# Blackpool Sexual Health Needs Assessment

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**1 Introduction**

Sexual health is an important and integral part of overall health. This is captured in the working definition of sexual health developed by the World Health Organisation (WHO):

> ‘Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled’

The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies and means that non-residents are entitled to use the sexual health services provided in Blackpool.

Sexual ill health is not equally distributed among the population. Those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include; young people, men who have sex with men (MSM), people from African communities, people living with the human immunodeficiency virus (HIV), sex workers, victims of trafficking, victims of sexual and domestic violence and abuse and other marginalised or vulnerable groups.

This sexual health needs assessment is intended to present a picture of the sexual health needs and current service provision for sexual health in Blackpool and to support the development of the Sexual Health Action Plan for Blackpool 2017 – 2020.

This document is based on the methodology recommended for a ‘rapid needs assessment’ as outlined in the Department of Health guidelines and as such draws primarily on existing data. The final stage of the process is analysing the gaps based on the available data and making recommendations for future service development. A range of stakeholders from statutory and voluntary sector service providers were involved in supporting this process.

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1.1 Summary

This local sexual health needs assessment conducted in 2016 acts in response to the changing landscape and needs of our population.

Sexual health clinical services and sexual health promotion activities are commissioned and provided by a range of organisations, from school delivered PSHE to CCG NHSE commissioned HIV treatment services. The aim of this needs assessment is to provide a framework to guide both our planning of services commissioned by the Health and Wellbeing Board partner organisations, and the operational delivery of public health interventions.

Despite the progress that has been made, Blackpool continues to face a range of challenges and still has higher levels of need for sexual health services than other areas. Clear priorities have been identified from the needs assessment, and in consultation with stakeholders this has directed a strong focus on sexual health inequalities. This also resulted in a plan to ensure that there are robust care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.

Blackpool continues to have amongst the highest prevalence of HIV in the North West and although the proportion of people diagnosed at a late stage is considerably lower than average this is not showing a year on year reduction in line with the national picture. Similarly, our teenage conceptions are down, but we need to continue to maintain this downward trend as we are still higher than nationally. Abortion rates in the 18-19 year olds are almost twice the national average and a significantly higher proportion of 15-19 year olds are diagnosed with a new Sexually Transmitted Infection (STI). Indeed, overall the burden of ill health is predominantly in our under 25s, so this again is a focus for our interventions.

The health needs assessment was presented at a stakeholder event, where a deep dive process was used to identify key actions to address the current issues faced in Blackpool and to horizon scan for the future.
2 Mapping Need

2.1 Blackpool’s population

Mid-year population estimates show Blackpool’s overall population as approximately 139,500 which is a slight decrease over the last three years. 49.3% (68,795) are male, 50.7% (70,783) female.

Blackpool’s population pyramid (Figure 1) shows that there are a higher proportion of older people than the England and Wales average and almost half of the population of Blackpool (48%) are aged over 45. It has a lower proportion in the under 40 age group, particularly in the 25-39 group where it was considerably lower than England and Wales averages. Young people, 15-24, make up 12% of Blackpool’s population. Nationally over half (53%) of all new sexually transmitted infections (STIs) are in this age group.

![Figure 1: Population Pyramid – mid-2015 estimated resident population](image)

Source: ONS mid-year population estimates, 2015

Blackpool currently has an aging population with projections showing an increase in the 65+ population continually in the coming years which is reflective of England as a whole (Figure 2).

The total population of Blackpool is projected to remain relatively static in the longer term, going from 140,500 in 2014 to 139,800 by 2039 (ONS mid-2014 based population estimates) though it does fall to a low of 138,800 in the mid 2020’s. Sexual health services will need to ensure they are able to understand and meet the particular sexual health needs of an ageing population.

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2.2 Ethnicity

A significantly smaller percentage of ethnic minority groups live in Blackpool compared to the national average. Approximately 3.3% of the population is from an ethnic minority compared to 14% in England and Wales. The main ethnic minority groups in Blackpool are non-British white, including people from Eastern Europe, Asian groups and people of mixed heritage.

Blackpool residents from an ethnic minority group could be more isolated and have more trouble in accessing culturally specific resources than those in areas with higher ethnic diversity. Blackpool is less likely to have a well-developed voluntary sector and/or community groups that are targeted to meet the needs of minorities, while staff in services may have less direct experience of particular issues and cultural needs of ethnic minorities. In addition to this, the services may have fewer resources such as information leaflets and marketing materials aimed at minorities within Blackpool.
The highest rates of STI diagnoses were found among people of black ethnicity and the majority of these cases were among people living in areas of high deprivation, especially in urban areas\(^4\). This high rate of STI diagnoses among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Services will need to ensure they take care to address the cultural needs of the minority population and be sensitive to the difficulties of meeting these needs in an area which lacks ethnic diversity.

### 2.3 Transience and migration

Blackpool has long been identified as having an issue with transience; the South Shore area has particularly high transience with a population inflow rate of 193 per 1,000 population. GP registration data also suggests that approximately 2% of people move around 3 times a year within Blackpool indicating a degree of ‘churn’ within the town and adding to the issues of transience. The age group most likely to move are the 20-29 year olds\(^3\).

Transient populations may not be engaged with traditional health services and may be less likely to be registered with a GP. They may have more difficulty in accessing services via traditional appointment systems due to potential difficulties in receiving postal and telephone services. People coming into the area from outside will not have knowledge of services and their locations; hence services should take particular care to continually market and promote their services.

There may also be implications for services in terms of contact tracing and follow up. Services should pay particular attention to the needs of more transient people and consider alternative methods of service delivery such as peripatetic/mobile services and outreach etc.

### 2.4 Income and employment

The number of people classed as unemployed is around 8% in Blackpool, higher than the national average of 5.9%. The number of people who are economically inactive (those who do wish to work or are unable to do so) in Blackpool is approximately 30%, again higher than the national average of 22%\(^5\). Incomes across Blackpool are among the lowest in the country, weekly earnings are approximately £319 compared to £426 nationally. Median gross annual earnings for all employees are approximately £16,384 in Blackpool compared to £22,487 nationally\(^6\).

Income and employment has implications for services; where limited resources and limited access to transport makes physical access to services problematic, services should strive to ensure that

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4 PHE, weekly Health Protection Report, Infection report HIV-STIs, Volume 10 Number 22, July 2016
6 ONS, Annual Survey of Hours and Earnings, 2014
they are accessible to the most deprived communities via public transport and explore options such as advice lines, peripatetic and outreach services.

3 High Risk Groups

3.1 Looked After Children (LAC)

Blackpool has the highest rate of LAC within England and has far higher rates than similar local authorities. Data for 2014 showed 445 children were looked after in Blackpool. The rate of LAC was 152 per 10,000 children compared to the national average of 60 per 10,000 in 2014\(^7\). The number of children in care has risen almost every year from 2008 with nearly double the amount from 2008 to 2014.

The available evidence shows that children in care often have a higher rate of poor sexual health and may be more prone to involvement in risky sexual activity, exploitive and abusive relationships and early parenthood. Many looked after young people in Blackpool may also have come to Blackpool from other areas in the region and beyond and as such are likely to have little or no knowledge of local services.

3.2 Parents with multiple children in care

A number of expectant mothers would be eligible for the Pause project\(^8\) in Blackpool, most of whom had had a number of children taken into care previously. Pause works with women who have experienced, or are at risk of, repeat removals of children from their care. It aims to break

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\(^8\) PAUSE [http://www.pause.org.uk/](http://www.pause.org.uk/)
this cycle and give women the opportunity to develop new skills and responses that can help them create a more positive future.

Early findings from the Pause project in Blackpool have indicated a significant number of women have had multiple children removed and taken into care. It is estimated approximately 140 women and 380 children may be in the cohort identified, though these figures may change as the scoping exercise develops. Sexual health services will need to consult with service users to support effective marketing/promotion of LARC to complex women. See section 9.2 - Contraceptive care.

3.3 Child Sexual Exploitation (CSE)

Blackpool experiences considerable levels of disadvantage with many families who are from socially and economically deprived backgrounds and who often have an array of complex needs that require additional support from a range of service providers. The proportion of ‘looked after children’ is high compared to many other authorities in England and Blackpool has the 10th highest rate of ‘children in need’ in England. Abuse and neglect represent the biggest need areas for safeguarding children in Blackpool and proportions of children in need under these categories are higher than seen elsewhere⁹.

Figures reported by Lancashire Constabulary show that there were 144 reports of crimes with a CSE element in Blackpool in 2015/16, a rate of 1.0 per 1,000 population (Figure 5). This is a slight increase from 131 in 2014/15 and is significantly higher than the Lancashire average of 0.4 per 1,000.

Figure 5: Recorded Crime with Child Sexual Exploitation qualifier: Blackpool and Lancashire, rate per 1,000 population

![Figure 5: Recorded Crime with Child Sexual Exploitation qualifier: Blackpool and Lancashire, rate per 1,000 population](http://www.blackpooljsna.org.uk/Developing-Well/Children-and-young-peoples-wellbeing/Child-Sexual-Exploitation.aspx)

Child Sexual Exploitation (CSE) in Lancashire is an operational priority area that represents a county wide threat. The **Awaken Project** is run jointly by Blackpool Children's Services and the police, based at Bonny Street Police Station. Its aim is to safeguard vulnerable children and young people under the age of 18 who are sexually exploited and to identify, target and prosecute associated offenders. **Blackpool Safeguarding Children Board** (BSCB) has a safeguarding policy in place to assist practitioners working with sexually active under 18s to identify and assess where relationships may be abusive and the young people may be in need of protection and/or additional services.

There is a requirement for sexual health services to attend BSCB and to ensure that it has safeguarding policies and procedures in place and to comply with the Blackpool Safeguarding Adult and Children Board’s guidelines. The service is also required to undertake the CSE Toolkit (developed by Brook) with all relevant users of the service and refer to other agencies such as child protection as per safeguarding policies.

### 3.4 Sex workers

Blackpool has a number of sex workers operating on the street, as well as in venues such as massage parlours and saunas. Sex workers as a group can be characterised by multiple vulnerabilities, for example, having been a looked after child or young person\(^{10}\) or having drug or alcohol problems\(^{11}\). Self-report of sexually transmitted infections (STIs), termination of pregnancy and sexual assault are also high in this group\(^{12}\). It is vital that the sexual health needs of this vulnerable group are prioritised in any sexual health strategy.

**Operation Azure** is a multi-agency partnership formed to tackle issues around sex work in Blackpool. This includes preventing the sexual exploitation of women and children and dealing with premises which are nuisances to the public.

The **Sex Workers Outreach and Support Service (SWOSS)** project is funded by Blackpool Council and provided by Renaissance at Drugline, Lancashire. The service supports all those over the age of 18 involved in the sex industry in Blackpool. This includes the provisions of free condoms, help with accessing sexual health and other health services, support with substance misuse issues and promotion of personal safety, sexual health and emotional health and wellbeing. Additionally, the service promotes the

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Ugly Mugs scheme, allowing sex workers to circulate descriptions of dangerous customers nationwide.

