Birmingham Sexual Health Rapid Needs Assessment (Draft)

Sexual ill health and wellbeing is strongly linked to deprivation and health inequality and presents significant cost to the public purse as well to the individual, with consequences including episodes of discomfort, long-term disability, emotional feelings of regret and possible discrimination.

In order to improve sexual health, we need an understanding of the sexual health needs of the population. Data from this rapid needs assessment will be used to inform commissioning and service design.

Key considerations for Sexual Health Strategic Commissioning Group (SCG)

- **Clearly define the scope of Sexual health commissioning for the city of Birmingham within the context of these findings**
- **Consider a phased approach for this needs assessment, focusing on unmet and unknown needs (e.g. LGBT, sex workers, sexual violence and coercion, people with learning disabilities) to further support the commissioning process and future service provision.**
- **Consider user and stakeholder views to further inform this needs assessment**
- **Consider the influencing role the SCG has to ensure consistent, early Sex and Relationships Education in schools, further supporting the development of resilience and other protective factors. Also ensure that education and signposting covers sexually transmitted infection, termination of pregnancy, and sexual assault services as well as contraception.**
- **Investigate and audit the duration and variable use of long-acting reversible contraception removal rate and its variable uptake across the city**
- **Investigate the reasons associated with repeat attenders for STI's**
- **Investigate the reasons associated with repeat abortions, particularly in the under 25's**

Key Sexual Health Priorities for Birmingham

- **Reduce % presenting with HIV at a late stage of infection.**
- **Reduce number of under-18 conceptions.**
- **Improve the chlamydia diagnosis rate in young adults.**
- **Reduce transmission of HIV, STIs and blood borne viruses.**
- **Reduce number of initial and repeat abortions.**
- **Ensure prompt access for earlier diagnosis and treatment.**
- **Increase use of effective good quality contraception.**
- **Reduce number of people repeatedly treated for STIs.**
- **Improve support for people vulnerable to, and victims of, sexual coercion, sexual violence and exploitation.**
- **Ensure better access to services for high risk communities.**

1. Population

- Birmingham is a changing city, since 2001 the population has increased by almost 90,000 (9.1%) to 1,073,045 people. The population of 15-44 year olds has seen a greater increase over the same time period of 12%, equivalent to 50,800 individuals. The population increase over the last decade is associated with more births, fewer deaths and international migration.

- Birmingham is a youthful city. Birmingham has more people in the younger age groups, while England as a whole has a greater proportion of older people - 45.6% of Birmingham residents are under 30, compared with 37.6% for England. In contrast 12.9% of our residents are over 65, compared with 16.4% nationally. The median age difference between the youngest ward (Selly Oak – 22years) and the oldest ward (Sutton New Hall – 45 years) in Birmingham is 23 years. Locally, there are marked variations across the city for the 15-44 population.

- Birmingham can celebrate a population from a wide range of national, ethnic and religious backgrounds. The largest ethnic group in Birmingham in 2011 was White British with 570,217 (53.1%). This proportion has decreased since 2001 (65.6%) and lower than the average in England (79.8%). Other large groups include Pakistani (144,627, 13.5%) and Indian (64,621, 6.0%) which have grown since 2001, while people defining themselves as Black Caribbean (47,641, 4.4%) have declined. More recent trends see people arriving from many different parts of the world, including Eastern Europe, Africa and the Middle East.

- 238,313 Birmingham residents were born outside the UK. Of these around 45% arrived during the last decade. 46.1% of residents said they were Christian, 21.8% Muslim and 19.3% no religion.

- 40% of Birmingham's population live in areas described as in the most deprived 10% in England. 23% of the population live in areas in the most deprived 5%.

- The changing age, ethnic, social and cultural structure of the population, especially the increasingly younger population, has important implications for the City's sexual and reproductive health needs.

