

NICE impact *sexual health*



NICE impact sexual health

This report highlights progress made by the health and care system in implementing NICE guidance. We recognise that change can be challenging to implement and may require pathway reconfiguration. It may also require additional resources, for example buying new equipment or providing training.

We work with partners including NHS England, Public Health England and NHS Improvement to support these changes, and we also look for opportunities to make savings by reducing ineffective practice.

Most adults are sexually active and good sexual health is important to individuals and communities. Poor sexual health can lead to unintended pregnancies and sexually transmitted infections.

This report considers how NICE's evidence-based guidance contributes to improvements in sexual health.



Contraception p4

Teenage pregnancy and abortion rates have fallen in the past decade. This section highlights NICE guidance on contraception and how it can help to prevent unwanted pregnancies.



Sexually transmitted infections p9

Sexually transmitted infection rates have stabilised over recent years though recent trends show that some infections are increasing. This section reviews how NICE recommended partner notification helps to stop the spread of sexually transmitted infections.



Spotlight on HIV p11

HIV is a virus that attacks the immune system and there is no cure. This section reviews the decline in new diagnoses of HIV and how the increase in testing for HIV has contributed. It also highlights the challenge posed by late diagnosis.



Commentary p14

Dr Asha Kasliwal, President of the Faculty of Sexual and Reproductive Healthcare, reviews recent achievements and considers NICE's role in improving sexual health.

Why focus on sexual health?

*Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality. Most people become sexually active between the ages of **16 and 24**.*

NICE impact reports review how NICE recommendations for evidence-based and cost-effective care are being used in priority areas of the health and care system, helping to improve outcomes where this is needed most.

NICE provides evidence-based guidance and advice to help improve health and social care services. The uptake of NICE guidance is influenced by close relationships with partners in the system, such as NHS England, NHS Improvement, Public Health England (PHE) and local authorities.

In 2013, the Department of Health and Social Care produced a [Framework for Sexual Health Improvement in England](#).

Many of the recommendations in this national framework are underpinned by NICE guidance and so, in this report, we have focused on what we know about the uptake and impact of our recommendations in this area.

Since 2005, when NICE published its guideline on [long-acting reversible contraception](#), we have produced a [suite](#) of guidelines and quality standards to support good sexual health. Our guidance covers specific conditions, such as HIV, and general principles of good sexual health, such as the provision of contraception.

We routinely collect data which give us information about the uptake of our guidance. To produce this report, we have worked with national partners to select those data which tell us how NICE guidance might be making a difference in priority areas of sexual health. They also highlight areas where there is still room for improvement.

7

guidelines

5

quality standards

2

interventional procedure
guidance

Contraception

Helping people to choose the method of contraception that suits them best, and increasing their awareness of how to use contraceptives effectively, will help to reduce unplanned pregnancies.

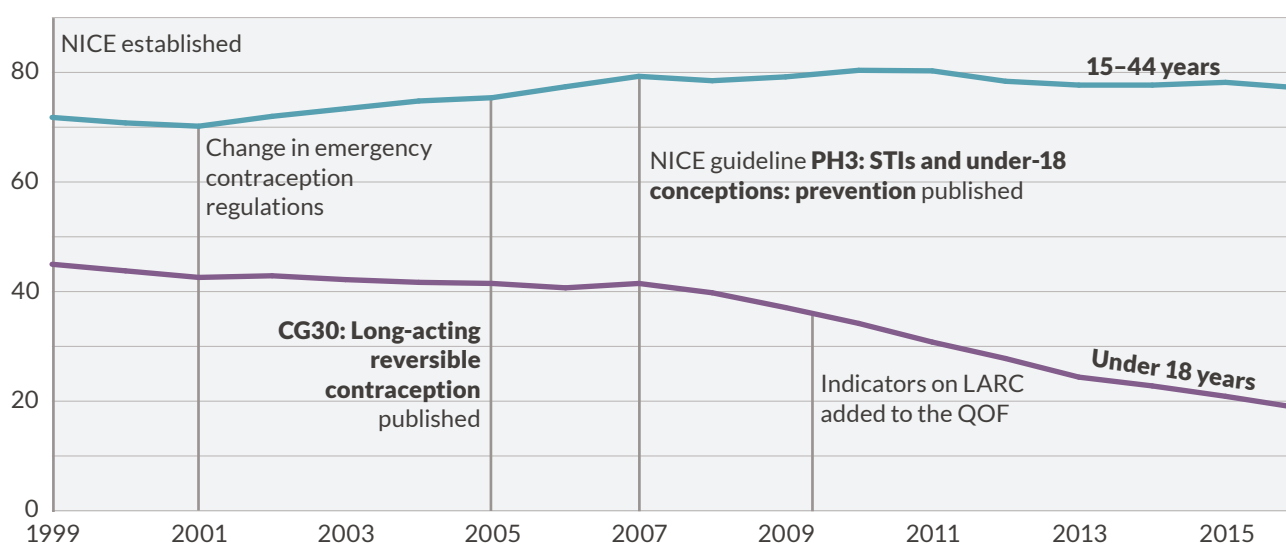
NICE's [quality standard](#) on contraception aims to ensure that people are given advice and information on all types of contraception. NICE's guideline on [contraceptive services for under 25s](#) includes recommendations for additional tailored support to meet the particular needs and choices of those who are socially disadvantaged or who may find it difficult to use these services. The NICE guideline on [preventing sexually transmitted infections and under 18 conceptions](#) covers one-to-one interventions aimed at reducing the rate of pregnancies in women aged under 18.