### 3.5 Lesbian, Gay, Bisexual and Transgender

Blackpool has a large population of lesbian, gay, bisexual and transgender (LGB+T) people. Accurate estimates of the numbers of the population are difficult to arrive at, although sexual orientation is now recorded in the national census. Local estimates have provided a figure of 7-8% of the population in Blackpool being lesbian, gay, bisexual or transgender (national estimates based on the Integrated Household Survey 2012 are 1.5%) which would give a figure of around 10,500 LGB+T people in Blackpool. Blackpool has a large number of LGB+T businesses such as entertainment venues, hotels and guesthouses, all of which attract visitors from outside of the area. It should also be noted that Blackpool’s LGB+T population is as likely to be affected by issues of transience and migration in and out of the area as is the rest of Blackpool’s population.

Lesbian, gay, bisexual and transgender people experience a number of health inequalities which are often unrecognised in health and social care settings. Research suggests that discrimination has a negative impact on the health of LGB+T people. Many people are reluctant to disclose their sexual orientation to their healthcare worker because they fear discrimination or poor treatment. Healthcare and other professionals commonly assume that LGB+T people’s health needs are the same as those of heterosexual people. The sexual health needs for LBG+T people are not homogeneous. Lesbians, gay men, bisexual men and women, transgender men and women, young LGB+T people and older LGB+T people will all have differing needs. Research commissioned by Stonewall indicates that a high proportion of lesbian and bisexual women and gay and bisexual men have never been tested for STIs.

Evidence also suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex. Stonewall’s research found that 51% of gay men had taken illegal drugs in the previous year, compared with 12% of men in the wider population.

Services should ensure that they are accessible and welcoming to LGB+T people. Services should ensure all staff undertakes training to understand the varying needs and potential barriers to access for LGB+T people and are able to actively challenge homophobia. Services should outreach to LGB+T groups and venues to increase awareness of their services. All sexual health services should maintain close links with local LGB+T community groups, youth groups and voluntary sector organisations. There is a particular need for sexual health materials such as posters and leaflets specifically for young LGB+T people in Blackpool. Much of the available materials are not age appropriate or are specific to other areas of the country.

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13 Stonewall (2013) Lesbian and Bisexual Women’s Health Survey
14 Stonewall (2013) Gay and Bisexual Men’s Health Survey
All sexual health services should give careful consideration to routinely monitoring the sexual orientation of their clients. This will enable services to ensure they are accessible to this group.

3.6 Prison Population

Blackpool does not have a prison, though Kirkham prison is located close by. This presents a number of challenges particularly related to sexual health for our prisoners who are on day release and choose to spend their time in Blackpool. This has placed a significant burden on prison health care in treating associated infections.

3.7 Vulnerable Adults (including Learning Disabilities)

Coping with puberty, sexual identity and sexual feelings can be more difficult for people with learning disabilities who might be struggling to understand their emotions and their body. The sexual needs of people with learning disabilities have historically been ignored and often, sexuality only becomes an issue to be discussed when there is a problem.

Sexual health services in Blackpool aim to improve access to service for people with a learning disability/mental health issue by working with mental health and learning disability teams to develop domiciliary care pathways for vulnerable groups not accessing services.

Service provision is also targeted at groups with particular needs who may be vulnerable and at risk from poor sexual health, including young people, gay and bisexual men, some black and minority ethnic groups as well as people with learning disabilities.

4 Alcohol

The consumption of alcohol within the Blackpool area is a historical and significant problem with alcohol having a negative impact on health, crime and the economy. Alcohol related mortality and hospital admissions for alcohol related conditions are significantly higher than the national average. Blackpool has a thriving and vibrant night-time economy, and like many towns and cities, that economy centres around entertainment premises licensed to sell alcohol. The alcohol industry brings some economic prosperity through employment, yet paradoxically 105,000 working days a year are lost in Blackpool due to alcohol misuse.

Although the number of alcohol-related sexual crimes each year is small, Blackpool residents are significantly more likely to be victims of alcohol-related sexual crime than England as a whole. There were 41 cases of alcohol-related sexual crime in 2012/13 experienced by Blackpool residents.

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There is evidence that alcohol consumption and drunkenness results in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour, such as not using contraception or condoms. Evidence from the England Gay Men’s Sex Survey 2014 found that 31% of men surveyed thought alcohol played a part in their HIV acquisition.

Alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age, and alcohol misuse is linked to a greater number of sexual partners and more pressure to have sex. Alcohol also increases the risk of sexual aggression, sexual violence and sexual victimisation of women. As such alcohol Identification and Brief Advice (IBA) interventions should be included in sexual health consultations. Services should continue training and refreshing their staff in IBA in order that they have the skills to raise the issue of alcohol with service users. In addition, sexual health services are also required to record AUDIT-C score for alcohol use and make active referrals to treatment services as appropriate.

5 Sexual Health

5.1 HIV and AIDS

The North West has a very similar outlook as the rest of the UK when looking at HIV, there has been a gradual decline in cases both regionally and nationally in the last 10 years. Public Health England (PHE) report an estimated 103,700 people were living with HIV in 2014.\(^\text{16}\) The overall prevalence in the UK in 2014 was 1.9 per 1,000 people aged 15 years and over. An estimated 18,100 (17%) were unaware of their infection and at risk of unknowingly transmitting HIV.

\(^{16}\) PHE, HIV in the UK – Situation Report 2015. Incidence, prevalence and prevention
Figure 7 shows the population prevalence of HIV and AIDS by local authority across the North West, 2014 and demonstrates that Blackpool continues to have amongst the highest prevalence of HIV in the region.

Figure 7: Population prevalence of HIV and AIDS - Number of cases of HIV per 100,000 population by local authority of residence, Cumbria and Lancashire, 2014

New diagnoses

New HIV diagnosis is not synonymous with prevalence; however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission. Although the majority of HIV diagnoses are made in genitourinary medicine (GUM) services, HIV testing has been introduced in a variety of different medical services and non-medical settings, including the expansion of self-sampling/self-testing\(^\text{17}\).

In the North West, 590 residents were newly diagnosed with HIV in 2014, a rise of 13% from 2013\(^\text{18}\). The highest proportion (62%) of all new diagnoses in North West residents were in men who have sex with men (MSM) (compared to 61% in 2013 and 42% in 2005). Of the MSM newly diagnosed with HIV 88% were white and 86% were UK born\(^\text{18}\). In Blackpool, the new diagnosis rate for residents aged 15-59 years in 2014 (10 per 100,000) is below that of England (12 per 100,000) (Figure 8). Of the 12 new cases in Blackpool in 2014 80% were male, 40% were aged 25-34 years and 33% were aged 35-44 years, 13% were in the 20-24 and 45-64 year age groups.

\(^{17}\) PHE, Sexual and Reproductive Health Profiles https://fingertips.phe.org.uk/profile/sexualhealth
\(^{18}\) PHE, Annual epidemiological Spotlight on HIV in the North West, 2014 data
Across the North West, the number of new diagnoses was highest in the 25-34 year age group in both males and females in 2014. In Blackpool the number is highest in males aged 25-44, with 9 new cases in this age range in 2014.

Prevalence

In 2014 there were 354 total cases of HIV and AIDS in Blackpool residents. Among these, 93.2% were white, 1.4% black African and 1.4% black Caribbean. With regards to exposure, 79.2% most likely acquired their infection through sex between men and 18.1% through sex between men and women.

The diagnosed HIV prevalence rate was 3.8 per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England (Figure 10). This has increased from the 2013 rate of 3.4 per 1,000 population aged 15-59 years. Blackpool is the only authority in Lancashire above the threshold.
whereby testing is recommended in general settings including all medical admissions and all new registrations in general practice (ie, 2 per 1,000 or 200 per 100,000).

**Figure 10:** HIV diagnosed prevalence rate

![Figure 10](image)

*Source: PHE, Sexual and Reproductive Health Profiles*

Figure 11 shows that Blackpool is one of only four lower tier local authorities in the North West with a diagnosed HIV prevalence rate in excess of 2 per 1,000 population which is the threshold for expanded HIV testing. The others were Salford (4.8), Manchester (5.8) and Liverpool (2.1).

**Figure 11:** Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by district in the North West, 2014

![Figure 11](image)

*Source: Public Health England, HIV and Aids New Diagnosis Database (HANDDD)*

In 2014, 37% of those living with HIV in Blackpool were aged between 45-54 years, 25% were 35-44 years, 24% 55 years and over and 14% 15-34 years. Males represented 92% of Blackpool residents living with HIV in 2014.
HIV testing and uptake
In Blackpool the percentage of eligible GUM episodes where an HIV test was accepted, as a proportion of those offered, was higher than the England average total for men, women and MSM.

HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission. As figure 12 shows the percentage of eligible new GUM patients who accepted a test, as a proportion of those eligible, is higher than the England average total.

Figure 12: HIV testing uptake and coverage (%) % uptake: 2015

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<tr>
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<th>Uptake</th>
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<th>Coverage</th>
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<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Men</td>
<td>Women</td>
<td>MSM</td>
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<tr>
<td>England</td>
<td>76.2</td>
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<td>81.2</td>
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<td>95.8</td>
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Source: Sexual and Reproductive Health Profiles, PHE

Figure 13 shows that HIV testing coverage in Blackpool has been consistently higher than the North West average since 2009 and higher than the England average since 2013.

Figure 13: Trend in HIV testing coverage in Blackpool, 2009-2015

Source: Sexual and Reproductive Health Profiles PHE
Route of infection

Of the estimated 103,700 people living with HIV in the UK, 45% were infected via MSM. Figure 14 shows that across Blackpool infection from MSM remains by far the highest exposure route (80% in 2014), but has fallen from 83% of all HIV cases in Blackpool in 2013.

While MSM remains the most common route of infection, figure 15 shows that the proportion of HIV from a heterosexual route has increased to 18% in 2014 from a constant 15% over the last few years. The recent increase is in male heterosexual diagnoses, a 52% increase from 25 cases in 2013 to 38 cases in 2014. Female heterosexual diagnoses have increased 23% from 22 in 2013 to 27 in 2014. By comparison, MSM increased 9% from 258 to 282.

Heterosexual contact was the second largest infection route for new diagnoses in North West residents in 2014 (36%). Infections in African born persons accounted for 38% of all heterosexually acquired cases in 2014 compared to 72% in 2005. Infections in UK born persons accounted for 46% of all heterosexually acquired cases in 2014.

The transmission of HIV through injecting drug use is low and accounted for <1% of new diagnoses in Blackpool and across the North West in 2014. However, according to the Gay Men’s Survey findings in 2014, 31% of the men diagnosed in the last year indicated other drugs played a part in their acquiring HIV, compared with 22% of those diagnosed for more than 12 months, suggesting that drugs (but not alcohol) are playing an increasing (but still not primary) role in the HIV epidemic.

Figure 14: HIV Exposure Groups, Blackpool and UK comparison, 2014

Source: PHE, HIV and STI Portal

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Late diagnoses
In the UK, many people are diagnosed at a late stage of HIV infection - this is defined as having a CD4 count under 350 within three months of a diagnosis. People living with HIV can expect a near-normal life span if they are diagnosed promptly. People diagnosed with HIV late continue to have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed early.16

Key strategic priorities for HIV are to reduce the proportion of late HIV diagnoses and to increase the proportion of HIV infections diagnosed. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection and it is essential to evaluate the success of expanded HIV testing. This indicator directly measures late diagnoses; over time it will show whether there is a trend towards earlier diagnosis.

