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information and design for better services

Comprehensive Sexual Health Needs Assessment for East Sussex Downs and Weald and Hastings and Rother PCTs

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CONTENTS

ABBREVIATIONS & ACRONYMS

CSW	Commercial sex workers
DH	Department of Health
ESD&W	East Sussex Downs and Weald
GP	General Practitioner
GUM	Genitourinary Medicine
H&R PCT	Hastings and Rother
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
LARC	Long Acting Reversible Contraception
LGBT	Lesbian, Gay, Bisexual, and Transgender
MSM	Men who have Sex with Men
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
PCT	Primary Care Trust
PSE	Public Sex Environments
SH	Sexual Health
SOPHID	Survey of Prevalent HIV Infections Diagnosed
SRE	Sex and Relationship Education
STI	Sexually Transmitted Infection
TP	Teenage Pregnancy
WRS	Workers Registration Scheme
YP	Young People

EXECUTIVE SUMMARY

1.1 The geography of East Sussex poses some particular challenges for tackling inequalities in the sexual health of the people living in the county. As with other PCT across the country, a combination of urban and rural localities can result in patchy service delivery and barriers to access for local residents. Partnership working and collaboration with a wide range of service providers is essential for overcoming these issues.

1.2 Critical potential partners for achieving targets and meeting the needs of the population include primary care (including commissioners), education and mental health. Further work may be required to ensure partnerships are in place with all key partners in the community and voluntary sector, as it is difficult to engage directly with users and non users of sexual health services.

1.3 Good data that is widely shared and widely understood is also vital to ensure there is a good understanding of what local needs are and how services are meeting those needs. The process of assessing needs should be a rolling programme and we have identified some Issues that both PCTs need to address including:

1.3.1 Development of data collection systems in line with the Department of Health's (DH) proposed Common Data Set for Sexual Health and HIV. A first steps approach would be to be in line with the Genitourinary Medicine (GUM) minimum data set.

1.3.2 Understanding about the value of using data as well as capacity building will be important for all local staff with responsibility for delivery and particularly for planning and monitoring sexual health services. Training and briefings should be provided to engender the required understanding and engagement.

1.4 In terms of balancing resources between prevention and treatment our assessment also identified that:

1.4.1 Further work is required to ensure prevention programmes are needs based and culturally appropriate.

1.4.2 Mechanisms for ensuring user (and potential-user) involvement in planning, delivery and monitoring and evaluation of services need to be built into future strategies and their action plans. This could be either through direct user involvement or by community group representation.

1.5 It was also noted that there has not always been an equalities and diversities officer in either of the PCTs but these positions need to be filled in order for someone in the PCT to take the lead (and have leverage to do so) on the sexual health needs of minority groups some of whom will belong to higher risk groups.

1.6 The STI profiles of both PCTs were found to be in line with national and regional trends for the most part. Where differences occurred these have been highlighted. Additional data shown in Table A, Annex 2 shows STIs diagnosed outside of GUM and the routine collation of these data is recommended. From GUM data this needs analysis found the following:

1.7 Hastings and Rother PCT

1.7.1 There has been a marked increase in chlamydia infections in males from 2001. This increase has been most dramatic in males ages 20-24. Though slight, there has also been an increase in new diagnosis in men over 35.

1.7.2 The increase in female infections has, on average, been steeper than that in males and is marked by a dramatic increase in infections in the 15-19 age group and also for women ages 20-24.

1.7.3 The current National target (as of April 1st 2008) is that 17% of 15-24 year olds should be screened as part of local chlamydia screening programmes. In order to meet this target, based on 2006 population estimates, this would equate to a target of around 3265 screens over the coming year, or over 3 times the number conducted in 2007.

1.7.4 There were 18 new diagnoses of gonorrhoea in 2006. This represents a steep increase since 1995, when there was only 1 reported case.

1.7.5 A total of 114 H&R residents sought HIV-related treatment in 2006, 25 more than in 2005. This represents a 29% increase from the number of residents seeking treatment in 2005 and a 72% increase from 2002. Though relatively low, this is an overall rate of 64 per 100,000 residents.

1.8 East Sussex Downs and Weald

1.8.1 There were a total of 190 new diagnoses of chlamydia in 2006, 86 in men and 104 in women. 57% of new diagnoses at GUM clinic were in people under 25 and 30% were in people under 20.

1.8.2 The current National target (as of April 1st 2008) is that 17% of 15-24 year olds should be screened as part of local chlamydia screening programmes. In order to meet this target, based on 2006 population estimates, this would equate to a target of around 5300 screens over the coming year, or nearly 3 times the number conducted in 2007.

1.8.3 Genital warts have increased more than any other STI in ESD&W. In 2006, there were 284 reported cases of warts, an 80% increase since 2005 and a 151% increase since 1996. There is also a notable increase in infections in men over 45, an apparent 550% increase between 1996 and 2006.

1.8.4 In 2006, ESD&W had 276 residents seeking HIV-related treatment, a 94% increase since 2002.

INTRODUCTION

This report presents the findings of a comprehensive sexual health needs assessment (SHNA) conducted by Design Options between January and March 2008 for the two East Sussex Primary Care Trusts of Hastings and Rother (H&R PCT) and East Sussex Downs and Weald (ESDW PCT).

In sections one and two we present separate profiles for the two PCTs covered by the assessment, detailing STI rates and prevalence for each and analysing other relevant contextual demographic data. In section three we have drawn together the results from our research and outreach with the local populations considered to be at higher risk of poor sexual health. This detailed assessment and profile of need is presented thematically across the two PCTs but with locality specific issues highlighted wherever found. In section four we present the findings of our gap analysis and have grouped issues and recommendations to reflect the cross area management structure of the two PCTs. In annex one we draw attention to any area specific findings and issues and highlight recommendations for different localities or area based services wherever applicable.

Map 1: PCT Coverage in East Sussex[1]

METHODS

The Department of Health commissioned guidance 'How to Guide: Sexual Health Needs Assessments' was used to inform this SHNA. The Design Options team undertook:

- A review and analysis of service data, STI data, relevant demographic information and related local documents and previous service reviews,
- Forty key informant interviews with service commissioners, service providers and practitioners and staff from related services including the Terence Higgins Trust, youth development services and drugs and alcohol,
- Interviews and key community representatives and individuals (via 1:1 interviews and focus groups) from higher risk groups,
- Service mapping and site visits.

A combination of research methods was used to gain information about the at higher risk groups in East Sussex.

- With young people focus group discussions were carried out using semi-structured questions around general health needs, perceptions and experiences of sexual health services. These sessions included participatory activities to engage the informants in analysis of their own situation. Sessions took place at two youth centres after school in Camber and Rye, with Year 10 and 11 students from Helen's Wood (Hastings) and Thomas Peacocke (Rye), at a youth group for LGBT people in Hastings, and a young parents' group in Newhaven.
- With asylum seekers, refugees and substance misusers, opportunistic one-on-one interviews were carried out with service users and through introductions from workers already engaged with these groups.
- Where there were few or no targeted services engaging with at risk groups, as for the commercial sex workers, long one-on-one interviews were carried out with individuals identified through a snowballing of initial contacts.
- Where a consultation with users and potential users was not possible, the information was gleaned from key informant interviews and existing reports.

SECTION ONE: HASTINGS AND ROTHER PCT

1. LOCAL CONTEXT

1.1 Hastings and Rother PCT (H&R PCT) was formed in 200 from Bexhill and Rother PCT and Hastings St. Leonards PCT. The area covered is mainly rural, with some peri-urban areas. There are a total of 39 GP practices, with approximately 120 doctors. Most sexual health services are offered at Ore Clinic, located in Ore on the outskirts of Hastings.

1.2 H&R PCT serves approximately 176,200 people, 23% under the age of 19 and 50% over the age of 45. 52% are H&R PCT are female, 48% male. The majority of H&R PCT residents are white, with small ethnic communities of Asians and Black Africans.

1.3 In terms of new communities and recent migrants the only data available comes from National Insurance registrations and the Home Office's Workers Registration Scheme. The data will only capture figures for people registering for work and indicates that the H&R PCT area, in line with the picture for the South East generally, has seen increased numbers of people from Eastern Europe and elsewhere in the world registering for work locally.

Table 1: National Insurance registrations in 2006/07 for H&R PCT

	Registrations	% "A8" countries	% rest of EU	% rest of world
Rother	300	50%	3%	47%
Hastings	600	57%	5%	38%

1.4 Since May 2004, the Workers Registration Scheme (WRS) shows a total of 2,680 A8 citizens[2] registered to work in East Sussex between May 2004 and March 2007. The great majority (86%) of A8 workers in East Sussex are under 35 years. Over half of all registrants in Eastbourne, Hastings and Lewes are under 25 years old. However the age profile is older in Rother with 22% over 35 years old.

Table 2: 2006 Provisional Estimates[3]

	M	F	Total
< 15	15.1	14.5	29.6
15-19	5.6	5.3	10.9
20-24	4.4	3.9	8.3
25-34	7.3	8.3	15.6
35-44	11.7	12.3	24
45+	40	47.8	87.8
Total	84.1	92.1	176.2

Table 3: Ethnicity and gender[4]

	M	F	Total
White	78.7	87	165.7
Mixed	1.1	1.1	2.2
Indian, Pakistani, Bangladeshi, or other Asian	1.3	1.2	2.5
Black Caribbean	0.3	0.3	0.6
Black African	0.7	0.6	1.3
Other Black	0.1	0.1	0.2
Chinese or Other Ethnicity	0.7	0.7	1.4

1.5 According to the Index of Multiple Deprivation, which reports data by local authority, Hastings District Council ranks as the 38th most deprived local authority area in England. Rother is less deprived, with an average position on the rank of 181st. The PCT area is socio-economically diverse, with underlying pockets of deprivation in more affluent areas in both the rural and urban areas. The Healthcare Commission, prior to the reorganization, placed Hastings and St. Leonards in the second band for sexual health and Bexhill and Rother in the third band, where band 1 indicates poor performance and band 5 excellent.

