



UK Health
Security
Agency

Spotlight on sexually transmitted infections in London

2020 data

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1. Summary

Sexually transmitted infections (STIs) remain an important public health problem in London. In 2020, the region continued to experience the highest rate of new STIs in England, more than double the rate seen in any other region.

More than 105,000 new STIs were diagnosed in London residents in 2020, representing a rate of 1,167 diagnoses per 100,000 population.

Of the 20 upper tier local authorities in England with the highest STI rates in 2020, 19 were in London. Rates ranged from a low of 442 new STI diagnoses per 100,000 population in Havering to 3,060 per 100,000 population in Lambeth.

After 2 years of increases, the number of new STIs diagnosed in London residents declined by 30% between 2019 and 2020. Reported numbers of the 5 major STIs declined: syphilis decreased by 8%, gonorrhoea by 15%, chlamydia by 33%, genital herpes by 41% and genital warts by 43%. However, despite this fall from 2019, the number of gonorrhoea and syphilis cases reported in 2020 were far higher than in 2016 (gonorrhoea increased by 72%, syphilis increased by 22%).

Access to sexual health services was impacted by the coronavirus (COVID-19) pandemic. STI testing (excluding chlamydia in under 25 year olds) fell markedly between 2019 and 2020, dropping by 25% in London, similar to the decrease seen in England (26% fall). There was a corresponding increase in the STI positivity reported in London, from 9.1% in 2019 to 9.6% in 2020.

UKHSA recommends that local areas should be working towards achieving a chlamydia detection rate of at least 2,300 per 100,000 among individuals aged 15 to 24 years. In 2020, the chlamydia diagnosis rate among London residents aged 15 to 24 years was 1,819 per 100,000 residents.

Men have higher rates of new STIs than women (1,511 and 804 per 100,000 residents respectively).

Gay, bisexual and other men who have sex with men (MSM) experience health inequalities related to STIs. They account for 43% of London residents diagnosed with a new STI (excluding chlamydia diagnoses reported via CTAD) and they represent 88% of those diagnosed with syphilis and 66% of those diagnosed with gonorrhoea (where gender and sexual orientation are known).

STIs also continue to disproportionately affect young people. London residents aged between 15 and 24 years accounted for 32% of all new STI diagnoses in 2020 with the highest rates seen in those aged 20 to 24 years. There has been a steep decline (82% decrease) between

2016 and 2020 in genital warts diagnosis rates in females aged 15 to 19 years. This follows the 2008 introduction for girls of vaccination against Human papillomavirus (HPV), the virus which causes genital warts.

Black Caribbeans also experience health inequalities related to STIs. Although only 11% of new STIs are in black Caribbeans, they have the highest rate: 2,760 per 100,000, which is 3 times the rate seen in the white ethnic group. The white ethnic group has the highest number of new STI diagnoses: over 50,200 (56%). Where country of birth was known, 56% of London residents diagnosed with a new STI in 2020 were UK-born (excluding chlamydia diagnoses reported via CTAD).

Shigella is a gut infection that causes diarrhoea and is caused by a bacteria found in faeces. Sex that may involve anal contact or contact with faeces is one way that the infection can spread. MSM are at increased risk. Although the number of Shigella infections among presumptive MSM declined during 2020, the number rebounded sharply in the latter half of 2021, with an estimated 412 infections among this group reported during 2021. Surveillance has also indicated a rise in cases of extremely antibiotic resistant *Shigella sonnei* infections in MSM.

Implications for prevention

During the COVID-19 pandemic in 2020, the UK government implemented national and regional lockdowns and social and physical distancing with a focus to stay at home. This led to a marked reduction across all regions in the capacity for sexual health services (SHS) to provide face-to-face consultations. With a reduction of face-to-face consultations, there was a rapid reconfiguration to increase access to STI testing online and via telephone consultations (1) leading to an increase of consultations of both types in 2020 (2).

The reduction in STI diagnoses between 2019 and 2020 is likely due to a combination of reduced testing due to SHS service disruption and changes in behaviour, but the large number of diagnoses in 2020 is clear evidence of sustained STI transmission. This is supported by evidence from community surveys which suggest that, although fewer people reported meeting new sex partners during 2020 compared to previous years, a substantial proportion still had an ongoing risk for STIs (for example, condomless sex with new or concurrent sex partners) during 2020 (2, 3, 4, 5, 6).

In 2020, sexual health screens (tests for chlamydia, gonorrhoea, syphilis, or HIV) decreased, contributing to a decrease in STI diagnoses in SHS and community-based settings in all regions, compared to 2019.

The impact of STIs remains greatest for young people, MSM and black ethnic minorities (2).

The high rates of STIs among young people aged 15 to 24 years are likely to be due to greater rates of partner change (7). While numbers remain high, the number of new STI diagnoses

among them fell in 2020, with considerable falls seen in first episodes of genital warts, first episodes of genital herpes and trichomoniasis. However, decreases in gonorrhoea and chlamydia were less pronounced. These decreases, especially in STIs usually diagnosed at face-to-face medical consultations, such as a first episode of genital warts or herpes, may partly be due to the reduction in these appointments during the pandemic. Chlamydia, gonorrhoea and infectious syphilis showed less of a fall as they can be diagnosed using self-sampling kits via internet testing. The larger fall in genital warts likely reflects the expected continuing decline in diagnoses since 2009 due to the National HPV Vaccination Programme that has achieved high coverage in girls and provided herd protection for heterosexual boys (2).

Implementation of Relationships Education in primary schools, as well as Relationships, Sex and Health Education (RSHE) in all secondary schools from September 2020 is expected to provide young people with the information and skills to look after their sexual health (8, 9, 10). An effective method to reduce the risk of acquiring STIs, condoms are distributed through a range of local services. Many areas in England continue to provide condom schemes which distribute condoms to young people (mostly under 20 years of age) through a variety of outlets (2, 11) and condoms are provided free from sexual health clinics for all ages.

Access to high quality factual information is essential for good sexual health and an on-line resource (12) and a telephone helpline (13) to provide advice on contraception, pregnancy and STIs continues to be funded. Additional guidance has been provided about seeking sexual and reproductive health advice during the COVID-19 pandemic (2, 14).

The early diagnosis and treatment of STIs is a key intervention for their prevention and control, and to reduce the harms of untreated infection. The National Chlamydia Screening Programme (NCSP) promotes screening for chlamydia, the most commonly diagnosed bacterial STI, in sexually active young women and other people with wombs or ovaries, on change of partner or annually. This reflects a change in focus in June 2021 to reducing the reproductive harm of untreated chlamydia infection. Chlamydia data within this report is up to December 2020, at a time when the NCSP provided opportunistic screening to all young people aged 15 to 24 years (15). Despite a decrease in chlamydia testing and diagnoses across all regions during 2020, chlamydia positivity remained stable, suggesting ongoing transmission among young people in 2020. There has been a long-term decline in the chlamydia detection rate among 15 to 24 year olds and notable variations by geographic area, often reflecting rates of testing. Given the large drops in national testing and the high positivity of women within sexual and reproductive health services, it is likely that some infected women and other people with wombs or ovaries remain undiagnosed. On a positive note, the increase of accessing chlamydia testing services on the internet in 2020 suggests that these services are acceptable to young people, although this may just reflect the disruption to service provisions during the pandemic (2).

In MSM, diagnoses of STIs decreased across all infections, reflecting a reduction in testing during 2020. Despite these decreases, diagnoses remained high for gonorrhoea, chlamydia

and infectious syphilis, with the highest rates in MSM living with HIV (2). This suggests that rapid STI transmission is occurring in dense sexual networks of MSM living with HIV. Condomless sex increases the risk of infection with STIs, hepatitis B and C.

The decrease in first episode genital herpes diagnoses among MSM may partly be explained by reduced face-to-face consultations, but also due to the implementation of the national roll out of the HPV vaccination in MSM aged up to 45 years attending specialist SHS and HIV clinics since April 2018.

As MSM continue to experience high rates of STIs they remain a priority for targeted STI prevention and health promotion work. There is a need to strengthen public health measures to reduce transmission of syphilis. National clinical guidelines recommend frequent testing in high-risk MSM (16), but surveillance data suggests this is not uniformly carried out. There are also concerns about poor knowledge and awareness of syphilis among MSM (2, 17). Therefore, published in June 2019, the Syphilis Action Plan has recommendations to address the continued increase in syphilis diagnoses in England (18). The plan is based upon action that optimises 4 prevention pillars:

1. increasing testing frequency of high-risk MSM and re-testing cases after treatment
2. deliver partner notification
3. maintain high antenatal screening coverage and vigilance
4. sustain targeted health promotion

The fall in Shigella infections among presumptive MSM during the COVID-19 response was likely to be due to a combination of decreased sexual contact and different health seeking (testing) behaviour. Given the rise in infections towards the end of 2021 and the report of extensively drug resistant infection (19), this should result in a renewed focus on promoting messages designed for MSM regarding practising good hygiene during and after sex (20).

In 2020, the population rates of STI diagnoses remained the highest among people of Black ethnicity, but this varied across Black ethnic groups. The high rate of STI diagnoses among Black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Data from a national probability sample indicate that men of black Caribbean or any other Black backgrounds are most likely to report higher numbers of recent sexual partners and concurrent partnerships. This, coupled with assortative sexual mixing patterns, may be maintaining high levels of bacterial STIs in these communities (2, 21).