In Blackpool, between 2012 and 2014, 35% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 42% in England. Despite late diagnosis rates being slightly better than the England, the rates have not shown the same gradual reduction as in the North West and England.

Heterosexuals were more likely to be diagnosed late (67% of males, 50% of females) than MSM (37%). By ethnic group, black Africans were more likely to be diagnosed late than the white population (63% and 42% respectively).18 Men with a bisexual (60%) or a straight/heterosexual identity (35%) were far less likely to have ever been tested according to the Gay Men’s survey carried out in 2014, and yet Blackpool has seen an increase in heterosexual males diagnosed (figure 15).
Men who have sex with men are advised to have an HIV and STI screen at least annually, and every 3 months if having unprotected sex with new or casual partners.

**Figure 16: % HIV late diagnosis Blackpool**

![Graph showing percentage of late HIV diagnosis in Blackpool, England, and North West England from 2009-2012.]

*Source: Sexual and Reproductive Health Profiles, PHE*

The data on continuing high prevalence and reducing incidence of HIV in Blackpool suggests a need to ensure the continuation of services to support people who are living with HIV. However, the higher rates of new infections amongst men who have sex with men in Blackpool suggest there is a need for continuing targeted prevention with this group. Sexual health promotion aimed at the general population should also ensure that a focus on HIV is maintained with the aim of reducing new infections amongst heterosexual people, particularly improving testing in males. Other groups vulnerable to increased higher-risk sexual behaviour should also be considered for targeted HIV testing i.e. substance users, sex workers and swingers. The focus should be flexible to enable targeting to move quickly as new evidence is made available.

**Figure 17: Number and percent of late HIV diagnosis Blackpool**

<table>
<thead>
<tr>
<th></th>
<th>Blackpool</th>
<th>North West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>2009-11</td>
<td>17</td>
<td>32.1</td>
<td>53.3</td>
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<tr>
<td>2010-12</td>
<td>13</td>
<td>37.1</td>
<td>52.7</td>
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<tr>
<td>2011-13</td>
<td>13</td>
<td>34.2</td>
<td>48.1</td>
</tr>
<tr>
<td>2012-14</td>
<td>14</td>
<td>35.0</td>
<td>45.8</td>
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</tbody>
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*Source: Sexual and Reproductive Health Profiles, PHE*

Importantly, we need to increase awareness and uptake of HIV testing by implementing BASHH testing guidance in primary care, ensuring HIV testing is accessible through secondary care, community settings, integrated sexual health services and on-line self-sampling.
HIV screening in Acute Medical Unit (AMU)
Since November 2013, patients attending the AMU in Blackpool have been offered a HIV test. The service ensures a collaborative and effective operational link with the Blood Borne Viruses (BBV) team and lead consultant.

In 2015/16, 70% of eligible patients were offered a HIV test with 2,577 of patients accepting (51.5%). As figure 18 shows, following a gap in service provision earlier in the year where there was a significant drop in the number of tests carried out, staff training has had a positive impact on the normalisation of testing and the subsequent uptake in the latter part of the year. This has resulted in a significant improvement in the uptake of tests on the AMU which has carried forward into the first quarter of 2016/17.

![Figure 18: Percentage uptake of HIV tests of patients offered in AMU](image)

In total, 6 patients were diagnosed HIV positive in 2015/16 from screening in AMU. These patients were not known to have undergone HIV tests previously. In the previous year less than half the number of screens had been carried out on the unit, with half the number of positive cases diagnosed.

Other key mechanisms in Blackpool are contributing towards the Public Health Outcome Framework indicator to reduce the numbers of late diagnosis. These include testing women in maternity services and women attending for termination of pregnancy:

- Testing women in maternity services, current uptake of over 95%.
- Testing women attending for termination of pregnancy has resulted in positive diagnoses\(^\text{20}\).

Screening in the community
The National Institute for Health and Clinical Excellence (NICE) has advocated for expanding testing outside clinical settings by engaging community organisations, developing local strategies to increase testing, and by providing rapid HIV tests. Testing in non-medical settings such as

\(^{20}\) Number not given due to confidentiality reasons
community HIV testing, self-sampling and self-testing for HIV broadens the options available to people wishing to take an HIV test.

The Harm Reduction Service in Blackpool (Renaissance) offers point of care testing within the Blackpool locality, with a focus on MSM.

The HIV home self-sampling service enables people to order tests online. This service is available to groups at higher risk such as MSM, Black African and Caribbean communities and sex workers. Tests are mailed to people’s address of choice, with self-taken samples of blood or saliva returned to the provider’s laboratory. Confirmatory testing is undertaken by local clinical services for all reactive tests, to date none of these have been positive, though there have been positives nationally. Since the introduction of the service in November 2015, 92 kits have been ordered, with a return rate of approximately 50%.

5.2 Other Sexually Transmitted Infections (STI’s)

In 2015, there were 434,456 new STI diagnoses made at Sexual Health Clinics in England. Of these, the most commonly diagnosed STIs were chlamydia (46%), genital warts (16%), non-specific genital infections (10%), and gonorrhoea (10%)\(^{21}\). The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM). Large increases in STI diagnoses have been seen in MSM, including a 21% increase in gonorrhoea and a 19% increase in syphilis. High levels of condomless sex probably account for most of this rise. Testing and partner notification are essential elements of STI management and control, protecting patients/partners from re-infection and long-term consequences from untreated infection, reducing the cost of complications and onward transmission.

There were 1,573 new STIs diagnosed in residents of Blackpool in 2015, a rate of 1120 per 100,000 residents (compared to 768 per 100,000 in England). Blackpool is ranked 26th highest for all new STI diagnoses out of 152 upper tier local authorities. Overall, diagnoses of new STIs have fallen slightly from 2014. The number of people diagnosed in Blackpool has fallen from 1,607 in 2014 to 1,573 in 2015 and the diagnosis rate has fallen from 1144 per 100,000 to 1120 per 100,000.

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However, when looking at new STI diagnoses excluding young people aged under 25 (the age group targeted by the National Chlamydia Screening Programme (NCSP)), the number and rate has risen slightly from 2014 to 2015 (figure 20). The trend in new STI diagnoses (exc. Chlamydia <25) in Blackpool has been and still is significantly higher than the national average and while recent years have seen a fall in newly diagnosed STIs, 2015 saw a slight increase from 1063 per 100,000 to 1095 per 100,000.

The 5 main STI diagnoses in Blackpool are chlamydia (51%), syphilis (1.3%), gonorrhoea (8%), genital warts (15%) and genital herpes (9%). HIV (0.8%) and other STIs account for the other 16%
of infections. Of the 5 main STIs diagnosed, 99% of females are in the heterosexual population. For males, 78% are heterosexual while 22% are gay, bisexual or other.

Figure 21 shows the trend in STI infection rates since 2009. There has been a slight increase in syphilis following what was a downward trend. While the number of syphilis and gonorrhoea is low, these infections are predominantly in MSM (reflecting higher levels of risky sexual behaviour).

The increase seen in gonorrhoea is in line with the national picture which has seen a sharp rise in recent years, exceeding 40,000 cases in 2015\textsuperscript{21}. Although improved test sensitivity and uptake may have contributed, increased gonorrhoea transmission is likely playing a major role. Reversing this trend is a public health priority given the spread of resistance to frontline antimicrobials used for treating gonorrhoea and the depletion of effective treatment options. The Gonorrhoea Resistance Action Plan for England and Wales makes recommendations on ensuring prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission.

There has been a general fall in genital wart infection and this is expected to continue as a positive effect from the national Human Papilloma Virus (HPV) vaccination programme for young women. MSM HPV vaccine could have an even greater influence if implemented.

**Figure 21: Trends by sexually transmitted infection, 2009-2015**

![Graphs showing trends in STIs](source.png)

Source: PHE, GUMCADv2 Report, Numbers and Rates of New STIs Diagnoses, HIV and STI Portal

Of the 1,573 new diagnosed STIs in 2015, 61% (953) were in the under 25 age group. Of these 40% were male and 60% female. Conversely, in the 25+ age group, 67% of new diagnoses were male
and 33% female. In comparison, across England only 52% of new diagnosed STIs are in the under 25 age group but the gender split is broadly the same as Blackpool.

**Figure 22: All new STIs in Blackpool by gender and age group, 2015**

![Bar chart showing new STIs by gender and age group in Blackpool, 2015](image)

*Source: PHE, GUMCADv2 Report, Numbers and Rates of New STIs Diagnoses, HIV and STI Portal*

Figure 23 shows the breakdown by STI diagnoses for males by sexual risk. It can clearly be seen that while the number of cases of gonorrhoea and syphilis is low, these infections are more predominant in the non-heterosexual community. When an increase in rates of gonorrhoea and syphilis in a population are seen, this reflects higher levels of risky sexual behaviour.

**Figure 23: Number and proportion of STIs in males by sexual risk, 2015**

![Bar chart showing STIs by sexual risk in males, 2015](image)

*Source: PHE, GUMCADv2 Report, Numbers and Rates of New STIs Diagnoses, HIV and STI Portal*

For cases in men where sexual orientation was known, 20% of new STIs in Blackpool were among men who have sex with men (Genitourinary Medicine (GUM) clinics only)\(^{22}\).

\(^{22}\) PHE, Blackpool Local Authority sexual health epidemiology report (LASER): 2014
There is a concern nationally in the rise in syphilis and gonorrhoea among MSM which linked with high levels of condomless sex. HIV serosorting, (the practice of engaging in condomless sex with partners believed to be of the same HIV status) increases the risk of infection from STI’s, hepatitis B and C, and sexually transmissible enteric infections like Shigella spp, and likely plays a role in the reported STI trends. For those who are HIV negative, serosorting increases the risk of HIV seroconversion as 14% of MSM are unaware of their infection\textsuperscript{16}.

While vaccination is a measure that can be used to control genital warts and hepatitis B, control of other STIs relies on consistent condom use, behaviour change to decrease overlapping and multiple partners, ensuring good access to testing and treatment, and ensuring partners of cases are notified and tested. A large fall in genital warts seen this year in young women is an expected positive effect of the national HPV vaccination programme.

Testing rates, positivity and diagnoses rates are linked. Figure 24 shows new STI diagnoses (excluding chlamydia in under 25’s) positivity rate among people accessing genitourinary medicine (GUM) services expressed as a percentage of the number of STI tests performed.

**Figure 24: STI testing positivity rate (exc. Chlamydia in under 25s)-Blackpool and England**

In 2015, Blackpool was higher than the North West and England, with a positivity rate of 5.9% compared to 5.5% and 5.2% respectively. Better detection rates are likely due to more risk taking behaviour and therefore higher levels of infections within our population as well as more targeted screening.

