Equality Impact Assessment for National Sexual Health Policy
January 2010
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Equality Impact Assessment for National Sexual Health Policy

January 2010

Prepared by the Sexual Health Policy team, Department of Health
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Executive summary

Introduction

The Department of Health (DH), like all other public bodies, has a legal duty to promote equality and eliminate discrimination. Equality impact assessments (EqIAs) form part of the DH Single Equality Scheme, a public commitment on how DH will meet those duties required of it by equality legislation. While equality legislation currently only requires policymakers within DH to assess the effects that a new proposal, or a change to existing policies, could have on equality in terms of race, disability and gender, DH extends this assessment to equality in relation to age, religion or belief and sexual orientation.

The aim of EqIAs is to narrow the health inequalities that exist in England, by ensuring that DH systematically assesses any effect that its functions, policy or strategy could have on equality. This EqIA sets out the current inequalities in sexual health, the national policies that are already in place to reduce or eliminate these inequalities, and an action plan to improve national sexual health policy by continuing to narrow them. It is important to note that the focus of the EqIA is on the existing national sexual health policy and not on local service provision.

The EqIA is based on a review of literature and an analysis of available statistics. The sections entitled ‘policy’ (in chapters 3, 4, 5 and 6) outline the activities of the Sexual Health Policy team at DH. The constraints of producing this assessment have left limited time available for broader consultation with stakeholders. However, it is expected that there will be an opportunity to consult with stakeholders in 2010, alongside any future sexual health strategy developments.

The current sexual health and HIV strategy ends in 2011, and consideration is already being given to what further action will be needed to continue with the improvements to sexual health. It is expected that the EqIA will contribute to the development of a future sexual health strategy.

Summary of the EqIA for national sexual health policy

The evidence outlined in the EqIA highlights the significant inequalities that exist within sexual health in England. However, many of those inequalities have already been addressed during implementation of the sexual health and HIV strategy. Policy initiatives have aimed to address the inequalities through targeted
programmes, such as chlamydia screening for young people, or HIV prevention work targeted at men who have sex with men, as well as at people from African communities. A summary of the EqIA for sexual health is provided below; information is presented according to each of the six DH equality strands.

Age

There are clear inequalities in the sexual health of young people. It has been shown that they have relatively high rates of unintended pregnancies and sexually transmitted infections (STIs), with the exception of HIV. While targeted policies are already in place to address these inequalities, there is some evidence to suggest that an increased focus on behaviour change could help further reduce inequalities.

There is data to suggest that the incidence of STIs in older people is increasing, although current numbers of STIs are relatively low, compared with younger age groups. It would be beneficial to consider the sexual health needs of this group, with a particular focus on the prevention of STIs. In addition, there is an ageing cohort of people living with HIV, and their needs should be taken into account when developing future sexual health policy.

Evidence, primarily from the USA, identifies the links between child sexual abuse and teenage pregnancy. Further consideration should be given to these links when developing policy initiatives to improve the sexual health of young people in the future.

Disability

There is limited data and research available on the needs of people with learning disabilities or physical disabilities. Consequently, people with disabilities have not to date been a focus for sexual health policy, and their needs should be considered in any future sexual health strategy development.

Gender

The sexual health needs of both males and females are currently considered in sexual health policy, and there are particular initiatives to address any gender inequalities, such as the National Chlamydia Screening Programme (NCSP) ‘Men too’ strategy. Other sexual health policy areas justifiably target females – such as the provision of abortion services. However, there is a potential need to further examine the sexual health needs of trans people. While it is estimated that the number of trans people in the UK is relatively low, it is a group that often has particular health needs and that can face discrimination.
Available evidence highlights the negative impact of sexual violence and abuse on the sexual health of victims/survivors. Policy developments and practice continue to improve sexual health service provision for victims/survivors; however, further consideration should be given to the sexual health needs of victims/survivors of sexual violence and abuse.

**Race**

While the relatively high rates of HIV among black African communities is currently being addressed through the funding provided to the African HIV Policy Network, other inequalities (such as the high rate of STIs or the relatively high abortion rates among certain communities) are not currently being addressed separately at a national level. Instead, the emphasis on tackling these inequalities is at primary care trust (PCT) level, where PCTs are expected to commission services to meet the needs of their local communities. There needs to be further consideration of this issue in any future sexual health strategy development.

**Religion or belief**

Sexual health policy should allow people to make informed decisions about their own sexual health, and these decisions may or may not be influenced by their religion or beliefs. If there is evidence to demonstrate links between religion or belief and inequalities in sexual health, then initiatives may be introduced. For example, the HIV ‘faith toolkits’ provide an example of an HIV prevention initiative that addresses the relatively high prevalence of HIV among Africans living in London, alongside evidence that over 80 per cent of this group adhere to either Christianity or Islam. Other similar opportunities should be considered, wherever relevant.

**Sexual orientation**

The data presented in the EqIA shows that sexual orientation impacts upon sexual health. In particular, there is strong evidence to demonstrate that men who have sex with men (MSM) have relatively high rates of HIV, and work is already under way to address this inequality. However, surveys of women who have sex with women (WSW) highlight the fact that more needs to be done to address the sexual health needs of this group.

**Action plan**

The action plan outlines the actions that the DH Sexual Health Policy team will undertake to address the inequalities in sexual health identified during the development of the EqIA. It is expected that the EqIA will provide an important
input to any future sexual health strategy development that takes place after the current strategy ends in 2011. Particular items for consideration include the following:

- The changing sexual health needs of older people, with a focus on the increasing STI rates found among older groups. In addition, the needs of the ageing cohort of people living with HIV should be considered.
- The sexual health needs of people with disabilities. Separate consideration should be given to people with physical disabilities and to people with learning disabilities.
- The sexual health needs of trans people.
- The relatively high rates of STIs among the black African and black Caribbean populations.
- The sexual health needs of WSW, with a particular focus on contraception and STI prevention and treatment.
- The sexual health needs of particular groups of people, such as the prison population, people with serious mental illness, sex workers and asylum seekers.
- How to influence behaviour change, so as to improve the sexual health of the population as a whole, with a particular focus on young people.
- The impact of sexual violence and abuse on sexual health, including risk-taking behaviour and sexual health inequalities.
- The impact of alcohol on risk-taking behaviour and sexual health inequalities.
- The impact of socio-economic factors on sexual health, with a particular focus on people living in deprived areas.
- How best to encourage and assist PCTs to commission services that address the sexual health inequalities in their local areas.

In addition, action should be taken by the Sexual Health Policy team, as follows:

- All future sexual health and HIV policy developments should consider the six DH equality strands.
- The EqIA for sexual health should be updated annually, to revise statistics and review content.
- The EqIA should form part of any consultation undertaken on any future sexual health strategy.
• Third sector and other partners in sexual health should be encouraged to analyse the impact of their work on equalities, with particular reference to the six DH equality strands.

• Consideration should be given to incorporating equalities information into the prevention framework.

• All sexual health specialist providers should be encouraged to work towards the ‘You’re Welcome’ accreditation, to make their services more welcoming to young people.

• Once a definition of disability has been agreed by the Information Standards Board (ISB), work should be undertaken to include disability in all the national datasets on sexual health.

• The impact of the Equality Bill should be reviewed, particularly in terms of preventing discrimination among disabled people and the ban on age discrimination.
1. Background

Introduction

1. The Department of Health (DH), like all other public bodies, has a legal duty to promote equality and eliminate discrimination. It is also legally required to foster positive relationships between different groups of people, eliminate harassment, and involve people in decisions regarding their health and social care and their access to services.

2. Equality impact assessments (EqIAs) form part of the DH Single Equality Scheme, a public commitment on how DH will meet those duties required of it by equality legislation. While equality legislation currently only requires policymakers within DH to assess the effects that a new proposal, or a change to existing policies, could have on equality in terms of race, disability and gender, DH extends this assessment to equality in relation to age, religion or belief and sexual orientation.¹

3. The aim of EqIAs is to narrow the health inequalities that exist in England, by ensuring that DH systematically assesses any effect that its functions, policy or strategy could have on equality.

4. This EqIA sets out the current inequalities in sexual health, the national policies that are already in place to reduce or eliminate them, and the action plan to improve national sexual health policy by continuing to narrow them.

5. Each key area of sexual health policy is addressed in turn: contraception, abortion, sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). Within each policy area, an equality assessment is provided across the six DH equality strands: age, disability, gender, race, religion or belief, and sexual orientation. Socio-economic deprivation is also considered, wherever it is relevant.

The national sexual health and HIV strategy

6. Good sexual health is an important aspect of health and wellbeing, and it is vital that people have the information, the confidence and the means to make choices that are right for them, regardless of their age, gender,

¹ DH 2009c.
ethnicity, sexual orientation, religion or belief or disability. It helps people to
develop positive relationships and enables them to protect themselves and
their partners from infections and unintended pregnancy.

7. In 2001, the Government published the National Strategy for Sexual Health
and HIV. This was a major milestone, as it placed sexual health and HIV
firmly on the national agenda and set out an ambitious 10-year programme
to tackle sexual ill health and to modernise the sexual health services in
England. Its aims were to:

- reduce the transmission of HIV and STIs;
- reduce the prevalence of undiagnosed HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs.

8. In 2007, the Government commissioned the Independent Advisory Group
(IAG) on Sexual Health and HIV to undertake a review of the progress made
in implementing the national sexual health and HIV strategy.

9. The IAG subsequently commissioned the Medical Foundation for AIDS and
Sexual Health (MedFASH) to work with it in developing the strategy review.
A comprehensive report was published in July 2008. It was welcomed by
the Government as providing a detailed and wide-ranging analysis of what
had been achieved so far and what still needed to be done to ensure that
people have both the information and the services that meet current and
future needs.

10. The strategy review recommended a wide-ranging set of actions at the
national, the regional and the local level, to respond to the new operating
environment and to drive further improvements.

11. As the review highlights, the period since the sexual health and HIV
strategy’s launch in 2001 has been a time of policy change, both in health
and in local government. The landscape is now very different, with devolved
decision-making in the health service and an increasingly important role
for local authorities as strategic leaders and partners in setting health and
wellbeing priorities and in identifying targets based on local need.

2 DH 2001a.
12. Within this changing context, considerable progress has been made, and many of the central commitments within the 2001 sexual health and HIV strategy and the accompanying implementation plan have been delivered. There have also been some real improvements in the sexual health of the population and in service provision. These include:

- falling teenage pregnancy rates;
- improvements in access to NHS-funded abortions; and
- transformed genitourinary medicine (GUM) services, with significantly improved access to testing and treatment and the introduction of chlamydia screening in every primary care trust (PCT) across the country.