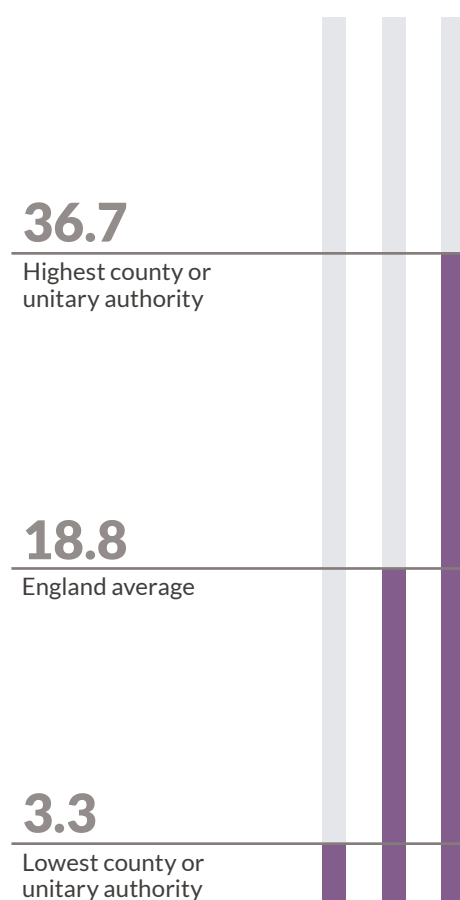
Conceptions in women under 18 fell by 60% between 1998 and 2016

In the UK, the Office for National Statistics (ONS) collects data on the [percentage of women under 16 and 18 who become pregnant](#). In England and Wales conceptions in women aged 18 and under have been reducing over time. While this reduction cannot be attributed to any one factor, a [study](#) in America found that 86% of the decline in the teenage pregnancy rate was due to improved contraceptive use.

Conception rate per 1,000 women in England and Wales



Rates of conception in women under 18 per 1,000 women aged 15 to 17 in England, 2016



36.7

Highest county or unitary authority

18.8

England average

3.3

Lowest county or unitary authority

Data up to March 2017 show that conception rates have continued to fall. However, PHE's [teenage pregnancy prevention framework](#) highlights that 60% of local authorities have at least 1 ward where the rate of teenage pregnancy is significantly higher than the England average. Data from the ONS show that rates of under 18 pregnancy vary widely between local authorities with a growing recognition that socio-economic disadvantage can be both a cause and a consequence.

Within the teenage pregnancy prevention framework, PHE provide a list of individual risk factors that are associated with women being more likely to experience pregnancy before the age of 18. These include women who have slower than expected academic progress or poor school attendance, who are looked after or leaving care, or who have experience of a previous pregnancy. Young women who have experienced multiple factors are at significantly greater risk.

NICE's guideline on contraceptive services for under 25s, referenced in the framework, recommends that additional, targeted support should be offered to socially disadvantaged young people. This could include offering one-to-one sessions, providing outreach services or providing relevant information in small manageable amounts, with more pictures and diagrams than text.

The ONS also collects [abortion statistics in England and Wales](#). There were around 193,000 abortions in 2017. The abortion rate has remained relatively stable, changing from 16 per 1,000 women in 2016 to 16.7 per 1,000 women in 2017. In general the rate has slightly declined since 2008 when the abortion rate was 17.5 per 1,000 women.

Long-acting reversible contraception

In 2005 NICE published its guideline on the use of [long-acting reversible contraception \(LARC\)](#) with an aim to increase the use of LARCs because their effectiveness does not depend on the person remembering to take or use them. In addition NICE's guideline and quality standard on contraception recommend that women asking for contraception are given information about, and offered a choice of, all methods of contraception including LARC.