**Re-infection**

Reinfection with an STI is a marker of persistent risky behaviour. In Blackpool, an estimated 9.1% of women and 10.6% of men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became re-infected with a new STI within twelve months. Nationally, during the same period of time, an estimated 7.0% of women and 9.0% of men presenting with a new STI at a GUM clinic became re-infected with a new STI within twelve months\textsuperscript{22}.
Also, an estimated 2.9% of women and 6.0% of men diagnosed with gonorrhoea at a GUM clinic in Blackpool between 2010 and 2014 were re-infected within twelve months. Nationally, it was 3.7% of women and 8.0% of men becoming re-infected with gonorrhoea within twelve months.

In Blackpool, an estimated 13.7% of 15-19 year old women and 14.9% of 15-19 year old men presenting with a new STI at a GUM clinic during the five year period from 2010 to 2014 became re-infected with an STI within twelve months. Teenagers may be at risk of reinfection because they lack the skills and confidence to negotiate safer sex.

**National Chlamydia Screening Programme (NCSP)**

The NCSP was established in 2003 to facilitate early detection and treatment of asymptomatic Chlamydia infection. Chlamydia is the most common bacterial sexually transmitted infection in England an up to 70% of women and 50% of men with the infection have no symptoms. If these infections remain undiagnosed and hence untreated, complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility can develop. Effective screening, when combined with good sexual health improvement messages, contributes to young people having better sexual health, as the offer of a test normalises testing for STIs, doesn’t increase risky behaviour and provides a gateway to more comprehensive sexual health services.

The PHOF includes an indicator to assess progress in controlling chlamydia in sexually active young adults. This recommends local areas achieve an annual chlamydia detection rate of at least 2,300 per 100,000 15-24 year old resident population to detect and treat sufficient asymptomatic infections to affect a decrease in incidence.

**Figure 25: Chlamydia detection rate per 100,000 aged 15-24 (PHOF indicator 3.02)**

![Chart showing chlamydia detection rate per 100,000 aged 15-24](source)

The chlamydia detection rate per 100,000 young people aged 15-24 years in Blackpool was 3,416 (compared to 1,887 per 100,000 in England) in 2015. The rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care,
sexual and reproductive health and genitourinary medicine services. Areas achieving or above the 2,300 detection rate should aim to sustain or increase, with areas achieving below it aiming to increase their rate. As shown in figure 25, Blackpool has a higher detection rate than England, though the detection rate has shown a decline. The fall between 2012 and 2013 was due to more targeted screening while the fall from 2014 to 2015 is line with the national picture, where the rate has fallen by 7.3%.

Nationally chlamydia detection rates are higher in females than males reflecting higher testing rates in females. Chlamydia detection rates among young females did not vary greatly between those aged 15-19 years and those aged 20-24 years. However, detection rates among males aged 20-24 years were up to 2.4 times higher than among males aged 15-19 years.

Chlamydia test coverage data represent the number of tests reported, and not the number of people tested. The NCSP recommends that all sexually active under 25 year old men and women be tested for chlamydia annually or on change of sexual partner (whichever is more frequent). There has been a decline in chlamydia testing coverage nationally and Blackpool has shown a similar decline since 2012 (figure 26). The decline is mostly attributable to fewer tests being carried out in non-specialist sexual health services and community venues. Improvements have also been made in data quality which may also account for the decline in data coverage with a reduction in double counting.

![Figure 26: Proportion of 15-24 year olds screened for chlamydia](source: PHE, HIV STI Portal)

The proportion of chlamydia tests that were carried out in in males under 25 years in 2015 was 20% compared to 80% of females in the same age range (figure 27). This demonstrates that work is needed to increase testing in young men in Blackpool.
The NCSP recommends that local authorities commission services that achieve a positivity rate of 5–12%. In 2014, 28.1% of 15-24 year olds were tested for chlamydia with a 13.4% positivity rate. Nationally, 24.3% of 15-24 year olds were tested for chlamydia with 8.3% positivity rate.

Partner notification (PN) is a key component in the management of chlamydia. In order to have an impact on the burden of disease, sexual contacts and partners need to be tested and treated. PN is the process by which sexual partners of individuals with diagnosed STIs are notified, informed of their exposure and offered treatment for infection. The performance standard for chlamydia partner notification is at least 0.4 contacts per index case. Recent data from April-December 2015 for Blackpool shows a partner treatment rate of 0.8.

PHE actively works to support local authorities’ data quality improvement initiatives. In 2016, a process of sector led improvement across Lancashire and Cumbria, initially looking at Chlamydia was undertaken. The data analysis highlighted a number of areas for consideration and plans and ideas for improvement were collated against the key areas of young men, data, delays in treatment and partner notification. Actions identified from this work are included in the action plan going forward.

5.3 Blood Borne Viruses (BBV)

There are ongoing clusters of acute Hepatitis B in various regions of England and Wales which have emphasised the importance of Hepatitis B vaccination, the need to improve quality of hepatitis B immunity status and vaccination reporting and the need to support provision of health promotion and outreach activities.
Outbreaks of Hepatitis B in MSM who identify as heterosexuals highlights the diversity of the MSM population and the need for culturally appropriate and sensitive targeting of health promotion messages, including at cruising sites and sex on premises venues, such as saunas. Due to the sexual transmission of Hepatitis B virus (HBV), especially among persons with HIV infection, and particularly in men who have sex with men, Hepatitis B screening should be considered at least annually (or more frequently depending on specific circumstances). HBV infection can be prevented by vaccination and in the UK immunisation is used for individuals at high risk of exposure to the virus\textsuperscript{23}.

5.4 Human Papilloma Virus (HPV)

The HPV vaccine protects against the two high-risk HPV types that cause over 70% of cervical cancers. In the UK, all 12-13 year old girls (school year 8) are offered HPV vaccination through the national HPV immunisation programme. Early findings from PHE support the expectation that vaccination will impact on cervical cancer\textsuperscript{24} and other HPV-related diseases in due course and it is anticipated that, with the new two-dose schedule, higher coverage of the completed course should be achievable, thus increasing the potential impact of the programme.

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{hpv-vaccine-coverage.png}
\caption{HPV vaccine coverage 2014/15, England, Blackpool and Lancashire}
\end{figure}

Source: PHE, Annual HPV vaccine coverage 2014 to 2015\textsuperscript{25}

Due to changes to the HPV schedule from September 2014 where two doses are offered (either within the academic year or over two academic years depending on the local programme), vaccine


\textsuperscript{25} Blackpool JSNA, Childhood Immunisations (5 years and over) [http://www.blackpooljsna.org.uk/Developing-Well/Children-and-young-peoples-health/Childhood-Immunisations-5-years-and-over.aspx]
overage data are not directly comparable to previous years\textsuperscript{26}. In 2014/15, 560 (93\%) 12-13 year old girls in Blackpool received one dose of the HPV vaccine. This compares to 89\% nationally.

6 Teenage Pregnancy

It is widely understood that teenage pregnancy and early motherhood can be associated with poor educational achievement, poor physical and mental health, social isolation, poverty and related factors. There is also a growing recognition that socio-economic disadvantage can be both a cause and a consequence of teenage motherhood. Qualitative research in the UK points to poor material circumstances, unhappiness at home or at school, and low expectations for the future as factors associated with high teen pregnancy rates\textsuperscript{27}.

Much of the reduction in teenage conception can be attributed to the Teenage Pregnancy Strategy which needed a full decade of implementation to show its capacity to effect change on this complex issue. The maternity rate of individuals younger than 18 years in England decreased slowly but steadily from its peak in 1996–98, but much more rapidly from 2007 to 2013, along with a decline in the abortion rate, halving the conception rate overall. The most substantial reductions were in the most deprived areas, where rates were originally highest. Participation in work, education, or training by young women who became mothers before age 18 years doubled over the period of the Teenage Pregnancy Strategy. The programme had many components, and while it’s still not known which were more effective than others, the combination of sex and relationships education, increased access to contraception, and social inclusion strategies are necessary elements\textsuperscript{28}.

Blackpool still has one of the highest teenage pregnancy rates in the UK\textsuperscript{29}.

\begin{itemize}
  \item In 2014, 95 women under the age of 18 in Blackpool became pregnant. 19 were aged under 16.
  \item The under 18 conception rate in 2014 was 37.3 per 1,000 women aged 15-17, significantly higher than the North West and England averages of 26.8 and 22.8 respectively.
\end{itemize}

\textsuperscript{26} Providers are contracted to provide two doses to all schools but due to the timing of delivery of the first dose and the requirement for a sixth month gap between doses, delivery of the second dose continued into the 2015/16 academic year and these data are therefore provisional.

\textsuperscript{27} A Harden et al. Teenage pregnancy and social disadvantage: Systematic review integrating controlled trials and qualitative studies. BMJ, 339 (2009), p. b4254


\textsuperscript{29} Blackpool JSNA, Teenage Conceptions \url{http://www.blackpooljsna.org.uk/Developing-Well/Children-and-young-peoples-health/Teenage-Conceptions.aspx}
- The under 16 conception rate was 8.1 per 1,000 women, higher than the North West and England averages of 5.1 and 4.4 respectively.
- Blackpool has the 10th highest under 18 conception rate out of 324 local authorities nationally, though the rate has fallen faster than the national and regional rate over the last ten years.
- Since 2004 the rate has fallen by 48% from 72.0 per 1,000 to 37.3 per 1,000. This compares to a 45% reduction across England.

Figure 29 shows the trend in Blackpool’s under 18 conception rate compared with the North West and England. It demonstrates that while significant improvements have been made, teenage pregnancy remains a significant problem for Blackpool.

In 2014, the estimated number of conceptions in Blackpool fell by 12% from 108 to 95. The number of conceptions do fluctuate year on year and despite increases in 2009 and 2011, the general trend continues to fall from the high rate of 81 per 1,000 in 2003. Figure 30 shows the trend in the rate and number of under 18 conceptions in Blackpool since 1998.
A number of factors could explain recent reductions in teenage conceptions, including:

- The programs invested in by successive governments (for example sex and relationships education, improved access to contraceptives (LARC) and contraceptive publicity).
- A shift in aspirations of young women towards education.\(^{30}\)
- The perception of stigma associated with being a teenage mother.\(^{31}\)

The size of the female population of child bearing age (women aged 15-44) will also influence the number of conceptions as there are peak age groups for maternities (25-29 and 30-34) and abortions (20-24) and the relative sizes of these groups will impact upon the number and rate of conceptions. Projected population estimates for females in Blackpool shows falling numbers of young women in the 15-24 age group until the mid-2020s which may impact on teenage pregnancy and abortions.

**Variation within Blackpool**

There is wide variation in teenage conception rates within Blackpool and pooled data for 2011-13 shows:

- There were 369 under 18 conceptions in Blackpool over the three year period, a rate of 47.6 per 1,000.
- Under 18 conception rates range from 16.9 per 1,000 in Ingthorpe to 116.1 per 1,000 in Talbot.
- 9 wards have significantly higher rates than the national average of 27.6 per 1,000.


• 2 wards have significantly higher rates than the Blackpool average of 47.6 per 1,000.
• 7 of the 9 wards have also had significantly higher rates in 2009-11 and 2010-12: Claremont, Clifton, Hawes Side, Park, Talbot, Tyldesley and Victoria.

