilis has fallen in women from 13 cases per year to less than 5, whereas in men it has remained relatively constant (with the exception of 2007 in which there was a sharp increase in the number of cases). In 2008 there were 207 cases of primary and secondary infectious syphilis diagnosed in local GUM clinics.

Local are consistent with trends in London and England, which show that after a sharp increase in diagnoses in the late 1990s and early 2000s, in recent years there has been little change in the number of new syphilis infections.

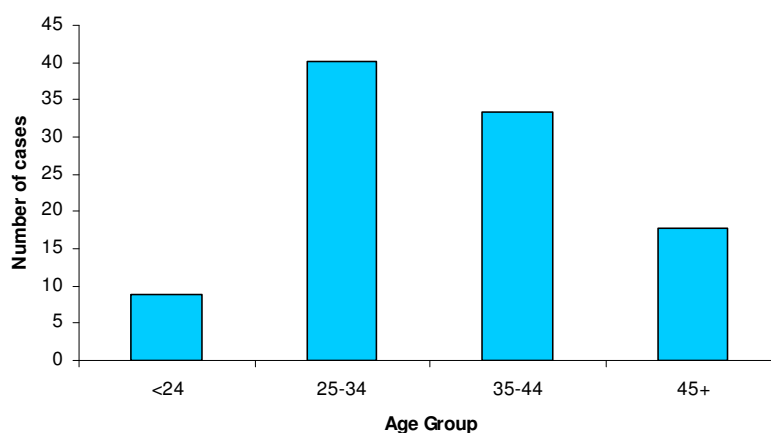
**Figure 13: Number of cases of syphilis, 2003-2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

Locally the majority of cases are in men (99%) – this is higher than in London and England (men account for 92% and 89% of syphilis cases in London and England respectively). The number of cases of primary and secondary infectious syphilis in women have not been presented because the numbers are so small. In men the number of cases aged <24 is low, with most cases in men aged 25-44. This age profile is similar to that of other STIs in Westminster males.

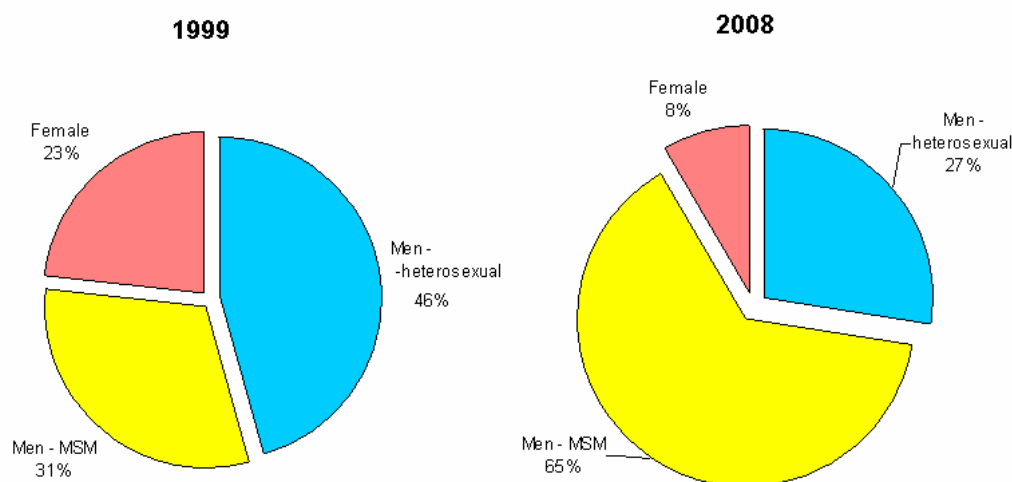
**Figure 14: Number of cases of primary and secondary infectious syphilis in men by age, 2008.**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

Westminster level data does not distinguish between heterosexual men and men who have sex with men, however, data for London shows that the majority of cases of primary and secondary infectious syphilis are in men who have sex with men; in London this proportion is increasing. In 1999, MSMs accounted for 31% of primary and secondary infectious syphilis cases in London – this rose to 65% in 2008.

**Figure 15: Diagnoses of syphilis by sex, London**



Source: National Enhanced Syphilis Surveillance System, 2006

Data from the National Enhanced Syphilis Surveillance System suggests that co-infection with HIV is common; in 2006, 37% of all people with infectious syphilis in London were known to be infected with HIV. Again, the majority of co-infections were amongst men who have sex with men.

In terms of ethnicity, White ethnic groups account for the largest number of infections, the majority of whom are MSM. Amongst heterosexual men and women, in London, Black and Black British ethnic groups appear to be overrepresented amongst heterosexual men and women with syphilis.

#### **4.5 Genital warts (herpes simplex)**

Genital herpes is a sexually transmitted infection caused by the herpes simplex virus (HSV). The virus is the most common ulcerative sexually transmitted infection in the UK, and is associated with physical and psychological morbidity. It can cause severe systemic disease in newborn infants and the immuno-suppressed; it may also facilitate HIV transmission.

Genital HSV is a chronic infection with many people experiencing frequent reoccurrences. There are two subtypes of HSV; type 1 typically causes oral herpes commonly known as cold sores whilst type 2 HSV is typically associated with genital infection. The virus is highly contagious and can be passed on easily from person to person, from direct close contact. However, many infections are asymptomatic, as a consequence approximately 80% of people infected with HSV are unaware that they have been infected.

**With the exception of 2007, there has been little year on year change in the number of diagnoses of herpes simplex**

**Herpes simplex appears to be more common in females than males – this is in contrast to other STIs (with the exception of chlamydia)**

**The number of infections is increasing in young persons aged 19 and under more than in any other age group**

#### **4.5.1 Genital herpes in England**

Numbers of genital herpes diagnoses have been rising gradually since the late 1980s. However, recent rises are particularly evident, which may in part be due to improved diagnostic testing. In England, the number of people diagnosed with first episode genital herpes increased by 10%, from 26,270 in 2007 to 28,957 in 2008. The number of people diagnosed with recurrent herpes also increased by a similar proportion (18,265 to 20,361).

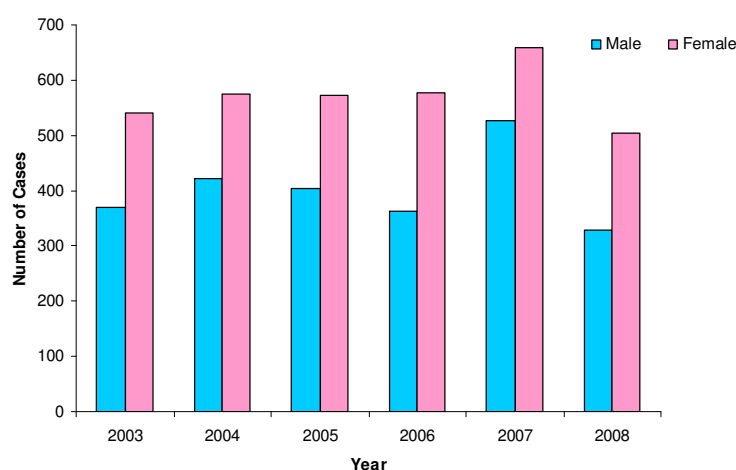
#### **4.5.2 Trends in Westminster**

Analysis of data from Jefferiss Wing, Dean Street and Mortimer Market GUM clinics show that the number of cases of first attack genital herpes infections remained relatively stable between 2003 and 2006, however there was a marked increase between 2006 and 2007; this is consistent with trends for syphilis and genital warts. The described increase in diagnoses was most notable amongst males. Between 2007 and 2008 the number of diagnoses amongst males and females fell back to pre-2007 levels.

This pattern observed locally is not consistent with trends in London and England, which show that the numbers of cases of first attack genital herpes infections are increasing.

In contrast to the local epidemiology of gonorrhoea and syphilis, females account for the majority of genital herpes infections locally; this is similar to the trends both regionally and nationally.

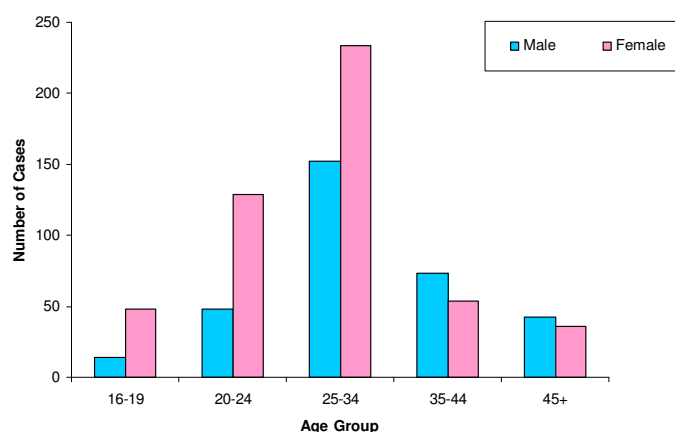
**Figure 16: Number of cases of first attack herpes simplex infections, 2003-2008.**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

The majority of first attack genital herpes cases occur between the ages of 24-34; this is similar for males and females. The number of cases in every age group, with the exception of the <19 age group, decreased between 2007 and 2008; the number of cases in the <19 age group increased by 27%.

**Figure 17: Number of cases of first attack herpes simplex infections, by age, 2008**



Source, KC60, 2003- 2008 (Dean Street, Jefferiss Wing and Mortimer Market)

## **4.6 Conclusions**

Overall, in recent years there has been little change in the number of diagnoses of STIs in GUM clinic settings. However, STIs remain an important public health problem locally, with around 6,500 diagnoses made in local GUM clinics each year. Furthermore, as many STIs are asymptomatic there is likely to be a significant population with undiagnosed infection.

The epidemiology of individual STIs differ slightly, however, there appear to be clear population groups who are disproportionately affected by STIs locally. These include young persons, Black ethnic groups and MSM. In Westminster, MSM account for significantly more STI diagnoses than they do elsewhere in the country and are, accordingly a key prevention group.



## 5: Epidemiology of HIV

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### Key Messages:

- 1,302 people in Westminster have been diagnosed with HIV and are accessing care – this is equivalent to 634 per 100,000 population aged 15 and over;
- In Westminster, HIV infection is predominantly concentrated in MSM and Black African ethnic groups particularly amongst persons aged 35-54 years old;
- Sex between men is the most common mode of transmission in Westminster
- The population of persons living with HIV is ageing - persons aged 40 and over now account for 38% of persons diagnosed and accessing care;
- There has been little change in the overall incidence of HIV, however, an increasing number of new diagnoses are in older persons and MSM, with a decreasing number of new diagnoses in African born heterosexual contacts

Human immunodeficiency virus (HIV) is an immunosuppressant viral infection, primarily spread in the UK through sexual contact. HIV infection can lead to the development of opportunistic infections, collectively known as acquired immunodeficiency syndrome (AIDS). Accordingly, HIV is associated with significant morbidity, mortality and high treatment costs.

Highly active antiretroviral therapy (HAART) is the current treatment of choice for HIV and is very effective at suppressing HIV infection, thus adding years to life for people with HIV. Treatment with HAART can, however, exacerbate other morbidities such as premature onset of coronary heart disease.

### 5.1 Prevalence of HIV

Prevalence refers to the proportion of individuals within a defined population who are infected at a given time. Ascertaining the prevalence of HIV in Westminster is problematic because not everyone with HIV will be diagnosed.

The main data source that has been drawn upon to understand the prevalence of HIV in Westminster is the Survey of Prevalent HIV Infections Diagnosed (SOPHID), which refers to those persons diagnosed with HIV and accessing care. However, data from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) has also been considered as it provides information not only on those persons diagnosed but on those with undiagnosed infection in disproportionately affected population groups.

#### **5.1.1 SOPHID**

SOPHID collects information regarding the number of persons diagnosed with HIV and accessing HIV related care and, therefore, provides a prevalence estimate based on persons diagnosed with HIV and accessing care. SOPHID data is, however, not representative of the true prevalence of HIV in Westminster as some people infected with HIV will not be accessing care and some will be undiagnosed.

The number of people living with HIV in Westminster and accessing care has been increasing year on year. Latest available data for 2008 shows that 1,302 people in Westminster were diagnosed with HIV and accessing care (SOPHID, 2008). This is equivalent to 634 per 100,000 population aged 15 and over; this is higher than the rate observed for London and the UK (353 per 100,000 and 100 per 100,000 respectively).

Since 2004, there has been an increase of 28% in numbers diagnosed and accessing care; this is largely due to increased numbers of people diagnosed with HIV - this is due to:

- Continued efforts to make HIV testing more easily accessible and the introduction of rapid point of care testing (POCT) technologies;
- Increased numbers of people diagnosed with HIV as a result of migration and ongoing transmission of the virus;
- Increased survival due to effective antiretroviral drugs.

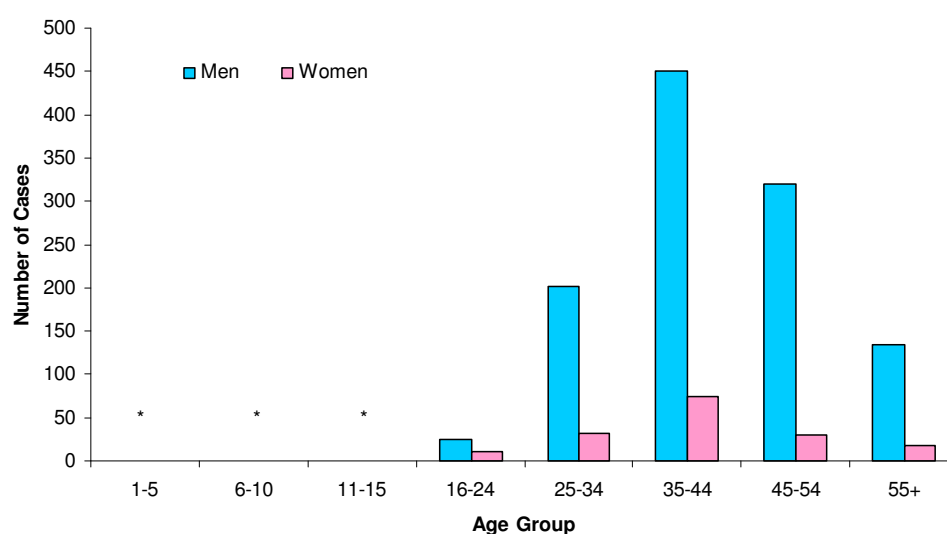
This increase is lower than in London and England (33% and 49% increase in cases diagnosed and accessing treatment respectively).

## What are the characteristics of those persons infected with HIV?

### (i) Age and sex

The majority of Westminster residents diagnosed with and accessing care for HIV are men (87%). For both sexes the majority of persons diagnosed with HIV are aged 35-44 (40%) followed by persons aged 45-54 (27%) (SOPHID, 2008)

**Figure 18: HIV infected persons accessing care by age and sex, Westminster: 2008**



Source: SOPHID 2008 \*small number excluded

### (ii) Ethnicity

Of those diagnosed and accessing care, 64% are White, 12% Black African and 19% from 'Other' ethnic groups.

Given the ethnic mix of the Westminster population, BME groups appear to be disproportionately affected by HIV in Westminster; this most likely reflects the routes of infection of HIV, with those whose probable route of infection was men who have sex with men<sup>1</sup> (MSM) more likely to be White and those acquiring HIV through heterosexual contact more likely to be Black African.

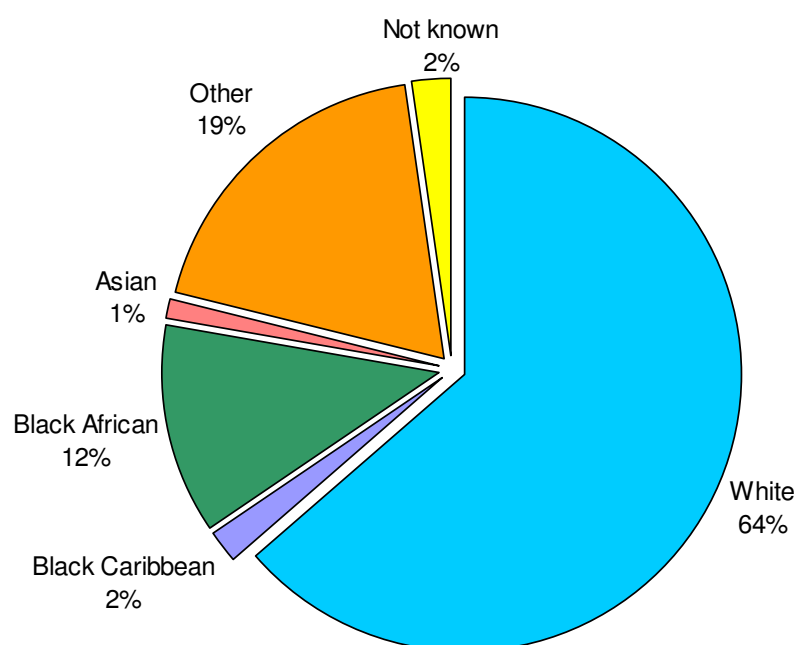
The ethnic distribution of HIV infection in Westminster differs from that in London and England; in Westminster the proportion of infections from BME groups is lower, whilst

<sup>1</sup> MSM refers to men who have sex with men. MSM is not a transmission route per se, but is in fact a population group. Therefore where the term MSM is used it is referring to both MSM as a population group but also to sex between men as a route of transmission.

the proportion of infections in persons from White ethnic groups is higher – this is because sex between men is the predominant mode of transmission of HIV in Westminster.

Person from 'Other' ethnic groups represent 19% of persons living with HIV in Westminster, however, further detail into what ethnic groups comprise 'Other' is not available from SOPHID.

**Figure 19: HIV infected persons accessing care by ethnic group, Westminster: 2008**

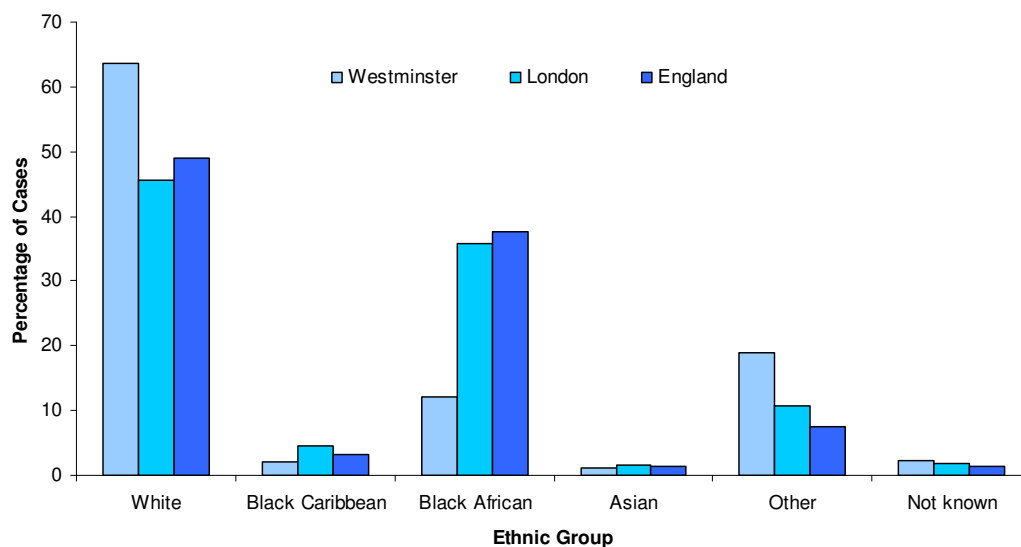


Source: SOPHID 2008

#### ***(iv) Route of transmission***

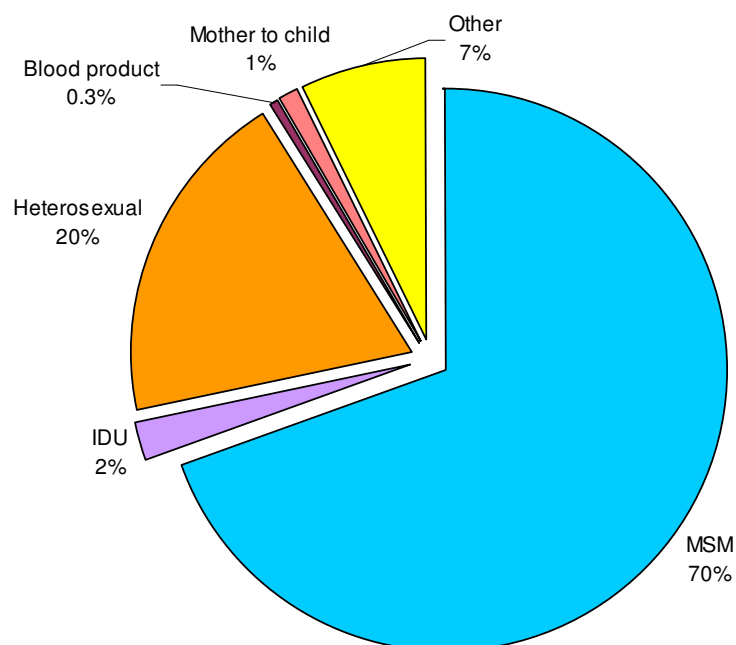
In Westminster the most common route of infection is MSM (70%) i.e. sex between men. A further 20% of cases were most likely acquired through heterosexual contact (9% heterosexual men and 11% heterosexual women). Other known routes of infection include injecting drug use, blood/blood product recipient and mother to child transmission; in Westminster these cases accounted for approximately 3% of cases.

**Figure 20: HIV infected persons accessing care by ethnic group, Westminster, London and England: 2008**



Source: SOPHID 2008

**Figure 21: HIV infected persons accessing care by prevention group, Westminster: 2008**

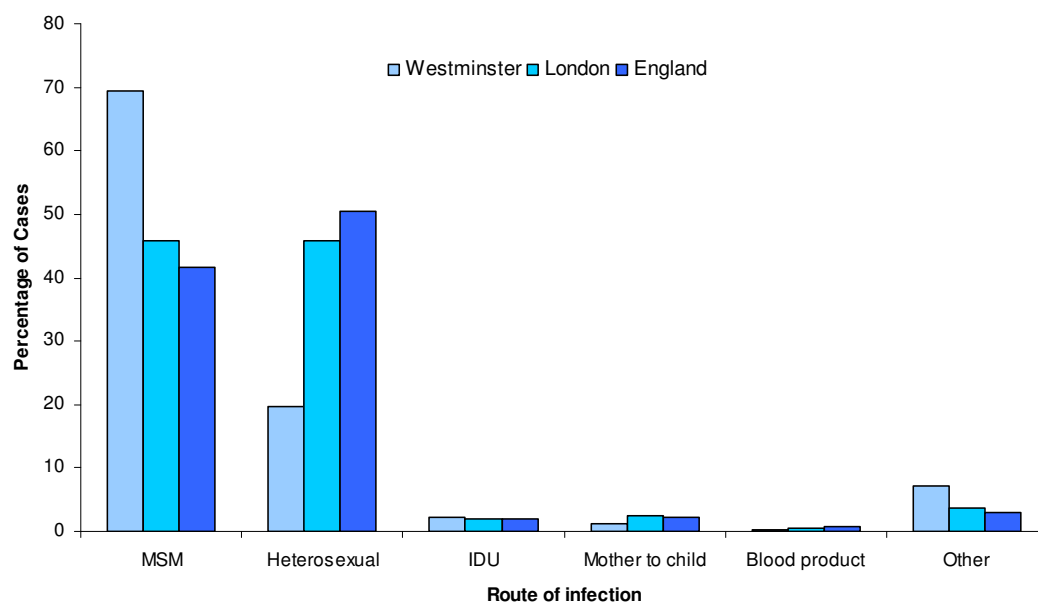


Source: SOPHID 2008

Routes of probable transmission of HIV in Westminster are different to that in London and England. Whilst MSM account for the largest proportion of Westminster residents diagnosed and accessing care (70%), MSM account for only 46% of cases in London and 42% of cases in England. The proportion of cases attributable to heterosexual contact in London and England is much higher than that in Westminster.

The routes of transmission observed in Westminster are most likely a reflection of the diverse demographics of the local population. Although it is difficult to estimate the size of the gay community in Westminster, MSM are likely to represent a larger proportion of the population of Westminster than they do in other parts of the country. Furthermore, the sub-Saharan population in Westminster is not known to be particularly large compared with other parts of London and England. Considered together, this in part explains why MSM account for a larger proportion of cases diagnosed and accessing care amongst Westminster residents compared to London and England and why the proportion of cases attributable to heterosexual contact is relatively low.

**Figure 22: HIV infected persons accessing care by prevention group, Westminster, London and England: 2008**



Source: SOPHID 2008

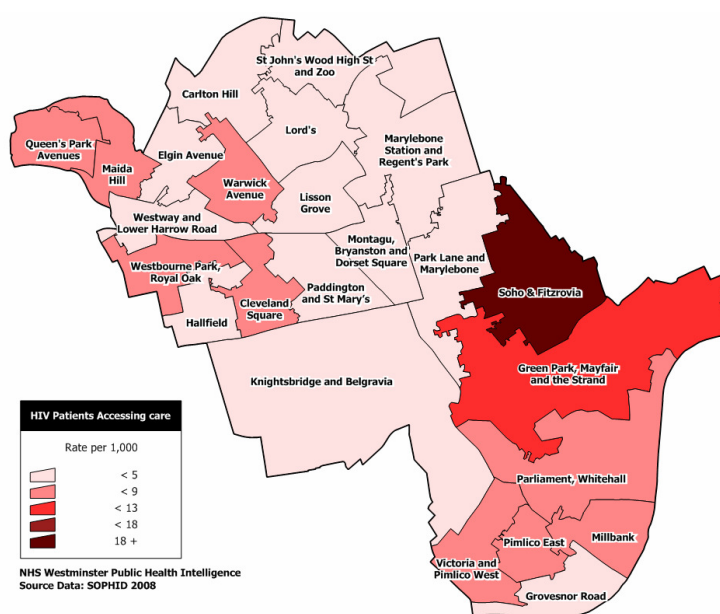
It should, however, be noted that although the proportion of cases attributable to heterosexual contact is lower in Westminster than in London and England, the actual

number of cases attributable to heterosexual contact in Westminster is significant and should not be ignored as an important route of transmission.

### **(iii)Place**

The number of persons diagnosed and accessing care as a proportion of the total population (prevalence) varies across Westminster. Prevalence is highest in the West End area of the borough and also in the north west and south of the borough. This is largely as expected given the ethnic distribution in the borough, although it should be noted that MSM account for the majority of infections in Westminster - little is known about the distribution of MSM in the borough in terms of residence.

**Figure 23: HIV infected persons accessing care by place of residence (middle super output area), 2008**



Source: SOPHID 2008

## **How have the characteristics of persons infected with HIV changed over time?**

### **(i) age, sex and ethnicity**

The ethnic and sex profile of persons with HIV in Westminster has remained relatively consistent in recent years, however, the age profile has shown signs of change. An increasing proportion of persons diagnosed and accessing care are older adults; in 2005, persons aged 45 and over accounted for just less than 30% of persons diagnosed and accessing care – by 2008 this had risen to 38%. This trend is

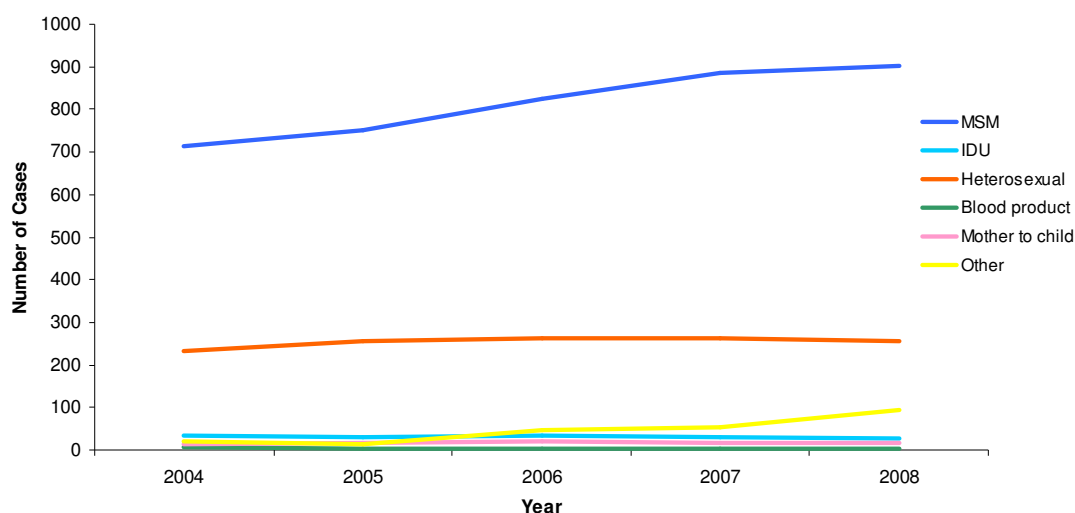
unlikely to reverse, as largely because of improved drug treatments and earlier diagnosis, persons with HIV are living longer.

Accordingly, the ageing HIV population in Westminster is likely to be an increasingly important issue for consideration when commissioning services for persons with HIV and raises questions about what is the best way to manage age-related conditions in older persons with HIV.

## (ii) route of transmission

Patterns of transmission of HIV have also changed over time. Overall there has been an increase in the number of Westminster residents diagnosed with and accessing care for HIV since 2004. This increase has not been consistent across all risk groups. Transmission of HIV amongst MSM, heterosexual women and mother to child prevention groups have proportionally increased, however, in terms of actual numbers, the increase in the number of cases is most marked amongst MSM. Interestingly, in the last two years for which data is available there has been a marked increase in the number of cases for which no route of transmission could be identified or where the route of transmission was identified as 'other'.

**Figure 24: HIV infected persons accessing care by prevention group, Westminster, London and England: 2004-2008**



Source: SOPHID 2008



### 5.1.2 Unlinked Anonymous Prevalence Monitoring Programme

The Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) monitors the prevalence of HIV in a number of key population groups (pregnant women, injecting drug users and genitourinary medicine clinic attendees) and provides prevalence estimates that include people with diagnosed and undiagnosed infection.

Table 3 shows the prevalence of HIV amongst GUM clinic attendees, intravenous drug users and pregnant women in London.

**Table 3: UAPMP prevalence of HIV, London 2007**

UAPMP	Population	Overall prevalence of HIV	Diagnosed prevalence of HIV	Undiagnosed prevalence of HIV
GUM clinic attendees in London	Heterosexual men	2.60%	1.97%	0.62%
	Heterosexual women	2.61%	1.93%	0.67%
	MSM	41.5%	38.8%	4.2%
Injecting drug users in London	Injecting drug users	4%	*	*
Pregnant women	Pregnant women	0.042%	*	*

Source: Health Protection Agency \* data not available

#### **(i) GUM Attendees in London**

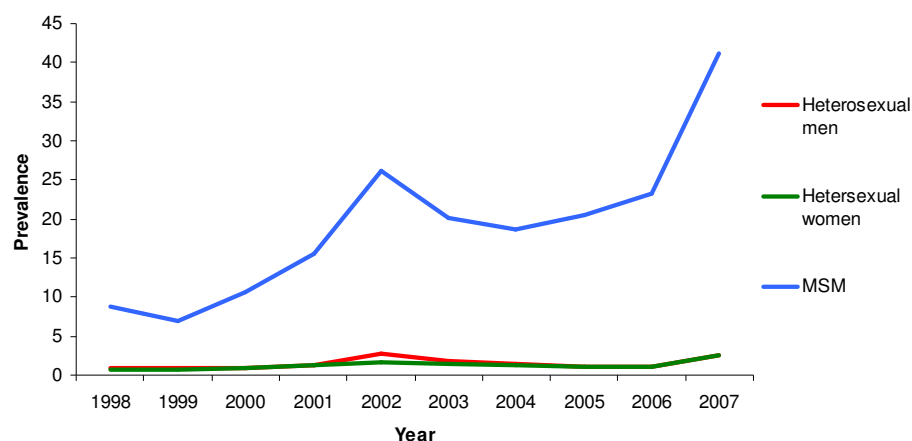
The estimated prevalence of HIV in heterosexual men and women is similar; approximately 2.60% of heterosexual men and 2.61% of heterosexual women attending GUM clinics in London were found to be HIV positive in 2007. The majority of men and women were previously diagnosed with HIV, suggesting that in this population group, levels of undiagnosed HIV infection are relatively low.

The estimated prevalence of HIV in MSM is high - 41.5% (this is significantly higher than the prevalence in England, 4.2%), however, again the majority of persons had been previously diagnosed with HIV infection.

It is important to note that the prevalence of HIV in MSM and heterosexual men and women attending GUM clinics is likely to be significantly higher than that in the general population. This is largely because the UAPMP survey of GUM clinic attendees uses left over specimens taken for syphilis tests to measure the prevalence of HIV amongst all GUM attendees. This sample is not representative of the Westminster population, as persons presenting to GUM for syphilis testing represent a relatively high risk group for HIV infection.

Looking at the UAPMP prevalence data over time, after a number of years of being relatively stable, the prevalence of HIV amongst heterosexual men, women and MSM increased significantly between 2006 and 2007 (figure 25).

**Figure 25: Estimated prevalence of HIV, London 1998-2007 (diagnosed and undiagnosed infection)**



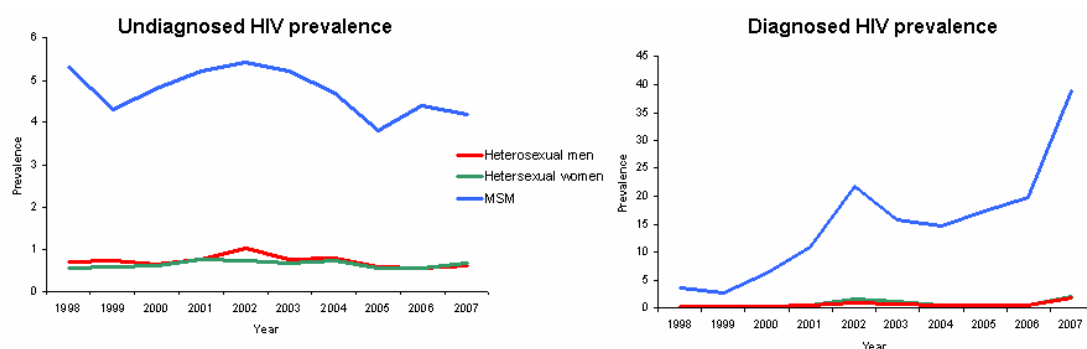
Source: Health Protection Agency

The prevalence of undiagnosed HIV has remained relatively stable over the past nine years in heterosexual men, women and MSM suggesting that the overall increase in prevalence of HIV appears to be attributable to the increase in the prevalence of diagnosed HIV infection (figure 26).

The fact that there has been little decline in the prevalence of undiagnosed HIV infection suggests that continued work is needed to identify undiagnosed HIV infections in heterosexual men and women and MSM.

Amongst MSM, the prevalence of undiagnosed infection was highest among persons aged 35-44 and 45 and over. This could be interpreted that younger men have a greater awareness of HIV and are thus more likely to be diagnosed, however, further work is needed to understand these trends. No data was available regarding the age of heterosexuals with undiagnosed infection.