Several HIV prevention activities can also have an impact on STI control and promote safer sexual behaviours. The London HIV Prevention Programme (LHPP) is a London-wide sexual health promotion initiative funded by London local authorities aiming to promote combined prevention choices for Londoners (22). The Office for Health Improvement and Disparities (OHID) within the Department of Health and Social Care (DHSC) have commissioned Terrence Higgins Trust to deliver a new National HIV Prevention Programme from November 2021 to March 2024. The Programme aims to improve knowledge, understanding and uptake

of combination HIV prevention interventions among populations most at-risk of HIV in England, particularly aimed at MSM and people of Black ethnicity and other groups in whom there is a higher or emerging burden of infection (23).

Proactive health promotion and high quality health education remain vital for STI prevention, through improving risk awareness and encouraging safer sexual behaviour. Consistent and correct condom use substantially reduces the risk of being infected with an STI. Prevention efforts should include condom provision, ensuring open access to SHS with STI screening and robust contact tracing, and focus on groups at highest risk such as young people, Black ethnic minorities and MSM. The UKHSA is working with DHSC in the development of a new Sexual and Reproductive Health Strategy, which will include a focus on reducing STIs and addressing inequalities (2).

Effective commissioning of high quality prevention and sexual health services that provide universal access and seek to address health inequalities, as highlighted in the Framework for Sexual Health Improvement in England, will promote delivery of important messages. The London Sexual Health Programme is a partnership of London boroughs who have worked together to develop a new collaborative commissioning model for open access sexual health services, which includes a new online (self-sampling) service (24).

UKHSA's main messages

It is important that health promotion and service access messages are sustained and reinforced. The main STI prevention messages are summarised below:

- using condoms consistently and correctly protects against HIV, other STIs such as chlamydia, gonorrhoea and syphilis, and unplanned pregnancy
- people at risk of HIV can also protect themselves by using HIV pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) medication, which is available from sexual health services
- people with HIV are unable to pass on the infection sexually if they are on treatment and have undetectable levels of the virus – this is known as 'Undetectable = Untransmittable' or 'U = U'
- vaccination against human papillomavirus (HPV) (for eligible MSM and those eligible as school-aged adolescents), hepatitis A and hepatitis B (for MSM and others with greater sexual health needs) will protect against disease caused by these viruses and prevent spread of these infections
- sexual health services offer free and confidential HIV and STI testing, condoms, PrEP/PEP, vaccination, and contraception advice:

- most services and local areas also provide the option of internet access to HIV and STI testing
- further advice on HIV and STIs, including how to access sexual and reproductive health services, is available through [Sexwise](#) and the national sexual health helpline on 0300 123 7123 (9am to 8pm Monday to Friday, 11am to 4pm Saturday to Sunday)
- regular testing for HIV and STIs is essential for good sexual health and everyone should have an STI screen, including an HIV test, annually if having condomless sex with new or casual partners – in addition:
 - women aged under 25 years who are sexually active should be screened for chlamydia on change of sexual partner or annually
 - gay, bisexual and other men who have sex with men should test for HIV and STIs annually or every 3 months if having condomless sex with new or casual partners

2. Charts, tables and maps

Figure 1 is a bar chart showing that the rate of new STI diagnoses per 100,000 in London (1,166.9) was much higher than any other UKHSA region.

Figure 1. New STI diagnoses by UKHSA region of residence: England 2020 (Data sources: GUMCAD, CTAD)

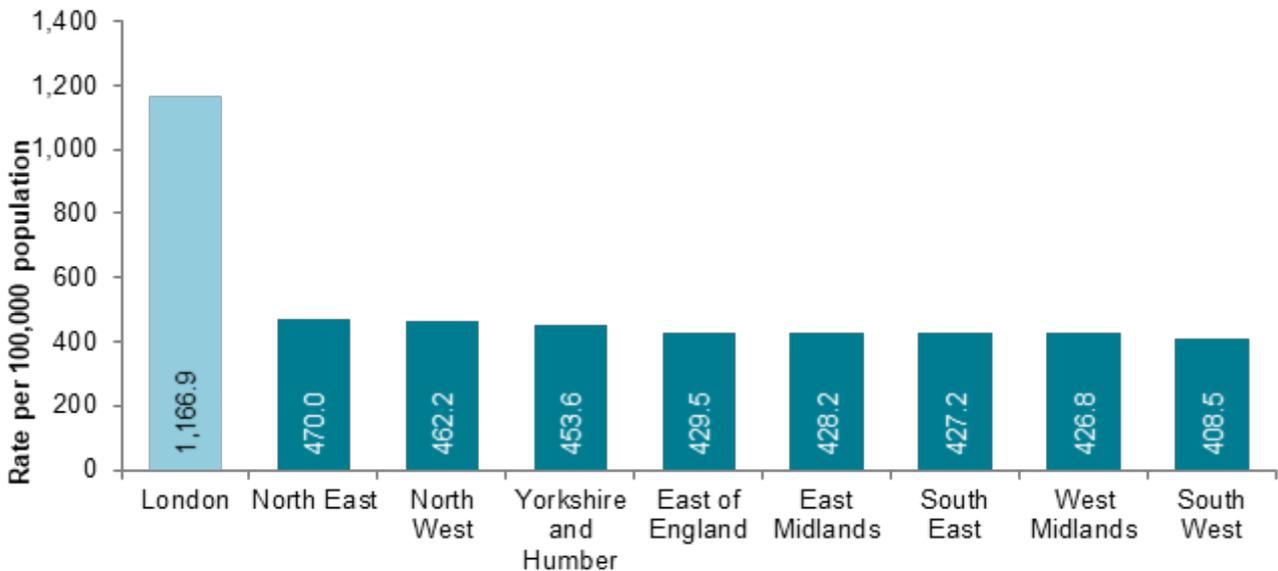
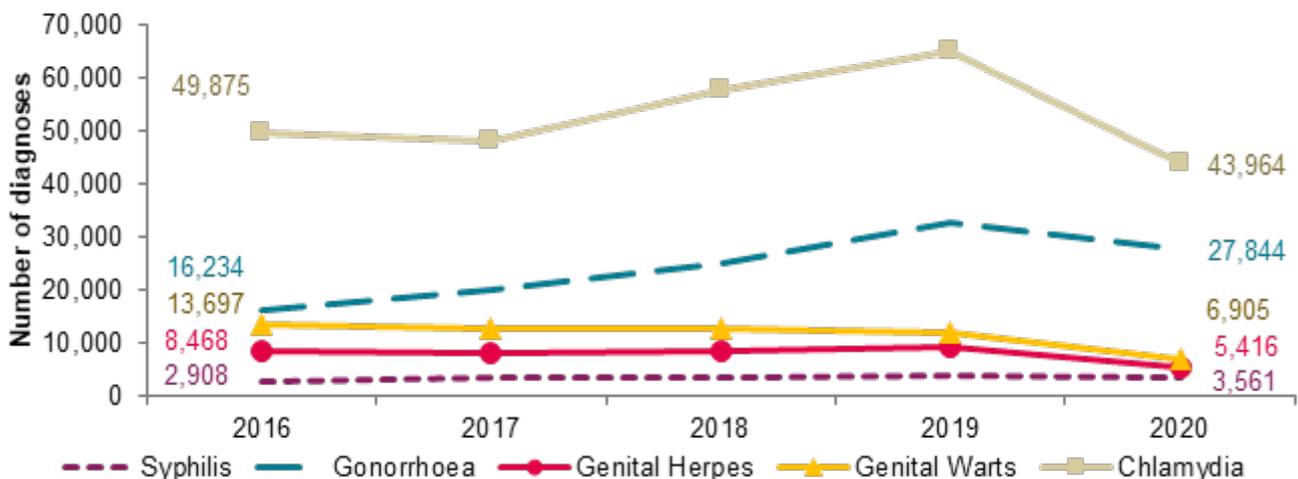


Figure 2 shows a trend line of the number of diagnoses of the 5 main STIs for London residents, showing falls in syphilis, gonorrhoea, genital herpes, genital warts and chlamydia from 2019 to 2020.

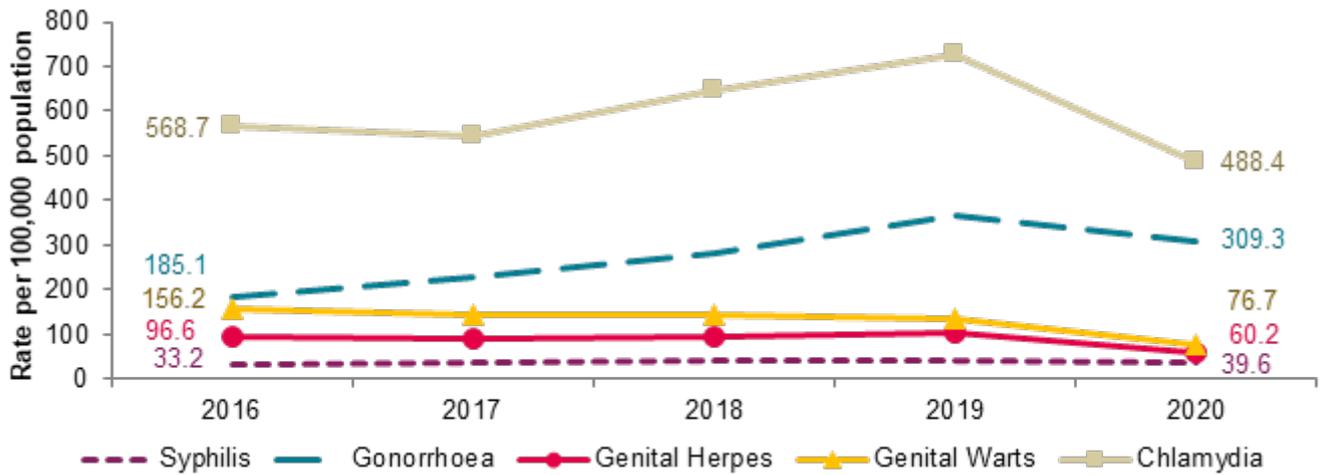
Figure 2. Number of diagnoses of the 5 main STIs: London residents, 2016 to 2020 (Data sources: GUMCAD, CTAD)



Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive nucleic acid amplification tests (NAATs) and additional screening of extra-genital sites in MSM.
 Any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination.
 Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs.
 Increases or decreases may also reflect changes in testing practices.