2. SEXUALLY TRANSMITTED INFECTIONS

2.1 Overview of STI data

2.1.1 Currently the only routinely available data on STI diagnosis is compiled using the Department of Health KC60 statistical returns via the Health Protection Agency from Genitourinary Medicine (GUM) clinics. These returns collect no information on patient area of residence, although clinics are at liberty to collect and collate this for their own records. A limitation of KC60 is an underestimate of the burden of STIs in the general population as diagnoses made in non-GUM settings are not recorded. Factors such as accessibility to GUM clinics, where public transport is poor or there are restricted opening times, will all add to the certain underestimation of local STIs that KC60 data provides. The data presented here are for new diagnoses of STIs as collected from KC60 forms from GUM clinics in H&R PCT. The primary source of data for estimating numbers of diagnosed HIV positive people seeking treatment is SOPHID (discussed in section on HIV). The latest available data from both sources is for 2006.

Table 4: Total New Diagnoses of STIs in 2006

Chlamydia

	2006 F	2006 M	2006 Total
<15	0	0	0
15-19	53	12	65
20-24	35	46	81
25-34	21	25	46
35-44	5	3	8
45 +	0	4	4
Total	114	90	204

Herpes

	2006 F	2006 M	2006 Total
<15	0	0	0
15-19	7	0	7
20-24	7	2	9
25-34	3	4	7
35-44	5	1	6
45+	3	1	4
Total	25	8	33

Syphilis

<15	0	0	0
15-19	0	0	0
20-24	1	0	1
25-34	0	0	0
35-44	0	1	1
45+	0	1	1
Total	1	2	3

Warts

<15	0	0	0
15-19	45	13	58
20-24	26	42	68
25-34	18	27	45
35-44	13	8	21
45+	5	6	11
Total	107	96	203

Gonorrhoea

<15	0	0	0
15-19	6	0	6
20-24	2	2	4
25-34	0	5	5
35-44	0	2	2
45+	0	1	1
Total	8	10	18

2.2 Chlamydia

2.2.1 There were 204 reported cases of chlamydia at GUM clinics in H&R PCT in 2006. 71% of cases were in people under the age of 25, with men age 15-19 and women age 20-24 most at risk. The 204 cases represent a marked increase over the past ten years; there were only 20 cases reported in 1995. There were more new diagnoses in females than in males, 114 versus 90. This has been a consistent trend in recent years (figures 1-3, Annex 2).

2.2.2 There has been a marked increase in chlamydia infections in males from 2001. This increase has been most dramatic in males ages 20-24. Though slight, there has also been an increase in infections in men over 35.

2.2.3 The increase in female infections has, on average, been steeper than that in males and is marked by a dramatic increase in infections in the 15-19 age group and also for women ages 20-24.

2.3 National chlamydia screening programme

2.3.1 38 out of the 40 GP practices in H&R PCT are now sites for chlamydia screening.[5] In addition 6 hostels offer screening, as well as local Sure Starts, colleges, and sporting venues. There were a total of 1085 screenings in 2007, a major increase from 333

individuals screened from April to December 2006. Of these tests, 883 were female and 202 were male.

2.3.2 There are a high proportion of males screening positive compared to the *number* of males screened. Between 20% and 30% of males in their 20s are screening positive. Overall, 8% of females are screening positive and 12% of males are screening positive. Nationally chlamydia is prevalent in 10% of people under 25.

2.4 Gonorrhoea

There were 18 new diagnoses of gonorrhoea in 2006. This represents a steep increase since 1995, when there was only 1 reported case. On average, gonorrhoea affects younger men (all cases in men in 2006 were under 25) and older women (all cases in women in 2006 were over 20).

2.5 Syphilis

Syphilis tends to be rare, though there are increasing cases reported in men who have sex with men (MSM) and co-morbidity with HIV. In 2006, there were 3 cases of syphilis in H&R PCT. One case was in a 20-24 year old woman, one in a 35-44 year old man, and one in a man over 45.

2.6 Herpes (Herpes Simplex Virus – HSV)

There were 33 reported new diagnoses of herpes at GUM clinics in 2006, a 267% overall increase from 2003. Increases have been marked in females in recent years with noticeable increases for males over 20 years in recent years.

2.7 Genital Warts (Human Papilloma Virus – HPV)

2.7.1 There were 203 new genital warts diagnoses in 2006, 107 in females and 96 in males. New infections in women have increased more rapidly than increases in male infections since 1998. The majority, 42%, of female cases are in women under 20 years of age, for men the corresponding figure is 14%. For men the majority of diagnoses, 44% are in men 20-24. For both men and women 33% of cases were in 20-24 year olds, 29% of positive individuals were under 20, 22% were 25-34, and the remaining 15% were over 35.

2.7.2 If recent trends continue, H&R PCT could see as many as 256 new cases in 2009, 130 in women and 126 in men.

2.8 Human Immunodeficiency Virus (HIV)

2.8.1 A note on HIV data sources: The primary source of data used in this needs assessment is SOPHID. This is the annual surveillance of HIV infected individuals seen for HIV-related care in England, Wales and Northern Ireland. It collates residence and limited epidemiological data on this group. These data are used for funding allocation by the Department of Health to plan local services and to target prevention and are used by commissioners for cross charging. It is important to note that these data only concern those people who have been diagnosed as HIV positive and are receiving HIV related care. They do not reflect undiagnosed HIV cases. It is estimated that 32% of HIV cases in the United Kingdom remain undiagnosed.

2.8.2 The UK has seen a 60% increase in individuals seeking HIV related treatment in recent years, with a steeper increase in areas *outside* of London, marking a departure from previous trends. Despite efforts in social marketing and awareness raising, late diagnoses continue to increase, often occurring too late for the individual to begin treatment, increasing

the risk of death. It is estimated that the cost of drugs alone for every new HIV positive individual is £7000 a year.

2.8.3 Total infections and projections: A total of 114 H&R residents sought HIV-related treatment in 2006, 25 more than in 2005. This represents a 29% increase from the number of residents seeking treatment in 2005 and a 72% increase from 2002. Though low, this is an overall rate of 64 per 100,000 residents. If this trend continues, there could be a minimum of nearly 200 individuals seeking HIV-related treatment in H&R PCT by 2010, approximately 145 men and 50 women.

2.8.4 Ethnicity and Age of residents seeking treatment: 59% of residents seeking treatment are white males, 19% Black African females, 10% white females, and 8% Black African males. This is a high percentage for Black African females, representing a rate of 37 per 1,000 (compared to 0.85 per 1,000 for white men, 0.12 for white women, and 15 per 1,000 for Black African men).

Table 5: Age and gender of individuals seeking HIV treatment, 2006:

	M	F	Total
16-24	4	7	11
25-34	12	9	21
35-44	26	12	38
45-54	23	3	26
55+	15	3	18
Total	80	34	114

2.8.5 There were no reported HIV cases in Black-Caribbean or Asian populations in 2006. Over the past few years, there have been a small number of Black-Caribbean males seeking treatment, but not in 2006. Though difficult to make specific projections based on available data, trends indicate increases in minority populations seeking treatment will continue into the future, creating a concentrated epidemic in a small ethnic community.

2.8.6 The majority of people seeking treatment are over 35. There were also two HIV-related deaths in this age range in 2006 (the third death was in a male under 25). One was a male over 55 who died without AIDS and one female age 35-44 with AIDS.

2.8.7 Route of transmission: 52% of reported cases were transmitted through sex between men, while 43% were through heterosexual transmission (15% men and 28% women). This represents a change from 2002 as the incidence of heterosexual sexually transmission has increased. This is in line with the national trend although slightly higher as a proportion. Transmission through intravenous drug use and mother-to-child transmission has declined.

2.8.8 Geography of HIV in Hastings & Rother: According to the SOPHID data, only 53% of residents seeking HIV-treatment sought treatment within the PCT at the Ore Clinic. This indicates that 47% of HIV-positive residents are seeking treatment elsewhere. The majority of these are seeking treatment in Brighton, London, or Avenue House in Eastbourne. This situation may be the result of people choosing services out of area due to the convenience of clinic opening times or proximity to work. It is not necessarily a negative reflection of the Ore clinic but further investigation of the issues behind the figures should be undertaken.

2.8.9 Timing of diagnosis: Timing of diagnoses is becoming more critical in relation to costs of treatment and the health outcomes for HIV positive individuals. The most at risk groups for late diagnosis are men engaging in heterosexual sex, older people and people infected

outside of the UK. If high risk groups are not tested early, the epidemic is more costly. There is good evidence that H&R PCT are diagnosing residents at an early stage, as 33% of residents seeking treatment report a CD4 cell count over 500. Only 8 individuals reported a CD4 count less than 200. 55% of residents seeking treatment fall in the 201-500 CD4 count category. 28 individuals seeking treatment have AIDS, 47 are asymptomatic, and 36 are pre-symptomatic.

2.8.10 If we project in line with the national figure of approximately 30% of HIV cases being undiagnosed, H&R PCT could currently have 150 people living with HIV.