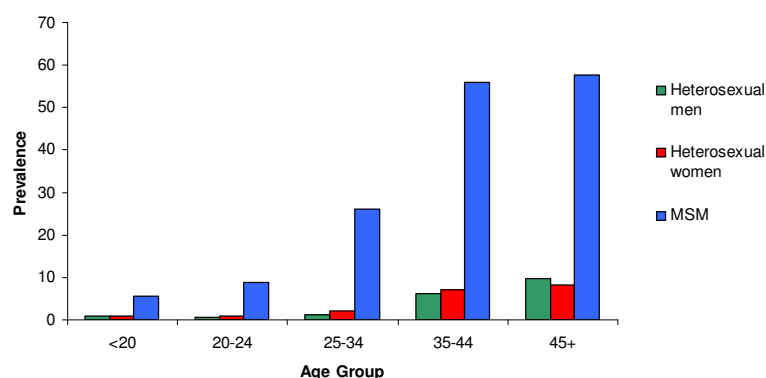
**Figure 26: Estimated prevalence of HIV, London 1998-2007**



Source: Health Protection Agency

For all risk groups, the overall prevalence of HIV increases with age, which is unsurprising given that people with HIV are living for longer and less likely to die prematurely as a result of infection. This data, however, does not identify the age at which HIV was acquired and it is likely that incident cases (i.e. new infections) are highest among younger age groups.

**Figure 27: Prevalence of HIV by age and route of transmission, 2007**



Source: Health Protection Agency

### **(ii) Antenatal testing and Injecting Drug Users Survey**

The estimated prevalence of HIV in pregnant women and IDUs in London is 0.042% and 4% respectively. The relatively high prevalence amongst IDUs is unsurprising given that they are an identified high risk group. At the time of writing no data was available regarding the prevalence of undiagnosed infection and so it is not possible to determine how likely these groups are to have undiagnosed HIV infection.

### **(iii) Other prevalence surveys**

In addition to the UAPMP, other surveys can be used to estimate the prevalence of HIV in Westminster. The Gay Men's Sex Survey surveys men in a range of settings; latest available data for 2008 found an HIV prevalence of 12.9% in Westminster residents (Sigma Research, 2008).

## **5.2 Incidence of HIV in Westminster**

Incidence is a measure of the number of new cases in a population over a defined period of time. As is the case for prevalence, ascertaining the incidence of HIV in Westminster is problematic, as because HIV infection is asymptomatic in the early stages of infection, persons are often not diagnosed at the time of infection, but instead at a later date. As a result, the incidence of HIV can only be calculated for newly diagnosed cases (as opposed to newly acquired infections) and also for new patients accessing treatment. However, it should be noted that such measures may not be an accurate reflection of current infection rates; the number of newly diagnosed cases and new patients accessing care may be influenced by a number of factors including diagnostic practices.

Despite the disadvantages associated with the data, understanding incidence patterns is essential to effectively target, monitor and evaluate HIV prevention and health promotion initiatives.

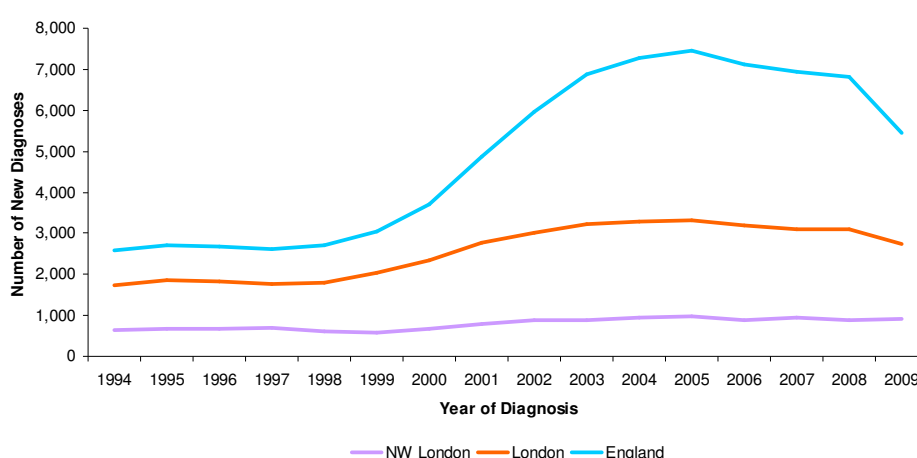
Since new diagnosis data is not linked to place of residence it is not possible to provide robust estimates of the incidence of HIV in Westminster based on new diagnosis data, however the number of new patients accessing HIV care is known locally. In 2009/10, 148 new patients accessed HIV treatment in Westminster.

Inferences can, however, be drawn from new diagnosis data available at North West London level, although, it should be noted that North West London data is not entirely generalisable to Westminster, with other boroughs within the North West sector likely

to have larger Black African and Black Caribbean populations and smaller MSM populations than Westminster.

Latest available data shows that there has been little change in the number of newly diagnosed HIV cases in North West London over the last five years. In 2009, 921 new HIV infections were detected. This is in contrast to the picture in London and England, where the overall number of new infections each year is decreasing (North West London Health Protection Unit, 2010).

**Figure 28: New HIV diagnoses, North West London 1994-2009**



Source: Health Protection Agency

### **5.2.1 What are the characteristics of those persons newly diagnosed with HIV?**

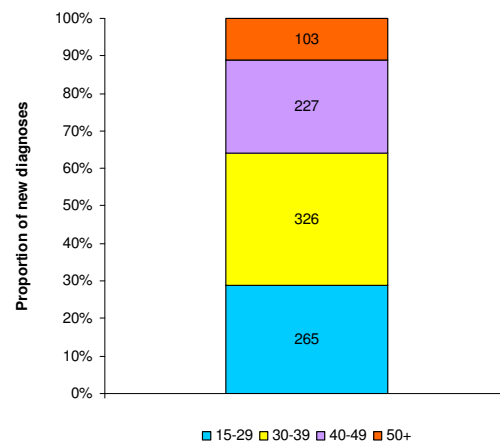
#### **(i) Age and Sex**

The majority of newly diagnosed HIV infections in the North West London sector are male (82%) and in terms of the age profile, the majority of new diagnoses are aged 25-39 years old.

#### **(ii) Ethnicity**

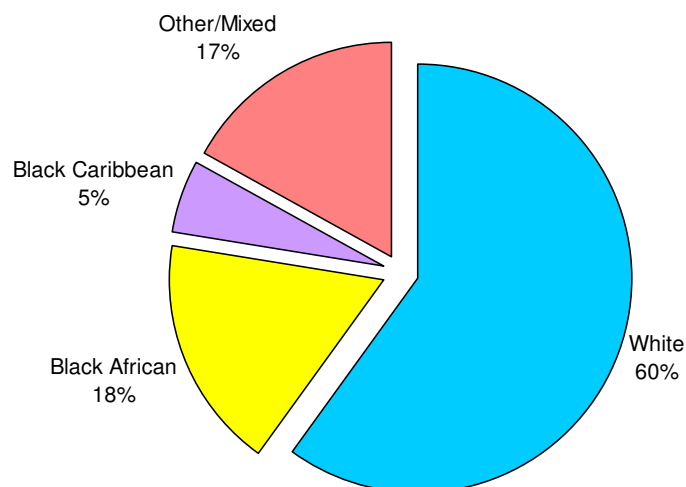
In terms of ethnicity, the majority of new HIV diagnoses are in persons from White ethnic groups, most of whom are males (94.2% of new diagnoses amongst persons from White ethnic groups are male); this is in contrast to London and England where persons from White ethnic groups represent a smaller proportion of new diagnoses. The second highest proportion of new diagnoses is amongst persons from Black African ethnic groups.

**Figure 29: New HIV diagnoses by age, North West London 2009**



Source: Health Protection Agency

**Figure 30: New HIV diagnoses by ethnicity, North West London 2007**

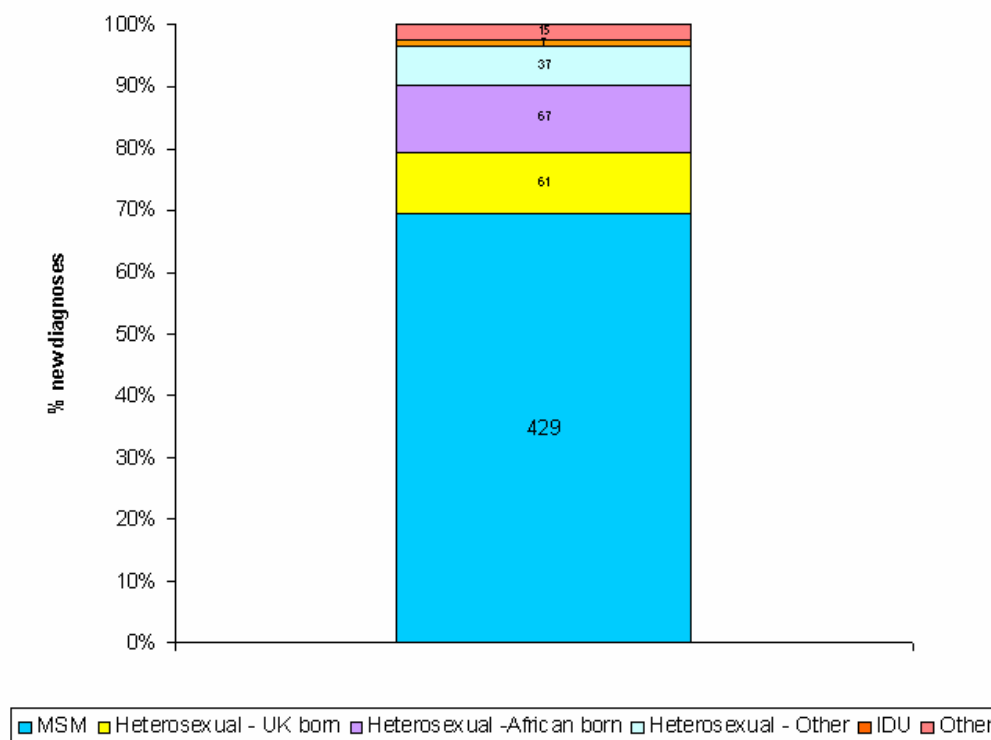


Source: Health Protection Agency

### **(iii) Prevention group**

MSM account for the largest proportion of new HIV diagnoses, followed by heterosexual contact - African born and heterosexual contact UK born.

**Figure 31: New HIV diagnoses by prevention group, North West London 2007**



Source: Health Protection Agency

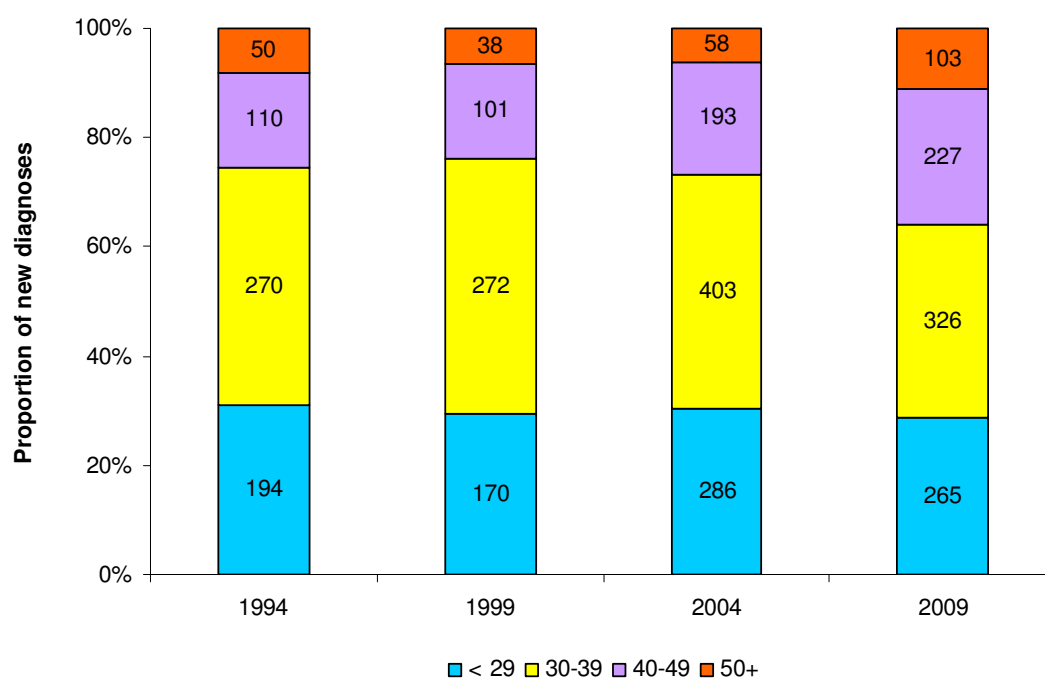
## 5.2.2 How have the characteristics of persons newly diagnosed with HIV changed over time?

### (i) age and sex

In North West London, men have consistently accounted for the majority of new diagnosed infections – between 1994 and 2009 there has been little overall change in the proportion of new diagnoses that men account for.

There have, however, been some changes with regards to age; although persons aged 30-39 have consistently represented the largest proportion of new diagnoses, the proportion has decreased in recent years. An increasing proportion of new diagnoses are in older persons, particularly those aged 50 and over.

**Figure 32: New HIV diagnoses by age, North West London 1995-2009**



Source: Health Protection Agency

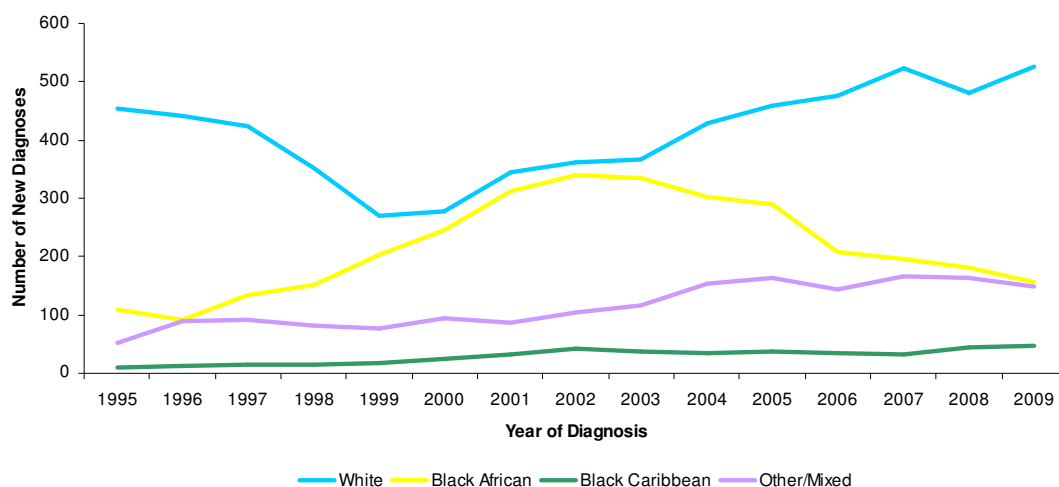
## **(ii) ethnicity**

The number of new diagnoses amongst persons from White ethnic groups has been increasing year on year since 1999, however the number of new diagnoses amongst persons from Black African ethnic groups has declined in recent years. The reasons for this are unclear, however this may be a result of changing patterns of migration, with less Black African immigrants coming to London (and being diagnosed and treated), improved control of the HIV epidemic amongst Black Africans, or a decline in the numbers of Black Africans being tested.

Proportionately, this is shown in figure 34; the proportion of new diagnoses from Black African groups has decreased over the last 15 years, whilst the proportion of cases from White and Other ethnic groups has increased slightly in the last five years.

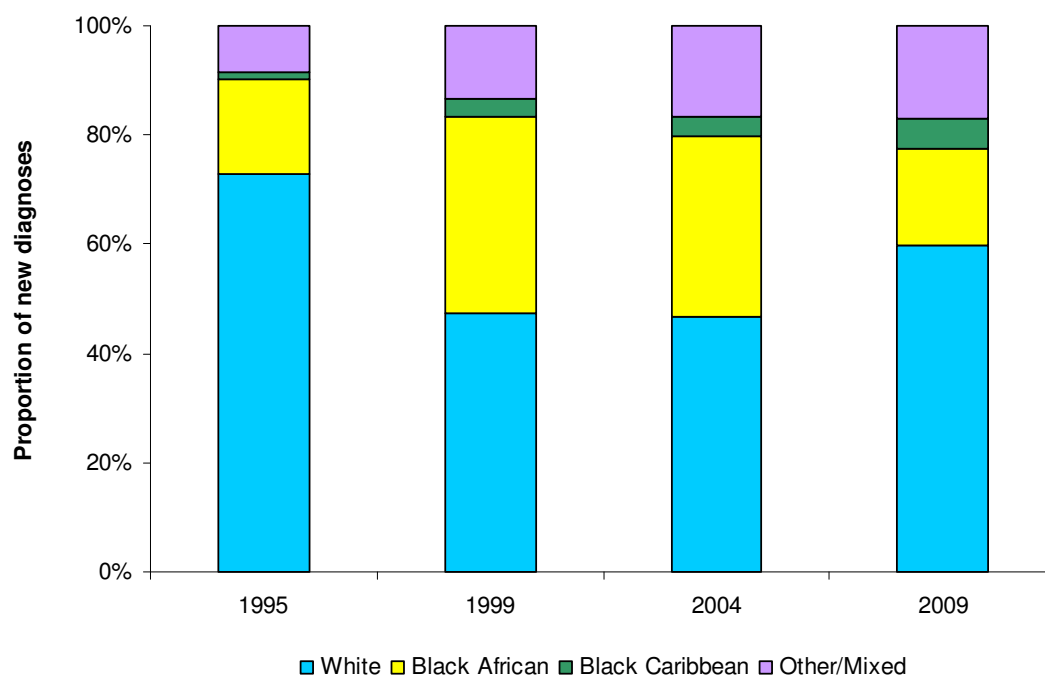


**Figure 33: New HIV diagnoses by ethnicity (numbers), North West London 1995-2009**



Source: Health Protection Agency

**Figure 34: New HIV diagnoses by ethnicity (proportions), North West London 1995-2009**

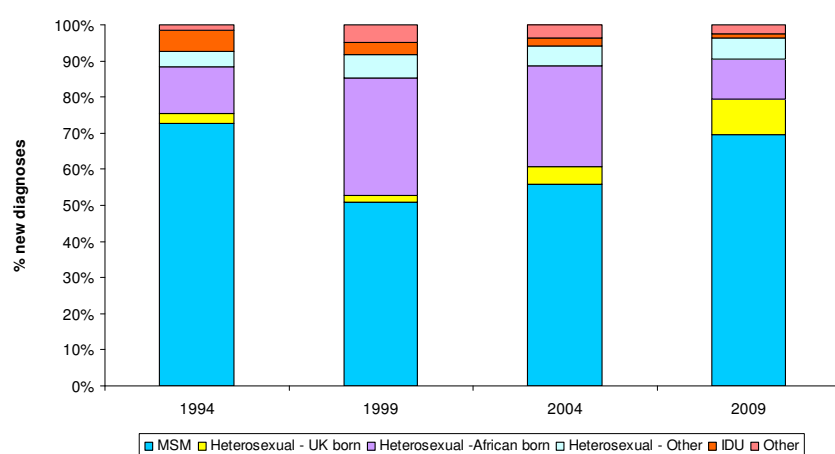


Source: Health Protection Agency

### (iii) Route of transmission

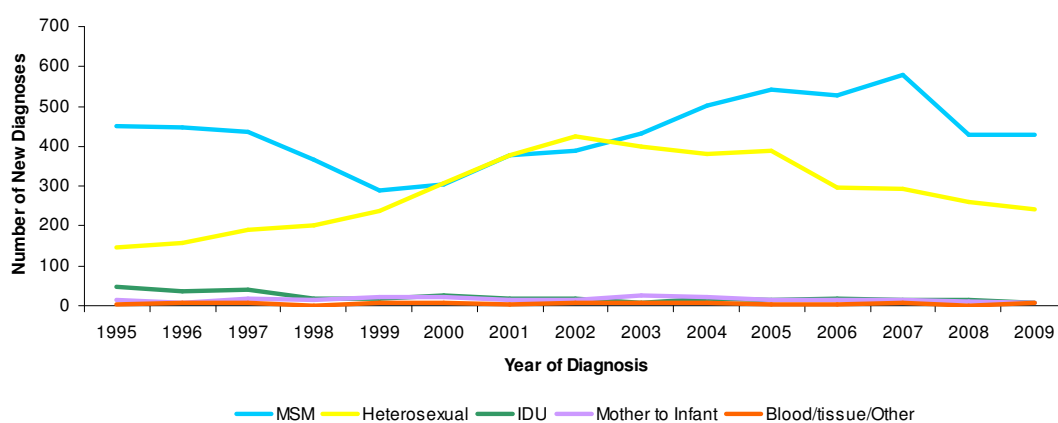
Consistent with the trends in ethnicity of new HIV diagnoses, the proportion of new diagnoses from heterosexual contact (African born) have decreased – the proportion of new diagnoses from heterosexual contact – African born is now similar to the proportion of new diagnoses from heterosexual contact – UK born (figure 35). In line with this trend, the proportion of new diagnoses among MSM has increased. In terms of actual numbers there has been no real increase in the number of MSM diagnosed with HIV in the last two years for which data is available (figure 36).

**Figure 35: New HIV diagnoses by route of transmission (proportions), North West London 1995-2009**



Source: Health Protection Agency

**Figure 36: New HIV diagnoses by route of transmission (numbers), North West London 1995-2009**



Source: Health Protection Agency

### **5.3 Conclusions**

Westminster is disproportionately affected by HIV infection and has one of the highest prevalences in the country. HIV also contributes to health inequalities in Westminster; the majority of infections are amongst MSM, although Black African ethnic groups are also disproportionately affected.

In recent years there has been little change in the overall number of new infections diagnosed each year – this is in contrast to the national picture where the number of new diagnoses is showing signs of decline. HIV, however, remains an important public health problem, as in Westminster an increasing number of new diagnoses are in older persons and also because persons with HIV are living longer. As a result, the local population infected with HIV is ageing. Accordingly, the changing profile of HIV in Westminster is likely to pose significant challenges in the future.

## 6: Epidemiology of Teenage Pregnancy

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### Key Messages:

- **Teenage pregnancy is commonly associated with poor outcomes for the teenage parent and the child;**
- **There has been a small decline in the rates of teenage conceptions in Westminster over the last decade;**
- **The teenage conception rate in Westminster is 37.3 per 1,000 females aged 15-17 years old- this is lower than the London and England rates;**
- **Teenage conception is highly correlated with deprivation, with teenage conception rates highest in more deprived areas;**
- **A high proportion of teenage conceptions in Westminster result in termination (74%) – this is significantly higher than in London and England.**

Teenage conceptions are defined as conceptions in persons aged under 18 years old (Teenage Pregnancy Unit, 2010). Teenage conceptions provide an indicator of early sexual behaviour and imply that teenage girls are also putting themselves at risk of contracting STIs through unprotected sex. Most teenage conceptions are unplanned and many lead to termination.

Teenage pregnancy is associated with significant health inequalities. A number of factors have been shown to be associated with an increased risk of teenage pregnancy. The following are considered to be at higher risk:

- Young people living in deprivation
- young people in care or leaving care
- children of teenage mothers
- children of lone parents
- young people with lower rates of educational attainment
- young people with low self esteem
- young people not in education, training or work at the age of 16
- young people who have been sexually abused
- young people with mental health problems
- young people who have had contact with the police.

It is important to note that for some women, having a child as a teenager is a positive experience, however, for many more the experience is a difficult one, either where a termination is sought or where the choice is made to bring up the child. As well as being an avoidable experience for women, abortions represent an avoidable cost for the NHS.

Teenage parenting is often associated with poor outcomes for both the teenage parent(s) and the child, with regards to the child's health, the emotional health and well-being of the mother and the likelihood of both the mother and child living in long term poverty.

In 1999, the National Teenage Pregnancy Strategy was launched. Three key aims were outlined:

- to establish a reduction in the rate of under-18 teenage conceptions by 15% by 2004 and 50% by 2010;
- to establish a firm downward trend in the rate of under-16 conceptions by 2010;
- to establish an increase in the rates of teenage mothers in education, employment and training by 60% by 2010.

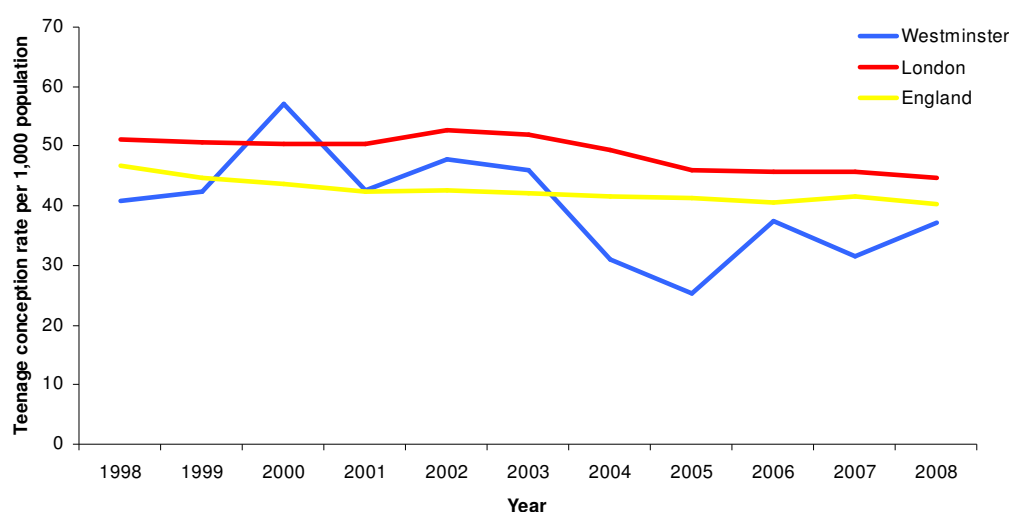
## **6.1 Incidence of teenage pregnancy in Westminster**

Westminster has lower rates of teenage pregnancy than both London and England overall. Latest available data for 2008 shows that the teenage conception rate in Westminster is 37.3 per 1,000 population; this compares to 44.6 per 1,000 in London and 40.42 per 1,000 in England.

Over the last decade the teenage conception rate has shown a small decline in Westminster (8% reduction between 1998 and 2008); this is lower than that observed in England (13% reduction).

Based on current trends it is unlikely that Westminster will meet the target set out in the National Teenage Pregnancy Strategy to reduce the rate of under-18 teenage conceptions by 50% by 2010.

**Figure 37: Trends in teenage conceptions, 1998-2008**



Source: Teenage Pregnancy Unit, February 2010

## **6.2 What are the characteristics of teenage conceptions in Westminster?**

### **(i) Age**

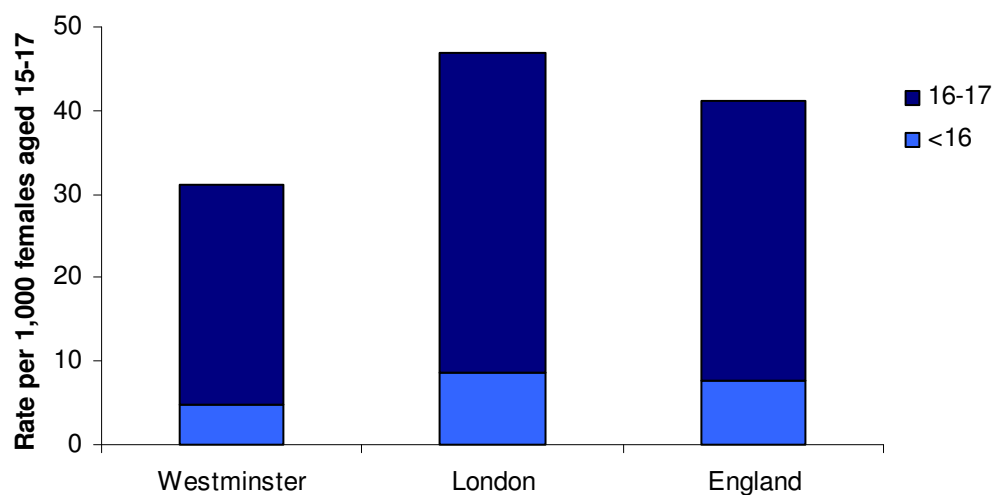
The latest available data describing teenage conceptions by age is for 2004-06. This data is due to be updated in the summer of 2010.

The majority of teenage conceptions in Westminster occur in girls aged 16 or 17, however, there are some conceptions in younger girls. In 2007 the under 16 conception rate in Westminster was 4.8 per 1,000 females; this compares to 8.6 and 7.6 in London and England. As expected, conception rates in girls aged 16 and 17 in Westminster are markedly higher than for girls aged under 16.

### **(ii) Place**

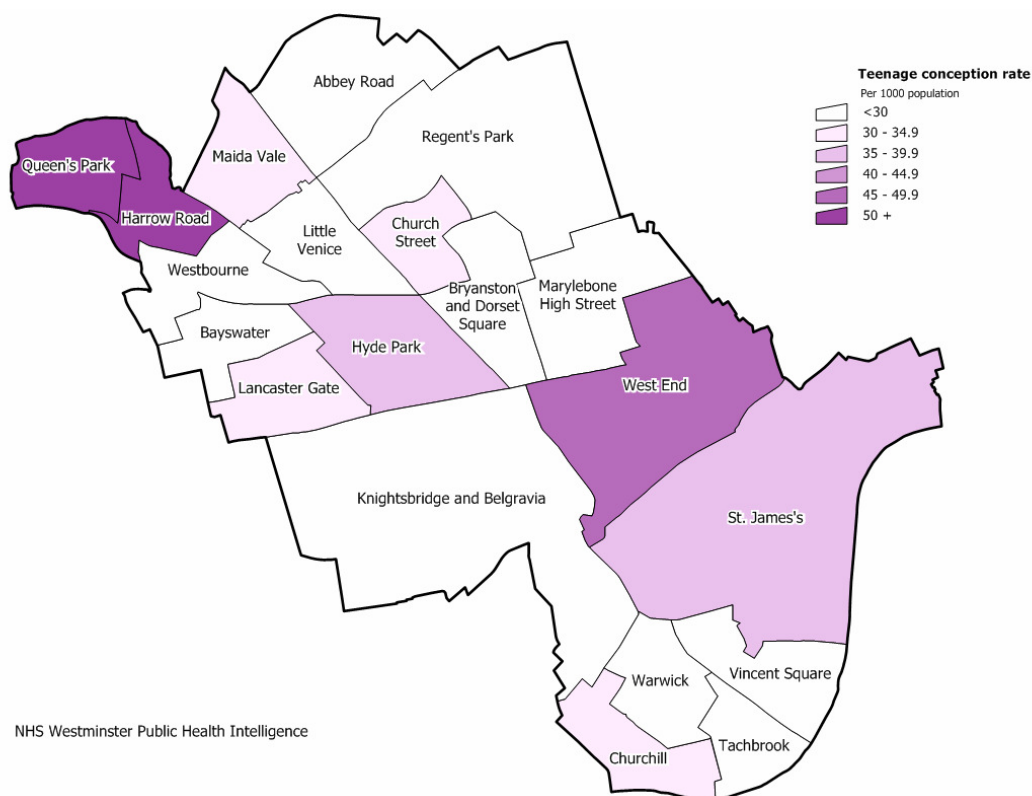
Local analysis shows that the teenage conception rate is not uniform across Westminster. Latest available ward level data (2004-2006) shows that Harrow Road, Queen's Park and West End wards have the highest teenage conception rates, whilst Knightsbridge and Belgravia and Marylebone High Street wards have the lowest teenage conception rates.

**Figure 38: Teenage conceptions by age, 2004-06**



Source: Teenage Pregnancy Unit, February 2010

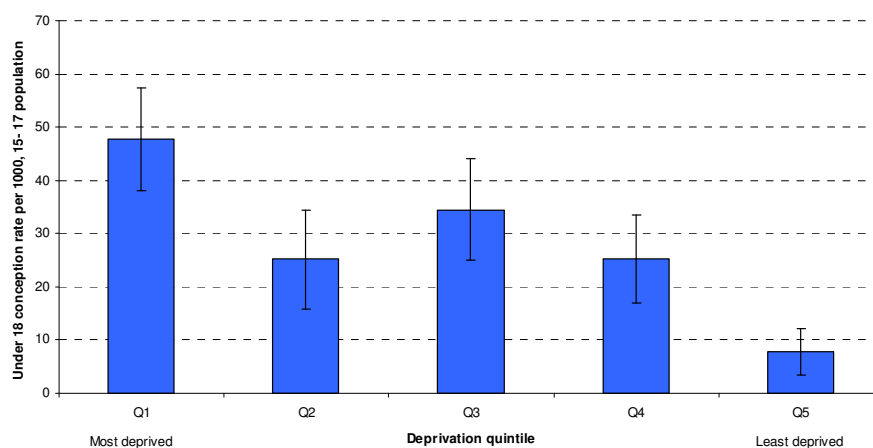
**Figure 39: Teenage conception rates by ward, 2004-2006**



Source: Teenage Pregnancy Unit, February 2010

Teenage conception is highly correlated with deprivation, with teenage conception rates highest in more deprived areas. Similarly, the proportion of teenage conceptions leading to birth (as opposed to abortion) is also highest in the most deprived areas.

**Figure 40: Teenage conceptions by deprivation quintile, 2004-2006**

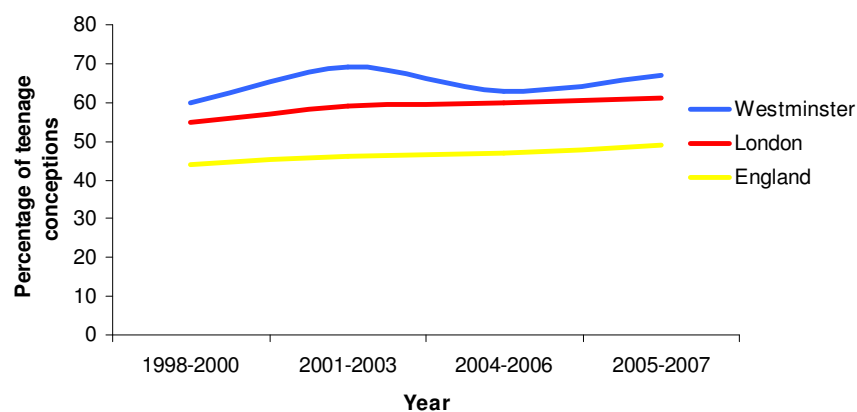


Source: Teenage Pregnancy Unit, February 2010

### 6.3 Teenage conceptions leading to termination

In 2007, 74% of teenage conceptions in Westminster resulted in termination; this is higher than both London and England (63% and 51% respectively). Three year rolling averages show that over the last decade the proportion of teenage conceptions resulting in termination both locally and nationally has risen.

**Figure 41: Teenage conceptions resulting in termination, 1998-2007 (three year rolling averages)**



Source: Teenage Pregnancy Unit, February 2010



## **6.4 Conclusions**

Although the teenage pregnancy rate in Westminster has declined over the last decade, Westminster is unlikely to meet the National Teenage Pregnancy Strategy target. Accordingly, teenage pregnancy remains a local priority, given that it is associated with significant health inequalities and is often associated with poor outcomes for both mother and child.