13. These improvements have been underpinned by the development of recommended best-practice standards and guidance across the whole of sexual health. This is a reflection of the national commitment and of the priority attached to improving sexual health during implementation of the strategy.

14. Although the 2008 sexual health strategy review acknowledges that progress and improvements have been notable, the scale and nature of sexual ill health and inequalities in England are still of concern: alongside increasing overall demand for abortion, there are more diagnoses of HIV and STIs.

15. The Government responded to the independent review of the sexual health and HIV strategy in 2009. Its report outlined the progress that has been made since 2001 and responded to each of the national-level recommendations made in the strategy review.

16. The current strategy ends in 2011, and consideration is already being given to what further action is needed if improvements to sexual health are to continue to be made. The outputs from the sexual health conference (to be held in February 2010) will form the basis for the Government’s consideration of the next steps.

**Sexual health equality and impact assessment**

17. Sexual health is a very broad area, which affects and has an impact on most of the population. However, the 2001 national sexual health and HIV strategy drew attention to the existence of inequalities in sexual health.

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*MedFASH 2005.*

*DH 2009d.*
It highlighted the link between social deprivation and poor sexual health, as well as the unequal distribution of sexual ill health across the population. It recognised that the greatest burden is borne by women, gay men, teenagers, young adults and black and minority ethnic groups. Reducing these inequalities has been a key part of sexual health policy development.

18. To ensure that all the work currently being undertaken to implement the national sexual health and HIV strategy supports the Department’s duties on equality, this EqIA was initiated in summer 2009. It is expected to contribute to the future development of a sexual health strategy.

19. It is important to note that, while this EqIA covers existing national sexual health policy, including new policy work initiated after the 2008 strategy review, it does not include information relating to local service provision. Regional and local sexual health policy is the responsibility of strategic health authorities (SHAs) and PCTs, respectively: they are responsible for commissioning services that meet the needs of their local populations. However, the DH sexual health commissioning framework, which is currently in development, will provide guidance and support for PCTs.

Methodology

20. The EqIA is based on a review of literature and an analysis of available statistics. Policy information outlines the activities of the Sexual Health Policy team at DH. The constraints involved in producing the assessment mean that there has been limited time available for broader consultation with stakeholders. However, it is expected that there will be an opportunity to consult with stakeholders in 2010, alongside any future sexual health strategy developments.
2. Equality strands and sexual health

Introduction

21. All policies and services, including those relating to sexual health, should be designed to meet the needs of the entire target population. This should include action to address inequalities, wherever relevant.

22. DH assesses policies by undertaking an analysis of six equality strands (age, disability, gender, race, religion or belief, and sexual orientation). This chapter provides background information on how these equality strands can have an impact on sexual health.

23. However, it is important to understand that people are individuals and may fall into more than one group. There are many examples of this ‘intersectionality’ in the available literature. For example, 14 per cent of respondents to Stonewall’s survey of women who have sex with women (WSW) said they had some form of disability.6

24. In addition to the six equality strands, particular groups of people may have specific sexual health needs, or else difficulties in accessing available services. These groups include the prison population, people with serious mental illness, sex workers and asylum seekers.

Age

25. In England, the age of consent for any form of sexual activity is 16 for both men and women, regardless of sexual orientation.

26. A factsheet, developed by fpa, indicated that in Great Britain:7

- The average (median) age at first heterosexual intercourse was 16 for both men and women.

- Nearly a third of men and a quarter of women aged 16–19 had had heterosexual intercourse before they were 16.

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6 Stonewall 2008.
7 fpa 2009.
• About 80 per cent of young people aged 16–24 said that they had used a condom when they first had sex.
• Fewer than one in 10 had not used contraception at all when they first had sex.

27. England has a historically high rate of teenage pregnancy, and, although the rate is now falling, it remains the highest in Western Europe: in 2007, the conception rate among girls aged 15–17 was 41.7 per 1,000, down 10.6 per cent since 1998.\(^8\)

28. The Sexual Offences Act 2003 provides definitions of the various forms of sexual offences, including rape and sexual assault, and includes offences committed against those aged under 16.\(^9\) Sexual violence, assault and abuse have negative consequences on the sexual health of victims/survivors. These can include STIs, as well as unwanted pregnancy and gynaecological problems for female victims/survivors, and can lead to sexual risk-taking behaviour and re-victimisation.

29. Research studies relating to the under-18s have found that:
• 21 per cent of girls and 11 per cent of boys experience some form of childhood sexual abuse.\(^{10}\)
• A third of 13–17-year-old girls suffer unwanted sexual acts in a relationship, including rape.\(^{11}\)
• Childhood sexual abuse is most prevalent in the 5–14 age group.\(^{12}\)

30. Research studies relating to those aged over 16 have found that:
• 23 per cent of women and 3 per cent of men have experienced sexual abuse as an adult (aged 16–59). Five per cent of adult women and 0.4 per cent of adult men have been raped.\(^{13}\)
• Men and women aged between 16 and 19 are significantly more likely to experience sexual abuse than are older people. Women aged 16–24 are

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\(^8\) ONS 2009.
\(^{10}\) Cawson et al. 2000.
\(^{11}\) Barter et al. 2009.
\(^{12}\) WHO Collaborating Centre for Evidence and Health Policy in Mental Health 2001.
\(^{13}\) HM Government 2007.
almost four times as likely to have experienced sexual abuse in the last year than are women aged 45–59.\(^\text{14}\)

- Young adults are more likely to be sexually abused if they experienced sexual abuse as children.\(^\text{15}\)

31. In addition, there is research, primarily from the USA, that identifies links between child sexual abuse and teenage pregnancy (see the chapter on Contraception for further information).

### Disability

32. The Office for Disability Issues recommends the use of the definition of disability under the Disability Discrimination Act (DDA) 1995. It defines a disabled person as someone who ‘has a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities’. It is important to emphasise that the needs of people with disabilities will vary greatly, and policies should be considered for their impact on people with different types of disability (such as physical, sensory, mental and learning disabilities, as well as mental incapacity) and combinations of disabilities.

33. The Office for Disability Issues estimates that there are over 10 million disabled people in Britain, of whom 5 million are over State Pension age and 800,000 are children.\(^\text{16}\) This estimate includes those people with a longstanding illness, disability or infirmity, and those who have significant difficulty with day-to-day activities. However, it is important to note that the estimate does not reflect the total number of people covered by the DDA, as the data is not available.

34. Anyone who has been diagnosed with HIV is automatically covered by the DDA.

35. Disabled people – like the rest of the population – can choose to have sexual relationships and can have a lesbian, bisexual, gay or heterosexual identity. TheSite.org highlights ways in which disability can affect people’s sexual relationships and health.\(^\text{17}\)

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\(^\text{14}\) Walker et al. 2006.
\(^\text{15}\) Humphreys 2000.
\(^\text{16}\) Office for Disability Issues (no date).
\(^\text{17}\) TheSite.org, *Disability and sexual confidence*. 
'Some people are born with a disability, but others may be affected by one later in life. Whether you’re hearing or speech-impaired, have a learning disability, or you’re a wheelchair user, different forms of disability and illness can affect the way you have sex, or the amount you do it. Your sex life could be affected by the disability in itself, because of side-effects of your medication, or psychological problems, such as anxiety about your performance and how your body may react.'

36. Data on the sexual health of people with disabilities is limited. Disability is not currently included in any of the national datasets on sexual health, as the Information Standards Board (ISB) has not yet agreed a definition of disability.

37. In 2005, Disability Now carried out a survey of 1,115 disabled people. The respondents had various disabilities – physically impaired (79 per cent), chronically ill (7.1 per cent), learning difficulty (2.5 per cent), mental health problem (2.1 per cent) and other (4.6 per cent). The results of the survey were as follows:

- 84.7 per cent of respondents had had sexual intercourse at some time;
- 68 per cent of respondents had had sex since becoming disabled;
- 94.3 per cent of respondents said they knew what safer sex was; and
- 27.4 per cent had been sexually abused or exploited.


- It is hard to produce precise information about the number of people with learning disabilities in the population.
- It is estimated that there are about 210,000 people with severe and profound learning disabilities: around 65,000 children and young people, 120,000 adults of working age and 25,000 older people.
- In the case of people with mild to moderate learning disabilities, lower estimates suggest a prevalence rate of around 2.5 per cent of the population – some 1.2 million people in England.
- Prevalence of severe and profound learning disability is fairly uniformly distributed across the country and across socio-economic groups. Mild to
moderate learning disability, however, has a link to poverty, and rates are higher in deprived and urban areas.

39. Issues around consent for examination and treatment are particularly relevant for people with learning disabilities.

40. There is little published material on the sexual health and wellbeing of young people with learning disabilities. However, CHANGE, a disability rights organisation, has recently carried out a research project on sexuality and young people with learning disabilities, with a particular focus on sex education. The findings of the research highlight the need for improved sex education for people with learning disabilities, including the provision of accessible information and increased support for parents and teachers.19

**Gender**

41. The sexual health needs of people will vary according to their gender, particularly as regards the provision of contraception and abortion services. However, people of all genders – including trans people – can be affected by STIs.

42. A DH publication defines the terminology used in reference to trans people:20

- ‘Trans’ is used to capture experiences of being gender variant in behaviour and preference, as well as social and legal gender change or transformation.

- ‘Transgender’ is a term used in the UK to describe those people who live part or all of their lives in their preferred gender role – they may use hormonal treatments to change their body form, but they will not generally seek to undergo gender reassignment surgery. Transgender is also used to describe cross-dressers and transvestites (drag queens and drag kings).

- ‘Transsexual’ describes those who seek gender reassignment treatments, including genital reconstructive surgery where possible. ‘Transsexual’ should be used as a descriptive term – as in ‘transsexual people’ or ‘someone who is transsexual’.

- ‘Intersex’ refers to people with both male and female sex signifiers.

