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Sexual and reproductive health statistics for England

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‘Sexual and reproductive health’ covers a broad range of health matters, from sexually transmitted infections (STIs) and contraception to relationships and conception. It is an important aspect of the overall health and wellbeing of both individuals and communities.

Poor sexual health can have numerous consequences, including unplanned pregnancies and abortions, as well as the transmission of STIs and HIV.

The most recent sexual health strategy, ‘A Framework for Sexual Health Improvement in England’, was published by the Department of Health in March 2013. It set an ambition to “improve the sexual health of the whole population”. There have been calls from select committees and other stakeholders for the government to produce a new strategy. In October 2019, the Johnson government said that the Department of Health and Social Care was leading work to develop an updated sexual and reproductive health strategy. This had not been published at the time of writing.

Commissioning sexual health services

In England, sexual health services are part of public health. This means that most ‘open access’ services (where people can use any sexual health clinic, in any area) are commissioned by local authorities rather than by the NHS. Responsibility for commissioning more specialised sexual health services, such as HIV treatment and care, is split between NHS England and integrated care systems (ICSs).

In 2023, there were 4.6 million consultations delivered by sexual health services in England. Except for a slight dip in 2020, due to disruption to services during the covid-19 pandemic, the number of consultations has increased steadily over the last decade. The scaling up of online and telephone service provision has contributed to this increase.

Spending on local authority-funded sexual health services in England has reduced in real terms from £776 million in 2013/14, when responsibility for public health was transferred from the NHS to local authorities, to £547 million in 2022/23.

Sexually transmitted infections (STIs)

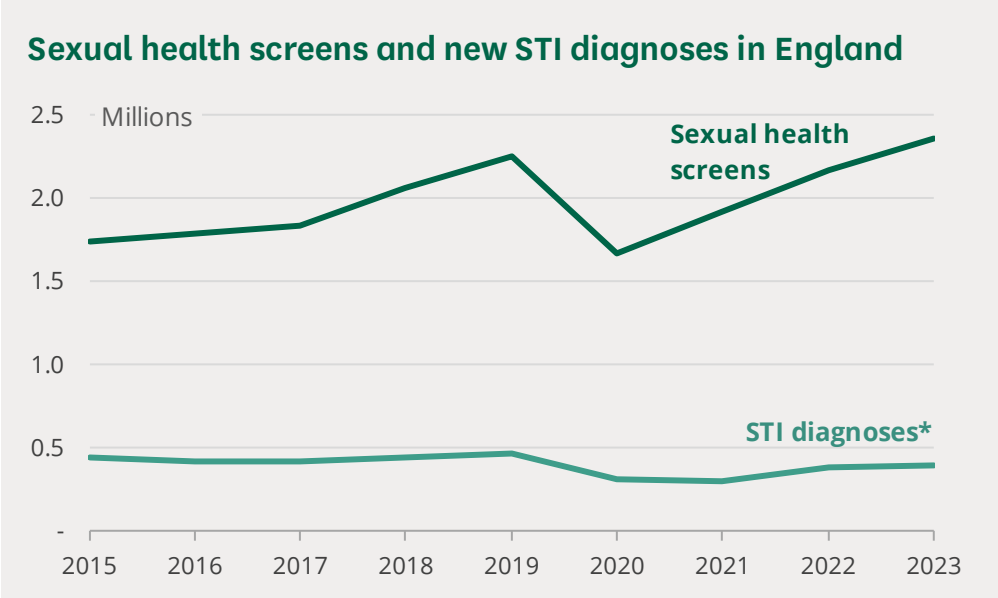
Sexually transmitted infections (STIs) are diseases, caused by bacteria, viruses, and parasites, that can be passed from one person to another through condomless sexual contact with an infected partner. Some STIs can also be transmitted to a baby during pregnancy, childbirth and breastfeeding. Other routes of transmission include sharing needles.

The prevention, diagnosis and treatment of STIs is vital to stop their onward transmission and to prevent the development of long-term health problems from undiagnosed and untreated STIs.

The chart below shows trends in the number of sexual health screens – diagnostic tests for chlamydia, gonorrhoea, syphilis or HIV – and new STI diagnoses since 2015. In 2023, 2.4 million sexual health screens were carried out and around 402,000 new STIs were diagnosed.