3. TEENAGE PREGNANCY & ABORTION

3.1 Teenage Pregnancy

3.1.1 H&R PCT teenage pregnancy (TP) data, broken down by local authority, shows rates in Hastings are significantly higher than national and regional averages, while rates in Rother are comparable with regional averages. Though combining these averages is useful for looking at the PCT as a whole, it is also useful to use this disaggregated data to examine TP rates alongside related factors such as deprivation. As outlined earlier in this document, Hastings has more deprivation than Rother so the findings are consistent.

Table 6: Teenage Pregnancy rates[6]

	Number of conceptions to those aged under 18, 2002-2004	Rate of conceptions to those aged under 18, per 1000 females aged 15-17, 2002- 2004	Percentage change in rate of conceptions to those aged under 18, 1998-2000 to 2002-04
Hastings	265	53.2	-18.2
Rother	139	32.1	0.3
Est. average		42.7	
South East	15,048	33.6	-8.1
England	118,448	42.0	-6.6

3.1.2 However, the change in rates in Hastings from 1998 until 2004 has been better than regional and national averages with proportionally greater decreases. Rother, which is reporting lower TP rates, has not made any marked reductions in teenage pregnancy.

3.2 Abortion

3.2.1 The estimated crude abortion rate for H&R PCT is approximately 16.4. This is higher than regional averages though lower than national averages. The average age of women seeking an abortion is slightly higher than regional and national averages. The rates of NHS-funded abortions under 10 weeks of gestation, however, are significantly lower than regional averages (table B, Annex 2).

4. SERVICE DEMAND

4.1 GUM Waiting Times

By August of 2007, H&R PCT was able to see 75% of patients within 48 hours, and offered 96% of patients an appointment within 48 hours. This is a marked improvement since the HPA and PCTs began tracking GUM waiting times. This target is used as a marker of the

accessibility of services but only refers to those seeking out GUM appointments and so can only ever be an indicative measure of service accessibility. It does not address people who utilize family planning or youth clinics, other outreach services or, perhaps most importantly, vulnerable populations who are not engaged in the health system at all.

4.2 Contraception Services

4.2.1 The KT31 form is the primary source of contraceptive data. This form is used to collect information on contacts at specialist community contraception clinics. Each individual is recorded only once per year at their first visit (or domiciliary visit). Information is collected on the total number of contacts, the number of clinic sessions, total number of contacts for young people (under 25), the main method of contraceptive, gender and disaggregated by age.

4.2.2 H&R PCTs contraception services are being accessed by an older female demographic. Few women are using long-acting reversible contraception, 4%, compared to the proportion nationally, 15%, and there is a concerning percentage of women who are reporting as maybe not using contraception (no method provided) compared to national figures, 42% and 27% respectively (Table C, Annex 2).

SECTION TWO: EAST SUSSEX DOWNS & WEALD PCT

5. LOCAL CONTEXT

5.1 East Sussex Downs and Weald Primary Care Trust (ESD&W PCT) was established on October 1, 2006, formed from Eastbourne Downs PCT and Sussex Downs and Weald PCT. The PCT covers the Eastbourne borough and the Lewes and Wealden districts and has a budget of £442 million. The PCT is located in the South East region, the South East Coast strategic health authority (previously Surrey & Sussex), and the East Sussex Hospitals Trust.

5.2 ESD&W PCT serves just over 320,000 residents, with an even balance of men and women. There are 17,900 young men and women between the ages of 15 and 19 and there are also a high number of residents over 45, a group, in both areas covered by this needs assessment and in line with national trends, found to have emerging and changing sexual health needs. ESD&W PCT area is not as deprived as H&R PCT, Lewes and Eastbourne local authorities rank worse than regional averages in respect of teenage pregnancy.[7]

Table 7: Population estimates for ESD&W[8]

	M	F	Total
< 15	28,900	27,300	56,100
15-19	9,200	8,700	17,900
20-24	6,400	6,900	13,300
25-34	16,500	17,200	33,700
35-44	21,700	23,200	45,000
45+	69,000	84,800	154,200
Total	151,700	168,100	320,200

Table 8: Census Data 2001, Ethnicity for two previous component PCT areas for ESW&D

% of PCT	Eastbourne Downs	Sussex Downs & Weald
White	97.4%	98.1%
Mixed	0.9%	0.7%
Asian	0.7%	0.5%
Black Caribbean	0.1%	0.1%
Black African	0.2%	0.1%
Chinese	0.4%	0.3%
Other Ethnic Group	0.4%	0.2%

5.3 The area is predominantly White, with small groups of ethnic minorities, the Asian community being the largest as recorded by the Census but there is also a considerable minority population of Gypsies and Travellers which extends across the two PCT areas. The Gypsy and Traveller communities consist of both housed and site based or transitory

families and individuals with the local transitory population increasing in the summer months. Sources of data on new immigrant communities have been discussed in Section 14. For ESD&W they show the following.

Table 9: National Insurance registrations in 2006/07 by district

	Registrations	% "A8" countries	% rest of EU	% rest of world
Eastbourne	910	48%	18%	34%
Lewes	420	36%	9%	55%
Wealden	540	42%	17%	41%

Table 10: Total registered on the Workers Registration Scheme 2004-2007

		Gender %		Age Group %		
Area	Number	Male	Female	<25	25-34	35+
Eastbourne	605	44.2	55.8	50.4	40.7	8.9
Lewes	465	55.4	44.6	51.6	44	4.4
Wealden	430	46	54	42.4	42.4	15.3

6. SEXUALLY TRANSMITTED INFECTIONS

6.1 Important Note on Data Quality

6.1.1 Design Options found considerable data quality problems with the data collected in ESD&W PCT via its sexual health services. The numbers reported in KC60 returns for past years are significantly lower than most other PCTs and whilst we would expect differences between areas local rates vary considerably with regional data and national rates. The data sets for 2006 appeared more robust in terms of the SOPHID data showing relatively high, but within a normal range against national comparisons, statistics on HIV. The KC60 returns divergence from regional and national figures could represent a potential underestimate of the actual picture of STI infections in ESD&W PCT. See Figure 4, Annex 2 for comparison.

6.1.2 The data presented in this section should therefore be viewed cautiously in terms of the *numbers* reported, the trends and differences between age groups and sexes however are probably more reflective of the local situation and so we have included analysis accordingly.

Table 11: Total New STI diagnoses at GUM clinics in ESD&W, 2006[9]

		2006					2006		
		M	F	Total			M	F	Total
Chlamydia	<15	0	2	2	Herpes	< 15	0	0	0
	15-19	14	41	55		15-19	3	4	7
	20-24	36	43	79		20-24	2	11	13
	25-34	34	14	48		25-34	3	7	10
	35-44	1	0	1		35-44	0	0	0
	45+	1	4	5		45+	2	1	3
	Total	86	104	190		Total	10	23	33
Gonorrhoea	<15	0	0	0	Warts	<15	0	0	0
	15-19	2	4	6		15-19	11	54	65
	20-24	0	2	2		20-24	56	51	107
	25-34	4	0	4		25-34	41	27	68
	35-44	2	0	2		35-44	12	15	27
	45+	3	0	3		45+	13	4	17
	Total	11	6	17		Total	133	151	284
Syphilis	<15	0	0	0					
	15-19	0	0	0					
	20-24	0	0	0					
	25-34	0	0	0					
	35-44	0	0	0					
	45+	2	0	2					
	Total	2	0	2					

6.1.3 There were 802 newly diagnosed STIs in 2006 (including 276 cases of HIV) according to the KC60 returns. This is an apparent increase of 167% since 1995 (because of data quality prior to 2006 this may be misleading). Across all of England, STIs have increased 61% since 1997. STIs in the South East Coast have increased 18% since 2002. Genital warts and chlamydia are the two most often reported STIs at GUM clinics, correlating to regional and national reports. New STI diagnoses in ESD&W increased 17% from 2005, compared to a national 2% increase and a regionally 3% increase. In the South East, chlamydia has shown a steep increase in recent years, while the overall trend has been a stabilization of genital warts, gonorrhoea, herpes, and syphilis.[10] Based on the KC60 data available ESD&W seems to differ from the pattern nationally and regionally.[11]

6.2 Chlamydia

There were a total of 190 new diagnoses of chlamydia in 2006, 86 in men and 104 in women. 57% of new diagnoses at GUM clinic were in people under 25 and 30% were in people under 20. The highest at risk group appears to be women aged 20-24, closely followed by women ages 15-19. Since 1996, infections in women ages 20-24 have increased 126% and infections in women ages 15-19 have increased 356%. Total infections in young people, both male and female between the ages of 15 and 19 have increased 511%. These increases have been less dramatic in recent years (Figure %, Annex 2).

6.3 Chlamydia Screening Programme

There were 1937 screenings in 2007, compared to 2145 in 2006 and 1912 in 2005. 1509 screenings were for females, 428 males and of these 162 individuals tested positive, 122 females and 40 males. 8% of females tested positive while 9% of males screened positive.

This is in line with national estimates that 10% of people under 25 years old are positive. Compared to H&R PCT, which had increased positive rates in older young people, rates for ESD&W showed a more even spread of positive diagnoses across age groups.

6.4 Gonorrhoea

There were 17 cases of gonorrhoea reported via GUM in ESD&W in 2006. Though the data, as discussed earlier, may not be completely reliable, there has been a larger increase in male infections than female infections in the past few years, with older men in particular being at risk. Since 1996 there have been marked peaks and troughs indicating local but small scale epidemics (Table E, Annex 2).

6.5 Syphilis

Nationally syphilis infection is commonly found to be associated with HIV infection. With the relatively high numbers of HIV infections in ESD&W it would be typical to see similar high numbers of syphilis infections, especially in MSM. However, in 2006, ESD&W only reported 2 cases of syphilis through the Avenue GUM clinic. 2 cases were reported in 2005, and only 1 or 0 cases in the years preceding. The data quality issue may be involved in this low reporting or it may be a genuine reflection of the low incidence of syphilis infection locally.

