Haringey Joint Strategic Needs Assessment:
Health Improvement

Sexual Health
Sexual Health

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Introduction

Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy illness or disease (see footnote 1).

The World Health Organisation definition of sexual health is:

‘Sexual health is a state of physical, emotional, mental and social well-being, related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence’.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
Sexual ill health is not equally distributed among the population. Those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include; young people, men who have sex with men (MSM), people from African communities, people living with HIV, sex workers, victims of trafficking, victims of sexual and domestic violence and abuse and other marginalised or vulnerable groups.

In 2001 the national strategy for sexual health & HIV was published with a number of aims:

- Reduce the transmission of HIV and sexually transmitted infections (STIs);
- Reduce the prevalence of undiagnosed HIV and STIs – in particular, by setting a national standard that all GUM services should offer an HIV test to clinic attendees on their first screening for STIs, and working towards shorter waiting times for urgent appointments in GUM services;
- Reduce unintended pregnancy rates, including setting a national standard that women who meet the legal requirements should have access to an abortion within 3 weeks of the first appointment with the referring doctor (other than in exceptional cases, for example where a longer wait is clinically appropriate);
- Improve health and social care for people living with HIV; and
- Reduce the stigma associated with HIV and STIs.

Haringey has made good progress in a number of areas within the national strategy, namely;

- HIV prevention work – Haringey is committed to commissioning primary and secondary HIV prevention work from community organisations,
- The reduction of the under 18 conception rate,
- Achieving the 48 hour genitourinary medicine (GUM) access target and

However, Haringey continues to face a range of challenges. The 2009 sexual health needs assessment demonstrates that Haringey faces high levels of need for sexual health services and there is evidence of poor sexual health in Haringey.

Improving sexual health outcomes continues to be a national and local priority. A Department of Health (DH) sexual health policy document is due in Spring 2012 and sexual health is one of the priorities in Haringey’s Health and Well Being Strategy.
In addition the recently published Public Health Outcomes Framework includes the following indicators:

- chlamydia diagnosis rates per 100,000 young adults 15 – 24
- proportion of persons presenting with HIV at a late stage of infection
- teenage conception rate
- health related quality of life for people with long term conditions
- improving access to primary care services
- improving functional ability of people with long term conditions

From April 2013 local authority public health teams will be responsible for commissioning comprehensive sexual health services including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention. Abortion services will remain within the NHS and be commissioned by clinical commissioning groups. Responsibility for sexual assault services, including sexual referral centres at least in the short to medium term, should rest with the NHS Commissioning Board.

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**Key Issues and gaps**

The Haringey 2009 sexual health needs assessment (see footnote 2) identified a number of areas that would contribute to improving access to sexual health services and improving sexual health outcomes. Some of the issues have been addressed and progress has been made however there remain areas for development.

1. **General Practice**

2009/10 data shows that Haringey is below the London average for contraceptive care. Approximately 17% of GPs provide services but good practice states that the level of contraceptive care conducted in primary care should be 80% of provision. In order to improve this position, NHS Haringey commissioned the Sexual Health In Practice (SHIP) training programme in 2011. The majority of general practices have accessed the training however activity needs to increase further.

**Gap**

Contraceptive service provision in general practice needs to continue to increase.
2. Increasing the uptake of Long Acting Reversible Contraception (LARC)

In 2008, 1.6% of women aged 15-44 in Haringey were prescribed a LARC. This placed Haringey 19th amongst London PCTs. Subsequent data analysis for 2009-10, has shown that Haringey’s position has improved to 2.2% (recorded in primary care).

**Gap**

Increasing the uptake of LARC is important because of its effectiveness as a method of contraception and for its significant cost savings. Promoting both the use of LARC and condoms for young women has been a focus of the teenage pregnancy prevention and support strategy.