2. Sexually transmitted infections (including HIV)

2.1 HIV

- In 2011, there were 1,515 people living with HIV in Birmingham – the second largest concentration of people living with HIV outside of London. There were 142 newly diagnosed cases of HIV in Birmingham residents during 2011. Since its peak in 2005 nationally there was a decrease of 21% in people newly diagnosed with HIV during 2011. This decrease is largely due to a reduction in the number of diagnoses reported among those born outside the UK.

- The rate of diagnosed HIV per 1,000 among persons aged 15-59 years was 2.3 per 1,000. There has been a gradual increase since 2009; 2009(2 per 1,000) and 2010 (2.2.per 1,000)[1]. Local authorities and NHS bodies, with a diagnosed HIV prevalence greater than two per 1,000 population of 15-59 years, can implement routine HIV testing for all general medical admissions as well as new registrants in primary care.

- Nationally new diagnoses among MSM have been increasing since 2007 with 3,010 cases recorded in 2011, an all-time high.

- Late diagnosis is the most important predictor of morbidity and short-term mortality among those with HIV infection. In Birmingham the proportion of HIV diagnoses where CD4 cell count was <350mm3 at the time of diagnosis was 50%, equivalent to the England average. During 2009-11, the proportion of cases where HIV was diagnosed late was 5.8% lower than the previous period (2008-10). Nationally, late diagnosis was lowest amongst MSM and varied greatly across ethnic groups of heterosexuals with Black African men and Black Caribbean men being the most likely to receive late diagnoses.

- Gay and bisexual men with HIV have continued sexual health needs after a positive diagnosis since secondary STIs increase the viral load of the individual and can make the person more infectious.

- International research suggests transgender women are found to be 49 times more likely to have HIV compared to the general population[2]

2.2 All STIs

- Sexually transmitted infections (STIs), including HIV, are one of the major infectious disease problems in the UK today. STIs impact enormously on morbidity ranging from the acute and chronic disease manifestations of HIV to complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility from untreated chlamydial and gonococcal infection, and cervical cancer from human papilloma virus (HPV).

- In terms of STIs, young people, Black minority communities and MSM are disproportionately affected. In 2012, there were 536 newly diagnosed cases of STIs in MSM compared to less than 5 cases in homosexual females.

- Over the last five years (2008-2012), Birmingham has seen a 28.4% increase in the rate of new STI diagnosis in GUM. Last year (2012) a total of 8,820 new infections were diagnosed.

- This number translates into 1039.1 per 100,000 population which is higher than both the national (792.1 per 100,000) and regional (739.3 per 100,000) rates[3]. STI diagnoses were highest in females aged 20-24 years (4,863.3 per 100,000) and males of the same age (4,159.6 per 100,000)[4].

[1] http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/Page/1272031707222
[2] Baral, S.D. et al (2012) *Worldwide Burden of HIV in Transgender Women: A Systematic Review and Meta-analysis.* The Lancet 2012: 13: 13
[3] Latest available year is currently 2011 - http://www.apho.org.uk/default.aspx?RID=117785&TYPE=FILES
[4] Public Health England Spotlight Report for Birmingham

- Rates of new STI diagnosis were highest in black males (4,233.1 per 100,000) and black females (3,400 per 100,000) whilst the lowest rates of new diagnosis were seen in Asian females (341.7 per 100,000) and Asian males (555.2 per 100,000).

2.3 Chlamydia

- In 2012, Birmingham achieved a chlamydia diagnostic rate of 2,345 per 100,000 – slightly exceeding the national target of 2,300. Birmingham had a higher diagnostic rate than both the national (1,979 per 100,000) and regional (1,878 per 100,000) average.

- Birmingham ranked 5th highest of 8 core cities for chlamydia diagnosis rates during 2012. Newcastle has the highest diagnosis rate at 3,543 per 100,000 and Sheffield had the lowest (1,852 per 100,000).

- Birmingham was below the core city average chlamydia diagnosis rate of 2,490.4 per 100,000 population aged 15-24 year olds.