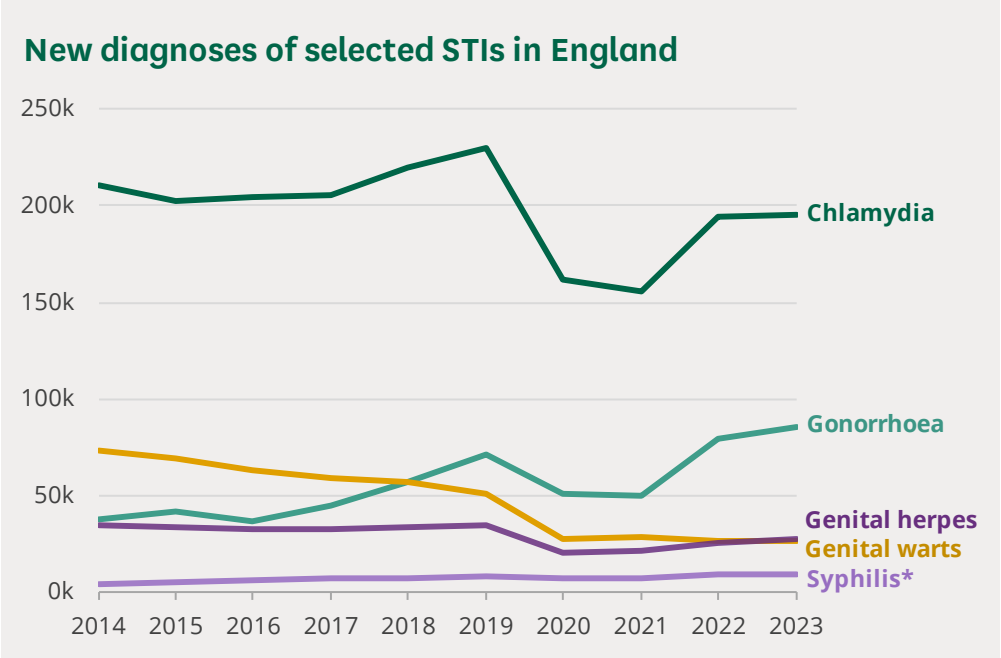
The pandemic disrupted sexual health screens and diagnoses, meaning there were fewer in 2020 and 2021 than in previous years, although numbers have since recovered.

Data on STI diagnosis indicates that young people; gay, bisexual and other men who have sex with men; and people from Black Caribbean ethnic backgrounds have disproportionately high rates of certain STIs.



Source: Data provided by the UK Health Security Agency (UKHSA), National STI surveillance data, GUMCAD

The most commonly diagnosed STIs in 2023 were chlamydia (49% of all new STI diagnoses), gonorrhoea (21%), first episode genital herpes (7%) and first episode genital warts (7%).



*Includes diagnoses of infectious syphilis (primary, secondary, early latent stages) only.

Source: Data provided by UKHSA, National STI surveillance data, GUMCAD

Over the last 10 years, there has been a decrease in the number of new diagnoses of many STIs, but gonorrhoea and syphilis have increased.

The number of gonorrhoea diagnoses in 2023 was the highest since records began in 1918, while the number of syphilis diagnoses was the highest reported since 1948. There is also concern that gonorrhoea has developed resistance to certain antibiotics, limiting the treatment options available.

HIV

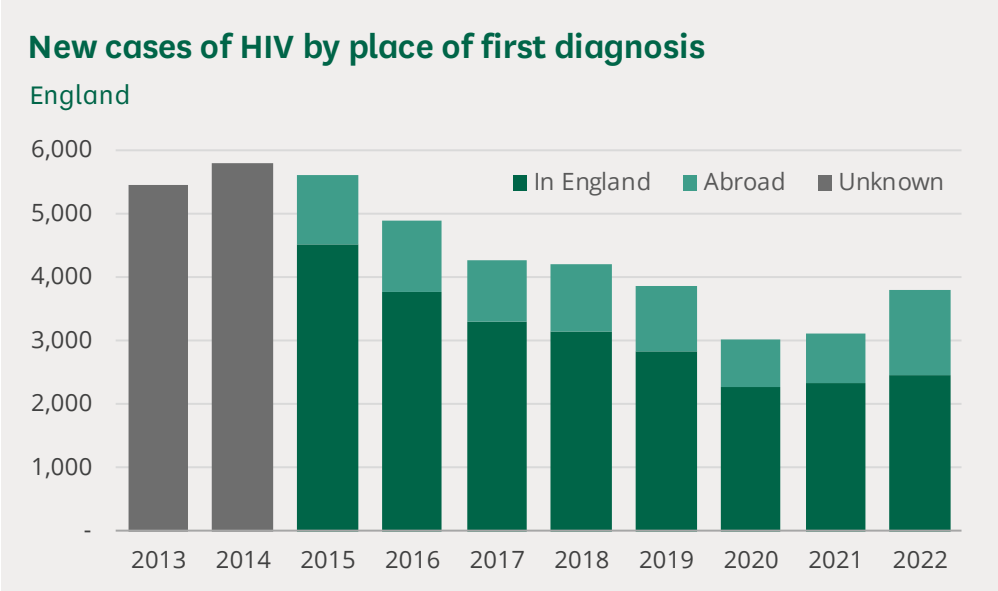
Human immunodeficiency virus (HIV) weakens a person's immune system and their ability to "fight everyday infections and disease". HIV does this by destroying certain white blood cells (known as 'CD4 cells') that tackle infection.