6.6 Herpes (Herpes Simplex Virus – HSV)

ESD&W saw 33 new cases of herpes in 2006, with a third (11) of cases in women ages 20-24. Marked increases have been seen since 1995 in both women and men under 25, with a 250% increase in 15-19 year olds and a 160% increase in 20-24 year olds. Data from the past decade shows that infections are consistently increasing more in women than men.

6.7 Genital Warts (Human Papilloma Virus – HPV)

Genital warts have increased more than any other STI in ESD&W. In 2006, there were 284 reported cases of warts, an 80% increase since 2005 and a 151% increase since 1996. There is also a notable increase in infections in men over 45, an apparent 550% increase between 1996 and 2006.

6.8 Human Immunodeficiency Virus (HIV)

6.8.1 In 2006, ESD&W had 276 residents seeking HIV-related treatment, a 94% increase since 2002, 75% male and 25% female. If these trends continue, there could be an estimated minimum of 536 HIV-positive residents in ESD&W by 2010. This estimated increase does not take into account the 30% of HIV infections that remain undiagnosed according to the national estimates.

Table 12: ESD&W Residents seeking HIV-related treatment: 2002-2006

Year	Total residents seeking treatment
2002	142
2003	170
2004	198
2005	240
2006	276
2010 Projection	536

6.8.2 Ethnicity and age of HIV positive individuals[12]: The majority of HIV-positive residents in ESD&W are white males over the age of 35. 80% of individuals seeking treatment are over 35, 47% over 45, and 20% over 55. The majority of infections continue to be in white men (62%), with notable infections in Black African women (16%), White females (8%), and Black African males (8%).

Table 13: Rates of HIV infection, per 1,000 (estimates)[13]

	M	F	T
White	1.2	0.1	0.6
Black African	104.3	177	143
Black Caribbean	8.2	0	3.8
Indian/Pakistani/Bangladeshi	1.1	0	0.5
Other	5.2	3.7	4.4

6.8.3 The rates of infection in the Black African population are notable and mirror the national trend which has seen HIV infection rising dramatically in the Black African community in a relatively short time. HIV infection has increased by 229% in Black African males and 193% in Black African females in England since 2002. If this trend is matched in ESD&W it is possible that nearly half of the Black African community (based on Census figures) could be HIV positive by the year 2010 (a potential 201 infections out of an estimated 500 people).

6.8.4 Routes of transmission[14]: In ESD&W, HIV is predominantly transmitted through sex between men, but heterosexual transmission is rapidly increasing, in line with the national picture. There are persistent, although low, rates of mother to child transmission and transmission through blood or blood products. Transmission via sex between men has increased 96% since 2002, but heterosexual transmission has increased 139% in men and 247% in women over the same period. It is likely that the increase in heterosexual transmission is explained by the rise in infection among Black African men and women.

6.8.5 Geography of HIV in ESD&W PCT[15]:
In 2006, only 43% of ESD&W residents seeking HIV treatment accessed services at Avenue House in Eastbourne. 40% are seeking treatment in Brighton and 12% of residents seek treatment in London. Within ESD&W, 45% of HIV positive people reside in Eastbourne, 31% in Lewes, and the remaining 24% in Wealden.

6.8.6 Timing of diagnosis[16]: Of the HIV positive residents in ESD&W, 34% have a CD4 count of 350 or lower, 8% below 200 and 37% have a CD4 count of 500 or higher. 70% of residents seeking treatment are on triple or more therapy.

6.8.7 Regional Comparison: The South East Coast has the largest HIV positive population in England. As in ESD&W, the majority of cases are in MSM, and increasingly among Black African women. In 2006 the South East Coast SHA pattern of most at risk age groups for HIV showed women ages 35-39 and men ages 40-44 to be most at risk. This profile of risk is the same for ESD&W PCT area.

7. TEENAGE PREGNANCY & ABORTION

7.1 Teenage Pregnancy

In 2002-2004, there were 985 under 18 conceptions in East Sussex County. Hastings, Eastbourne, and Lewes all show high rates of teenage pregnancy but also show the most improvement in figures in recent years. Though Rother and Wealden report lower rates of under 18 conceptions, these areas have actually shown an *increase* in incidence in recent years (Table F, Annex 2).

7.2 Abortion[17]

Availability of NHS funded abortion services under 10 weeks of gestation is an indicator of the strength of sexual health services in a PCT. The percentage of NHS funded abortions at under 10 weeks gestation in ESD&W PCT is lower than both regional and national averages, especially in Eastbourne (Table G, Annex 2).

8. SERVICE DEMAND

8.1 GUM Waiting Times

In June 2007, the National Support Team executed a rapid assessment of sexual health services in ESD&W, an area identified as most challenged in meeting the 2008 target of seeing 100% of GUM patients within 48 hours.[18] HPA quarterly returns in August 2007 reported that ESD&W was seeing 73% of patients seeking care at GUM clinics. At the time of reporting more recent data was unavailable.

8.2 Contraception Services

There were 6,600 clinic attendances at Avenue House, 3,600 first contacts with females and 700 first contacts with males. In common with H&R PCT the use of LARCs in ESD&W is below regional and national averages. Additionally, the 'no method used' category is higher than regional and national averages.

SECTION THREE: HARD TO REACH AND AT RISK GROUPS

9. HOMELESS

9.1 Homeless households

It is difficult to pinpoint a figure for the number of homeless individuals residing and/or seeking services in ESD&W and H&R PCTs – chaotic lifestyles, high mobility, and transient temporary addresses. Additionally, it has been noted that official council statistics only report those in priority need who have been able to register as homeless with the council. Many individuals do not fall squarely within this category and are not reported. With these caveats in mind, ESCC estimates that in 2006-7 there were 648 homeless households accepted as in priority need by the LA. Eastbourne: 160; Hastings: 241; Lewes: 51; Rother: 47; Wealden: 149. It is also critical to understand that there are three other councils that place families and individuals in the Eastbourne area; these numbers are not included here. These numbers are therefore much lower than the actual number of individuals in need of services.

The Homeless Health Team estimates that there are more young, single homeless men accessing services in the PCT than women or families, though they have clients from a wide variety of demographic characteristics. In general, priority need families are placed in accommodations that tend to have kitchen facilities (and therefore they do not attend the Salvation Army hot meal services) and are visited by a health worker. However, these families are also moved around quite a lot, and may move into an area where they are not aware of available services and/or GPs. Single persons are usually placed in accommodations without a kitchen facility and therefore seek hot meals at the Salvation Army. They do not qualify for health visitors and may therefore have more difficulty accessing health care, including sexual health services.

As it stands, the Homeless Health Team is currently all female, which creates some difficulties in engaging males.

9.2 Sexual health needs

9.2.1 This group have complex sexual health needs often compounded by substance misuse issues and chaotic lifestyles. Transactional sex among those who are desperate for somewhere to stay or in order to fund substance misuse habits has been noticed among both men and women.

9.2.2 The Homeless Health Team nurses (6) distribute condoms, provide pregnancy testing, screen for chlamydia, signposting, and assistance and support in making appointments for other needed sexual health services. The Team, in the past, had held sexual health clinic in partnership with the Salvation Army and the PCT, but these clinics were not adequate to meet the specific needs of homeless individuals in the PCT. The Team now engages in outreach through and with other organizations providing services to these individuals, with the aim to bring services directly to the individuals where possible (rather than expecting individuals to access available services on their own).

One of the nurses on the Team shared an anecdote where the nurse bumped into a female client one evening, outside of the service delivery setting, and the female client needed a smear, but was not capable of accessing her GP or make an appointment herself. The nurse was able to make the appointment for the woman, but with no address and no phone,

there was no way to directly contact the woman in need. The nurse had to call all the organizations where the female client was known to access services, leave written notes, and hope that the message would be passed along to the woman. To this end, the nurse noted that additional training and clinical capabilities for the in-house nursing staff on the Homeless Health Team would greatly improve the availability and accessibility of sexual health services for the homeless population in the PCT. As the Team already has ties and links to this hard to reach group, this is the most direct and efficient care pathway.

9.2.3 Other practitioners report that sexual health is as awkward a subject to broach with homeless people as with any other group and so take up of services branded specifically as sexual health may be off putting leading to low take up.

10. YOUNG PEOPLE

10.1 Issues and Attitudes

10.1.1 Not all of the young people involved in the workshops were sexually active although sex was something they were thinking about. Some showed a willingness to delay sexual intercourse until in a long-term relationship or until their partner was ready: *"she's a bit young for that, she's only 15, I don't really mind. I'm not going to force her to do it but then it if comes to it then I'm not going to say no"*.

10.1.2 The majority believed that 14-15 was a good age to start having sex, not necessarily sexual intercourse as people were curious and experimenting. Some reported that the right age depended on *"if you're in a deep relationship"*.

10.1.3 Among those who were not parents, teenage pregnancy was widely condemned and boys and girls stated that *"getting a girl pregnant is stupid, it messes your life up, you've got so much to look forward to you don't want to bother with that, that's for later on in life".*

10.1.4 Teenage parents had differing views. Some had conceived accidentally and some had become pregnant intentionally and were offended by other people assuming that they had done something wrong: *"I was on top of the world when I found out I was pregnant".*

10.1.5 Knowledge of condoms and approval of using them as a default method was widespread among the young people consulted and was seen as protection against teenage parenthood and STIs among those who were sexually active. *"I would definitely use a condom. I don't want to get a girl pregnant".* Some sensible and well informed views were expressed: *"I keep myself safe. I don't sleep with just anyone and I use a condom if I do. I have a condom in my purse"*. However, the teenage parents had not used condoms before conceiving, due to a combination of factors including believing that it would never happen to them and male partners complaining about condom use.