More detailed work on teenage pregnancy has been undertaken by the Children and Young Person's Team at NHS Westminster. For further information please contact Anna Varela-Raynes at NHS Westminster: [Anna.Varela-Raynes@Westminster-pct.nhs.uk](mailto:Anna.Varela-Raynes@Westminster-pct.nhs.uk)

## 7: Epidemiology of Abortion

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### Key Messages:

- There has been little change in the abortion rate in Westminster in recent years;
- The abortion rate in Westminster is 19 per 1,000 women aged 15-44 – this is higher than the national rate, but lower than the rate in London;
- Abortion rates are highest in women among women aged 18-24, however, the abortion rate in Westminster women aged <18 and 30 and above is also high compared to England as a whole;
- Given the ethnic profile of the Westminster population, persons from White, 'Other' and Asian ethnic groups are more likely than other ethnic groups to have an abortion;
- Westminster has one of the highest proportions of privately funded abortions in England;
- A high proportion of abortions are conducted under 10 weeks gestation – a higher proportion than in London and England, suggesting that Westminster women have good access to abortion services;
- St Mary's Hospital, Chelsea and Westminster Hospital, MSI and BPAS are the main providers of abortion services to Westminster women.

Unintended pregnancies can be associated with poor sexual health outcomes. Furthermore, unintended pregnancies are seen as a reflection of poor access to contraceptive services and are associated with sexually transmitted infections.

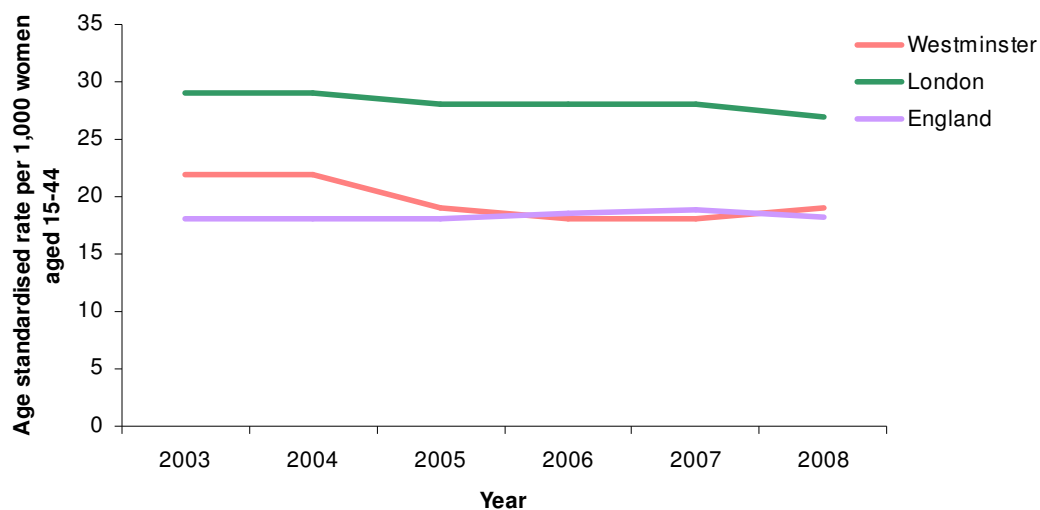
In order to better understand abortion trends in Westminster, a range of data sources have been drawn upon. Firstly Office of National Statistics (ONS) data was used to determine local abortion rates and understand how these compare regionally and nationally, as well as identifying the number of privately funded abortions and gestation period at time of abortion. Secondly, local data from providers was requested in order to better understand who are the women in Westminster requiring termination of pregnancy (TOP) in terms of age, ethnicity and ward of residence.

## 7.1 Incidence of abortion in Westminster

In 2008, the age standardised rate of abortion in Westminster is 19 per 1,000 women aged 15-44; this is lower than the rate in London (27 per 1,000 women) but higher than in England (18.3 per 1,000).

In the early 2000s, rates fell to levels in line with the national average, however, in recent years rates have remained about the same, or rising slightly.

**Figure 42: Abortion rates in women aged 15-44, 2003-2008**



Source: Office of National Statistics

## 7.2 What are the characteristics of Westminster women undergoing abortion?

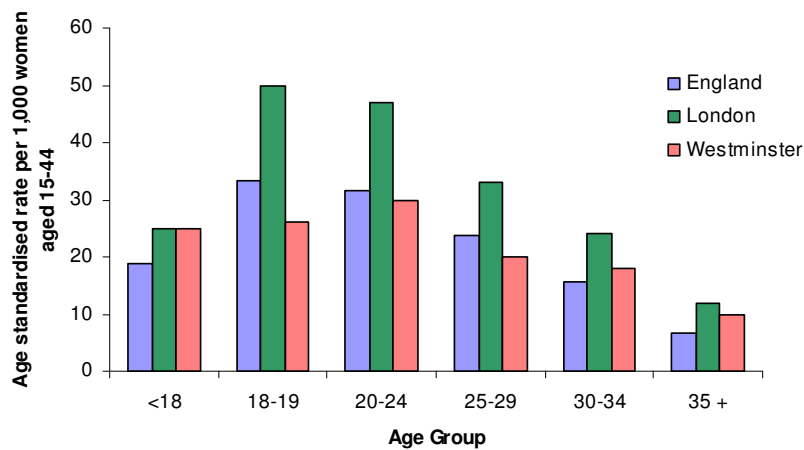
### (i) Age

In Westminster, abortion rates are highest amongst women aged 18-19 and 20-24 (as is the case regionally and nationally), however, the rate of abortion in both Westminster and London is also relatively high in women aged <18 and 30 and above compared to England.

Using local data from providers to break down age band further shows that the majority of women in Westminster aged <18 having abortions are aged 16 and 17 – very few abortions occur in Westminster in persons younger than this. In terms of women aged 35 and above having abortions, the majority are aged 35-39, however, it should be noted that a significant number of women in their forties in Westminster

are seeking abortions; in 2009/10, 7.3% of abortions in Westminster women were in women aged 40 and over.

**Figure 43: Abortion rates by age, 2008**

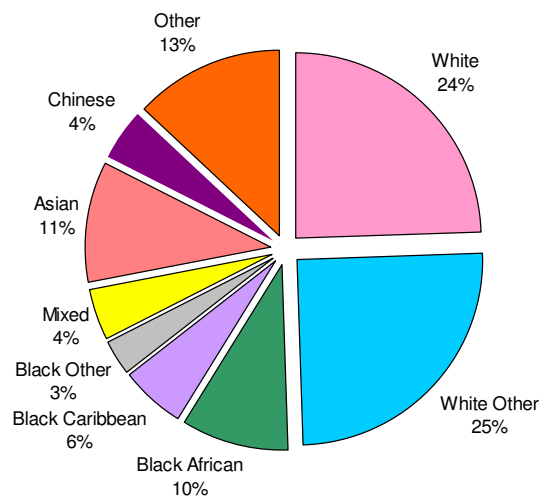


Source: Office of National Statistics

**(ii) Ethnicity**

Latest available local data from providers shows that the majority of abortions are in women from White Other ethnic groups – followed by White and ‘Other’ ethnic groups. Given the ethnic mix of the Westminster female population of reproductive age – persons from White, ‘Other’ and Asian ethnic groups are overrepresented.

**Figure 44: Abortion by ethnic group, Westminster 2009/10**



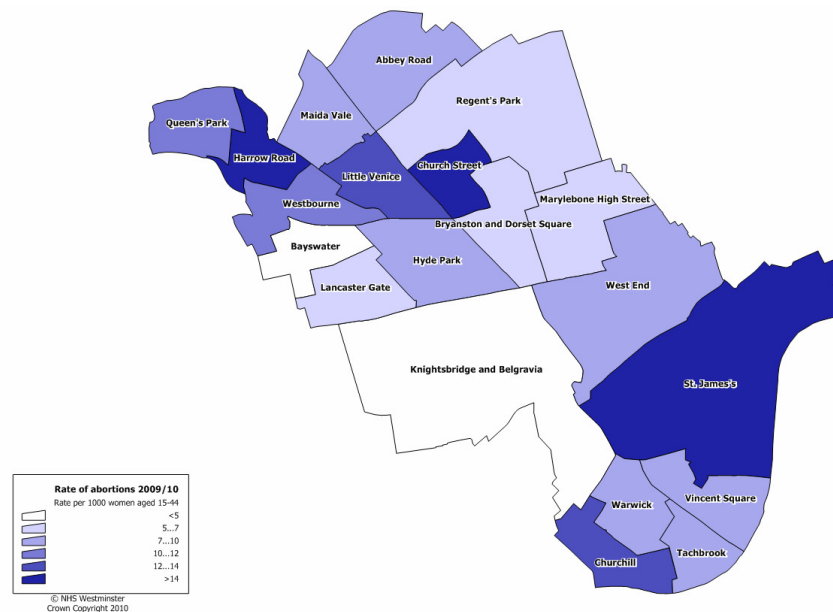
Source: Secondary User Service, Marie Stopes International & British Pregnancy Advisory Service

### (iii) Place of residence

Local analysis shows that the abortion rate is not uniform across Westminster.

Abortion rates are highest in wards in the North West of the borough as well as St James' and Churchill wards.

**Figure 45: Abortion by ward of residence, Westminster 2009/10**



Source: Secondary User Service, Marie Stopes International & British Pregnancy Advisory Service

In persons aged under 18, almost all abortions were in women living in the North West of the borough – an area experiencing high deprivation.

### (iv) Privately funded abortions

A large proportion of abortions in Westminster are privately funded – 30% (this is the second highest in the country being Kensington and Chelsea at 31%) and compares to 15% in London and 9% in England.

### (v) Gestation period

Early access to abortion is essential and Department of Health Policy states that women who are legally entitled to an abortion should have access to the procedure as soon as possible. Furthermore, the risk of complications increases with increasing gestation.

The Chief Medical Officer recommends that 70% of abortions should be performed under 10 weeks.

In 2008, 82% of abortions in Westminster were conducted at between 3 and 9 weeks gestation; this compares to 77% in London and 72% in England. This most likely reflects the ease of access to and responsiveness of services available to Westminster residents.

It is also useful to examine the proportion of abortions that are repeat abortions in women under 25 years of age. Repeat unintended pregnancy and subsequent abortion is associated with increased pregnancy risks. Furthermore, repeat abortions may reflect access to contraception and education surrounding contraception amongst women aged 25 and under as well as other more complex social factors.

Latest available data for Westminster shows that 29% of abortions performed in 2008 in women aged 25 and under were repeat abortions; this compares to 31% in London and 24% in England. This is a relatively high proportion and suggests that further work is needed to better understand the reasons why young women have multiple unintended pregnancies (for example, are there particular characteristics of these young women, do they find contraception hard to access etc) to tailor appropriate interventions for the Westminster population.

### **7.3 Place of abortion**

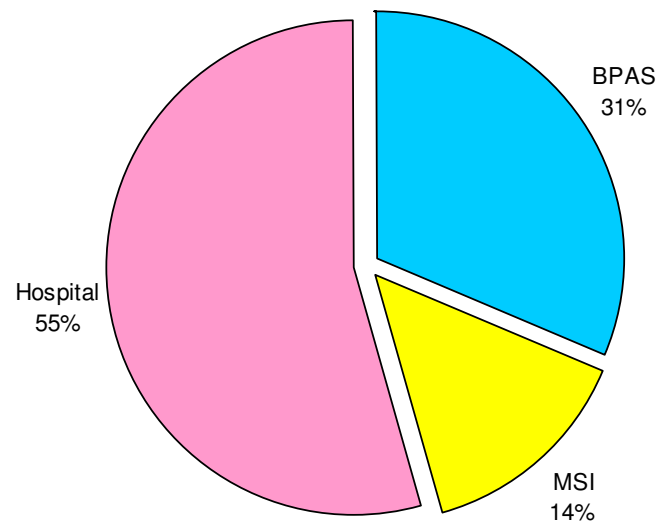
There are a range of abortion services commissioned by NHS Westminster; the three main providers in the borough are:

- Hospital providers;
- Marie Stopes International (MSI);
- The British Pregnancy Advisory Service (BPAS).

The majority of NHS funded abortions in Westminster women are carried out by hospital providers (55%); St Mary's Hospital is the main hospital provider, followed by Chelsea and Westminster Hospital and University College Hospital.

BPAS and MSI are also important providers of NHS funded abortion services, accounting for 31% and 14% of NHS funded Westminster abortions respectively.

**Figure 46: NHS funded abortions by provider, Westminster 2009/10**



Source: Secondary User Service, Marie Stopes International & British Pregnancy Advisory Service

## **7.4 Conclusions**

There has been little change in the rate of abortion in Westminster women in recent years and the rate remains higher than the national average. Overall, access to abortion services in Westminster is good however, there are large variations in the rate of abortions between women of different ages, place of residence and also ethnic groups. The reasons for this are unclear and accordingly, further work is needed to understand the underlying reasons for these differences.

## **Provision of Sexual Health Services in Westminster**



## **8: Overview of Sexual Health Services in Westminster**

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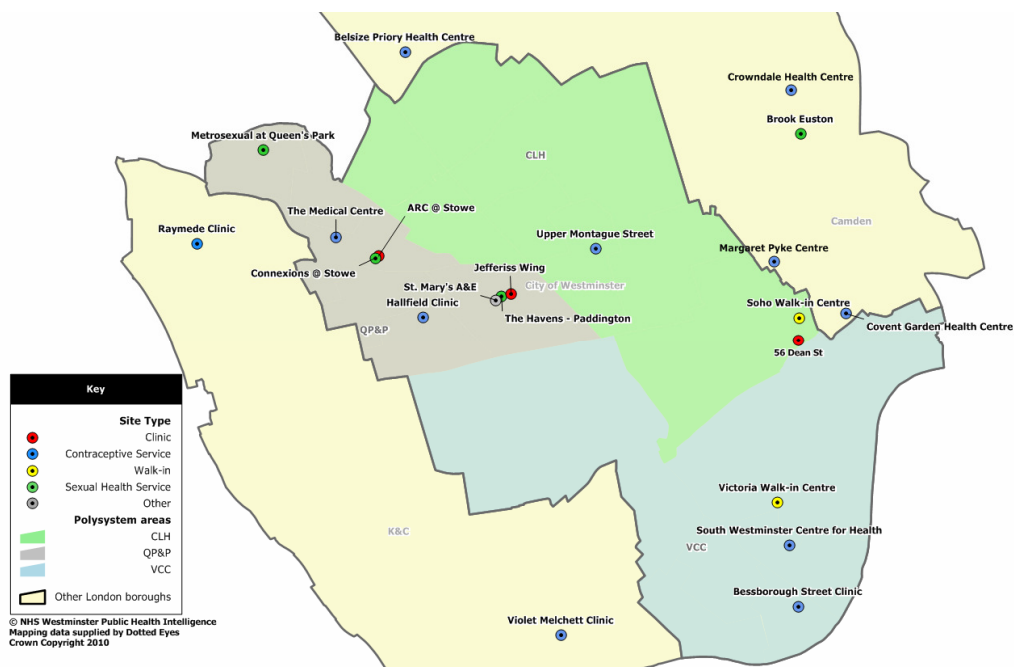
NHS Westminster and Westminster City Council commission a range of services with regards to the prevention, testing and management of sexual and reproductive health in Westminster.

The following chapters describe the current provision of sexual and reproductive health services in more detail, as well as attempting to understand who is using services and for what reasons. However, it should be noted that it is beyond the scope of this needs assessment to describe and understand all services that may contribute to the prevention of STIs, HIV, unintended pregnancies and other poor sexual health outcomes, as a large number of services and projects contribute to the prevention of poor sexual health, either directly or indirectly.

This needs assessment primarily focuses on the following services areas:

- Sexual health services provided in primary care and other community settings (contraception and STI diagnosis and treatment);
- GUM
- Community contraceptive services;
- Abortion services;
- HIV and other blood borne virus testing;
- HIV prevention;
- Management and treatment of HIV;
- National Chlamydia Screening Programme.

**Figure 47: Overview of sexual and reproductive health services provided in Westminster**



Note: GPs and community pharmacies are important providers of sexual health services. For information on the Westminster GPs and community pharmacies, please see Appendix A.

## 9: General Practice

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### Key Messages:

- **General practice is an under used resource for sexual health;**
- **However, the provision of sexual health services in general practice is inconsistent across the borough;**
- **Women are more likely to access their GP for sexual health than men;**
- **Levels of screening for HIV and STIs are low;**
- **The majority of women in Westminster access contraception via their GP – the most common form of contraception provided is the pill, whilst provision of LARC is low;**
- **GPs are the main NHS provider of EHC in Westminster;**
- **There is a growing body of evidence to support the increase in the provision of sexual health services in general practice.**

Recent government policy places an increasing emphasis on providing sexual health services in the community and accordingly, GPs are an important provider of sexual health services. However, the Independent Advisory Group on Sexual Health and HIV (2006/2007) suggests that sexual health is a low priority for GPs. This is because many GPs are not trained to treat sexually health holistically and do not engage with sexual health issues.

### 9.1 Overview of sexual health services provided in primary care

The All Party Pro-Choice and Sexual Health Group of 122 PCTs (2007) found that the provision of sexual health services by GPs was 'erratic, uncoordinated and poorly planned.' A recent service mapping exercise in Westminster showed that locally the provision of sexual health services in general practice was generally poor and varies considerably across the borough. Furthermore, provision of data to better understand sexual health in the context of primary care was patchy.

The main sexual health services provided in general practice in Westminster include:

- STI screening;
- Testing for blood-borne viruses;
- Contraception, including LARC.

For a detailed overview of sexual health provision, see Appendix B.

## 9.2 STI and blood-borne virus testing in general practice

Local data suggests that a small number of tests for STIs occur in general practice settings. The majority of Westminster GPs use laboratories based at Imperial to process their tests.

The most common STI tested for in general practice settings (using Imperial laboratories) was herpes simplex virus – in 2009, 2,572 tests were processed. This was followed by chlamydia in which 1,826 tests were processed and then HIV and syphilis. From the data available it is not possible to determine the number of tests that were processed for gonorrhoea – such tests are coded as either urethral or vaginal swab and include tests for gonorrhoea amongst other conditions – therefore, it is not possible to distinguish between a test for gonorrhoea and other conditions.

**Table 4: STI testing in general practice, Westminster 2009**

STI	Males		Females	
	N	%	N	%
Herpes Simplex Virus	9	0.4%	2,531	99.6%
Syphilis	67	30%	155	70%
Chlamydia	92	5%	1,734	95%
HIV	137	39%	214	61%

Source: Imperial Healthcare Trust

For all conditions the number of tests was higher in females than males – this was particularly the case for herpes simplex virus and chlamydia. This is unsurprising given that women are more likely to engage with GPs for other reasons including contraception and cervical screening. Furthermore, the tests performed on men most frequently tend to be those requiring blood tests rather than genital examination/urine collection.

## 9.3 Contraception

General practice plays a key role in the provision of contraception; nationally it is estimated that three quarters of women accessing contraception do so via their GP. This figure is much quoted, although it is not clear if the proportion is similar in Westminster. In their 2007 report, the All-Party Parliamentary Pro-Choice and Sexual

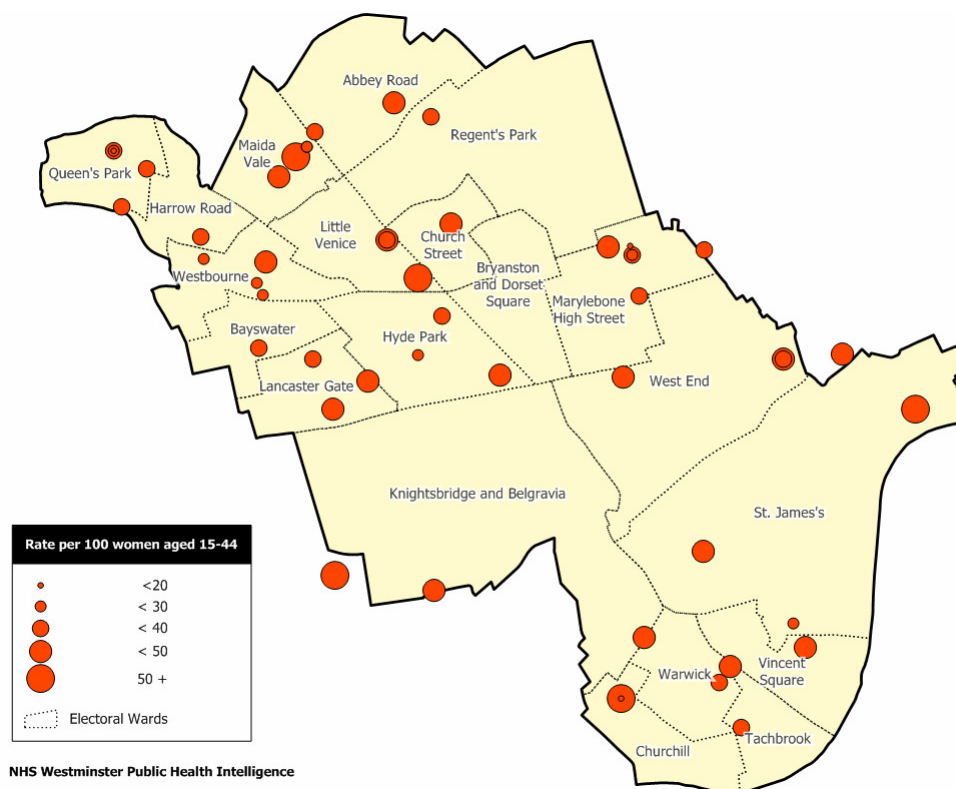
Health Group found that nationally the offer of contraceptive services in general practice was poor. The APPG report estimated that 70% of women were not being offered the full range of contraceptive methods by GPs. This is likely to be the case in Westminster - as is outlined in Appendix B, the contraceptive 'offer' varies between GP practices, particularly with regards to LARC.

### 9.3.1 Combined and progestogen only pill

Oral contraception is the most common form of contraception provided by GPs. The majority of women access oral contraceptives through their GPs. Latest available data for 2008/09 shows that the overall rate of oral contraception prescribing by Westminster GPs was 40.7 per 100 women aged 15-44. This was highest for the combined oral contraceptive (32.7 per 100 women aged 15-44) compared to the progestogen only contraceptive (8 per 100 women aged 15-44).

Prescribing of oral contraceptives in general practice, however, varies significantly between practices, ranging from 12.1 per 100 women aged 15-44 to 65.2 per 100 women aged 15-44.

**Figure 48: Prescribing of oral contraception by Westminster GPs, 2008/09**



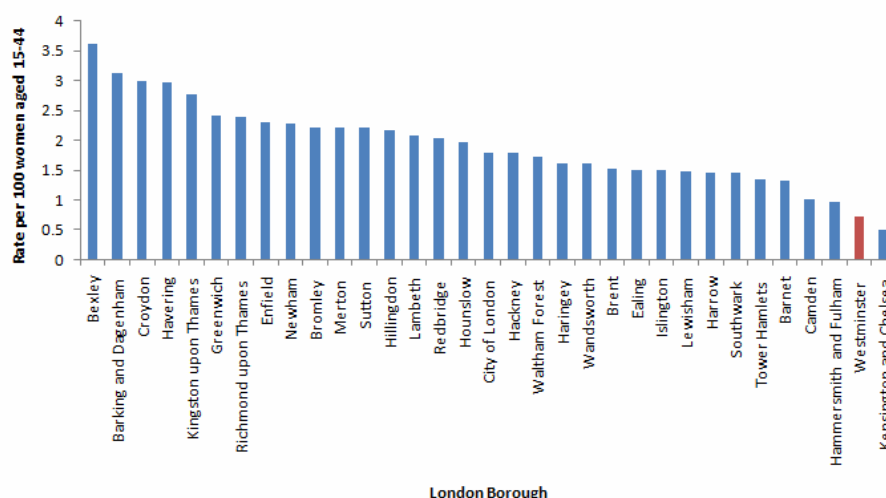
Source: ePACT

Currently little is known about the prescribing of oral contraceptives by different population subgroups in Westminster; ePACT data (which is the main source of prescribing data) does not record information such as age, ethnicity or disability, and therefore, it is unclear how prescribing varies other than by GP practice. Accordingly, there is a need for further local data collection to capture this data – this may be in the form of an audit.

### 9.3.2 LARC

The rate of GP prescribing of LARC in Westminster is low. Latest available data for 2007/08 shows that prescribing rates by Westminster GPs are the second lowest in London.

**Figure 49: Overall LARC prescribing rate per 100 women aged 15-44 in GP Practices, London 2007/08**



Source: Sex and Our City: Sexual Health Indicators Report

Provision of LARC by the 52 GP practices in Westminster is, however variable, with prescribing of different LARC methods varying between GP practices. Overall, depo-provera is the most commonly prescribed LARC by Westminster GPs followed by the IUCD.

#### (i) Depo-provera

Depo-provera prescribing varied greatly between GPs in Westminster. The rate of prescribing was highest for Paddington Green Health Centre (4.77 per 100 women

aged 15-44), The Westbourne Green Surgery (4.85 per 100 women aged 15-44), Lisson Grove Health Centre (4.49 77 per 100 women aged 15-44) and The Doctor Hickey Surgery (5.35 per 100 women aged 15-44). Seven GPs did not prescribe any depo-provera in 2007/08.

**Table 5: Prescribing of LARC by Westminster GPs, 2008/09**

<b>LARC</b>	<b>Overall prescribing rate per 100 women aged 15-44</b>
Depo-provera	1.42
IUS	0.1
Implant	0.04
IUD	0.14

Source: ePACT

#### **(ii) IUS**

Only twelve GPs fitted an IUS in Westminster; this was highest for Paddington Green Health Centre (0.66 per 100 women aged 15-44) and the Cavendish Health Centre 0.79 per 100 women aged 15-44).

#### **(iii) Implant**

Only five GPs prescribed the progestogen implant in Westminster in 2008/09.

#### **(iv) IUCD**

Only eleven GPs fitted the IUCD in Westminster in 2008/09; this was highest for the Third Floor Lanark Road Medical Centre (1.84 per 100 women aged 15-44).

Whilst it is clear that very little LARC provision is occurring in general practice, the exact reasons for this are unclear at present. However, there may be training issues, for example GPs and nurses have not undergone the necessary training to enable them to fit LARCs competently or awareness of LARC may be poor amongst GPs and patients. In order to better understand the reasons underlying the low prescribing rates, further work is needed to understand the uptake, acceptance and knowledge of LARC amongst women attending general practice for contraception. Furthermore, engagement with GPs is essential to understand prescribing practices and potential

barriers to prescribing LARC. Upon identification of the factors associated with low levels of prescribing, appropriate interventions can be implemented, for example, increased provision of training for GPs and practice nurses.

**Figure 50: LARC prescribing by GP practice, 2008/09**

Source: ePACT

In 2005, NICE published guidelines on LARC (NICE, 2005); these included recommendations around the management of women being prescribed LARC, the information women should be given and issues that should be considered before



fitting LARC such as STI testing. It is currently unclear how Westminster GPs are working to the NICE recommendations. For example, the NICE guideline recommends that IUDs and IUSs should only be fitted by trained personnel with continuing experience of inserting at least one IUD or IUS a month (NICE, 2005).

Accordingly, mechanisms for monitoring the provision of LARC in primary care are required to ensure that standards of care are in line with the NICE guideline. NHS Westminster is currently reviewing its locally enhanced scheme which considers issues around competency.

### **9.3.5 Emergency contraception**

General practice is the main provider of NHS funded emergency hormonal contraception in Westminster. In 2008/09, Westminster GPs prescribed emergency hormonal contraception in 977 cases – this is equivalent to an overall rate of 1.5 per 100 women aged 15-44.

## **9.4 Information gaps**

Overall data pertaining to the uptake of sexual health services in general practice is poor and where it does exist is patchy. Little is known about the demography of persons accessing sexual health services in primary care, for example, age, ethnicity, sexual orientation and deprivation experienced, and accordingly, it is difficult to identify unmet need and inequalities in access to sexual health services in general practice.

## **9.5 Conclusions**

General practice is an under used resource for sexual health, however, the provision of sexual health services in general practice is both limited and inconsistent across the borough. Further work is needed to improve the sexual health 'offer' in general practice. However, the population groups currently not accessing general practice are poorly understood and accordingly, further work is needed locally with residents to understand the barriers to accessing sexual health services in primary care settings.

There is a growing body of literature, including the national evaluation of one stop sexual health services, that shows it is possible to provide more comprehensive sexual health services in the general practice setting, with support from specialist health services. Locally a literature review conducted by the Commissioning Decision

Support Service found that 'hub and spoke' models of service system provide a good approach between specialist ('hub') and partner ('spoke') providers and also found evidence supporting outreach programmes for general practice in engaging people with sexual health services. Taking sexual health histories at GP registration was found to facilitate normalising sexual health in the general practice setting.

The literature review highlighted that although there is a growing amount of evidence for improving the provision of sexual health services in general practice, that provision should not replace other services, and that consideration should be given to particular population groups – the provision of sexual health services for some population groups in general practice settings may not be acceptable. Accordingly, further work should be conducted with local population groups such as MSM, lesbian women, BME populations etc, to understand how acceptable sexual health provision in general practice settings is and as highlighted previously, the potential barriers to accessing general practice.

#### Recommendations

- Further work is needed to understand how acceptable the offer of sexual health services in general practice is to the Westminster population and understand the barriers to accessing sexual health in this setting;
- The provision of sexual health services in general practice settings should be improved – this includes STI/HIV testing and contraception, including LARC;
- Improved data collection methods are needed to ensure that activity of general practices with regards to sexual health can be monitored.

## **10: Other Sexual Health Services Delivered in Community Settings**

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### **Key Messages:**

- **Sexual health services are not only provided by general practice but also in other community settings;**
- **Westminster has recently commissioned a community based sexual health service in the North West of the borough – Metrosexual Health @ Queen's Park;**
- **In the first five months of the service opening, over 200 people accessed the service – the majority of whom are registered with Westminster GPs;**
- **Black and Asian ethnic groups are underrepresented amongst MSH attendees;**
- **There are a large number of pharmacies in Westminster – all sell EHC over the counter and 8 provide EHC free to persons aged 13-19;**
- **Although geographical access is good, there are a number of barriers to accessing EHC in pharmacy settings including stigma and cost;**
- **21 pharmacies in Westminster provide chlamydia screening, however, the number of screens conducted is low.**

Sexual health services are not only provided by general practice but also in other community settings. This is in line with the direction for community services set out in the government white paper, *Our health, our care, our say* (Department of Health, 2006).

In Westminster, some sexual health services are also provided in walk in centres and pharmacies. Furthermore, Westminster has recently commissioned Metrosexual Health @ Queen's Park to provide sexual health services in the North West of the borough.

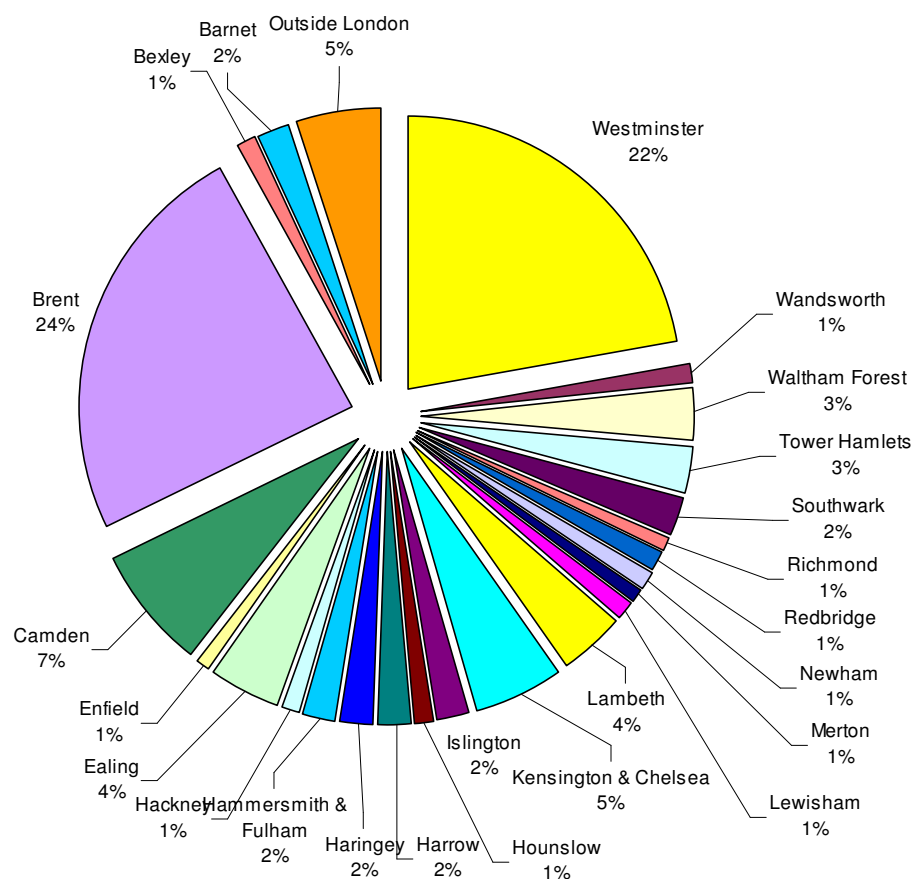
### **10.1 Metrosexual Health @ Queen's Park (MSH)**

The MSH @ Queen's Park service was established at the beginning of August 2009, with the main aim of the service being to provide sexual health services in community settings. The nurse-led service is located in the North West of Westminster, an area of high deprivation with a large BME community.

Although the service has been in existence for only a short period time, data from the first five months was analysed to provide an early understanding of the impact of the introduction of the service.

Although the MSH service is based in Westminster, Westminster residents only accounted for 22% of attendances- the remaining 78% were from a range of boroughs, including Brent. However, anecdotal evidence suggests that the majority of patients are registered with Westminster GPs and so, for example, many of the patients attending who reside in Brent will actually be Westminster registered patients.

**Figure 51: Patients attending MSH by borough of residence, October-December 2009**



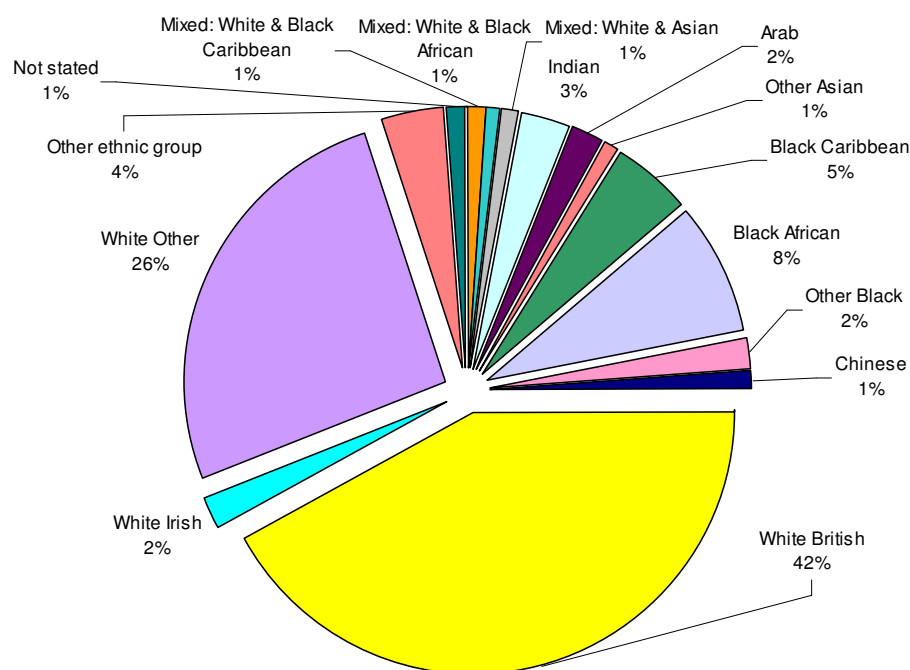
Source: MSH @ Queen's Park

This highlights the disparity between the Westminster resident and Westminster registered populations, which requires further understanding as it has significant

implications on meeting local sexual health targets and funding. PCT funding for acute services is determined by GP registration, whilst GUM services are paid according to PCT of residence. Furthermore, local sexual health targets such as the late HIV diagnosis target and chlamydia screening target are based on PCT of residence. Therefore, although the MSH service appears to be providing a sexual health service in a community setting for Westminster's GP registered population, it is not maximising the impact on local sexual health targets to the extent that it should be.