3. Improvements to the termination of pregnancy referral pathway and service

The earlier in pregnancy an abortion is performed, the lower the risk of complications and the lower the cost. In Haringey, late presentation, particularly by some young women was thought to be in part due to a long and complicated referral pathway and absence of a self referral. Additionally, a large proportion of abortions were carried out in hospitals, which are twice as expensive as the preferred provider, British Pregnancy Advisory Services, (BPAS).

Following a pilot in 2010 self-referral was introduced to improve access. In late December 2011, BPAS successfully received confirmation from the Care Quality Commission, to provide assessments and early medical abortions at Lordship Lane Health Centre this will ensure the majority of women are treated locally.

**Gap**

Planning is taking place for abortions for women with complicated medical conditions to be moved to local hospitals. Late abortions continue to take place in St Thomas’ in South London. There remains a need to consider integration of STI/HIV testing for all women in commissioned services.

4. Reducing repeat terminations

Continuing to provide effective support for women to access contraception, including condoms, is essential to reducing subsequent unplanned pregnancies and providing protection against STIs.
5. Emergency Hormonal Contraception, (EHC) 4YP Pharmacy Scheme

EHC is a low cost service to support reduction in unplanned pregnancies and abortions. The free scheme for under 25 year olds to be available in 18 participating pharmacies across Haringey including two which offer Sunday openings. A number of pharmacies also offer chlamydia testing and treatment for young men and women under 25 as well as registration to the local pan London C-Card condom distribution scheme, Come Correct.

Gap

Further analysis is needed to identify repeated use of EHC and barriers to accessing contraception.

6. C-Card Scheme, Come Correct

The scheme provides young people under 25 years of age with access to free condoms, advice and information from a range of health and non-healthcare settings across the borough and is linked with the Pan London Come Correct Scheme. It is an evidence-based effective intervention (see footnote 3).

Gap

Uptake to date has been low.

7. HIV Prevention

African and Caribbean people living with HIV comprise over half of Haringey’s HIV positive population and make up about 80% of the service user profile that are utilising Haringey’s HIV treatment services. Their needs are often affected and compounded by issues arising from immigration status, employment patterns, income and socio-economic factors.

Gay men living with HIV make up the other majority group amongst Haringey’s HIV positive population. Many travel out of borough to utilise HIV treatment and sexual health services. Reasons for this identified by service users include perceptions that other services were more tailored for gay men and that out of borough locations meant more anonymity and confidentiality.

The Healthy Alliances programme is a collaborative commissioning arrangement between NHS Enfield, NHS Haringey and Haringey and Enfield Councils funding

8. Sex Workers & Sexual Health on Call (SHOC)

Sex workers suffer from greater health inequalities due to a complex range of issues. Many may be new arrivals and some may be trafficked. On a daily basis, sex workers are probably exposed to greater risk of STIs and therefore, need to access local services to continue to be checked regularly for STIs and to have access to condoms. SHOC provides a confidential service for female sex workers living or working in Haringey and Enfield.

9. Teenage pregnancy prevention and support

See JSNA chapter - Teenage Pregnancy

Who is at risk and why

There has been a marked increase in STIs in England over the last ten years. The most common conditions now are chlamydia, non-specific urethritis and wart virus infections, but almost all STIs are becoming more common. Rates of STIs vary across England with highest rates in London. Between 1999 and 2008, there has been a reported increase in GUM clinic diagnoses of chlamydia of 116%, of Herpes of 65%, genital warts of 29%, of gonorrhoea of 1%, and of syphilis of 1032%.