NHS Digital measures [contraception use in women attending Sexual and Reproductive Health \(SRH\) services](#). Since the publication of NICE's guideline on LARC in 2005 the use of

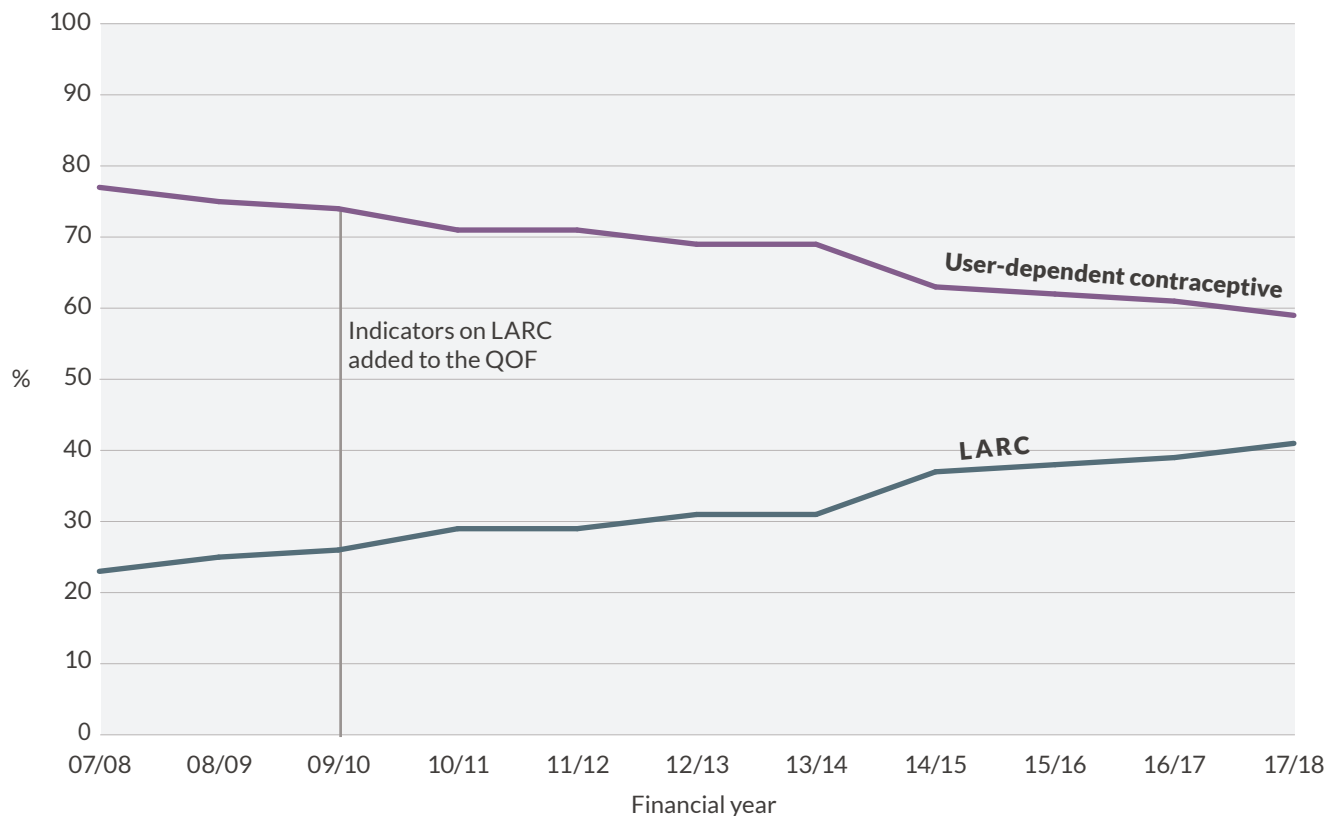
Long-acting reversible contraception (LARC) is a contraceptive method that requires administration less than once per cycle or month.