In the first five months that the service was in operation, 216 individuals accessed the service. The majority of persons attending MSH were aged 25 and over (58.5%) and described themselves as heterosexual (80%). In terms of ethnicity, the majority of attendees were from White ethnic groups (70%) followed by Black ethnic groups (13%) and Asian ethnic groups (4%).

**Figure 52: Patients attending MSH by ethnic group, October-December 2009**



Source: MSH @ Queen's Park

Given that in Queen's Park and Harrow Road wards persons from Black and Asian ethnic groups represent a significant proportion of the population, persons from Black and Asian ethnic groups appear to be underrepresented amongst MSH service

users. A key aim of the MSH service is to reduce late diagnosis of HIV; given the fact that persons from Black ethnic groups are particularly at risk from being diagnosed late in Westminster, it is likely that this service will have limited impact on the proportion of persons diagnosed late with HIV as those persons most at risk are not presenting to the service. Accordingly, further work is needed to engage with persons from Black, Asian and other BME groups.

## **10.2 Pharmacy**

Pharmacies also have an important role to play in sexual health. All pharmacies in Westminster sell emergency hormonal contraception (EHC). At present routine data on the number of people buying EHC over the counter in Westminster is not routinely collated. However, in 2006 a small number of pharmacies in four wards with high teenage pregnancy rates were asked to record how many items of emergency contraception they provided over a four week period.

Overall, 112 items were provided, the majority bought over the counter (as opposed to prescribed). In 12 instances, customers refused to buy EHC on the grounds of cost.

Because there are a large number of pharmacies across Westminster, access to over the counter EHC is good in terms of physical access, however, a snapshot survey of people obtaining over the counter EHC identified barriers to its use. 75% of respondents said that they felt uncomfortable asking for EHC in a pharmacy. 47% of respondents thought that EHC was too expensive, whilst 45% said that cost may have prevented them from using it.

There are currently 8 pharmacies in Westminster that provide free EHC; 6 of these are in the Queen's Park and Paddington area and 2 in the Victoria and Pimlico area (these areas were chosen on the basis of their high teenage conception rates).

In 2007/08, there were 197 contacts (across 10 pharmacies) and in the first 11 months of 2009/10 there were 135 contacts (across 8 pharmacies).

21 pharmacies in Westminster are currently signed up to the chlamydia screening locally enhanced service with the National Pharmaceutical Association Contract with chlamydia commissioners. Latest available data shows that the number of screens

conducted in pharmacy settings in Westminster is low – just 1.3% (n=57) of female screens and 0.7% (n=32) of male screens were in pharmacy settings.

For further information on the National Chlamydia Screening Programme, see section 14.

### **10.3 Conclusions**

Sexual health services are provided in a range of primary care settings, however, further work is needed to expand on the current 'offer' and overcome barriers to accessing sexual health services in such settings.

## **11: GUM Services**

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### **Key Messages:**

- **There is a good choice of accessible sexual health services available to Westminster residents – the Jefferiss Wing, Dean Street and Mortimer Market are the main clinics which local people access;**
- **An increasing number of people in Westminster are accessing GUM services; in 2009/10, 19,109 people attended a GUM clinic on at least one occasion;**
- **Despite good access to GUM services, there appear to be particular population groups that are less likely to access GUM services. These include young men, particularly young MSM and young men from White British ethnic groups, lesbian women and heterosexual men.**
- **The majority of attendances were for STI/HIV testing, however, significant numbers of other infections such as balantia, vaginitis and candidosis appear to be diagnosed in local GUM clinics;**
- **GUM clinics are an important provider of contraceptive services, particularly for young persons; in 2009/10 over 1,000 people accessed contraception from local clinics;**
- **Overall access to local GUM clinics is good – in 2009/10, 99.9% of Westminster residents were offered an appointment at a GUM clinic within 48 hours of initial contact, however, the proportion being seen within 48 hours varied between GUM clinics and was highest for those clinics with walk in services.**

### **11.1 GUM services in Westminster**

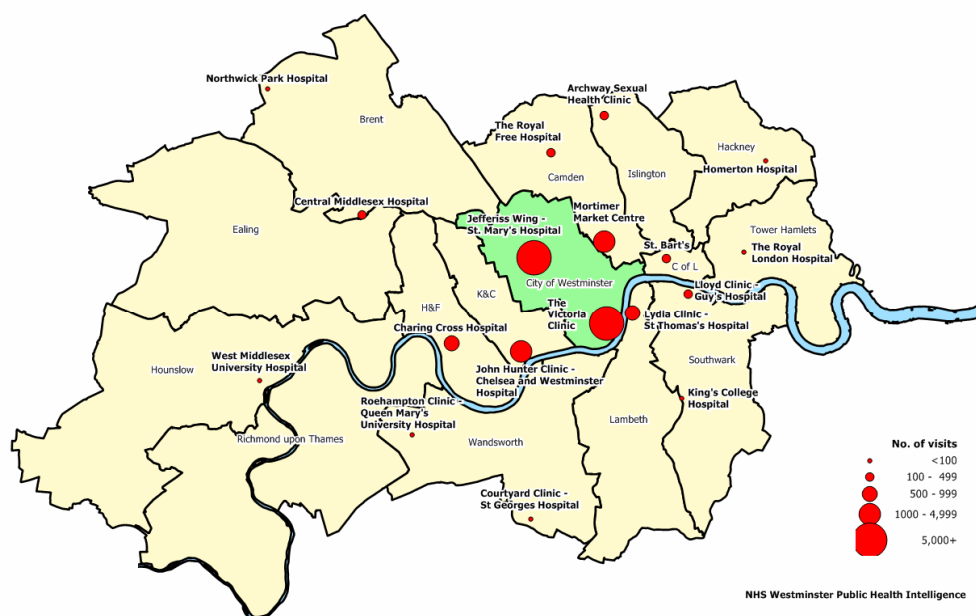
GUM services are the main provider of sexual health services in Westminster. There are 29 specialist GUM services in London, however, the Jefferiss Wing at St Mary's Hospital, the Victoria Clinic (now 56 Dean Street) and Mortimer Market are the most frequently accessed by Westminster residents; in 2008/09 these clinics represented 93% of all GUM clinic attendances by Westminster residents.

Overall this suggests that local GUM clinics are acceptable to those Westminster residents that choose to access GUM services, as few persons attend GUM services out of borough. However, it should be noted that in 2009, the Victoria Clinic moved from its location in the South of the borough to 56 Dean Street in Soho and,



therefore, the main GUM providers in Westminster are now in central Westminster. There are now no GUM services in the North or South of the borough, although transport links are good.

**Figure 53: Sexual health services accessed by Westminster residents, 2008/09**



Source: Unify

A wide range of services are offered in GUM clinic settings from STI/HIV testing, provision of contraception, risk assessment and signposting, and cervical screening, amongst others. The services provided by the three main GUM clinics used by Westminster residents are detailed in Appendix C.

In addition to the mainstream services outlined, local GUM services also provide specialist services for specific population groups. These include young persons, MSM, persons experiencing sexual dysfunction and men and women who sell sex.

## 11.2 How many people use GUM services?

Between April 2009 and March 2010, Westminster residents accounted for 23,438 attendances at GUM clinics; of the 23,438 attendances, 19,109 were first attendances. This represents an 18% increase from 2008/09 in which there were 19,913 attendances in total.

### 11.3 What are the characteristics of persons using local GUM services?

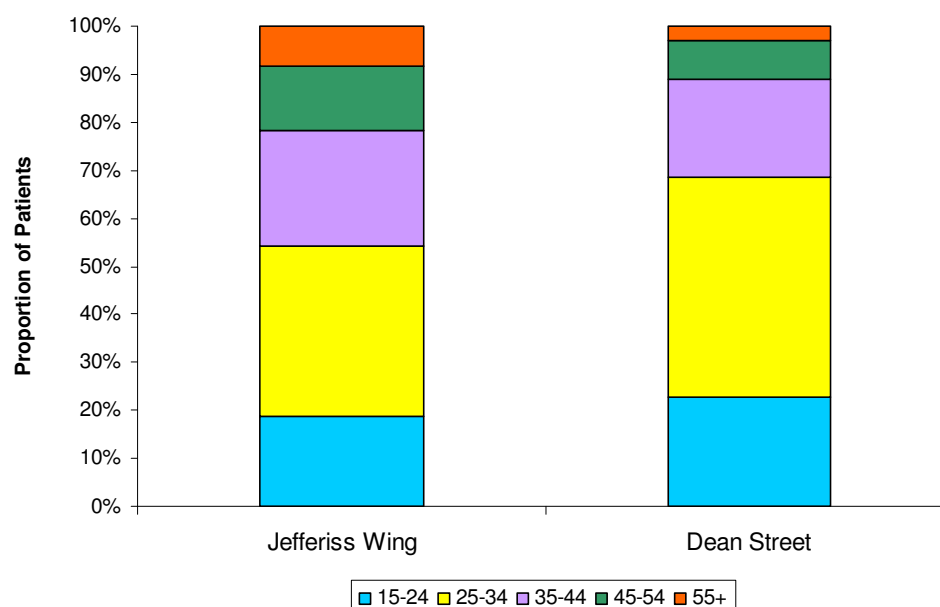
In order to better understand the population in Westminster who are accessing GUM services, data from the two main clinics (Jefferiss Wing and Dean Street) was analysed.

#### 11.3.1 Age and Sex

Overall similar numbers of males and females access GUM services in Westminster; 52% of persons accessing GUM are male and 48% female. However, at an individual clinic level, a slightly higher proportion of persons attending the Jefferiss Wing are female, whilst men represent a slightly higher proportion of persons seen at Dean Street.

In terms of the age of persons accessing GUM services, the majority are aged between 25 and 34, however, the age profile of attendees differs between the two clinics; the population attending Dean Street being younger than the population attending the Jefferiss Wing. In terms of the overall gender/age split, the profile of men attending GUM clinics is older than that of women.

**Figure 54: Age profile of GUM clinic attendees, 2009/10**



Source: Jefferiss Wing, St Mary's Hospital and 56 Dean Street

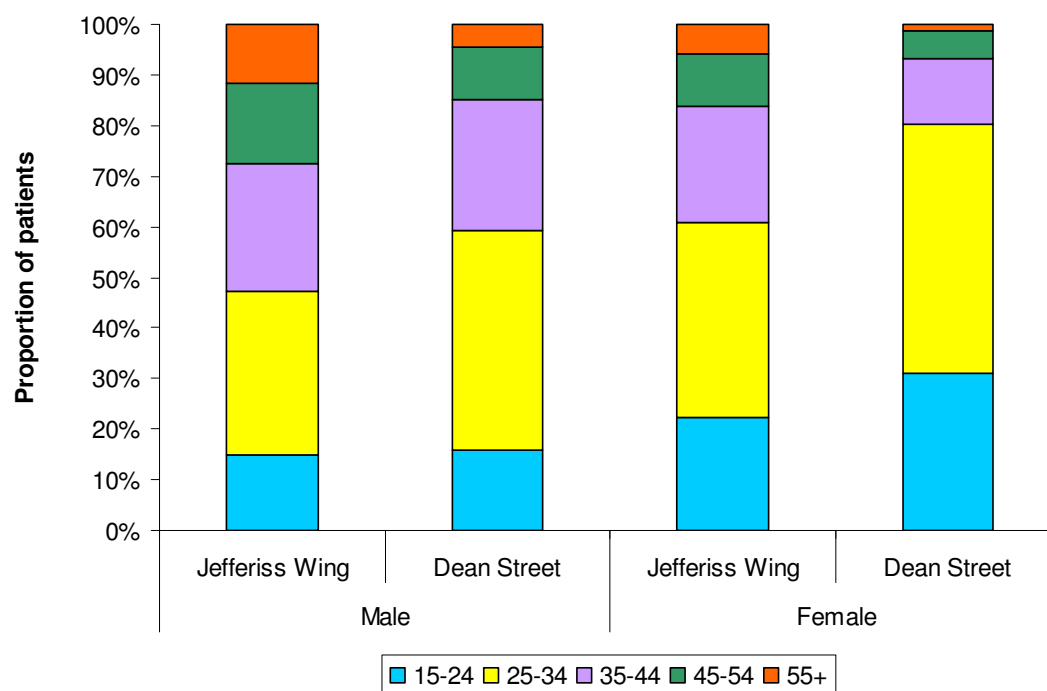
*Dean Street:* The male population attending Dean Street is slightly older than that of females; the majority of women are aged 15-34 whilst the majority of men are aged

25-44. After the age of 34, women appear much less likely to use Dean Street, however, men appear to continue using Dean Street beyond this age.

*Jefferiss Wing:* As is the case for Dean Street, the male population attending the Jefferiss Wing is older than that of females; the majority of women are 15-34, whilst the majority of men are aged 25-44. Men and women aged 35 and over, however, represent a significant proportion of attendees (53% of male and 39% of female attendees).

Overall, younger men, particularly those aged 15-24 appear underrepresented in attendances - men aged 15-24 account for 16% of all GUM clinic attendances by men – this compares to 24% for women.

**Figure 55: Age and sex profile of GUM clinic attendees, 2009/10**



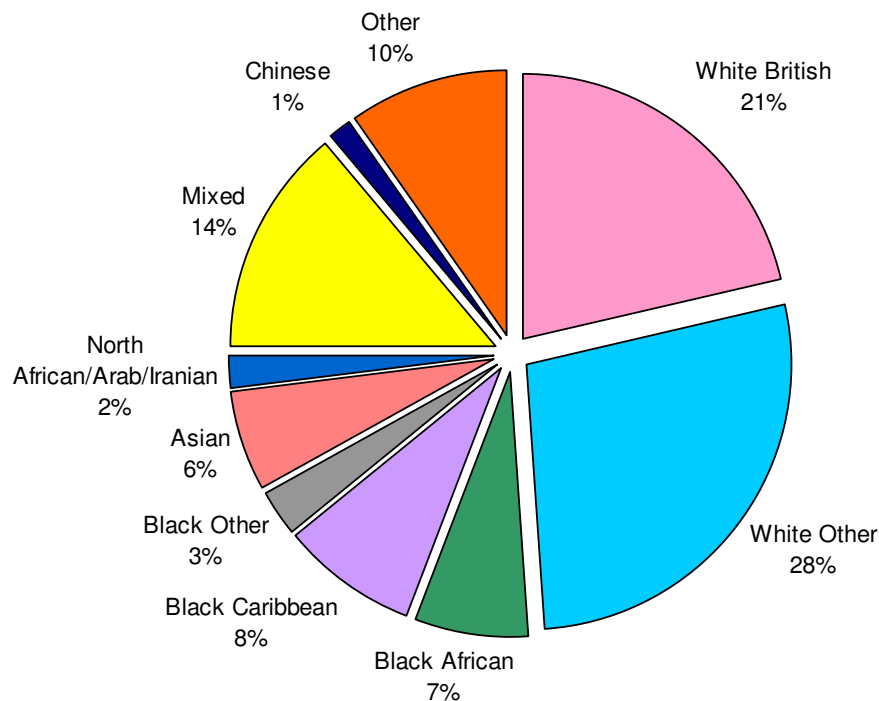
Source: Jefferiss Wing, St Mary's Hospital and 56 Dean Street

### 11.3.2 Ethnicity

Ethnicity data was available for the Jefferiss Wing only. The ethnic mix of persons attending the Jefferiss Wing was similar for males and females. The majority of persons attending the Jefferiss Wing are White British or White Other, however, given the ethnic mix of the overall Westminster population, persons from White British ethnic groups appear to be underrepresented, whilst persons from White

Other ethnic groups are over represented. A significant proportion of attendees are from BME groups.

**Figure 56: Ethnic distribution of GUM clinic attendees, 2009/10**



Source: Jefferiss Wing, St Mary's Hospital and 56 Dean Street

### 11.3.3 Sexual orientation

In terms of sexual orientation, almost all of the women presenting to GUM described themselves as heterosexual (lesbians accounted for 0.03% of all female attendances), suggesting that very few lesbians are accessing GUM services in Westminster.

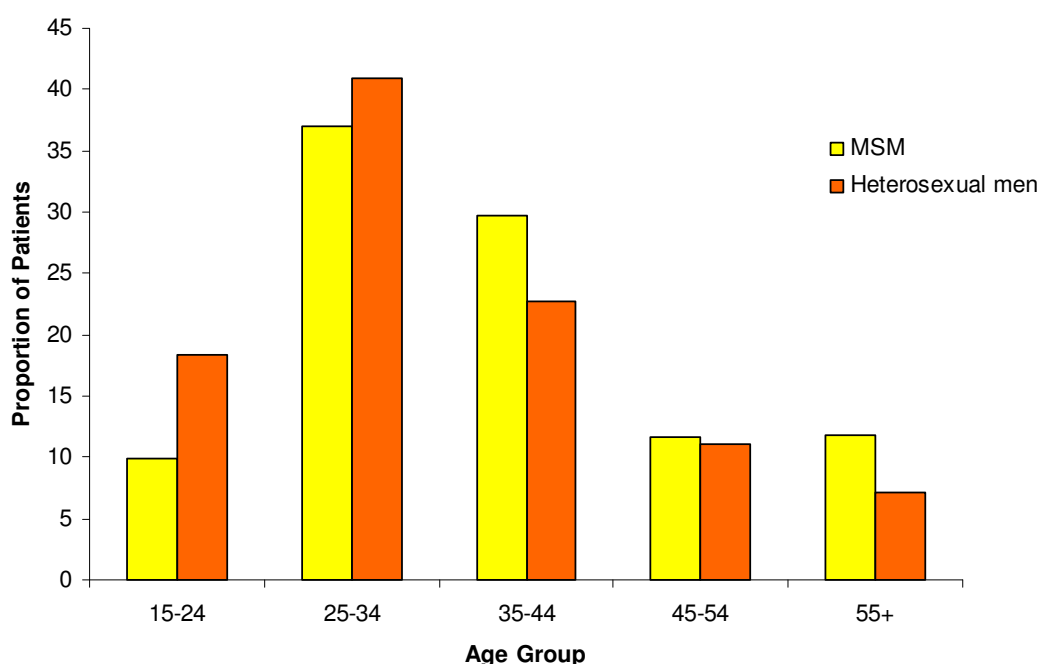
The underrepresentation of lesbian women amongst GUM attendees may be because lesbian women are getting their sexual health needs met elsewhere, however, it could also reflect that lesbian women either have a poor awareness of their sexual health (and, therefore, do not use services), or simply choose not to use services. Accordingly, further work is needed to understand the awareness of sexual health amongst lesbian women in Westminster, the acceptability of services, where they access services and also whether lesbian women have unmet sexual health needs, for example around cervical cytology and diagnosis of STIs.

Overall, significant numbers of MSM are accessing GUM services in Westminster; in 2009/10, over 1,000 MSM attended, representing 33% of all male attendances at GUM clinics. MSM appeared more likely to attend the Dean Street GUM clinic than the Jefferiss Wing; MSM accounted for 20% of male attendances at the Jefferiss Wing compared to 39% of attendances at Dean Street.

Overall only 66% of males accessing GUM services in Westminster described themselves as heterosexual. Given the population structure in Westminster, this is lower than expected and suggests that heterosexual men are underrepresented amongst GUM clinic attendees.

The age profile of MSM and heterosexual men accessing GUM clinics is broadly similar. Young MSM appear to be underrepresented, however, this may be a reflection of the mobility of the young MSM population.

**Figure 57: Male GUM clinic attendees by sexual orientation, 2009/10**



Source: Jefferiss Wing and 56 Dean Street

#### 11.3.4 Place of residence

Postcode information was not available for either Dean Street or the Jefferiss Wing, therefore, where local people were coming from to access GUM services was not

established. Further work should be undertaken to establish where in the borough persons accessing GUM services reside, to better understand issues around geographical location and deprivation and access to GUM services.

## **11.4 What are the reasons why people use GUM services in Westminster?**

### **11.4.1 Diagnosis of infection/condition**

The reasons why individuals attend GUM clinics are numerous. A range of codes are used to identify reasons for attendance, but because of the number of codes used and also the way in which the codes are used makes it difficult to analyse – codes are assigned based on diagnoses made and also services provided.

The majority of attendees attend for STI/HIV testing – the most common STIs diagnosed include genital warts, chlamydia and gonorrhoea. However, significant numbers of other conditions such urinary tract infections, balanitis/vaginitis and candidosis are also being identified.

With regards to diagnosis of infection, condition or disease, the most common conditions diagnosed were balanitis/vaginitis, candidosis, genital warts, chlamydia and gonorrhoea.

### **11.4.2 Contraception**

Whilst provision of contraceptive services does not traditionally occur in GUM clinic settings, as part of an integrated service model where individuals do not have to access different services for different sexual health needs, it seems logical to offer such services if there is a clear need – this is acknowledged in the national strategy for sexual health and HIV.

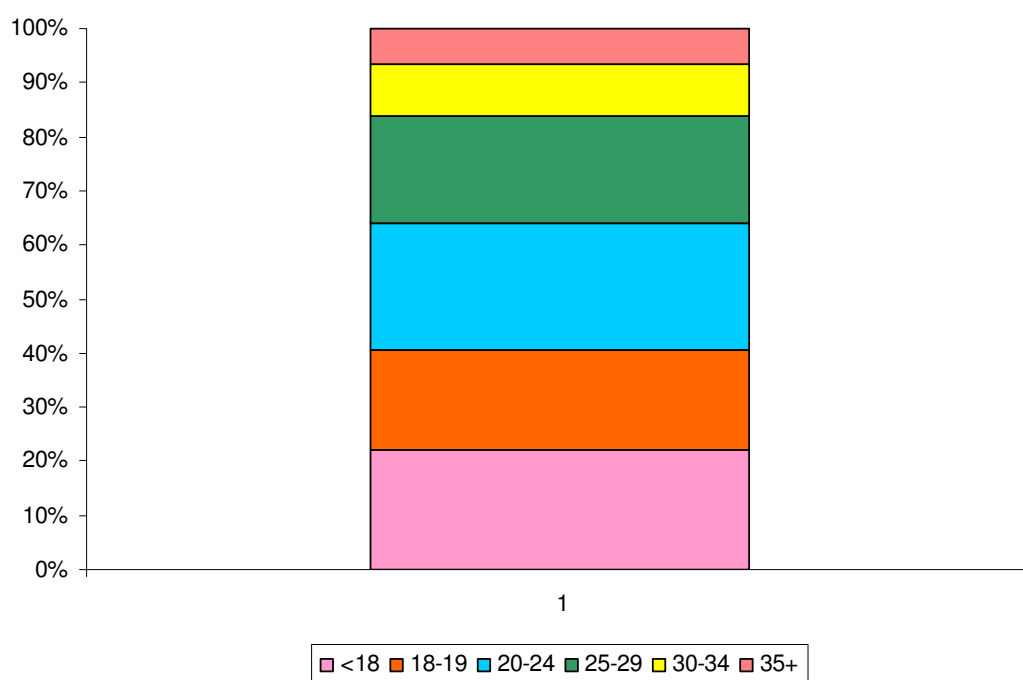
Up until April 2010, there was no formal offer of contraception at the Jefferiss Wing (not including young peoples services). However the Jefferiss Wing has historically provided some contraceptive provision to those in need. From April 6<sup>th</sup> 2010, formal contraceptive provision has been in place and women attending for STI screens or treatment are offered contraception. Furthermore, women not using any contraceptive method will be identified.

56 Dean Street also provides a range of contraceptive services.

In 2009/10, over 1,000 Westminster residents accessed contraception from the Jefferiss Wing and Dean Street, demonstrating that local GUM clinics are an important provider of contraceptive services to Westminster residents.

Demographic data from the Jefferiss Wing shows that young people are more likely to access contraception in GUM settings than older people; persons aged 24 and under account for 19% of all GUM clinic attendees at the Jefferiss Wing, but account for 64% of people accessing contraception. This is in contrast to community contraceptive clinics where young persons are underrepresented in persons accessing contraception.

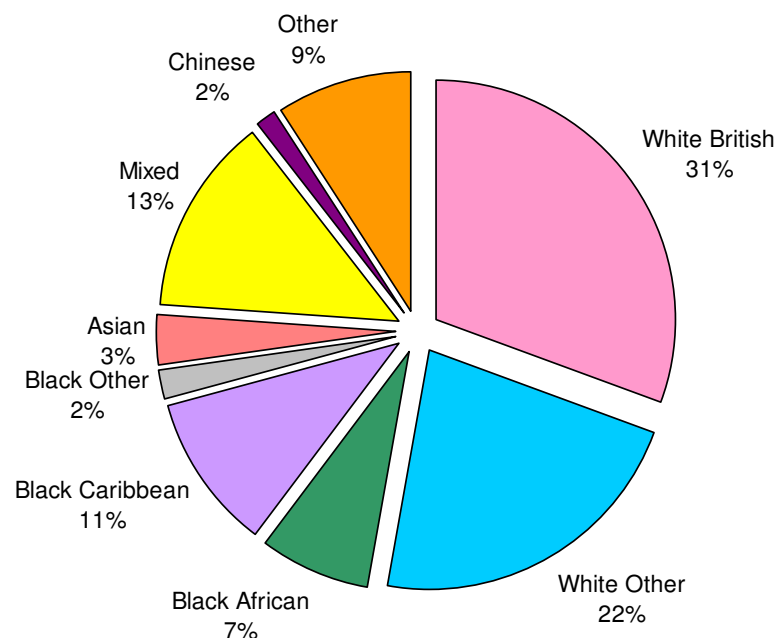
**Figure 58: Age profile of Westminster residents accessing contraception at the Jefferiss Wing, 2009/10**



Source: Jefferiss Wing

The ethnic profile of persons accessing contraception at the Jefferiss Wing is similar to the overall population attending the Jefferiss Wing; the majority of persons attending the Jefferiss Wing are White British or White Other.

**Figure 59: Ethnicity of persons accessing contraception at the Jefferiss Wing, 2009/10.**



Source: Jefferiss Wing

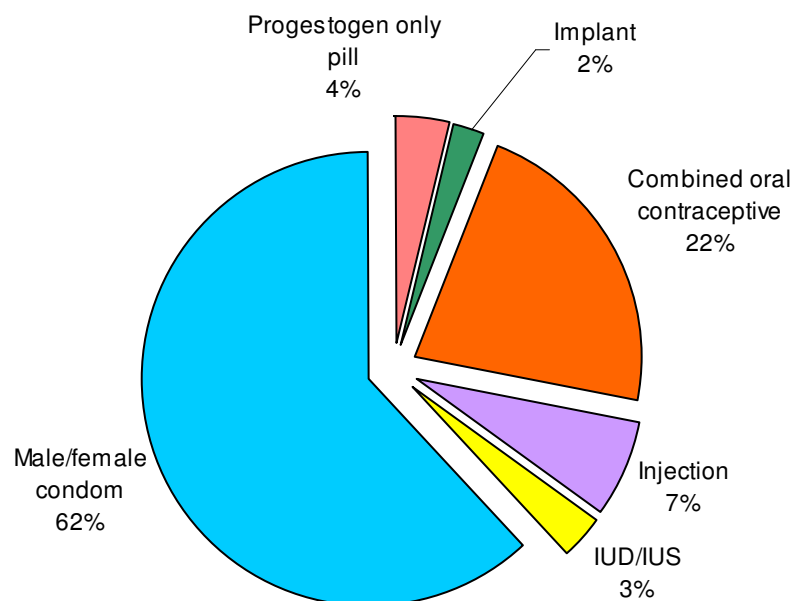
User dependent methods of contraception were the most common form of contraception accessed by Westminster residents accessing contraception from local GUM services. Condoms were the most common form of contraception, accounting for 62% of all contraception accessed, followed by the combined oral contraceptive (22%) and the injection (7%). Levels of LARC prescribing are low.

Emergency hormonal contraception (EHC) is also available at GUM clinics; in 2009/10, EHC was provided on 343 separate occasions by Westminster residents.

In addition to the contraceptive methods outlined, a number of individuals were also recorded as having received contraceptive advice, so although no contraception was provided, advice was given.



**Figure 60: Type of contraception accessed by Westminster residents attending GUM services, 2009/10.**



Source: Jefferiss Wing and 56 Dean Street

The data presented shows that the provision of contraception in GUM clinic settings is acceptable to persons attending GUM clinics, particularly young persons accessing GUM clinics. However, it is important to note that long term follow up of patients may be an issue given the model of GUM service provision. Accordingly, clear mechanisms should be in place to link in with other services for long term follow up such as GPs and community contraceptive services.

#### **11.4.3 Pregnancy testing and referral to abortion services**

Pregnancy testing and referral to abortion services are also available in local GUM clinics. In 2009/10, 247 pregnancy tests were requested by Westminster women attending.

#### **11.5 Access to GUM clinics**

Historically poor access to sexual health services has been linked to the continuing rise in sexually treated infections, whilst delayed treatment and untreated infections further exacerbate the increasing trend as further individuals become infected.

As a result, the Operating Framework of the NHS identified 48 hour access to GUM clinics as a priority.

In 2009/10, 99.9% of Westminster residents were offered an appointment to be seen at a GUM clinic within 48 hours of initial contact – this compares to 99.6% in 2008/09.

Looking at the three main clinics that Westminster residents attend shows that 100% of patients are offered an appointment within 48 hours at Jefferiss Wing and Dean Street and 99.7% of patients attending Mortimer Market.

Although almost all patients are offered an appointment within 48 hours, a smaller proportion of patients are actually seen within 48 hours. Overall, for Westminster residents, only 82.9% of patients were seen within 48 hours; this varied between GUM clinics, with 100%, 50.3% and 79.6% of patients at Jefferiss Wing, Dean Street and Mortimer Market being seen within 48 hours.

**Table 6: 48 hour GUM access, Westminster 2009/10**

<b>GUM Clinic</b>	<b>% offered an appointment within 48 hours</b>	<b>% seen within 48 hours</b>
<b>Jefferiss Wing</b>	100%	100%
<b>Dean Street</b>	100%	50.3%
<b>Mortimer Market</b>	99.7%	79.6%

Source: Unify

The large disparity between the clinics most likely reflects the appointment systems which the clinics use. The Jefferiss Wing offers a general walk in service where a time slot system is used<sup>2</sup>. At Dean Street some services are walk in, however, STI testing, contraception (excluding emergency contraception) and specialist services are appointment only. The majority of services at Mortimer Market are also by prior appointment. This suggests that the gap between the proportion of patients offered a

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<sup>2</sup> If you are one of the first patients to attend at the start of the day, you will be seen within the first two hours unless you prefer to return later. If you are not one of the first patients, you will be given a time at which to return later that day.

48 hour appointment and the proportion seen within that time between the different GUM clinics, is in part due to the appointment systems in place.

Research by Chelsea and Westminster Hospital NHS Foundation Trust into the reasons for the gap in the three GUM clinics that it operates, suggested that a mixture of patient and clinic factors were responsible for the gap (Mohabeer *et al*, 2010). Reasons for attending more than 48 hours after initial contact included the lack of convenient appointment times, personal preference of patients as they felt there was no urgency to be seen and cancellation of appointments by patients. Providing information regarding the nature and potential complications of STIs was found to promote earlier attendance as was lifestyle suited, non-traditional opening hours and greater provision of walk in services.

## **11.6 Conclusions**

There is a good choice of accessible GUM services available to Westminster residents. Overall local services appear to be acceptable to local residents, as few people go out of borough to access GUM services.

An increasing number of people are accessing local GUM services, with around 19,000 people attending on at least one occasion in the last year – this is equivalent to 8% of the total Westminster population. However, some population groups do not appear to be accessing GUM services and it is unclear if they are choosing to access other services. Accordingly, further work is needed to understand the underlying reasons regarding why some population groups are underrepresented amongst GUM attendances.

Westminster residents access a wide variety of services provided by local GUM clinics including, STI/HIV testing, diagnosis and management of other genitourinary conditions, pregnancy testing and contraception amongst others. This is in line with an integrated service model.

### **Recommendations**

- Further work is needed to understand why some population groups are less likely to access GUM services than others;
- A range of conditions are being diagnosed and managed in GUM clinic settings, some of which could potentially be managed in general practice or

other settings such as community contraceptive services – further work is needed to understand the reasons for this;

- The provision of contraception in GUM clinic settings should continue to be monitored to ensure that appropriate mechanisms for follow up are in place and that mechanisms are effective.

## **12: Community Contraceptive Services**

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### **Key Messages:**

- Overall, access to community contraceptive services in Westminster is patchy;
- In 2009/10, 4,163 Westminster women accessed community contraceptive services, equivalent to 6.3% of the female population aged 15-44 – this is lower than the proportion nationally;
- Women aged 25 and over account for the majority of persons accessing community contraceptive services – the numbers of young men and women attending are low;
- Contraception is the main reason why persons access community contraceptive services, however, WCS provide a range of other services to Westminster persons including cervical smear testing, pregnancy testing and post abortion work;
- In 2009/10, 34% of women attending WCS who were eligible underwent a cervical smear;
- Based on first contact data, user dependent methods of contraception were the most common forms of contraception used by women attending community contraceptive services, however, the fitting, checking and removal of LARCs accounts for a significant proportion of WCS activity which is not reflected in first contact figures;

Provision of contraception is an important health care service, contributing to better maternal and child health as well as having a key role to play in protecting against both unplanned pregnancies and STIs. The Audit Commission (2003) reported that for every £1 spent on contraceptive services, the net gain to the NHS was £11.

For many, contraception and fertility are long term issues, extending from the teenage years into older age. Accordingly, the provision of contraception is an essential health care service, required across a large period of a person's life.

## **12.1 Overview of contraceptive services in Westminster**

### **12.1.1 Overview**

Westside Contraceptive Services (WCS) is the main provider of community contraceptive services in Westminster.

Services are provided at seven locations across Westminster, however, clinics in Hammersmith & Fulham and Kensington & Chelsea are also accessed by Westminster residents.

In total, in Westminster, the service provides 37 hours of walk in and bookable clinic time per week; most of this is provided in two hour blocks on various days of the week. Of the 37 hours provided, 15 hours are in the evening (5.30 pm onwards) and two are at the weekend on a Saturday morning.

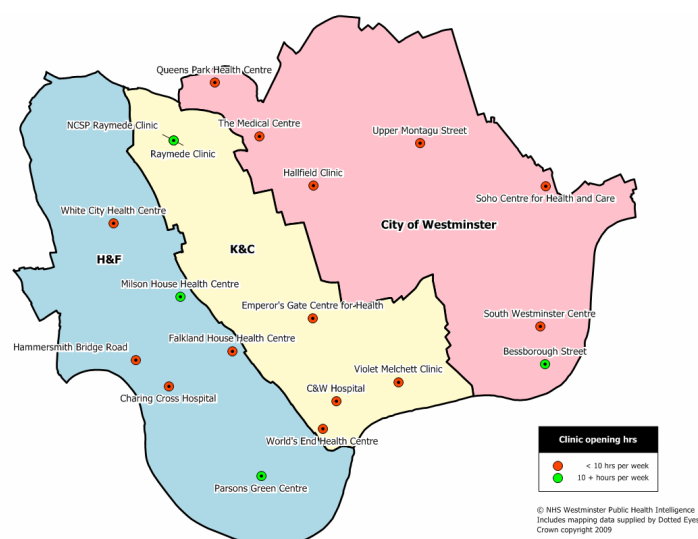
The service offers mixed access with the majority of sessions being appointment clinics that also accept walk in patients up to the capacity of the session. If service capacity is reached, clients walking in are triaged to alternative sessions unless they are an emergency (in which case they will be seen).