HIV is treated using antiretroviral medicines (sometimes called antiretroviral therapy – ART). These stop the virus replicating in the body and allow the immune system to repair itself and prevent further damage. While there is currently no cure for HIV, ART is effective and can enable people with HIV to live a long and healthy life.

In January 2019, the government committed to achieving zero new transmissions of HIV in England by 2030 and, in 2021, put in place an action plan setting out how it would achieve this target.

The chart below shows a decline in the number of new cases of HIV diagnosed in England between 2014 and 2021, followed by an increase in 2022.

This increase was largely explained by a rise in cases which were first diagnosed abroad. These infections were likely acquired abroad and therefore do not reflect a rise in transmission in England.



Note: Reliable data on new cases of HIV by place of first diagnosis is only available from 2015 onwards.

Source: UKHSA, HIV: annual data tables – country and region data tables, October 2023

Reproductive health

Reproductive health affects both men and women; the World Health Organization says that it includes "all matters relating to the reproductive system and to its functions and processes". The British Medical Association, however, notes that the reproductive health of a population is "typically measured by pregnancy related 'morbidity' outcomes such as rates of abortion or repeat abortion and teenage pregnancy".

Conception rates among women of childbearing age in England have declined in recent years, with the data suggesting that the rate in 2021 was the lowest since 2001.

Conception rates among girls under the age of 18 fell year-on-year between 2007 and 2020, before increasingly slightly in 2021.

There were 252,000 legal abortions carried out in England and Wales in 2022, which is the highest number ever recorded. Between 2012 and 2022, abortion rates increased for women of all ages, except for those aged 18 and below.

1 Sexual and reproductive health: overview

'Sexual and reproductive health' covers a broad range of health matters, from sexually transmitted infections (STIs) and contraception to relationships and conception. It is an important aspect of the overall health and wellbeing of both individuals and communities.

The Department of Health and Social Care (DHSC) has adopted the World Health Organization's (WHO) definition of sexual health. This views it not simply as the "absence of disease, dysfunction or infirmity" but rather positive wellness:

> [...] a state of physical, emotional, mental and social well-being in relation to sexuality [...] Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.[1]

The WHO also emphasises that good sexual health depends on access to:

- comprehensive, good-quality information about sex and sexuality
- knowledge about the risks individuals may face and their vulnerability to adverse consequences of unprotected sexual activity
- sexual health care
- an environment that affirms and promotes sexual health.[2]

Poor sexual health can have numerous consequences. STIs, for example, are a key contributor to poor health. They are often asymptomatic and can have a direct impact on both sexual and reproductive health (particularly if they are left untreated) through "stigmatization, infertility, cancers and pregnancy complications and can increase the risk of HIV".[3] There is also a risk of transmission to others. In the case of syphilis (an STI caused by the bacterium Treponema pallidum), there may be life-threatening neurological and cardiovascular complications if it is left untreated.[4]

1 WHO, Sexual health: definitions, 2006, accessed 24 April 2024
2 WHO, Sexual health: overview, accessed 17 July 2024
3 WHO, Sexually transmitted infections (STIs), May 2024
4 National institute for Health and Care Excellence, Complications | Background information | Syphilis. December 2019; NHS, Syphilis, May 2022

Other consequences of poor sexual and reproductive health include:

- unplanned pregnancies and abortions
- psychological consequences, including from sexual coercion and abuse
- poor educational, social and economic opportunities for teenage mothers, young fathers and their children
- HIV transmission
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer
- recurrent genital herpes
- recurrent genital warts
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- poorer maternity outcomes for mother and baby.[5]

1.1 Sexual health strategy in England

The most recent sexual health strategy was published by the Department of Health in March 2013. 'A Framework for Sexual Health Improvement in England' set an ambition to "improve the sexual health of the whole population" and to:

- reduce inequalities and improve sexual health outcomes;
- build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex; and
- recognise that sexual ill health can affect all parts of society – often when it is least expected.[6]

More detailed objectives from the strategy are presented in the box below.