10.1.6 Sex fuelled by alcohol was widely reported as negatively affecting the propensity to use condoms.

10.1.7 Knowledge about chlamydia and chlamydia screening was not high.

10.1.8 Gaps in knowledge or misunderstandings about other methods of contraception were noted and several of those consulted had negative ideas about abortion: *"I don't think its right 'cos it kills the baby".*

10.1.9 The teenage parents felt pressured by midwives and health visitors to take up LARCs. Some appreciated that these methods were useful because they had difficulty in remembering to take the pill and wanted to delay a second pregnancy or space births. However, others felt that this reflected negative attitudes towards teenage pregnancy.

10.1.10 The young parents were aware of a much fuller range of contraception but reported difficulties in accessing preferred methods due to GPs' concerns about the costs of methods such as the myrena coil and less commonly-used versions of the pill.

10.1.11 Some of the young people were aware of outlets to access free EHC but were unable to pay the £20-£25 over-the-counter charge. They preferred to access free EHC from their GP or sexual health clinic but were too embarrassed to go repeatedly.

10.1.12 Few of the young people consulted were aware of c-card and those who were aware of it had learnt about it from friends rather than being told about it in school or by the youth service. However, even those whose friends were on c-card didn't know how to get registered for it.

10.1.13 Contrary to what some practitioners reported, young people in the East of the area didn't seem to think it was too hard logistically to get to the Ore clinic or Avenue House, even though the transport routes were complex and irregular. Those in the rural areas went to Hastings or Eastbourne as often as once a week and appeared used to living off the beaten track in terms of all services. Some felt that the cost of bus travel was too high.

10.1.14 For young people in the rural areas, Saturday opening hours at Ore or any services in Hastings were required because during the week they were reliant on school busses to get back to Rye or Camber areas. They preferred walk-in to appointments.

10.2 Communication about sexual health

10.2.1 Mums were seen by several young people as a non-judgemental source of information and support: *"I can talk to my mum about anything. I told her when I lost my virginity"*. Mothers who had themselves been teenage parents were seen as particularly approachable. *"She said I could ask her for help but I should make my own decisions".* Some of the boys consulted reported that they would turn to their mums first if worried that their girlfriend were pregnant

10.2.2 Girls reported that their friends were important to them when anticipating something difficult such as going to a GP for contraception or going to the Ore Clinic. They were also a source of information, not always accurate, and were powerful in influencing attitudes towards contraception and SH *"I don't like the injections, my friend went on them and she put on loads of weight*".

10.2.3 Some of the young people had good relationships with youth workers and thought they'd turn first to the youth workers if they had a problem *"If it was something serious I could talk to the youth worker"* and in terms of Connexions *"they're quite friendly, quite young people in there they made you feel welcome".*

10.3 Information and Education

10.3.1 Among the young people consulted formal SRE had not appeared to have had much of an impact and was often reported as not very conducive to learning seriously about SH *"the boys just make fun of it"* and *"I wouldn't be able to ask a serious question".*

10.3.2 Sessions where external speakers came in, rather than normal classroom teachers, were preferred. DVDs also had a higher impact as it put a face on an issue.

10.3.3 Sexuality had not been discussed in any of the SRE the young people had received.

10.3.4 Health promotion through media campaigns had not widely registered with the young people consulted and when it had it was not felt to be terribly useful: *"that crap advert with the people trying to get it on, they just tell you the names of the diseases, none of the signs".*

11. BLACK AND MINORITY ETHNIC GROUPS

11.1 In the 2001 census, the population of East Sussex was 97.7% White, which compares with 95.1% in the South East and 90.9% in England and Wales. However, in 2001, 3% of the population in Hastings was Black or Asian, as was 4% of the population in Eastbourne. Since 2001, East Sussex's population has become more ethnically diverse, and at a faster rate of change than nationally. By mid-2004, the Black and Asian population had grown by 6,300 people.

11.2 There has not always been an Equalities and Diversities officer in the PCTs but these positions need to be filled in order for someone in the PCT to take the lead (and have leverage to do so) on BME sexual health needs.

11.3 There is no targeted SH provision for the settled BME population although they are likely to have complex and diverse needs. The voluntary sector groups are organized collectively through 'Hastings Intercultural Organisation' which represents a good route to do some organized SH promotion work with BME organizations as it has a database of organizations, email list and newsletter.

12. GYPSIES AND TRAVELLERS

12.1 There are 4 Gypsy and Traveller sites in East Sussex with 26 pitches at Maresfield; Hailsham; Robertsbridge and Polegate. Brighton and Hove have 23 transit pitches at Horsdean.

12.2 Young females are often removed from sex education classes in schools. The degree of knowledge around sexual health therefore can be quite minimal.

12.3 Young travellers are often kept away from drugs awareness knowledge in line with the reasoning that any knowledge about the subject is likely to lead to an increase in the desire to experience it. Consultees at one of the young people events who were from a traveller background reported cannabis use.

12.4 Reproductive health is an issue for women from this community which is affected by cultural attitudes. Routine cervical screening or breast examination are often viewed as intrusive and a taboo subject within health matters

13. ASYLUM SEEKERS AND FAILED ASYLUM SEEKERS

13.1 Background Information

13.1.1 There are 83 asylum seekers supported by the National Asylum Support Service in Hastings, plus an additional 15 who are living with their own contacts in the city. However, service providers estimate that the actual number of asylum seekers and failed asylum seekers may double that.

13.1.2 The profile of asylum seekers has changed over the last 2-3 years. Typically asylum seekers tended to be single, young men from the Middle East (Iran, Iraq, Kurdish areas, Palestine, Turkey) but now there are more asylum seekers coming from more distant locations. Asylum services and associated services are now seeing more Africans from Zimbabwe, Eritrea, Sudan, Cameroon, Congo and the Ivory Coast. Although numbers appear to be reducing those who become known to services are staying in the area and are complex cases involving multi-agency support.

13.1.3 Asylum seekers in Hastings used to be housed in hostels such as the Adelphi Hotel which 2-3 years ago had 250 bed-spaces and reportedly gained an international reputation as an unpleasant place to be housed. Now people are being housed in flats and are living independently. This has apparently led to increased isolation.

13.1.4 The picture of asylum seekers and refugees in the county will change dramatically over the next few years. Under the 2007 New Asylum Model asylum seekers and refugees will no longer be housed in Hastings but until the new system is embedded Hastings will retain 100 bed-spaces. Although under the new scheme the Home Office is aiming for no supported asylum seekers in Hastings by 2011 it is likely that the reality will be that undocumented asylum seekers and refugees, and those caught in the transition of the systems, will remain in the area.

13.2 Sexual health needs

13.2.1 The sexual health needs are complex but varied. Many asylum seekers are single and some of them develop sexual relationships whilst they are in the UK – mostly with compatriots. Some single men are known to use commercial sex workers (CSW). They may also attempt to initiate sexual relationships with local women. There were some reports of men from the Middle East starting relationships with young English girls and even engaging in a degree of opportunistic transactional sex with young girls. The scale of this kind of situation could not be confirmed or the extent to which it reflects the profile of asylum seekers in Hastings today.

13.2.2 Failed asylum seekers and those who have disappeared from the authorities do not receive any financial or other support and may not wish to make themselves known to any health services, even when they need them, as they wish to remain hidden.

13.2.3 As the profile of this community has changed there are increasing numbers of families with young children in which women are sexually active and have the usual needs to control fertility. As in the general population, women were more engaged with contraception than men, who only engage with getting condoms. Do not appear to be involved in discussing contraception options with their female partners.

13.2.4 The men consulted did not seem to be particularly interested or knowledgeable about contraception, which seemed to be a largely female domain, apart from condoms.

13.2.5 Attitudes to partnerships and monogamy varied among the asylum seekers and refugees consulted. For some of the single men and women there was a very strong Christian/Muslim

ethic of abstinence: "If I'm in a relationship I can't sleep with my boyfriend until marriage, that's my commitment and also the character from my family", "she's the one and last". For others among the men there were sexual histories of previous relationships, divorces, concurrent relationships and CSW use.

13.3 HIV

13.3.1 First generation migrants from Africa make up a large proportion of the HIV caseload in East Sussex and are often diagnosed after arrival in the UK. Although there is no formal care pathway requiring new asylum seekers to have their sexual health checked encouragement from the Ore Clinic via Links means some people are referred. From the consultations it emerged that some asylum seekers considered the visit to the Ore Clinic as an inevitable or almost compulsory part of their arrival process with HIV testing being seen as 'screening' that may influence their cases.

13.3.2 Men from South African countries were quite aware of HIV however, people from countries like Eritrea, Somalia and West Africa not so aware of HIV.

13.3.3 They experienced barriers to attendance in terms of transport costs although some services helped on this front.

13.3.4 Practitioners were aware of several cases of late HIV diagnosis among asylum seekers and were aware that people were presenting with HIV related health issues at GPs which may go unrecognised. Training for GPs is being developed.