Figure 31: Wards in Blackpool with significantly higher under 18 conception rates than the national average, 2011-13

Locally, regionally and nationally, the abortion rate among females under 18 has changed only slightly since 2005 (figure 32), so the decline in conceptions has been essentially among those resulting in a birth. Accordingly the proportion of teenage pregnancies resulting in abortion has risen significantly, reaching 43.2% in Blackpool in 2014 and 51.1% in England (figure 33).
Termination of pregnancy

One proxy for unintended pregnancy is information on abortions to understand which women are more at risk of an unintended pregnancy. Reducing unwanted pregnancies is an ambition in the Department of Health’s Framework for Sexual Health Improvement in England (2013). The Department of Health’s policy also states that women who request an abortion should have early access to services if legally entitled to an abortion under the Abortion Act 1967. Although clinical commissioning groups (CCGs) are now responsible for commissioning most abortion services, local authorities are responsible for commissioning comprehensive sexual health services including contraception services and advice, and sexual health specialist services such as young people’s
sexual health and teenage pregnancy services, outreach, sexual health promotion and services in schools, colleges and pharmacies.

Data from the Department for Health shows that for women resident in Blackpool in 2015:\(^\text{32}\):

- The total number of abortions was 531, up from 508 in 2014.
- The age standardised abortion rate was 20.1 per 1,000 women aged 15-44. This is slightly higher than the rate of 19.8 in 2014 and significantly higher than the national average of 16.2 per 1,000.
- The abortion rate was highest for women aged 18-19 years (at 42.5 per 1,000) unlike the national picture where the abortion rates are highest for women aged 20-24 (figure 35).
- Almost half (49%) of abortions in Blackpool are to women aged under 25 compared to 42% nationally.
- There were 41 abortions to young women aged under 18 in Blackpool in 2015, a rate of 16.1 per 1,000. This is significantly higher than the national average of 9.9 per 1,000.
- The under-16 abortion rate in Blackpool in 2012-14 was 4.7 per 1,000 women compared to 3.0 per 1,000 across England\(^\text{33}\).

**Figure 34: Trend in abortion rate (18-44 and under 18), 2009-2015, Blackpool and England**

Blackpool has seen no significant changes in the overall rate of termination of pregnancy (all ages), which remain significantly higher than the rates for England. However, under 18 rates have shown a similar decrease to the national trend with rates falling from 22.3 per 1,000 in 2009 to 15.5 per 1,000 in 2014. 2015 has shown a slight but not significant increase to 16.1 per 1,000.


\(^{33}\) ONS Conception statistics, 2014
Abnormality under 10 weeks

Department of Health policy is that women who request an abortion should have early access to services if legally entitled to an abortion under the Abortion Act 1967. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality.

Data shows that in Blackpool in 2015:

- 90.4% of abortions were carried out at under 13 weeks gestation, 81.4% were carried out under 10 weeks compared to 77% in 2009 and 37% in 2004.
- 96% of NHS funded abortions in Blackpool are carried out by the independent sector compared to 70% across England.

Medical abortions now account for just over half of all abortions. The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall...
percentage of abortions performed at under ten weeks gestation. It is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or use of anaesthetics\textsuperscript{34}.

- In Blackpool 360 (83.7\%) of the abortions performed under 10 weeks was medical.
- This compares to 62.7\% nationally.
- Of abortions over 10 weeks, 11.1\% were medical in Blackpool compared to 19.2\% nationally.

**Repeat abortions and abortions after birth**
Over a quarter of England abortions in the under 25 year old age group are repeat abortions. This is an indicator of access to (or lack of) good quality contraception services and advice as well as problems with individual use of contraception. The proportion of women having an abortion after a birth is a guide to awareness of post-partum contraception need at a local level and the possible need to develop more effective “secondary prevention” interventions to help the first-time pregnant and parenting young people manage their future reproductive lives and prevent further unplanned pregnancies.

**Figure 37: Proportion of repeat abortions and having an abortion after a birth, 2015**

\textit{Source: Dept of Health, Abortions Statistics and PHE, Sexual and Reproductive Health Profiles}

In Blackpool in 2015\textsuperscript{35}:

- There were 200 repeat abortions in women of all ages, 64 in women aged under 25 and 136 in women aged 25 and over.
- Repeat abortion rates in women aged under 25 are similar to the national average (26.5\%).
- The proportion of repeat abortions in women aged under 25 years was 25\%. This compares with 25\% in 2009 and 27\% in 2005.
- By comparison, England’s repeat abortions for the same period were 26.5\% in 2015, 24.7\% in 2009 and 24\% in 2005.

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\textsuperscript{34} PHE, Sexual and Reproductive Health Profiles, Abortions under 10 weeks that are medical
\textsuperscript{35} Dept of Health Abortions Statistics and PHE Sexual and Reproductive Health Profiles
There were 94 (33.1%) women aged under 25 who had an abortion after a previous birth. This is a reduction from 37.6% in 2014 and is similar to the national average of 28.2%.

Contraception after an abortion
Increasing access to long-acting reversible contraception (LARC) for women of all ages is one of the priorities identified in the 2013 ‘Framework for Sexual Health Improvement in England’\(^{36}\). NICE has issued guidance which states that LARC is a cost effective method of contraception and increasing uptake will reduce unintended pregnancies. An increase in the provision of LARC is a proxy measure for wider access to the range of contraceptive methods and should also lead to a reduction in rates of unintended pregnancy\(^{37}\).

Figure 38: Percentage of women in Blackpool leaving with LARC after an abortion, 2014/15

![Graph showing percentage of women leaving with LARC after abortion by age group]

Source: Marie Stopes International Customer Relationship Management (CRM) database

There was an increase in repeat abortions leaving termination of pregnancy services with a LARC method from 47% in 2013/14 to 65% in 2014/15. The greatest increase in uptake of LARC method was seen in women aged 24-35 years with an increase of 19%, however, there was no change in those aged 18-24.

Figure 39: % of repeat abortions leaving with a LARC method by age group

![Graph showing percentage of repeat abortions leaving with LARC by age group]

Source: Marie Stopes International data


\(^{37}\) NICE, Long-acting reversible contraception: Guideline CG30 2005 (updated 2014)
A focus is needed on resources to increase the uptake of LARC and to increase the general use of contraception in higher risk groups.

8 Mapping Demand

The majority of Blackpool residents use sexual health services within Blackpool. In 2015, only 3% of Blackpool service users attended clinics outside of Blackpool. Conversely, of all patients using services within Blackpool, 41% come from outside the local authority (Figure 40).

Figure 40: Patients attending clinics in Blackpool by residency status, 2015

Source: GUM Clinic Activity Dataset report, HIV and STI Web Portal

8.1 Genitourinary Medicine (GUM) clinic

There has been a 15% increase in the number of Blackpool residents attending the GUM service at Whitegate Drive Health Centre from 2011 to 2015 (figure 41). 97% of Blackpool residents choose to attend the GUM service in Blackpool, making up 58-60% of patient flow throughout the year. The majority of the remaining patients attend from the Fylde and Wyre area.

Figure 41: Attendances to Whitegate Health Centre GUM by Blackpool residents 2011 -2015

Source: PHE, HIV/STI Portal, GUMCADv2 Report
Sexual Health Screens
There were 6,597 first attendances at SHS by Blackpool residents in 2015, a decrease from 6,840 in 2014. First attendances are new and re-booked ‘face-to-face’ attendances at the start of a new sexual health episode. 45% of these first attendances were male and the over 25’s made up just over half (54%) of all attendances. Almost three quarters (74%) had a sexual health screen, that is where a combination of 2 or more of the following tests are taken; chlamydia, gonorrhoea, HIV and/or syphilis. Approximately 32% were diagnosed with a STI (Figure 42).

Figure 42: Number of first attendances, screens and STI diagnoses, Blackpool residents, 2015

While the number of first attendances decreased from 2014, the number of screens taken has increased 3% from 4,745 in 2014 to 4,899 in 2015. The biggest increase in the number of screens has been in males aged 25-34 and females aged 20-24, though proportionally males aged 65+ and females aged 45-64 have seen the biggest rise (31% and 20% respectively).

Figure 43: Trend in sexual health screens by age and gender, 2013-2015

Source: PHE, HIV/STI Portal, GUMCADv2 Report
(Sexual health screens taken at a follow-up attendance are not included in this report)
8.2 Tier 2 STI testing in Primary Care

The Tier 2 General Practitioner (GP) led Sexual Health Service was developed in 2007/08 to provide testing and treatment of sexually transmitted infections in the community – Level 2 STI services. The service was designed to complement the sexual health service available through GUM, with GUM taking on the role of training and governance and the treatment of the more complex sexual health conditions.

The service is currently provided by the following GP practices, though the service delivered from North Shore surgery ceased in October 2016 because of staff retirement.

- Harris Medical Centre (part of Adelaide St Surgery)
- Gorton Street Practice
- Waterloo Medical Centre
- North Shore Surgery
- Stonyhill Medical Centre
The service is open to any resident, whether registered at the practice or not. Patients testing positive at the Tier 2 service are treated, with partner notification undertaken. However, those testing positive for more complex conditions such as HIV, Syphilis and Gonorrhoea would be referred to the Tier 3/Level 3 service for treatment.

There are different models of delivery depending on the service provider - for example, GP-led or nurse-led, offering booked appointments and/or drop-ins. During a ‘new appointment’ (patient’s first appointment), patients are offered a full STI screen.

Practitioners at all the delivery practices will manage symptomatic MSM and practitioners at all the practices, apart from North Shore will manage pregnant women with STIs. These are traditionally not managed in primary care but practitioners will consult with the Level 3 service and refer when necessary.
Figure 46: Number of new appointments (when the patient is tested) for the last two complete years and for 2016/17 (April – August).

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of New Appointments</th>
<th>Type of STI /BBV found</th>
<th>Average Positivity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>785</td>
<td>Chlamydia, Genital Herpes, Genital Warts, Gonorrhoea, Trichomonas, Syphilis</td>
<td>23.0%</td>
</tr>
<tr>
<td>2015/16</td>
<td>816</td>
<td>Chlamydia, Genital Herpes, Genital Warts, Gonorrhoea, Hepatitis B, Hepatitis C</td>
<td>14.5%</td>
</tr>
<tr>
<td>2016/17 (1/4/16-31/8/16)</td>
<td>290</td>
<td>Chlamydia, Genital Warts, Genital Herpes, Gonorrhoea</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

The most commonly diagnosed infections are Genital Warts, Chlamydia and Genital Herpes. Although the overall positivity rate for the service has dropped from 2014/15, the positivity rate for 2015/16 was still significantly high for a sexual health service delivered through primary care. All five service providers now record and upload data for GUMCADv2 but this data is not yet available.

**Tier 2 contraception in primary care**

The Department of Health’s Framework for Sexual Health Improvement in England\(^\text{36}\) includes the ambition to reduce unwanted pregnancies among all women of fertile age through:

- increased knowledge and awareness of all methods of contraception among all groups in the local population,
- increased access to all methods of contraception, including long-acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners.