5 Office for Health Improvement and Disparities, Sexual and reproductive health and HIV: applying All Our Health, updated March 2022

6 Department of Health, A Framework for Sexual Health Improvement in England (PDF), March 2013, p4

1 Sexual health strategy objectives[7]

- Continue to reduce the rate of under-16 and under-18 conceptions.
- Reduce unintended pregnancies among all women of fertile age.
- Reduce onward transmission of, and avoidable deaths from, HIV.
- Reduce rates of STIs among people of all ages.
- Prioritise prevention.
- Ensure all adults have access to high quality services and information.
- Build knowledge and resilience among young people.
- Provide rapid access to high quality services.

Some of these objectives are measured as part of the Public Health Outcomes Framework (PHOF) in England. The PHOF is a tool that enables local authorities to assess progress in improving public health while also facilitating comparisons with other areas and national averages. The five main sexual health PHOF measures are:

- Under-18 conceptions
- Chlamydia detection rate
- New STIs diagnosis (excluding chlamydia in the under 25s)
- Prescribing of long-acting reversible contraception (LARC) excluding injections (females aged 15 to 44)
- People presenting with HIV at a late stage of infection.[8]

The Health and Social Care Select Committee, in its 2019 report on sexual health, recommended that the government "develop a new sexual health strategy, to provide clear national leadership in this area".[9] The government accepted the committee's recommendation and agreed to produce an updated sexual and reproductive health strategy.[10]

7 Department of Health, A Framework for Sexual Health Improvement in England (PDF), March 2013, p10

8 Office for Health Improvement & Disparities, Integrated sexual health service specification, Produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency (PDF), 20 March 2023, p7-8

9 Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19, 2 June 2019, HC 1419, para 15

10 Government Response to the Health and Social Care Committee report on Sexual Health, October 2019, CP186 (PDF), p7

A new strategy, however, has not been forthcoming. In 2020, the British Association for Sexual Health and HIV and the Terrence Higgins Trust (a HIV and sexual health charity) said that a national sexual health strategy was "urgently needed", adding that there was currently no "long-term vision for sexual health" in England.[11] Similarly, in 2024, the Local Government Association called on the government to "publish a new 10 Year Sexual and reproductive Health Strategy to help prevent and treat [STIs] in the long term".[12]

The Chief Medical Officer for England, Professor Sir Chris Whitty, told the Women and Equalities Select Committee in January 2024 that he was "very sympathetic" to the idea of a new sexual health strategy because much had changed over the past 10 years. He also stressed that any new strategy must "not throw out stuff that's good."[13] In its report on The prevalence of sexually transmitted infections in young people and other high risk groups, the Women and Equalities Committee called on the government "to develop the coherent, cross-sector strategy on sexual health it committed to in 2019".[14]

A government response to the Women and Equality's Committee's report had not been published at the time of writing.

11 BASSH and the Terrence Higgins Trust, State of the Nation: Sexually Transmitted Infections in England, February 2020

12 Local Government Association, STI surge: Sexual health services at breaking point due to rising demand, January 2024

13 Q19, Women and Equalities Committee, Oral evidence: Prevalence of STIs among young people, HC 463, 24 January 2024

14 Women and Equalities Committee, The prevalence of sexually transmitted infections in young people and other high risk groups, Fifth Report of Session 2023–24, 26 March 2024, para 70

2 Sexual and reproductive health services

2.1 Commissioning

In England, sexual health services are part of public health. This means that most services are commissioned by local authorities rather than by the NHS. The development of this commissioning model follows the transfer of the majority of public health to local government in 2013 under the Health and Social Care Act 2012. For further information on public health and local government see section 10 of the Library briefing on The structure of the NHS in England.

Open access sexual health services

Local authorities are responsible for commissioning open access sexual health services including:

- most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception (see below for further explanation)
- STI testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies.[15]

The service models used by local authorities to deliver sexual health services vary across England. The UK Health Security Agency (UKHSA) notes that there are:

> [...] distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genito-urinary medicine (GUM)[16] services [through] to fully integrated sexual health services in the community.[17]

For example, under the GP contract, GPs provide 'essential services'; these are mandatory for all GPs to deliver to their patients. GPs can provide other clinical care, known as 'additional services'. 'Contraceptive services' are defined in the GP contract as 'additional services' and most GPs do provide

15 UK Health Security Agency, Commissioning local HIV sexual and reproductive health services - GOV.UK, February 2023

16 Genito-urinary medicine involves the diagnosis and treatment of people with STIs, including HIV. It is also sometimes used to refer to sexual health services more broadly.