Examples of LARC are:

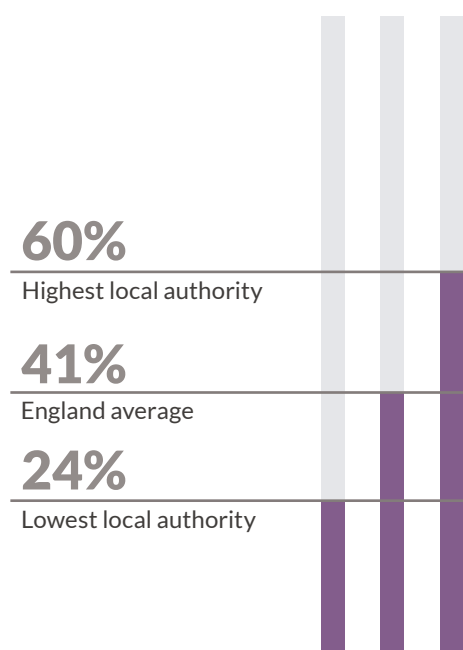
- copper intrauterine devices
- progestogen-only intrauterine systems
- progestogen-only injectable contraceptives
- progestogen-only subdermal implants

Women using SRH services for contraception, by main method of contraception in England

user dependent contraceptive, such as the oral contraceptive, has gradually decreased over time from 77% in 2007/8 to 59% in 2017/18. During the same time period use of LARCs have increased from 23% to 41%.



LARC uptake by local authority in England, 2017/18



Data on contraceptives from SRH services may not be representative of total contraceptive use. This is because contraceptives can be obtained from different sources and not all women will attend an SRH service. Contraceptives can be obtained through GPs, specialist clinics and from pharmacies (through prescription or [patient group direction](#) if available), while non-prescription items like condoms can be bought over the counter.

Primary care data was made available after the publication of the [LARC](#) guideline, when an indicator was added to the Quality and Outcome Framework (QOF). A [study](#) led by researchers at Imperial College London evaluated the impact of the QOF on the prescribing of LARCs. It estimated that an additional 110,000 women were being prescribed a LARC as a result of the QOF implementation. However, there remains wide regional variation in the use of LARCs.

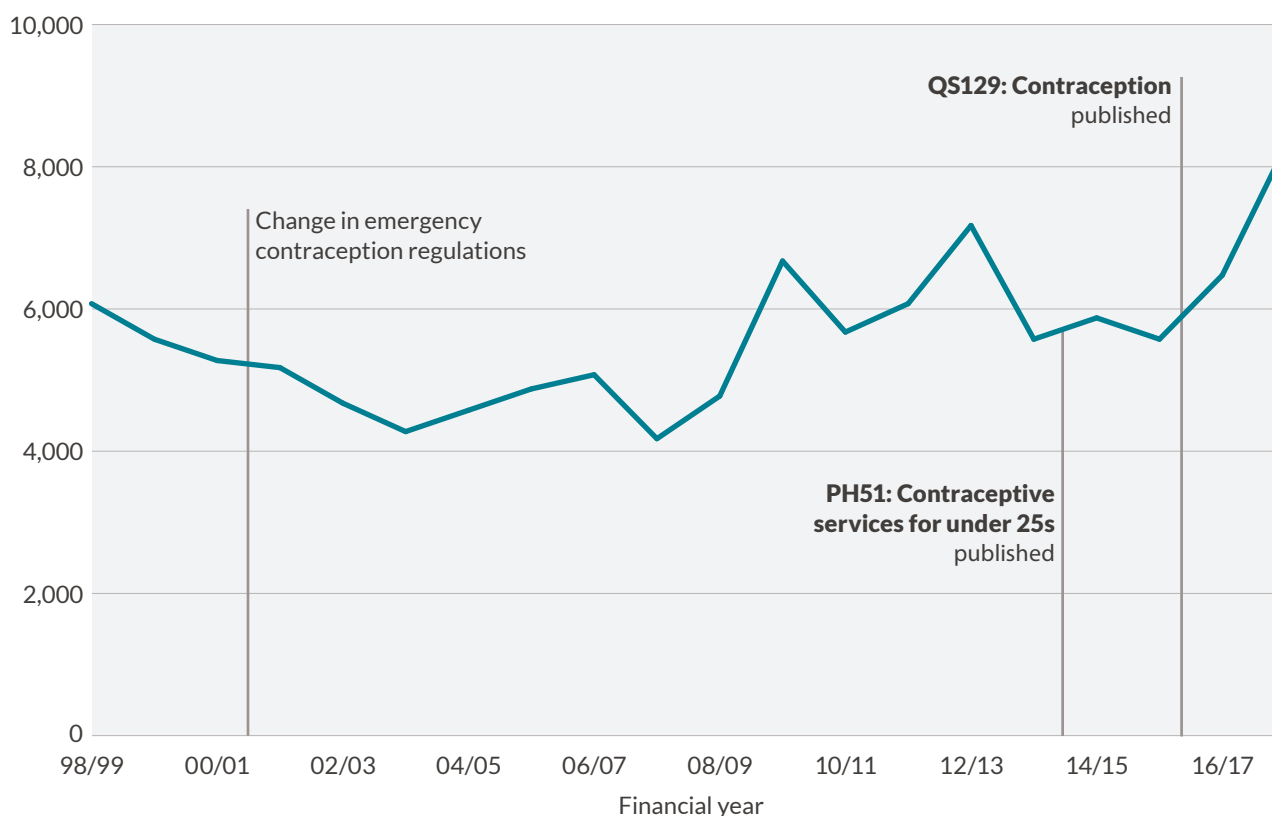
Emergency contraception

Emergency contraception is available if sex occurs without using contraception, or if contraception might have failed. There are different types of emergency contraception including the intrauterine (IU) device and emergency hormonal oral tablets (levonorgestrel or ulipristal acetate).