Sexual ill health is not equally distributed among the population. Those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include:

- young people (aged between 15 – 25)
- men who have sex with men (MSM)
- people from Black African communities
- people from Black Caribbean communities
- people living with HIV
- sex workers
- victims of trafficking
- victims of sexual and domestic violence and abuse
other marginalised or vulnerable groups, eg children in care and care leavers

Sexually transmitted infections in Haringey in 2010

STI and Acute STI activity data (see footnote 4) from Whittington Health highlights the following:

- **Genital Herpes** – most likely to be female (65%) or heterosexual males, most likely to be White (61%) or Black Caribbean.
- **Genital Warts** – most likely to be heterosexual males (48%) or female (40%) and most likely to be white (70%) or Asian (other than Chinese) (11%).
- **Gonorrhoea** - most likely to heterosexual males (38%) or female (30%) and most likely to be white (57%) or Asian (other than Chinese)(16%).
- **Syphilis** – most likely to be MSM and most likely to be white.
- **Chlamydia** – over 1000 more chlamydia diagnosis were made in 2010 compared to 2009.

HIV & AIDS in Haringey

- The most prevalent route of infection is MSM.
- Trends suggest that ‘women who have sex with men’ is becoming the second most common route of HIV infection, and that by 2012 these two routes of infection may be at similar levels.
- Black Africans made up the highest number of new HIV diagnoses between 2004 and 2008.
- More White men and women were newly diagnosed with HIV between 2004 and 2008 than those who were Black Caribbean, despite their ethnic group having a higher estimated prevalence (0.4% compared with 0.09%).
- 35% of people newly diagnosed with HIV between 2002 and 2006 had a CD4 count of less than 200 which is an indicator of late diagnosis. This compares with 33% across London for the same period.
- HIV tests have increased in recent years among all at risk populations including Black Africans and MSM however the projected rate of growth of new HIV diagnosis and undiagnosed HIV infection makes increasing uptake of tests a priority.
- In 2009, Haringey had the highest prevalence rate of HIV in pregnant women which was 7.5 per 1000 women giving birth.
• Two thirds of the Haringey population living with HIV live in the east of the borough.

The level of need in the population

Haringey faces high levels of need for sexual health services and there is evidence of poor sexual health, including:

• having the 11th highest prevalence of diagnosed HIV in London in 2010 (see footnote 5) (this is an improvement on 2009 when Haringey was 10th) (see footnote 6).

• Haringey residents were ranked with the 7th highest STI rate in London in 2010 (this is an improvement on 2009 when Haringey was 6th highest in London) (see footnote 7).

• Ranked 19th amongst London Primary Care Trusts in 2008 in terms of prescribing of LARC, although 2009-2010 local data shows a small improvement.

• Spending the least per head on sexual health services of London PCTs (£15.50 compared to Camden PCT which spends the most at £57.67) (see footnote 8).

• Whilst there have been reductions achieved in Haringey’s under 18 conception, the 2010 rate of 64.7 per 1000 was the highest in England and Wales (see footnote 9).

• The age-standardised abortion rate for 2010 was 32.5 per 1000 (aged 15 – 44 females), significantly higher than the England rate (17.6 per 1000) and an increase on 2009’s rate (see footnote 10).

• 2010 data showed Haringey had the highest positivity rate for HIV in antenatal screening in London (see footnote 11).

Current services in relation to need

Haringey commissions a comprehensive range of services to support the general population and identified at risk groups. Current services include the following:
1. Contraception and Sexual Health Services (CaSH) provided by Whittington Health

CaSH treats approximately 11,000 patients each year in Haringey. The services are fully integrated GUM with sexual health and contraceptive and reproductive health) and includes 4YP Haringey and the HIV prevention team. CaSH is based at St Ann’s Hospital with three other community based clinics located across the borough. CaSH also provides an HIV satellite service together with the North Middlesex University Hospital which has a cohort of around 139 patients a year. All services and clinics are promoted via the Sexual Health in Haringey website (external link) and a helpline is available.

