Public Health England

Protecting and improving the nation's health

Health promotion for sexual and reproductive health and HIV

Strategic action plan, 2016 to 2019

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

This strategic action plan sets out Public Health England's (PHE) approach to improving the public's sexual and reproductive health and reversing the HIV epidemic.

PHE will use its expertise to enhance data and surveillance; to build on the evidence base for commissioning effective interventions; and to lead and support our local, regional and national partners in the implementation of evidence-based public health interventions across the system.

PHE has developed this plan within the parameters of two frameworks. The Department of Health's 2013 publication, *A Framework for Sexual Health Improvement in England,* provides the national strategic approach to sexual health improvement and the *Public Health Outcomes Framework* provides the key set of indicators against which progress is tracked.

PHE is committed to working with its partners to ensure that the right actions are carried out for the right people, in the right place, at the right time. PHE will tailor its approach to address the needs of:

- key population groups – targeting interventions towards those who are at risk of, or are particularly adversely affected by, poor sexual and reproductive health and HIV
- key geographical areas – delivering appropriate and specific interventions and support to areas with poor sexual and reproductive health and with high levels of HIV infection
- key life stages – focusing preventative interventions on critical periods of risk in people's lives

PHE will use its strengths in data, scientific evidence, evaluation and community engagement to undertake activity that will achieve the following in England:

1) Reduce the burden of HIV infection by decreasing HIV incidence in the populations most at risk of new infection and reducing rates of late and undiagnosed HIV in the most affected communities. PHE will:
    - support and facilitate national and local partners to deliver increases in HIV testing in areas of high prevalence (>2:1000) and among populations at heightened risk of HIV
    - facilitate the development and implementation of innovative technologies and interventions for HIV prevention
    - monitor performance through surveillance and reporting of new HIV diagnoses, CD4 count at the time of HIV diagnosis, HIV testing rates, and condom use

2) Reverse the rapid increase in sexually transmitted infections (STIs) in populations most at risk of infection. PHE will:

- support national and local partners to carry out primary prevention activities and ensure easier access to appropriate STI testing, for example via the National Chlamydia Screening Programme
- monitor and respond to the emergence of gonococcal antimicrobial resistance

PHE will achieve both aims of reducing HIV and STIs by supporting programmatic approaches to promoting safer sexual behaviours and risk reduction strategies, including consistent condom use.

3) Minimise the proportion of pregnancies that are unplanned. PHE will:

- ensure that women of all ages are able to access information about their available choices for contraception, together with the evidence for effectiveness
- support commissioners and providers of contraceptive services through the provision of relevant data and intelligence on the use of reproductive health services

4) Reduce the rates of under 18 and under 16 conceptions as well as narrow the variation in rates across the country. PHE will:

- provide improved data to local authorities
- promote evidence and effective practice to reduce teenage pregnancy and improve the public health outcomes for the school age population, and
- ensure that young people have access to accurate information on sexual and reproductive health

The health promotion actions described in this document are an integral part of PHE's wider sexual and reproductive health and HIV work programme, and relate closely to other PHE activities, for example those addressing children and adolescents, mental health, and drugs and alcohol.

PHE will use this action plan to work towards integrating these related work programmes in order to address the wider determinants of good sexual and reproductive health and HIV prevention.

1. Purpose and scope

PHE has set short to medium-term priorities for improving sexual and reproductive health and preventing HIV. These health promotion priorities form part of PHE's overall sexual and reproductive health and HIV work programme.

This action plan will help PHE to deliver these activities effectively and develop its business case for investment both nationally and locally. It complements the Department of Health (DH) *Framework for Sexual Health Improvement in England*[1] and describes how PHE will work towards the outcomes identified within the DH framework and the Public Health Outcomes Framework.

PHE's work on drugs and alcohol, children and young people, and mental health all closely relate to, and support, the sexual and reproductive health and HIV priorities outlined here. The organisation's activities in community engagement, behavioural insight and social marketing should also enhance the sexual and reproductive health and HIV work programme.

In this document, we focus on how PHE's strengths in data, scientific expertise, and evaluation can be developed to advance the evidence base for health promotion in sexual and reproductive health and HIV prevention. We describe how PHE can best support local partners to carry out effective health promotion interventions.

PHE will aim to ensure that:

- the evidence base for sexual and reproductive health promotion and HIV prevention is strengthened
- interventions across the system are evidence based and cost effective
- the impact of interventions on health behaviours and health outcomes are evaluated
- good practice and innovations are identified and shared
- interventions are appropriately targeted at the populations most at risk

A PHE working group developed this action plan. It incorporates feedback from across PHE directorates and from external stakeholders.

2. Background

Introduction

WHO has defined sexual health as "…a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity".[2] Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health".[3] This includes primary prevention initiatives aimed at individual behaviour, as well as a wide range of social and environmental interventions.

The past decade has seen great improvements in the quality and scope of sexual and reproductive health promotion and HIV prevention. However, sustaining and expanding interventions to address sexual and reproductive health and HIV outcomes must remain a priority, because:

- poor sexual and reproductive health and ongoing transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing, and result in significant costs for health service and local authority budgets
- sexual relationships, although an intensely private matter, are a major component of the wellbeing of the whole adult population and of wider society
- there is a strong association between poor sexual and reproductive health and other risk behaviours, and by seeking to improve sexual and reproductive health and HIV outcomes, these other determinants of health may also be identified and addressed
- sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities, and improving sexual and reproductive health and HIV outcomes will address these major health inequalities

Our partners

NHS England's *Five Year Forward View* states that "the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies".[4] Increased investment in prevention is needed to reduce future costs associated with poor health and wellbeing.