Figure 3 shows a trend line of the diagnosis rates of the 5 main STIs for London residents, which shows the same trends as figure 2.

Figure 3. Diagnosis rates of the 5 main STIs: London residents, 2016 to 2020 (Data sources: GUMCAD, CTAD)



Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive nucleic acid amplification tests (NAATs) and additional screening of extra-genital sites in MSM. Any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination. Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs. Increases or decreases may also reflect changes in testing practices.

Table 1 shows that chlamydia was the most commonly diagnosed STI with 43,964 diagnoses in 2020. The greatest proportional increases from 2016 to 2020 were seen in syphilis and gonorrhoea diagnoses, increasing by 22% and 72% respectively. The greatest proportional fall from 2019 to 2020 was in genital warts (by 43%).

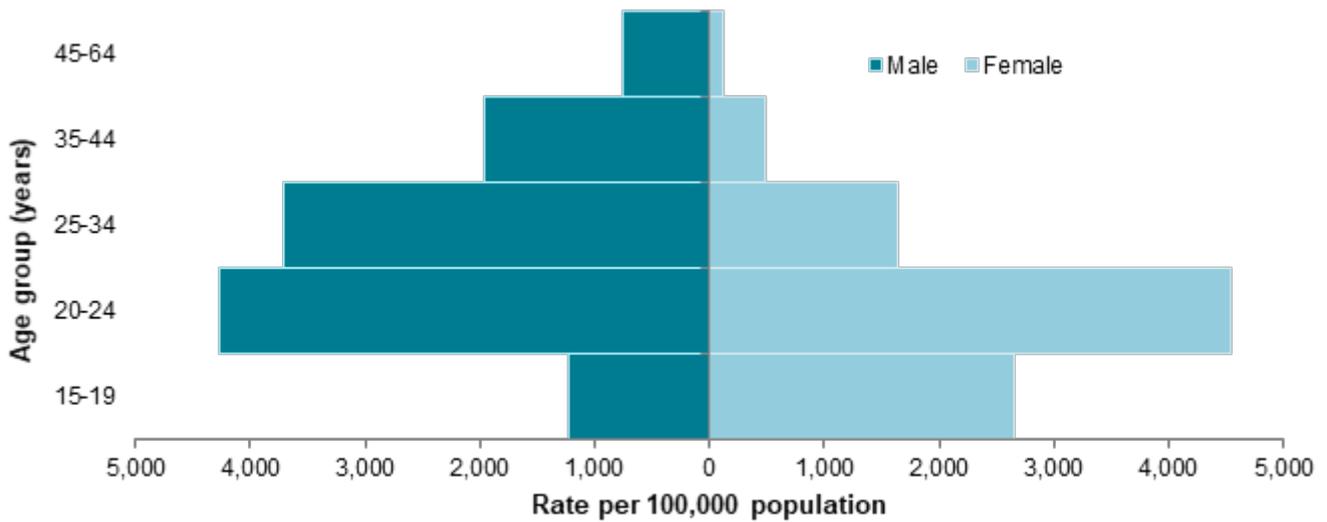
Table 1. Percentage change in new STI diagnoses: London residents
Data sources: GUMCAD, CTAD

Diagnoses	2020	% change 2016 to 2020	% change 2019 to 2020
New STIs	105,051	-12%	-30%
Syphilis	3,561	22%	-8%
Gonorrhoea	27,844	72%	-15%
Chlamydia	43,964	-12%	-33%
Genital herpes	5,416	-36%	-41%
Genital warts	6,905	-50%	-43%

See notes for Figure 3.

Figure 4 is a bar chart showing rates of STIs by age group. The highest rates are seen in males and females aged 20 to 24 years.

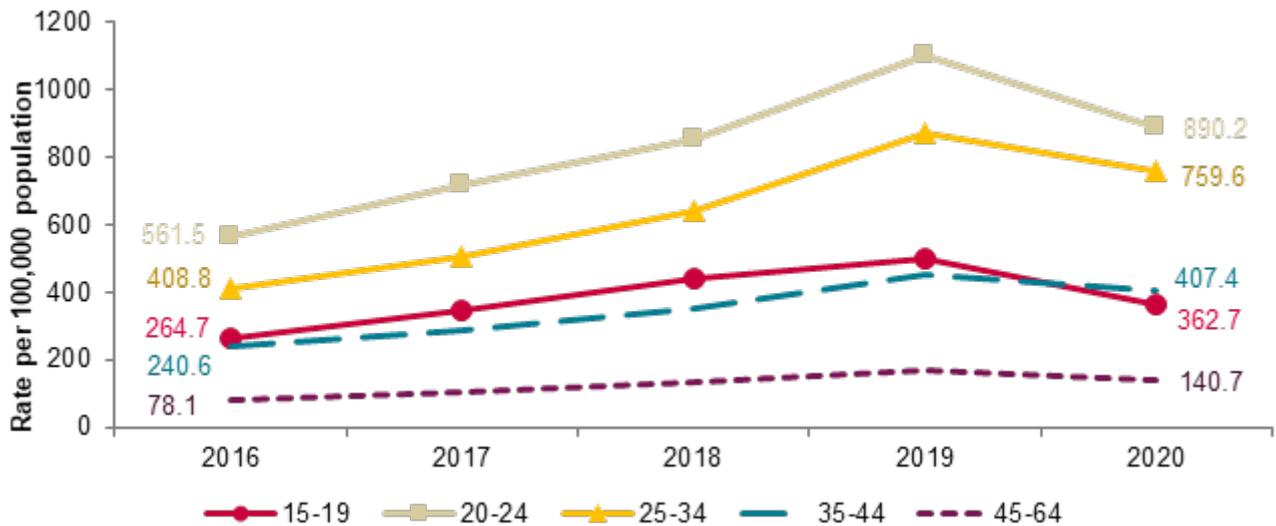
Figure 4. Rates of new STIs per 100,000 residents by age group and gender in London, 2020 (Data sources: GUMCAD, CTAD)



Age-specific rates are shown for those aged 15 to 64 years only.

Figure 5 shows rates of gonorrhoea per 100,000 residents by age group in London, 2016 to 2020. This shows that rates were highest in those aged 20 to 24 years. Rates in all years declined from 2019 to 2020. (Note that age-specific rates are shown for those aged 15 to 64 years only.)

Figure 5. Rates of gonorrhoea per 100,000 residents by age group in London, 2016 to 2020 (Data source: GUMCAD)



Age-specific rates are shown for those aged 15 to 64 years only.

Figure 6 shows rates of genital warts per 100,000 residents aged 15 to 19 years by gender in London and shows that rates in both males and females fell from 2016 to 2020, the rate of decrease being higher among females.

Figure 6. Rates of genital warts per 100,000 residents aged 15 to 19 years by gender in London, 2020 (Data source: GUMCAD)

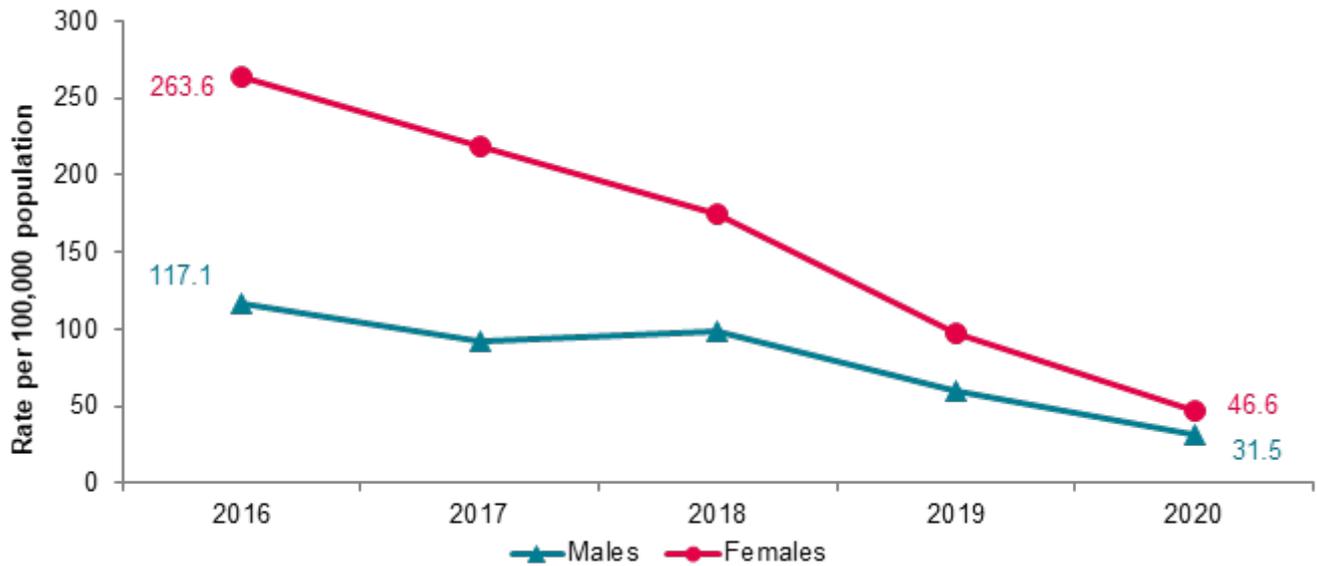


Figure 7 is a bar chart showing rates by ethnicity per 100,000 population of London residents diagnosed with a new STI in 2020. It shows that rates in Black Caribbeans per 100,000 were significantly higher than rates in White and Black African and other ethnic groups.