The PHOF indicator of GP prescribed LARC (excluding injections), replaces an earlier indicator which included injections, because:

- injections rely on repeat visits/administration within the year and have a higher failure rate than the other LARC methods,
- injections are easily given in primary care and do not require the resources and training that other LARC methods require,
- injections are outside local authority contracts.

The rate per 1,000 women of long acting reversible contraception (LARC) prescribed in primary care was 19.5 for Blackpool, 23.1 for North West and 32.3 per 1,000 women in England (Figure 47). However, this is prescribing data and may not include implants purchased through central supply of implants provided to the practices by the Integrated Sexual Health Service, Whitegate Drive.
Figure 47: Rate of GP prescribed long acting reversible contraception (LARC) excluding injections, Blackpool and England

Source: PHE Sexual and Reproductive Health Profiles

Figure 48: Number and types of contraception provided by SHS and general practice in Blackpool: 2014

Source: SRHAD, Sexual and Reproductive Health Services and PACT NHS Prescription Services' Prescribing Database

9 Contraceptive services

9.1 Emergency hormonal contraception (EHC)

Emergency contraception can be used following unprotected intercourse, contraceptive failure, incorrect use of contraceptives, or in cases of sexual assault. It is intended for occasional or emergency use, not as a primary contraceptive method for routine use. Use of EHC is closely linked to a reduced rate of unplanned pregnancies for women of all ages and the availability of EHC is essential in reducing the teenage conception rate and also the number of unplanned pregnancies which result in termination.
A service review was undertaken as part of a programme of reviews of all Public Health services to establish whether the Pharmacy EHC scheme was meeting the needs of the population and to consider the comparative benefits of alternative service models.

EHC in pharmacy settings offered opportunities for easier access when young women may have been at risk from an unplanned pregnancy and sexually transmitted diseases (STIs). However, findings from the review showed that few patients accessing community pharmacy were given the wrap around service they would receive from their GP or sexual health service, particularly STI screens and follow-on contraception. Not only are the majority of young people screened for STIs at the sexual health services, they also receive the contraception of their choice; with nearly 50% taking up long acting reversible contraception (LARC). Essentially, the demand for EHC from pharmacies from those under the age of 19 was found to be low in Blackpool, with most young people accessing EHC for free through Connect Young Peoples service (figure 50). Following the
review it was decided to discontinue the provision through pharmacies and provide all EHC through sexual health services and primary care.

9.2 Contraceptive care

Good contraception services have shown to lower rates of teenage conceptions. Knowledge, access and choice for all men and women to all methods of contraception to aid in the reduction of unwanted pregnancies is supported by the government and the Faculty of Sexual and Reproductive Healthcare (FSRH).

In 2014, of 1,577,014 attendances at SRH services by residents in England where regular contraception was prescribed, 6005 were by residents from Blackpool.

Compared to the national average, a greater proportion of attendees at contraception services are in the younger age groups, eg. 32% of Blackpool attendees are aged under 20, compared to only 24% nationally. This may go some way to explaining the declining teenage conception rate; fewer births indicate more young people are on contraception.

![Figure 51: Proportion of SRH services attendees by age group, Blackpool and England: 2014](source)

Long Acting Reversible Contraception (LARC)

In 2014, the rate of LARCs prescribed in SRH services per 1,000 women aged 15 to 44 years was 65.6 for Blackpool and 31.5 for England. This does not include LARCs that may have been prescribed in other services, such as termination of pregnancy (TOP) services, which may account for a significant amount.

Figure 52 compares proportions of each contraceptive method prescribed to residents in Blackpool and England. Of all contraceptive methods prescribed, the main methods of
contraception for residents in Blackpool were 29.7% LARC, 21.1% injectable contraception and 49.2% user dependent method (UDM), compared to 23.0% LARC, 12.3% injectable contraception and 64.7% UDM, for residents in England.

**Figure 52: Proportion of LARC, injectable and UDM contraception prescribed by age group among residents of Blackpool and England: 2014**

The number of LARCs reported is not indicative of compliance as data on LARC removals are not available. However, Blackpool sexual health service data (figure 53) shows that since 2012/13, a significant number of women in Blackpool have had the hormonal contraceptive implant removed compared to other LARC methods. In 2014, Blackpool SRH services showed a higher proportion of women were having the implant removed, 5.5 compared to 2.3 and 2.7 in the NW and England respectively. An audit of the number of early removals will be required to better understand compliance with the method compared with reasons such as family planning/referrals for removal from primary care.

**Figure 53: Contraception prescribed in SRH services**

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive injections administered</td>
<td>315</td>
<td>274</td>
<td>313</td>
</tr>
<tr>
<td>Hormonal contraceptive implants fitted</td>
<td>590</td>
<td>553</td>
<td>624</td>
</tr>
<tr>
<td>Hormonal contraceptive implants removed</td>
<td>405</td>
<td>548</td>
<td>609</td>
</tr>
<tr>
<td>IUD’s fitted</td>
<td>117</td>
<td>124</td>
<td>128</td>
</tr>
<tr>
<td>IUD’s removed</td>
<td>62</td>
<td>68</td>
<td>61</td>
</tr>
<tr>
<td>IUS fitted</td>
<td>149</td>
<td>125</td>
<td>126</td>
</tr>
<tr>
<td>IUS Removed</td>
<td>71</td>
<td>78</td>
<td>97</td>
</tr>
</tbody>
</table>

*Source: Blackpool Teaching Hospitals sexual health service data*
**LARC Incentive Scheme**

Women with substance misuse issues are often socially marginalised, with poor access to general and reproductive healthcare, particularly evident with females who inject drugs\(^{38}\). One of the objectives of Blackpool’s Sexual Health Action Plan 2013-15 was to prioritise prevention by targeting preventative initiatives at key groups, ultimately reducing the number of children in care.

In 2014, a local audit\(^{39}\) was undertaken looking at contraceptive use and parental responsibility in female clients of drug and alcohol treatment services, with responses from 19% (111) of women in treatment at the time. The work was undertaken to help inform the feasibility of developing an incentive scheme to promote long acting reversible contraception in chaotic drug and alcohol users.

Key results of the audit were:

- 68% of women taking part were in treatment for heroin use;
- 77% of women had children, with most women having 2 or more;
- 56% of children were living with people other than their mother; 8% with their father or stepparent, 13% with their extended family and 12% in foster care, children’s home or adopted;
- 71% of women were still menstruating;
- 32% of women had had unprotected sex – 35% of those in the previous 12 months;

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\(^{39}\) Blackpool Council, Contraceptive use audit in female clients of Horizon substance misuse treatment service and exploration of the use of a potential incentive scheme, September 2014
Only 26% of women were using contraception, with 58% of these relying on condoms or oral contraceptives, methods which rely heavily on correct usage and compliance. Respondents were asked about what kind of incentive would work best for LARC, the majority of respondents selected shopping vouchers. This was further discussed during a focus group with female service users, though some women felt that a small cash incentive would be more practical than a shopping voucher.

All the women in this focus group felt that offering an incentive for LARC would be a positive development and that it would encourage them to access more reliable contraception. All the women in the focus group were aware of LARC methods as were the majority of Horizon staff members interviewed as part of this work.

**Uptake of LARC in Horizon Drug and Alcohol Integrated Treatment Service**

Approximately 68% (124 individuals) of eligible females in treatment were referred for LARC for the period April 2015–March 2016, with 31% of those referred receiving LARC as a contraceptive method. Eleven women were pregnant or became pregnant when they entered the treatment system.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of females in treatment</th>
<th>No. eligible for referral for LARC</th>
<th>No. who received LARC</th>
<th>Pregnant or became pregnant</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>183</td>
<td>124</td>
<td>38</td>
<td>11</td>
</tr>
</tbody>
</table>

**Cervical Screening**

Cervical Screening has been provided as part of the wider offer of Sexual Health Services which were transferred to Local Authority control in April 2013. The legal framework which requires Local Authorities to provide a range of Sexual Health measures specifically indicates that Cervical Screening Services are now the responsibility of NHS England (NHSE). However, an element of opportunistic (cytology with a method) cervical screening was retained within the revised Sexual Health offer, as it is deemed to be an important option within the pathway. A number of routine (cytology only) screens were also agreed, up to 145, in addition to opportunistic, as per the level of activity at the transfer baseline.

A total of 229 smears were carried out by the service in 2015/16, 111 of which were opportunistic and 118 were routine.
11 Young People – Sexual Health and Relationships

11.1 Personal, Social and Health Education (PSHE)

The Schools White Paper ‘The Importance of Teaching’, published in November 2010, states that children need high quality SRE so that they can make wise and informed choices. Whilst it is compulsory for all maintained schools to teach some parts of sex education, i.e. the biological aspects of puberty, reproduction and the spread of viruses, the broader topic of sex and relationships education is currently not compulsory but is contained within non-statutory PSHE in the National Curriculum and is strongly recommended within SRE Guidance. School governors are by law expected to give ‘due regard’ to this guidance. Academies and free schools do not have to follow the National Curriculum and so are not under this obligation but if they do decide to teach SRE, they also must have regard to the guidance.

Academies have greater freedoms than maintained schools, including not having to follow the National Curriculum.

<table>
<thead>
<tr>
<th>Maintained Schools</th>
<th>Academies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required to have a broad and balanced curriculum</td>
<td>Required to have a broad and balanced curriculum</td>
</tr>
<tr>
<td>Must have regard to SRE Guidance 2000</td>
<td>Must have regard to SRE Guidance 2000</td>
</tr>
<tr>
<td>Sex education is compulsory as part of the statutory Science Curriculum</td>
<td>Sex education is not compulsory</td>
</tr>
<tr>
<td>Requirement to have up-to-date policy on SRE</td>
<td>There is no requirement</td>
</tr>
</tbody>
</table>

In view of the above, and that two of Blackpool wards have consistently higher referrals for child sexual exploitation, SRE should be given high priority in all secondary schools in Blackpool, including academies. This may also go some way to address the high teenage pregnancy rates seen in some areas of the town.

11.2 Connect

Attendances at the young people’s sexual health service ‘Connect’ have declined from around 8,500 in 2011/12 to 5,200 in 2015/16. Reasons for the fall in attendances include rectification of data quality issues and Connect ceasing to run the C-Card (condom distribution) scheme in 2012/13. A higher number of young people (under 25) have attended the ‘all age’ service at Whitegate Drive rather than the Connect Young People’s centre.

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40 Dept for Education and Employment, Sex and Relationship Education Guidance, DfEE 0116/2000, July 2000
on Talbot Road in the last 3 years (figure 57). However, despite a reduction in the number of attendances year on year at both services, the greater reduction (22%) has been at Whitegate Drive compared to 11% at Connect in the same period. From April 2016, the ‘all age’ and ‘young people’ services have been re-commissioned as two separate contracts. It is expected that innovative developments and marketing of the dedicated young people service will reverse this trend, with an expectation that more young people will access sexual health services through Connect.

Figure 57: Young people (<25) total attendances at Blackpool sexual health clinics.