Services offered include:

- A confidential walk in service, Monday to Saturday
- Advice and provision on most methods of contraception
- Emergency contraception
- Pregnancy testing and referral for termination of pregnancy
- Sexual health screening, advice, treatment and referral to clinics
- HIV testing
- Chlamydia testing for under 25s
- Appointments are offered for procedures, insertion of coils (IUD/IUS) and implants

2. 4YP Haringey, Young People’s Service

A dedicated confidential walk in sexual health and contraception clinic for young people under 25. Services offered include:

- Emergency contraception
- Prescription and advice on most methods of contraception
- Pregnancy testing, advice and referral for termination of pregnancy
- Screening and treatment for STIs
- Chlamydia testing
- HIV testing
- Information about STIs, risk and safer sex practice
• Registration to Come Correct, C-Card Condom Scheme

3. 4YP Pharmacy Scheme

4YP participating pharmacies offer free EHC to young women under 25. Some of the pharmacies also offer Chlamydia screening and treatment for both men and women under 25 and registration to Come Correct, the Pan London C-Card Condom Scheme. Pharmacy details are available on the Sexual Health in Haringey website (external link)

4. Sexual Health Outreach on Call Service – for sex workers (SHOC)

SHOC provides a confidential service for female sex workers living or working in Haringey and Enfield and offer support for the following issues:

• Sexual health
• Substance misuse
• Outreach
• Safety at work
• Domestic and gender based violence
• Legal issues

5. HIV/AIDS Community Nursing Service

Based at St Ann’s Sexual Health Centre, the Clinical Nurse Specialist HIV/AIDS provides specialist advice to patients and professionals across Haringey. There is an open referral policy and the service provides a range of interventions to support the HIV Positive person as well as signposting to: local voluntary services, drug therapy education and adherence issues, whole needs assessment, physical assessment skills and advanced nurse prescribing.

6. HIV Outreach Service

Provides weekly services offering walk in HIV testing and advice at two Haringey libraries

7. HIV Prevention

The Healthy Alliances programme is a collaborative commissioning arrangement between NHS Enfield, NHS Haringey and Haringey and Enfield Councils funding

8. Termination of pregnancy

The main provider is BPAS in addition Whittington Health is commissioned to provide an assessment clinic, now co-located with BPAS at Lordship Lane Health Centre.

9. General practice

All Haringey GPs are currently contracted to deliver Enhanced Contraceptive Services.

10. North Middlesex Hospital

Provides HIV diagnostics, treatment and care.

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Service users and carers opinion

In order to capture the views of Haringey residents, of both service users and those not accessing services, in depth interviews and focus groups were conducted with 70 people living in Haringey as part of the 2009 needs assessment. These interviews and focus groups were conducted in order to uncover the following:

- The perception of Haringey residents of the services and how they may be improved, including barriers to accessing services and gaps in provision
- What people like about the services
- The level of awareness of services, whether Haringey residents know what services are available and how to access them
- Why people do not use some or all of the services
- Peoples’ awareness of sexual health and risk
- Establishing who experiences difficulties or language barriers when accessing services

Here is a snapshot of the findings.
Misinformation

Incorrect information about some aspects of sexual health presented a barrier to accessing the appropriate services. This was especially the case around contraceptives, with several young people concerned that long term use of oral contraceptives or repeated use of EHC would likely cause infertility. There was also misinformation about HIV, with many young people believing that HIV was a “death sentence” and not knowing that advances in HIV treatment have dramatically extended the lives of people living with HIV.

More sexual health services in general practice

In addition to more clinics throughout the borough, young people in care were interested in seeing more sexual health services offered through GP practices in order to improve accessibility and convenience.

If you could get more services at the GP that would take pressure off the central system. I think decentralisation is good.

- Young Mixed White and Black Man Living in Care, aged 18-24

Young mothers - as a group, young mothers were the most satisfied with the services they received from St. Ann’s, although the geographical location caused some difficulties.

The clinic at St. Ann’s always has people that you can talk to about contraception. Nothing stops me from using them if I need to.

- Mixed White and Caribbean Young Mother, aged under 18

Stigma and discrimination

Many felt there was widespread stigma against people living with HIV and that this included healthcare professionals such as GPs, nurse consultants, dentists and administrative staff. One woman described that when she disclosed her HIV positive status while giving birth, the nurses walked out of the room and later after the birth they would not allow her to breastfeed her child.