Overall, access appears patchy in Westminster. Although geographically there appears to be good access to community contraceptive services, with clinics located in the north and south of the borough, clinic times are limited (figure 61); thus suggesting that access may be an issue. The Raymede and Violet Melchett clinics are the geographically closest clinics with the longest clinic opening hours, however, neither of these is located in Westminster.

Individuals can access services either by self referral or formal referral (for example from a GP or health visitor) or by self-referral. An estimated 80% of patients self-refer, 10% are referred from primary care and the remainder are referred from secondary care and the third sector.

Margaret Pyke is the main provider of community contraceptive services across Brent, Camden and Islington. Although these services are not commissioned for Westminster residents, Westminster residents are known to access some of their services.

**Figure 61: Sites of provision of community contraceptive services across Westminster, Hammersmith & Fulham and Kensington & Chelsea**



Source: NHS Westminster

### 12.1.2 Services provided

WCS provides level 1, 2 and 3 contraceptive services. These are outlined in table 7.

**Table 7: Contraceptive services provided by Westside**

Level 1	Level 2	Level 3
<ul style="list-style-type: none"> <li>Sexual history taking, risk assessment &amp; signposting</li> <li>Pregnancy testing &amp; counselling</li> <li>Referral for abortion</li> <li>Provision of emergency oral contraception</li> <li>Condom distribution</li> <li>Health promotion</li> <li>Hormonal contraceptive/ Depo-Provera</li> <li>Cervical screening &amp; referral</li> <li>Chlamydia screening as part of the NCSP</li> </ul>	<ul style="list-style-type: none"> <li>IUD insertion &amp; removal (including emergency IUD fitting)</li> <li>IUS</li> <li>Contraceptive implant insertion and removal</li> <li>Counselling &amp; referral for vasectomy</li> </ul>	<ul style="list-style-type: none"> <li>Specialist level responsibility for provider quality, teaching &amp; training &amp; clinical governance</li> <li>Contraceptive outreach</li> <li>Highly specialised contraception</li> <li>Difficult IUD insertion &amp; removal</li> <li>Difficult implant removal</li> </ul>

Source: London Health Observatory & Health protection Agency

## **12.2 How many people access community contraceptive services?**

In 2009/10, 4,163 Westminster residents accessed Westside Contraceptive Services, accounting for, 6,345 attendances. In total, across Westminster, Hammersmith & Fulham and Kensington & Chelsea, 26,458 patients accessed community contraceptive services, accounting for 42,448 attendances. 6,923 of these attendances were at Westminster located clinics.

Westminster residents, therefore, account for 15% of clinic attendances across the three boroughs which the service is commissioned, whilst Westminster located clinics account for 16.3% of clinic attendances.

Overall, in 2009/10 6.3% of the female population aged 15-44 in Westminster attended a community contraception clinic – this compares to 11% nationally.

It is also worth noting that Westminster residents were responsible for 1,384 attendances at Margaret Pyke Services, although it is not clear how many patients accessed services.

In total Westminster residents were responsible for 7,729 attendances at community contraceptive services in 2009/10.

## **12.3 Which clinics do Westminster residents access?**

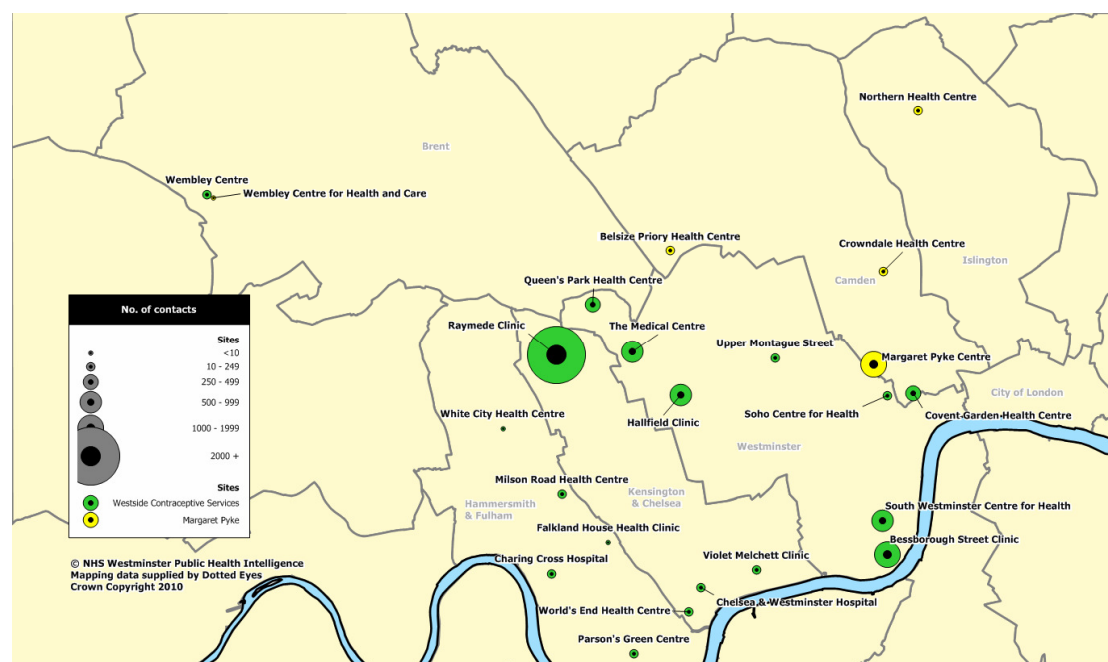
Westminster residents access a range of clinics across Westminster, Hammersmith & Fulham, Kensington & Chelsea and also Brent. In 2009/10, the majority of patients accessed the Raymede Clinic, followed by Bessborough Street and South Westminster Centre for Health. An overview of all clinic activity of Westminster residents is shown in figure 62.

## **12.4 What are the characteristics of Westminster residents accessing community contraceptive services?**

In order to better understand the population in Westminster who are accessing community contraceptive services, data from all Westside Contraceptive Service's clinics in the boroughs of Westminster, Hammersmith & Fulham and Kensington & Chelsea was analysed – only persons with a Westminster postcode were selected, regardless of the location of the clinic they attended. No data was available for persons accessing Margaret Pyke Services, therefore, the following analysis relates only to Westside Contraceptive Services.



**Figure 62: Overview of community contraceptive clinic activity, Westminster residents 2009/10**



Source: Westside Contraceptive Services and Margaret Pyke Services

### 12.4.1 Age and sex

The vast majority of Westminster residents accessing community contraceptive services are female; 99.3% of persons accessing community contraceptive services are women and 0.7% are male. This differs to the picture regionally and nationally; in 2008/09 men accounted for 6.9% and 10.6% of persons accessing community contraceptive services in London and England respectively. However, it should be noted that men who attend community contraceptive services to pick up condoms only are not reflected in this data.

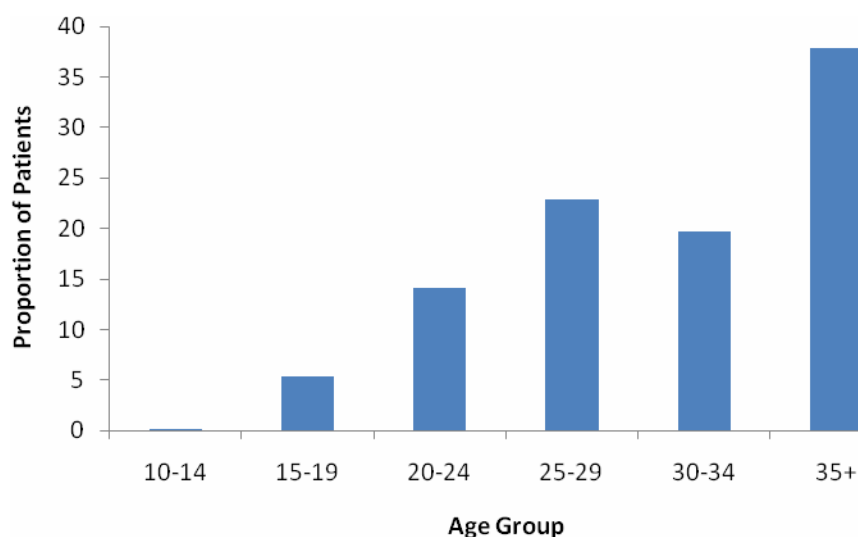
In terms of the age of persons accessing community contraceptive services, the majority are aged 25 and above and in particular 35 and above.

Age specific rates were calculated for female first contacts<sup>3</sup>. Rates were highest for women aged 35-44 (8.7 per 100 resident population) and lowest for women aged 15-19 (4.3 per 100 population). This is in contrast to the national picture in which the first contact rate was highest for women aged 15-19 years old, with the rate declining with

<sup>3</sup> A first contact in the financial year is the first time a client is seen in the year by the contraceptive service. A subsequent contact with the same service provider does not count as a first contact, so each client is recorded only once as a first visit in any year by any trust.

age. In Westminster the first contact rate for women aged 35-44 was slightly higher than is observed nationally.

**Figure 63: Age profile of community contraceptive service attendees, 2009/10**



Source: Westside Contraceptive Services

Overall, the first contact rate per 100 population in Westminster was lower than that nationally, suggesting that women in Westminster are much less likely to access community contraceptive services than in England as a whole, particularly young women.

Age specific rates were not calculated for men as the numbers were deemed to be too small for meaningful analysis.

**Table 8: First contacts (females) at community contraceptive clinics: age specific rates**

	Rate per 100 population	
Age Group	Westminster	England
15-19	4.3	18.4
20-24	4.8	15.9
25-34	5.8	9.3
35-44	8.7	6.5

Source: NHS Information Centre and Westside Contraceptive Services

NB: Data for Westside Contraceptive Services relates to 2009/10 data whilst national level data pertains to 2008/09 and is the latest available public data. Therefore the two figures are not directly comparable. National data has been provided for contextual reasons only.

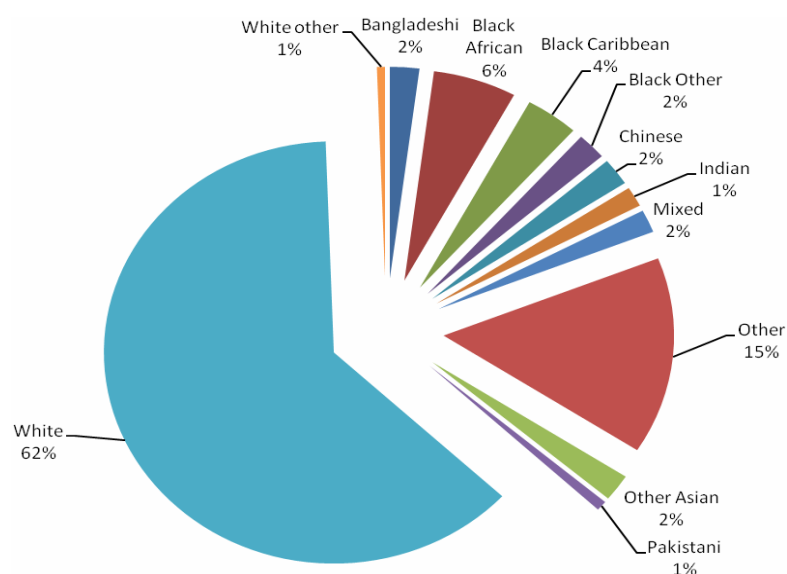
### 12.4.2 Ethnicity

The majority of persons attending community contraceptive services are from White ethnic groups, followed by Other and Black African ethnic groups. However, given the ethnic mix of the Westminster population, persons from Black and Other ethnic groups appear to be overrepresented, whilst persons from Asian, Chinese and White ethnic groups are underrepresented.

### 12.4.3 Place of residence

Postcode information was only available for those persons attending clinics located in the Northern areas of Westminster and Kensington & Chelsea. Therefore, a complete analysis of where local people were coming from to access community contraceptive services was not undertaken – the lack of availability of data for clinics in the South would have skewed any analysis.

**Figure 64: Ethnic distribution of community contraceptive service attendees, 2009/10**



Source: Westside Contraceptive Services

Accordingly, further work is needed to ensure that complete postcode information is collected across all clinics to better understand issues around geographical location and deprivation and access to community contraceptive services.

## **12.5 What are the reasons why people access community contraceptive services?**

Again because of available data, this section relates to Westside Contraceptive Services only.

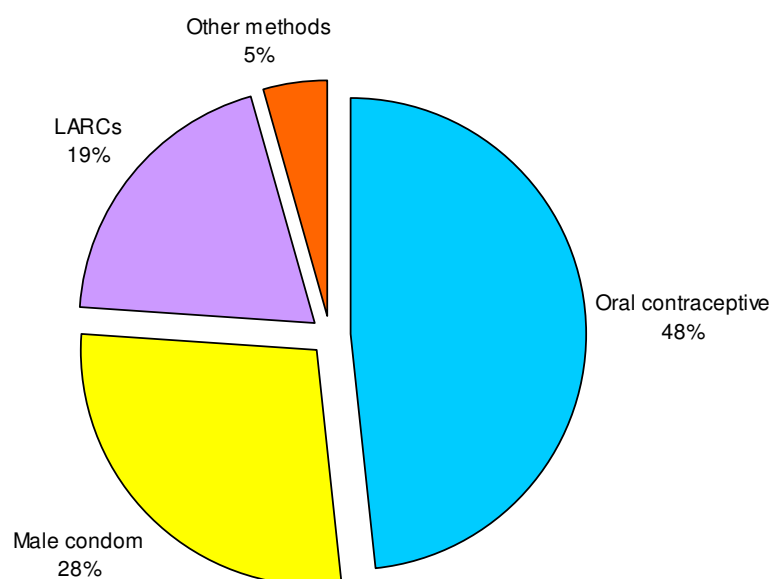
### **12.5.1 Contraception**

The majority of persons attending community contraceptive clinics do so for contraceptive advice and the primary method of contraception chosen or already in use is recorded. A proportion of persons attending community contraceptive clinics are seeking advice on other matters, for example cervical screening (these figures were excluded from the analysis on primary method of contraception, consistent with methods of analysis used by the NHS Information Centre).

Whilst primary method of contraception provides an understanding of the different methods of contraception used by persons attending community contraceptive clinics (and allows regional and national comparison), it should be noted that there are some limitations of this indicator, despite its inclusion in KT31 returns. Department of Health guidance states that 'the main method of contraception for new clients is that chosen after counselling; for existing clients it is the principal method in use unless a change is advised. For new clients, the main method should be the substantive method chosen and not any interim method, even if the choice is not made until a subsequent attendance or visit.' However, methodology used by the NHS Information Centre (KT31) reports the main method dispensed from the clinic at time of first attendance.

Overall, user dependent methods of contraception were the most common form of contraception used by women attending community contraceptive clinics, particularly the pill. This was the primary method chosen by almost half of all women (48%), followed by the male condom (28%). These proportions are slightly higher than those observed regionally and nationally (table 9).

**Figure 65: Primary method of contraception chosen by Westminster women attending community contraceptive services, 2009/10 (KT31 methodology)**



Source: Westside Contraceptive Services

The third most common method of contraception was LARC, with 19% of women attending community contraceptive services choosing this method; this is slightly lower than the proportion nationally (24%).

**Table 9: Primary method of contraception chosen by Westminster women attending community contraceptive services, Westminster, London and England**

Main method of contraception	% of all methods		
	Westminster	London	England
Oral contraceptive	48%	41%	44%
Male condom	28%	26%	26%
LARC	19%	23%	24%
Other method	5%	8%	6%

NB: London and England data 2008/09, Westminster 2009/10

Source: Westside Contraceptive Services and NHS Information Centre

Overall, LARC prescribing is lowest in young women – this is unsurprising given that low numbers of young women access community contraceptive services. However, given the low levels of LARC prescribing in general practice and in GUM settings (where a significant number of young people appear to be accessing contraception), this suggests that there is an unmet need particularly for young women.

#### **12.5.2 LARCs fitted and removed**

Because of the limitations associated with using the main contraceptive method at the time of the first clinic attendance, it is useful to look at all activity to get a clearer idea of LARC activity at community contraceptive services. The following analysis refers to local data extracted from Westside Contraceptive Services.

LARC related activity represents a significant proportion of Westside Contraceptive Services activity. Of the 6,345 attendances in 2009/10, 23% (1,436) were LARC associated attendances i.e. LARC fitting, checking or removal. Overall LARC activity was lowest in women aged 15-24, whilst most LARC activity was in older women, particularly women aged 35 and above.

#### **12.5.3 Emergency contraception**

Westside Contraceptive Services provide emergency contraception – both the EHC and the emergency IUD. In 2009/10, emergency contraception was provided to Westminster residents by Westside Contraceptive Services on 152 separate occasions – this is lower than the number provided by GUM and general practice.

#### **12.5.2 Other reasons**

In addition to contraceptive services, Westside Contraceptive Services provide a range of services as part of a holistic approach to fertility. Just under half of the first contacts recorded in 2009/10 were for reasons designated 'other'. From currently available data sources it is not clear specifically what constitutes 'other.'

From available datasets, attempts have been made to better understand what other activities includes, however, further work is needed to provide a more complete picture of the services provided by Westside Contraceptive Services.

### **(i) Cervical cytology**

In 2009/10, 1,134 Westminster women underwent a cervical smear test at Westside Contraceptive Services – this is equivalent to 34% of women attending Westside Contraceptive Services aged 25 and over (i.e. eligible for a cervical smear). From the data available, it is unclear whether women are undergoing cervical smears as part of a whole package of care provided by Westside Contraceptive Services (i.e. women attend for contraception and also get their routine smear done at the same time) or whether women are accessing Westside Contraceptive Services for cervical screening only. Accordingly, further work is needed to unpick this issue and if women are attending for cervical screening only, the reasons for this need clarifying.

### **(ii) Pregnancy testing**

WCS carry out pregnancy testing for those women requiring it. Data was not available for all clinics – however, for those clinics in the South of the borough (including South Westminster Centre for Health and Bessborough Street), 92 pregnancy tests were carried out in 2009/10 (out of 2,332 total attendances, equivalent to 3.9% of attendances). Anecdotal evidence suggests that this figure is much higher in practice and, therefore, there may be some issues around data collection.

### **(iii) Post abortion activity**

Westside Contraceptive Services also provide post abortion support as well as advice and referral for abortion. The current data collection system codes this type of activity as other – accordingly, it is difficult to elucidate how much abortion related work Westside Contraceptive Services is doing.

## **12.6 Conclusions**

Overall, the provision of community contraceptive services in Westminster is patchy in terms of opening hours, therefore it is not surprising that the number of persons in Westminster accessing community contraceptive services is low.

The majority of persons using community contraceptive services are women, particularly women aged 25 and over. Accordingly, further work is needed to understand why men and young women are not accessing the local services.

Most women attend community contraceptive services for contraception - based on first contact data, user dependent methods of contraception were the most common

forms of contraception used by women. The level of LARC prescribing was slightly lower than that in London and England. However, it should be noted that current national indicators do not accurately reflect the substantive method of contraception chosen by women. Based on first contact data, in Westminster 19% of women chose a LARC method, however, LARC activity accounted for 23% of clinic activity. Accordingly, further work is needed to develop robust indicators of activity, particularly around LARC given that there is a target attached.

In addition to contraceptive services, a range of other services are being provided by WCS, including amongst others cervical smear tests and post abortion work. However, this activity is currently poorly understood. Accordingly further work is needed to enhance data collection methods so that this type of activity can be monitored and better understood.



## 13: Condom Distribution Scheme

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### Key Messages:

- The condom distribution scheme provides free male and females condoms and dams to Westminster residents to improve access and remove barriers to practice safe sexual health;
- The scheme targets the whole population, however there are a number of key target groups;
- The scheme has not undergone a robust evaluation, however, some gaps around provision to MSM, persons with HIV, rough sleepers and BME groups have been identified.

### 13.1 Overview of Condom Distribution Scheme

The Condom Distribution Scheme has been in existence since 1992 and primarily aims to improve access to condoms, information and sexual health services. The scheme provides a delivery services as well as training and advice to all member agencies regarding a range of sexual health products.

By providing free male and female condoms and dams to clients, agencies can remove barriers of cost and embarrassment, making it easier for people to practice safer sexual activity. It also provides an opportunity to engage with service users, providing them with information about sexual health and give them an opportunity to discuss their feelings.

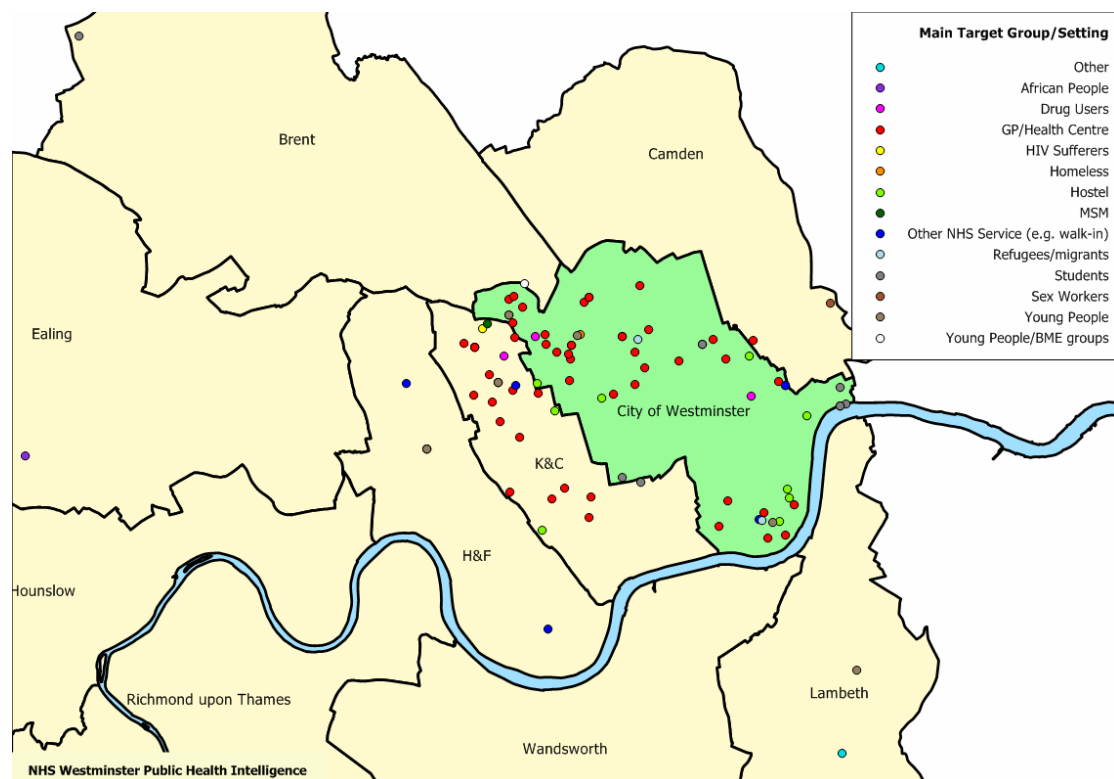
The Condom Scheme targets the general population, however, within this group the following are considered to be key target groups:

- BME Communities
- homeless people
- injecting drug users
- men who have sex with men
- people living with HIV
- people with emotional or mental health needs
- people with learning disabilities
- people with physical disabilities

- refugees and asylum seekers
- sex workers
- young people

Figure 66 shows the distribution of services signed up to the Condom Distribution Scheme. It is, however, difficult to draw accurate conclusions regarding access to condoms as the map merely shows the location of the service – this is not necessarily an accurate reflection of who the condoms are being distributed to. The service works across a number of boroughs, although some community organisations (that receive condoms) work across London.

**Figure 66: Provision of condoms by the condom distribution scheme**



Source: NHS Westminster

**Table 10: Provision of condoms by the condom distribution scheme by main target group**

Main target group/setting	Number of services in Westminster
African people	0
GP or health centre	38
Other NHS service e.g. walk in centre	2
Drug users, particularly those injecting	3
Young people	6
Students	10
Hostels	6
Homeless	1
Refugees/migrants	2
Persons with HIV	1
Sex workers	1
Men who have sex with men	0
BME groups	1

Source: NHS Westminster

There has not been a robust analysis of the Condom Distribution Scheme in Westminster, however, a crude analysis of the above data shows some gaps with regard to some key target groups. The majority of the scheme members are GPs or services for students or young people, whilst there are few services signed up to the scheme who target MSM, persons with HIV, rough sleepers and BME groups, including African people.

## 13.2 Conclusions

The Condom Distribution Scheme provides male and female condoms and dams to Westminster residents through a number of services. Although the scheme is aimed at the general population, a number of key target groups have been identified.

Based on the number of services operating in Westminster, there appear to be some gaps around provision for MSM, persons with HIV, rough sleepers and BME groups. However, no robust evaluation of the service has been undertaken. Accordingly, further work is needed to fully evaluate the Condom Distribution Scheme, to ensure

that the service is improving access to condoms for those indentified as being in greatest need.

## **14: National Chlamydia Screening Programme**

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### **Key Messages:**

- **Screening coverage has increased significantly over the last year; in 2008/09 6.7% of 15-24 years olds were screened – this compares to 27.7% in 2009/10;**
- **Screening coverage, however, varies and is lowest in females, older age groups and persons from White, Asian and Other ethnic groups;**
- **Despite the overall increase in screening coverage, the proportion of persons testing positive has decreased, suggesting that those persons most likely to have chlamydia are not being identified through the NCSP;**
- **Screening coverage needs to continue to increase to have an impact of the prevalence of chlamydia;**
- **Delivering a high volume of screens in core services is challenging given the poor uptake of core services locally and the good provision of GUM services.**

### **14.1 What is the National Chlamydia Screening Programme?**

The National Chlamydia Screening Programme (NCSP) aims to control and prevent chlamydia through the early detection and treatment of asymptomatic infection, thus preventing the development of sequelae and reducing onward transmission.

Screening is aimed at the highest risk group for chlamydial infection in England, young people under 25 who are sexually active.

The NCSP adopts an opportunistic approach to chlamydial screening, extending opportunities to young people to be tested in locations they frequently visit, with the aim of normalising the idea of regular screening among young people so that they expect to be screened annually or when they change partner.

### **14.2 What are the targets -Vital Signs**

The Vital Signs Indicator for 2008/09 included a target of achieving 17% for chlamydial screening and testing in sexually active young persons between 15 and 24 years of age. For 2009/10 this target rose to 25% and in 2010/11 the target is expected to be 35%.

In the analysis of NCSP data, it should be noted that chlamydia testing that occurs in GUM clinic settings is not part of the NCSP and so tests occurring in GUM clinics do not count towards Westminster's Vital Signs target. Given that in 2008/09 Westminster residents (all ages) were responsible for 19,913 visits to GUM clinics, NCSP data is not likely to be a true reflection of the extent of chlamydia testing in all persons aged 15-24 in Westminster.

## 14.3 Coverage

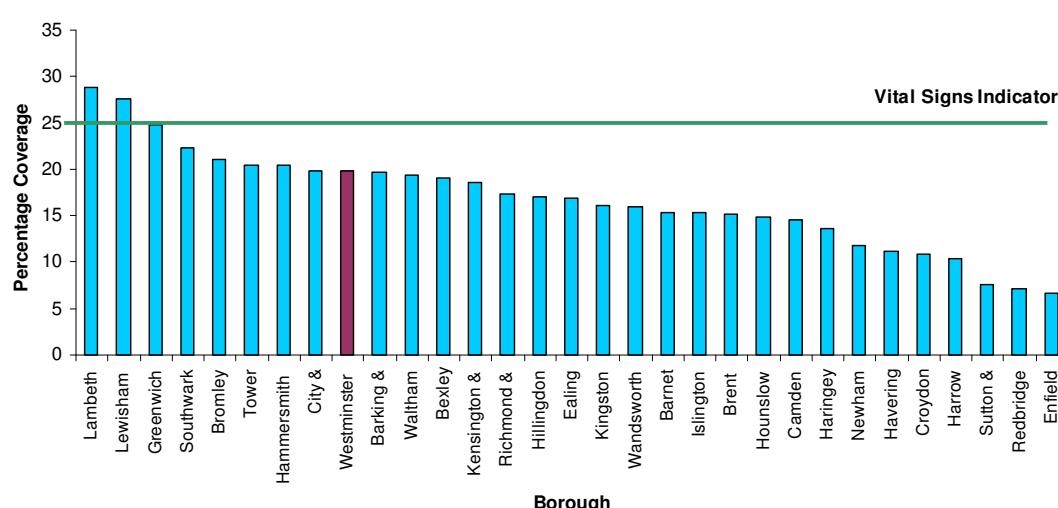
### 14.3.1 Coverage in Westminster

Coverage describes the number of persons who have been screened as part of the NCSP as a proportion of those persons eligible for screening. Latest available data shows that in 2009/10, 9,225 persons aged 15-24 were screened as part of the NCSP – this equivalent to a coverage of 27.7% (unverified data<sup>4</sup>). This is a significant increase on 2008/09 where 1,680 persons were screened (equivalent to coverage of 6.7%).

### 14.3.2 How does coverage in Westminster compare to London and England?

Latest available data for benchmarking, shows that Westminster has the ninth highest coverage in London. For the period April 2009-December 2009, 19.4% of 15-24 year olds had been screened. This compares to 16.4% in London and 13.8% in England.

**Figure 67: Cumulative coverage of the NCSP, London April-Dec 2009**



Source: NCSP

<sup>4</sup> Data from the Chlamydia Screening Office database. Data still to be checked and verified by the Health Protection Agency.

### 14.3.3 Coverage in Westminster by person and place

In order to improve the coverage of the NCSP in Westminster it is important to better understand the population of young people who are being screened and, accordingly, identify those persons not being screened so that interventions to increase coverage can be appropriately targeted.

Coverage was calculated using activity data from the Chlamydia Screening Office Database and 2006 based ONS population projections for 2009. According to these population projections there are 36,900 persons aged 15-24 resident in Westminster. However, most recent population estimates (ONS 2008 mid year population estimates) suggest that there are approximately 33,300 persons aged 15-24 years old resident in Westminster. Accordingly, the coverage reported on for the Vital Signs target may be an underestimate of the actual coverage based on uncertainty around denominator data.

Coverage by age, sex and ethnicity in Westminster is summarised in figure 68.

#### (i) age and sex

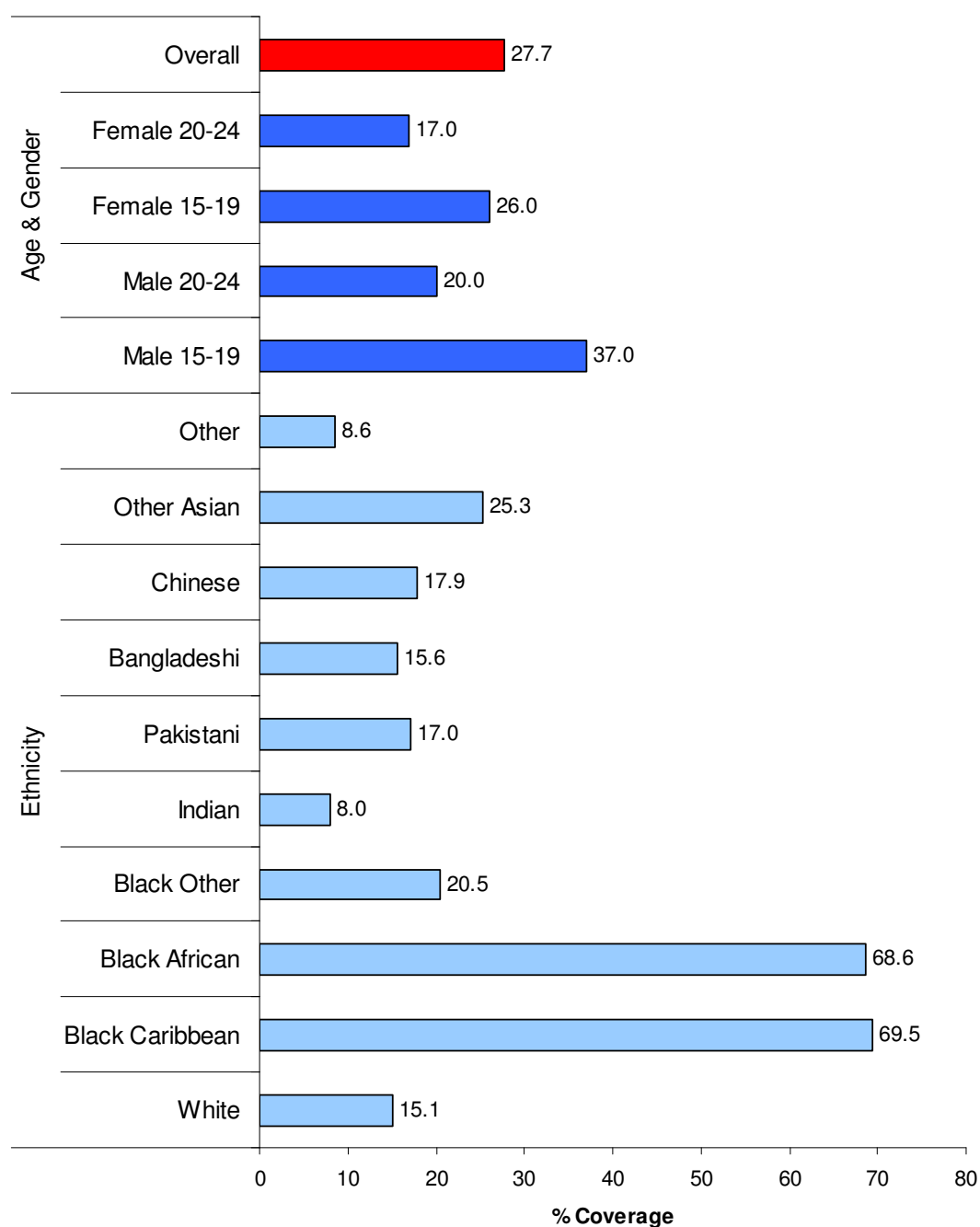
Overall screening coverage in 2009/10 was higher in males than females (26% of males aged 15-24 were screened compared to 19% of females aged 15-24 years old). Screening coverage, however, decreased with age, with the coverage in both males and females aged 20-24 lower than in males and females aged 15-9 years old.