National policy goals in sexual and reproductive health and HIV will only be achieved by PHE supporting local authorities, clinical commissioning groups and other organisations with public health responsibilities to improve the sexual and reproductive health of their population, as measured by primary PHOF indicators. PHE provides advice and evidence to support action on local health needs.

Strategic context

In *A Framework for Sexual Health Improvement in England,* DH sets out steps towards achieving a reduction in sexual health inequalities, building an open and honest culture around sex and relationships, and recognising that sexual ill health can affect all ages and parts of society. Four priorities for sexual health improvement are identified in the framework. These are to reduce rates of:

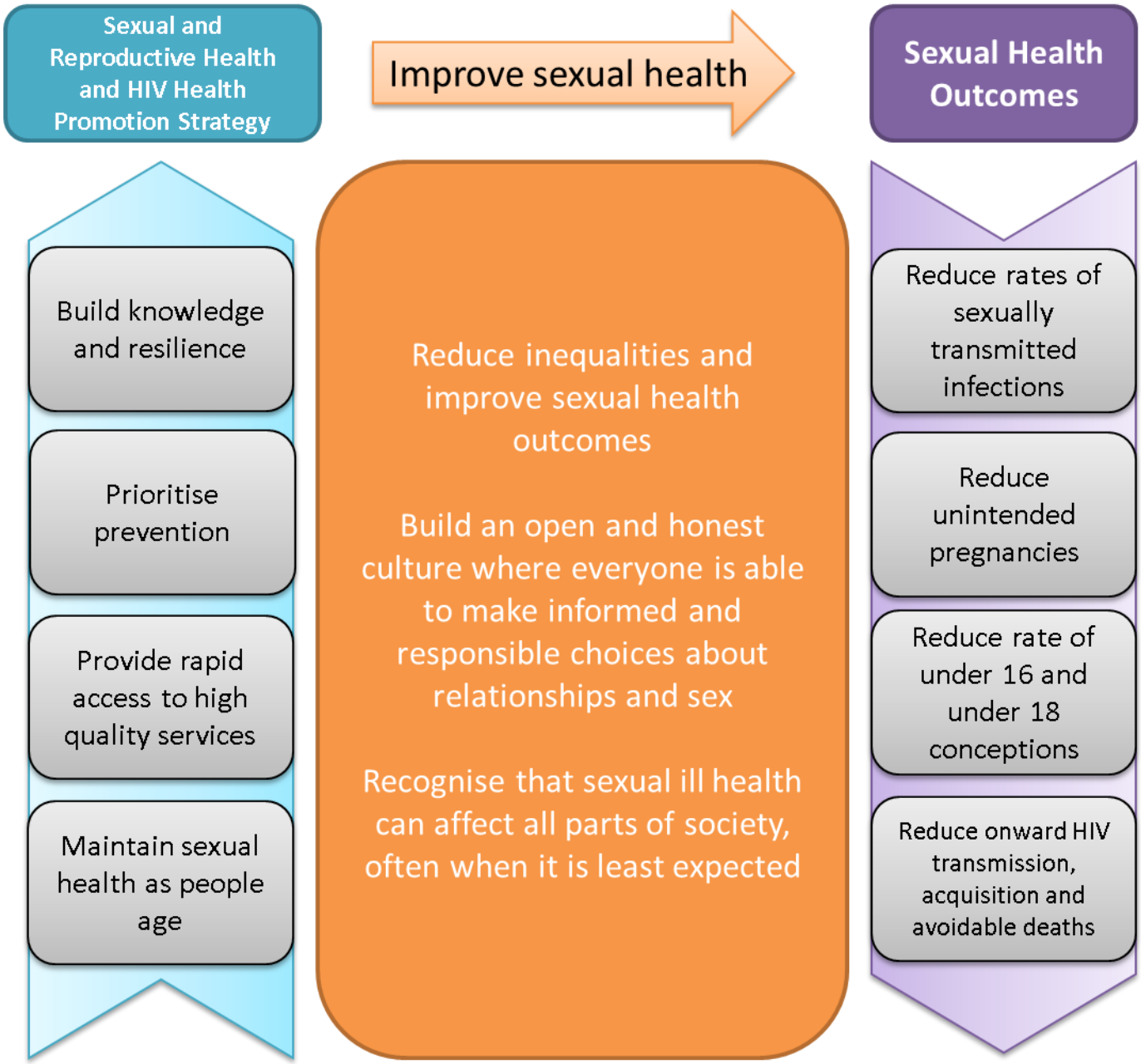
- onward HIV transmission, acquisition and avoidable deaths
- sexually transmitted infections (STIs)
- unplanned pregnancies
- teenage conceptions (under 16 and under 18)

The Public Health Outcome Framework (PHOF) focuses on opportunities to improve and protect health across the life course and reduce inequalities in health.[5] The following sexual health indicators are included under the Health Protection and Health Improvement domains:

- people presenting for HIV at a late stage of infection
- under 18 conceptions
- chlamydia diagnoses among 15–24 year olds

The following diagram (Figure 1) describes how the priorities in the Framework for Sexual Health Improvement underpin PHE's strategic action plan for sexual and reproductive health and HIV.