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19 For further information, please see: www.changepeople.co.uk/showPage.php?id=9
20 DH 2007e.
43. There is no publicly available statistical data on which to base firm estimates of the numbers of trans people in the UK. But in 2005, the Women and Equality Unit indicated that there were an estimated 5,000 transsexual people in the UK.\footnote{Women and Equality Unit (Department of Trade and Industry) 2005.}

44. Trans people can have a lesbian, bisexual, gay or heterosexual identity.\footnote{DH 2007b.}

45. Women are disproportionately the victims/survivors of sexual violence and abuse, and such abuse is massively under-reported by both female and male victims/survivors.\footnote{HM Government 2007.}

46. Sex workers – like the rest of the population – form a diverse group, and their sexual and health behaviour will vary greatly. However, sex workers may have particular sexual health needs, and these are likely to differ according to their gender and personal circumstances.\footnote{UK Network of Sex Work Projects 2009.}

**Race**

47. The most common ethnic group found in the 2001 census of England and Wales was White: British (87 per cent). It was followed by White: Other White (2.7 per cent), Asian or Asian British: Indian (2.1 per cent), Asian or Asian British: Pakistani (1.4 per cent), White: Irish (1.3 per cent), Black or Black British: Caribbean (1.1 per cent) and Black or Black British: African (1 per cent). Other ethnic minorities each represent below 1 per cent of the population.\footnote{Office for National Statistics (ONS) 2003b.}

48. It is important to note that there are significant variations in the ethnic groups found across different areas of England and Wales. For example, the greatest concentrations of black or black British people with a cultural background from the Caribbean are to be found in Lewisham and Lambeth (12 per cent of the population).\footnote{Office for National Statistics (ONS) 2003b.}

**Religion or belief**

49. In the 2001 census of England and Wales, over 70 per cent of people gave their religion as Christian, followed by almost 15 per cent who said they did not follow a religion. Muslim was given by 3 per cent, Hindu by 1.1 per cent and less than 1 per cent of the population gave their religion as
Sikh (0.6 per cent), Jewish (0.5 per cent), Buddhist (0.3 per cent) or other religions (0.3 per cent).

50. However, as with ethnic groups, there are significant variations in the distribution of religions across England and Wales. For example, 36 per cent of the population of Tower Hamlets are Muslim, compared with 4 per cent in Greenwich.26

51. Religious and cultural views can influence attitudes towards abortion, contraception and sexual relationships.27 For example, pre-marital sex and same-sex relationships are prohibited by some religions. Some religions embrace trans people, whereas others do not. In addition, some religions require patients to be treated by a doctor or nurse of the same sex.28

52. It should never be assumed, however, that an individual who belongs to a specific religious group will necessarily be compliant with, or completely observant of, all the views and practices of that group.29

Sexual orientation

53. There is little reliable data on the lesbian, gay and bisexual population.30 Sexual orientation is not currently included in the national census. However, in 2004, the Department of Trade and Industry (DTI) reviewed a range of research to develop an estimate that between 5 and 7 per cent of the population is lesbian, gay or bisexual.31

54. As with everyone, WSW and men who have sex with men (MSM) are socially and culturally diverse groups, and some of them may not self-identify as ‘lesbian’, ‘gay’ or ‘bisexual’.

55. It is important to stress that people’s sexual behaviour cannot be deduced from their sexual orientation. For example, a bisexual woman might only have sex with women, or a lesbian may have sex with men.32

56. Lesbian, gay, bisexual and trans (LGBT) people may delay seeking help for a health problem and be less likely to access routine health screening because

26 ONS 2003b.
27 DH 2009a.
28 DH 2009a.
29 DH 2009a.
31 DTI 2004.
32 DH 2007d.
of a fear of encountering homophobic attitudes, a reluctance to disclose their sexual orientation to a healthcare worker and the lack of knowledge and awareness about LGBT health needs.33

57. A Stonewall survey of 6,000 WSW found that half had had negative experience of healthcare, including sexual healthcare, in the previous year, and a similar number felt unable to be open with their GP about their sexual orientation.34

58. Many WSW are likely to have unmet sexual health needs, and the Stonewall survey highlights the fact that there is considerable ignorance among healthcare workers about those needs. The Manual for Sexual Health Advisers35 also points out that high percentages of WSW in all studies give a history of having previous or current sexual contact with men. The manual emphasises that an accurate sexual history is of vital importance in any assessment of risks and interventions.

33 DH 2007c.
34 Stonewall 2008.
35 Society of Sexual Health Advisers 2004.
3. Contraception

Introduction

59. All sexually active women from their teenage years to, in some cases, their late 50s are at risk of unintended pregnancy.

60. Women who are approaching menopause need to keep on using contraception for 12 months after their last period, if they have sex with a man and do not want to get pregnant. This is because periods can become irregular before they stop altogether, and pregnancy can still occur during this time.

61. Contraception can be divided into methods with user failure (such as oral contraception or condoms) and methods with no user failure (sterilisation and long-acting reversible methods). Long-acting reversible methods include the intrauterine device (IUD), hormonal injections, the intrauterine system (IUS) and the contraceptive implant.

62. It is vital to ensure that couples and individuals use the most appropriate type of contraception. The National Institute for Health and Clinical Excellence (NICE) guidance indicates that, if 7 per cent of women switched from oral contraception to long-acting methods, the NHS could see a saving of around £100 million a year through a reduction of 73,000 in the number of unintended pregnancies.\(^\text{36}\)

63. The age-standardised abortion rate per 1,000 women aged 15–44 is the key indicator of unintended pregnancy. In 2008, it decreased to 18.2, compared with 18.6 in 2007.\(^\text{37}\)

64. A source of data on contraception in England is the Office for National Statistics (ONS) report, *Contraception and Sexual Health 2007/08*.\(^\text{38}\) It presents the results of a survey on contraception and sexual health carried out by the ONS in 2007/08 on behalf of the NHS Information Centre. Questions on contraceptive use and sexual health were asked of women aged 16–49 and men aged 16–69.

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\(^{36}\) NICE 2005b.

\(^{37}\) DH 2008a.

\(^{38}\) Lader and Hopkins 2008.
Age

65. The ONS survey, *Contraception and Sexual Health 2007/08*, found that:

- Among contraceptive users, younger women were more likely than older women to be using oral contraception or the male condom. Conversely, older women were more likely than younger women to rely on sterilisation or partner’s vasectomy.

- Among both men and women, the percentage using condoms was highest in the younger age groups and decreased with age.

- There was no consistent variation in awareness of emergency hormonal contraception (EHC – sometimes called the ‘morning-after pill’) or emergency IUD between women in the different age groups. Some 91 per cent of women said they had heard of the morning-after pill, a percentage that has remained relatively stable since 2000/01. By contrast, awareness of the emergency IUD has fallen from 49 per cent in 2000/01 to 37 per cent in 2007/08.

- Use of EHC was more common in those women at risk of pregnancy aged under 30 than among older women. Single women were more likely than their married counterparts to have used EHC.39

- In 2007/08, the percentage of men and women who had been sterilised increased with age. The percentage of women who had been sterilised increased from 2 per cent among those aged 16–29 to 16 per cent of those aged 45–49. The percentage of men who had undergone a vasectomy increased from only 1 per cent of those aged 16–29 to 30 per cent of those aged 50–54 and then remained relatively constant thereafter.

66. The peak age group for attendance at a community contraceptive clinic was 16–19, based on the rate per 100 population.40

67. The abortion rate is highest among women aged 20–24 (32 per 1,000 women). By individual age year, the highest rate is among women aged 19 (36 per 1,000).41 Younger women are at greater risk of unintended pregnancy for both behavioural reasons (higher number of sexual partners,

39 Women were defined as ‘at risk’ of pregnancy if they were in a heterosexual relationship and were neither pregnant nor reliant on surgical methods of contraception (self or partner sterilisation).
40 NHS Information Centre 2008.
41 DH 2008a.
less likely to be in an established relationship) and biological reasons (more fertile) than are women aged over 24.

68. Longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life. At age 30, mothers who gave birth as teenagers are 22 per cent more likely to be living in poverty than mothers who gave birth aged 24 or over. They are also much less likely to be employed or living with a partner. Teenage mothers have three times the rate of post-natal depression observed in older mothers. The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers.

69. DH and the Department for Children, Schools and Families (DCSF) share a Public Service Agreement (PSA) target to reduce teenage conceptions by 50 per cent by 2010. Steady progress is being made towards this target: 2007 annual conceptions data shows a 10.7 per cent decline in the under-18 conception rate since the 1998 baseline year. However, England still has one of the highest rates of teenage pregnancy in Western Europe, and progress is not sufficient to meet the PSA target.

70. There is increasing evidence from the USA and from visits to high-performing areas of England that provision of high-quality contraception services is crucial in reducing teenage pregnancy. Some 80 per cent of under-18 conceptions occur among 16- and 17-year-olds, and it is vital for sexually active young people to have access to the full range of methods of contraception.

71. There is evidence that the quality of information about contraception provided by general practice needs to improve. A study of 14 practices across Trent, England, identified young women who had conceived before the age of 20. The overwhelming majority of those teenagers who had become pregnant had attended general practice during the previous 12 months.

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42 Social Exclusion Unit 1999.
43 Social Exclusion Unit 1999.
44 Social Exclusion Unit 1999.
45 Social Exclusion Unit 1999.
46 ONS 2009.
48 Santelli et al. 2007.
49 DCSF 2006b.
50 ONS 2009.
(93 per cent); many of them had sought contraceptive advice (71 per cent) and had been prescribed oral contraception (50 per cent).

72. There is evidence to link alcohol consumption and teenage pregnancy. For example, an evidence review found that early, regular alcohol consumption is associated with both an early onset of sexual activity and multiple sexual partners, while alcohol use at first sex is associated with lower levels of condom use at first intercourse.52

73. In addition, available evidence, particularly from the USA, indicates that childhood sexual abuse is a risk factor for teenage pregnancy for both boys and girls:

- Both males and females who have experienced sexual abuse are more likely to have ever been pregnant or to have ever had sex that resulted in a pregnancy.53
- Women who were sexually abused as children are significantly more likely to fall pregnant as adolescents than are their counterparts who were not abused (36 per cent versus 21 per cent).54
- Male victims/survivors of both physical and sexual abuse and of exposure to maternal abuse before adulthood are more than twice as likely as other men to be involved in the pregnancy of a teenager.55

74. The associations between teenage pregnancy and childhood sexual abuse can be both direct and indirect. Direct associations occur when young women become pregnant as a direct result of sexual abuse. For example, a research study in the USA found that 23 per cent of young women who are sexually abused become pregnant by the perpetrator (primarily their boyfriend or friend).56 Other studies highlight the indirect associations: where experience of childhood sexual abuse is associated with early initiation of sexual activity, failure to use contraception, multiple sexual partners, substance use and abuse, and other risk factors, all of which are associated with a higher likelihood of experiencing a teenage pregnancy.

52 Bellis et al. 2009.
55 Rosenberg 2002.
Disability

75. Some forms of contraception may not be appropriate for people with certain disabilities. For example, some spina bifida sufferers are allergic to latex, so they need to use non-latex condoms and dental dams for safer sex.\(^{57}\)

76. People with learning disabilities may have special and specific needs around sexual health and contraception. For example, they may require information on contraception to be delivered in a different format, or they may need support to enable them to communicate their choices.