**Table 11: Coverage by age and sex, Westminster 2009/10**

Age Group	Males	Females
15-19	37%	26%
20-24	20%	17%
Overall	26%	19%

Source: Chlamydia Screening Office Database and ONS 2006 population projections

**Figure 68: Overview of coverage, Westminster 2009/10**



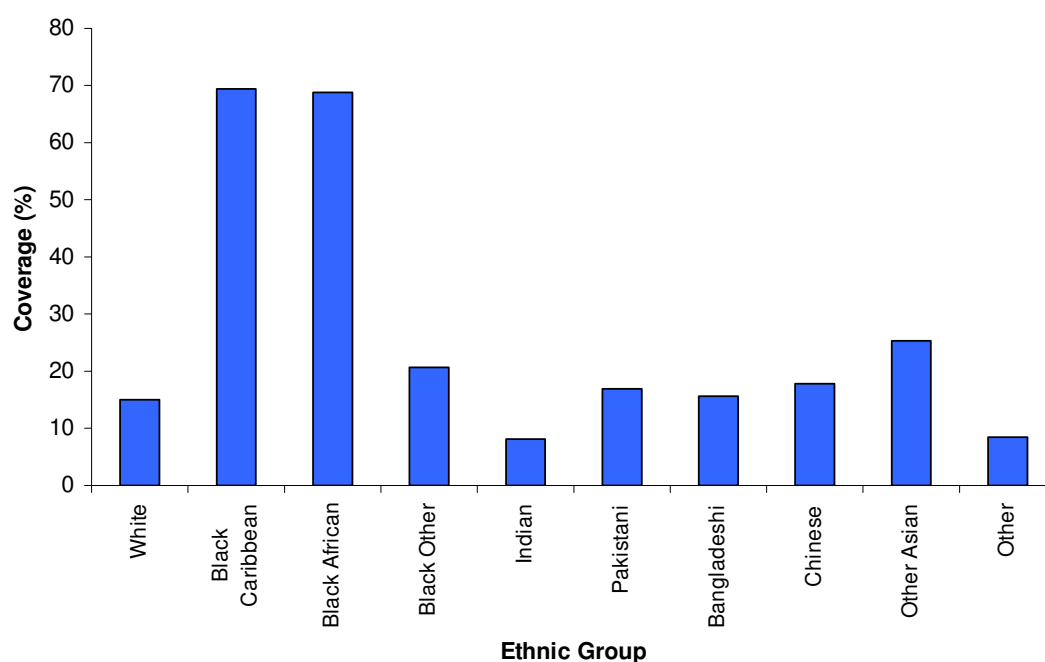
Source: Chlamydia Screening Office Database and ONS 2006 population projections

## (ii) Ethnicity

Screening coverage was shown to vary greatly between different ethnic groups. Coverage was highest amongst Black Caribbean and Black African ethnic groups and lowest amongst White, Asian and Other ethnic groups.



**Figure 69: Coverage by ethnic group, Westminster 2009/10**



Source: ONS 2006 based population projections for 2009 and Chlamydia Screening Office Database

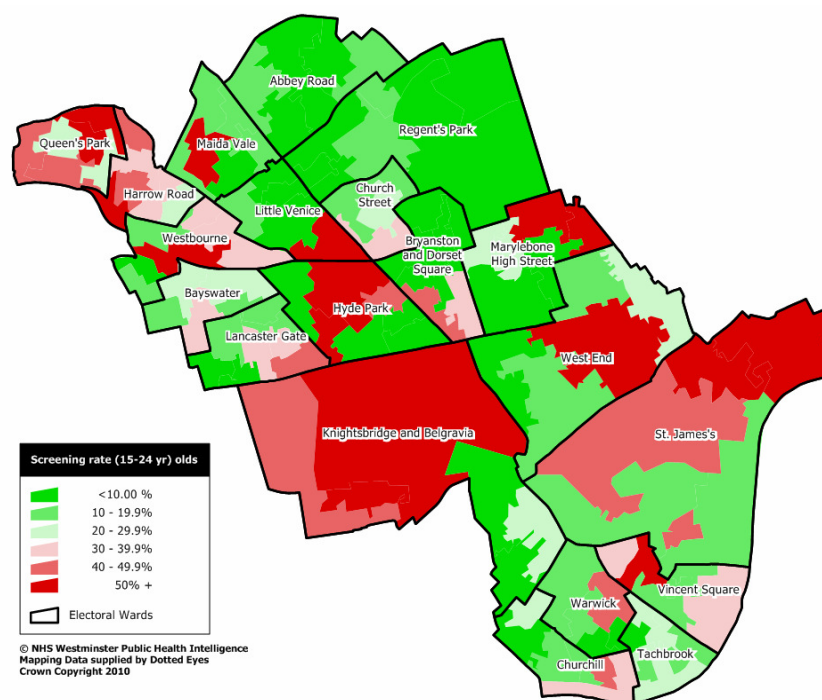
It should be noted that ethnicity was not recorded in over a quarter of screens. Although this is an improvement on 2008/09 (ethnicity was not recorded in 37% of screens) further work is needed to improve the recording of ethnicity on screening records. This is essential to better understand the uptake of chlamydia screening in different ethnic groups of Westminster.

### **(iii) Place**

There was wide variation in screening coverage across Westminster both within and between wards. In men coverage was highest in the north west of the borough, in parts of Knightsbridge & Belgravia, West End, Hyde Park and St James' Park wards and lowest in the north east quadrant of the borough and pockets in the south. In women, a similar geographical pattern of coverage was observed.

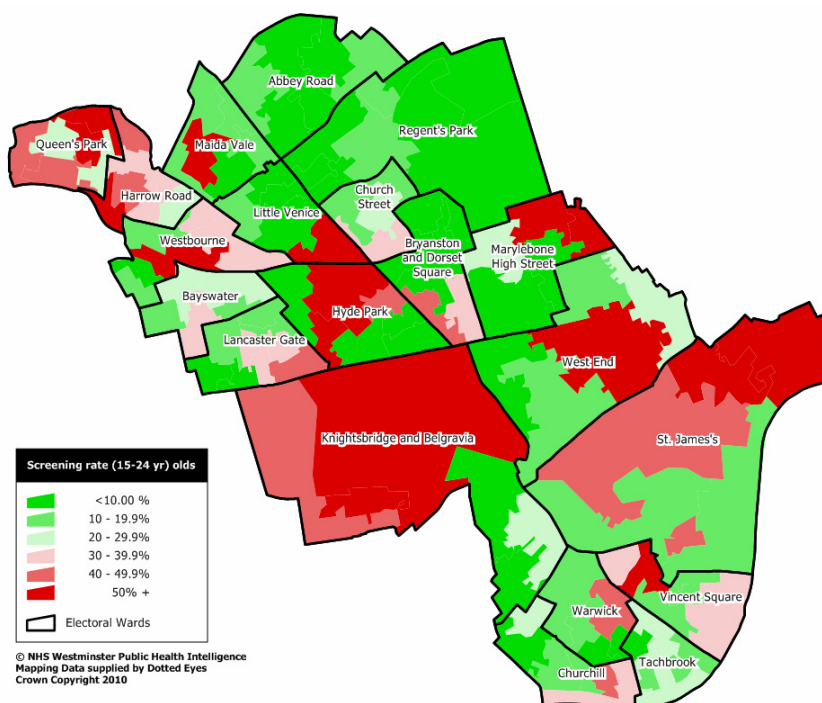
It should, however, be noted that a significant number of screens did not contain postcode information – these screens could, therefore, not be attributed to different Westminster wards.

**Figure 70: Coverage by ward of residence, males Westminster 2009/10**



Source: ONS 2006 based population projections for 2009 and Chlamydia Screening Office Database

**Figure 71: Coverage by ward of residence, females Westminster 2009/10**



Source: ONS 2006 based population projections for 2009 and Chlamydia Screening Office Database

## **14.4 Positivity**

Positivity describes the proportion of persons who have been screened for chlamydia who test positive and is an important measure of how effective the local screening programmes is at screening and identifying those persons most likely infected with chlamydia. Unfortunately there is no baseline of the prevalence of chlamydia in the population eligible for screening.

In 2009/10, 2.4% of persons screened as part of the NCSP in Westminster were positive – this is lower than in 2008/09 (4.7%). This is lower than in London and England (5% and 6% respectively).

Despite the significant increase in coverage of the NCSP between 2008/09 and 2009/10, the low positivity attained in 2009/10 (compared to 2008/09), suggests that locally, those persons most likely to have chlamydia are not being identified through the NCSP. Accordingly, more targeted approaches to screening are needed to identify those persons most likely infected.

### **14.4.1 Who are the people testing positive?**

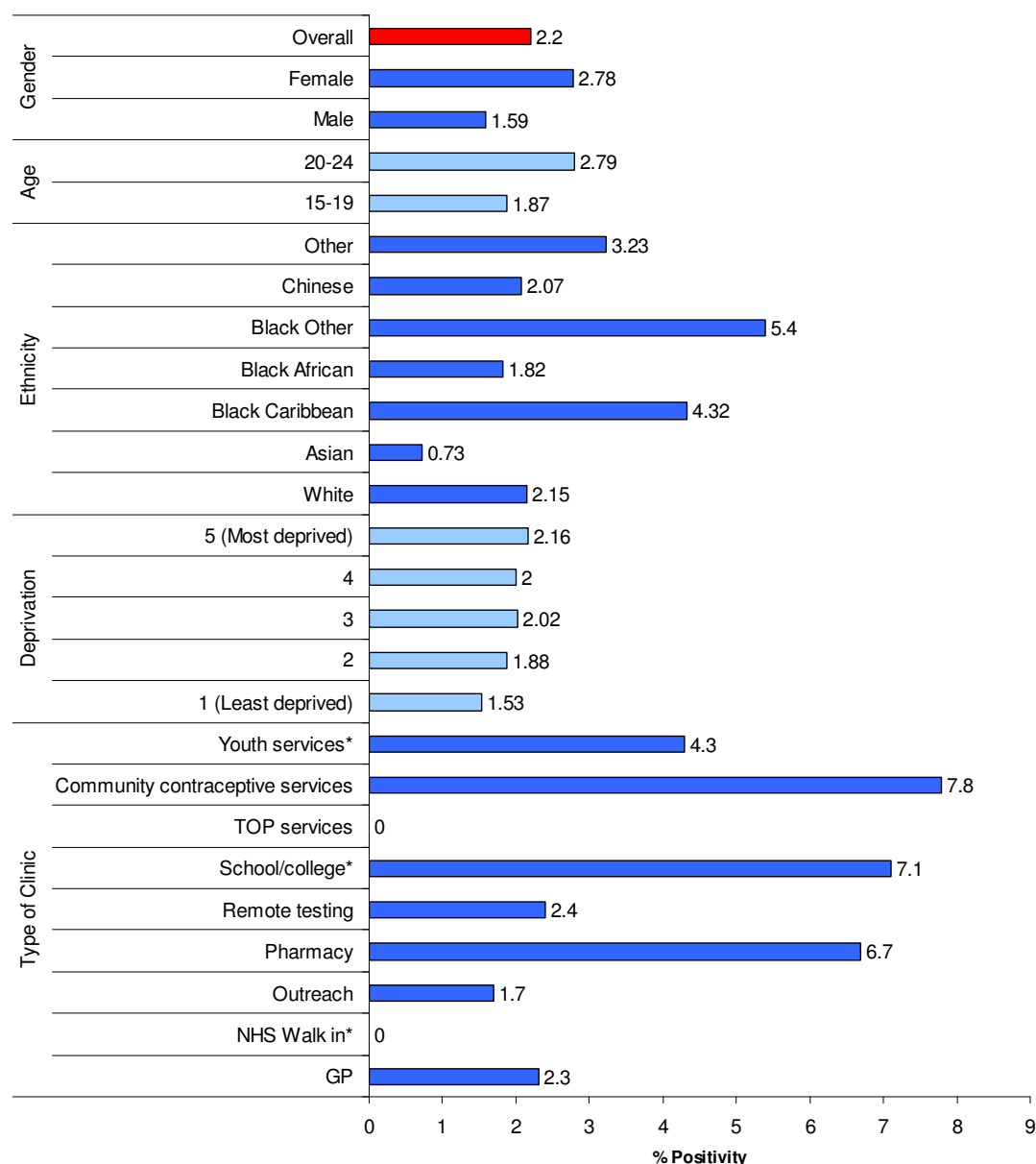
Analysis of those persons testing positive can help better understand local risk groups for chlamydia and accordingly inform appropriately targeted screening. In Westminster those groups where positivity was highest include:

- Females;
- Persons aged 20-24;
- Black Caribbean, Black Other and Other ethnic groups;
- Persons residing in areas of high deprivation;
- Persons attending for screening at community contraceptive clinics and pharmacies.

It should be noted, however, that such analysis can only be conducted on persons presenting for chlamydia screening and that positivity in those groups who do not attend for screening cannot be determined.

14% of persons who were diagnosed positive for chlamydia in 2009/10 had previously been screened as part of the NCSP, the majority of whom were females. From the data available it is not possible to say whether these individuals previously tested positive.

**Figure 72: Population testing positive for chlamydia (as a proportion of all screens)**



Source: Chlamydia Screening Office Database and ONS 2006 population projections

\* small numbers, therefore, results may not be robust

## 14.5 Repeated screening

A key aim of the NCSP is to normalise the idea of regular chlamydia screening amongst young people, so that they expect to be screened annually or when they change partner. This is reflected in the chlamydia screening target – persons should be screened for chlamydia every year whilst they are aged between 15 and 24 (regardless of whether or not they have previously been screened).

If Westminster is to continue to improve its screening coverage and begin to normalise the concept of chlamydia screening locally, it is important that young people are engaged with the programme and return for screening in subsequent years. It is, therefore, useful to look at 'repeat screens' to better understand how successful the local screening programme is at 'retaining' young people in the NCSP.

Of those persons screened in 2009/10, only 8.2% had been screened as part of the NCSP in previous years. This is low; however it is most likely a reflection of the low number of people screened in 2008/09. Given the data available it is not possible to look at the proportion of persons screened in 2008/09 who returned for a screen in 2009/10.

Those persons least likely to have been previously screened (after adjusting for age as some persons would not have been eligible for screening in previous years) include females and persons from White British and Black ethnic groups.

The proportion of persons previously screened as part of the NCSP provides an important measure of (i) is Westminster managing to retain people in its local chlamydia screening programme and (ii) is Westminster truly 'normalising' chlamydia screening for young people? Accordingly, data on the proportion of persons screened that have previously been screened as part of the NCSP should be monitored on an annually basis.

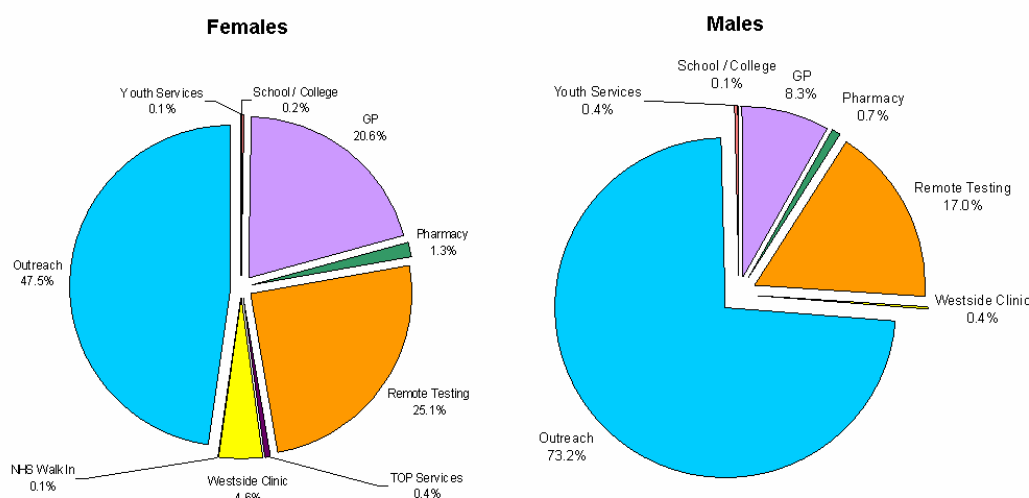
## **14.6 Where are people being screened?**

### **14.6.1 Setting of screen**

Young people in Westminster access chlamydia screening in a range of settings including outreach settings, community contraceptive services, pharmacies and remote testing sites.

The majority of screens in both males and females occurred in outreach settings followed by remote testing and general practice. However, amongst men, 90% of screens were carried out in outreach or remote testing settings with only 8.3% of screens in general practice and very few screens in other settings. Amongst females, the predominant setting for screens was outreach (but this was not to the same extent as for men) followed by remote testing. Just over 20% of screens in females occurred in GP settings. Furthermore, a small number of screens have occurred in community contraceptive service and pharmacy settings.

**Figure 73: Chlamydia screens by type of clinic, Westminster 2009/10**



Source: Chlamydia Screening Office Database

The reasons for these patterns are unclear but seem to suggest that chlamydia screening as currently offered in core service settings<sup>5</sup> is not acceptable to young people in Westminster, with outreach and remote testing settings being preferred.

The NCSP suggests that engaging core primary care services who see young people everyday is essential in developing a sustainable and successful local chlamydia screening programme and recommends that 60% of screens should occur in core services.

However, there may be a number of reasons why the number of screens in core service settings in Westminster is so low; firstly young people may not be using core services and secondly those young people that are using core services may either not be offered a chlamydia screen or choose not to take a chlamydia screen. Therefore, locally we need to understand:

- Are young people accessing core services?
- Are young people who are accessing core services being offered chlamydia screening?
- Is chlamydia screening in core services acceptable to young people?

<sup>5</sup> Core services include general practice, community and sexual health services, community pharmacy and termination of pregnancy services.

Currently, the answers to the above questions are not clear and accordingly, further work is needed to understand chlamydia screening in this context locally.

Further work is also needed locally to better understand young person's perceptions of chlamydia screening in general and understand what settings and circumstances are most acceptable and convenient for them to be screened in.

#### **14.6.2 Location of screen**

Chlamydia screening is available in a wide variety of locations and settings in Westminster and also surrounding boroughs – these are shown in figure 74. The majority of screens (at fixed locations) are in the North West and West End of Westminster, with very few screens occurring at fixed locations in the South of the borough.

A number of screens are not represented in figure 74 – these are screens that cannot be assigned to a particular location and include:

- Postal kits ( 1,860 screens)
- Terrence Higgins Outreach (245 screens)
- Westside Contraceptive Services Outreach (234 screens).

**No. of screens**

- <5
- <10
- <50
- <100
- <200
- 200+

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Source data: NCSP  
Mapping Data supplied by Dotted Eyes  
Crown Copyright 2010

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## **14.7 How do we increase the uptake of chlamydia testing?**

Chlamydia screening should be convenient and acceptable to young people in Westminster; accordingly any attempt to increase access to screening should consider the views of young persons in Westminster. To date, little is known about what settings and screening practices are acceptable and preferred by young people locally and, accordingly further work is needed to better understand the needs of young persons.

The NCSP regularly shares examples of best practice from around the country on its website around increasing coverage in a range of settings. A summary of this evidence to date is provided.

The NCSP recommends that Chlamydia screening programmes are built around the existing core services of general practice, contraceptive and sexual health services, community pharmacy and termination of pregnancy services. Therefore, much of the evidence presented is based on increasing the uptake of screening in these settings. However, it is important to note that achieving high screening uptake in core services is likely to be challenging for Westminster as there is some evidence to suggest that the numbers of young people accessing core services is not significantly high. Furthermore, in Westminster there is a choice of accessible GUM services which young people may also choose to access for STI testing, including Chlamydia.

### **(i) Outreach: postal testing**

The NCSP is an opportunistic screening programme, however, postal kits can be used as an adjunct to opportunistic screening; postal kits appear to have been a successful method in Westminster in engaging young people in the chlamydia screening programme. A recent review of the national evidence evaluated three main types of post kit distribution (NCSP, 2009):

- Letters inviting young persons to complete and enclosed postal kit;
- Letters inviting young people to request a postal kit via text or website;
- Letters inviting young people to attend a venue so as a GP surgery to be screened.

Screening uptake was variable for the different mail out methods described, however, uptake appeared highest where postal kits were enclosed for completion. Positivity among young people tested via maillots was found to be around 7%; this is lower than the average positivity among NCSP screens but within the observed range in

the various NCSP settings. Accordingly, one of the recommendations of this evaluation was that screening should be appropriately targeted to ensure that persons most likely infected with chlamydia are being identified through the screening programme.

Overall postal chlamydia testing was found to be feasible and acceptable to young persons and has been shown to increase screening volumes compared to opportunistic screening alone. However, it is not clear from the evidence presented whether screens were incentivised (for example by voucher schemes) which may have a confounding effect on the results presented.

Where the target population is being identified from GP registers, 'ghost' patients were found to be a significant problem; it is estimated that between 20 and 45% of young adults may be 'ghost' patients on GP registers. Sending testing kits directly to young people was found to achieve higher return rates than asking people to request a test via other means, however, the potential costs and wastage of such methods as well as ethical concerns were raised.

The results described are consistent with local trends in Westminster – postal testing significantly contributed to Westminster's increase in screening coverage, and appeared to be acceptable to local young people, however, positivity rates attained confirm that postal testing kits do not appear to be identifying those persons most likely infected with chlamydia.

Practical guidance on conducting successful mailouts is available at: [NCSP Professional Site](#) and should be considered when developing local postal testing initiatives.

## **(ii) Outreach: other**

A number of programmes have piloted chlamydia screening at outreach venues such as nightclubs, festivals and other large events to maximise access and opportunities to screen young persons, particularly the more hard to reach young people. For example (Mills *et al*, 2009),

- Testing in nightclubs in Birmingham;
- Developing links with local football academies in Liverpool.

Evidence supporting testing in a wide variety of locations is not consistent across the country; social marketing research in Northumberland and Tyne and Wear found that young people would prefer to be offered screening in pharmacy, general practice and contraceptive and sexual health services. The majority of respondents stated that they would refuse a test if it was offered in a school, college or university, workplace, youth service, pub/club, gig or festival.

This inconsistency highlights the need to work closely with young people locally to understand where they would prefer screening to be offered.

### **(iii) Community contraceptive services**

One of the recommendations of the NCSP is that PCTs build their programmes around existing core services such as community contraceptive services. Evidence suggests that community contraceptive services are highly acceptable venues for chlamydia screening for a number of reasons (NCSP, 2010):

- High uptake of screening
- High positivity amongst those tested
- Good treatment compliance

Providing a large proportion of NCSP screens in community contraceptive services is difficult for Westminster, as large numbers of young persons do not use community contraceptive services – in 2009/10, 808 Westminster residents aged 15-24 accessed community contraceptive services.

Many of the examples of good practice where a high proportion of NCSP screens have been provided by community contraceptive services have community contraceptive services in city centre locations with convenient opening hours and consequently high footfall (NCSP, 2010). This may go some way to explain why Westminster has found providing large numbers of screens in community contraceptive services challenging – local community contraceptive services do not have a high footfall of young people and access is patchy in terms of both geographical location and opening times in Westminster. This suggests that if Westminster is going to be able to deliver a significantly large proportion of NCSP screens in community contraceptive settings, access to such services needs to be improved.

There is, however, some scope to develop services locally in such settings, because out of the 808 persons attending community contraceptive services, only 230 chlamydia screens were carried out; this is equivalent to 28% of Westminster residents attending community contraceptive services who are potentially eligible for screening.

There may be a number of reasons explaining why the uptake of testing in such settings is low; firstly persons may have been tested elsewhere (or within the past year, or since their last partner change, etc) and so do not require another test; secondly testing in such settings may be unacceptable to young persons using community contraceptive services and so an offer of a test is declined; or thirdly, testing is not offered by providers. Therefore, further work is needed to better understand the reasons for the relatively low number of screens occurring in this setting. Such work will involve working with young people to understand the acceptability of screening in community contraception setting, local audits to investigate reasons for refusal of screening and also working with staff to understand barriers to uptake of screening in such settings.

A review of the literature has identified a number ways in which Westminster can potentially improve the uptake of screening in local community contraceptive services (given the current service location and opening times) (NCSP, 2010). These include:

- Engaging staff
- Improved staff training
  - Mentoring;
  - Protected learning time;
  - Offer of STI testing and management as part of staff career development;
- Provision of information on testing at reception and also advertisement of testing in waiting rooms;
- Tailoring system to staff and facilities, for example access to toilets in the waiting room;
- Consider out opt rather than opt in approaches
- Strong performance management and monitoring
  - Work on targets set by commissioner;
  - Controlled system for monitoring who has had a screen or if not why not (which is marked on all client records);

- Regular auditing;
- Innovation and partnership working
  - Outreach work with local colleges
  - Working collaboratively with peer educators.

In all of the examples of good practice, receptionists were seen as key to the whole screening system, especially in ensuring that young persons return to the clinic for treatment. Examples of receptionist involvement that was shown to increase uptake of screening included:

- Providing prompts to clinical staff to offer chlamydia screening, for example, electronic prompts on IT systems, leaflets in casenotes;
- Receptionists offering a chlamydia testing pack to those who attend for condoms only;

#### **(iv) General Practice**

Nationally, there is strong evidence to suggest that young people regularly access their GP – between 60% and 83% of people aged <25 visit their GP each year (NCSP, 2009). Furthermore, NCSP pilot studies found that screening in general practice settings is acceptable to young people and that the uptake of the test offer was high. However, locally there is poor understanding of the acceptability of Chlamydia screening in general practice and also no robust evidence to show how many young people locally regularly visit their GP. Accordingly, PCTs should monitor the footfall of the target population through general practice and assess how many additional screens could potentially be offered.

All opportunities to increase the uptake of Chlamydia screening in general practice should be explored – every time a young person visits their GP should be seen as an opportunity.

The NCSP (2009) suggests many ways in which GPs can be more engaged in the screening programme. These include:

- Renummerating general practices;
- Provision of ongoing training and support;
- Engaging all surgery staff including practice managers, receptionists and practice nurses;
- Regular feedback;

- Publicising the availability of screening.

Furthermore, in a recent literature review (NCSP, 2009), it was found that many of the examples of good practice where a high number of screens have been carried out had:

- A screening champion;
- Normalised screening so that all risk patients were offered opportunistic screening when they attended;
- Facilitated screening using a variety of time-saving methods including computer prompts, test kits in reception areas, youth clinic and receptionist involvement;
- Sustained screening through frequent reminders to practices;
- Training prior to registration as a training site;
- Advertised screening to the 'at risk' population.

In addition to increasing screening coverage, it is important that a robust policy for partner notification is in place.

#### **(v) Community pharmacies**

Community pharmacies are well placed to offer chlamydia screening as they having long opening hours and a high street presence (NCSP, 2009). Furthermore, pharmacists are already providing sexual health services, with most pharmacists selling pregnancy tests, emergency hormonal contraception and condoms, and some pharmacists offering NHS emergency hormonal contraception.

Screening can be offered in many different ways in pharmacy settings – approaches include:

- Tests offered to clients in the age group attending for other reasons;
- Tests offered in relation to other sexual health related products such as emergency hormonal contraception;
- Offer made by pharmacy/counter staff;
- Grab bins positioned in prominent places (kits may be returned directly to pharmacy or by post to the lab).

Evaluation of screening initiatives in community pharmacy settings showed that overall users liked the convenience, speed and anonymity that screening in such settings offered, with the highest screening volumes in those pharmacies located in

anonymous places such as train stations, however, high risk groups were found to be less likely to access screening in such settings (NCSP, 2009). However, it is important to note that for Westminster this is likely to result in a large proportion of out of area screens. Embarrassment was identified to be a key barrier to users requesting tests in community pharmacy settings.

A review of the literature identified a number of ways in which the number of screens could be maximised (NCSP,2009). These include:

- Embedding chlamydia screening within a package of sexual health care to be delivered in pharmacies;
- Targeting pharmacies such as those where there are few specialist sexual health services, areas with high positivity rates, near further education colleges or secondary schools;
- Provision of ongoing support and training, feedback on performance and encourage, for example via a local pharmacy champion;
- A toilet available for use by the public may improve return rates;
- Convenient opening hours;
- Develop links between pharmacy and the sexual health network;
- Renumeration.

#### **(vi) Incentivising screening**

A recent review of the literature by the NCSP found limited evidence to support incentivising chlamydia screening, although further analysis and evaluation of current schemes as part of the NCSP are continuing (NCSP, 2009).

## **14.8 Conclusions**

Achieving high screening coverage is challenging for Westminster. This is for a number of reasons including:

- Potentially low numbers of young people accessing GPs;
- Low numbers of young people accessing community contraceptive services;
- High numbers of young visitors to the area making outreach at city centre locations and events poor value for money for Westminster, as the number of non-resident screens often outweighs the number of resident screens;
- A choice of accessible local GUM services.

Despite these barriers, coverage of the chlamydia screening programme in Westminster has increased significantly over the last year, however, testing rates

need to continue to increase for the screening programme to have an impact on the prevalence of chlamydia. Currently coverage of the screening programme is variable, both geographically and between gender, age and ethnicity, whilst positivity rates are low. Accordingly, testing rates need to be increased, particularly amongst those groups where coverage is low and amongst those population groups where positivity is highest to ensure that those persons at highest risk of chlamydia infection are identified. Furthermore, the proportion of screens in core services needs to be increased, with embedding of chlamydia screening into core services.

A wealth of evidence exists from across the country around different settings in which to offer chlamydia screening and methods by which coverage can be increased, however, every population is unique and it is important to understand locally what is acceptable to young persons. Therefore, a key step forward should involve young persons in informing and developing the chlamydia screening programme.

Much local work to date has focused on increasing screening coverage, with little focus on the uptake of treatment and partner notification. Accordingly, further work should seek to clarify that clear treatment and partner management pathways are in place in Westminster to both prevent onward transmission of chlamydia and reduce the prevalence of complications of chlamydia infection.

### Recommendations

- Coverage of the NCSP needs to continue to increase in Westminster – this will be achieved by providing widespread access to Chlamydia screening and improving the uptake of screening in core services;
- Variation in screening coverage should be addressed by appropriately targeting females, older age groups and White Asian and Other ethnic groups;
- A better understanding of the number of young persons accessing core services locally is needed;
- Service users should be involved in developing the NCSP – further work is needed to better understand what screening settings and practices are acceptable to young people in Westminster;
- Local indicators should be developed to measure the success of the local screening programme beyond that of the Vital Signs target. These indicators



should consider coverage, positivity and retention in the screening programme;

- The recording of ethnicity should be improved to better understand variation in screening coverage and positivity;
- Further work is needed to clarify treatment and partner management pathways and improve and streamline.

## **15: Prevention, Testing and Management of HIV**

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### **Key Messages:**

- In Westminster, HIV prevention activity is commissioned both locally and through the pan-London HIV Prevention Programme, however, the immediate and ongoing impact of the programme is not well tested;
- In Westminster there is widespread access to HIV testing, however, there is scope to improve the uptake of HIV testing across all settings including in GUM clinics, primary care settings and General Medicine;
- In 2008, 22% of adults diagnosed with HIV were diagnosed late – a reduction on previous years – this reduction is particularly marked amongst heterosexual men and women;
- Despite recent decreases, heterosexual men and women, particularly men, however, remain a high risk group for late diagnosis;
- HIV is a long term condition and therefore, many people living with HIV have complex needs;
- Accordingly, management of HIV infection is more than antiviral treatment, but involves counselling, emotional and peer support, advice and advocacy and positive self management.

### **15.1 Prevention of HIV**

#### **15.1.1 What is HIV prevention?**

HIV prevention is generally viewed in terms of three broad categories – primary, secondary and tertiary:

- Primary prevention aims to prevent transmission of the virus and prevent uninfected persons becoming infected;
- Secondary prevention aims to prevent persons infected with HIV from transmitting the virus;
- Tertiary prevention aims to enable people with HIV to stay well and slow progression of the disease.

#### **15.1.2 HIV prevention in Westminster**

HIV prevention programmes in Westminster are commissioned on two levels -locally and at a pan London level. Locally, Westminster commissions the following HIV prevention initiatives that are aimed at BME groups, MSM, young homeless persons and sex workers:

- Brook London – safer sex programme and condom distribution for homeless young people
- CLASH (Central London Action on Sexual Health, sex worker programme)
- Naz Project London – BME sexual health promotion programme and HIV prevention
- Terrence Higgins Trust – SWISH (Sex Workers Into Sexual Health)
- Youth Projects International – safer sex programme and condom distribution for African young people
- Terrence Higgins Trust- NRG – LGBT youth provision
- Praed Street Project and Working Men Project

However, a significant proportion of HIV prevention activity is commissioned collaboratively through the Pan London HIV Prevention Programme. The programme primarily targets three prevention groups – gay men, African communities and people living with HIV – the scope of this programme is outlined in table 12.

**Table 12: Overview of the Pan London HIV Prevention Programme**

Men who have sex with men	African Communities	People with HIV
Gay Men's Initiative Partnership – gay men's health trainer service	Terrence Higgins Trust – African mass media	National AIDS Manual & Terrence Higgins Trust – treatment information
Gay Men's Initiative Partnership – gay men's counselling & mentoring	Terrence Higgins Trust & HEAL – African small media	National AIDS Manual & Terrence Higgins Trust – HIV health trainers
London Lesbian & Gay Switchboard – Gay men's telephone line	Terrence Higgins Trust – African organisational development	
PACE – Gay men's group work	Terrence Higgins Trust & HEAL – African health promotion skills	
Terrence Higgins Trust – Gay men's group work		
Camden Provider Services – Gay men's condom distribution		
Terrence Higgins Trust – Gay men's mass media		
GMFA – Sex and Health magazine		
GMFA – gay men's small media		
GMFA – gay men's website		

The Pan London HIV Prevention Programme has been running for two years. Monitoring and evaluation of the programme indicates that the programme overall

has faced significant challenges in delivery. Data does show that all work streams are active in Westminster. In particular, the group work, sex and health magazine distribution and condom distribution work streams for Gay Men, and HIV health trainer and treatment information distribution work streams are strong in Westminster. The immediate and ongoing impact of the entire programme is less well tested and this remains an issue.

Further work is needed at a pan London level to better understand the current and potential reach of the programme. This must include an analysis of gaps and unmet needs.

An improved understanding of the pan London work should assist in identifying priorities for commissioning local HIV prevention activities. This is essential as local activities have not been reviewed for some time. Given the changing profile of HIV set out in this paper, examining locally commissioned HIV prevention activities is crucial.

It is difficult therefore to draw a firm conclusion about whether the combination of a regional and local approach to commissioning of HIV prevention services works for Westminster. However, it is likely that Westminster will draw significant benefit from a sustained pan London approach, particularly with regard to MSM. This is because of both the epidemiological profile of people with HIV in Westminster, and the attraction of the bars, clubs, gyms and other venues targeting MSM that exist in Westminster that will attract this population to live here. It is unlikely that Westminster would be able to commission such an extensive programme of work in isolation.

In addition to understanding the prevention needs of particular risk groups in Westminster, further work is needed to better understand wider determinants associated with HIV infection and changing patterns of risk taking behaviour. Examples of such determinants include:

- Potential increased use of methamphetamine (crystal meth) and ongoing use of other substances such as cocaine and ketamine amongst MSM and sex workers, and the impact of substance use on sexual risk taking behaviour
- Young men engaging in sexual contact with older male partners who have HIV

- The practice of 'sero-sorting' amongst MSM i.e. choosing partners on the basis of their HIV status so that they do not have to use condoms.
- The impact of outbreaks of other STIs such as syphilis, lymphogranuloma venereum (LGV) and most recently Hepatitis A amongst MSM on behaviours and prevention needs

It is no longer enough to say that the main risk group for HIV infection in Westminster are MSM – much more detailed understanding of the prevention needs of other populations is needed if programmes are going to be effective.

## **15.2 Testing for HIV**

If persons are to benefit from HIV treatment, a diagnosis must be made so that a referral to specialist care can be made. Furthermore, testing has an important role in prevention; the process of testing, including pre and post test counselling, may be used to raise awareness of HIV infection and educate individuals about how the virus is transmitted and how individuals can avoid contracting it and passing it on to others. Interventions such as cognitive behavioural therapy following a negative HIV diagnosis have also been shown to have a significant impact on behaviour change for a period of up to 12 months.