Figure 7. Rates of new STIs by ethnic group per 100,000 residents in London, 2020 (Data sources: GUMCAD, CTAD)

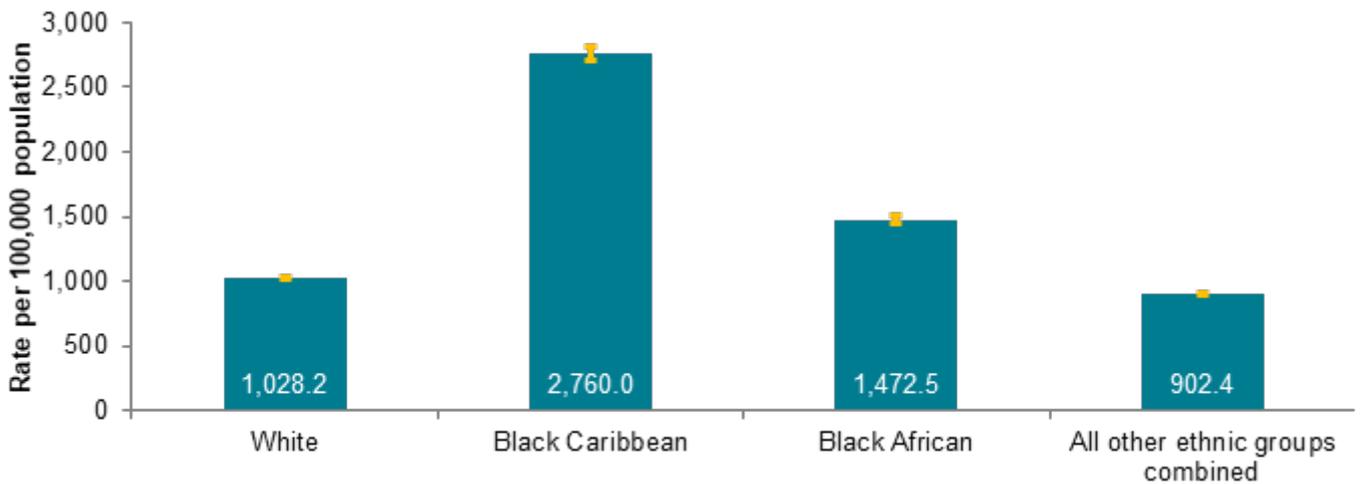


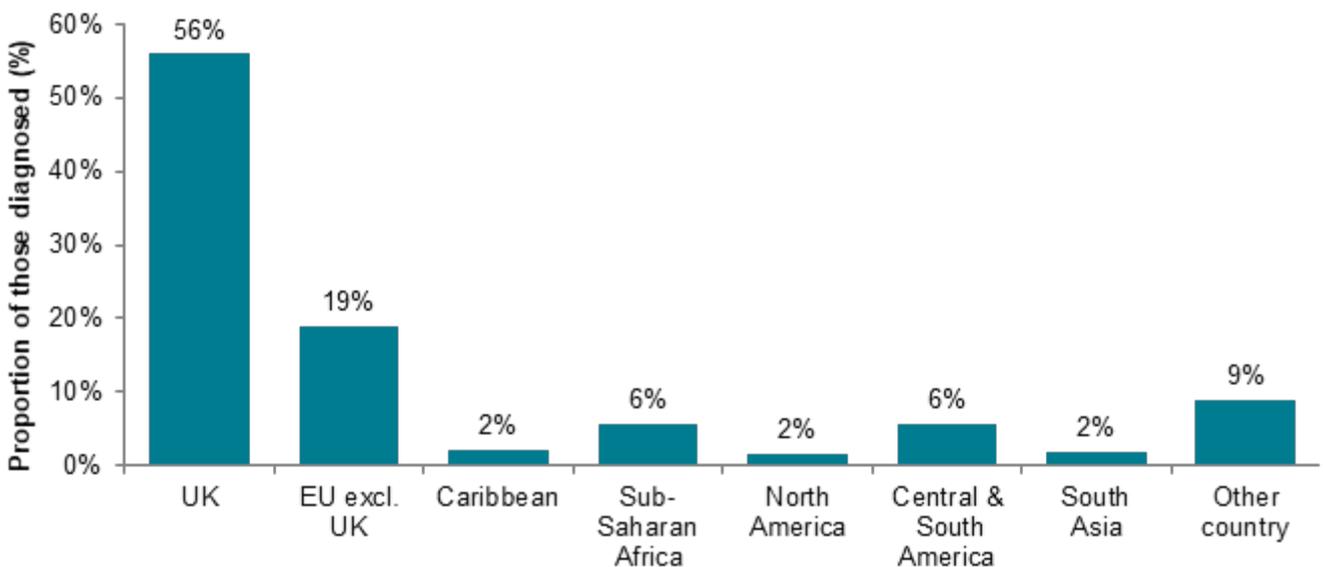
Table 2 shows that the highest numbers of STIs were in White (50,253) population groups, representing 56% of the total. Black Caribbean population groups made up 11%, Black African 9% and other black and minority ethnic groups 24% of the total where ethnicity was known.

Table 2. Proportion of London residents diagnosed with a new STI by ethnicity: 2020
(Data sources: GUMCAD, CTAD)

Ethnic group	Number	Percentage excluding unknown
White	50,253	56%
Black Caribbean	9,511	11%
Black African	8,451	9%
All other ethnic groups combined	21,368	24%
Unknown	15,468	

Figure 8 is a bar chart showing proportions of London residents diagnosed with a new STI by world region of birth in 2020. It shows that UK-born constitute the highest proportion of London residents diagnosed with a new STI (56%) with the next highest being EU born (19%).

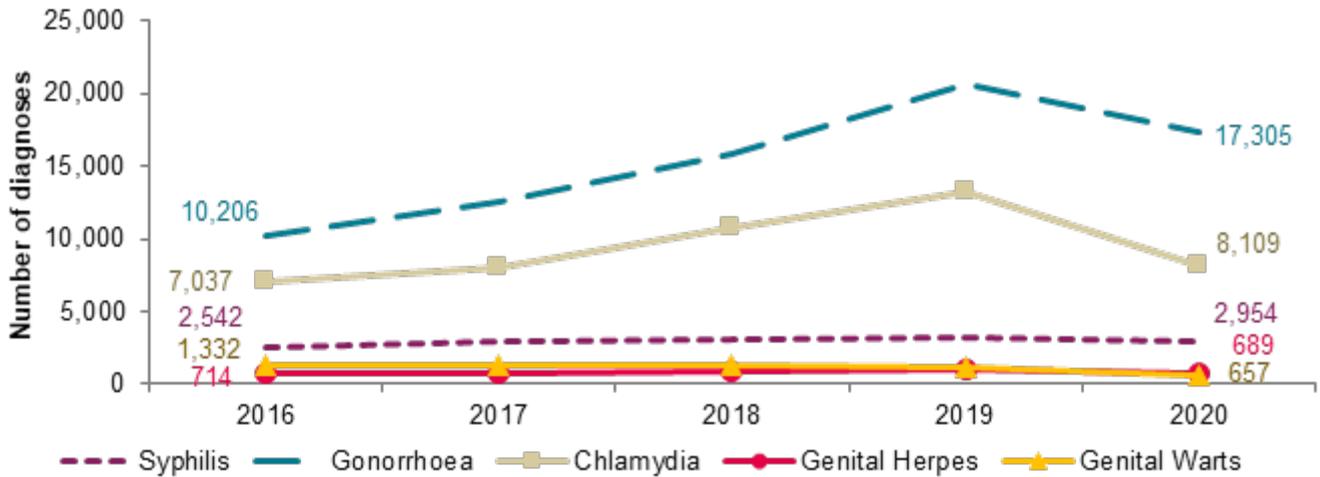
Figure 8. Proportions of London residents diagnosed with a new STI by world region of birth: 2020 (Data source: GUMCAD data only)



Data on country of birth is not collected by CTAD. All information about world region of birth is based on diagnoses made in specialist and non-specialist services which report to GUMCAD.