77. The NICE guidance on long-acting reversible contraception states that:\(^{58}\)
   - Women with learning and/or physical disabilities should be supported in making their own decisions about contraception.
   - When a woman with a learning disability is unable to understand and take responsibility for decisions about contraception, carers and other involved parties should meet to address issues around the woman’s contraceptive need and to establish a care plan.
   - Healthcare professionals should have access to advocates for women with sensory impairments or learning disabilities.

Gender

78. All the currently available methods of contraception (with the exception of natural family planning, the male condom and male sterilisation) are primarily used by women. However, patient choice is paramount, and both men and women who request contraceptives should be given information about all methods, including long-acting reversible contraceptives (LARCs).

79. The ONS survey, *Contraception and Sexual Health 2007/08*, found that:\(^{59}\)
   - The majority of women under 50 (74 per cent) were using contraception.
   - The most popular method of contraception among the survey respondents was oral contraception (28 per cent), followed by the male condom (24 per cent).
   - Approximately one woman in four (26 per cent) was not currently using a method of contraception; of those, just over half (14 per cent of all women under 50) were not engaged in a sexual relationship with a man.

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\(^{57}\) TheSite.org. *Sex when you’re disabled.*

\(^{58}\) NICE 2005a.

\(^{59}\) Lader and Hopkins 2008.
• Among those who were in a heterosexual relationship, the main reason for a woman not using contraception was that her partner had been sterilised (53 per cent). The next most common reason was planned pregnancy (15 per cent).

• The percentages of men and women who had used a condom in the previous year were similar to those recorded in previous years of the survey – 43 per cent of men and 50 per cent of women.

80. Men accounted for only 10 per cent of attendances at NHS community contraception clinics in 2007/08, although this figure is increasing.60

81. The Brook report, Boys’ and young men’s use of sexual health services: A summary of a review of the academic literature,61 found that, because young men mainly visit sexual health services for condoms, which they can obtain elsewhere, they often do not use sexual health services prior to having sex. The gender differences are significant, with the median period for young men between first sex and their initial visit to the service being two years, compared with around eight weeks for young women.

82. Health professionals should be sensitive to the needs of female-to-male transgender patients who may have chosen not to have surgery or who are awaiting surgery and may still have contraceptive needs.

83. Studies, particularly within the USA, have highlighted the links between sexual abuse and use of contraception. For example, research has found that females who have experienced sexual abuse are less likely to use contraception at first sex and the last time they had sex; are more likely ever to have had sex without contraception; are less likely to use contraception consistently; and are more likely never to use it.62 Female victims/survivors of sexual violence or abuse are much more likely than non-abused women to have had their partner prevent them from using contraception and to have had a partner refuse to use a condom in order to prevent infection.63

Race

84. Joint guidance published by DH and DCSF in 2006 highlighted evidence that young people from certain ethnic groups are much more (or less) likely to experience teenage pregnancy than others, even taking account

60 NHS Information Centre 2008.
61 Brook 2007.
63 Women’s Resource Centre 2008.
of the effects of deprivation. For example, teenage pregnancy rates vary dramatically between London boroughs with similar levels of deprivation, but a different ethnic composition. In some instances, a borough’s rate is double that of a similarly deprived borough with a different ethnic make-up.

85. Establishing the precise impact of ethnicity on teenage pregnancy is difficult for several reasons: ethnicity has only just begun to be recorded at birth registration; black and minority ethnic (BME) groups are over-represented in deprived areas, where high rates would be expected; and sexual behaviour, knowledge and attitudes may vary considerably within ethnic groups. Nevertheless, the available evidence does indicate that girls and young women from some ethnic groups are more likely to become pregnant before they are 18. We do know from other data sources, including census data, that there are higher rates of teenage pregnancy among black, black Caribbean and mixed white/black Caribbean groups.

86. NICE guidance states that healthcare professionals should have access to trained interpreters for women who do not speak English.

87. One indicator of unintended pregnancy is the abortion rate. The chapter on abortion highlights differences in the abortion rate by ethnicity. Women in white ethnic groups are under-represented in the abortion statistics (compared with their position in census data), whereas women of black or black British and Asian and Asian British ethnicity are over-represented. This demonstrates that black or black British, Asian and Asian British women may have unmet contraceptive needs.

Religion or belief

88. The religion or beliefs of an individual or their community can have an impact on the service user’s choice of contraception method, as well as on their ability to access contraceptive services. The factsheet Religion, contraception and abortion, developed by fpa, aims to reflect the predominant attitudes to contraception of the main religious groups in the UK. The factsheet is summarised below.

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64 DCSF 2006a.
65 NICE 2005a.
<table>
<thead>
<tr>
<th>Religion</th>
<th>Religion’s views on contraception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhism</td>
<td>Most Buddhists believe that conception occurs when the egg is fertilised, so contraception that prevents fertilisation is not ordinarily a problem. Emergency contraception is likely to be unacceptable. However, as Buddhism is open to personal interpretation, attitudes to this and other questions of birth control will vary.</td>
</tr>
<tr>
<td>Christian (Catholic)</td>
<td>Artificial methods of contraception should not be used; however, in practice there is a reliance on natural family planning to allow couples to space child-bearing.</td>
</tr>
<tr>
<td>Christian (Protestant)</td>
<td>Contraception is generally accepted, as long as it is agreeable to both partners, although methods that prevent a fertilised egg from implanting tend to be less acceptable.</td>
</tr>
<tr>
<td>Hinduism</td>
<td>All methods of contraception are permitted.</td>
</tr>
<tr>
<td>Islam</td>
<td>Contraception is acceptable to space child-bearing, where there is concern for the physical or mental wellbeing of the mother, or for personal reasons dictated by conscience. Vasectomy is strictly forbidden, although female sterilisation may be permissible if the woman’s life is endangered or her mental health could be seriously affected by a pregnancy.</td>
</tr>
<tr>
<td>Judaism</td>
<td>The sources in Jewish law state categorically that a man may not use any form of contraception. However, as the sources make no mention of females and contraception, most (if not all) use this omission to reach the interpretation that females may use contraception.</td>
</tr>
<tr>
<td>Sikhism</td>
<td>Birth control by contraception is an acceptable practice.</td>
</tr>
</tbody>
</table>

### Sexual orientation

While it is acknowledged that WSW have a lower risk of unintended pregnancy, a survey of sexual behaviour between women demonstrates that WSW may have sexual histories with both male and female partners. While 98 per cent of the whole sample gave a history of sexual activity with women, 85 per cent of the sample reported sexual activity with men (although for 70 per cent this was four or more years ago\(^67\)). Thus WSW may also have a need for contraception.

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\(^{67}\) Bailey et al. 2003.
Policy

90. Contraception should be available and accessible to all couples and individuals who require it. Couples and individuals should have a choice of method, and the information should be available to support them in deciding which contraceptive method(s) to use. It is recognised that choices may be affected by religion or belief, disability and age, among other factors.

91. Contraception services are free and confidential – including to young people under the age of 16, as long as they are mature enough to understand the information and the decisions involved.

92. Contraception is available free of charge through a range of providers, including GPs, community contraceptive clinics, some GUM clinics, sexual health clinics and young people’s services.

93. The provision of contraceptive services at the local level is the responsibility of PCTs. They need to determine – and then meet – the contraceptive needs of their local population, and they should examine equalities issues as part of this work. In February 2008, DH announced an extra £26.8 million investment for 2008/09 to improve women’s access to contraception and to help reduce the number of teenage pregnancies. Of this money, £12.8 million was distributed to PCTs in their main allocations. PCT general allocations were uplifted by a further 5.5 per cent in 2009/10. Some PCTs have used these central funds to try to narrow health inequalities. For example, Blackburn with Darwen PCT drew on the money to fund training clinics and to develop a LARC campaign, in order to tackle the increasing number of women from Asian ethnic groups who have abortions.

94. DH is currently producing a tool to support GPs in providing appropriate contraceptive information for patients during a standard GP consultation. It is hoped that the tool will be available by the end of 2009/10.

95. Teenage pregnancy is both a cause and a consequence of social exclusion, health inequalities and child poverty. Reducing England’s historically high rates of teenage pregnancy continues to be a government priority. The under-18 conception rate is one of the lead indicators used to measure progress against PSA 14 (Increase the number of children and young people on the path to success).

96. The Government’s decision to make personal, social, health and economic education (PSHE) – including sex and relationships education (SRE) –
statutory at all key stages will ensure that young people receive a more comprehensive SRE programme and that there is a more consistent offer across schools. DCSF is leading on the implementation of this policy.

97. The ‘You’re Welcome’ quality criteria set out principles that will help health services (including non-NHS provision) to become more welcoming to young people. They cover areas that are to be considered by the commissioners and providers of health services. Sexual health specialist providers should be encouraged to work towards the ‘You’re Welcome’ accreditation, and to make their services more welcoming to young people. A programme to support consistent implementation of ‘You’re Welcome’ has been put in place across the nine regions, working through the Government Offices. At the end of March 2009, 68 per cent of PCT areas had signed up to implement ‘You’re Welcome’ and to work to its national priorities in 2009/10. Health services that have implemented the ‘You’re Welcome’ quality criteria include general practice, health services in education settings, contraception and sexual health services, and abortion service providers.

98. Work has started to examine ways in which the Government can better support research, interventions and prevention in the field of sexual health and alcohol misuse, in order to reduce risk-taking behaviour, particularly among young people. The work will also consider the role of alcohol in sexual violence and abuse, and the resulting impact on the sexual health of the victim/survivor. A consultation meeting with researchers, academics and public health professionals took place in May 2009. Work to implement the findings from the workshop will take place over the coming year.

99. NICE guidance states that healthcare professionals should be aware of the law as it relates to the provision of advice and contraception for young people and for people with learning disabilities. Child protection issues and the Fraser guidelines should be considered whenever contraception is provided to women below the age of 16. 68

100. At the national level, DH has provided some funding to help PCTs address the sexual health issues faced by young people with learning disabilities. For example, it has funded Leeds PCT to make available as a national resource a learning pack that has been developed locally on ‘Puberty and Sexuality for Children and Young People with a Learning Disability’.

68 NICE 2005a.
101. DH has recently established a national support team on the response to sexual violence, with funding of £1.4 million. Working with the Home Office, its role is to deliver on the Home Secretary’s commitment that each police force area should have a sexual assault referral centre (SARC) by 2011. The team works locally to bring together experts from the health service (including sexual health, children and young people, mental health, primary care and emergency medicine), SARCs, forensic services, the Crown Prosecution Service, the third sector and the police to advise on developing local service provision for victims of sexual violence.