Figure 1. Key objectives to be addressed through the strategic action plan



PHE is focusing on these key sexual health priorities, while recognising that many social, criminal and public health issues also have serious impacts on sexual and reproductive health. Issues that should be considered when developing health promotion interventions include:

- women who suffer domestic abuse and sexual assault. The Home Office's *Action Plan For Ending Violence Against Women and Girls in the UK* includes actions specifically to address female genital mutilation[6]
- sexual exploitation of children. The Department for Education's *Action Plan for Tackling Child Sexual Exploitation* sets out actions to address sexual exploitation[7]
- alcohol and drug use are associated with the sexual risk-taking behaviour. Reducing harmful drinking is a PHE priority and a resource of local interventions to reduce harmful drinking is available from PHE's Alcohol Learning Centre[8]

People's sexual health needs, risks and challenges vary with age, and health promotion activities should support people as they pass through different stages of life. Our emphasis on education and early prevention should achieve the greatest improvements in sexual health and reductions in health inequalities.

We consider the individual's total health and wellbeing needs, and consider how we can best prevent disease and promote good sexual health at different stages of life. Delivering a universal entitlement to high quality personal, social, health and economic education (PSHE) and sex and relationships education (SRE) will help to ensure that all children and young people acquire age-appropriate knowledge, understanding and skills. Some elements of SRE, such as HIV and STIs, are a compulsory part of National Curriculum science at Key Stage 4 (from September 2016), but this does not have to be adhered to by academies and free schools.

Good sexual and reproductive health is important for everyone, but sexual ill health affects some population groups more than others. This means that many sexual health promotion activities need to achieve universal coverage (for example information on sexual and reproductive health), while others need to reach key populations with highest risk of adverse sexual health outcomes (for example HIV tests for men who have sex with men [MSM]). The balance between providing universal and targeted interventions will vary across the country, to reflect the different sexual health needs of local populations.

Universal approaches need to be promoted together with targeted interventions aimed at key populations. Local needs assessment should be performed to identify the needs of the different local communities, to inform local sexual and reproductive health promotion activities.

3. Supporting the local system

Sexual and reproductive health promotion and HIV prevention is provided within a complex system. PHE support is important to ensure evidence-based and high quality commissioning across the system; from planning a pregnancy and giving a child the best start in life, to providing information and access to sexual and reproductive health services in later life.

PHE supports the local sexual health system through a network of sexual health facilitators based at PHE Centres and other public health experts. They help in the commissioning process by providing data and evidence to improve local services.

In addition to its support for local teams, PHE has an important national role in surveillance and research; scientific expertise; social marketing; and providing and developing resources to support local and national activities. It is vital that activities at the national and local level are co-ordinated and coherent, share the same objectives and work synergistically.

4. Groups at risk

Certain population groups are particularly affected by poor sexual and reproductive health. Interventions targeting specific communities should be developed to ensure that they do not exacerbate feelings of isolation, discrimination or stigma.

Young people

Many adverse sexual health outcomes occur in young people, regardless of their sexuality. All young people need to have the knowledge and ability to seek help and guidance. Activities should promote and enable access to appropriate contraception, screening for STIs (especially chlamydia via the National Chlamydia Screening Programme) and condom use.

These activities should work in synergy with activities such as those aimed at building resilience as well as those targeting associated risk behaviours such as drug and alcohol use. The highest rates of STIs diagnoses are among young women, who may also experience adverse outcomes associated with teenage pregnancy.

Men who have sex with men

Gay, bisexual and other men who have sex with men (MSM) experience a disproportionately high burden of STIs and HIV. Health promotion activities targeting MSM should aim to prevent the transmission of STIs and HIV by encouraging condom use, promoting safer sex and regular testing and screening, as well as supporting measures to control outbreaks of STIs. A whole system approach is needed to combat stigma and discrimination and address other inequalities for MSM identified as being associated with sexual ill health (including mental wellbeing and alcohol and drug use). PHE's MSM action plan 2015–16 uses a whole system approach to promoting health and wellbeing, including mental health.[9]

Black and minority ethnic populations

Black African and black Caribbean communities are disproportionately affected by HIV and STIs in different ways. Activities that promote condom use and address stigma and discrimination should be supported in both communities, but the primary focus of health promotion activities should differ. The priority should be to increase HIV testing among black African communities, and to promote condom use and reduce sexual risk behaviours among black Caribbean communities. HIV prevalence is highest among black African women, and rates of late diagnosis are highest among black African men.