Figure 9 shows a trend line for diagnoses of the 5 main STIs in specialist sexual health clinics (SHCs) among men who have sex with men (MSM) London residents, from 2016 to 2020. It shows large increases in the number of diagnoses of gonorrhoea from 2016 to 2019, with a subsequent fall from 2019 to 2020. The number of syphilis, chlamydia, genital herpes and genital warts diagnoses fell from 2019 to 2020.

Figure 9. Diagnoses of the 5 main STIs among MSM: London residents, 2016 to 2020
(Data source: GUMCAD data only)



Data on sexual orientation is not collected by CTAD. All information about MSM is based on diagnoses made in specialist and non-specialist services which report to GUMCAD.

Any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive nucleic acid amplification tests (NAATs) and additional screening of extra-genital sites in MSM.

Any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination.

Any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs.

Any increase or decrease may reflect changes in testing.

Table 3 shows the number of the main STI diagnoses among MSM London residents in 2020 and the percentage change since 2016 and 2019. It shows that gonorrhoea was the most common STI in MSM in 2020. From 2016 to 2020, a large proportional increase was seen in gonorrhoea (70%) and increases were also seen in syphilis (16%) and chlamydia (65%). The number of genital warts diagnoses fell by 51% from 2016 to 2020. The number of STIs fell from 2019 to 2020.

Table 3. Percentage change in new STI diagnoses in MSM: London residents (Data sources: GUMCAD data only)

Diagnoses	2020	% change 2016 to 2020	% change 2019 to 2020
New STIs	33,150	26%	-25%
Syphilis	2,954	16%	-8%
Gonorrhoea	17,305	70%	-16%
Chlamydia	8,109	15%	-39%
Genital Herpes	689	-4%	-30%
Genital Warts	657	-51%	-44%

See notes for Figure 9.

Figure 10a is a bar chart showing the rate of new STI diagnoses per 100,000 population among London residents by local authority of residence in 2020. It shows that the rate of new STIs per 100,000 by London local authority compared to London (1,167). The rates per 100,000 in local authorities ranged from 442 in Havering to 3,060 per 100,000 in Lambeth.

Figure 10a. Rate of new STI diagnoses per 100,000 population among London residents by local authority of residence (UTLA): 2020 (Data sources: GUMCAD, CTAD)

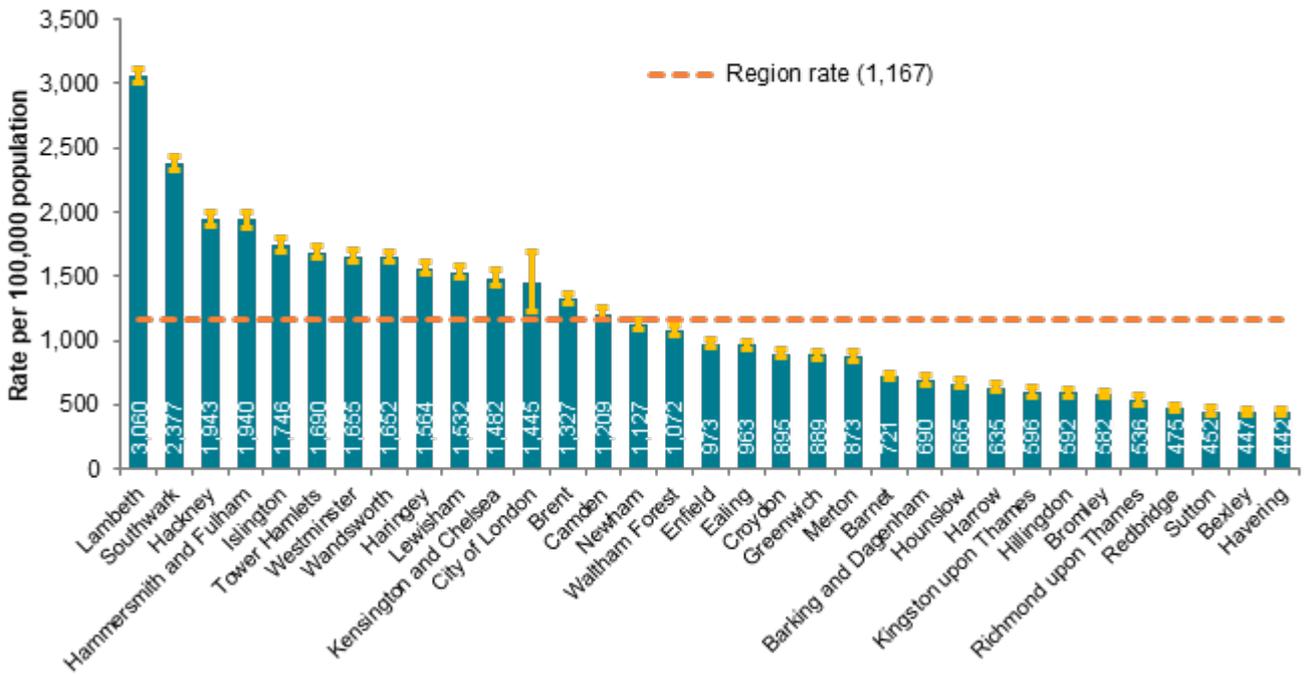


Figure 10b is a bar chart showing the rate of new STI diagnoses (excluding chlamydia diagnoses in persons aged 15 to 24 years) per 100,000 population aged 15 to 64 years among London residents by local authority of residence in 2020. It shows the rate of new STIs (excluding chlamydia in 15 to 24 year olds) by London local authority compared to the rate in England (609) and London (1,391) per 100,000 15 to 64 year olds. The rates in local authorities ranged from 494 per 100,000 in Sutton to 3,547 per 100,000 in Lambeth.

Figure 10b. Rate of new STI diagnoses (excluding chlamydia diagnoses in persons aged 15 to 24 years) per 100,000 population aged 15 to 64 years among London residents by local authority of residence: 2020 (Data sources: GUMCAD, CTAD)

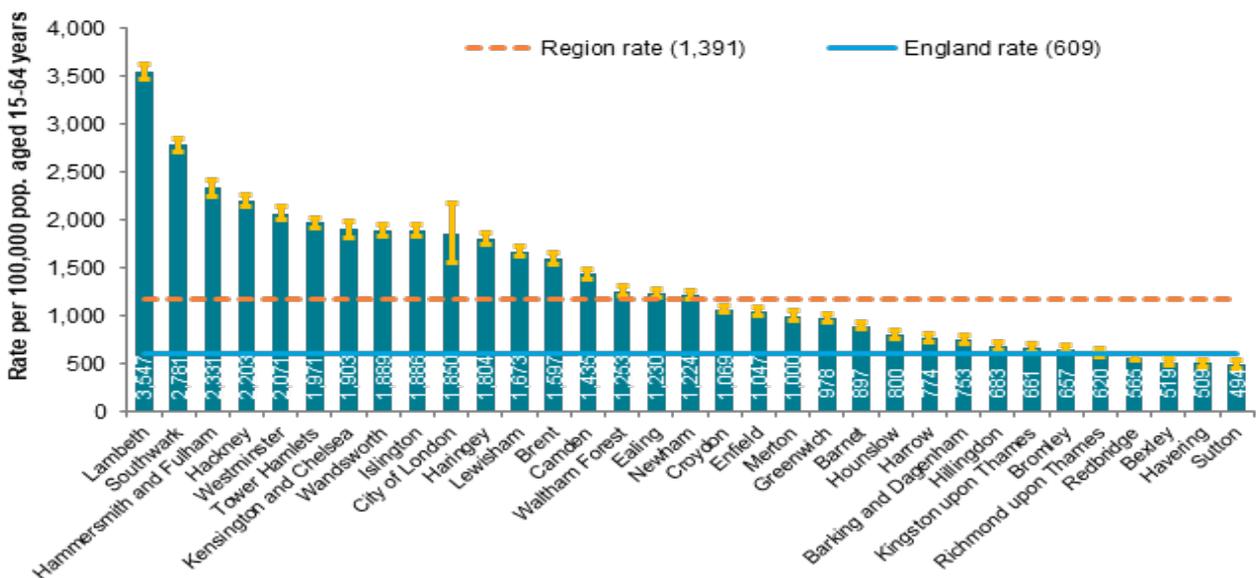


Figure 11 is a bar chart showing the chlamydia detection rate per 100,000 population aged 15 to 24 years in London residents by local authority of residence in 2020. It shows a large variation in the chlamydia detection rate in young people in London boroughs from 835 per 100,000 in Redbridge to 3,408 in Lambeth. Seven local authorities had a chlamydia detection rate of over 2,300 per 100,000.