102. A health taskforce has been established as part of the current cross-government consultation on the strategy to tackle violence against women and girls. It will identify the role and the response of health services in preventing violence and abuse, and in identifying and supporting women and girls who are victims of such violence and abuse. It is expected to make recommendations on what more could be done to meet their physical, sexual and mental health needs.

103. The section above on religion or belief notes the views of the major religions on the use of contraception. However, it is important to emphasise that health professionals should not make assumptions about individual contraception choices on the strength of known religious beliefs.

104. With regard to sexual orientation, the sensitive recording of sexual history is now considered to be an element of good practice in any sexual health service. Guidance on this issue will be included in the package of information DH is preparing for general practice.

National sexual health campaign

105. A new communications programme has been developed, following the decision to introduce a campaign to increase young people’s awareness of effective contraception and to boost the take-up of chlamydia testing.

106. The new campaign strategy focuses on a single campaign identity, within which there will be specific messages about contraception, condoms, STIs and relationships. The umbrella brand, ‘Sex. Worth talking about’, highlights the importance of talking openly about sexual health and relationships and will be used across all elements of the campaign.

107. The first wave of campaign activity began in November 2009 and focuses on increasing awareness of the range of contraceptive choices. In particular,
it will discuss the benefits of longer-lasting methods, for which there are low levels of knowledge.

108. In 2010, the focus will shift to chlamydia, and this activity will run through to the end of the financial year. This is the first national campaign support for the National Chlamydia Screening Programme (NCSP).

109. At the simplest level, the key audiences for the campaign break down into four groups: the under-16s; the over-16s; parents and stakeholders (such as healthcare professionals); and youth support workers and teachers. The focus on these groups is a reflection of the relatively high level of diagnosis of STIs (especially chlamydia) among young people and of the high number of unintended pregnancies, as indicated by the relatively high abortion rate among young women (see later chapters for evidence). However, as the campaign aims to address behavioural factors that contribute to specific sexual health issues, the audiences reached by these activities may well extend beyond that basic age range, as behaviours are rarely rigidly defined by age.

110. The mainstream campaign targets both men and women, since the decision to apply safer-sex behaviours is one that may be taken both individually and jointly. The safer-sex message is relevant to the whole population, regardless of gender identification.

111. The mainstream campaign focuses primarily on a heterosexual audience, although creative testing will be used to ensure that messages do not have unintended implications for those who do not identify as heterosexual.

112. The mainstream campaign aims to present messages across ethnicities and religions or beliefs. The campaign recognises that different religious and belief systems view matters of sexual health in different ways. It aims to present safer sexual health as a range of choices and options that are available for individuals to select according to their personal needs and requirements.

113. The campaign has no specific remit to target any distinct disability issues, as the available evidence does not indicate that this audience is a key at-risk group. The wider issues addressed by the campaign are the acceptability of safer-sex behaviours, and as such are appropriate to all population groups.
4. Abortion

Introduction

114. Abortion is legal in Great Britain if it is performed within the terms of the Abortion Act 1967 (as amended) (‘the Act’). The law states that abortions must be carried out in a hospital or a specialised licensed clinic, and that women seeking an abortion, for whatever reason, must have grounds under the Act. A pregnancy may only be terminated if two registered medical practitioners are of the opinion, formed in good faith, that an abortion is justified within the terms of the Act, in the light of their clinical judgement as to all the particular circumstances of the individual case.

115. The Government has a responsibility to monitor the provisions of the Act as they are, unless Parliament chooses to amend the law further.

116. The DH publication Abortion Statistics, England and Wales\textsuperscript{69} found that, in 2008, for women resident in England and Wales:

- The total number of abortions was 195,296, compared with 198,499 in 2007 – a fall of 1.6 per cent.
- 91 per cent of abortions were funded by the NHS; of these, over half (58 per cent) took place in the independent sector, under NHS contract.
- 90 per cent of abortions were carried out at under 13 weeks gestation; 73 per cent were at under 10 weeks.
- Medical abortions accounted for 38 per cent of the total.
- 1,988 abortions (1 per cent) were carried out under ground E – risk that the child would be born handicapped.

117. The absolute risk of complications at the time of abortion is low. However, the earlier in pregnancy an abortion is performed, the lower the risk of complications.\textsuperscript{70}

\textsuperscript{69} DH 2008a.

\textsuperscript{70} Royal College of Obstetricians and Gynaecologists (RCOG) 2004.
Age

118. Women could be at risk of unintended pregnancies throughout their reproductive lives. All women of childbearing age can access an abortion, provided two doctors agree that there are grounds for the abortion, under the Act.

119. In 2008, the abortion rate was 18 per 1,000 women overall. The rates of abortion were higher than average for ages 15–19 (24 per 1,000), 20–24 (32 per 1,000) and 25–29 (24 per 1,000), and lower than average for women aged over 30 and under 15.

120. In 2008, the abortion rate was highest for women aged 19 (36 per 1,000), the same as in 2007. The under-16 abortion rate was 4.2 per 1,000 and the under-18 rate was 18.9 per 1,000 – both lower than in 2007.\(^{71}\)

121. There is some variation in ‘abortion proportions’ (i.e. the proportion of under-18 conceptions that end in abortion) at the local authority level. Between 1997 and 1999, the proportion ranged from 25 per cent to 69 per cent in Great Britain. There is a strong correlation between abortion proportions and measures of social deprivation, with areas that are more deprived experiencing lower abortion proportions.\(^{72}\)

122. A survey of 883 women who had obtained second-trimester abortions at non-NHS units found that there were no substantial variations by age, and median gestations were only one week longer for women under 18 than for those who were older than that. Women under the age of 18 were, however, significantly more likely than older women to report delays in the early stages of the decision-making process. Reasons given included: having a suspicion of pregnancy but not doing anything about it; not being sure what they would do if they were pregnant (leading to a delay in taking the pregnancy test); concern about what an abortion involved; and waiting before asking for the procedure. According to the research, younger women were also more likely to raise concerns about how their parents would react. In common with older women, the women’s relationships with their partners played a significant role in the decision-making process.\(^{73}\)

\(^{71}\) DH 2008a.
\(^{72}\) Lee et al. 2004.
\(^{73}\) Ingham et al. (no date).
Disability

123. There is little data or research available on abortion among women with disabilities.

124. Information relating to any disability of the woman having an abortion is not captured on the abortion notification form (HSA4), even though her disability may be a factor in seeking an abortion.

Gender

125. The provision of abortion services is only relevant to women of reproductive age and to trans people with female reproductive organs.

126. The decision to terminate a pregnancy rests with the woman and her doctors. Legally, the woman’s spouse or the father of the child has no rights to demand or refuse an abortion. However, in many cases, a woman will discuss the question with her partner, and the partner will often accompany the woman to the clinic.

Race

127. The revised HSA4 form, introduced in 2002, allows ethnicity to be recorded, as self-reported by the woman involved. Ethnicity was recorded on 94 per cent of the forms received for 2008, compared with 80 per cent in 2003.

128. Some BME groups have higher rates of unintended pregnancy and abortion. Whereas women from white ethnic groups are under-represented in the abortion statistics (compared with census data), women of black or black British, Asian and Asian British ethnicity are over-represented. Of those women whose ethnicity was recorded in 2008:74

- 76 per cent were reported as white (compared with 2001 census data of 91 per cent of the population);
- 10 per cent were recorded as black or black British (compared with 2001 census data of 2.1 per cent of the population); and
- 8 per cent were recorded as Asian or Asian British (compared with 2001 census data of 3.5 per cent of the population).

74 DH 2008a.
129. This inequality also shows up in data on the ethnicity of women who had already had one or more abortions (see graph below).  

![Graph showing ethnicity and previous abortions](image)

Religion or belief

130. Most of the six major religions of the UK – Buddhism, Christianity, Hinduism, Islam, Judaism and Sikhism – either condemn abortion or allow it only in very limited circumstances, such as when the mother’s life is at risk or the baby is likely to be born with a genetic disease or severe disability, and where the baby has no chance of survival outside the womb. When abortion is allowed, it is normally only permitted in the very early stages of pregnancy.  

131. The factsheet *Religion, contraception and abortion*, developed by fpa, aims to reflect the attitudes to abortion of the main religious groups in the UK. The factsheet is summarised in the table overleaf.

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75 DH 2008a.
76 DH 2009a.
77 fpa 2004.
<table>
<thead>
<tr>
<th>Religion</th>
<th>Religion’s views on abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhism</td>
<td>There is no single Buddhist view on abortion. Some Buddhists believe that the fetus has rights equal to those of an adult, and therefore terminating a pregnancy could be seen as killing a sentient being. Others do not believe that all beings are equal, and if continuing the pregnancy were to pose a severe health risk for the woman, the fetus would not be seen as equal to the woman.</td>
</tr>
<tr>
<td>Christian (Catholic)</td>
<td>Regards abortion as the termination of a human life and therefore impermissible.</td>
</tr>
<tr>
<td>Christian (Protestant)</td>
<td>Combines strong opposition to abortion with a recognition that there can be – strictly limited – circumstances in which it may be morally preferable to any available alternative.</td>
</tr>
<tr>
<td>Hinduism</td>
<td>Generally opposed to abortion, except where it is necessary to save the mother’s life.</td>
</tr>
<tr>
<td>Islam</td>
<td>Abortion is not permitted, although many accept that it may be allowable in certain cases.</td>
</tr>
<tr>
<td>Judaism</td>
<td>As a rule, abortion is prohibited unless the life of the mother is at risk or continuing with the pregnancy poses a severe threat to her health. Although termination is not ideal, there are exceptional circumstances, such as rape, where abortion is not forbidden.</td>
</tr>
<tr>
<td>Sikhism</td>
<td>Abortion is acceptable only in extreme circumstances, such as rape or to save the mother’s life.</td>
</tr>
</tbody>
</table>

**Sexual orientation**

132. As well as heterosexual women, WSW who also have sex with men can become pregnant and may decide to seek an abortion.

133. Information relating to the sexual orientation of the woman having an abortion is not captured on the HSA4 form, although marital status is (including civil partnerships).
Policy

134. DH monitors the provisions of the Act. It ensures that policies and practices continue to be fit for purpose and to facilitate high-quality service delivery.

135. Early access to abortion services (and the provision of choice of method) are key strategic objectives. The national sexual health and HIV strategy states that women who meet the legal requirements should have access to an abortion within three weeks of referral, in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

136. DH has made investments to improve early access to abortion, as well as to improve the performance of PCTs in this area. Considerable progress has been made in terms of accessibility. In 2008, 72 per cent of NHS-funded abortions took place at under 10 weeks, compared with 51 per cent in 2002. PCTs are encouraged to provide abortion services that meet the diverse needs of their communities.