NICE's [guideline](#) and [quality standard](#) on contraception recommend that women who ask for emergency contraception should be told that an IU device is more effective than an oral pill. While measuring contraception use in women attending a SRH service, NHS Digital looked at the type of emergency contraception provided.

It found that while there has been a decrease in the overall use of emergency contraceptives in SRH services, the use of IU devices has increased, accounting for 2.8% of all emergency contraceptives in 1998/99 to 9.7% in 2017/18. However with less than 1 in 10 women using an IU device as an emergency contraceptive more work is required to promote their benefit.

IU devices provided by SRH services in England



Since 2001 emergency contraception has been reclassified from a prescription only medicine to a pharmacy only medicine. This means that, subject to meeting assessment criteria after discussion with the pharmacist, it can be purchased over the counter at a pharmacy without a prescription. Some localities may also have other supply mechanisms in place such as [Patient Group Directions](#). Such supply routes would not be measured within the SRH data. Emergency contraception can also still be obtained from a prescriber, such as a GP or nurse prescriber.

Contraception after childbirth

NICE's [guideline](#) and [quality standard](#) on contraception highlight that women should be offered a choice of all contraceptive methods by their midwife within 7 days of delivery.



In 2013, 2015 and 2017 around 90% of women said they had been given information or offered advice about contraception after childbirth

This is because supporting women to make an informed choice about contraception after childbirth will help to reduce the risk of future unplanned pregnancies. Advice and information should be given as soon as possible after delivery because fertility may return quickly. Providing advice about contraception after childbirth also helps avoid the risk of complications associated with an inter-pregnancy interval of less than 12 months.

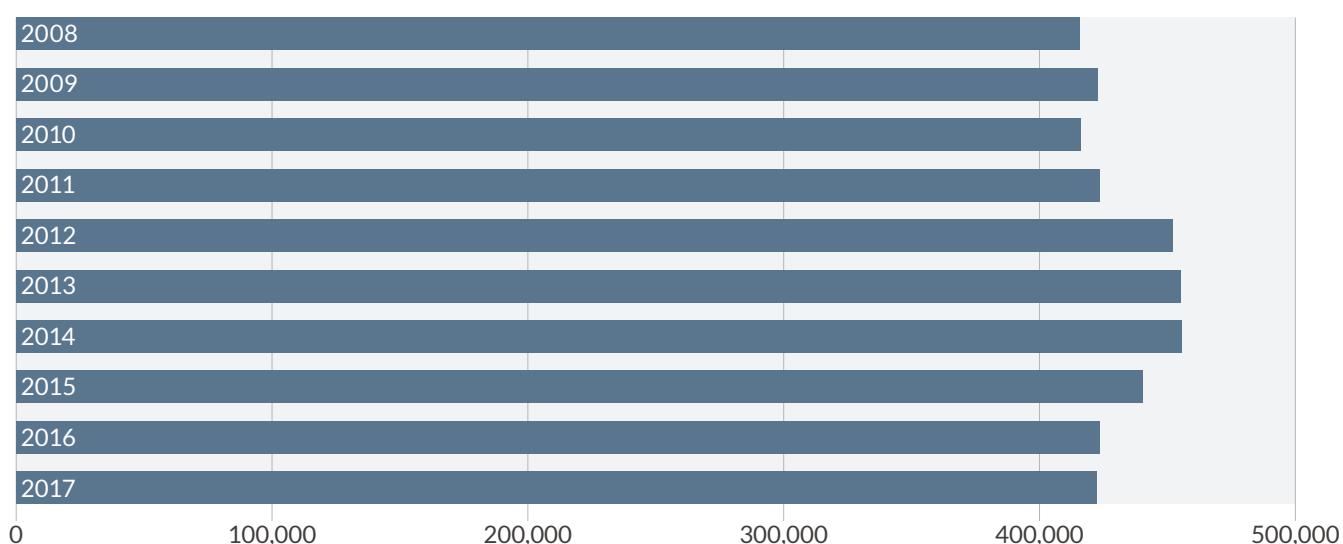
The Care Quality Commission (CQC) [maternity services survey](#) asked women whether they were given information or offered advice from a healthcare professional about contraception. In 2013, 2015 and 2017 one in 10 women said that they had not been given information or offered advice about contraception after childbirth indicating more work needs to be done.