They have camouflaged ways of discriminating against you, like saying, “We are fully booked.”

- Ugandan Woman Living with HIV, aged over 60
HIV awareness-raising

Some of the gay men living with HIV described the need for awareness-raising amongst the general public.

I wish people weren’t so ignorant about HIV.

- White British Gay Man Living with HIV, aged 45-59

Location and history

Most of the gay men were accessing sexual health services outside of Haringey. For some this was due to perceptions that services elsewhere are better tailored to gay men, and for others it was because they felt services outside of Haringey were far away and easier to access anonymously and with confidentiality.

Location is important. I don’t want to be seen in case of gay-bashers.

- Mixed White and Black Gay Man, aged 18-24

Staff attitudes

Gay men described staff attitudes as very important in their choice of sexual health services. In some cases bad experiences with a single staff member had contributed to their choice to go out of borough for sexual health services.

I think that intimidating or unhelpful staff just reduce attendance.

- Mixed White and Black Gay Man, aged 18-24

Poverty

Poverty affects sexual health by increasing the likelihood of risk behaviour, such as having unprotected sex. Participants also explained how poverty increases the risk, or necessity, of selling sex for some people from African and Caribbean backgrounds in Haringey.

No money means no condoms!

- Montserratian Man, aged 45-59
Low levels of familiarity with sexual health services

While most of the Eastern European interviewees were accustomed to utilising GP services; two out of three had not accessed any sexual health services through GUM, Family Planning/CASH, or any other provider.

This is the first time I’m hearing anything about sexual health since I came here.

- Polish Man, aged 18-24

Low levels of interest or dismissive attitudes

A prominent barrier within some Eastern European communities is a low level of interest or dismissive attitude toward sexual health. Several interviewees described sexual health as “not important” and did not understand why they should be concerned about their own sexual health.

I don’t consider sexual health to be important and I was only tested on my partner’s request. STIs can easily be treated, they are not serious. I don’t understand the need for clinics because you can buy condoms anywhere.

- Hungarian Man, aged 30-44

Dismissive attitudes toward HIV

Attitudes regarding HIV are often dismissive amongst Turkish and Kurdish communities, especially for men who see HIV as an issue only affecting gay men or promiscuous women.

Language

Language presents a barrier to Turkish and Kurdish people in Haringey who do not feel confident accessing sexual health services without translators.

Language, I needed a translator because I can’t speak full English.

- Kurdish Man, aged 30-44

Location

For young people it is important to be able to access sexual health services that are near to the places where they live, study and congregate. Whereas several young
people described difficulty or inconvenience in accessing St. Ann’s, many were accessing the 4YP bus because of its mobility and marketing to young people.

I use 4YP. It is obvious as it is on the high street, and they are understanding to young people.

- Mixed Arab and African Young Woman, aged under 18

**Contraceptives in school**

Provision of contraceptives in educational settings was seen as an effective method of outreach and a convenient alternative to accessing clinics.

They should offer contraception in school as it would cut down on the number of young people going to clinics so often.

- Mixed Arab and African Young Woman, aged under 18

**Expert opinion and evidence base**

Expert opinion comes from the Department of Health, Royal Colleges, National Institute of Clinical Excellence (NICE) and The Medical Foundation for AIDS and Sexual Health (MEDFASH).


The strategy indicated long-term commitment to modernise and improve sexual health services. The main aims of the strategy were to:

- Reduce the transmission of HIV and STIs, with a national goal of achieving a 25% reduction in the number of newly acquired HIV infections and gonorrhoea infections by 2007.
- Reduce the prevalence of undiagnosed HIV and STIs – in particular, by setting a national standard that all GUM services should offer an HIV test to clinic attendees on their first screening for STIs, and working towards shorter waiting times for urgent appointments in GUM services;
- Reduce unintended pregnancy rates – including setting a national standard that women who meet the legal requirements should have access to an abortion within 3 weeks of the first appointment with the referring doctor (other than in exceptional cases, for example where a longer wait is clinically appropriate);
- Improve health and social care for people living with HIV; and
- Reduce the stigma associated with HIV and STIs.