- Local coverage of the NCSP was 27.5% in 2012, exceeding the national (25.8%) and regional (24.3%) coverage of the population aged 15-24 who had been tested for chlamydia during the year.

- Birmingham did however have less population coverage than the core city average of 30.4%.

- Of GUM diagnosed chlamydia in 2012, where sexual orientation was known, heterosexual cases represented 94.4% of the total. Of those cases who were homosexual, 99.2% were MSM.

2.4 Gonorrhoea

- Between 2011 and 2012, Gonorrhoea cases diagnosed in GUM increased by 14%. Although still increasing, the trend is slowing (following a previous increase of 59% seen between 2010 and 2011).

- Over the last 5 years, Birmingham has seen the rate of new cases of Gonorrhoea diagnosed at GUM clinic increase by 67.5% from 56.7 cases per 100,000 in 2008 to 95 cases per 100,000 in 2012.

- In 2011, Birmingham's rate of diagnosed gonorrhoea in GUM clinic ranked second highest of the 8 core cities, and was above the core city rate of 62.3 cases per 100,000. The rate of diagnosed cases of gonorrhoea was highest in females aged 20-24 years (286.9 per 100,000) and males of the same age (411.8 per 100,000). This age group was also the highest nationally (140.9 per 100,000 and 249.1 per 100,000 respectively)

- Males of black ethnic origin had the highest rate of GUM diagnosed gonorrhoea (518.4 per 100,000) followed by females of mixed origin (369.0 per 100,000).

- Of the cases of GUM diagnosed gonorrhoea in 2012, where sexual orientation was known, heterosexual cases represented 73.4% of total cases. Of those cases who were homosexual, 100% were found in MSM.

2.5 Syphilis

- Between 2010 and 2012 there were 91 males and 14 female diagnoses of syphilis[5]. The rate of syphilis diagnosed at GUM clinic has seen a marked reduction of 81.4% in the past 5 years (2008-2012).

- For the latest comparable year (2011) the diagnosis rate of syphilis in Birmingham was lower than the national rate and only slightly higher than the regional rate[6]. Birmingham has the second lowest rate of syphilis diagnosis of 8 core cities, and was below the core city average rate of 6.1 cases per 100,000 population (2011). There is a marked difference in the incidence of diagnosis between genders. Between 2010 and 2012, the ratio of male : female diagnosis was 7:1[7]

- Of the cases in 2012 where sexual orientation was known, heterosexual cases of GUM-diagnosed syphilis represented 33% of the total cases. Of those cases who were homosexual, 100% were found in MSM.

2.6 Genital Warts

- In Birmingham, there were 1,487 diagnosed cases of genital warts during 2012, an increase of 8% from 2011. The incidence of new cases was greater in males (832 cases) who also saw a greater % increase (11%) than females (655 cases) over the same period (5%).

- The rate of diagnosed cases of genital warts was highest in males aged 20-24 years (621.0 cases per 100,000) and females of the same age (555.3 cases per 100,000). This reflected the pattern nationally. Females of mixed origin had the highest rate of genital warts (345.2 per 100,000) followed by males of the same background (321.2 per 100,000).

- Of the cases in 2012 where sexual orientation was known, heterosexual cases of GUM diagnosed genital warts represented 94.2% of the total cases. Of those cases who were homosexual, 98.5% were in MSM.

- The HPV vaccination programme was introduced in Birmingham in September 2008. In 2011/12, 84.1% of girls aged 12-13 received all three doses of the vaccine, slightly lower than the national programme coverage of 86.8%[8].

2.7 Genital Herpes

- The rate of genital herpes has seen an increase of 37.7% over the last 5 years with the latest figures showing there to be 63.5 cases per 100,000.