Sexually transmitted infections

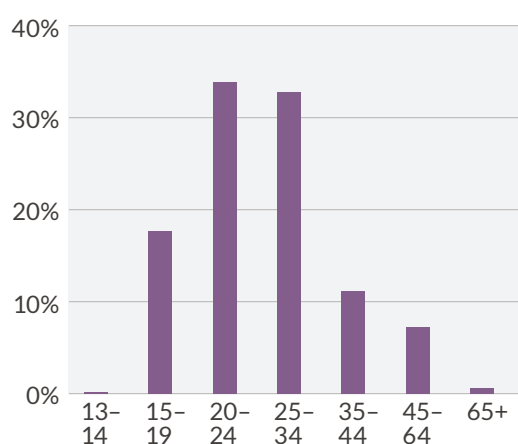
The number of newly diagnosed sexually transmitted infections (STIs) has stabilised over the last 2 years, but trends such as an increase in antimicrobial resistant infections are concerning. Most diagnoses of STIs are in younger people.

In 2017 there were approximately **420,000** new diagnoses of sexually transmitted infections (STIs) in England, around the same number reported in 2016.

Number of new STI diagnoses in England



Proportion of new STI diagnoses in England by age, 2017



Of these, the most commonly diagnosed STIs were: chlamydia (203,116; 48%), first episode genital warts (59,119; 14%), gonorrhoea (44,676; 11%).

Recent trends show there were:

- 7,137 diagnoses of syphilis reported in 2017, a 20% increase relative to 2016 and around 150% increase relative to 2008;
- 44,676 diagnoses of gonorrhoea reported in 2017, a 22% increase relative to 2016 and around a 200% increase relative to 2008;
- emergence of antimicrobial resistant *Neisseria gonorrhoeae*.

The greatest impact of STIs are in younger people, with 50% of all new STI diagnoses in people under 25.

Partner notification

NICE's guideline on [the prevention of sexually transmitted infections \(STI\) and under-18 conceptions](#) recommends that people diagnosed with an STI should be provided with support to get their sexual partners tested and treated. This is known as partner notification and is also highlighted in the NICE [quality standard](#) on sexual health.

Partner notification is essential in assisting in the control of sexually transmitted infections as it can break the 'chain' of transmission and reduce reinfections. It can also ensure that partners are tested, and if necessary treated, as soon as possible to prevent health complications.

As part of PHE's [National Chlamydia Screening Programme \(NCSP\)](#), partner notification forms a key element in the identification, management and control of chlamydia and forms part of the NCSP Chlamydia Care Pathway.



94% of people diagnosed with chlamydia had a documented offer of partner notification

The [NCSP audit report](#) focuses on the 'notify partners' component of the chlamydia care pathway. In 2017, the audit found that 94% of people diagnosed with chlamydia had a documented offer of partner notification, a minor increase from 92% in 2015.

The challenge highlighted by the audit was contacting partners. It found that only 67% of partner contacts were 'contactable'. While only 31% of all contacts attended a sexual health service within 4 weeks, 46% of contacts who were 'contactable' attended. It highlights that more work is required to contact partners of people diagnosed with an STI.

Spotlight on HIV

HIV (human immunodeficiency virus) attacks the immune system, and weakens the person's ability to fight infections and disease. While there is no cure for HIV, there are treatments to enable most people with the virus to live a long and healthy life, if they receive prompt diagnosis.

In 2015 an estimated **101,200** people were living with HIV in the UK. HIV diagnoses have continued to decline over the past decade with a substantial decrease over the past 2 years.

In 2017 there were **4,363** new diagnoses of HIV, which was a 28% reduction from the 6,043 new diagnoses in 2015. It is thought that this reduction in diagnosis is generally due to the large increase in HIV testing combined with rapid access to anti-retroviral therapy, which decreases the transmissible levels of the virus, as set out in [trends in new HIV diagnoses](#) published by PHE.



There was a 28% reduction in new diagnoses of HIV between 2015 and 2017

NICE produced a [guideline](#) and [quality standard](#) on encouraging uptake of HIV testing in 2011 and 2017 respectively.