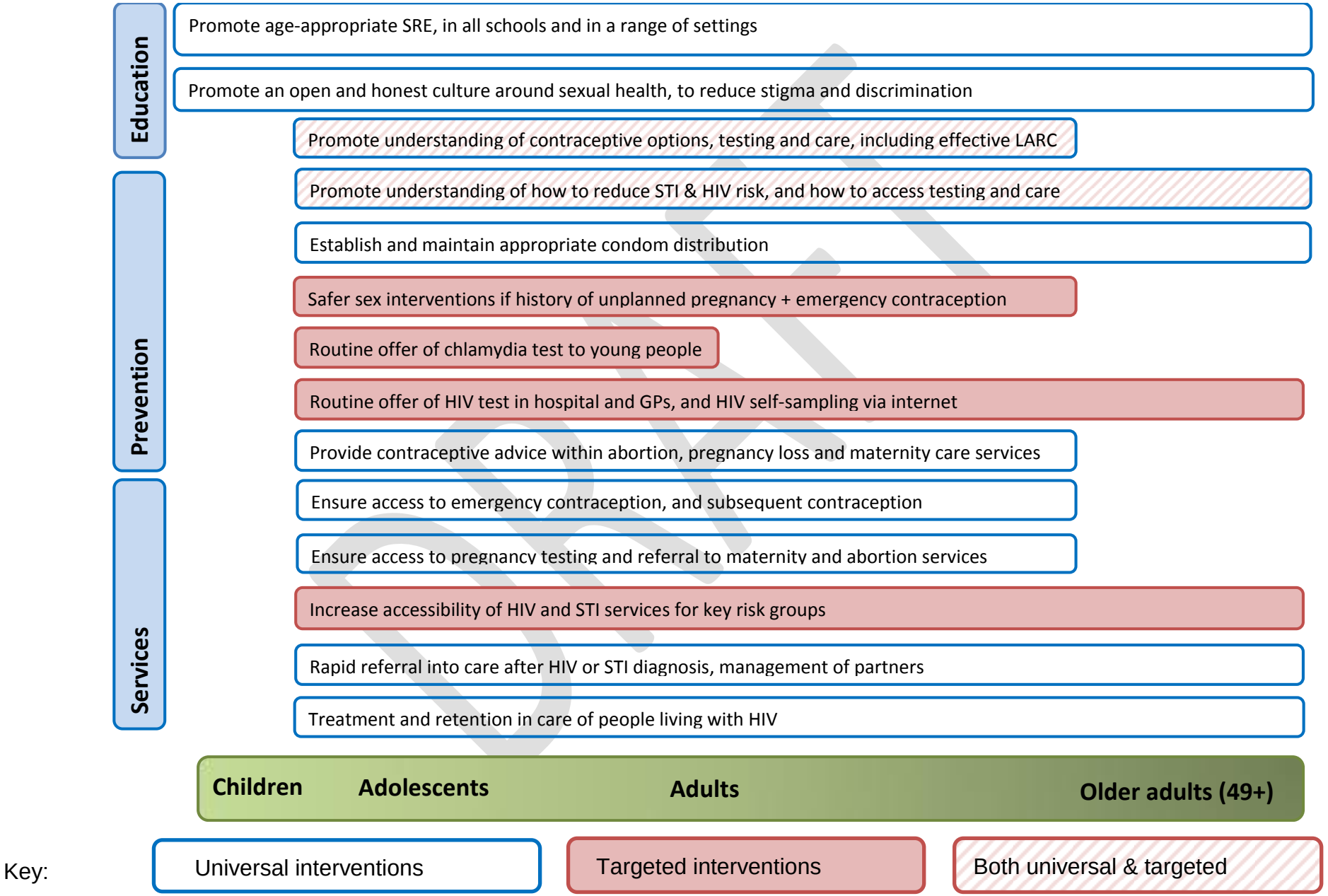
The sexual and reproductive health needs of people arriving from other countries should also be addressed nationally and locally. These communities may not share the sexual and reproductive health needs of their country of origin, due to the differential characteristics of those most likely to migrate.

Women of reproductive age

Although women aged 15 to 44 make up just 20% of the population of England, they experience the greatest burden of poor reproductive health. This includes unplanned pregnancy, which is associated with poor maternal and child outcomes. All women of reproductive age should have universal access to services offering the full range of contraceptive options, as well as information on the effectiveness of different methods. In addition to this universal approach, there should be targeted support for those at greatest risk of unplanned pregnancy, such as women from black and minority ethnic groups, women who have had two or more children, those aged less than 20 and those with lower educational attainment.

Figure 2 describes the key universal and targeted health promotion approaches for sexual and reproductive health across different life stages, and across a range of services.

Figure 2. Key targeted and universal health promotion approaches



5. Health promotion priorities

This section sets out PHE's aims, based on the four priorities identified by DH in *A Framework for Sexual Health Improvement in England*. For each priority we set out:

- a needs assessment to outline the burden of ill health, costs incurred, at-risk groups and strategic context
- the actions PHE will undertake to address these priorities

PHE will use its strengths in data, scientific evidence, evaluation and community engagement to undertake activity that will:

1) Reduce the burden of HIV infection by decreasing HIV incidence in the populations most at risk of new infection and reducing rates of late and undiagnosed HIV in the most affected communities. PHE will:

    - support and facilitate national and local partners to deliver increases in HIV testing in areas of high prevalence (>2:1000) and among populations at heightened risk of HIV
    - facilitate the development and implementation of innovative technologies and interventions for HIV prevention
    - monitor performance through surveillance and reporting of new HIV diagnoses, CD4 count at the time of HIV diagnosis, HIV testing rates, and condom use

2) Reverse the rapid increase in STIs in populations most at risk of infection. PHE will:

    - support national and local partners to carry out primary prevention activities and ensure easier access to appropriate STI testing (for example via the National Chlamydia Screening Programme)
    - monitor and respond to the emergence of gonococcal antimicrobial resistance

PHE will achieve both aims of reducing HIV and STIs by supporting programmatic approaches to promoting safer sexual behaviours and risk reduction strategies, including consistent condom use.