[5] HIV and STI Portal https://www.hpawebservices.org.uk/HIV_STI_WebPortal
[6] http://www.apho.org.uk/default.aspx?RID=117791&TYPE=FILES
[7] HIV and STI portal
[8] The HPV vaccine which also protects against genital warts was introduced in September 2012. Whilst the coverage for this year is not yet available, the principle of coverage from the previous year may be applied.

- The rate of genital herpes was highest in females aged 20-24 (299.3 cases per 100,000) followed by females aged 15-19 years of age (200.6 cases per 100,000). For males, the age group 20-24 was the most affected (135.1 cases per 100,000). Females of mixed origin had the highest rate of genital herpes (297.6 cases per 100,000) followed by females of black ethnic origin (288.6 cases per 100,000).

- Of the cases in 2012 where sexual orientation was known, heterosexual cases of GUM diagnosed genital herpes represented 95.8% of the total cases. Of those cases who were homosexual, 95.7% were in MSM.

2.8 Hepatitis B

- The Hep B vaccination is available on the NHS for anyone who may be at increased risk of hepatitis B or its complications. At risk groups include[9]:

    - MSM
    - Injecting drug users, or partners who injects drugs
    - People who change their sexual partners frequently
    - Street workers

- Nationally the frequency of new diagnosis of Hepatitis B has declined from 19.3 per 100,000 in 2008 to 16.2 per 100,000 in 2010, and then increased slightly to 16.9 per 100,000 in 2011.

- Less than 10% of individuals testing positive for Hepatitis B were identified as having an acute infection with the proportion of acute infections declining over time, suggesting an on-going pool of undiagnosed individuals[10].

- A greater proportion of males tested positive compared to females each year. From 2008 to 2011, 2.1% of males and 1.2% of females tested positive for Hepatitis B.

- Nationally 8.9% of Black/Black British individuals and 6.9% of Other and/or Mixed origin individuals tested positive compared to 2.8% of Asian/Asian British individuals and 0.9% of White/White British individuals. A greater proportion of males tested positive than females in all ethnic groups.

2.9 Hepatitis C

- Laboratory reports of Hep C in Birmingham residents declined slightly from 22.2 cases per 100,000 in 2008 to 21.2 cases in 2012 – equivalent to a reduction of one actual case during the period[11]. These cases may include those with a positive test for Hep C antibody (a marker of past infection) and / or detection of Hep C RNA (a marker of persistent infection).

- Nationally the proportion of individuals testing positive declined between 2008 and 2010, from 3.4% to 2.5% then increased slightly in 2011 to 2.6%.

[9] http://www.nhs.uk/conditions/vaccinations/pages/hepatitis-b-vaccine.aspx
[10] http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317137853783
[11] PHE - LabBase

- Overall, a greater proportion positive was observed among males compared to females. However, females testing in prisons had a consistently high proportion positive than males in the same environment.

- The proportion testing positive for Hepatitis C varied slightly by ethnic group; 2.7% of individuals of White/White British ethnic origin tested positive compared to 2.6% of Asian/Asian British origin individuals, 1.7% of other or mixed ethnic origin individuals and 0.9% of Black/Black British origin individuals.

- The highest proportion of positive tests was observed in specialist drug services (18.0%) and prison services (11.9%).

3. Contraception, conception and abortion

- Nationally, around four million people per year use NHS contraception services. Of these, approximately three quarters see a GP with the remainder attending NHS contraception services or RSH clinics - family planning clinics and independent clinics provided by third sector organisations such as Brook. There are three categories of contraceptives;

    - Long acting reversible contraception (LARCs) – intra-uterine devices (IUD and IUS), injectables and implants. IUD and IUS are very similar but the main difference is some operate 'mechanically' ('coils') and others contain the hormone progesterone or, less commonly, a combination of both male and female hormones,
    - User-dependent – oral contraceptives, male condoms, female condoms, contraceptive patches and vaginal ring and
    - Other – cap/diaphragm, other chemicals, natural family planning, vasectomy.