137. The Secretary of State has the power under the Act to approve a class of place, outside of hospitals, for the provision of early medical abortion in the community in which women live. To build on progress already achieved, DH commissioned a project to assess the safety, effectiveness and acceptability of early medical abortions in community medical settings. The project evaluation report was published in 2008, and further consultation will take place with stakeholders and service users.

138. Late abortions – defined as 20–24 weeks gestation – tend to be performed by a relatively small number of doctors in different locations around the country. It may be difficult for women to access services, and for doctors and PCTs to know where to refer. In some cases, this has resulted in women continuing with their pregnancy against their wishes. Protocols on late abortions have been developed. These will form part of the good practice guidance being finalised for publication, and will sit within the sexual health commissioning framework.

139. The forthcoming service specification for the NHS contract for abortion service providers highlights that one of the objectives is:

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81 DH 2001a.
82 RCOG 2004.
83 DH 2008a.
84 DH 2008b.
‘to offer high-quality, impartial support and advice to all service users who request an abortion, regardless of age, ethnicity, language, disability, sexual orientation, religious or personal circumstances’.

140. The decision to terminate a pregnancy rests with the woman and her doctors. If an abortion is requested by a young woman (under 16 years of age), doctors have an obligation to encourage the young woman to involve her parents or guardian, but generally they should not override the patient’s views.

141. The evidence presented above shows that, while all women of reproductive age may have an abortion, young women are more likely to have an abortion than older women. As outlined in the chapter on contraception, efforts are being made to ensure that clear messages are given to young people about resisting peer pressure to have early sex and about using contraception when they do become sexually active, in order to avoid an unwanted pregnancy. The national sexual health campaign (outlined in the previous chapter) targets young people with the aim of improving their sexual health. Of particular relevance to abortion is the first wave of the campaign, which will focus on contraceptive choices, with a particular focus on increasing awareness of long-acting methods of contraception. The campaign messages have been tested across a wide range of groups, including young BME representatives.

142. The RCOG evidence-based guidance, *The Care of Women Requesting Induced Abortion*, is clear that professionals involved in abortion services should be equipped to provide women with tailored support to meet their individual needs. Specific requirements are in place to meet the needs of young adults; women whose understanding of the English language is limited; and those with a disability.\(^85\) In addition, clinicians caring for women requesting abortions are advised to identify those patients who require more support in decision-making, and to ensure that they are referred to the appropriate care pathways.

143. It is DH policy that any personal, religious or cultural needs relating to the disposal of the fetal tissue should, wherever possible, be met and should be documented in the woman’s medical notes.\(^86\) NHS trusts will wish to ensure that this information is available and clear to all (bearing in mind any particular difficulties the woman or couple may have, such as literacy skills or language).

\(^{85}\) RCOG 2004.

\(^{86}\) DH (no date).
5. Sexually transmitted infections

Introduction

144. STIs, including HIV, remain among the most important causes of illness due to infectious disease across all age groups, but particularly among younger people. If left untreated, many STIs, including chlamydia and gonorrhoea, can lead to long-term fertility problems. Infection with HIV or the strains of human papillomavirus (HPV) that cause cervical cancer can lead to long-term illness and possible death.

145. Overall, STIs increased in 2008 by 0.5 per cent – from a total of 397,909 new cases recorded in 2007 to 399,738 new cases recorded in 2008. The table below shows the number of new diagnoses at UK GUM clinics of the five main STIs for all ages, from 2006 to 2008.

<table>
<thead>
<tr>
<th>STI</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>113,713</td>
<td>121,791</td>
<td>123,018</td>
</tr>
<tr>
<td>Genital warts</td>
<td>83,616</td>
<td>89,515</td>
<td>92,525</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>18,863</td>
<td>18,649</td>
<td>16,629</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>21,877</td>
<td>26,270</td>
<td>28,957</td>
</tr>
<tr>
<td>Syphilis</td>
<td>2,683</td>
<td>2,633</td>
<td>2,524</td>
</tr>
</tbody>
</table>

Age

146. People of any age are able to contract an STI.

147. In Sexually Transmitted Infections and Young People in the United Kingdom: 2008 Report, the Health Protection Agency (HPA) highlighted a number of issues relating to young people between the ages of 16 and 24:

- Young people are the group most at risk of being diagnosed with an STI (other than HIV). Young people represent only 12 per cent
of the population, yet in 2007 they accounted for nearly half of all STIs diagnosed in GUM clinics across England, including 65 per cent of chlamydia, 55 per cent of genital warts and 50 per cent of gonorrhoea infections.

- For infections such as chlamydia, genital herpes and HIV, the rates are an underestimate, as asymptomatic infections can remain undiagnosed. In addition, many young people may be diagnosed by their GP or as part of the NCSP, rather than at a GUM clinic.

- Since 1998, there has been a rise in the diagnosis rates of almost all STIs among young people attending GUM clinics. Aside from indicating increased unsafe sexual behaviour among young people, these increases reflect greater ascertainment of cases, through more testing and improved diagnostic methods.

- The excessive morbidity among young people due to STIs – a consequence of both increased sexual activity and possible susceptibility to infection – highlights the importance of well-targeted interventions among this population. Of particular concern are younger females, aged 16–19, who have the highest reported rates of diagnosed chlamydia and genital warts.

148. In 2008/09, there were nearly 760,000 chlamydia screens performed under the NCSP on young people aged 15–24 (a 127 per cent increase over the 335,000 performed in 2007/08), and the positivity rate was 7.3 per cent.90

149. Within the NCSP, chlamydia positivity was higher among those who reported two or more sexual partners in the last 12 months (11.8 per cent) than among those who did not (7.8 per cent),91 which suggests that encouraging safer sexual behaviour could help to reduce the transmission of STIs, including chlamydia.

150. There is also some evidence of increasing STIs among older groups. For example, a study in the West Midlands showed an increasing rate of sexual infections in people over 45 years of age. The study looked at regional data for the period 1996–2003 and found an upward trend in the number of visits made by over-45s to GUM clinics for STIs. In 1996, this age group comprised 3.9 per cent of all clinic visits; by 2003, the figure had risen to 4.5 per cent. The study focused on five STIs – chlamydia, genital herpes, genital warts, gonorrhoea and syphilis. The most commonly diagnosed infection among

90 NCSP 2009a.
91 HPA 2008c.
Sexually transmitted infections over-45s was genital warts, accounting for almost half (45 per cent) of cases. Genital herpes was the next most common, affecting almost one in five (19 per cent).92

Disability

151. As there is no nationally agreed definition of disability, no information relating to an individual’s disability is collected at the national level by GUM clinics or within the NCSP. There is, therefore, limited data available to analyse.

Gender

152. The NCSP currently screens more women aged under 25 than men. In 2008/09, 504,395 women under 25 were screened for chlamydia in places other than GUM clinics, compared with 252,727 men from the same age group. The positivity rates of the NCSP programme are not consistent across women and men: 8.1 per cent of women under 25 test positive for chlamydia in the NCSP, compared with 7.4 per cent of men from the same age group. There is significant divergence in the rates once ethnicity is taken into account: the highest positivity rate is found among black Caribbean men (12.7 per cent) and the lowest among men from ethnic groups that originate in the Asian subcontinent (2.2 per cent).93

Race

153. The HPA report *Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report*94 highlights the following:

- Black African and black Caribbean communities in the UK are disproportionately affected by STIs. The higher prevalence of STIs in both the black African and the black Caribbean populations means that, even though their levels of high-risk sexual behaviour may be similar to those of other communities, they run an increased risk of acquiring an infection.

- The black Caribbean community is disproportionately affected by bacterial STIs, especially gonorrhoea. Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) in 2007 shows that, among heterosexuals diagnosed with gonorrhoea at 26 GUM clinics, 26 per cent were black Caribbean and 6 per cent were black 92 HPA 2008e.
93 NCSP unpublished 2008/09 data, as of 27/07/09.
94 HPA 2008d.
African. By contrast, a much lower proportion of gonorrhoea diagnoses among MSM were black Caribbean (2 per cent) or black African (2 per cent).

- Data from Enhanced Syphilis Surveillance in England and Wales in 2007 shows that, among heterosexuals, black Africans and black Caribbeans accounted for 10 per cent and 7 per cent, respectively, of all new diagnoses. By contrast, a much lower proportion of diagnoses among MSM were black Caribbean (2 per cent) or black African (1 per cent).

154. In 2008/09, the NCSP performed over 760,000 screens of people aged under 25 years, with an overall positivity rate of 7.9 per cent. This was highest among young black Caribbeans (11.3 per cent), compared with 7.9 per cent among both black Africans and the white population, 8.8 per cent among black British and 2.9 per cent among Asians.95

Religion or belief

155. Given the sensitive nature of the information, it is considered inappropriate to collect data – either from diagnoses in a GUM clinic or under the NCSP – on an individual’s religion or belief. There is, therefore, limited data available to analyse.

Sexual orientation

156. Everyone who is sexually active is at risk of STIs, regardless of their sexual orientation.

157. It is often incorrectly assumed that WSW are not affected by STIs. However, WSW can engage in sexual activity that may have a negative impact on their sexual health, including contracting STIs.96

158. In a survey of over 6,000 WSW, it was found that:97

- Less than half of WSW had ever been screened for STIs.
- Half of those who had been screened had an STI, and a quarter of those with STIs had only had sex with women in the previous five years.
- Three-quarters of those who had not been tested did not believe they were at risk.

95 NCSP unpublished 2008/09 data, as of 27/07/09.
96 DH 2009b.
97 Stonewall 2008.
• Of those who had not been tested, two in five had had sex with men in the past five years.

• One WSW in 14 surveyed said that she had been forced to have unwanted sex.

159. The HPA’s 2008 report on *Sexually Transmitted Infections and Men who Have Sex with Men in the UK* found that:98

• In the UK, MSM are disproportionately affected by STIs, and newly diagnosed cases of all STIs (with the exception of non-specific urethritis and gonorrhoea) are continuing to rise in this group.

• Surveillance indicates that a high proportion of MSM with an acute STI were also infected with HIV – for example, 32 per cent of those diagnosed with gonorrhoea, 40 per cent of those with syphilis, 78 per cent with lymphogranuloma venereum (LGV) and 97 per cent with hepatitis C.

• Despite a small drop in 2007, gonorrhoea remains the second most common STI (after non-specific urethritis) among MSM in the UK, and there has been a 23 per cent increase in cases since 2000. MSM accounted for 30 per cent of all men diagnosed with gonorrhoea in 2007 (39 per cent of them aged 25–34).