13.3.5 Practitioners and consultees reported problems with disclosing HIV status to other people. Men were more reluctant than women. However, in some cases attitudes and understanding were improving and the importance of information was recognised *"I have enough information and I can understand the condition. If you are on medication you have longer life expectancy than someone who is diabetes. That is reassuring".*

14. NON-ASYLUM SEEKING IMMIGRANTS

14.1 Background Information

14.1.1 There are large populations of migrant workers in East Sussex, some of whom have papers and some of whom do not according to members of these communities. If migrant workers do not have papers it is likely they will work for cash and so they will not appear on the two systems that can be used for estimating their numbers. The main populations come from Poland, Czech Republic, Albania, Lithuania and Russia.

Table 14: National Insurance registrations in 2006/07 by district

	Number of registrations	% "A8" countries	% rest of EU	% rest of world
Eastbourne	910	48%	18%	34%
Hastings	600	57%	5%	38%
Lewes	420	36%	9%	55%
Rother	300	50%	3%	47%
Wealden	540	42%	17%	41%

East Sussex	2,770	47%	12%	41%
South East	80,130	43%	15%	42%
England & Wales	631,780	42%	16%	42%

14.1.2 Since May 2004, the Workers Registration Scheme (WRS) requires all employed workers (not self employed) from the 8 newest EU member countries to register for work in England & Wales. The countries are Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia, and are referred to as "A8" countries.

- A total of 2,680 A8 citizens registered to work in East Sussex between May 2004 and March 2007.
- 35% have registered to work for an employer based in Hastings compared to just 9% in Rother.
- 53% of A8 workers in East Sussex came from Poland compared to two thirds nationally.
- Over 70% of East Sussex A8 migrants work in administration and hospitality.
- The majority (86%) of A8 workers in East Sussex are under 35 years.
- Over half of all registrants in Eastbourne, Hastings and Lewes are under 25 years old.
- There are slightly more males in Lewes and more females in Eastbourne.

Table 15: Total registered on the Workers Registration Scheme 2004-2007

		Gender %		Age Group %		
Area	Number	Male	Female	<25	25-34	35+
Eastbourne	605	44.2	55.8	50.4	40.7	8.9
Hastings	940	50.3	49.7	51.6	29.8	18.6
Lewes	465	55.4	44.6	51.6	44	4.4
Rother	240	46.8	53.2	37	41.3	21.7
Wealden	430	46	54	42.4	42.4	15.3
East Sussex	2,680	48.8	51.2	48.7	37.8	13.5
South East	76,570	55.3	44.7	45.4	39.2	15.1
England and Wales	562,610	57.6	42.4	43.4	38.9	17.4

14.2 Sexual health needs

14.2.1 The young age profile of this population means that they will have considerable sexual and reproductive health needs.

14.2.2 Language barriers have reportedly caused problems in terms of immigrants accessing sexual health services and some of the more transitory populations are not register with local GPs either.

14.2.3 Practitioners nationally are reporting seeing increasing cases of Eastern European immigrants with HIV who have become infected through unprotected MSM in this country. There are also considerable numbers of female migrants seeking abortions during there time in the UK.

14.2.4 It is also reported that as many of the countries new migrants are coming from are strongly Catholic there are challenges around sexual health promotion and promoting service access.

15. PRISONERS

15.1 Lewes prison is a male-only prison, containing convicted and remand adults and local remand for young offenders. It has an operational capacity of 558. Condom distribution and HIV and Hepatitis testing take place within the prison, but consultees who had been inmates at Lewes prison did not recall any sexual health promotion.

15.2 Links between the prison and the sexual health promotion team have declined in recent years, which represents a missed opportunity for intense one-on-one work.

15.3 At the time of writing, Lewes prison was carrying out a health needs assessment. Readers should refer to East Sussex Downs and Weald PCT to consult the needs assessment directly.

16. MEN WHO HAVE SEX WITH MEN (MSM)

16.1 Background Information

16.1.1 Census data from 2001 shows that within the whole of the South East, after Brighton and Hove, Lewes has the most cohabiting same sex couples. Eastbourne is 5th on the same list and Hastings 7th. As a proxy measure to indicate the size of the likely gay and MSM population in the two PCTs this data suggests that they are likely to be a significant population and larger than expected due to proximity to Brighton and London. Anecdotally, members of these communities and practitioners have reported an often age or stage of life linked migration of MSM from Brighton to Hastings, Lewes and Eastbourne.

16.1.2 The UK Gay Men's Sex Survey 2006, conducted by Sigma research[19] provides the most detailed information available on sexual behaviour and sexual health needs among MSM in East Sussex. The survey counted a small number of men from ESDW and H&R PCTs (51 men). Compared with the South-East Coast area in general, there was a concentration of men aged below 20 years or over 50 years, in keeping with local reports indicating that the relatively cheap housing in the area draws in younger MSM who commute to work in London or Brighton as well as older MSM who move from Brighton to buy properties.

16.1.3 94% of respondents were White British with 3% Asian and 3% Mixed ethnicity. 97% identified themselves as gay and only 3% as bisexual, although 6% had a female sexual partner in the previous year. Overall 9% were married to a woman and 6% were in a civil partnership with a man. 27% were living with a male partner, 27% were living alone and the remainder were in other types of households.

16.1.4 With its proximity Brighton, with its large range of LGBT venues, there are only a few 'formal' LGBT venues in ESD&W and H&R PCTs. These are focussed in Eastbourne and Hastings. Outreach workers reported that The Hartington pub in Eastbourne is the only active venue and is accessible by entry-phone and that Juicy Fruit and Pothouse in Hastings have closed down but recently events have been held on the pier or at a pub called the Crown House.

16.1.5 There are a number of prominent public sex environments (PSE) between Brighton and Hastings, including Holywell in Eastbourne, Arlington Woods and the Long Man of Willmington and the beaches East of Fairlight.

16.2 Sexual health needs

16.2.1 The East Sussex respondents in the Sigma survey had a smaller number of male sexual partners in the previous year than in the South East coast area in general. However, the survey found high levels of risky behaviour: 54% of respondents had unprotected anal intercourse compared to 33% who had protected anal intercourse in the previous year.

16.2.2 Half the men surveyed in East Sussex had never been tested for HIV and a further 25% had been tested more than a year ago, which was worse than for the South East coast area in general.

16.2.3 Locally it was reported that outreach and sexual health promotion received a rather jaded response from MSM and that attitudes to sexual health and HIV in particular were changing as more people were seen to be surviving and living with HIV.

17. SEX WORKERS

17.1 Background Information

17.1.1 The sex industry in East Sussex is concentrated in Eastbourne, with fewer venues in Hastings and other areas. There are 11 known flats and private houses in Eastbourne ("parlours" or "flats"). There are few street workers although street work is known to go on occasionally along the seafront in Eastbourne and Hastings.

17.1.2 The female sex workers are largely White British with increasing numbers of Polish and other Eastern European women. There are ethnic tensions among the sex workers linked to protecting patches.

17.1.3 The workforce in the establishments changes extremely rapidly, and new workers are recruited via the Friday Ads. It was reported that the CSW in the establishments tolerated by the police did not have problems with drug or alcohol use and it was understood that female sex workers in the parlours in Eastbourne and Hastings were not generally working in order to support serious drug habits. Rather, they tended to get involved in sex work to pay back a debt and then stay in the industry because of the relatively high hourly rates it can offer: *"It's given us a better quality of life but I don't do it for the wrong reasons, I do it for the right reasons, I do it for my kids".*

17.1.4 Anecdotally, male sex work is known to be more common in Eastbourne than in Brighton. There are male sex workers for female as well as male clients (i.e. gigolos and rent boys). It does not appear to be organised, and consists of men working opportunistically. Transactional sex among homeless men has been observed where there is financial need to fund a drugs habit (see homeless section).

17.2 Sexual health needs

17.2.1 The sex workers consulted were adamant that they always use condoms with clients. There remains a risk of infection due to concurrent relationships, unprotected sex with regular partners and unprotected oral sex with clients. The need for using condoms to perform oral sex was not as strongly perceived as for vaginal sex.

17.2.2 Condoms and lubricant were obtained commercially or, previously, from the outreach worker from Avenue House.

17.2.3 The sex workers consulted were using a regular method of contraception as well as condoms, i.e. the pill or an IUD. One had accepted an IUD after starting sex work because it had been recommended by Avenue House. They did not have concerns about unplanned pregnancies from sex work. However, they were not using condoms with regular non commercial partners, some of whom were men who were already married.

17.2.4 Psychosexual needs were reportedly important among this group. The sex workers consulted had difficulties in reconciling commercial sex work with their regular relationships and desire for intimacy. One had accessed psychosexual counselling via Avenue House, and reported positively about the service.

18. SUBSTANCE MISUSERS

18.1 Add Action in Hastings have 4-500 people using the needle exchange – some in treatment, some not. Numbers are not on the rise but recently they've noticed an increase in the numbers of "treatment naïve" people coming in. Instances of problematic heroin use are going down – YP are scared of it. However, problematic cocaine use is increasing.

18.2 This group had diverse sexual health needs but almost universally they had chaotic lifestyles with sexual health not being a priority. Many reported they had not "got it together" enough to take control over their sexual health.

18.3 The people consulted had noticeably complex relationship involving broken relationships and casual sex in addition to long-term partnerships, although none admitted to anything recent or to any concurrent relationships. Some reported sexually abusive pasts that contributed to their substance misuse.

18.4 The people consulted did not volunteer information about their involvement personally in transactional sex although the drugs team report that there are a few women who have disclosed it to them in confidence. Transactional sex among male drug users is also happening but rarely.

18.5 None of those interviewed from this group were using condoms but when they had they paid for them with one woman expressing the view that it was the men's responsibility.

18.6 In terms of reproductive health, chaotic lifestyles had meant issues of access to timely terminations and issues around not recognising the need for pregnancy testing when periods were missed as general bad health often lead to erratic menstruation.