The subsequent implementation plan in 2002 introduced the Independent Advisory Groups for Sexual Health, HIV, Teenage Pregnancy and the National Chlamydia Screening Programme (an opportunistic screening programme targeting sexually active adults aged under 25).

2. The white paper ‘Our Health Our Care Our Say; a new direction for community services’ (2006) identified the need to improve sexual health provision as a key priority for primary care.

3. Sexual health and GUM services were re-emphasized as one of the six national priorities outlined in 2006 by the DH as part of NHS System Reform and the NHS Operating Framework 2006-07, in particular the provision of appointments to GUM services within 48 hours.

4. MEDFASH (external link) recommended standards for sexual health services (2005), the Royal College of Obstetricians and Gynaecologists Faculty of Family Planning and Reproductive Healthcare developed service standards for sexual health services (FFPRHC) (2006) and the MEDFASH (external link) Recommended Standards for NHS HIV Services (2003) were developed to enable people to have prompt and convenient access to consistent, equitable and high quality sexual healthcare. They are not setting-specific and serve as a recognised tool for planning, developing and evaluating local services, as well as for local performance management.

5. The DH Choosing Health: making healthier choices easier, 2004 included a commitment to modernise sexual health services (external link).

7. HIV in Primary Care (2004) is a guide for GPs, practice nurses and other members of the primary healthcare team (PDF, 2.44MB - external link).

8. NICE guidance

i) Prevention of sexually transmitted infections and under 18 conceptions (2007) (external link)

ii) Increasing the uptake of HIV testing among men who have sex with men (2011) (external link)

iii) Increasing the uptake of HIV testing among black Africans in England (2011) (external link)

iv) Long-acting reversible contraception (2005) (external link)

9. In 2011 the Faculty of Sexual and Reproductive Healthcare, Royal College of Obstetricians and Gynaecologists outlined eleven general service standard statements (PDF, 2.71 MB - external link).

While it has been often said that there is insufficient researched and written about the cost-effectiveness of interventions related to sexual health, the current provision of services nationally does not reflect what is known about the health economics and there are, for example, many potentially cost-saving or highly cost-effective interventions that are insufficiently invested in.

In 2005 the DH published a guide for commissioners and planners (see footnote 12) that looked at six subject areas;

1. Health promotion
2. Screening
3. Treatment
4. Service delivery and organisation
5. Fertility control (contraception & abortion not including fpa Review)
6. Other

There are difficulties in comparing across different interventions due to differences in methodology, how outcomes and costs are measured, setting (for example, international or UK) and study population. Interventions have been allocated to these broad categories where there is compelling evidence rather than individually ranked by precise cost-effectiveness measures.
Cost-saving Interventions

Above averagely cost-effective Interventions compared with current NHS expenditure - Less than £100 per Quality Adjusted Life Year (QALY).

Averagely cost-effective Interventions compared with current NHS expenditure (most NHS interventions are in this category) - £100 to £10,000 per Quality Adjusted Life Year

At upper end of cost-effectiveness, but within current NHS range of expenditure – £10,000 to £30,000 per Quality Adjusted Life Year

1. Health promotion and disease prevention

There are numerous cost-effective and, importantly, cost saving interventions aimed at promoting sexual health especially due to the high costs associated with HIV/AIDS. Interventions are more cost-effective when they effectively target high-risk groups.