- Nationally 28% of the total first female contacts attending services for contraceptive reasons only, received LARC (2011/12). Across Birmingham NHS contraceptive services, this proportion was much lower at 13%.

- There are four providers of NHS contraceptive services within Birmingham. Of these, New Attitudes saw the largest proportion of its female clients receiving LARC at first contact (27%) whilst Birmingham Brook saw the fewest female clients receiving LARC at the same point (7%). This difference is likely to be due to the younger age range of clients attending the Brook service.

- During 2011 there were 746 teenage conceptions within Birmingham giving a rate of 34.3 conceptions per 1,000 females aged 15-17[12] . Between 1998 and 2011, Birmingham achieved a 41.1% reduction in its under-18 conception rate and a 36% reduction in the actual number of conceptions during the same time period. The reduction in conception rates seems to be driven by the reduction in conceptions as opposed to an increase in abortions within this age group. Rates within Birmingham wards range from 19 per 1,000 in Hall Green and 83 per 1,000 in Shard

[12] Office of National Statistics (ONS)

End.[13] In 2011 Birmingham had the second lowest teenage conception rate within its core cities cluster, although it had the highest actual number of conceptions.

- The variation in the under-18 conception rate at ward level largely reflects the pattern of deprivation, poor educational attainment and disengagement at schools, with the majority of conceptions occurring in the most deprived wards.

- In Birmingham, following national trends, there is some encouraging evidence that the rate of abortions has levelled off and may be decreasing. In 2011, there were 5,667 NHS funded abortions in Birmingham, of which 83.5% were under 10 week's gestation. National under-10 week abortion percentage was 77.9%.

- Percentage of abortions in age under 19 years that are repeat abortions for Birmingham in 2011 was 13.3%, compared to a national figure of 10.9%. For the Under 25 age group this varies considerably by geographical location across the city. Data available by PCT (Pre-NHS reform 2011) indicated that repeat terminations were higher than one in every three procedures (36%) in Birmingham East & North PCT compared to 29% in HoB PCT and 31% in South Birmingham. The England average is 25.5%.

4. Sexual Exploitation, Violence and Coercion

- In 2012/13, the Sexually Inappropriate Behaviour Team received 108 referrals for CYP ranging from 5-19 years of age; 26% were for children from BME groups, and 30% were for children with a recognised disability/ special need.

- 16,500 children from across England were identified as being at high risk of Child Sexual Exploitation (CSE) during the period April 2010-March 2011. Although the majority of victims are female, difficulties in recognising sexual exploitation among boys and young men are likely to have led to an underrepresentation of male victims.

- In 2011, an audit of Birmingham Looked After Children (LAC) records found that 2% of children aged 0-10 years, and 25% aged 11-17 were identified as being at risk of CSE. Children in residential care were identified at greatest risk, with 42% being identified as at risk of sexual exploitation.

- Research into sexual exploitation in gangs[14] suggested that a disproportionate number were living in residential care when the abuse began, and the vast majority of which were female. Victims were most commonly 15 years old, however ranged from age 4 to 19. Nearly a third of victims (28%) were from black and minority ethnic backgrounds.

- Gang-associated girls and young women can be vulnerable to sexual violence and exploitation within gang-affected neighbourhoods[15]. Although young men can also be vulnerable to gang-

[13] Latest ONS ward level data is 2008-2010

14 http://www.childrenscommissioner.gov.uk/info/csegg1

15 Ending Gang and Youth Violence and the Tackling Child Sexual Exploitation Action Plan (DfE 2011)

associated sexual violence or exploitation (a risk that must not be overlooked), as with other forms of sexual exploitation and violence, young women appear to be disproportionately impacted. This includes both young women who are directly associated with gangs and those with secondary association through relationship, such as siblings.