• By the end of August 2008, a cumulative total of 672 cases of LGV had been diagnosed among MSM in the UK. The greatest proportion of cases were in the 35–44 age group (45 per cent) and were diagnosed in London (72 per cent).

• Between 2000 and 2007, diagnoses of infectious syphilis among MSM in GUM clinics increased over 11-fold – from 130 cases to 1,463.

**Policy**

160. As with other infectious diseases, the prevention and control of STIs is based on reducing the duration of infection (e.g. through early testing and treatment), reducing the number of susceptible individuals (e.g. through the provision of HPV vaccination) and reducing the transmission of infection (e.g. through changes in sexual behaviour, including regular condom use).

161. Improvement in access to and uptake of screening and testing for HIV and STIs is a major objective of the national strategies and policies across the UK. In addition to the benefits for the person, early screening and testing for HIV

98 HPA 2008b.
and STIs will reduce the likelihood of onward transmission. This is particularly true of those infections that have a long interval between the time of infection and the development of symptoms, such as chlamydia, syphilis and HIV.

162. In the UK, the majority of sexual health screens and voluntary and confidential HIV tests take place in sexual health clinics, commonly known as GUM clinics. Data on the number of screens/tests offered and taken up has been collected for all GUM clinics since 2003 in England.

163. In order to improve access to GUM clinics, from 2005/06 to 2007/08 the key target for sexual health was the offer of an appointment within 48 hours at GUM services. The vast majority of PCTs have delivered on this target, which is a considerable achievement. The figures for March 2008 show that 98.9 per cent of first attendees were offered an appointment within 48 hours,99 compared with only 49 per cent in May 2005.100 The Operating Framework for the NHS101 states that is a target to be maintained in 2010/11.

164. Equality issues have been considered in developing the sexual health information for the NHS Choices website.102 There is specific information on the sexual health needs of WSW, MSM, women, men, older people and young people, with particular reference to STIs.

165. The NCSP was established in England in 2003, with the objective of controlling chlamydia through the early detection and treatment of asymptomatic infection, thereby preventing the development of morbidity and reducing onward disease transmission. The programme targets sexually active people under the age of 25. It has found that two in every 25 people tested carry chlamydia. Without this programme, it is likely that many of the young people who tested positive, and their partners, would not have found out that they had chlamydia.

99 DH GUM Access Monthly Monitoring (AMM) return.
100 UK Collaborative Group for HIV and STI Surveillance 2007.
101 DH 2009e.
102 www.nhs.uk/livewell/sexualhealth/Pages/Sexualhealthhome.aspx
166. Young men often lack knowledge about chlamydia and chlamydia screening, and they also have certain misconceptions about the nature of the test that put them off being tested. In order to increase the number of screens among men, the NCSP launched its ‘Men too’ strategy in November 2007. The aims of the strategy are to raise awareness of the importance of screening men, both for their own sexual and reproductive health and to contribute to preventing reproductive morbidity in women. This was followed up, in July 2009, by a document entitled *Involving young men in chlamydia screening: A practical guide*. The guide is designed to improve access to high-quality chlamydia screening services by young men. Its target audience is those who commission and provide such services.

167. As outlined in chapter 3, the national sexual health campaign is targeting young people in an effort to improve their sexual health. Of particular relevance to STIs is the second wave of the campaign, with its focus on increasing uptake of chlamydia screening within the context of the NCSP.

168. The Government’s decision to make PSHE – including SRE – statutory at all key stages will ensure that young people receive a more comprehensive SRE programme and that there is a more consistent offer across schools.

169. Sexual Health Direct, provided by fpa through its contract with DH, is considering options for making information more accessible to certain groups (such as the visually and the hearing impaired) and is looking into the provision of electronic versions of some core leaflets in languages other than English.

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103 NCSP 2007.
104 NCSP 2009b.
6. HIV

Introduction

170. The HPA publication *HIV in the United Kingdom: 2009 Report* indicated the following:\(^{105}\)

- The number of people living with HIV in the UK continues to rise, with an estimated 83,000 infected at the end of 2008. Over a quarter (27 per cent) of these people were unaware of their infection.
- During 2008, there were 7,298 new diagnoses of HIV in the UK, representing a slight decline on previous years.
- Uptake of HIV testing in antenatal and GUM clinics continued to improve in 2008, reaching 95 per cent and 93 per cent respectively.
- In 2008 over half of patients were diagnosed with a CD4 cell count under 350 per mm\(^3\) – the threshold at which treatment is recommended to begin – within three months of diagnosis.
- Men who have sex with men and black African heterosexuals remain the groups with the highest HIV prevalence within the UK.

Age

171. *Sexually Transmitted Infections and Young People in the United Kingdom: 2008 Report* highlighted a number of issues relating to HIV and young people:\(^{106}\)

- The number of new HIV diagnoses in young people in the UK remains relatively low compared with older age groups. In 2007, 702 young people were diagnosed with HIV, which represents 11 per cent of all new HIV diagnoses. However, this is still nearly three times the number reported in 1998 (258).
- Nearly all young people diagnosed with HIV in 2007 were infected either through heterosexual contact (48 per cent) – the largest group being black Africans, who were probably infected abroad – or through sex between men (48 per cent). The majority of this latter group were white and were probably infected in the UK.

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\(^{105}\) HPA 2009b.
\(^{106}\) HPA 2008c.
• The data for 2007 shows that, of the 46,114 young people who attended sentinel GUM clinics in England, Wales and Northern Ireland, nearly all (92 per cent) accepted voluntary confidential testing for HIV, with little variation by sex or sexual orientation.

172. By the end of June 2009, 9,874 children (including individuals now aged 16 years or older, but diagnosed before their 16th birthday) were reported as having been born in the UK to HIV-infected mothers since the beginning of the epidemic. Of these children, 9 per cent acquired HIV infection from their mothers. The estimated proportion of exposed infants (born to both diagnosed and undiagnosed HIV-infected women) who became infected decreased from 12 per cent in 1999 to approximately 2 per cent in 2007. Almost all children diagnosed with HIV in the UK in 2008 were reported to have been infected through mother-to-child transmission, and 60 per cent of them were born abroad.107

173. The estimated proportion of HIV-infected women who had their infection diagnosed before giving birth remains high, at over 90 per cent in 2007. This high rate of detection in pregnancy means that the estimated proportion of exposed infants who become infected also remained low, at less than 5 per cent.108

174. The proportion of diagnosed individuals aged over 50 accessing HIV care has increased over the past decade, from one in ten in 1999 to one in six in 2008.109

**Disability**

175. Anyone diagnosed with HIV is automatically covered by the Disability Discrimination Act (DDA) 1995. The DDA sought to end the discrimination that many disabled people faced, and has been significantly extended, including by the 2005 DDA. The DDA requires public bodies to promote equality of opportunity for disabled people.

176. There is little data on HIV prevalence among people with disabilities. However the Joint United Nations Programme on HIV/AIDS (UNAIDS) highlights the fact that people with disabilities may be at risk of HIV infection for a number of reasons, including limited access to HIV prevention and support services; increased risk of sexual violence; and reduced access

107 HPA 2009b.
108 HPA (no date).
109 HPA 2009b.
to HIV education, information and prevention services. This could, for example, be due to the lack of information in accessible formats (such as Braille) or the exclusion of people with disabilities from SRE provided in mainstream schools.\textsuperscript{110}

**Gender**

177. In 2008, there were more men than women diagnosed with HIV. From a total of 7,298 individuals, 4,614 were men and 2,684 were women, representing a rate of 0.15 diagnoses per 1,000 men and 0.09 per 1,000 women.\textsuperscript{111}

178. Improvements in antenatal screening resulted in 95 per cent of pregnant women accepting a routine antenatal HIV test in 2008.\textsuperscript{112}

**Race**

179. The HPA report *Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report* indicated the following:\textsuperscript{113}

- In England, the diagnosed prevalence of HIV was 3.7 per cent among black Africans – nearly 10 times higher than among black Caribbeans (0.4 per cent), and over 40 times the rate found in the white population (0.09 per cent).

- In 2007, there were 2,691 new HIV diagnoses among black Africans, representing 40 per cent of all new diagnoses in the UK. The majority had acquired their infection heterosexualy, in Africa. Among black Africans, the number of HIV diagnoses reported in 2007 shows a continuing decline since the peak of 3,976 diagnoses reported in 2003.

- Black Africans accounted for 69 per cent of all new diagnoses among heterosexuals, of whom two-thirds were women. Among black African heterosexuals, the majority (88 per cent) were reported as most likely to have been infected in Africa. By comparison, among newly diagnosed black Caribbean heterosexuals, the majority (55 per cent) had most likely acquired their infection in the UK, with a further 26 per cent in Latin America and the Caribbean.

- Some 5 per cent of black African men were thought to have acquired their infection through sex between men. Among black Caribbean men,

\textsuperscript{110} UNAIDS 2009.
\textsuperscript{111} HPA 2009b.
\textsuperscript{112} HPA 2009b.
\textsuperscript{113} HPA 2008d.
the figure was estimated at 51 per cent, compared with 84 per cent among white men.

- In 2007, the number of new AIDS cases diagnosed among black Africans (276) had also declined from the peak reported in 2003 (550), as had the number of deaths among black Africans living with HIV (from 184 to 124).

- In 2007, among those newly diagnosed with HIV, the percentage of late diagnoses (i.e. after the point when treatment should have begun) was highest among black Africans (42 per cent). Some 27 per cent of HIV diagnoses among black Caribbeans were late. Where information was available, most black Africans who had received a late HIV diagnosis had been resident in the UK for more than two years.

- In a sentinel network of 16 GUM clinics across the UK, HIV testing uptake has increased steadily among sub-Saharan African attendees – from 34 per cent (1,094 out of 3,207) in 1998 to 85 per cent (6,082 out of 7,127) in 2007. The rates of uptake were very similar among heterosexual men and women.

180. Unlinked anonymous HIV testing of residual syphilis blood samples from attendees at 16 GUM clinics across the UK in 2008 indicates that the prevalence of previously undiagnosed HIV among heterosexuals born in sub-Saharan Africa was relatively high (at 21 per 1,000) compared with the prevalence among heterosexuals born elsewhere outside the UK (4.2 per 1,000) or among UK-born heterosexuals (1.8 per 1,000).¹¹⁴

**Religion or belief**

181. A 2007 survey showed that approximately 73 per cent of Africans living in the UK professed adherence to Christianity and 18 per cent to Islam.¹¹⁵ Given the relatively high HIV prevalence among black Africans living in the UK, this survey suggests that faith could provide an important way of reaching black African communities for HIV prevention work.