![Graph showing attendances at Blackpool sexual health clinics](source: Blackpool Teaching Hospitals Sexual Health Service)

Figure 58 demonstrates that a greater proportion of young people aged under 25 attend sexual health services in Blackpool compared to older age groups. However, whereas the number of attendances in people aged 25-35 has not changed in the last 3 years, a gradual reduction has been seen in the number of attendances in the under 25 age group. In 2013/14, young people under 25 in Blackpool made up 60% of all attendances at SRH, decreasing to 55% in 2015/16. Nationally, young people make up approximately 40% of all attendances and this proportion has not changed significantly over the last three years.

Figure 58: All clinic attendances (by age) – Blackpool residents

![Bar chart showing attendances at Blackpool sexual health clinics by age](source: BTH Sexual Health Service)
11.3 Health Related Behaviour Survey (School Health Education Unit)

The SHEU survey provides valuable insight into the health behaviours children of young people and this insight is expected to be used in very practical ways to shape services based on need. Results from the 2015 SHEU Survey show 47% of Year 10 boys and 63% of Year 10 girls say they know how to access contraceptive and sexual health advice locally. Thirty six per cent of pupils said that school lessons were their main source of information about sex. PHSE within Blackpool schools aims to improve on this by raising greater awareness, knowledge and understanding.

- 8% of Year 10 pupils said that they were currently in a sexual relationship.
- 15% said that they had a sexual relationship in the past and 4% said they were currently in a relationship and thinking about having sex.
- 47% of pupils said they have used an Internet chat room.
- 10% of pupils said they have received a chat message that scared them or made them upset.
- 45% of pupils said they have seen images aimed at adults
- 30% (63% Year 10 boys) of pupils said they had looked online for pornographic or violent images, games or films.

11.4 Wellbeing in Sexual Health (WISH): Young People’s Harm Reduction Service

The WISH team offer 1-1 and group support to young people under 18 regarding sexual health and relationship issues. The team support schools with their delivery of sexual health and relationships education and training to professionals on how to support young people who engage in risk taking behaviours.

The service is available to young people aged under 18, but extends to under 25 for young people with a learning disability. The team’s primary focus is on young women to reduce the risk of under 18 conception. The team offer 1-1 and group sessions for vulnerable young women and group sessions for young men. The team work predominantly with schools and colleges but also receive referrals from other services, such as clinical sexual health services. As the service is offered throughout Blackpool schools and colleges, it is also accessed by some out of area residents.

Group and 1-1 work focuses on sexual health issues, contraception, healthy relationships, challenging gender stereotypes and raising aspiration. Sexually active young people are encouraged to access STI testing, particularly Chlamydia testing. The work with young women focuses on improving access to LARC and WISH workers will often accompany young women to
appointments for contraception. More recently, the team have been working closely with young people’s clinical sexual health services to implement domiciliary visits for LARC, particularly for high risk young people.

A mobile provision called ‘The Bus’ also operates for young people aged 13-19 years. The bus allows the WISH team and other professionals to listen and give advice and information on sexual health, relationships, drugs, alcohol, smoking and other issues. The team also coordinate the C-Card scheme – a condom distribution scheme for young people.

<table>
<thead>
<tr>
<th>Young women accessing WISH: 2015/16</th>
<th>% accessing LARC</th>
<th>% accessing other contraception (exc. condoms)</th>
<th>% tested for Chlamydia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Work: 1,034</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>One-to-One: 263</td>
<td>73.1</td>
<td>25.25</td>
<td>73%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young men accessing WISH (group work only)</th>
<th>Assertive outreach sessions delivered by ‘The Bus’</th>
<th>Young people receiving a brief intervention during assertive outreach</th>
<th>Young people registered with a C-Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>737</td>
<td>413</td>
<td>2,867</td>
<td>900</td>
</tr>
</tbody>
</table>

C-Card Scheme
The WISH team took over the running of the C-Card (condom distribution) Scheme in April 2013. This is a free condom distribution scheme providing quick, easy and confidential access to condoms for 13-18 year olds. Young people are registered onto the scheme by a nurse or other trained professional. Under-16’s have to re-register after getting six lots of condoms and over-16’s after ten lots of condoms. This allows the nurse/trained professional to monitor the sexual activity and safeguard the young people where issues are identified. There was on average 750 clients registered with the C-card scheme at any one time in 2015/16.

12 Prevention and Harm Reduction

12.1 Attitudes to Sexual Health - National Survey of Sexual Attitudes and Lifestyles (Natsal)

Due to the cost and complexity of such studies, limited work has been undertaken locally to determine the trends in attitudes to sexual health. Hence, information is drawn from national studies, such as the National Survey of Sexual Attitudes and Lifestyles (Natsal) 2013. This was the third survey carried out in Britain and the researchers interviewed 15,162 men and women aged 26–74 between September 2010 and August 2012.
Over the 1990’s, there was an increase in the number of opposite sex partners people reported and more people reporting same sex experience. Over the last decade there have been further increases for women, so the gender gap is narrowing. The percentage of people reporting sexual intercourse with someone of the opposite sex before the age of 16 has not increased substantially since the mid 1990’s (Figure 60), with approximately 1 in 3 young people reportedly having sex before the age of 16.

**Figure 60: Percentage of the population who have ever had same sex experience and sexual intercourse with someone of the opposite sex before age 16**

Data from the survey provides the first population prevalence estimates of non-volitional sex in Britain. Non volitional sex is a term which includes coercion, sexual assault and rape by friends, partners or strangers, i.e. sex against your will since the age of 13. In most cases the person responsible was someone known to the individual (Figure 61). This was the first of the NATSAL surveys to include questions on sexual violence (outside the context of crime) and was strongly associated with a range of adverse health outcomes in both men and women.

**Figure 61: Person responsible at most recent occurrence of sexual violence**
Over the past decade, national sexual health strategies in Britain have aimed to increase access to sexual health services and STI/HIV testing. Compared with previous surveys, more people reported having an HIV test or going to a sexual health clinic in the past 5 years. It is encouraging to see that these increases were even larger in those at highest risk, such as people who reported multiple partners.

The researchers found that unplanned pregnancy was less common than has been found in studies done in some other high income countries such as the USA. This may in part reflect the fact that contraception is provided free of charge in Britain under the NHS.

Sexual lifestyles in Britain have changed substantially in the past 60 years, with changes in behaviour ostensibly more evident in women than men. The continuation of sexual activity into later life emphasises that consideration of sexual health and wellbeing is needed throughout the life course.

Condom use and the use of contraception had increased over the period of the three studies. The main source of sexual health education is now schools. In the 1990 survey most advice was sourced from friends.

While most people have had vaginal sex in the past year, other practices are less common, especially anal sex. Anal sex was most frequently reported by young people. This is important in relation to communicating the risk of HIV in both the younger heterosexual population and men who have sex with men.

According to the survey, overall, around one in a hundred people aged 16-44 had Chlamydia, although this varied by age, peaking at almost one in twenty women aged 18-19 and one in thirty men aged 20-24. Although people who reported more partners in the past year were more likely to have Chlamydia, Chlamydia was found in people who reported only one partner in the past year.

The percentage of men reporting the use of sex workers in the past five years was 4% with 0.1% of women (4 in 100 men and 1 in 1,000 women).

The key issues raised by the NATSAL survey will be addressed by this action plan, alongside the findings of the needs assessment.

12.2 Renaissance at Drugline Lancashire: Sexual Health Services in Blackpool

Renaissance provides a range of harm reduction services including non-clinical, co-ordinated support for individuals who are living with or who are affected by HIV, Hepatitis C or affected by sexual violence. This includes the lesbian, gay, bisexual and transgender (LGBT) community and
populations at high risk of poor sexual health, for example, sex workers and men who have sex with men (MSM). As part of the Horizon Project, Renaissance at 102 Dickson Road have 2 dedicated LGB&T Development Leads who have been working in Blackpool for many years. They each support the needs of the LGB&T community, particularly around sexual health issues and have targeted work with peer support groups for Trans community members as well as LG&B social and support groups. The LGB&T Development Leads also coordinate a team of sexual health outreach workers that offer community interventions in LGB&T focused venues as well as saunas and public sex environments. (Figure 62).

**Figure 62: Sex Worker Contacts**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total contacts</th>
<th>Individuals working from home</th>
<th>Individuals working from Parlours</th>
<th>Parlour contacts per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>201</td>
<td>43</td>
<td>13*</td>
<td>154</td>
</tr>
<tr>
<td>2012-13</td>
<td>193</td>
<td>19</td>
<td>14*</td>
<td>174</td>
</tr>
<tr>
<td>2013-14</td>
<td>200</td>
<td>6</td>
<td>Unknown</td>
<td>180</td>
</tr>
<tr>
<td>2014-15</td>
<td>198</td>
<td>11</td>
<td>Unknown</td>
<td>173</td>
</tr>
<tr>
<td>2015-16</td>
<td>265</td>
<td>9</td>
<td>Unknown</td>
<td>253</td>
</tr>
</tbody>
</table>

*different people per month

Data is recorded on the parlours visited and not the number of individuals working in parlours.

The sex worker community in Blackpool has changed over recent years. In 2006, the service worked with mainly English parlours and a few Thai. Since 2012, three Polish parlours have been established whereby sex workers come to Blackpool for eight weeks and then return to Poland. The women inform their families they are working in factories and return with the money they have made in Blackpool.

Polish sex workers are engaging with services, however language barriers have been encountered as some of the women can only speak a small amount of English, or none at all. In the last 3 years, there has been an influx of women needing specific support, with Polish women also coming to Blackpool to organise a termination. However, they are being asked to return to the city they have travelled from (e.g. Manchester) to access the pregnancy advisory service there. Horizon, Dickson Road has had an information list translated into Polish and a Polish drop-in has been set up, where a translator is employed to help the Sexual Health worker converse with the sex workers. Recently a small number of Romanian women have commenced work at one of the Polish parlours and this will need to be monitored with liaison with the police as and when required.

The service expanded its offer of HIV tests in 2014 to include dry blood spot testing and 135 tests were carried out in 2015/16. Of those which were reactive and referred for a confirmatory serological test, less than 5 were positive. However, there were 12 Hepatitis C positive results (Figure 63). These were
undertaken in the needle exchange at Dickson Rd, by assertive outreach workers at the Salvation Army and church soup kitchens, in hostels and in saunas by the sex worker outreach.

<table>
<thead>
<tr>
<th>Year</th>
<th>Dry blood Spot Test</th>
<th>60 second (Insti)</th>
<th>+/ve</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>135</td>
<td>65</td>
<td>12 Hep C positive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;5 reactive HIV</td>
</tr>
<tr>
<td>2016/17 – Q1</td>
<td>43</td>
<td>19</td>
<td>&lt;5 Hep C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No HIV reactive</td>
</tr>
</tbody>
</table>

Figure 63: Blood Borne Virus testing

Renaissance, under GUM governance, now provide HIV insti-testing as part of the Public Health England MSM testing programme in venues throughout the town. The ‘Insti’ 60 second HIV tests carried out during the same period resulted in <5 people reactive tests. The tests were undertaken at Dickson Road or in a sauna. Sixty five ‘insti’ tests were undertaken in the year.