18.7 Male steroid users were known to have increased sexual appetites and, as a consequence, indiscriminate sex.

18.8 The substance misusers consulted all reported trying to stay away from other users particularly in terms of future relationships *"if he was using I wouldn't have nothing to do with him".*

18.9 Most of the substance misusers are male. Hepatitis C infection is high. Sharing needles is a continued problem – but also problems with information – e.g. they don't realise that drawing up from the same spoon counts as sharing.

SECTION FOUR: GAPS AND RECOMMENDATIONS

19. CONCLUSIONS AND RECOMMENDATIONS

19.1 Successes

19.1.1 There are many successes to be built upon in H&R and ESD&W PCTS. Significant strengths include very strong foundations in partnership working and an integrated model approach to sexual and reproductive health service delivery. The needs assessment found that there are a number of challenges to be addressed if progress is to continue in terms of meeting the sexual health needs of the local population and in particular those groups most at risk of poor sexual health. These include:

- the collection, analysis and use of data in planning services to ensure need is being met and inequalities addressed;
- finding creative and cost effective was to roll out the integrated model to rural areas;
- building stronger partnerships in some key areas;
- clarifying commissioning arrangements;
- development of specific PCT links with higher risk groups and their representatives;
- development of culturally appropriate prevention and behaviour change programmes

19.1.2 The East Sussex sexual and reproductive health service is well placed – based on current work and commitment of staff – to move from being a reactive service to being a proactive, responsive service based on need with a strong focus on primary prevention.

19.2 Overarching recommendation: Review, strategise and action plan

19.2.1 The two PCTs are advised to collate and review the results of the past 5 years self assessments, such as the teenage pregnancy self assessment and the pilot *You're Welcome* assessments, and reports on sexual and reproductive health. The material from these reviews could then be grouped under the theme headings Design Options have used to present the findings of this needs assessment and combined with these results.

19.2.2 It is then recommended that the PCT and partners determine whether there is current agreement about the recommendations pulled together from the various reports and, if so, establishes whether these have been actioned or delivered.

19.2.3 The actions that are still required, in conjunction with those recommendations from this report that the PCTs agree should be progressed, then form the basis for a new SH action plan.

19.2.4 Although the sexual health plan will have a wider remit, it will be important that the process fits with Children and Young People's planning as well as the Local Area Agreement and local development plans.

19.2.5 The plan should include named leads, set timeframes and resources. Progress should be reviewed quarterly or six monthly. It is critical that the plans be needs driven and contributing to a reduction in inequalities, so improved data will be important (see surveillance below)

19.3 Findings and key themes

The findings from this needs analysis have been organised into specific themes:

1. **Strategy and leadership**
2. **Partnerships**
3. **Surveillance, monitoring and evaluation**
4. **Service delivery**
5. **Prevention and behaviour change**
6. **User engagement**
7. **Workforce**
8. **Communication**
9. **Service environment**
10. **Commissioning**
11. **Safety**
12. **At risk groups**

The actual findings are reported in Annex 1.

ANNEX ONE: KEY FINDINGS

1. STRATEGY AND LEADERSHIP

Recommendations:

- Strategy and action plan development: see overarching recommendation, above.
- Identify champions within the PCTs, Local Authorities and LSPs to help develop and implement the above and be accountable for specific actions.

2. PARTNERSHIPS

This needs assessment found that one of the strengths across East Sussex is the good relationships between teams and partners but that these were often informal and could be strengthened to increase efficiency if they were formalised. Critical potential partners for achieving targets and meeting the needs of the population include primary care (including commissioners), education and mental health. Further work may be required to ensure partnerships are in place with all key partners in the community and voluntary sector, as it is difficult to engage directly with users and non users of sexual health services.

Recommendations:

- A new managed network is under development. Formalisation of the broader SH network should also include formalisation of the HIV network between the areas, to include Brighton, and incorporate an HIV-pharmacist network. The development of the networks should take into account some staff concerns about 'genericisation' and potential reduction in autonomy.
- Ensure all partners and staff are on board with new managed network arrangements by holding training workshops to agree shared approaches and models. This will help overcome any fears as highlighted above.
- Review the effectiveness of partnerships working in sexual health (e.g. annually) to ensure efficiency. Celebrate the successes the partnership achieves (e.g. annual celebration lunch on Valentine's Day or World AIDS Day).
- Sexual health partnerships and their champions should monitor the LAAs to ensure sexual health indicators are included in these. PCTs local development plans should also be monitored for sexual health indicator performance from the Vital Signs list of indicators.
- Where need has been identified, develop partnerships to ensure key areas have effectively working partnerships to address need.
- Partnership working with THT in Hastings appears stronger than Eastbourne but there is scope to strengthen the role of THT in Eastbourne particularly to reduce the use of specialist clinical staff time to address social care issues (e.g. housing, immigration) which THT are better equipped to provide and which would maximise the skills and abilities of senior clinical staff in GUM delivery.

3. SURVEILLANCE, MONITORING AND EVALUATION

Accurate data and intelligence are required for effectively targeted programmes, performance management and regulation, as well as assuring the population that their needs are being met. According to staff with responsibility for data and information, the information system is relatively new and data quality is an issue, although the area is getting more systematic with its information systems. Eastbourne services have been unsuccessful in appointing a data post-holder. The post has now been re-branded to AfC6 and recruitment is expected in the near future.

A range of data issues were raised during interviews. The overall sense was that data and information were areas that needed to be significantly strengthened. People referred to a wide range of priority groups; most of these were identified through 'local knowledge' and 'good word of mouth' rather than access to up-to-date, useable data and information collected through monitoring processes, analysed and disseminated for use. Areas that appear to need strengthening include ethnic monitoring and sexual orientation (wherever possible) to ensure service providers and participants are clear why these are important areas to collect data.

Common Dataset for Sexual Health (CDSSH) will provide a single standard structure for collecting high quality data on sexual health in the NHS in England. With the expanding delivery of sexual health services outside genitourinary medicine (GUM), the aim of these developments is to improve the quality and coverage of data on testing and diagnosis of sexually transmitted infections (STI), and thereby provide relevant information for identifying public health priorities and informing service planning.

Recommendations:

- Data collection systems are developed in line with the Department of Health's proposed Common Data Set for Sexual Health and HIV. A first steps approach would be to be in line with the GUM minimum data set.
- Understanding about the value of using data as well as capacity building will be important for all local staff with responsibility for delivery and particularly for planning and monitoring sexual health services. Training and briefings should be provided to engender the required understanding and engagement.
- Effective protocols should be developed for data sharing, the use of which should be part of capacity building. Informal arrangements should be formalised so that they do not rely on individual relationships.
- Systems for analysing and disseminating information for use by planners, service providers, media etc should be developed and implemented.

4. SERVICE DELIVERY

There were widespread, overwhelmingly positive views about the benefits of the integrated sexual health service provision. Interviewees felt that the integrated services were strongest in urban areas. Despite the integrated service model in place, there is an imbalance of provision, with rural areas not getting access to both reproductive (family planning) and GUM services in the same location. Primary care representatives felt that primary care providers are the natural place for people to go for routine sexual health issues.

Targeted programmes – for prevention, treatment and care are essential to ensure effective services for those who need them most. Concerns were raised that contraceptive services did not receive the attention they should in primary care - both in terms of the whole spectrum of contraceptives (especially LARC) not being provided, and primary care staff assuming no additional skills were required in this area.

The You're Welcome initiative – Department of Health criteria to ensure health services are young people-friendly – was seen as having the potential to improve services across the area.

Recommendations:

- As part of the process of developing a needs-based plan for SH, it would be useful to visit other areas that have a rural-urban service area to identify useable solutions for hub and spoke delivery across the area.

- Eastbourne service should consider a structure that provides overall strategic and clinical leadership. As example of this could include a senior nurse (modern matron) overseeing Level 3 services (Eastbourne and Hastings) and acting as focal point for practice nurses and their training and supervision.
- Senior clinical nurse presence to the GUM service (along with clinical supervision, individual performance reviews and day-to-day nurse management)
- Multi-skilled nursing team in terms of clinical / health advising / GUM / contraception
- Scope to develop the local chlamydia screening programme with new opportunities for A&C staff (administer the programme, texting results, results clerks within agreed protocols)

5. PREVENTION AND BEHAVIOUR CHANGE

It is important to get the balance right between prevention and treatment – particularly in an area like sexual health. It is also important to use treatment as an opportunity to ensure clients know how to protect themselves and their partners in the future.

SRE/PSHE in schools is a critical area for contributing to the sexual health of young people but there is not a joined-up approach to sex and relationship education for young people and provision is inconsistent across East Sussex.

Recommendations:

- Further work is required to ensure prevention programmes are needs based and culturally appropriate (see higher risk groups below)
- At LSP level, there needs to be understanding and commitment to delivering a consistent, high quality SRE/PSHE programme across East Sussex. Links with Education need to be developed and champions established and nurtured to ensure consistent SRE as a matter of urgency.

6. USER ENGAGEMENT

User engagement in sexual health can be difficult, apart from networks that can be developed with regular service users – for example people living with HIV. It is important to remember when considering user feedback that it does not represent the views of those who are unable or unwilling to attend the services – or those who are not prepared to give feedback. In the sexual health field, it is often only from regular services users that responses can be gained, for example, from HIV service users.

In relation to young people, the You're Welcome scheme should help provide input but further work with potential service users would help ensure services that are accessible and appropriate.