- Victims of CSE have a range of vulnerabilities but also identify a range of common themes including; a particularly strong association between CSE and a child having being reported missing on at least one occasion, disengagement from school, manifested in truanting, a lack of interest and frequent poor behaviour, including bullying peers. Chaotic and at times, aggressive behaviour of some victims, lead to a perception of risk to other children, by the police and social services. [16]

- In 2012/13, Barnados Amazon directly supported 142 CYP[17] who had been sexually abused or exploited. It is traditionally difficult for boys and young men to access services for victims of sexual abuse - about 13% of children receiving counselling were male. About 35% of service users were from black and minority ethnic backgrounds, and approx. 9% of service users were children with special needs. There were 20 CYP on the waiting list.

- Quantifying the extent to which children and young people are victims of sexual violence is challenging for definitional and methodological reasons. Moreover, as with adults, the nature of the problem tends towards under-reporting: the majority of sexual assaults on children were committed by other children and most victims knew the offender [18]

- Over 620 serious sexual offences against children and young people were reported to West Midlands Police in 2010. The most common offence was sexual assault of a female under 13 (196 cases, 31% of the total), followed by rape of female between 13-15 (26%) and rape of a female under 13 (23%)[19].

- Abused children and young people are more prone to sexually transmitted infection and they are at increased risk of mental health problems and homelessness. The relatively high prevalence of sexual violence in young women is exacerbated for those with pre-existing vulnerabilities and for some, may be associated with several other life risks.

- The annual incidence of sexual violence reported to the Police is just under 55,000 which is as many as the number of strokes (60,000) that occur in women across the UK.[20] However, sexual violence is under-reported as a crime. Only 11% of victims of serious sexual assault told police about the incident and few reveal the experience of prior sexual assault when using healthcare facilities. In 22.9% of cases where a young person aged 11-17 was physically hurt by a parent or

16 Out of mind, out of sight: Breaking down the barriers to understanding child sexual exploitation - Child Exploitation and Online Protection Centre – June 2011

17 CYPF funding only

18 NSPCC, 2011

19 Sexual Violence Needs Assessment for the West Midlands Police Force Area 2011

20 The Report of the Taskforce on the Health Aspects of Violence against Women and Children. Responding to Violence against Women and Children – the Role of the NHS. March 2010.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113728

guardian, nobody else knew about it. The same applied in 34% of cases of sexual assault by an adult and 82.7% of cases of sexual assault by a peer.

- It is estimated that approximately 193,000 adults living in the West Midlands have been a victim of some form of sexual violence at some point in their adult lives - just under half are believed to live in Birmingham[21].

- Young people are at greater risk of sexual violence. This is especially true for females: those aged 16 to 19 were twice as likely to be victims of sexual violence as those aged 20-24 - and 11 times more likely to be victims than those aged 55-59[22].

- In addition, poorer groups were found to have an elevated risk. Unemployed males and females were 2.8 and 2.6 times more likely to be victims of sexual violence than employed males or females respectively. *Long standing disability* also appeared to be a risk factor across both sexes, although this was only statically significant for males;

- Sexual violence can worsen the impact of inequalities in women, the vulnerable and the disadvantaged, and is often linked to domestic violence. The long-term effects of sexual violence are associated with depression, anxiety, post-traumatic stress disorder, psychosis, substance misuse, self-harm and suicide**.**

- In Birmingham (2010-12), hospital admissions for violence (including sexual violence) were significantly worse than the England average (97.6 per 100,000) – 3,173. Violent offences (including sexual violence) over the period 2010/11 are also significantly worse than England average (15.2 per 1000) – 15,786[23]

- In 2010/11 there were 340 female rapes in Birmingham a decrease from 2009/12, 412[24]. From 2011-12 data, Birmingham had a rate of 64.0 per 100,000 police recorded rapes in females – higher than the national rate of 52.1 per 100,000[25] Birmingham ranked 5th highest of 8 core cities for police recorded rape of a female during this period.