¹¹⁴ HPA 2009b.
¹¹⁵ Sigma Research 2008.
182. The HPA publication *HIV in the United Kingdom: 2009 Report* indicates the following:\(^{116}\)

- After adjusting for missing information relating to the cases reported, an estimated 58 per cent (4,220) of people diagnosed in 2008 acquired their infection heterosexually (1,630 men and 2,590 women) and 38 per cent (2,760) through sex between men. The number of HIV diagnoses among people infected heterosexually has declined from a peak of 5,020 in 2004, while new diagnoses among MSM have remained high.

- New HIV diagnoses among those who acquired their infection heterosexually within the UK have risen from an estimated 740 in 2004 to 1,130 in 2008.

- Late diagnosis is an important determinant of HIV-related morbidity and mortality in the UK.\(^{117}\) In 2008, the proportion of heterosexual men diagnosed with a CD4 cell count under 200 per mm\(^3\) within three months of diagnosis was 44 per cent – higher than the figures for both heterosexual women (36 per cent) and MSM (20 per cent).

183. The HPA report *Sexually Transmitted Infections and Men who Have Sex with Men in the UK: 2008 Report* outlined the prevalence of HIV among MSM:\(^{118}\)

- In 2007, an estimated 32,000 MSM were living with HIV; of these, at least one in four of those aged 15–59 was not aware of being infected.

- The prevalence of HIV (both diagnosed and undiagnosed infections) among MSM aged 15–44 was estimated in 2007 to be 8.5 per cent within London, 3.7 per cent elsewhere in England and Wales, and 5.3 per cent overall.

- MSM accounted for 42 per cent of all the reported HIV infections seen for care during 2007 in the 15–59 age group. However, among everybody seen for HIV care, the proportion of HIV-infected MSM decreased from 58 per cent in 1998 to 42 per cent in 2007. During the same period, the median age of MSM accessing care increased from 36 to 41.

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116 HPA 2009b.
117 HPA 2008a.
118 HPA 2008b.
184. There has been a large rise in newly diagnosed HIV infections among MSM. In 2007, there were 2,679 newly diagnosed HIV infections among MSM (increasing to 3,160 if adjusted for missing data) – an increase of 74 per cent since 2000.119

185. There has also been an increase in the uptake of HIV testing among MSM. Of the 45,748 HIV tests offered to MSM in 2007, 86 per cent were accepted – up from 81 per cent in 2003.120 However, unlinked anonymous testing of residual syphilis blood samples from MSM attending sentinel GUM clinics across the UK during 2007 showed that the proportion with previously undiagnosed HIV infection was 3.4 per cent. Of those unaware of their infection, 65 per cent were newly diagnosed at that visit; however, 35 per cent left the clinic undiagnosed.121

Policy

186. DH has sustained and increased its investment to £2.9 million a year in 2009/10 for the targeted HIV health promotion programmes for MSM and African communities, managed by the Terrence Higgins Trust and the African HIV Policy Network, respectively. The Terrence Higgins Trust, through the CHAPS (Community HIV and AIDS Prevention Strategy) partnership, designs and delivers information, campaigns and other materials specifically targeting MSM. The African HIV Policy Network, through the National African HIV Prevention Programme, develops and disseminates information and materials on HIV prevention, targeting people from African communities living in England.

187. DH has also funded work through the African HIV Policy Network to produce two linked toolkits that help Christian and Muslim faith leaders address issues of stigma around HIV within their communities. The support HIV-infected people get from their faith leaders and communities is an important factor in combating the stigma that they still face. The toolkits were launched in June 2009.

188. DH is funding eight pilot projects both in and outside London to look at ways of offering HIV testing outside traditional GUM settings, including in primary care, accident and emergency rooms and so on.

119 HPA 2008b.
120 HPA 2008b.
121 HPA 2008b.
189. DH is currently undertaking a review of the charging provisions for HIV treatment included in the National Health Service (Charges to Overseas Visitors) Regulations 1989 (as amended). Charges for HIV treatment currently apply to overseas visitors who are not entitled to free NHS care, including undocumented migrants and rejected asylum seekers (although diagnosis and treatment for other STIs is free to all visitors).

190. DH is providing funding to MedFASH to look at HIV testing in secondary care settings (non-HIV specialists) as a follow-up to *HIV for non-HIV specialists: Diagnosing the undiagnosed*, published in 2008.\(^{122}\)

191. The Chief Medical Officer has sent a letter to the presidents of the Medical Royal Colleges and the chair of the Academy of Medical Royal Colleges, inviting feedback and engagement in action to tackle undiagnosed HIV.

192. There are no age limits for HIV treatment.

\(^{122}\) Baggaley 2008.
7. Equality impact assessment

Introduction

193. The previous chapters have highlighted the significant inequalities that exist in sexual health in England. However, since the inception of the sexual health and HIV strategy, many of these inequalities have been recognised and addressed. Policy has already sought to address these inequalities through targeted initiatives, such as chlamydia screening for young people or HIV prevention work aimed at MSM and people from African communities. The underlying principle of the sexual health strategy is that everyone should be able to access services, though the needs of the target groups should be prioritised.

Age

194. There are clear inequalities in sexual health for young people: they have been shown to have relatively high rates of unintended pregnancies and STIs (with the exception of HIV). However, targeted policies are already in place to address these inequalities, although an increased focus on behaviour change could help to further reduce inequalities.

195. Evidence, primarily from the USA, identifies the links between child sexual abuse and teenage pregnancy. Further consideration should be given to this area when developing policy regarding the sexual health of young people.

196. There is data to suggest that STIs in older people are increasing, although the current figures for STIs in this group are low. It would be beneficial to consider the sexual health needs of this group, paying particular attention to the prevention of STIs.

197. In addition, there is an ageing cohort of people living with HIV. Their needs should also be taken into account when developing future sexual health policy.

Disability

198. There is limited data and research available on the needs of people with learning disabilities and physical disabilities. Consequently, people with disabilities have not been a focus for sexual health policy to date. The sexual
health needs of people with disabilities should be considered in any future sexual health strategy development.

Gender

199. The sexual health needs of both males and females are currently considered in sexual health policy, and particular initiatives have been introduced to address any gender inequalities, such as the NCSP’s ‘Men too’ strategy. Other sexual health policy, such as the provision of abortion services, is justifiably targeted at females.

200. However, there is a potential need to further examine the sexual health needs of trans people. Although it is estimated that the number of trans people in the UK is relatively low, they are a group that often has particular health needs and that can face discrimination.

201. Available evidence highlights the negative impact of sexual violence and abuse on the sexual health of victims/survivors. Policy developments and practice continue to improve sexual health service provision for victims/survivors; however, further consideration should be given to the sexual health needs of the victims/survivors of sexual violence and abuse.

Race

202. While the relatively high rates of HIV among black African communities is currently being addressed through the funding provided to the African HIV Policy Network, other inequalities (such as the high rates of STIs or higher abortion rates among certain communities) are not currently addressed separately at the national level. Instead, the emphasis on tackling these inequalities is at PCT level, where PCTs are expected to commission services to meet the needs of their local communities. Further consideration should be given to this issue in any future sexual health strategy development.

Religion or belief

203. Sexual health policy should be based on providing people with a choice, allowing them to make decisions about their own sexual health. These may or may not be influenced by their religion or beliefs.

204. The HIV faith toolkits provide an example of sexual health interventions designed to address sexual health inequalities that are linked to race and HIV diagnoses. Other similar opportunities should be considered, wherever relevant.
Sexual orientation

205. The data presented in this EqIA shows that sexual orientation has an impact on sexual health. In particular, there is strong evidence to show that MSM have relatively high rates of HIV, and work is already under way to address this inequality. However, surveys of WSW highlight the fact that more needs to be done to address the sexual health needs of this group.
8. Action plan

206. This action plan outlines the actions that the DH Sexual Health Policy team will take to address the inequalities in sexual health identified during the development of the EqIA.

207. It is expected that this EqIA will provide an important input to any future sexual health strategy development that takes place once the current strategy ends in 2011. Particular items for consideration include:

- The changing sexual health needs of older people, with a focus on the increasing STI rates found among older groups. Also the needs of the ageing cohort of people living with HIV.

- The sexual health needs of people with disabilities. Separate consideration should be given to people with physical disabilities and people with learning disabilities.

- The sexual health needs of trans people.

- The relatively high rates of STIs among the black African and black Caribbean populations.

- The sexual health needs of WSW, with a particular focus on contraception and STI prevention and treatment.

- The sexual health needs of particular groups of people, such as the prison population, people with serious mental illness, sex workers and asylum seekers.

- How to influence behaviour change to improve the sexual health of the population as a whole, with a particular focus on young people.

- The impact of sexual violence and abuse on sexual health, including risk-taking behaviour and sexual health inequalities.

- The impact of alcohol on risk-taking behaviour and sexual health inequalities.

- The impact of socio-economic factors on sexual health, with a particular focus on people living in deprived areas.

- How best to encourage and assist PCTs to commission services that address the sexual health inequalities in their local areas.
In addition, action by the Sexual Health Policy team should be taken as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Target date</th>
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<tbody>
<tr>
<td>Ensure that all future sexual health and HIV policy developments consider the six DH equality strands.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Ensure that the EqIA for sexual health is updated annually to revise statistics and review content.</td>
<td>Ongoing – annual update.</td>
</tr>
<tr>
<td>Ensure that the EqIA forms part of any consultation undertaken on future sexual health and HIV strategy.</td>
<td>Alongside the development of any future sexual health and HIV strategy.</td>
</tr>
<tr>
<td>Encourage third sector and other partners in sexual health to analyse the impact of their work on equalities, with particular reference to the six DH equality strands.</td>
<td>Ongoing.</td>
</tr>
<tr>
<td>Consider incorporating equalities information into the sexual health prevention framework that is currently in development.</td>
<td>Spring 2010.</td>
</tr>
<tr>
<td>Encourage all sexual health specialist providers to work towards the ‘You’re Welcome’ accreditation, to make their services friendlier to young people.</td>
<td>Providers may choose to work towards a suggested date of April 2011.</td>
</tr>
<tr>
<td>Work towards including disability in all the national datasets on sexual health, once a definition of disability has been agreed by the Information Standards Board (ISB).</td>
<td>To be agreed once a definition of disability has been decided by the ISB.</td>
</tr>
<tr>
<td>Review the impact of the Equality Bill, particularly on the prevention of discrimination against disabled people and the ban on age discrimination.</td>
<td>Spring 2010 (the Equality Bill is due to come into force in autumn 2010).</td>
</tr>
</tbody>
</table>

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