Recommendations:

- As part of the strategic action plan, build in mechanisms for ensuring user (and potential-user) involvement in planning, delivery and monitoring and evaluation of services to ensure needs based delivery. This could be either through direct user involvement or by community group representation.
- Develop systematic cycles for reviewing user feedback and ensure that the results are shared among partners (including the voluntary sector) with actions developed in a timely way to explore issues or address them as they arise.

7. WORKFORCE

Workforce development and training were identified by this needs assessment as areas needing further development especially in relation to providing an integrated service as staff need to widen their skill base. Training and development – both for SH staff and more generic service providers – is critical to achieving targets and meeting need and training constantly needs to be reviewed to ensure it is up to date and responsive to local population needs and changes, for example in relation to new migrant communities or new higher risk HIV groups.

Recommendations:

- As part of development of the overall plan for SH, ensure staffing is provided in relation to meeting need.
- Develop an approach to training and development that includes engagement with key bodies for those who are priorities for training (e.g. the PEC and other key bodies for primary care, Education).
- To ensure staff are on board with any changes under development, include them in the planning and roll-out of approaches.
- The PCT should plan to have a protected training budget in future finance cycles
- The PCT should work with GP practices to promote the role and scope of practice nurses to better use their skills and abilities.

8. COMMUNICATIONS

Communication – with partners (for example about data and information), the media (for example to highlight new services or celebrate successes) and to ensure behaviour change and access to services – is critical to a successful programme. Some partners felt they were not routinely included in communications relevant to SH via the PCT. This assessment found that service branding and promotion was inconsistent and patchy with little targeted promotion or information.

Recommendations:

- As part of the SRH plan, develop a detailed strategy for partnership communication (including sharing information about meetings, data, strategies, reports, etc) which includes GPs
- Develop a programme of behaviour change communication (approaches to sexual health promotion messages) and information, education and communication approaches and access information with service users and non-users involvement
- Continue the work that has started on service promotion via the media and extend this to include wider use of websites and local publications including those of neighbouring areas such as Brighton as this is where young people and some MSM may access information.

9. SERVICE ENVIRONMENT AND FACILITIES

Three main issues were identified by this needs assessment under this general theme: ensuring that confidentiality is supported and accommodated within facilities; ensuring that there is sufficient space for administration within premises; addressing the lack of access and poor facilities in rural areas.

Recommendations:

- As part of the SRH policy, and in line with *You're Welcome* criteria, include confidentiality as an element in facility design.
- When space is an issue the use of contact cards indicating the purpose of a visit can overcome the problem of being overheard.
- When planning and redesigning services, build in enough space for staff to carry out administrative and non-clinical activities. Look for creative, low/no cost ways to ensure confidentiality in waiting rooms and reception areas.

10. COMMISSIONING

It is clear that there needs to be greater clarity about commissioning arrangements and that they need to be disaggregated as historic arrangements are dispensed with.

Recommendations:

- Clarify commissioning arrangements as a matter of priority. If current arrangements with Brighton and Hove are continued, an adjustment will be needed to ensure administrative costs to allow more regular monitoring and evaluation.
- Develop strong links with PECs and PBC to ensure engagement with primary care.
- There is need for more awareness and training to encourage general practice to offer more HIV testing.

We identified several issues relating to the **chlamydia screening** programme and therefore make the following recommendations:

- Engage with more enthusiastic / supportive venues / services in the start-up period of the local programme (leaving the more difficult ones until later)
- Concentrate on high-volume testing venues as opposed to many small-volume venues as this is labour intensive for the chlamydia staff.
- Ensure the core requirements of the screening programme are met in full.
- Better use of the skills and abilities of the A&C team could be made in this programme – looking at administration hub for the programme as well as adapting A&C staff roles into 'results-clerk' roles.
- We strongly recommend that the role of chlamydia coordinator is carefully recruited to as this is a pivotal role and the holder must have the ability to liaise and champion screening at PCT and SHA level. Where a coordinator role is weak, screening will be affected.

11. SAFETY

Some Eastbourne clinical rooms were noted to have seating arranged that would put service users between staff and exits. For staff safety there should be no barriers for staff to exit. While all Eastbourne rooms have panic buttons, one room was observed to have a number of leaflets blocking access to it.

12. HIGH RISK GROUPS

In addition to the issues raised under the profiles of need for each higher risk group presented earlier, the following specific PCT addressable recommendations arose from this needs assessment.

12.1 Asylum seekers and failed asylum seekers

The SH clinics ought to have access to Language Line as both practitioners and service users reported difficulties with translation and interpretation and because it is not acceptable for service users to rely on family members or family for these services.

Links should continue to receive investment from the PCT because it plays a critical role in linking asylum seekers and failed asylum seekers to healthcare. The established service at Links has created opportunities for failed asylum seekers to access treatment that would otherwise be impossible.

Make sure the asylum seekers know that they are entitled to sexual health care yet also that it is not a compulsory screening.

12.2 Men who have sex with men

Outreach services need to be increased dramatically as there are relatively few points of contact and the existing services are not running consistently.

Outreach needs to be creative as the safe sex message appears to be tired and not addressing the real barriers to condom use.

The face-to-face counselling on sex, relationships and MSM issues could be expanded to include some more intensive work looking at 'life skills' (negotiating sex, self-efficacy etc), which may be a powerful complement to the safe sex message.

Networks need to be developed proactively and involve all representative groups such as the Hastings Rainbow Alliance and Eastbourne Rainbow Network

SRE needs to incorporate a systematic focus on sexuality that is meaningful and useful to the young people. Reliance on videos is better than teachers if the teachers are too embarrassed to deliver it, but outside agencies should also be brought in to provide meaningful and memorable sessions.

12.3 Sex workers

Better intelligence of the local sex working community is needed to gauge the need for services.

Outreach services from Avenue House may not be required on a regular fortnightly basis but should not be dropped altogether. The good working relationships developed with the establishments should not be allowed to drift and will need to be regularly re-established given the transience of the workforce.

The Ore Clinic should also consider making links with the known establishments in Hastings to raise the profile of the SH clinic.

More intensive one-on-one work needs to be done with the sex workers surrounding concurrent relationships and issues of infidelity.

A profile of male sex workers needs to be developed and contacted proactively.

Links with the homeless services and substance misuse need to be developed to address issues of opportunistic transactional sex.

12.4 Substance misuse

SH promotion in prison needs to be reinvigorated – links with the prison have 'died down' but this represents a critical missed opportunity for intense work on sexual health.

The health section of the triage could be expanded to include specific prompts around sexual health. The question on sex work is commonly skipped by drugs nurses and needs to be reworded to reflect the more fluid nature of transactional sex.

Condoms could be provided to substance misuse services from the PCT and the availability of free condoms publicised to this group.

Training should be provided to substance misuse nurses surrounding sexual health and in particular around pregnancy testing and chlamydia screening. The drugs services can build on the good relationships they have with clients and provide a good route to getting quite marginalised people involved in sexual health.

Outreach sessions from the SH clinics in the needle exchanges and drugs services have not been accessed by very many users. They need to be offered regularly and consistently in order to reach the users, as they do not currently remember which day of which week the nurse will be there. However, given the chaotic nature of the lives of the users the satellite service of the SH clinic appears to be valuable in accessing a very hard to reach group.

12.5 Young people

Some services seemed unaware of the specific needs of young people. A rolling programme of You're Welcome Criteria Training, Child Protection Issues and Fraser Competency Training should be developed and offered across services.

While general practitioners are required to have CRB checks it is only recommended that other staff have CRB. The PCT should require all staff in contact with young people and vulnerable adults to have CRB checks and should also insist on the same via SLAs with pharmacists, youth workers and the voluntary sector.

EHC provision via pharmacists, although not solely an issue for young people, was found to be problematic and not as consistent or widely available service as service mapping indicates. The PCT needs to ensure that a designated pharmacist is available to prescribe EHC at weekends in both the Hastings and Eastbourne urban hubs to enable easy access by young people via public transport.

A concerted effort to promote the existing services for young people, such as the C-card scheme, is needed as levels of awareness are patchy.

Whilst recognising the need for us all to improve communication about SRE to partners, we should continue the highly regarded work of the East Sussex School Improvement Service. Current good practice should be shared; schools and practices causing concern are targeted and all schools work towards embedding high quality SRE, supported by partner agencies and in line with the new national changes to the curriculum and well-being agenda.

[1] ESD&W Website: http://www.eastsussexdownswealdpct.nhs.uk/images/map.gif

[2] The A8 countries are the newest EU member countries: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.

[3] National Office of Statistics, 2006
[4] National Office of Statistics, 2005
[5] PCT Report, January 2007
[6] Data collected by the Health Protection Agency and the Association of Public Health Observatories
[7] Measured as crude rate/1000 female pop aged 15-17, 2002-2004
[8] National Office of Statistics, mid-2006 estimates
[9] KC60 Returns
[10] Choosing Health in the South East: Sexual Health
[11] National and regional statistics published by the HPA, also from KC60 returns
[12] SOPHID Data
[13] HIV data taken from SOPHID, population statistics from National Office of Statistics 2001 Census. Data is not available broken down by ethnicity and gender, so an estimation was made based on the total population gender breakdown (47% male, 53% female). Additionally, due to lack of available data, we used 2006 numbers of HIV positive people with 2001 census data to calculate the most appropriate rate, as the population will not have increased nearly as much as rates of HIV infection.
[14] SOPHID Data
[15] SOPHID Data
[16] SOPHID Data
[17] Data collected by the Health Protection Agency and the Association of Public Health Observatories
[18] Report provided by the PCT.
[19] Sigma Research (2006) Country and regional data reports from vital statistics. Gay Men's Sex Survey 2006. Accessed from http://www.sigmaresearch.org.uk/go.php/local/gay/local06