Accordingly, provision of a choice of easily accessible, high quality services that provide HIV testing is essential if Westminster is to reduce the number of newly acquired HIV infections, reduce the number of undiagnosed HIV infections and reduce the proportion of persons diagnosed late.

In Westminster HIV testing is available in a range of settings; these include in primary care, community services, antenatal care, GUM clinics and drugs services.

### **15.2.1 HIV testing in GUM clinics**

Latest available data shows that in 2008 the three main GUM clinics used by Westminster residents (Jefferiss Wing, Dean Street and Mortimer Market) offered over 55,000 HIV tests, although it should be noted that not all of these tests relate to Westminster residents. Of the 55,189 tests, 10,216 were in MSM and 44,973 were in heterosexuals.

It is important to note that an offer of an HIV test does not necessarily mean that an individual undergoes an HIV test – a test may be declined. Uptake of HIV testing

describes the number of persons who are tested for HIV as a proportion of all persons offered an HIV test in GUM clinics. There is considerable variation in HIV testing uptake between different prevention groups in London. Generally, HIV testing uptake is higher amongst MSM compared to heterosexuals (explaining the lower prevalence of undiagnosed HIV infection in MSM compared to heterosexuals).

Latest available data for 2008 shows that for MSM for Jefferiss Wing, Mortimer Market and 56 Dean Street the uptake of testing was 81%,85% and 88% respectively (London range: 78% - 100%). For heterosexuals the uptake was 74% for Jefferiss Wing, 93% for Mortimer Market and 77% for 56 Dean Street (London range: 71% - 98%).

**Table 13: Uptake of HIV testing in GUM clinics, Westminster 2008**

GUM Clinic	Uptake of testing	
	MSM	Heterosexual
Jefferiss Wing	81%	74%
56 Dean Street	88%	77%
Mortimer Market	85%	93%

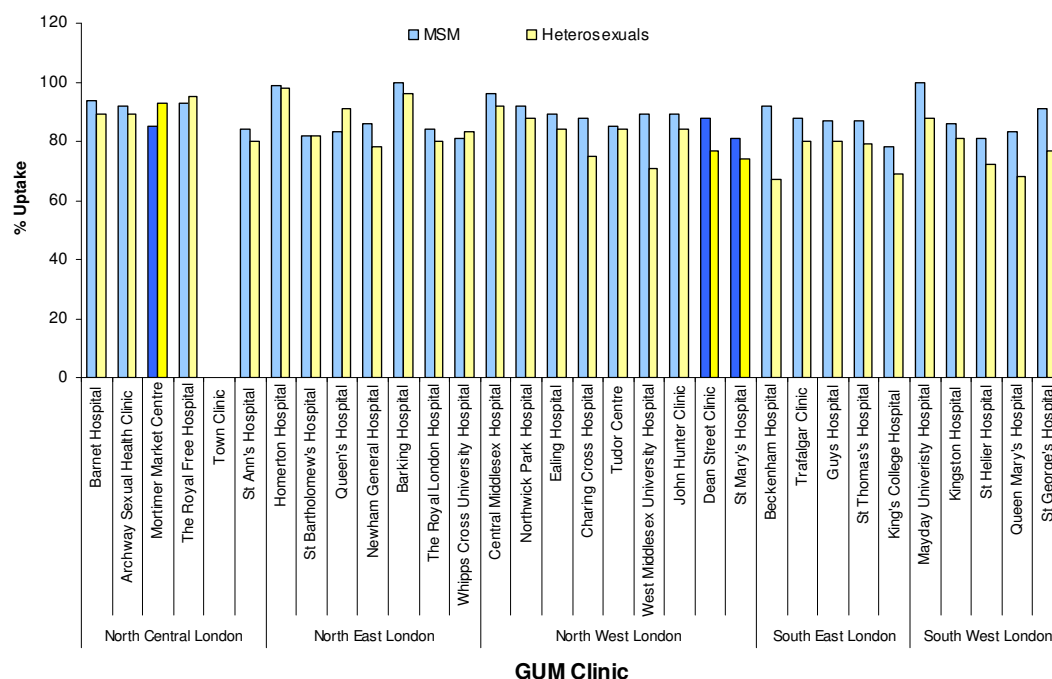
Source: HPA & The London Sexual Health Programme

There is clearly a need to optimise HIV testing in GUM clinic settings – particularly amongst those groups with a low uptake. In Westminster, those persons and clinics with relatively low uptake (compared to the rest of London) include:

- heterosexuals attending Jefferiss Wing and 56 Dean Street
- MSM attending Jefferiss Wing, Mortimer Market and 56 Dean Street.

The London Sexual Health Programme suggests that one of the ways this might be done is through the introduction of opt-out HIV testing services, however, locally further work is needed to better understand testing protocols and the characteristics of those persons not being tested.

**Figure 75: Uptake of HIV testing in GUM clinics London, 2008**



Source: HPA & The London Sexual Health Programme

### 15.2.2 Antenatal HIV testing

St Mary's Hospital is the main provider of antenatal services for Westminster residents. In 2008, 97.2% of women booked in for antenatal care were tested for HIV - this is higher than the London average (HPA & The London Sexual Health Service, 2010).

### 15.2.3 Westminster Blood-borne Virus Service

The Westminster Blood-borne Virus Service was established in 2008 and is a partnership between Westminster Drug Project, Central and North West London NHS Foundation Trust and the Hungerford Drug Project. The BBV Service is provided by a number of agencies across Westminster and is targeted at screening problematic drug users for hepatitis B, hepatitis C and HIV.

Between April 2008 and December 2009 the service tested 868 individuals out of 1,027 people presenting to the service – this represents an uptake of 85%. Of those tested, 42 individuals were positive, representing a positivity of 4.8%

#### **15.2.4 MSH@Queen's Park**

The MSH@Queen's Park service was commenced at the beginning of August 2009, with the main aim of the service being to provide STI screening in primary care settings and to increase the number of persons aged 15-24 screened for chlamydia.

Latest available data for the period August 2009 to December 2009 shows that 216 individuals accessed the service, of whom 163 underwent an HIV test (equivalent to an uptake of 75%). This uptake of testing is similar to that of heterosexuals and MSMs attending the Jefferiss Wing at St Mary's Hospital, but lower than the uptake at Dean Street.

#### **15.2.5 Primary Care**

Little is known about HIV testing in general practice in Westminster. It is currently unclear which GPs undertake HIV testing and which do not. In order to better understand HIV testing practices, data was requested from the laboratories which Westminster GPs use for testing. Data was available for 31 out of 52 GP practices in Westminster.

Of those 31 practices for which data was available, 28 practices conducted 351 HIV tests during the period November 2008 – November 2009. The majority of practices conducted only a handful of tests (between 1 and 20), however, five practices conducted between 20 and 64 tests – these were all in the North of the borough - however this is most likely a reflection of the availability of laboratory data. Overall, the pattern of testing in general practice settings across the borough appears to be patchy.

Compared to the level of testing in GUM, antenatal and community services, the level of HIV testing in primary care is low and further work is needed to improve provision. Primary care has a key role to play in the provision of HIV testing outside of the traditional GUM clinic setting; in addition to increasing the provision of testing, it is thought that offering testing in primary care helps 'normalise' HIV testing, so that it is seen as a routine investigation rather than a specialised clinical investigation.

The UK National Guidelines for HIV testing recommend that HIV testing should be considered in all men and women registering in general practices where the prevalence of HIV in the local population is at least 2 per 1,000 population (which it is



in Westminster) (HPA & The London Sexual Health Service, 2010). Furthermore, testing is thought to be most effective if targeted at persons aged between 15 and 59 years old.

In terms of deciding which practice patients should be offered HIV testing, some pilots have targeted all new patients whilst other pilots have targeted all patients in appropriate ages – results are currently awaited.

#### **15.2.6 General Medicine**

The UK National Guidelines for HIV testing recommend that universal HIV testing should be offered to all general medical admissions where HIV prevalence in the local population exceeds 2 per 1,000 (HPA & The London Sexual Health Service, 2010). As described previously, the prevalence of HIV for most areas in Westminster is higher than 2 per 1,000. This suggests that in Westminster, testing should be offered to all general medical admissions.

#### **15. 2.7 Other**

In addition to those services described, HIV testing in Westminster is also provided by the Terrence Higgins Trust, however, suggests that the Terrence Higgins Trust is testing few Westminster residents. Dean Street and St Mary's also provide outreach services in a range of settings.

### **15.3 Late diagnosis of HIV in Westminster**

#### **15.3.1 What is late diagnosis?**

Late HIV diagnosis is defined as an individual diagnosed with a CD4 count <200cells/mm<sup>3</sup> within three months of diagnosis (HPA & The London Sexual Health Service, 2010).

Early diagnosis of HIV is important because it improves morbidity and mortality associated with HIV as well as ensuring that newly diagnosed people with HIV can receive effective treatment, care, counselling and support to reduce onward transmission.

In London there is an HIV prevention target to reduce late diagnosis by 15% by 2010/11 from the 2004/05 baseline<sup>6</sup>.

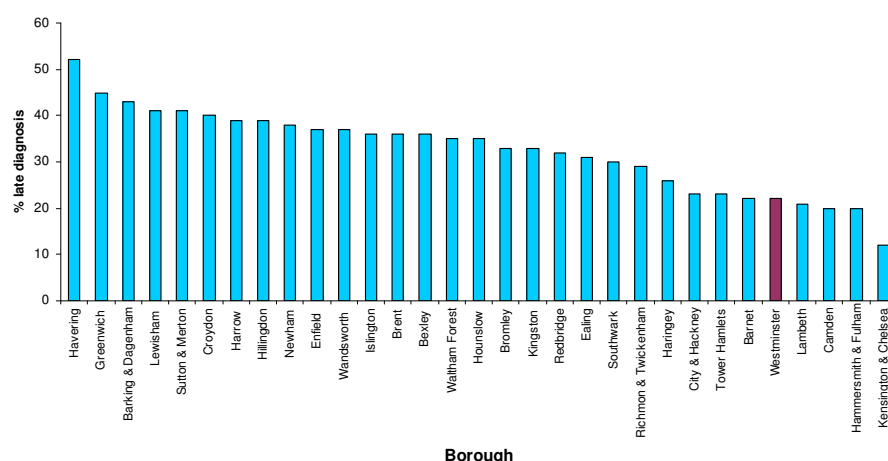
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<sup>6</sup>Numerator definition: the total number of HIV-infected London residents aged 15 years and above who were diagnosed in a calendar year with PCT of residence where the CD4 cell

### 15.3.1 What proportion of diagnoses in Westminster are late diagnoses?

In Westminster in 2008, 22% of adults aged 15 years and over were diagnosed late – this compares to 31% in London and 32% in England and is the fifth lowest proportion in London.

**Figure 76: Late diagnoses by London PCT, 2008**



Source: The London Sexual Health Programme and HPA

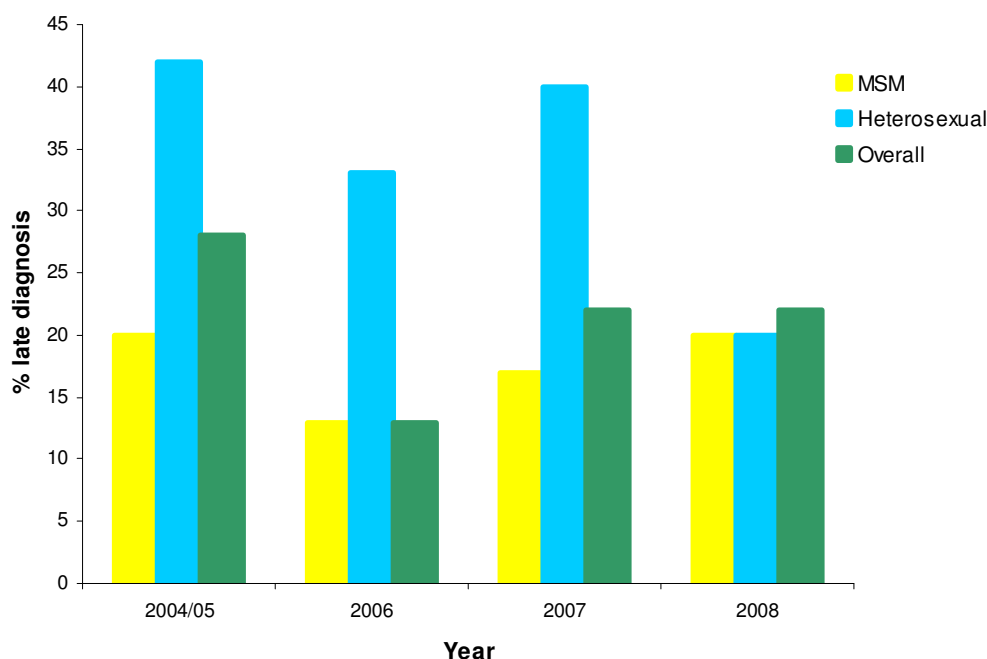
In terms of time trends in Westminster, the proportion of late diagnoses in heterosexual men and women have decreased in recent years from 42% in 2004/05 to 20% in 2008. However, amongst MSM the overall proportion of late diagnoses has not changed (after an initial decrease) in the period 2004/05 to 2008.

Overall there has been a small reduction in the proportion of late diagnoses amongst heterosexuals and MSM, however, year on year figures should be interpreted with caution as large fluctuations may result because of the small numbers involved.

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count was less than 200 cells per mm<sup>3</sup>. Denominator definition: the total number of HIV-infected London residents aged 15 years and above who were diagnosed in a calendar year with PCT of residence and CD4 cell count reported.

**Figure 77: Late diagnosis by prevention group, Westminster 2004-2008**



Source: The London Sexual Health Programme and HPA

### 15.3.2 Who are the people in Westminster who are diagnosed late?

In Westminster the proportion of adults diagnosed late is similar for MSM (20%) and heterosexual men and women (20%) – this is in contrast with the picture in London and England in which heterosexual men and women are much more likely to be diagnosed late than MSM.

**Table 14: Proportion diagnosed late by prevention group, 2008**

	Westminster	London	England
MSM	20%	18%	20%
Heterosexual	20%	42%	

Source: The London Sexual Health Programme and HPA

More detailed data is not available at a local level describing the characteristics of populations diagnosed late, however it is thought that the majority of late diagnoses amongst heterosexual men and women are the result of persons having acquired their infection abroad, many years before their arrival in the UK (where they are subsequently diagnosed).

The proportion of MSM diagnosed late has changed little in recent years, however the proportion of heterosexually acquired infections diagnosed late has fallen and is now half the level in London. This is most likely a reflection of the fall in the number of African born heterosexually acquired infections.

National data suggests that heterosexual men are more likely to be diagnosed late than heterosexual women – this is most likely due to earlier diagnosis among women offered HIV tests as a routine part of their antenatal care.

The latest HPA report on STIs in Black African and Black Caribbean communities in the UK (Health Protection Agency, 2008) suggests that late diagnosis of HIV in Black African is particularly high compared to other ethnic groups. Of the new diagnoses in 2007, 42% of Black Africans and 27% of Black Caribbeans were diagnosed late. Where information was available, most Black Africans who were diagnosed late had been resident in the UK for longer than two years, suggesting that further work is needed to increase HIV testing amongst Black Africans.

In order to appropriately target testing and interventions to persons most at risk of late diagnosis, a better understanding of the characteristics of persons diagnosed late with HIV is needed. For example, it would be useful to know the ethnicity and age of MSM diagnosed late as well as the ethnicity, age and sex of heterosexuals diagnosed late. However, limited no information is readily available on the characteristics of those persons diagnosed late at both a local and national level. Collaboration with the London Sexual Health Programme HPA should be explored in the future to provide the intelligence to better understand this population.

### **15.3.3 Where are the people who are diagnosed late?**

Whilst postcode level information about where people diagnosed late reside in Westminster is not available, inferences can be drawn from the identification of those population groups that are most at risk and where geographically in Westminster these population groups are.

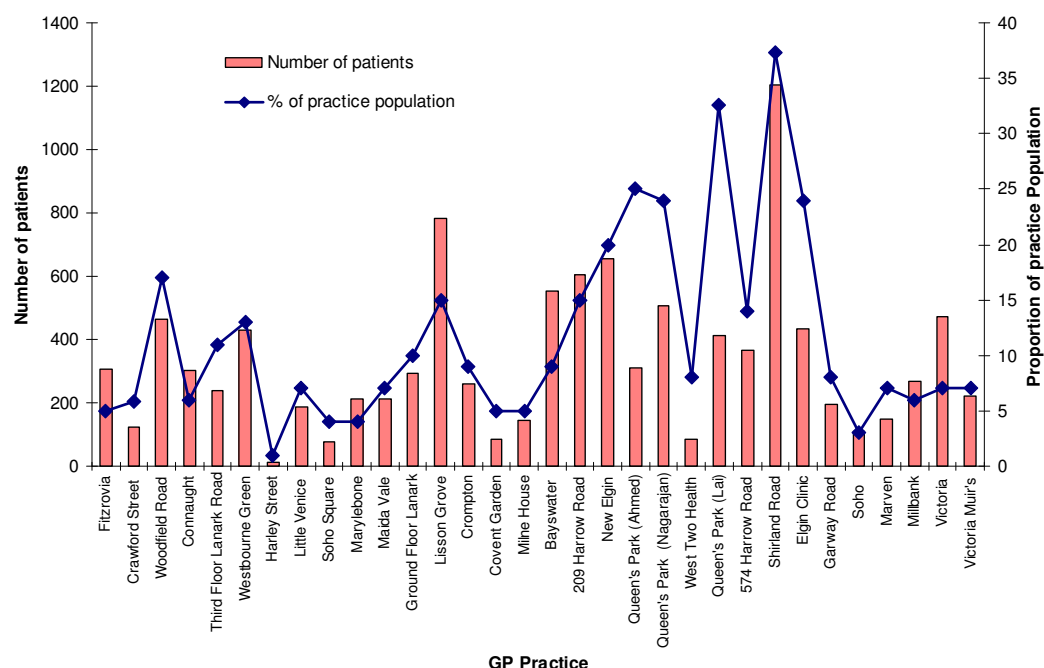
Little data is available describing the distribution of MSM within Westminster in terms of residence or GP registration, however, data regarding Black ethnic groups is available at ward and GP practice level.

According to the 2001 Census the areas of Westminster with the highest proportion of persons from Black ethnic groups are found mainly in Queen's Park, Harrow Road, Westbourne and Church Street Wards. This suggests that initiatives to increase the uptake of HIV testing amongst Black African heterosexuals should be targeted in the North West of the borough.

Analysis of GP practice data which describes GP practice populations by ethnicity shows that practices in the North West of the borough and also in the Church Street ward have the highest proportion of persons from Black ethnic groups (figure 78)

Identifying MSM via place of residence or registered GP is not possible because such data is not available.

**Figure 78: Proportion of the population by GP practice who are from Black ethnic groups**



#### 15.3.4 Reducing the number of persons diagnosed late

Evidence from the Health Protection Agency shows that many persons who are diagnosed late with HIV have had recent contact with healthcare professionals prior to their diagnosis; this suggests that opportunities are being missed for HIV diagnosis

(HPA & The London Sexual Health Service, 2010). Accordingly, evidence suggests that commissioning services to provide HIV testing outside of GUM clinic settings and to those groups with the highest rates of late diagnosis of HIV is essential if the target to reduce HIV late diagnosis is to be achieved.

Historically in Westminster the highest rates of late diagnosis have been in the heterosexual population, however, in recent years the proportion of persons diagnosed late has been similar in heterosexual and MSM populations. Furthermore, whilst interventions which promote HIV testing and raise awareness of the benefits of early HIV diagnosis in high prevalence groups is important, it is unlikely to be sufficient to meet the NHS London performance target on their own. Accordingly, the London Sexual Health Programme recommends that PCTs develop new models of service provision in both primary and secondary care.

The London Sexual Health Programme has issued commissioning guidance to reduce the proportion of persons diagnosed late (HPA & The London Sexual Health Service, 2010). These recommendations should be considered for Westminster. The key points include:

- Optimising current HIV testing in GUM and antenatal care;
- Introduce the routine offer of an HIV test in specific services e.g. hepatitis clinics, termination of pregnancy services and TB services;
- Pilot and evaluate community based point of care testing;
- Work with healthcare staff to raise awareness of clinical indicators of HIV and to train staff to offer an HIV test, aiming to 'normalise' the HIV test;
- Promote HIV testing in high risk communities;
- Improve follow up with individuals that have previously taken an HIV test to promote retesting;
- Commission counselling and one to one interventions for people diagnosed with HIV in acute and community settings;
- Commission positive self management programmes for people with HIV.

As is highlighted in previously, Westminster is already acting upon the outlined recommendations, however, further work is needed to build upon and optimise current testing initiatives. Furthermore, given the large number of visitors to Westminster (either for work or leisure), persons accessing HIV testing services in Westminster will include Westminster residents as well as non-residents. Whilst

testing initiatives that are accessible to all serve a 'greater good', when commissioning services Westminster should consider whether the services commissioned are reaching Westminster residents and thus contributing to the London target and providing value for money. For example, only 22% of persons seen at Metrosexual Health@Queen's Park are from Westminster - therefore, although Westminster commissions this service, it is primarily seeing (and testing) non-Westminster residents. Consequently, this service will not have as large an impact on the late diagnosis target as it potentially should.

## **15.4 Management of HIV**

The experience of living with HIV is a challenging one. HIV infection is a long term condition that requires not only medical treatment, but also support services that span health and social care.

Research by Sigma identified a number of challenges that person living with HIV face and found that anxiety, depression, sleep problems, sex related problems and issues around self-confidence were the most commonly reported issues associated with HIV infection. Research by the Medical Foundation for Aids and Sexual Health also highlighted the complex needs and challenges faced by people living with HIV. These are summarised below:

- Coping with the psychological and physical effects of a long term condition;
- Stigma associated with HIV infections which results in fear, secrecy and misinformation;
- Adhering to treatment which often involves demanding regimes of different drugs;
- Maintaining good sexual health and preventing onward transmission of HIV;
- Managing the impact of HIV on partners, friends and family members.

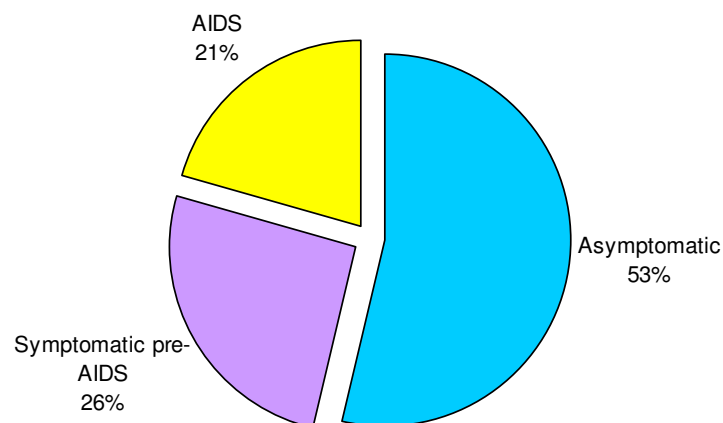
### **15.4.1 Who are the people being managed with HIV?**

SOPHID is the main source of information on persons diagnosed and accessing care got HIV. As highlighted in section 5, as of 2008, 1,302 persons were accessing HIV care, the majority of whom are men aged 35-54 years old.

In terms of clinical stage of infection, the majority of Westminster residents accessing care are described as asymptomatic (53%). This however, is likely to change in the future, as a result of persons living for longer with HIV, an increasing proportion of

persons accessing HIV care are likely to have progressed to symptomatic pre-AIDS and AIDS.

**Figure 79: Clinical stage of infection, Westminster 2008**

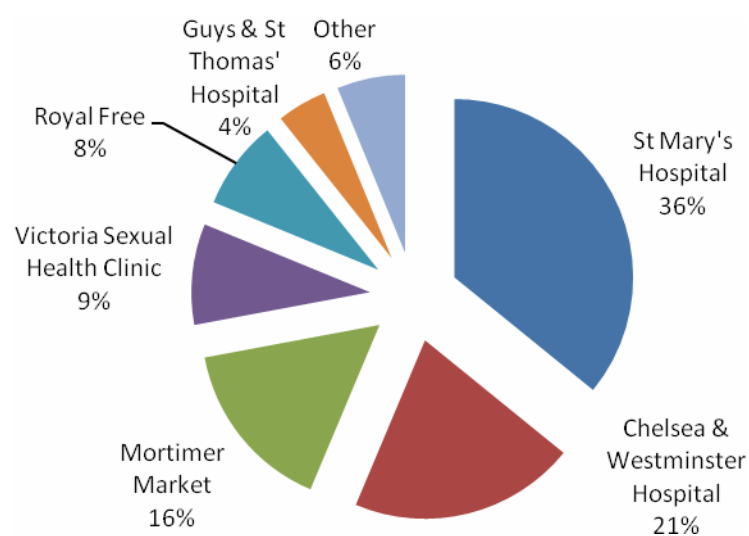


Source: SOPHID

#### 15.4.2 Where are people being managed?

The majority of people diagnosed and accessing HIV care, have their treatment delivered in acute settings. In Westminster the main providers of this care are St Mary's Hospital, followed by Chelsea & Westminster Hospital and Mortimer Market.

**Figure 80: Place of HIV treatment, Westminster 2008**



Source: SOPHID



### **15.4.3 Overview of management of persons with HIV**

In addition to commissioning treatment services, Westminster jointly commissions<sup>7</sup> care and support services for persons living with HIV. These services are outlined below.

#### **(i) positive self management**

Living Well and the Terrence Higgins Trust are commissioned to provide flexible positive self management programmes, which include workshops on life coaching, community support and complimentary therapies.

#### **(ii) advice and advocacy**

Advice and advocacy services are provided by Camden Citizens Advice Bureau and includes advice and casework, particularly around housing and welfare rights as well as signposting to specialist immigration advice. The service is also beginning to provide advice around better money management and returning to employment.

#### **(iii) counselling, emotional and peer support**

The Terrence Higgins Trust, Living Well and Positively Women provide counselling, emotional and peer support to Westminster residents living with HIV.

#### **(iv) children and families support**

Children and families support is provided by Body and Soul. Support is provided for children and young people who are either affected by HIV, such as children of HIV positive parents, or children and young people who themselves are infected with HIV. Furthermore, family interventions and support and transition interventions for young adults are also provided.

In addition to the described services, Westminster also commissions day and palliative care services and specialist clinical care for HIV related brain impairment.

## **15.4 Conclusions**

Effective prevention and HIV testing programmes are essential to reduce the number of newly acquired HIV infections. HIV prevention activity in Westminster is primarily aimed at key prevention groups including BME groups including African communities, MSM, young homeless persons, sex workers and people with HIV. However, the immediate and ongoing impact of HIV prevention activity in the context of the

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<sup>7</sup> Jointly commissioned refers to services commissioned across NHS Westminster and Westminster City Council

changing profile of HIV in Westminster is not well understood and accordingly, further work is needed to better understand the current and potential reach of HIV prevention activity.

Early diagnosis of HIV is not only an essential outcome of HIV prevention, but is associated with improved health outcomes. In Westminster there is widespread access to HIV testing services which has contributed to the lower than national average proportion of infections diagnosed late. However, there is the potential for further improvement, increasing the uptake of HIV testing in all settings in which it is offered and further improving access to screening in new settings.

Upon diagnosis, effective management of HIV is essential, as living with a long term condition such as HIV is often challenging and persons often have multiple, complex needs. Accordingly, management of HIV infection is much more than antiviral treatment, but includes support services that span both health and social care. In recent years, Westminster has developed a comprehensive range of management services in addition to the treatment services it commissions in acute settings. It is important that these services are continually evaluated to ensure that they are meeting the needs of the changing profile of persons with HIV in Westminster.

## **Recommendations:**

### **Prevention**

- Further work is needed at pan London level to better understand the current and potential reach of the Pan London HIV Prevention Programme;
- Further work is needed to understand the prevention needs of particularly risk groups in Westminster, particularly the wider determinants associated with HIV infection and changing patterns of risk taking behaviour;

### **Testing and late diagnosis**

- Uptake of HIV testing in all settings should be improved – this will require a better understanding of local testing protocols in testing settings and also a better understanding of the reasons why persons do not accept an HIV test;
- HIV testing should be offered to all adults registering in general practice in Westminster;
- HIV testing should be offered to all general medical admissions in Westminster;

- The Department of Health has funded eight projects across the country piloting HIV testing in a range of healthcare and community settings. The results of these pilots will be available in August 2010 and should be considered locally;
- Two NICE guidelines regarding HIV testing are currently in development; increasing the uptake of HIV testing among Black Africans in England and; increasing the uptake of HIV testing amongst men who have sex with men. These guidelines, which are expected to be published in March 2011, should be considered locally. Please see: <http://guidance.nice.org.uk/PHG?Wave19/3> and <http://guidance.nice.org.uk/PHG/Wave19/4>
- Consider the recommendations of the London Sexual Health Programme.

### **Management**

- The changing profile of persons diagnosed with HIV and accessing care in Westminster should be continually monitored to ensure that currently commissioned services are appropriate for local needs;
- The ageing profile and increasing length of time infected is likely to increase the challenges faced by people living with HIV and should be considered when commissioning services in the future.

## **Key Prevention groups**

## **16: Key Prevention Groups**

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### **16.1 Introduction**

Sexual health has an impact on a significant proportion of the Westminster population, however, this report has highlighted the existence of clear inequalities in sexual health in Westminster. This is consistent with national findings which show that women, MSM, teenagers, young adults and BME groups are disproportionately affected by poor sexual health.

Because of the clear inequalities in sexual health outlined, young people, MSM and BME groups have been identified locally as key prevention groups in greater need of services locally. This section of the needs assessment focuses specifically on these prevention groups and describes both the sexual health need and provision of sexual and reproductive health services specifically for the key prevention groups.

It is, however, important to note that although these prevention groups have been considered independently, that people are individuals and may fall into more than one group – this is often described as intersectionality.

### **16.2 Young people**

There are clear inequalities in the sexual health of young people, with young people experiencing relatively high rates of unintended pregnancy and STIs (with the exception of HIV). In England, young people (aged 15-24) represent 12% of the population, but account for approximately half of all STIs diagnosed in GUM clinic settings. Accordingly, young people have been identified as a key prevention group locally with regards to sexual health.

#### **(i) Sexual behaviour of young people**

The National Survey of Attitudes and Lifestyles (Johnson *et al*, 2001) suggests that the average age of first heterosexual intercourse for men and women was 16 years, however one third of men and a quarter of women reported having sex before the age of 16. The Gay Men's Sex Survey (2002) found that the average age at which a man first had any sexual experience with another man was 17.5 years.

Young people from Black African and Black Caribbean ethnic groups were more likely to be younger than 16 years old at the time of first sex, whilst young people from Indian and Pakistani ethnic groups were least likely to have sex before the age of 16 (Fenton *et al*, 2005).

Young people leaving school at 16 are also more likely to have sex for the first time before they are 16 than persons who continue their school education beyond 16; 60% of boys and 47% of girls leaving school at 16 with no qualifications reported having sex before the age of 16 compared to 19% of boys and 20% of girls who continued their school education.

### **(ii) Use of condoms**

Brook Central (2005) suggest that the majority of sexually active young persons have used a condom at some point in time, but two thirds reported using condoms inconsistently. In general, condoms were most likely to be used by those having sex for the first time with a partner with whom they were in a relationship with. Where condom use was not reported, this was most common amongst those persons having sex with a person they had only just met but had not previously had sex with and were not dating.

Overall young people reported using condoms as a method of contraception as opposed to protection from STIs. Furthermore, of those that did report using condoms, a third reported applying the condom late on at least one occasion.

### **(iii) Sexually Transmitted Infections**

Young persons are disproportionately affected by STIs with the exception of HIV. In Westminster, young people (aged 15-24) represent 14.1% of the population, but in 2008 accounted for 35% of all STIs diagnosed in local GUM clinic settings. For asymptomatic infections, the rates are likely to be an underestimate as a significant number of infections will be undiagnosed.

**Table 15: STIs diagnosed by local GUM clinics, 2008**

STI	Number of STIs diagnosed		Proportion of all STIs diagnosed in GUM clinic settings
	15-19	20-24	
Syphilis	*	17	9%
Gonorrhoea	88	173	29.1%
Herpes simplex – first attack	62	177	28.7%
Anogenital warts	102	391	31.3%
Chlamydia	347	668	41.6%

Source: KC60, 2008

In addition to diagnoses made in GUM clinic settings, 255 people were diagnosed with chlamydia as part of the NCSP.

#### **(iv) Access to services**

##### ***General Practice***

The number of young persons accessing their GP for sexual health services is not known due to current data limitations, however, anecdotal evidence suggests that it is low. Further work is needed to understand the reasons for this, however, it should be noted that this is not an issue unique to sexual health.

##### ***GUM services***

Imperial College Healthcare Trust provides a sexual health service for persons aged 20 and under, the Adolescent Resource Centre (ARC). The service consists of two weekly walk in services, one hospital based and one community based within a joint youth centre and Connexions one stop shop:

- ARC at the Jefferiss Wing, Tuesdays 15.00-17.00
- ARC at the Stowe Centre, Thursdays 15.00-18.00

ARC provides a range of services including:

- Sexual health screening;
- Contraception including condoms and emergency contraception
- Testing and treatment for STIs;

- HIV;
- Pregnancy testing;
- Advice and support
- Safer sex information.

Chelsea and Westminster Hospital Trust also provides a sexual health service for persons aged 20 and under, Cont@ct; this service operates Monday to Friday 15.30 – 16.30 and is also a walk in service, set up in response to local findings that suggested young people wanted clinics that ran more frequently than once a week, that were open after school and were preferably walk in services. Cont@ct provides the following services:

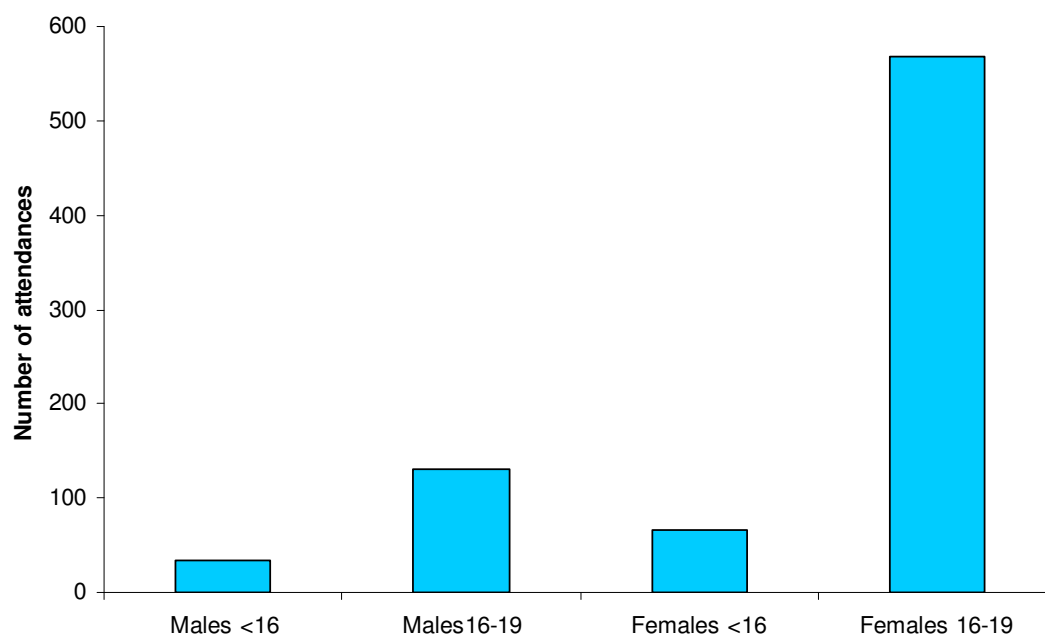
- Testing for STIs;
- HIV tests.
- Emergency contraception and pregnancy testing;
- Contraception;
- Free condoms;
- Hepatitis B vaccinations for at-risk individuals;
- Sexual health advice and counselling;
- Information and advice for those who have been sexually assaulted/abused.