Figure 11. Chlamydia detection rate per 100,000 population aged 15 to 24 years in London residents by local authority of residence: 2020 (Data sources: GUMCAD, CTAD)

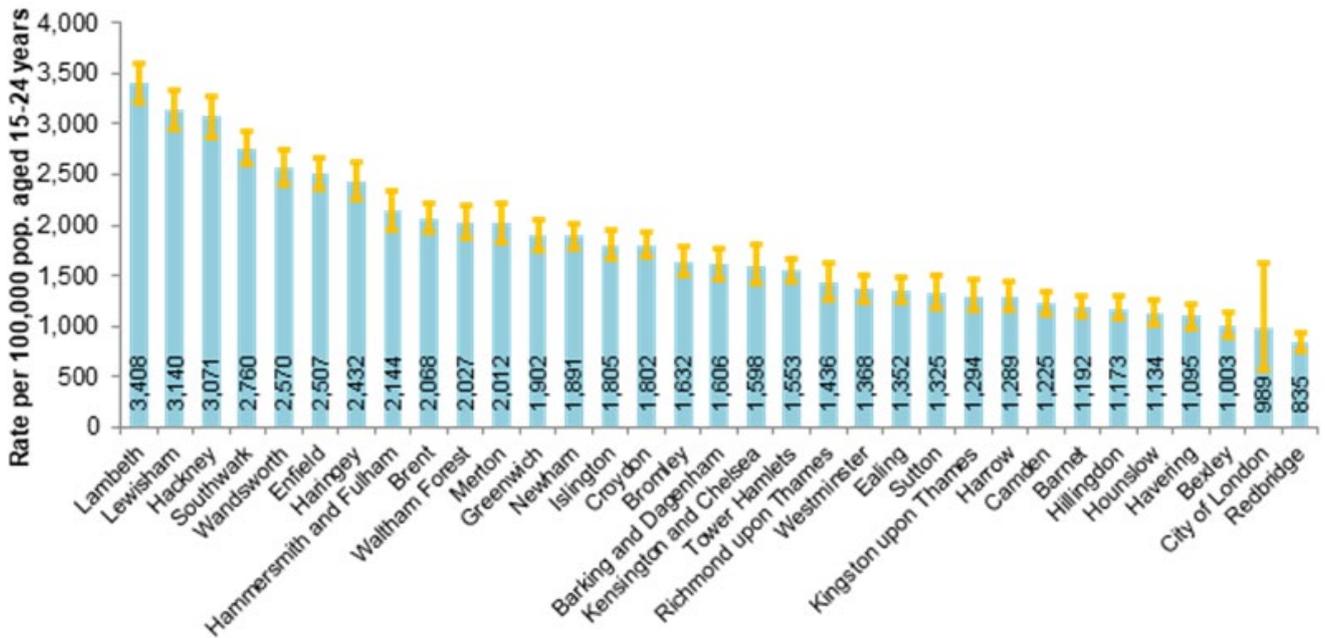


Figure 12 is a bar chart showing the rate of gonorrhoea diagnoses per 100,000 population in London residents by local authority of residence in 2020. It shows a very large variation in the rate of gonorrhoea in London local authorities from 83 per 100,000 in Sutton to 1,024 in Lambeth.

Figure 12. Rate of gonorrhoea diagnoses per 100,000 population in London residents by local authority of residence: 2020 (Data source: GUMCAD)

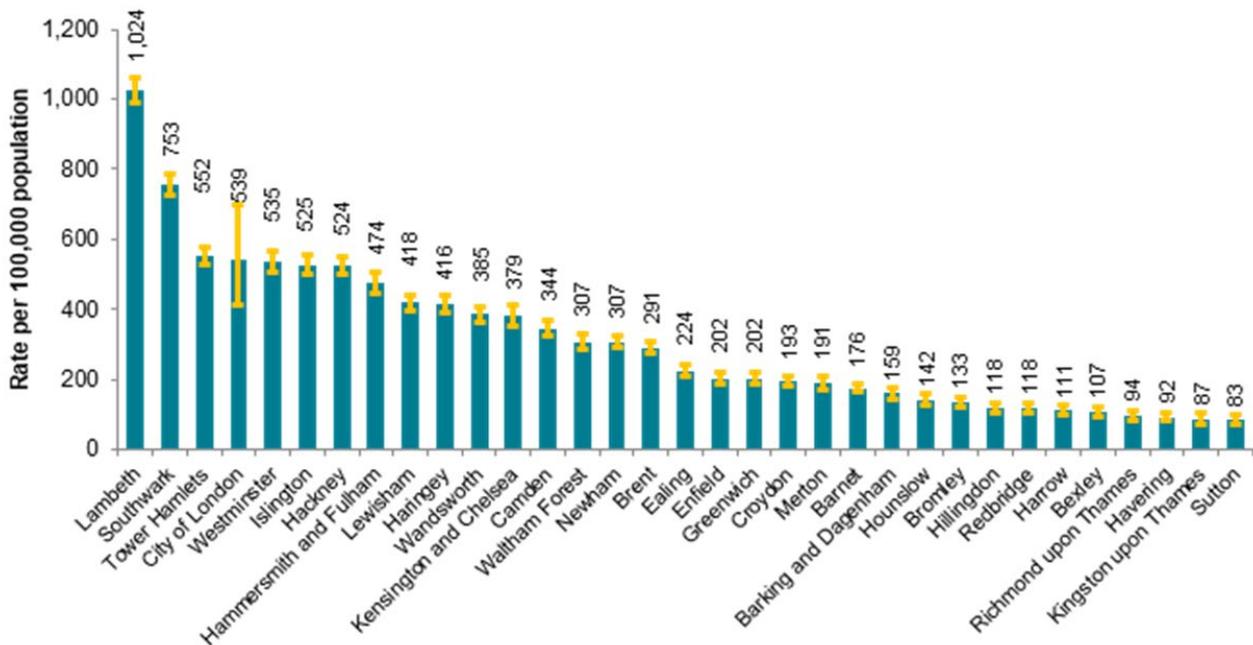
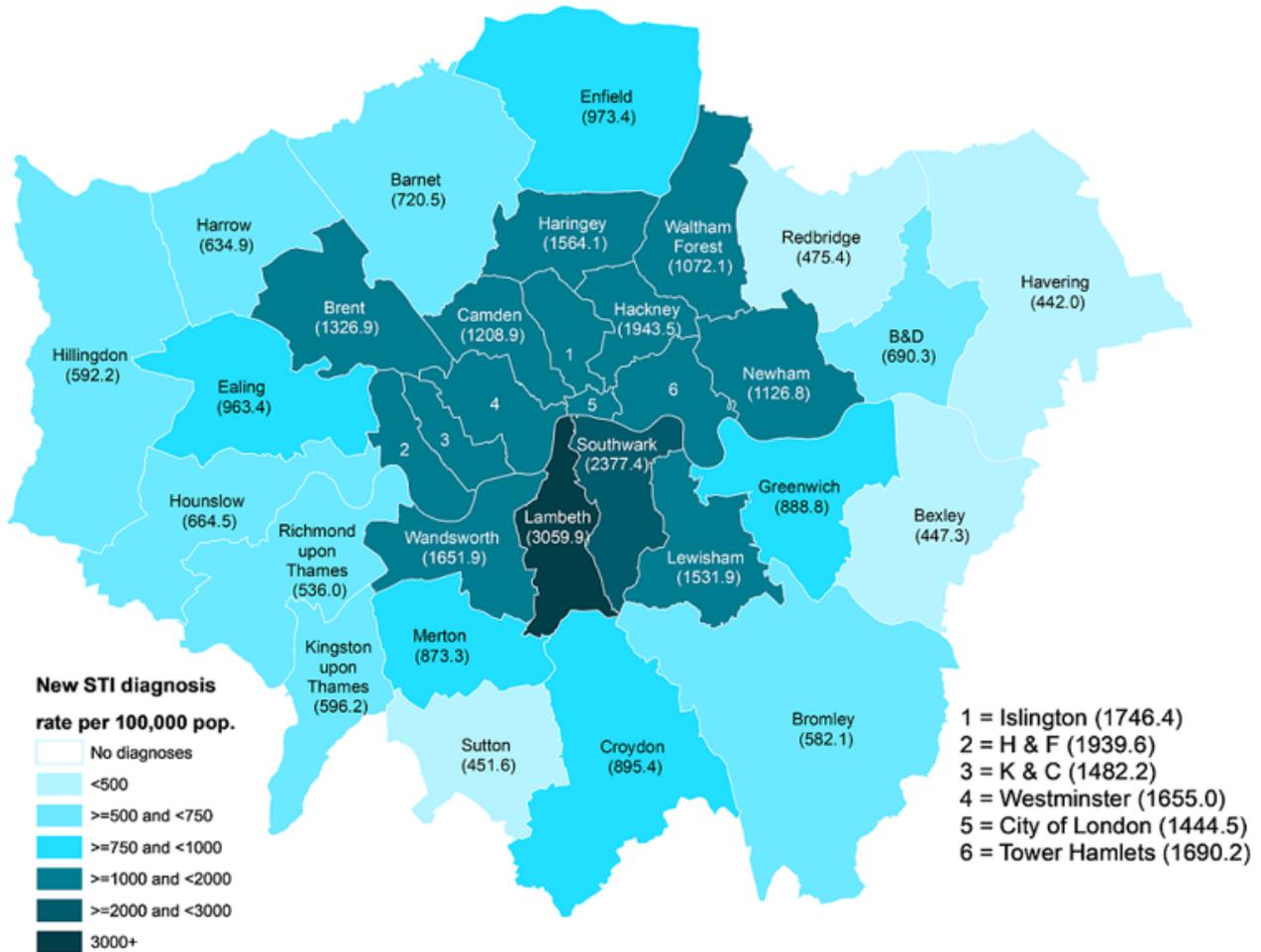


Figure 13 is a map of new STI rates per 100,000 residents by local authority in London in 2020. In general more central areas of London had higher STI rates compared to outer London boroughs.