Cost-saving

- Free condom provision for medium and high risk groups (mainly MSM and sex workers)
- Condom subsidy or tax reduction schemes
- Outreach health promotion and safe sex programmes for high risk groups (mainly MSM and sex workers) and hard to reach groups
- Provision of AIDS risk reduction messages in gay bars
- Safer sex skills training session/cognitive behavioural intervention for MSM
- Peer-leader interventions for MSM
- High quality integrated Sex and Relationships Education (SRE) - includes especially Safer Choices School Programme evaluation (a 2-year multi component education programme in US high school students)
- Needle exchange provision to prevent HIV in injecting drug users

Above averagely cost-effective

- Behavioural HIV risk reduction sessions for high risk women
Averagely cost-effective

- 1-day cognitive-behavioural HIV risk reduction intervention in male adolescents
- Intervention based on individualised risk assessment and counselling, peer education, optional HIV testing, and referrals to needed healthcare services, for gay and bisexual male adolescents
- Use of condoms only 20% of the time by MSM – the message here is that only when condom use is high are condoms cost-saving in this group – in that case condoms are hugely cost-saving.

2. Screening

Screening strategies such as targeting all pregnant women for HIV, and young women for chlamydia, are clearly cost-effective - they help lead to early treatment, averting costs of complications (such as infertility), and onward transmission.

Cost-saving

- Antenatal syphilis screening
- Antenatal screening for HIV in high risk women
- Screening for syphilis in high-risk prison population
- Many modelling studies conclude chlamydia screening is cost-saving:
  - for selected population groups at high risk;
  - for young women.

There are some uncertainties about complication rates which means there is more work needed to fine-tune estimates of benefits of screening. Most studies do not use dynamic modelling which may lead to underestimation of the benefits of screening.

Above averagely cost-effective

- Antenatal syphilis screening
- Antenatal HIV screening in high-risk areas

Averagely cost-effective

- Antenatal screening for HIV
Chlamydia Screening for other groups – young men, older women. The note above about chlamydia screening studies also applies here.

Not very cost-effective but within current NHS range

- Screening (and suppressive therapy) to identify discordantly infected heterosexual couples with no history of herpes (HSV-2) infection
- HIV screening in acute care settings

Uncertain

- Gonorrhoea screening in high risk patients

3. Treatment interventions for STIs

Comprehensive and accessible STI treatment services are cost-saving. Highly Active Antiretroviral Therapy (HAART) is also averagely cost-effective.

Cost-saving

- Comprehensive and accessible (including extended outreach) STI treatment services in groups at high risk of HIV

Above averagely cost-effective

- Comprehensive treatment of bacterial STIs for the general population

Averagely cost-effective

- Retroviral treatment for HIV – including HAART

Note that the increased treatment costs of HIV/AIDS makes some prevention interventions more cost effective

- Routine HIV testing for STI clinic attendees.

4. Service Organisation and Delivery

Prompt treatment of STIs and effective partner notification are key elements of cost-effective prevention interventions.
Cost-saving

- Temporary increase in STI services capacity to gain control of a high equilibrium incidence of STIs

Above averagely cost-effective

- Good access to STI services with very short or no waiting times so that a low equilibrium level of infection incidence is maintained
- Partner notification.

5. Fertility Control Services (including contraception and abortion)

Accessible contraceptive services which reflect women’s preferences are cost saving.

Cost-saving

- Contraceptive services, in themselves, result in reduced cost and increased benefit
- Provision of an "ideal" profile (the choice women would make if given full information and offered the range of methods) of contraceptive services that better reflect women’s preferences could save NHS at least £500 million over 15 years. (This is mostly a move from combined oral hormonal to longer acting methods)
- Reducing the delay in obtaining an abortion – savings to the NHS of from £645,000 to £30 million per annum are estimated depending on women’s choice of method.
- Access to over the counter oral contraception
- Access to emergency contraception.

The overall message is clear there is evidence and consensus that investment in sexual health interventions is good value for money and in many cases cost-saving. Key examples in the cost-saving category are:

- Widespread condom provision;
- Outreach safe sex training for high risk groups;
- School Education Programmes;
- Needle exchange services;
Many screening programmes;
High quality and rapid access STI services;
Wide choice of contraceptive services; and
Abortion services provided with minimal delay.