3) Minimise the proportion of pregnancies that are unplanned. PHE will:

    - ensure that women of all ages are able to access information about their available choices for contraception, together with the evidence for effectiveness

- support commissioners and providers of contraceptive services through the provision of relevant data and intelligence on the use of reproductive health services

4) Reduce the rate of under 18 and under 16 conceptions as well as narrow the variation in rates across the country. PHE will:

- provide improved data to local authorities
- promote evidence and effective practice to reduce teenage pregnancy and improve the public health outcomes for the school age population
- ensure that young people have access to accurate information on sexual and reproductive health

5.1 Reduce onward HIV transmission, acquisition and avoidable deaths

Burden of ill health

In 2014, 6,151 people were newly diagnosed with HIV infection in the UK and 85,489 people were living with HIV accessed care, a 5% increase over the previous year.[10] An estimated 103,700 people were living with HIV, of whom 17% (18,100) were unaware of their infection and at risk of unknowingly passing on HIV if having sex without a condom.[11]

People living with HIV who are diagnosed late have a tenfold increased risk of death in the year following diagnosis compared to those diagnosed promptly. In 2014, 40% of new diagnoses were made late (CD4<350 cells/mm^3), a decline from 56% in 2005; 613 people with HIV infection were reported to have died in 2014, most of whom were diagnosed late.[10]

Costs incurred

An estimated £630m was spent in 2012/13 on HIV treatment and care.[12] This represents 49% of the NHS's expenditure on infectious diseases, and an average annual spend of £13,900 for each person accessing HIV services.

Each new case of HIV infection is estimated to incur between £280,000 and £360,000 in lifetime treatment costs. If the estimated 4,000 UK-acquired infections diagnosed in 2011 had been prevented, £1.9 billion in lifetime treatment and clinical care costs would have been saved.[13]

Those diagnosed late incur twice the direct medical costs for HIV care in the first year after diagnosis compared with those diagnosed early.[14] This is largely due to increased inpatient hospital care costs, which are 15 times higher for those diagnosed late. Subsequent HIV care costs, for those diagnosed late, remain 50% higher in the years following diagnosis due to increased rates of hospital admission and increased costs of providing treatment.[15]

Who is at risk?

Most HIV transmission and acquisition in the UK occurs through sexual contact (both between people of the same and opposite sex). The number of infections acquired through other routes of transmission (such as injecting drug use, nosocomial infection and mother-to-child-transmission) are comparatively small.

Several population groups are at particular risk of HIV infection:

- MSM continue to be the group most affected by HIV infection: they made up 45% (38,432) of people accessing HIV care in the UK in 2014.[10] MSM have the highest number of new infections diagnosed annually (3,360 in 2014), nearly a third of whom (29%) were diagnosed late
- black African heterosexual men and women make up the second largest group of people living with HIV: they made up 60% (24,590) of heterosexuals accessing care in 2014.[10] Late diagnosis is particularly high in this group, with 58% of new diagnoses being made late. Over half (59%) of heterosexuals newly diagnosed in 2014 were likely to have acquired their infection in the UK
- people who inject drugs represent a very small proportion of people living with HIV, with the prevalence in this group remaining below 1–2% since the start of the epidemic[16]

Strategic context

A combination approach to HIV prevention is likely to be most effective. This should include biomedical, behavioural and social/structural components, and combine interventions such as condom promotion, behaviour change and increased HIV testing.[17] HIV testing, especially in populations most at risk, is a central component of the current HIV prevention strategy.[18]

This has two main benefits: an improved prognosis among individuals who are diagnosed promptly; and reduced transmission from those who are aware of their HIV status due to reductions in risk behaviour and lower viral load while on treatment (an effect known as treatment as prevention). The reduction in the proportion of individuals diagnosed with HIV at a late stage of infection is a major PHOF indicator in the Health Protection domain. [5]

Modelling has shown that increasing levels of HIV testing among MSM can drastically reduce HIV incidence, assuming that levels of condomless sex do not increase.[19] It is vital to promote condom use as a risk reduction measure.

National HIV testing guidelines recommend the routine offer of an HIV test to general medical admissions and to adults registering in general practice in areas where diagnosed HIV prevalence is greater than two per thousand among 15–59 year olds.[20] Access to an HIV test has been facilitated by removing the need for pre-test counselling, introducing testing in medical services, widespread introduction of self-sampling for HIV and legalising the sale of self-test kits.[21]

Partner notification has also been shown to be effective in diagnosing HIV, and should be implemented in line with best practice.[22]

Interim results from the PROUD[23] and IPERGAY[24] studies clearly demonstrate the effectiveness of pre-exposure prophylaxis in preventing HIV acquisition among at-risk MSM, in combination with condom use. The NHS Clinical Reference Group is reviewing the scope and nature of delivery to key populations.

PHE's MSM action plan 2015-16 highlights the importance of not considering sexual health in isolation, but as an area of health that influences and is influenced by other areas, including mental health, alcohol and drug use. One of its objectives is to reduce the proportion of MSM reporting use of harmful illicit substances, including reduction in the proportion reporting 'chemsex' or steroid abuse.

The prompt implementation of a wide network of needle exchange services has contributed to the prevention and control of the HIV epidemic among people who inject drugs.[25]

HIV prevention is a rapidly changing field, with recent advances in testing, treatment as prevention, and pre-exposure prophylaxis. All of these changes, together with evolving sexual risk behaviours will affect the epidemiology of the infection and the future development of this strategic action plan.