- The British Crime Survey (BCS) shows that access to services for victims of serious sexual assault is a major issue - just 2% access a SARC[26]. Sex workers accounted for 1.6% of SARC service users; there is insufficient data to know if this figure is proportionally high or low, but stakeholder interviews suggested that this group is particularly wary of attending the SARC.

- There is very limited Birmingham specific information relating to sexual violence and coercion in vulnerable population groups. Specific groups, such as people with learning disabilities or sex workers, are known to suffer high rates of victimisation; yet they are not well covered by the BCS or recorded crime statistics.

[21] Sexual Violence Needs Assessment for the west Midlands Police Force Area 2011
[22] Sexual Violence Needs Assessment for the west Midlands Police Force Area 2011
[23] Public Health Outcomes framework
[24] Sexual Health Balance Scorecard
[25] Sexual Health Balance Scorecard
[26] Sexual Violence Needs Assessment for the West Midlands Police Force Area - 2011

- One quarter of LGBT respondents to the *Out and About* survey indicated that they has been victims of domestic abuse[27].

5. Access to treatment Services

- There are two providers of GUM clinics in Birmingham – University Hospitals Birmingham NHS Trust (UHB) and Heart of England Foundation Trust (HEFT).
- In total there were 66,066 attendances (clients from any area) at Birmingham GUM clinics during 2012 - 24% were by non-Birmingham residents.
- There were a total of 57,077 attendances to GUM clinics (any area) by Birmingham residents during 2012 – an overall increase of 9.9% from 2011. For Birmingham clinics only, Hawthorne House (HEFT) saw an increase in clinic attendance by Birmingham residents (36.2%) in 2012 compared to a slight reduction in attendance at Whittal St - UHB (0.2%) over the same period.
- From 2009 to 2012, Hawthorne House saw a greater increase in attendance by Birmingham residents (47.8%) compared to Whittall St (12.4%)
- Data is still unclear relating to repeat attendance for a new episode of care.
- Data relating to access for other sexual health services in the city is currently unclear.

6. Unmet or unknown needs

- We still don't know whether key at-risk groups (e.g. LGBT, sexual workers, and care leavers) are using genito-urinary medicine (GUM). We also do not know enough about the circumstances relating to people presenting for treatment (e.g. coercion).
- Locally there is insufficient detailed information on the sexual health of lesbians and bisexual women, and this needs to be addressed by better data collection and research. Nationally it is suggested that less than half of lesbian and bisexual women have ever been tested for sexually transmitted infections. Over half of lesbian and bisexual women who have been tested for sexually transmitted infections have had an infection (a quarter of all respondents)[28]. The women who had been diagnosed reported the following infections: genital warts, chlamydia, genital herpes, pelvic inflammatory disease, Hepatitis B and C. There is no local data available to establish local trends.
- From recent local research[29] has identified higher risk of unwanted and /or unsafe sex, lack of knowledge of STIs and contraception amongst the transgendered population, with poor sexual health education generally.

[27] Out and about: Mapping LGBT Lives in Birmingham – Wood 2011
[28] Hunt, R. and Fish, J. (2008) Prescription for Change: Lesbian and Bisexual Women's Health Check 2008
[29] Equal Access, Equal Outcomes: A Strategy to Improve the Health and Wellbeing of Lesbian, Gay, Bisexual and Transgendered Communities in Birmingham - 2013

- The findings of a recent survey suggest 77% of transgendered people found it hard or extremely hard/ impossible to access trans-specific sexual health literature or information[30]. There is no targeted transgendered specific sexual health advice or interventions available in the city.

- In the same survey, 64% of transgendered respondents had never visited a sexual health clinic. Avoidance of sexual health services is common in the transgendered community which stems from body dysphoria and fear of inappropriate/ prejudicial treatment from health professionals.

- Practitioners may make assumptions about how transgendered people have sex (and who with) leading to underestimation of risk, e.g. a trans-man ticking 'gay' on forms may still be at risk of unplanned pregnancy, or a trans-woman may still need access to condoms etc. Lack of awareness of transgendered people and of these issues by staff, both clinical and administrative, can lead to difficulties.