In other words, a commissioning organisation is actually allocating resources inefficiently if it does not invest (or indeed disinvests) in sufficient of these services to cover the relevant population adequately. Most other interventions listed above are of cost-effectiveness well within the range accepted by the NHS as good value for money.

Projected service use in 3-5 years and 5-10 years

Haringey’s population projections, ethnicity profiles and fertility rates identified in the JSNA demographic context suggests that service use in 3-5 years and 5-10 years will increase.

Unmet needs and service gaps

Unmet needs include:

- Normalising condom use, STI screening and knowing HIV status for anyone who is sexually active or/planning to be
- Improving participation of communities and groups at risk in health promotion and prevention
- Access to services for LGBT people from BME groups in Haringey (including Turkish, Kurdish, Eastern European, Black African, Black Caribbean)

Service gaps include:

- Implementation of routine, universal HIV testing for general medical admissions and new registrants in general practice should be prioritised.
- The implementation of routine, universal testing policies in STI clinics should be reviewed so that no one leaves the clinic without knowing their HIV status.
People most-at-risk of HIV infection (e.g. MSM, black Africans and people who inject drugs) should have an annual HIV test. MSM should consider more frequent testing (see footnote 13).

**Recommendations for Commissioning**

1. Consider which activities should be commissioned at a local, sector or pan-London level.

2. As part of the transition work (responsibility for sexual health services moving to local authorities in April 2013) Haringey should review its commissioning arrangements to ensure it is commissioning for outcomes, equitable access and value for money.

3. Haringey needs to continue to commission prevention and health promotion services to meet local need. Haringey should examine their commissioned prevention activities, maximise the potential within existing provider contracts and work collaboratively on social marketing and screening opportunities where it would improve the quality of local services.

4. Priority should be given to commissioning sexual health interventions with the greatest potential for cost effectiveness and impact on health outcomes. These include incentivising LARC through all contraceptive service providers and abortion service providers, population level chlamydia screening, HIV testing and prompt access to abortion and GUM.

5. Haringey should consider the role of primary care within the provider landscape including development and monitoring of enhanced service specifications.

6. Prioritise STI and HIV prevention with free distribution of condoms

7. Consider increasing STI and HIV testing in community based services and for general medical admissions and new registrants in general practice. Late diagnosis of HIV = 15 times the costs of earlier diagnosis (see footnote 14)

8. Reduce repeat terminations by providing targeted follow up support to access contraception, in particular LARC and condoms for high risk groups (under 25s).
9. Continue to commission community based pharmacies to provide free EHC for young women under 25 as EHC is the last service that can impact on a conception not taking place.

10. Increase the uptake of contraception, in particular LARC, in primary care.

11. Provide a comprehensive borough wide free condom scheme for young people under 25.

12. Continue targeted community outreach for young people under 25 to include provision of LARC and other contraception and sexual health services, including STI and HIV testing and advanced supply of Emergency Hormonal Contraception. £1 in contraception = £11 savings in NHS costs (see footnote 14)

**Recommendations for further needs assessments**

- HIV Prevention
- Sexual health promotion and community engagement
- Abortion and access to contraception

**Key Contact**

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**Footnotes**

1. Better prevention, better services, better sexual health – The national strategy for sexual health and HIV (2001) (external link)
5. Health Protection Agency (2011) HIV Epidemiology in London 2009 data (PDF, 2.91 MB - external link)
7. Health Protection Agency (2011) STI Annual Data Tables (external link)
8. MEDFASH (2008) Sex in Our City (PDF, 2.16 MB - external link)
10. Association of Public Health Observatories (2011) Rate Total Abortions, by PCT and SHA, 2010 (external link)
11. Health Protection Agency (2011) HIV Epidemiology in London 2009 data (PDF, 2.91MB - external link)