PHE actions to reduce HIV transmission, acquisition and avoidable deaths

Data and surveillance

PHE will:

- continue to publish local data to help local government and other organisations understand patterns of HIV diagnoses within communities and persons accessing care. This will include:
    - monitoring late diagnosis of HIV infection
    - monitoring HIV testing uptake at sexual health clinics to improve access
- develop monitoring of HIV testing in other healthcare and non-healthcare settings
- evaluate the delivery and impact of health promotion campaigns and interventions to reduce sexual risk behaviour and increase HIV testing

Evidence

PHE will:

- establish a framework to evaluate the effectiveness of local and national HIV prevention aimed at the most at-risk groups (MSM and black Africans)
- develop and disseminate the evidence base and learning from community development programmes targeted at reducing HIV risk among MSM and black Africans
- develop an action plan for monitoring sexualised drug use among MSM
- review and promote HIV testing in line with NICE guidelines

Public health interventions and implementation

PHE will:

- support local government to maximise the potential of evidence-based prevention interventions to reduce sexual risk including access to condoms
- evaluate recalling high-risk MSM for an HIV test using self-sampling
- establish and evaluate a new national HIV self-sampling service
- provide and support community and social media based sexual health promotion programmes to target HIV prevention at the most at-risk groups, including encouraging routine and regular HIV and STI testing among MSM and Black Africans
- work through PHE sexual health teams with local authorities and the NHS to increase the coverage and frequency of HIV and STI testing among MSM and black Africans in a range of settings, using commissioning guidance and tools

5.2 Reduce rates of sexually transmitted infections

Burden of ill health

If not successfully treated, STIs can lead to a number of sequelae such as pelvic inflammatory disease, ectopic pregnancy, infertility and cervical cancer. Some STIs, most notably gonorrhoea, have demonstrated increasing levels of resistance to antibiotic treatment.[26]

In 2014, approximately 440,000 diagnoses of STIs were made in England.[27] The most commonly diagnosed STI was chlamydia (206,774 diagnoses), followed by genital warts (70,612), gonorrhoea (34,958) and genital herpes (31,777). Numbers of STI diagnoses decreased by 0.3% when compared to 2013 overall, however, there was a 19% increase in diagnoses of gonorrhoea and a 33% increase in diagnoses of infectious syphilis. Over the past decade, diagnoses of gonorrhoea, syphilis, genital warts and genital herpes have increased considerably, most notably among men.

Costs incurred

In 2014/15 local authorities committed to spend £671m annually on sexual and reproductive health services.[28] Of this, £383.5m was to be spent on STI testing and treatment and £103.5m on advice, prevention and promotion. Together these costs accounted for nearly a quarter (24%) of their annual public health grant.

Who is at risk?

Several population groups are at particular risk of STIs:[27]

- young people: the majority of STI diagnoses made among heterosexual GUM attendees in 2014 were among those aged 15 to 24, who accounted for 63% (57,558/91,901) of chlamydia diagnoses, 55% (8,722/15,814) of gonorrhoea, and 42% (12,223/29,240) of genital herpes
- MSM: the majority of syphilis and gonorrhoea diagnoses among male GUM clinic attendees are among MSM (86% and 68% respectively in 2014). In 2014, rapid increases in rates of STI diagnoses were reported, in particular syphilis (46% increase from 2013) and gonorrhoea (32% increase). An increasing proportion of STIs are diagnosed among MSM living with HIV, who have four times the population rate of acute bacterial STIs compared with MSM who are HIV negative or undiagnosed.[29] This may reflect increasing adoption of HIV seroadaptive behaviours in this population as well as changes in diagnostic and screening practices. There is growing concern that an increase in sexual risk behaviour due to sexualised drug

use and social networking apps for finding casual partners may lead to increased transmission of STIs
- the highest rates of STIs among adults are seen among people of black African and black Caribbean ethnicity, and the majority of these cases are among persons living in areas of high deprivation. These high rate of STI diagnoses are most likely due to a combination of cultural, economic and behavioural factors

Strategic context

Local authorities are mandated to commission comprehensive sexual health services at a local level, including the provision of information, advice and support on STIs. Sexual health services are confidential and open access; referral from a GP or other health care professional is not required. Consultation, diagnostic tests and prescribed STI treatment are free of charge for the user, regardless of residency status or age.

Central to preventing onward transmission of STIs is early diagnosis through increased testing (for example, partner notification) and screening (for example, the National Chlamydia Screening Programme) as well as the promotion of safer sex, especially condom use.

The national vaccination programme for human papillomavirus (HPV) offers all 12–13 year old girls a vaccine that protects against the most common strains that cause cervical cancer.

PHE actions to reduce rates of sexually transmitted infections

Data and surveillance

PHE will:

- continue to develop sexual health data outputs at local level, guided by stakeholder needs
- continue to monitor rates of STIs, and identify outbreaks and epidemics
- provide timely data to monitor the emergence of resistance and decreased sensitivity to antimicrobials used to treat gonorrhoea and monitor treatment failures
- enhance intelligence on the prevalence of alcohol and drug use (including 'chemsex' drugs) among MSM to support local areas in assessing need
- establish a surveillance system for HPV among women undergoing cervical screening

Evidence

PHE will:

- evaluate the effectiveness of chlamydia screening, including its impact on prevalence, PID and ectopic pregnancy rates
- increase the understanding and the knowledge base of the behaviours, attitudes, and factors that influence the risk of STI acquisition and transmission, and barriers to risk reduction strategies, in the black Caribbean community and MSM
- develop a framework to evaluate the effectiveness of local and national STI prevention aimed at the most at-risk groups (MSM and black Caribbean)
- develop and disseminate the evidence base and learning from community development programmes targeted at reducing STI risk among MSM and black Caribbean groups
- use our extensive surveillance data to maximise understanding of the epidemiology and risk factors associated with emerging STI epidemics, and thereby identify priorities for interventions

Public health interventions and implementation

PHE will:

- support the commissioning of condom delivery, open access sexual health services and STI screening, focusing on groups at highest risk
- support national campaigns to promote condom use and behaviour change in communities most at risk of STIs
- work with local authorities to identify areas with low chlamydia screening positivity rates and develop action plans to address this
- make Sex Worth Talking About resources available to local authorities