Figure 13. Map of new STI rates per 100,000 residents by local authority in London: 2020

(Data sources: GUMCAD, CTAD)



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Figure 14 is a map of new STI rates per 100,000 residents by middle super output area in London in 2020. It provides more detail of local areas with higher rates of STIs, which are more concentrated in more central areas.

Figure 14. Map of new STI rates per 100,000 residents by middle super output area (MSOA) in London: 2020 (Data sources: GUMCAD, CTAD)

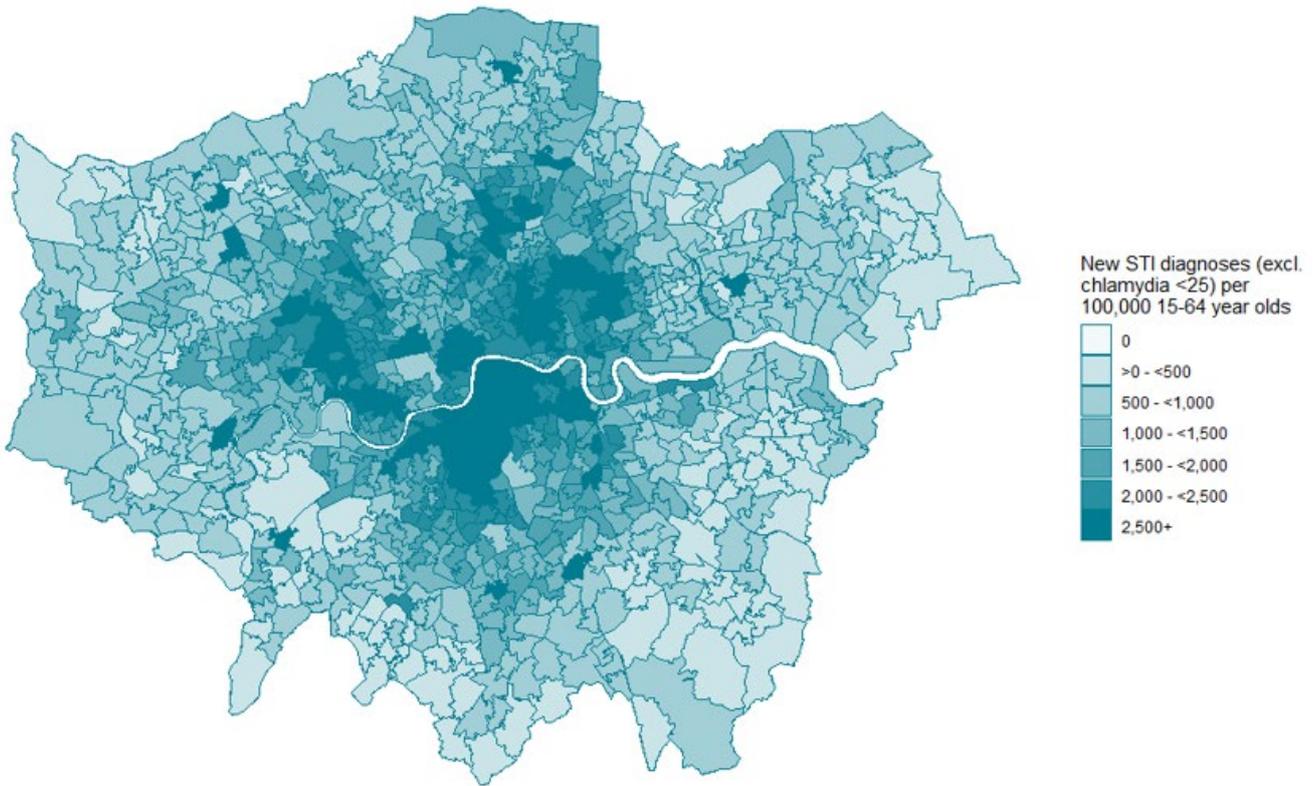


Figure 15 shows trend lines for the STI testing rate (excluding chlamydia in under 25 year olds) per 100,000 population in London and England residents aged 15 to 64 years from 2016 to 2020. After a rise in testing from 2016 to 2019 in both London and England, the testing rate fell from 2019 to 2020. The testing rate in London remained higher than England throughout.

Figure 15. STI testing rate (excluding chlamydia in under 25 year olds) per 100,000 population in London residents aged 15 to 64 years: 2016 to 2020 (Data sources: GUMCAD, CTAD)

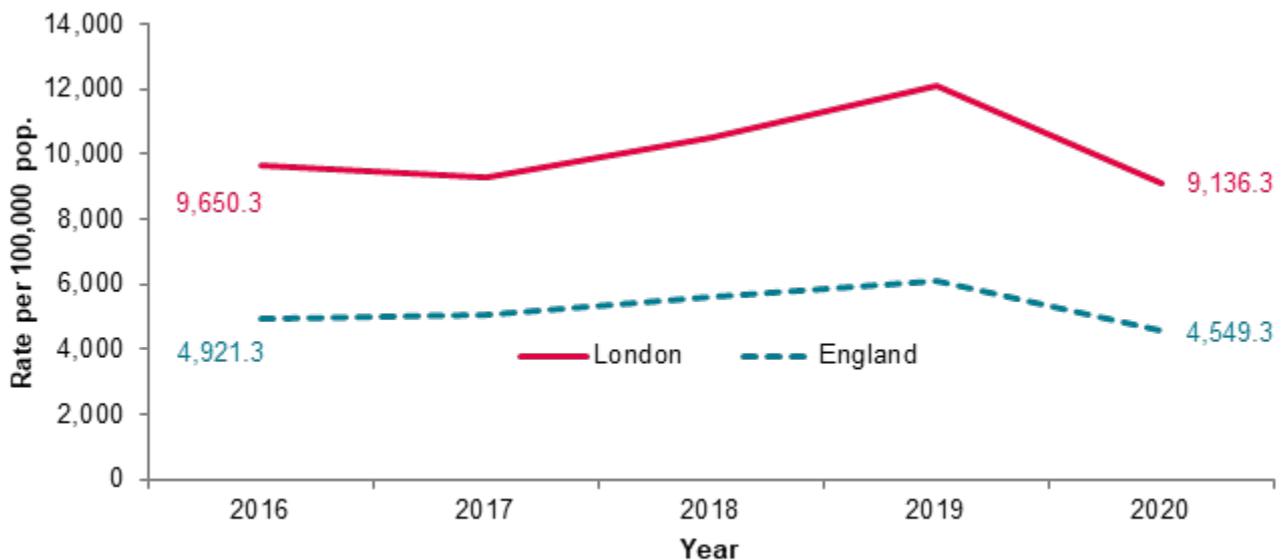
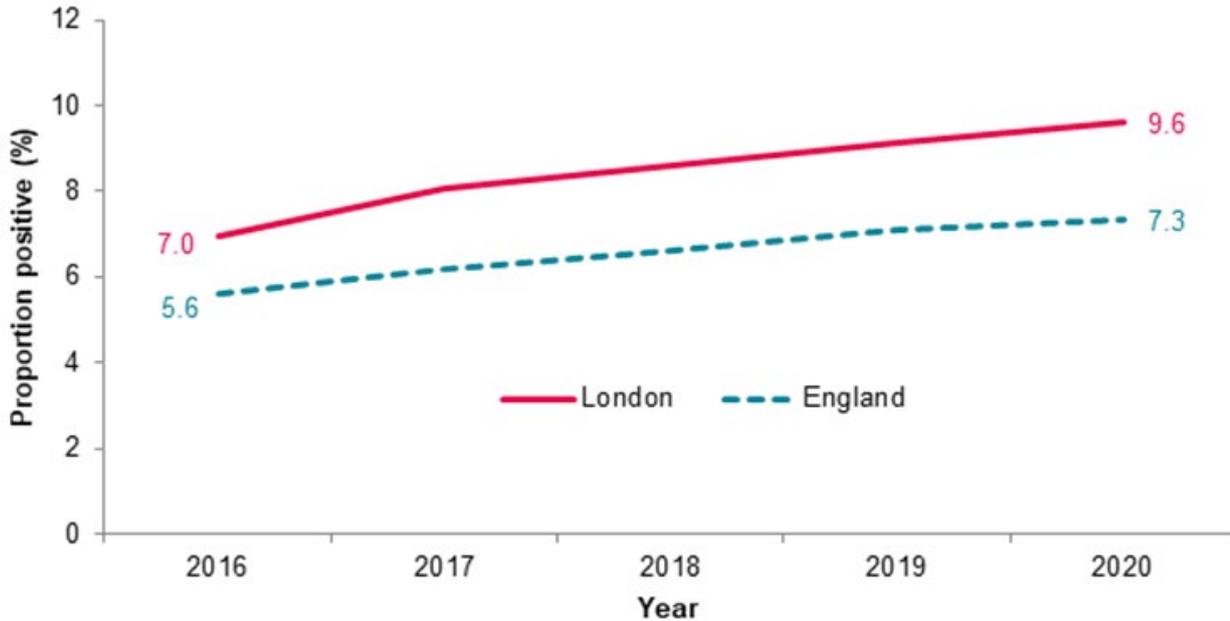


Figure 16 shows trend lines for the STI positivity rate (excluding chlamydia in under 25 year olds) in London and England residents from 2016 to 2020. It shows that London positivity was higher than England throughout, and increases were seen for both from 2016 to 2020.