- There is little specific evidence on the prevalence of sexual violence in LGBT communities. The prevalence of domestic violence (related to, but not the same as sexual violence) may be comparable to that of the general population, but slightly higher amongst lesbians and bisexuals, and significantly higher amongst transgendered individuals. However, reporting rates are lower across all LGBT groups[31].

- We do not know whether the needs of asylum seekers with HIV are being met effectively both by statutory and voluntary services. Other sexual health needs of asylum seekers and refused asylum seekers are unknown as residency status is not a routinely collected data field.

- Little is known about those accessing HIV voluntary services or social care for support and they represent a group whose needs may not currently be fully met.

- Sex workers have substantial sexual health needs, although it is not fully clear how many are using sexual health services in Birmingham. Across the UK, surveys of women involved in the sex industry have identified a disproportionate number of girls and young women with backgrounds of local authority care[32]. The health needs of male or young sex workers and 'off street' sex workers also remains unknown.

- The teenage pregnancy rate in Birmingham is declining and is currently at its lowest rate. This could indicate that service provision to support teenage pregnancy prevention has been effective. However, no local data is available on the causes of unplanned pregnancy or contraception failure or attitudes / knowledge in relation to accessing EHC across the city.

- The age at which children were most vulnerable to unwanted and regretted sex was identified nationally as 14 years, reinforcing the need for effective and consistent sex and relationships education to be in place early in the school career.

[30] Transgender Sexual Health in Birmingham – Needs Assessment (2012)
[31] Sexual Violence Needs Assessment for the West Midlands Police Force Area - 2011
[32] Young Women, Local Authority Care and Selling Sex: Findings from Research *British Journal of Social Work (2008)* 38, 1408–1424

- An understanding of the current curriculum for sex and relationship education in schools is required, in addition to how young people's knowledge of the practical use of contraceptives and STI awareness is developed. How young people's perceptions and understanding of acceptable/ appropriate behaviour within interpersonal relationships, and what constitutes a healthy relationship generally needs to be developed and where necessary, appropriately challenged.

7. Conclusions

Despite efforts to help control STIs, including the improved availability of treatment services in the city, the numbers of STI diagnoses remain higher than they were ten years ago and for many STI's these rates are increasing. While much of this increase is associated with more testing and improved diagnostic sensitivity, it is clear that high rates of infection persist in some population groups such as MSM, the black and mixed minority communities, and young adults.

The late stage of diagnosis in new cases of HIV and the continued rise in HIV in Birmingham is concerning. Improved uptake of testing for HIV is therefore vital for early detection and treatment to reduce morbidity and mortality.

Existing prevention efforts, such as greater STI screening coverage and easier access to sexual health services, need to be sustained and supported by earlier diagnoses to help reduce further transmission of infection. More importantly, prevention work needs to integrate with the core treatment offer to reduce repeat presentations, particularly in high risk groups.

More needs to be done to 'normalise' testing among sexually active young people and to ensure this service is easily accessible. There is potential to ensure that chlamydia testing is integrated into other services accessed by young people.

Long Acting Reversible Contraception (LARC) is the most effective form of contraception. LARC provision in Birmingham is comparatively lower than the national average. Although there has been a significant increase in the provision of LARC in areas of the city, more needs to be done.

The rate of repeat abortion in Birmingham is higher than the rate for England with, available data indicates there is considerable scope to reduce this through better access to effective methods of contraception. Contraception needs to be seen as part of the overall package of care for women undergoing abortions.

Although improving, reducing teenage pregnancy remains a significant challenge in areas of Birmingham. More needs to be done to identify and support young people at risk of teenage pregnancy, and young parents.

While accounting for less than 1% of all recorded crime, sexual violence is hugely under-reported and consensus opinion is that the scale of sexual violence and abuse is significant.