5.3 Reduce unplanned pregnancies

Burden of ill health

Estimates of the proportion of pregnancies that are unplanned vary from nearly one in three (30%)[30] to one in six (16%) pregnancies.[31] In a national survey, among women aged 16–44 who self-reported their pregnancy as unplanned, the majority (57%) resulted in a termination, with only 6% being carried to full-term.[31] Unplanned pregnancies are associated with poorer pregnancy outcomes and increased risk of maternal mental health problems.[1]

Costs incurred

While abortions do not equate to unplanned pregnancy (not all abortions are for pregnancies that are unplanned, and not all unplanned pregnancies end in abortion), they represent the majority of the medical costs incurred from them. In 2010, unplanned pregnancies resulted in an estimated £193m of direct medical costs to the NHS, of which £143m were due to the costs of providing induced abortions.[32]

Unplanned pregnancy leading to maternity results in significant long-term social costs due to childcare, housing and education needs, reduced earning potential, and the impact on the criminal justice system and social care. Economic modelling estimates wider public sector costs of unintended pregnancy and STIs to be £27–57bn cumulatively between 2015 and 2020, based on current levels of access to contraceptive and STI services.[33]

Who is at risk?

Women aged 16–19 have the highest proportion of pregnancies that are unplanned (45%). However, most unplanned pregnancies (62%) take place among women aged 20–34, who have more pregnancies overall.[31] Unplanned pregnancy is more prevalent among women who have two or more children or no children, compared to those with one child. Factors strongly associated with unplanned pregnancy include first sexual intercourse before 16 years of age, current smoking or non-cannabis drug use and lower educational attainment.

Rates of abortion are highest among women aged 20–24 (51,000 in 2013, representing a crude rate of 31 per 1,000 women).[34] Among conceptions that take place within marriage, the age group with the highest proportion resulting in abortion are women aged 40 or over (22%), and the only age group with increasing rates of abortion are those over 35. This group may represent women who no longer consider themselves to be at risk of pregnancy, are more likely to terminate due to health risks, are less likely to use contraception, have poorer access to the most effective methods of contraception or may not be in a position to negotiate condom use in new relationships.

The proportion of women who had an abortion in 2013 who had previously had an abortion was higher among women of black ethnicity (49%) than women of Asian or white ethnicity (33% and 36%, respectively). This is likely to be due to a combination of underlying factors, including barriers to accessing services and obtaining information about contraceptive choices.

Strategic context

Local authorities are required to offer a broad range of contraception and advice on preventing unplanned pregnancy: all contraception supplied must be free to the patient.[35]

Commissioning standards produced by the Faculty of Sexual and Reproductive Health state that every individual should have access to contraception both from a GP and/or an alternative open-access specialist provider to whom GPs can refer.[36]

The National Institute for Health and Care Excellence (NICE) published clinical guidelines in 2005 (updated in 2013) on long-acting reversible contraception (LARC).[30] These recommend that women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception methods.

NHS England has announced details of a major review of the commissioning of NHS maternity services. The review will assess current maternity care provision and consider how services should be developed to meet the changing needs of women and babies.[37]

PHE actions to reduce unplanned pregnancy

Data and surveillance

PHE will:

- provide data on reproductive health indicators to support high-quality care across NHS, local authority and NHSE boundaries at local level

Evidence

PHE will:

- support high-quality, accessible information resources to empower people to manage their own reproductive health needs, and make informed contraceptive and care choices
- examine the benefits of using technology to improve services—for example, online appointment and prescribing systems, remote access delivery systems and prescribing kiosks—to improve patient pathways and reduce costs for routine management of reproductive health

Public health interventions and implementation

PHE will:

- help SRH and school nurse services to work across organisational and professional boundaries, breaking down barriers in how care is provided to deliver a high standard of individualised care at times and places accessible to the public
- provide leadership to manage a system of care, not organisations. These will be locally variable; we know from experience that no one size fits all
- build on previous work carried out to reduce under 18 conceptions, and apply this learning to services for all age groups
- ensure that high-quality information on contraceptive choices are widely communicated to both lay and professional audiences
- support local campaigns to promote contraceptive use, especially among young women at the beginning or the end of the family building cycle

5.4 Reduce rate of under 16 and under 18 conceptions

Burden of ill health

Teenagers have the highest rate of unplanned pregnancies, with teenage mothers, young fathers and their children experiencing disproportionately poor health, emotional wellbeing and economic outcomes. Teenage pregnancy, measured by the under 18 conception rate, is declining but remains among the highest in Europe (24.3 conceptions per thousand women aged 15–17) and progress varies between local areas.[38]

While becoming a parent is a positive choice for some young people, teenage parenthood is often associated with poor health and social outcomes for both the mother and child.

- babies born to teenage mothers have a 41% higher infant mortality rate than those born to older mothers.[39] Teenage pregnancies also lead to increased rates of low birth weight, pre-term birth and asphyxia, which are associated with long-term complications[40]
- young mothers are more likely to suffer postnatal depression and poor mental health for up to three years after the birth. They are less likely to complete their education and more likely to experience adult poverty; young fathers are twice as likely to be unemployed, even when accounting for levels of deprivation.[41] As a result, children born to teenage parents have a 63% increased risk of living in poverty[42]

Costs incurred

Teenage conceptions that lead to live births have a negative impact on the future employment and long-term earning potential of the mother and child, as well as being more likely to incur health and social care costs. It has been estimated that every £1 invested in contraception saves the NHS £11 in addition to significant, yet formally unquantified, welfare costs.[43]

Who is at risk?