In 2009, 549 individuals accessed the ARC, accounting for 799 attendances – it is not however clear from the data how many of these persons are Westminster residents. The majority of activity was at the Jefferiss Wing based clinic – 688 total attendances compared to 111 at the Stowe.

In terms of who is accessing ARC, the majority of attendees are females aged 16-19 years old. However, in a recent study looking at the different characteristics of patients attending hospital based services compared to community based services, found that the proportion of men attending community based services was higher than that attending hospital based services.



**Figure 81: Patients attending the ARC by age and sex, 2009**



Source: ARC

This data alongside that presented in section 11 (which examined overall GUM clinic activity) shows that young men are particularly underrepresented amongst service users. This suggests that there is an unmet need with regards to the sexual health of young men. Accordingly, further work is needed to understand the barriers to accessing sexual health services, particularly for young men in Westminster.

The reasons for young people attending GUM clinics is similar to the population as a whole, however, young people are more likely than other age groups to access contraception in GUM clinic settings than other age groups.

### ***Community contraceptive services***

Young women in Westminster are significantly less likely to access community contraceptive services than young women in England as a whole. In 2009/10, 815 persons aged between 10 and 24 accessed community contraceptive services on at least one occasion. This is equivalent to 4.3 per 100 females aged 15-19 and 4.8 per 100 females aged 20-24.

## **(v) Conclusions**

Young people in Westminster are disproportionately affected by poor sexual health, however, young people, particularly young men are underrepresented in GUM clinic and community contraceptive service attendees. Furthermore, anecdotal evidence suggests that young people are not accessing sexual health services in primary care.

In terms of geographical access, in a recent health equity audit it was reported that the provision of sexual health services was not adequate in the Queen's Park and Paddington locality of Westminster. However, the findings of this needs assessment suggest that there is a significant unmet need with regards to the provision and use of sexual health services amongst young people in general in Westminster. This appears to be particularly true of South Westminster. This conclusion is based on the fact that:

- The provision of community contraceptive services in Westminster is patchy, particularly in the South of the borough - furthermore, use of community contraception services by young people is low;
- The opening hours of the young person specific sexual health services are short – it is questionable whether persons can make their way on public transport across Westminster before closing time (most school classes finish at 15.30).

A review of the literature conducted by the Commissioning Decision Support Service considered the issue of access to contraceptive and sexual health services for young people. Young people reported that it was important that they had time and opportunity to explore their issues and concerns about sexual health, as opposed to being rushed through services. A number of barriers to accessing services were highlighted including:

- Knowledge of available services;
- Concerns around confidentiality;
- Lack of confidence that concerns would be taken seriously;
- Attitudes that practice staff show towards them;
- Opening times – going straight from school was found to be the best time.

There were many references to young persons, particularly teenagers not accessing their GP for sexual health services and also young BMEs, particularly South Asians not accessing sexual health services.

### **16.3 Men who have sex with men**

There are clear inequalities in the sexual health of MSM, with MSM experiencing high rates of STIs and HIV infection.

#### **(i) STI/HIV infection**

With the exception of gonorrhoea, published KC60 data does not distinguish between STI diagnoses made in heterosexual men and MSM – therefore, a robust estimate of the number of STIs diagnosed in local GUM clinic settings cannot be provided using KC60 data as was produced for young persons. However, some inferences can be drawn from local data provided by the Jefferiss Wing.

Best available national estimates suggest that MSM represent 7% of the population. In 2009/10, MSM accounted for 9% of patients attending the Jefferiss Wing on at least one occasion, but accounted for 19.7% of all STI diagnoses.

**Table 16: Proportion of all STIs diagnosed at the Jefferiss Wing that occurred in MSM, 2009/10**

	<b>Proportion of all diagnoses</b>
Syphilis	47%
Gonorrhoea	31%
Herpes simplex	16%
Anogenital warts	11%
Chlamydia	17%

Source: Jefferiss Wing

MSM are particularly disproportionately affected by syphilis and gonorrhoea (47% and 31% of cases respectively), although the figures presented in table 16 are lower than those described in previous chapters. This is most likely because diagnoses made at Dean Street (which sees a significant number of MSM) were not considered in this analysis.

Because only data from the Jefferiss Wing was available for analysis, further analysis of the characteristics of MSM (for example, ethnicity and age) was not conducted because numbers were considered too small for robust analysis. However, with the introduction of the Genitourinary Medicine Clinic Activity Dataset (GUMCAD), such analysis can be done in the future.

As is clear from previous chapters, MSM are also disproportionately affected by HIV; 70% of persons diagnosed and accessing care for HIV are MSM – this proportion is significantly higher than in London and England. Locally further data pertaining to the characteristics of MSM with HIV is not published, for example age and ethnicity, however, this would be useful to better understand the local epidemiology of HIV in the highest risk group for infection in Westminster. Data is available at London and England level, however, given the unique profile of HIV in Westminster, this data was not seen as generalisable to the Westminster MSM population.

#### **(ii) Access to services**

In addition to the mainstream sexual health services outlined previously, Imperial College Healthcare Trust provides a sexual health service for gay and bisexual men under 30 years of age (Guys@Mary's). The service is appointment based, open every Wednesday from 18.00 to 21.00. A range of services are available including:

- Sexual health screening;
- Vaccination
- Safe sex advice
- Rapid HIV testing

Chelsea & Westminster Hospital NHS Foundation Trust also provide specialist clinics for MSM, including outreach sessions.

Overall, significant numbers of MSM are accessing local GUM services; in 2009/10, over 1,000 MSM attended, representing 33% of all male attendances at GUM clinics.

#### **(iii) Conclusions**

MSM are disproportionately affected by poor sexual health, however, overall MSM appear to be accessing GUM services suggesting that local GUM services are acceptable to MSM (although some age groups appear less likely than others to access). However, where there are suggestions of unmet need and gaps in services,

for example around HIV prevention and late diagnosis, it is difficult to clarify the need due to data limitations. Accordingly, to better understand MSM and sexual health, and target interventions accordingly, data collection should be improved to better understand the epidemiology of sexual health amongst MSM and changing patterns of risk behaviour.

#### **16.4 Black and minority ethnic populations**

There is much evidence to suggest that persons from BME groups, particularly young persons, are disproportionately affected by poor sexual health. The HPA report, Sexually Transmitted Infections in Black African and Black Caribbean Communities in the UK (2008) highlighted that Black African and Black Caribbean ethnic groups in particular are disproportionately affected by STIs.

It is important to note that the BME population in Westminster is extremely diverse, however, establishing locally the precise impact of ethnicity on poor sexual health is difficult because of data limitations.

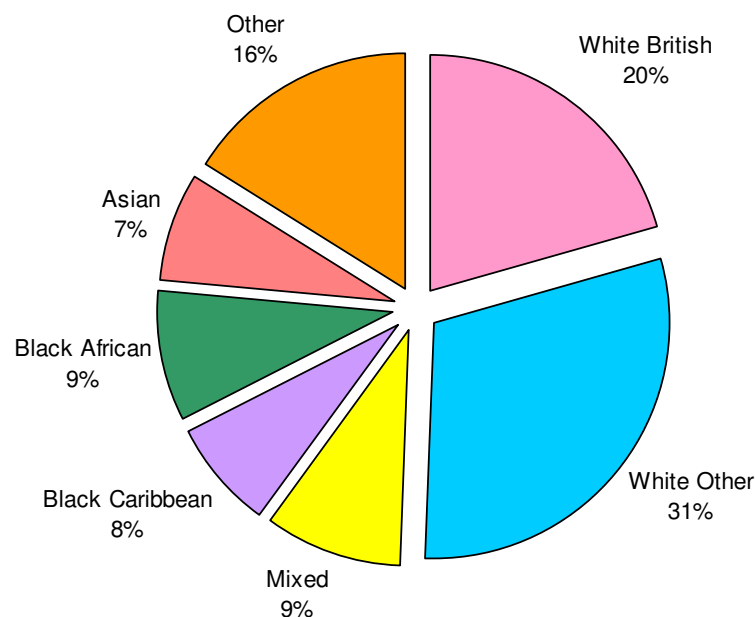
##### **(i) STI/HIV infection**

Published KC60 data does not provide ethnicity information on persons diagnosed with STIs in GUM clinic settings – therefore, a robust estimate of the number of STIs diagnosed in local GUM clinic settings cannot be provided using KC60 data as was produced for young persons. However, some inferences can be drawn from local data provided by the Jefferiss Wing, although caution should be exercised as the data presented is based on small numbers.

In 2009/10, persons from White British ethnic groups accounted for 20% of all STIs diagnosed in Westminster residents (where ethnicity was known), with BME (including White Other) accounting for 80% of diagnoses.

Whilst it is difficult to draw robust conclusions from an analysis of such small numbers, the overrepresentation of BME groups amongst STI diagnoses is consistent with the published literature. The ethnic distribution is, however, broadly similar to the ethnic profile of persons attending the Jefferiss Wing in 2009/10.

**Figure 82: STI diagnoses by ethnicity, Jefferiss Wing, 2009/10**



Source: Jefferiss Wing

With regards to HIV, BME groups account for 36% of the Westminster population diagnosed and accessing care for HIV. Given the ethnic mix of the Westminster population, BME groups are disproportionately affected by HIV, particularly the Black African population. However, the proportion of persons diagnosed and accessing care for HIV from BME groups is lower than that in England and London (despite the ethnic diversity of Westminster).

Because of the limitations of SOPHID data, the local understanding of ethnicity and HIV infection is restricted to broadly defined ethnic groups that are useful for national data purposes. Unsurprisingly, given the ethnic diversity of the Westminster population, 'Other' ethnic groups account for 19% of all persons diagnosed and accessing care for HIV, however, locally, there is limited available data pertaining to who comprises 'Other'. Evidence from some providers suggests that there may be a sizable population of people with HIV in Westminster who are from Eastern Europe who are accessing services, however, further work is needed to quantify such anecdotal evidence. Accordingly, further work is needed locally to better understand the sexual health inequalities experienced by BME groups, expanding on the broad ethnic descriptions in nationally reported data sources.

## **(ii) Access to services**

Overall, BME groups appear to be overrepresented in GUM and community contraceptive service attendees as well as being overrepresented in the NCSP. However, given the sexual health inequalities outlined, this is as expected – as a population in clear need, persons from BME communities would be expected to be more likely to access services. However, there are some disparities between different ethnic groups.

For example, persons from White and Asian ethnic groups are underrepresented amongst persons being screened as part of the NCSP. Persons from 'Other' ethnic groups appear to be overrepresented in GUM clinic and WCS clinic attendees and accordingly further work is needed to understand this. This, however, is a complex issue; much local information on ethnicity is derived from the 2001 Census. Since 2001, the ethnic composition of Westminster has changed significantly and as a result the number of people living in Westminster from 'Other' ethnic groups is thought to have increased – something which has not been captured in population data. Accordingly, it is difficult to understand whether or not persons from 'Other' ethnic groups are overrepresented because they are in greater need of services, or because the size of the population has increased.

Overall, across all services for which ethnic monitoring data was available, Black ethnic groups represented a significant proportion of attendees, in line with that expected given the proportion of the population they represent and the clear need for services.

## **16.5 Sex workers**

Sex workers include persons who sell sex and also persons who work in the sex industry. It is generally considered that the risk of contracting an STI or HIV increases with the number of sexual partners a person has – it is therefore, thought that sex workers are at a higher risk of STIs/HIV because of their numerous sexual partners.

Compared to other parts of the country, London has a high number of sex workers and, accordingly, a need for specific sexual health services for this challenging and often diverse population. As a result of this need, Imperial College Healthcare Trust established two services specifically for men and women who sell sex or who work in the sex industry.

It is beyond the scope of this needs assessment to examine the sexual health needs of sex workers in Westminster – a more discrete, detailed piece of work is needed to examine this complex issue. Future work should consider the general health needs of sex workers, as well as the sexual health needs, as well as wider issues such as violence, living conditions, migration issues etc.

For the purposes of this needs assessment, an overview of the specialist services provided has been given.

#### **16.5.1 The Praed Street Project (PSP)**

The Praed Street Project was launched in 1985 and provides comprehensive sexual health care for female sex workers. The service provides a mix of clinic and walk in appointments during the week as well as providing 1:1 counselling, outreach work and a helpline. Outreach work is done to engage new clients and also re-engage existing clients.

The service is an example of a holistic service providing a range of clinical services as well as support around:

- Sexual health education;
- Peer education;
- Safety and violence;
- Immigration and trafficking;
- Mental health problems;
- Negotiation skills;
- Budgeting;
- CV training;
- Child protection;
- Exiting sex work;
- Referral and advocacy to a range of services.

Because female sex workers often have numerous complex ongoing issues to address, PSP has developed links with numerous other services, in order to help address other health and social issues. Services include:

- UK Network Sex Work Services;
- Westminster Policy Group for Sexually Exploited Children;
- Vice Steering Group;



- UK Human Trafficking Centre Steering Group;
- Drugs services – Westminster Drugs Service, The Caravan and Blenheim Drug Project;
- London Sex Workers Forum;
- Union of Sex Workers;
- Westside Contraceptive Services.

### **16.5.2 Working Mens Project (WMP)**

The Working Mens Project was established in 1994 and provides a specialist sexual health and HIV prevention service for male sex workers based at St Mary's Hospital, but also provides outreach in local brothels as well as via the internet. Between June 2008 and June 2009, there had been 433 outreach contacts (117 internet and 316 brothel) and 745 clinic episodes, suggesting a clear need for the service.

Like the Praed Street Project, the working Mens Project provides a range of services.

The main services provided include:

- Advice on sexual health;
- Information about sexual risks;
- Condoms, lubricants and PEPSE where indicated;
- Signposting for other services;
- Advice on work related issues;
- TB screening and referral to TB team.

## 17: Conclusions

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Westminster is disproportionately affected by poor sexual health with high numbers of STIs diagnosed in local clinics and a prevalence of HIV more than six times higher than the rest of the country. Locally, sexual health is associated with significant health inequalities – there is a clear link between social deprivation and poor sexual health. Women, MSM, young persons and persons from BME groups are disproportionately affected. Accordingly sexual health remains an important public health problem in Westminster.

In recent years there have been significant developments around service provision for the better, however, gaps in services remain and there are areas of clear need that require attention if Westminster is to achieve real improvement in the sexual health of its population.

This needs assessment has attempted to provide a comprehensive overview of sexual health in Westminster. However, sexual health is a complex issue and not all issues have been addressed in this paper. Accordingly, there is further work that needs to be undertaken in the future, building on this needs assessment, to better understand the sexual health needs of the Westminster population and target interventions accordingly. Particular areas that should be considered in the future include:

- The changing sexual health needs of older people;
- The needs of the ageing cohort of people living with HIV;
- The sexual health needs of people with disabilities including physical and learning disabilities;
- The sexual health needs of trans people;
- The sexual health needs of women who have sex with women, including contraception, STI prevention and treatment and cervical screening;
- The sexual health needs of particular population groups such as the homeless, sex workers and persons with serious mental illness;
- How to influence behaviour change so as to improve the sexual health of the population as a whole;
- The impact on sexual violence and abuse on sexual health, including risk taking behaviour and sexual health inequalities;
- The wider determinants of sexual health;

- The wider determinants of HIV infection and changing risk taking behaviour.

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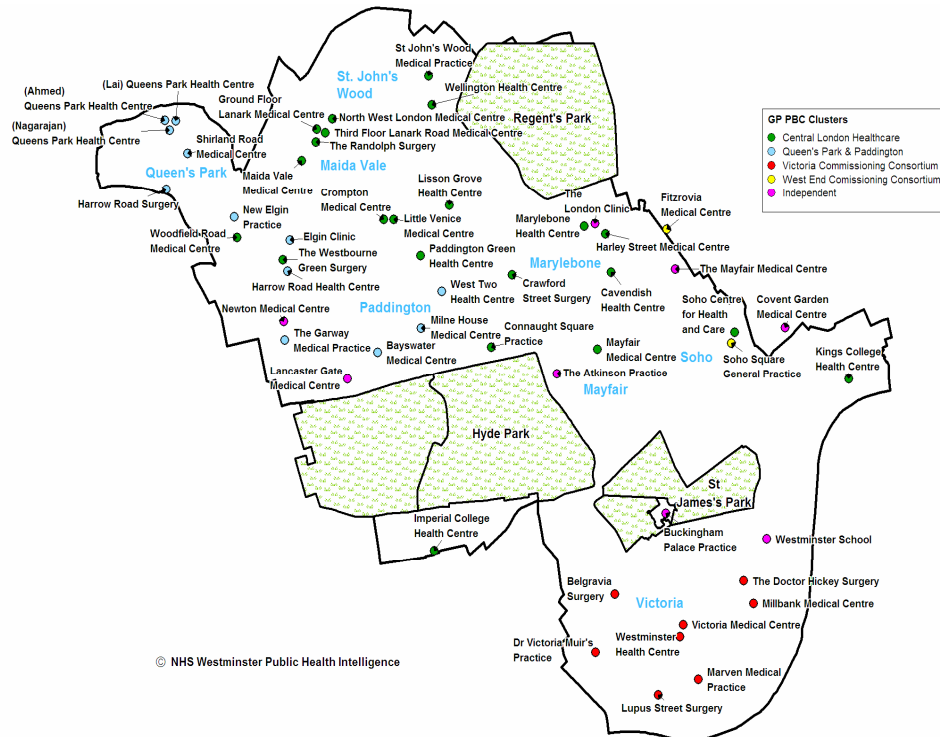
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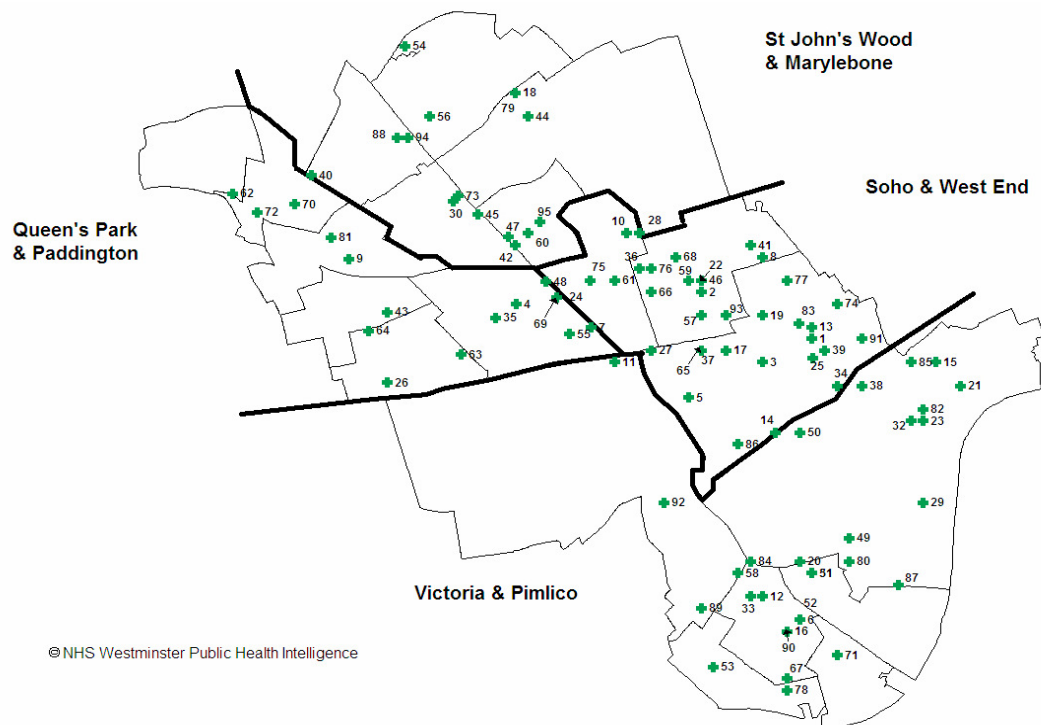


# Appendix A

## GP Practices in Westminster



## Community Pharmacies in Westminster



# Appendix B

NHS Westminster Primary Care Sexual Health mapping 2008/09 2009/10

PBC Clusters & Community Pharmacies (signed up to sexual health Local Enhanced Schemes)	Central London Health care 22 practices & 6 community pharmacies (on Sexual Health Local Enhanced Schemes)	Victoria Commissioning Consortium 9 practices & 8 community pharmacies (on Sexual Health Local Enhanced Schemes)	Queens park/ Paddington 12 practices & 6 Community Pharmacies (on Sexual Health Local Enhanced Schemes)	Newton Medical centre / Lancaster Gate 2 practices  Community Pharmacies on Sexual health Local enhanced schemes	Other Practices 6 practices
Reg Pop in General practice	133883	48182	49566	11229	5463
Reg pop 16-24 yrs Practices on the Chlamydia Local Enhanced Scheme 2008/09	22440 (17%)	5315 (11%)	4414 (9%)	1085 (10%)	400 (6%)
Reg female Pop 15-44 yr From ePACT data 2008/09	35969 (27%)	10134 (21%)	11711 (24%)	3061 (27%)	1044 (16%)
Practices signed up to Local Enhanced Schemes 08/09 Substance misuse LES Includes HIV testing	Chlamydia screening - 22 practices IUD - 7 practices Implant - 4 practices Substance misuse - 4 practice Under 25 Chlamydia screens-307 IUD-106 Implant-21	Chlamydia screening -8 practices IUD-1 practice Substance misuse-1 practice No practice on HIV/STD LES Under 25 Chlamydia screens -74 IUD-9	Chlamydia screening- 12 practices IUD - 2 practices Implant - 1 practices Subs misuse- 3 practices Under 25 Chlamydia screens- 85 IUD - 19 Implant 1	Chlamydia screening -1 practices Under 25 Chlamydia tests-23	Chlamydia screening- 3 practice No IUD implant Subs misuse LES Under 25 Chlamydia tests-26
Sexually Transmitted Infection Tests from Lab data from 27 practices 08/09	HIV 14 practice - 194 Hep B 14practices-396 HSV 1 practice-2	Unable to access Lab data	HIV 6 practices- 168 Hep B 10 practices-377 HSV 1 practice -4	HIV 2 practices-79 Hep B 2 practices-65 HSV 1 practice-6	Unable to access Lab data
ePact data 08/09 Contraception prescribing data outside of the Local Enhanced Scheme	1) Combined Hormonal pill 23 practices-3050 2) Progesterone only pill 18 practice -2730 3) EHC 17 practices-522 4) Inject / progest 17 practice-51 5) IUD 7 practices -67 6) Mirena 7 practice-51 7) Implant 3 practice-14	1) Combined Hormonal pill 10 practices-3073 2) Progesterone only pill 9 practices-1202 3) EHC 7 practices -164 4) Inject / progest 5 practices= 165 5) IUD 1 practice-3 6) Mirena 1 practice-4 7) Implant 1 practice-1	1) Combined Hormonal pill 10 practices-3124 2) Progesterone only pill 10 practice-912 3) EHC 7 practices-127 4) Inject/progest 8 practices-163 5) IUD 2 practice -7 6) Mirena 1 practice-9 7) Implant 1 practice-12	1) Combined Hormonal pill 2 practices -1038 2) Progesterone only pill 2 practices -146 3) EHC 2 practices-21	1) Combined Hormonal pill 974 6 practices 2) Progesterone only pill 4 practice-165 3) EHC 3 practices- 27
Com pharmacy Local Enhanced scheme 08/09 Rough Activity by PBC cluster 08/09 08/10	6 pharmacies on Chlamydia LES Chlamydia screens-12	3 pharmacies on EHC LES 5 pharmacies on Chlamydia LES EHC-55 Chlamydia screens-47	7 pharmacies on EHC LES 6 pharmacies on Chlamydia LES EHC-215 Chlamydia screens -55	No EHC or Chlamydia provision	3 Chlamydia LES 2 Chlamydia screens

## Appendix C

### Gum Service Mapping

GUM Service	Level 1 Services	Level 2	Level 3
<b>Jefferiss Wing, St Mary's Hospital</b>	<ul style="list-style-type: none"> <li>Sexual history taking, risk assessment and sign posting</li> <li>Asymptomatic STI testing and treatment (men and women)</li> <li>Simple partner notification</li> <li>HIV testing including pre test discussion and giving results</li> <li>Point of care HIV testing</li> <li>Pregnancy testing and counselling</li> <li>Referral for abortion</li> <li>Provision of emergency hormonal contraception</li> <li>Contraception information</li> <li>Condom distribution</li> <li>Health promotion</li> <li>Hormonal contraception/ Depo-Provera</li> <li>Cervical screening and referral</li> </ul> <p>Screening and vaccination for Hepatitis B</p>	<ul style="list-style-type: none"> <li>IUD insertion and removal (including emergency IUD fitting)</li> <li>Symptomatic STI testing and treatment (men and women)</li> </ul>	<ul style="list-style-type: none"> <li>Specialist level responsibility for provider quality, teaching and training and clinical governance</li> <li>STI outreach: female and male sex workers, young MSM &lt;30 and young people</li> <li>Specialist services for 'at risk' groups: appointment and drop in for female and male sex workers, young MSM &lt;30 and young people</li> <li>Specialist infection management</li> <li>Genital dermatoses</li> <li>Coordination of partner notification</li> <li>Specialist HIV treatment and care</li> <li>Psychosexual/erectile dysfunction service</li> <li>Provision and follow up of post exposure prophylaxis for HIV</li> <li>Sexual assault services</li> </ul>
<b>56 Dean Street</b>	<ul style="list-style-type: none"> <li>Sexual history taking, risk assessment and sign posting</li> <li>Asymptomatic</li> </ul>	<ul style="list-style-type: none"> <li>IUD insertion and removal (including emergency IUD fitting)</li> <li>Symptomatic</li> </ul>	<ul style="list-style-type: none"> <li>Specialist level responsibility for provider quality, teaching and training and clinical governance</li> </ul>

	<p>STI testing and treatment (men and women)</p> <ul style="list-style-type: none"> <li>• Simple partner notification</li> <li>• HIV testing including pre test discussion and giving results</li> <li>• Point of care HIV testing</li> <li>• Pregnancy testing and counselling</li> <li>• Referral for abortion</li> <li>• Provision of emergency hormonal contraception</li> <li>• Contraception information</li> <li>• Condom distribution</li> <li>• Health promotion</li> <li>• Hormonal contraception/ Depo-Provera</li> <li>• Cervical screening and referral</li> <li>• Screening and vaccination for Hepatitis B</li> </ul>	<p>STI testing and treatment (men and women)</p>	<ul style="list-style-type: none"> <li>• STI outreach: weekly STI/HIV testing in university student clinic, 3x weekly Hepatitis B vaccination and Hep B/HIV screening in Soho, weekly STI/HIV testing in Soho primary care, weekly blood-borne virus screening and vaccination in homeless hostels</li> <li>• Specialist services for at risk groups: MSM, contact clinics for young people in local education settings, residents of homeless hostels</li> <li>• Specialist infection management</li> <li>• Genital dermatoses</li> <li>• Coordination of partner notification</li> <li>• Difficult IUD insertion and removal</li> <li>• Specialist HIV treatment and care</li> <li>• Psychosexual/erectile dysfunction service</li> <li>• Provision and follow up of post exposure prophylaxis for HIV</li> <li>• Sexual assault services</li> </ul>
<b>Mortimer Market</b>	<ul style="list-style-type: none"> <li>• Sexual history taking, risk assessment and sign posting</li> <li>• Asymptomatic STI testing and treatment (men and women)</li> <li>• Simple partner notification</li> <li>• HIV testing including pre test discussion and giving results</li> <li>• Point of care HIV testing</li> <li>• Pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Symptomatic STI testing and treatment (men and women)</li> </ul>	<ul style="list-style-type: none"> <li>• Specialist level responsibility for provider quality, teaching and training and clinical governance</li> <li>• STI outreach: CLASH Piccadilly for commercial sex workers</li> <li>• Contraception outreach</li> <li>• Specialist services for 'at risk' groups: commercial sex workers</li> <li>• Specialist infection management</li> <li>• Genital dermatoses</li> <li>• Coordination of partner notification</li> </ul>

	testing and counselling <ul style="list-style-type: none"> <li>• Referral for abortion</li> <li>• Provision of emergency hormonal contraception</li> <li>• Contraception information</li> <li>• Condom distribution</li> <li>• Health promotion</li> <li>• Hormonal contraception/ Depo-Provera</li> <li>• Screening and vaccination for Hepatitis B</li> </ul>		<ul style="list-style-type: none"> <li>• Specialist HIV treatment and care</li> <li>• Psychosexual/erectile dysfunction service</li> <li>• Provision and follow up of post exposure prophylaxis for HIV</li> <li>• Sexual assault services</li> </ul>
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Source: Sex and Our City

## Appendix D

### Breakdown of NCSP Screens by location, 2009/10

Clinic Name	Number of screens
Blank	6
Ashville Surgery (Aras, Jenkins, Noori)	*
Barlby Road Surgery (Tahir)	*
Bayswater Medical (Silva & Vranakis)	31
Baywood Chemists	*
Benson Pharmacy, 276 Harrow Road	6
Bessborough Street Clinic @ South Westminster Centre (WCS)	7
Boots Pharmacy, 114 Queensway (18925)	*
Boots Pharmacy, 124 High Street (16566)	*
Boots Pharmacy, 175 Edgware Road (25859)	*
Boots Pharmacy, 42-44 Warwick Way (16585)	*
Boots Pharmacy, 60 Kings Road (18929)	*
Boots Pharmacy, 96-98 Notting Hill Gate (16616)	*
Boots Pharmacy, Unit 7 Broadway Retail Centre (38418)	*
BPAS London Central	19
Brook (K&C)	*
Brook London - Outreach	1841
Calder Chemists, 55-57 Notting Hill Gate	*
Cavendish Health centre (Chase, Youngerwood, Fraser & Chierakul)	28
Centrepont Hostel, 25 Berwick Street	*
Chemstar Ltd, 1 Clifton Road	*
Colonnades Pharmacy, 30 Porchester Road	16
Colville Health Centre (Chung)	*
Colville Health Centre (Pettifer, Blake & Mok)	*
Covent Gardens Medical Centre (Pathmanathan)	*
Crawford Street Surgery (Amakye & Wong)	37
Curie Chemists, 445 Edgware Road	*
Dave Pattison	*
Devonshire Pharmacy, 215 Edgware Road	*
Dr Hickey Surgery (Hickey & O'Reilly)	*
Dr Victoria Muir Practice (Muir)	148
Elgin Clinic (Mackney)	*
Emperor's Gate Centre For Health (King, Stott & Pankhurst)	*
Emperor's Gate Centre for Health (WCS)	*
Fitzrovia Medical Centre (Evans, Johnson & Ludders)	26
Gee's Pharmacy, 27-29 Warwick Way	*
Golborne Medical Centre (Dathi)	*
Golborne Road Young Peoples Service	*
Greycoat School - School Nurse (Keri Styles)	*
Hallfield Clinic (WCS)	*
Hammersmith & Fulham Web Based Postal Kits	13
Hyde Park Barracks Medical Centre	*
Imperial College Health Centre (Weinreb, Freedman, Daniels, Allen)	12
Kensington & Chelsea Web Based Postal Kits	52
Kings College Health Centre (Chase)	8
Knightsbridge Medical Centre (Sweeney & Brunton)	6

Lanark Medical Centre (Gazzar)	*
Lisson Grove Health Centre (Mintz, Brown, Bakker, Wormell, Kamalarajah, Henderson)	109
Little Venice Medical Centre (Barnwell & Cobb)	50
Maida Vale Medical Centre (Wright)	*
Market Chemist, 85 Church Street	*
Marylebone Health Centre (Goodstone & Oviedo)	34
Meanwhile Gardens Medical Centre (Jasani & Kraemer)	*
Metrosexual Health	343
Milne House Medical Centre (Soe, Takhar)	78
Milson Road Health Centre (WCS)	*
My Pharmacy Ltd, 10 Pole Road	*
Nashi Pharmacy, 55 Westbourne Grove	23
North Kensington Medical Centre (Swade & Kelso)	*
Not Otherwise Assigned (NOA)	62
Notting Hill Medical Centre (Chess & Garner)	*
Paddington Academy - School Nurse (Maeve Nolan)	42
Paddington Green Health Centre (Purssell, Crème, Froome, Chopra)	21
Parson's Green Walk In	*
Portmans Pharmacy, 93-95 Tachbrook Street	6
Queens Park Health Centre (Ahmed)	12
Queens Park Health Centre (Lai Chung Fong)	8
Queens Park Health Centre (WCS)	*
Randolph Surgery (Berger, Martin & Glover)	29
Raymede Clinic (WCS)	174
Soho Family Planning Clinic (WCS)	*
Soho Square General Practice (Cheung & Brassey)	53
Soho Square Surgery (Bark)	18
Soho Walk In Centre	*
South Westminster Centre for Health (WCS)	*
St John's Wood Medical Practice (Charkin, Abadi, Miller, Craft, Jones)	67
Teenage Pregnancy H&F	21
Terence Higgins Trust Outreach	245
The Belgrave Medical Centre (Shakarchi)	6
The Connaught Practice (O'Hare)	10
The Garway Medical Practice (Buchanan-Barrow, Williams, Huang & Phornnarit)	27
The Health Centre (Srikrishnamurthy)	84
The Marven Medical Practice (Jerijan, Neogi and Rodgers)	10
The Medical Centre (Garfield, Sarnicki)	27
The Medical Centre (Honey)	6
The Medical Centre (WCS)	7
The New Elgin Practice (Quilliam & Tate)	56
The Newton Medical Centre (Shortall, Simons, Kadas & Dock)	83
The Pembridge Villas Surgery (Sharma, Reid & Ramsden)	40
The Portland Road Surgery - (Watson & Topham)	*
The Surgery (Bninski-Mizgalski)	*
The Surgery (Dias)	*
The Surgery (El-Borai & Adib)	*
The Surgery (Parameshwaran)	*
The Surgery (Ramasamy, Abbas & Nannithamby)	10
The Surgery (Steeden & Hussein)	7
Third Floor Medical Centre (Abouzekry)	13
Upper Montagu Street Clinic (WCS)	*
Victoria Medical Centre (Rankine, Alexander, Thakore, Nguyen)	31

Victoria Pharmacy, 58 Horseferry Road	*
Vineyard Pharmacy, 241 Elgin Avenue	*
Violet Melchett Clinic (WCS)	*
Warwick Pharmacy, 34-36 Warwick Way	6
WCS Outreach	234
WCS Postal Kits	7
Wellington Health Centre (Constantinidou, Leigh, Lunt)	102
West Two Health (Langdon)	11
Westbourne Grove Medical Centre (Cheng, O'Connor & Chin)	*
Westminster Health Centre (Mitchell, Munday, Tew)	6
Westminster PCT Web Based Postal Kits	1793
Whitekat Collective Trust	2608
World's End Health Centre (WCS)	*
Youth Projects International (H&F)	52
Youth Projects International (Westminster)	398
<b>Total</b>	<b>9398</b>

Source: Chlamydia Screening Office Database \* Numbers less than 5 have been suppressed