Figure 16. STI testing positivity rate (excluding chlamydia in under 25 year olds) in London residents: 2016 to 2020 (Data sources: GUMCAD, CTAD)



The numerator for the STI testing positivity rate now only includes infections which are also included in the denominator. These are: chlamydia (excluding diagnoses in those aged under 25 years), gonorrhoea, syphilis and HIV. Up to 2018 (data for 2017) it included all new STIs.

Table 4 shows the number of diagnoses of new STIs by UKHSA region of residence, data source and data subset in 2020. It shows that the highest number of STIs were diagnosed in London residents with the majority of new STIs being diagnosed in specialist SHCs.

Table 4. Number of diagnoses of new STIs by UKHSA region of residence, data source and data subset 2020 (Data sources: GUMCAD, CTAD)

UKHSA region of residence	GUMCAD: specialist SHSs	GUMCAD: non-specialist SHSs*	CTAD**	Total
East Midlands	11,470	5,184	4,182	20,836
East of England	17,879	4,003	6,204	28,086
London	73,984	7,995	23,072	105,051
North East	8,558	1,222	2,820	12,600
North West	24,313	2,607	7,131	34,051
South East	27,397	1,888	8,935	38,220
South West	14,289	2,042	6,784	23,115
West Midlands	17,406	3,687	4,354	25,447
Yorkshire and Humber	16,659	1,521	6,886	25,066

* Diagnoses from enhanced GPs reporting to GUMCAD are included in the 'Non-specialist sexual health services (SHSs)' total.

** Including site type 12 chlamydia from GUMCAD.

Table 5 shows the number of diagnoses of the 5 main STIs in London by STI, data source and data subset in 2020. It shows that the majority of new STIs are diagnosed in specialist SHCs.

Table 5. Number of diagnoses of the 5 main STIs in London by STI, data source and data subset 2020 (Data sources: GUMCAD, CTAD)

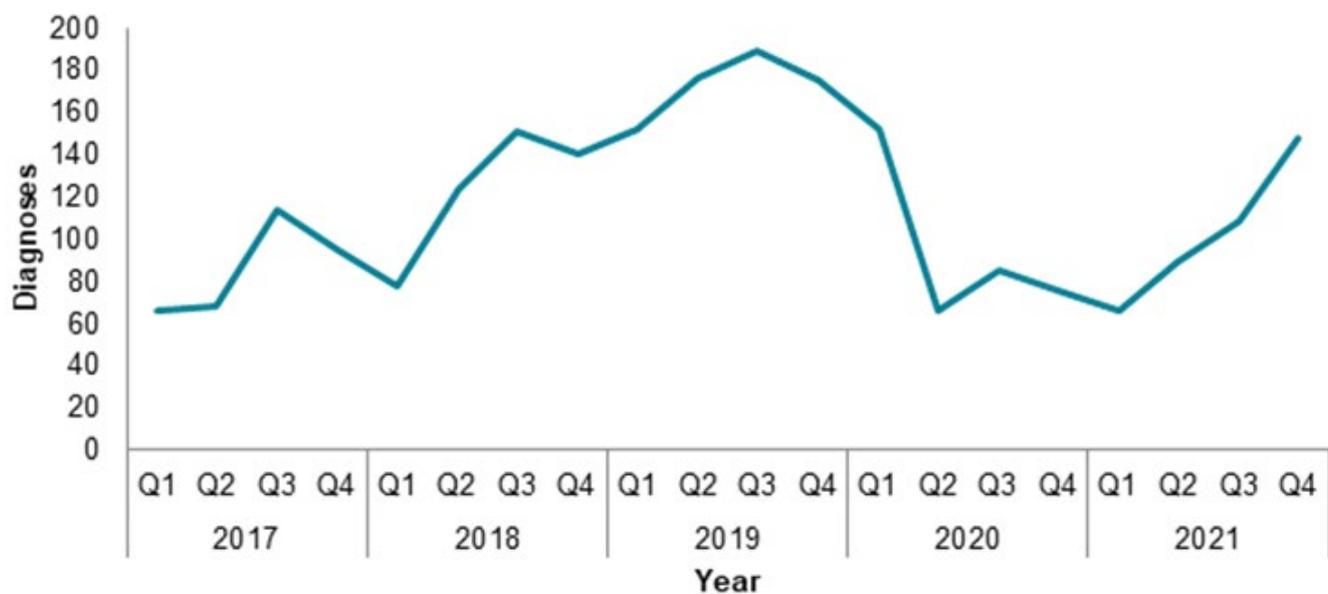
5 main STIs	GUMCAD: specialist SHSs	GUMCAD: non-specialist SHSs*	CTAD**	Total
Syphilis	3,545	16		3,561
Gonorrhoea	21,115	6,729		27,844
Chlamydia	20,495	397	23,072	43,964
Genital herpes	5,199	217		5,416
Genital warts	6,666	239		6,905

* Diagnoses from enhanced GPs reporting to GUMCAD are included in the 'Non-specialist sexual health services (SHSs)' total.

** Including site type 12 chlamydia from GUMCAD.

Figure 17 shows a trend line for the number of Shigella diagnoses in London residents presumed MSM from 2017 to 2021. Diagnoses peaked in quarter 3 of 2019, fell markedly from quarter 1 to quarter 2 of 2020 and then rose again from quarter 2 2021 onwards.

Figure 17. Shigella diagnoses in London residents presumed MSM* by year and quarter: 2017 to 2021 (Data source: SGSS)



* Presumed men who have sex with men are adult males aged 16 years or older with no history of foreign travel.

3. Information on data sources

Find more information on local sexual health data sources in the [UKHSA guide](#).

This report is based on data from the GUMCAD and CTAD surveillance systems published on 6 September 2021 (data to the end of calendar year 2020), with the exception of Figure 17 (Shigella diagnoses) which is based on data from SGSS extracted on 4 April 2022 (data to the end of calendar year 2021).

3.1 GUMCAD

This disaggregate reporting system collects information about attendances and diagnoses at specialist (Level 3) and non-specialist (Level 2) sexual health services. Information about the patient's area of residence is collected along with demographic data and other variables. GUMCAD superseded the earlier KC60 system and can provide data from 2009 onwards. GUMCAD is the main source of data for this report.

Due to limits on how much personally identifiable information sexual health clinics can share, it is not possible to deduplicate between different clinics. There is a possibility that some patients may be counted more than once if they are diagnosed with the same infection (for infection specific analyses) or a new STI of any type (for new STI analyses) at different clinics during the same calendar year.

3.2 CTAD

CTAD collects data on all NHS and local authority or NHS-commissioned chlamydia testing carried out in England. CTAD is comprised of all chlamydia (NAATs) tests for all ages (apart from conjunctival samples), from all venues and for all reasons. CTAD enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through estimation of the coverage of population screening, proportion of all tests that are positive and detection rates.

For services which report to GUMCAD and for which CTAD does not receive data on the patient's area of residence (for example, SHSs), information about chlamydia diagnoses is sourced from GUMCAD data.

3.3 SGSS

Second Generation Surveillance System (SGSS) stores and manages data on laboratory isolates and notifications. It captures routine laboratory surveillance data on infectious diseases and antimicrobial resistance from diagnostic laboratories across England.

3.4 New STIs

New STI diagnoses comprise diagnoses of the following: chancroid, LGV, donovanosis, chlamydia, gonorrhoea, genital herpes (first episode), HIV (acute and AIDS defining), *Molluscum contagiosum*, non-specific genital infection (NSGI), non-specific pelvic inflammatory disease (PID) and epididymitis, chlamydial PID and epididymitis (presented in chlamydia total), gonococcal PID and epididymitis (presented in gonorrhoea total), scabies, pediculosis pubis, syphilis (primary, secondary and early latent), trichomoniasis and genital warts (first episode), *Mycoplasma genitalium*, shigella.

3.5 Calculations

Confidence Intervals were calculated using [Byar's method](#).

Office for National Statistics (ONS) mid-year population estimates for 2020 were used as a denominator for rates for 2020. ONS ceased producing estimates of population by ethnicity in 2011. Estimates for that year were used as a denominator for rates for 2020.

4. Further information

As of this year, all analyses for this report include data from non-specialist (Level 2) SHSs and enhanced GP services as well as specialist (Level 3) SHSs.

For further information, access the online [Sexual and Reproductive Health Profiles](#). These include a downloadable summary profile of local authority sexual health (SPLASH).

For your local report go to [Sexual Health Profiles](#) – start, data view = ‘reports’, geography – area type = ‘Counties & UAs’ – region ‘London region’, geography version = 2020/21.

For more information on local sexual health data sources, see [the UKHSA guide](#).

5. About the Field Service

The Field Service was established in 2018 as a national service comprising geographically dispersed multi-disciplinary teams integrating expertise in Field Epidemiology, Real-time Syndromic Surveillance, Public Health Microbiology and Food, Water and Environmental Microbiology to strengthen the surveillance, intelligence and response functions of UKHSA.

You can contact your local Field Service team at fes.seal@phe.gov.uk

If you have any comments or feedback regarding this report or the Field Service, contact josh.forde@phe.gov.uk

6. Acknowledgements

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- local SHSs for supplying the SHS data
- local laboratories for supplying the CTAD data
- UKHSA Blood Safety, Hepatitis, Sexually Transmitted Infections (STI) and HIV Division for collection, analysis and distribution of data

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UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

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