Poverty, disengagement from school and poor academic progress are all associated with pregnancy before 18; however, the majority of conceptions to under 18s are to young women without specific risk factors.[44]

There is an association between alcohol-attributable hospital admission and teenage pregnancy, and evidence that alcohol consumption by young people increases the likelihood of sex at a young age, and sex without contraception or condoms.[45]

Strategic context

In *A Framework for Sexual Health Improvement in England,* DH sets out the ambition to continue to reduce the rate of under 16 and under 18 conceptions by ensuring that all young people receive appropriate information and education to enable them to make informed decisions, and have access to the full range of contraceptive methods and services.[1]

Effective prevention requires a universal approach, including high-quality SRE and easy access to contraception for all young people, with more intensive support for those at risk, combined with actions to increase resilience and aspiration.

NICE public health guidance on the prevention of STIs and under 18 conceptions (2007) incorporated an evidence review of intervention effectiveness[46] NICE also published guidance in 2014 on contraceptive services with a focus on young people up to the age of 25.[47]

Local authorities retain the lead role for advice, prevention and health promotion for tackling teenage pregnancy, including commissioning contraception services.[35]

The rate of conceptions per 1,000 females aged 15–17 is a PHOF indicator in the Health Improvement domain. Progress on teenage pregnancy will contribute to other PHOF indicators, including the infant mortality rate, and rates of adolescents not in education, employment or training.

Written evidence submitted by PHE to the Education Select Committee inquiry into PSHE and SRE in schools states that “PHE is of the view that there should be a universal requirement for schools to teach age appropriate PSHE and SRE and that the quality of this should be assessed by Ofsted alongside the core curriculum”.[48]

PHE actions to reduce the rate of under 16 and under 18 conceptions

Data and surveillance

PHE will:

- disseminate to local authorities, quarterly, annual and ward level data on under 18 conception rates
- integrate conception data into local authority Early Years, Child Health and Young People's Health Profiles
- provide data and intelligence to support leaders within education settings to identify and respond to the health and wellbeing needs of their local school-age population

Evidence

PHE will:

- build and disseminate the evidence of what works to improve public health outcomes, including sexual and reproductive health, for the school-age population
- define and promote a public health contribution to promoting resilience and life skills of children and young people to strengthen healthy relationships and sexual health
- promote training and capacity building of the wider school-age workforce to increase and improve delivery of SRE and PSHE

Public health interventions and implementation

PHE will:

- promote effective and innovative practice on SRE and PSHE, signposting tools and resources and contributing to building the capacity of educators as part of the wider public health workforce.
- develop the Rise Above campaign to help young people gain knowledge and emotional resilience around sexual health
- promote relevant NICE guidance and examples of effective local practice on universal and targeted interventions to improve young people's early access to reproductive and sexual health services
- provide up-to-date factsheets on reproductive and sexual health for use by non-specialist educators and practitioners to promote accurate and consistent information
- provide and promote a national source of accurate information on reproductive and sexual health for young people with an up-to-date database of local services
- identify government and NGO communication channels to young people, parents and practitioners and integrate information on reproductive and sexual health to increase knowledge, normalise discussion and promote an open and honest culture

6. Programme evaluation

This programme aims to provide effective interventions to improve sexual and reproductive health. PHE actions included in this programme will be evaluated to determine their effectiveness and to shape our future work. The interventions aim to:

- change sexual risk behaviours in key population groups
- increase HIV testing rates
- improve individuals' knowledge of sexual and reproductive health and services
- support local commissioners

A monitoring and evaluation framework will be developed that sets out what information will be collected to monitor the programme's activity, impact on knowledge and awareness, and on health and behaviour outcomes.

7. Conclusion

Poor sexual and reproductive health can affect anyone. People are affected in different ways, at different stages of their lives. Sexual and reproductive health promotion activities should aim to promote an open and honest culture around sexual health by enhancing knowledge and awareness, signposting appropriate services, providing appropriate clinical and non-clinical prevention services and combatting stigma and discrimination.

Health promotion activities commissioned at the national and local level should be co-ordinated and coherent, and have shared aims and objectives. To make a difference, PHE will need to ensure that its sexual and reproductive health promotion work develops closely with related topic areas such as children and young people, drugs, alcohol and mental health and with allied fields of expertise such as behavioural insight, social marketing and local public health leadership.

Through a programme of activities, PHE will aim to make a major contribution to improving sexual and reproductive health and HIV prevention in England. PHE will use its strength in scientific expertise, surveillance and data analysis, and local public health leadership to identify where interventions are needed, how they should be appropriately targeted, and to publish useable data, guidelines and other resources to support local activity.

Many of the work streams, for example, surveillance and epidemiology, are already well established and appreciated by our local partners. Other activities, such as evaluation of the effectiveness of health promotion activities and provision of contraceptive information, are still under development. In combination, all of them will assist our local teams in commissioning effective prevention services.

Through this strategic action plan, PHE aims to reduce health inequalities and achieve improvements in sexual and reproductive health and HIV prevention across the life course. Realising this will require effective implementation and evaluation, as well as collaboration with communities and partner organisations, PHE will publish regular updates about progress.

Appendix 1: List of abbreviations

DH	Department of Health
FPA	Family Planning Association
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
LARC	Long-acting reversible contraception
MSM	Men who have sex with men
Natsal	National Survey of Sexual Attitudes and Lifestyles
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
PHOF	Public Health Outcome Framework
PSHE	Personal, social, health and economic education
SRE	Sex and relationships education
SRHH	Sexual and reproductive health and HIV
STI	Sexually transmitted infection

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