12.3 Sexual exploitation, violence and abuse

Sexual and domestic violence and sexual exploitation and abuse can be issues for men, women and children. More than one-third (38%) of all rapes recorded by the police in England and Wales in 2010/11 were committed against children under 16 years of age, and 49% of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16. Service providers should be alert to these issues and be able to provide support and make onward referral for victims including to the police, social services and specialist health and third sector services. Although routine enquiry about domestic violence in pregnancy has been undertaken for a number of years in antenatal settings, there has been less focus on screening in women having an abortion. Studies show an association between domestic violence and termination (and repeat termination) of pregnancy.\(^{41}\) Evidence shows that such violence can severely affect the mental and sexual and reproductive health of victims.\(^{36}\)

Across Blackpool:

- Abuse and neglect represent the biggest need areas for safeguarding children in Blackpool and proportions of children in need are higher than seen elsewhere;
- Early findings from the PAUSE\(^8\) project have indicated a significant number of women have had multiple children removed and taken into care. Early indications estimate approximately 140 women and 380 children are in the cohort identified. Although these figures may change as the scoping exercise develops.
- Although low in volume, rape has the greatest impact in terms of harm in Blackpool. The number of recorded rapes has been increasing during the last 3 years;

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- Mental illness can impact on sexual behaviour, impairing judgement, especially for individuals dependent on alcohol and other substances;
- Self-report of STIs, termination of pregnancy and sexual assault are high in sex workers;
- Poor access to sexual health services for sections of our society who need it the most.

It is widely acknowledged reliable information on the volume of sexual offences is difficult to obtain because a high proportion of offences are not reported to the police. However, we need to ensure that sexual violence pathways are available to all agencies, and there is equity of provision. Rape is not a gender specific issue but evidence does suggest it disproportionately affects females. The Ending Violence against Women and Girls Strategy 2016-2020\(^{42}\) aims to increase awareness in children and young people of the respect and consent in relationships and that abusive behaviour is wrong – including abuse taking place on line.

Overall, there is a correlation between sexual health and other key determinants of health and wellbeing, such as alcohol and drug misuse, mental health and violence (particularly violence against women and girls), contributing to a reduction in health inequalities.

Sexual assaults and rape offences are significantly higher in Blackpool than the Lancashire and national average. Although low in volume (average of 115 offences per year over the last three years), rape has the greatest impact in terms of harm in Blackpool, accounting for 39% of the total\(^{43}\). The number of recorded rapes has been increasing during the last 3 years.

- Increasing trend over the last 4 years.
- Issues around young victims and inter-relationship offences.
- Increase in the number of historical offences being reported.
- 90% of victims are female
- 87% victims knew the offender

![Figure 64: Key harm categories for Blackpool](source: Safer Lancashire Strategic Assessment, 2015, Blackpool District Profile)

\(^{42}\) HM Govt, Ending Violence against Women and Girls Strategy 2016-2020, March 2016

\(^{43}\) Safer Lancashire Crime Report 2015
12.4 New and emerging trends and developments

‘Chemsex’
An emerging trend of sexualised drug use has been identified. Chemsex is a commonly used term to describe sex under the influence of drugs taken immediately before and/or during sexual contact. It is a rapidly emerging pattern of drug use, not just amongst men who have sex with men as often assumed, but heterosexual patients as well. The main drugs chemsex refers to are GHB/GBL, mephedrone, crystal meth, cocaine and ketamine. Use of these drugs by gay men in London appears to have risen sharply from relatively low levels and, as yet, there is little data to inform appropriate harm reduction services. Chemsex is changing the way some gay and bisexual men socialise, including the organisation of private parties online or via smartphone apps and sourcing sexual partners with the explicit intention to use drugs together.

The risk of chemsex drugs can be:
- having sex with more people than planned to
- Within the gay community there is an increased risk of unprotected anal and rough sex
- Chemsex can prolong sex sessions giving an increased opportunity for infections to be passed on, so people may be at risk of getting an STI
- Sharing of needles to inject with can spread diseases and injecting may increase risk of overdosing
- Shigella is a bacterium which has been linked to gay men who use chemsex drugs.

Pre-exposure prophylaxis (PrEP)
The new HIV initiative is joint between NHS England and Public Health England, and follows the recent Court of Appeal ruling that NHS England, alongside local authorities, has the power, although not the obligation, to fund the provision of anti-retroviral drugs for the prevention of HIV, known as pre-exposure prophylaxis (PrEP). PrEP is a course of HIV drugs taken before sex to reduce the risk of getting HIV. The UK’s PROUD study reported an 86 per cent reduction in HIV infections in gay men taking PrEP. NHS England is working in partnership with PHE to run a number of early implementer test sites to research how PrEP could be commissioned in the most clinically and cost effective way.

HPV Vaccine for MSM
PHE is currently piloting the new human papillomavirus (HPV) vaccination programme for MSM in selected clinics across England. HPV is one of the most common sexually transmitted infections in the UK. Following reviews of all the epidemiological and economic evidence, as well as vaccine

safety and efficacy, a targeted HPV vaccination programme for MSM is considered an effective way to reduce the number of preventable HPV infections and their onward transmission in the MSM population\textsuperscript{46}.

13 Conclusion

This needs assessment provides an illustration of the current status of sexual health in Blackpool, and the data behind it will continue to be updated on-line at Blackpool JSNA. Some of the key challenges which have been highlighted are:

- Teenage conception, abortions and repeat abortions
- Sexually transmitted infections and re-infections
- National Chlamydia Screening Programme (NCMP) ages 15-24
- HIV and late diagnoses
- Sexual exploitation, violence and abuse (inequalities)

14 Recommendations

Based on the needs assessment, the following recommendations have been highlighted for consideration:

<table>
<thead>
<tr>
<th>4.1 Teenage Conception, Abortions and Repeat Abortions</th>
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<tbody>
<tr>
<td>• Strengthen the provision of contraception, including LARC for all women of fertile age.</td>
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<tr>
<td>• Develop follow up pathways between contraceptive/termination of pregnancy services.</td>
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<tr>
<td>• Develop targeted approaches for 18-19 year old women at risk of unplanned pregnancy.</td>
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<tr>
<td>• Utilise opportunities to promote LARC through collaborative working – targeting women with complex needs.</td>
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<tr>
<td>• Increase the number of eligible clients within the Drug and Alcohol Integrated Treatment System being referred for LARC.</td>
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<table>
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<tr>
<th>4.2 Sexually transmitted infections and re-infections</th>
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<tbody>
<tr>
<td>• Ensure GP’s are undertaking partner notification where appropriate, offering training if needed.</td>
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<tr>
<td>• Raise awareness of reinfection rates in young people under 25.</td>
</tr>
<tr>
<td>• Ensure young people under 25 are aware of the services available to them.</td>
</tr>
<tr>
<td>• Effectively manage Gonorrhoea treatment.</td>
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</tbody>
</table>

\textsuperscript{46} PHE, HPV vaccination pilot for men who have sex with men (MSM) 2016 Information for healthcare professionals
• Extend targeted testing to other groups vulnerable to higher-risk sexual behaviours i.e. substance users, sex workers and swingers.
• Work in collaboration with partner agencies to provide domiciliary outreach to young people not engaging with services, for example looked-after young people.
• Development of digital access and self-management of asymptomatic patients.
• Ensure information, including harm reduction messages about Chemsex are made available and promoted to high risk group.

4.3 National Chlamydia Screening Programme (NCMP) ages 15-24
• Scale up of opportunistic screening through NCSP
• Ensure treatment and partner notification standards are met
• Improve follow up and contact tracing between TOP/SHS for chlamydia positive patients
• Increase access and uptake of screening to SHS services for young men
• Explore innovations to target young men in chlamydia screening
• Ensure NCSP data collection process is in line with CTAD mandatory data set

4.4 HIV and late diagnoses
• Increase awareness and uptake of HIV testing, ensuring HIV testing is accessible through secondary care, primary care, community settings, integrated sexual health services and on-line self-sampling.
• Investigate cases of late diagnoses to identify missed opportunities for testing in primary care.
• Work with primary care, offering training and support, to increase HIV testing in line with the BASHH guidance.
• Continue to work with AMU (Combined Assessment Unit) to increase HIV screening rates in secondary care.
• Develop targeted services for MSM, including the pilot of a ‘men only’ clinic.

4.5 Sexual exploitation, violence and abuse (inequalities)
• Ensure that NICE recommendations on harmful sexual behaviour among children and young people are reflected in relevant plans (BCSB CSE operational plan).
• Ensure that there are clear care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.
• Continue to improve measures to protect and support children and young people from exploitation, violence and abuse.
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- Reduce inequalities in sexual health by targeting vulnerable groups and communities with greater sexual health needs and tackling the stigma and discrimination associated with HIV and poor sexual health in partnership with other agencies.
- Improve access to sexual health services for people with mental health/learning disability.
- Ensure all services are aware of the particular needs of black and minority ethnic groups and people with learning disabilities in terms of sexual health.
- Ensure young people experience comprehensive relationship and sex education in schools.
- Ensure there is a uniform offer of support to victims of rape and sexual violence.
- Target problematic places and people of concern in terms of sexual assault, CSE and ‘missing from home’.
- Ensure provision of an Independent Sexual Violence Advisor (ISVA) for victims of sexual violence (including child ISVA).
15 **Glossary of terms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AMU</td>
<td>Acute Medical Unit</td>
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<td>BASHH</td>
<td>British Association for Sexual Health and HIV</td>
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<td>BBV</td>
<td>Blood Borne Virus</td>
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<tr>
<td>BSCB</td>
<td>Blackpool Safeguarding Children’s Board</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CSE</td>
<td>Child Sexual Exploitation</td>
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<td>EHC</td>
<td>Emergency Hormonal Contraception</td>
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<tr>
<td>FSRH</td>
<td>Faculty of Sexual and Reproductive Healthcare</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GUM</td>
<td>Genitourinary Medicine</td>
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<tr>
<td>GUMCAD</td>
<td>GUM Clinical Activity Dataset</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>IBA</td>
<td>Identification and Brief Advice</td>
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<tr>
<td>ISVA</td>
<td>Independent Sexual Violence Advisor</td>
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<tr>
<td>IU</td>
<td>Intrauterine</td>
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<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<td>LAC</td>
<td>Looked After Children</td>
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<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>NATSAL</td>
<td>National Survey of Sexual Attitudes and Lifestyles</td>
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<td>NCSP</td>
<td>National Chlamydia Screening Programme</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
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<tr>
<td>PN</td>
<td>Partner Notification</td>
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<tr>
<td>PrEP</td>
<td>Pre-Exposure Prophylaxis</td>
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<tr>
<td>PSHE</td>
<td>Personal Social and Health Education</td>
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<tr>
<td>SHEU</td>
<td>School Health Education Unit</td>
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<tr>
<td>SHS/SRH</td>
<td>Sexual Health Services/Sexual Reproductive Health services</td>
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<tr>
<td>SRE</td>
<td>Sexual Relationship Education</td>
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<tr>
<td>SRHAD</td>
<td>Sexual and Reproductive Health Activity Data</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy (Abortion)</td>
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<tr>
<td>UDM</td>
<td>User Dependent Method (of contraception)</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WISH</td>
<td>Wellbeing in Sexual Health</td>
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