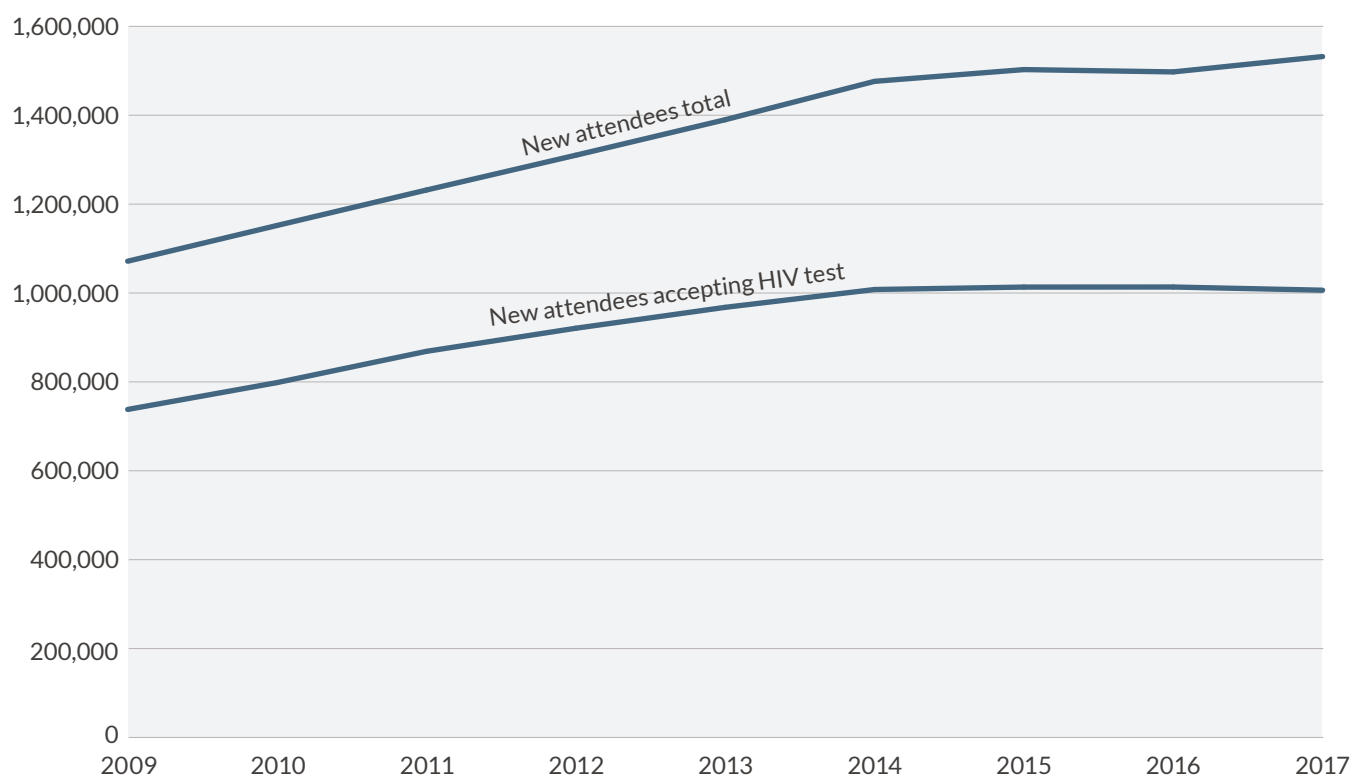
It is too early to know the additional effect on HIV transmission of pre-exposure prophylaxis (PrEP). NICE's [evidence summary on PrEP](#) found that while PrEP is effective in reducing HIV acquisition in high-risk people, there are issues relating to uptake, adherence, sexual behaviour, drug resistance, safety, prioritisation for prophylaxis and cost-effectiveness.

NHS England has launched the [PrEP Impact Trial](#), which aims to answer key questions about the use of PrEP by groups at a higher need in England. The trial was announced by NHS England and Public Health England in a joint statement on 4 December 2016. The trial is planned to last three years and enrol 10,000 participants at high risk of acquiring HIV.

Increasing uptake of HIV testing

NICE recommends that everyone who attends a specialist sexual health service for any testing or treatment should be offered an HIV test. The 2017 PHE report on [HIV testing in England](#) highlights that, of people attending a sexual health service, 84% were offered an HIV test, while only 63% were tested. This testing identified 2,323 HIV diagnoses.

Number of new attendees at an SRH service in whom an HIV test was accepted, in England



NICE recommends that people who may have been exposed to HIV by a person newly diagnosed with HIV are offered a test. This will ensure that they are diagnosed as quickly as possible and reduces the risk of onward transmission. The PHE report found that 86% of people notified were offered an HIV test, and 84% were tested for HIV. The number of people tested as a result of HIV partner notification has increased by 43% between 2012 and 2016.

NICE guidance on HIV testing and [tuberculosis \(TB\)](#) recommend that people attending services for treatment of TB are offered an HIV test, as HIV infection is a known risk factor for progression from latent TB infection to TB disease. Data from PHE's [TB Strategy Monitoring Indicators](#) show that the proportion of people diagnosed with TB who were offered an HIV test increased from 93% in 2012 to 97% in 2016. However this fell to 96% in 2017.

Late diagnosis

The NICE [quality standard](#) on HIV testing suggests late diagnosis as an outcome measure that should be monitored to assess the impact of the quality standard.

A late diagnosis for HIV means that a person has tested positive for HIV after the virus has already begun to damage their immune system. People whose infection is diagnosed late have a 10-fold increased risk of dying within the first year of diagnosis. There is also an increased risk of onward transmission as people diagnosed late would have been unaware of their HIV infection for approximately 3 to 5 years. Late diagnosis is also associated with a higher cost to the NHS, largely due to a higher rate of hospital admissions and increased costs of treatment.

Public Health England reviewed late diagnosis when reviewing [trends in new HIV diagnoses](#).

Late diagnosis is defined as HIV diagnosed at a late stage of infection when the CD4 count was below 350 cells/mm³ at diagnosis.

In 2017 the overall late diagnosis rate was 43% for people aged 15 years and above in the UK. This has remained at over 40% for the past 5 years. In 2017 there were 230 people with an AIDS-defining illness reported at HIV diagnosis, which indicates that the HIV virus has already severely damaged the person's immune system, and reduces treatment options. Given the continued high proportion of people diagnosed late with HIV, more needs to be done to increase testing and to ensure people are diagnosed early.

Commentary

Dr Asha Kasliwal, December 2018

Dr Asha Kasliwal is President of the Faculty of Sexual and Reproductive Healthcare (FSRH)



Sexual health is an integral part of overall health, well-being and quality of life. Sexual and reproductive health (SRH) care does not just cover the provision of contraception and the prevention and treatment of sexually transmitted infections (STIs). It supports sexual well-being, irrespective of an individual's background or sexual orientation, and includes the planning of families and abortion care. It begins with education and ends with encouraging post-reproductive health, across a person's life course.

This is reflected in the suite of guidance published by NICE covering several aspects of the breadth of good sexual health care. The 2005 NICE guideline on [long-acting reversible contraception \(LARC\)](#) had a positive impact in increasing the uptake of LARCs, the most effective methods of contraception to prevent unplanned pregnancies. Likewise, the guideline on STIs and under-18 conceptions has played a role in mainstreaming the importance of prevention to tackle the historically high rates of teenage pregnancies in the UK.



NICE guidance can help to achieve improvements in the population's sexual health and address sexual health inequalities.

Quality guidance at national level, along with consistent commitment and a holistic approach as seen through the teenage pregnancy strategy, can truly achieve encouraging results in SRH. Stabilising of STI rates and a reduction in new HIV diagnosis are welcome trends. I look forward to the upcoming NICE quality standard on sexual health and the NICE guideline on termination of pregnancy.

As the data in this report highlights, there is much more we can do to enhance access, quality of care and improve health inequalities. Despite the continuous downwards trend, regional inequalities in teenage pregnancy rates persist. Emergency contraception follows a similar pattern, and young women's access varies according to the level of deprivation in their area of residence. Many challenges remain: access and uptake of emergency IUD fitting, late diagnosis of HIV, rising syphilis and gonorrhoea rates and the emergence of antimicrobial resistant *Neisseria gonorrhoeae*. Another area for improvement is post-pregnancy contraception.

Implementing NICE recommendations will require leadership and a joined-up, multidisciplinary approach across professional boundaries.

I believe we can turn these challenges into opportunities to change ways of working and introduce innovative solutions to provide the best care for the people we serve, improve the population's health and address health inequalities. NICE guidance can help commissioners, service managers and healthcare professionals achieve that.

We would like to thank Dr Asha Kasliwal for her contribution to this report.

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Any enquiries regarding this publication or any other enquiries about NICE and its work should be made to:

National Institute for Health and Care Excellence
10 Spring Gardens
London SW1A 2BU
Telephone: +44 (0)300 323 0140
Fax: +44 (0)300 323 0148

National Institute for Health and Care Excellence
Level 1A, City Tower
Piccadilly Plaza
Manchester M1 4BT
Telephone: +44 (0)300 323 0140
Fax: +44 (0)300 323 0149

Email: impact@nice.org.uk
Website: www.nice.org.uk