17 UKHSA, Commissioning local HIV sexual and reproductive health services, updated February 2023

them. If GP practices opt-out of providing contraceptive services, they will receive a deduction in funding and NHS England is required to commission the services from another provider.[18]

Certain types of contraception, however, are deemed to be an 'enhanced service'. This includes contraceptive device fittings and injectable contraception. GPs can, but are not required, to offer enhanced services; additional funding is provided if enhanced services are offered, but there is no deduction in funding if they are not offered.[19] Provision of these services therefore varies locally.[20]

To try to address local variations in service provision, the Office for Health Improvement and Disparities, and the UK Health Security Agency, have jointly published an 'Integrated sexual health service specification'. It states that provision "should be designed to meet the needs of local populations and work to reduce inequalities in both access and health outcomes".[21]

Specialised sexual and reproductive health services

Responsibility for commissioning more specialised sexual health services is split between NHS England and integrated care systems (ICSs, of which there are 42 across England).

ICSs commission:

- most abortion services
- sterilisation and vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology, including any use of contraception for non-contraceptive purposes. [22]

NHS England commissions:

- contraception provided as an additional service under the GP contract
- HIV treatment and care
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs

18 The King's Fund, GP Funding And Contracts Explained, June 2020
19 An additional payment is made if the practice offers local enhanced services.
20 BMA, Enhanced services GP practices can seek funding for, March 2023
21 Integrated sexual health service specification, Produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency, March 2023 (PDF)
22 UK Health Security Agency, Commissioning local HIV sexual and reproductive health services - GOV.UK, February 2023

- sexual health elements of prison health services
- sexual assault referral centres
- cervical screening
- specialist fetal medicine services.[23]

Some have identified the division of commissioning responsibilities between three sets of organisations (local authorities, ICSs and NHS England) as presenting difficulties to the users, providers and staff of sexual health services. For example, the Health and Social Care Committee said, in its 2019 report on sexual health, that the 2012 act had broken up "interlinked services into [three] different silos" which, in turn, had "led to a greater number of system boundaries, relationships and funding pots to negotiate".[24]

Public Health England (PHE) acknowledged in its 2017 review of sexual health commissioning that commissioning arrangements were viewed as complicated, complex and fragmented by those responsible for sexual health services.[25]

The Health and Social Care Committee reported that while efforts had been made to address these problems, the evidence it received "was clear that fragmentation remains a significant obstacle to effective commissioning".[26]

Accessing services

Changing commissioning structures, combined with the growing financial challenges facing the NHS and local authorities, have also affected access to sexual and reproductive health services.

Numbers of consultations

In 2023, there were 4.6 million consultations delivered by sexual health services in England.[27] Except for a slight dip in 2020, due to disruption to services during the covid-19 pandemic, the number of consultations has increased steadily over the last decade from around 3.0 million in 2013,[28] demonstrating growing demand for sexual health services.

The scaling up of telephone and online service provision to enable continued access during the pandemic has contributed to the overall increase in the

23 UK Health Security Agency, Commissioning local HIV sexual and reproductive health services - GOV.UK, February 2023

24 Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19, 2 June 2019, HC 1419, para 29

25 PHE, Sexual Health, Reproductive Health and HIV. A Review of Commissioning (PDF), August 2017, p15

26 Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19, 2 June 2019, HC 1419, para 29

27 UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 3

28 UKHSA, Sexually transmitted infections (STIs): annual data tables (various editions) [Archived]

number of consultations in recent years. Fewer consultations have taken place face-to-face as the number being delivered online and over the phone have increased. Between 2019 and 2023, the proportion of face-to-face consultations decreased from 85% to 49%. Over the same period, the proportion of online consultations increased from 13% to 42%, and telephone consultations from 1% to 9%.[29]

Waiting times for appointments

Guidelines published by the National Institute for Health and Care Excellence (NICE) state that people contacting a sexual health service about an STI should be offered an appointment, or the option to attend a walk-in clinic, within two working days.[30] There is not an equivalent waiting time standard for accessing all sexual health services for other reasons.

The Terrence Higgins Trust, a sexual health charity, reported in 2023 that there was "no data currently being reported in any of the nations about waiting times" for accessing GUM services. When the (then) Department of Health last monitored GUM clinic appointment waiting times in England, in November 2011, "89% of people attending a sexual health service for the first time were offered an appointment within 48 hours across Great Britain".[31]

A 'mystery shopper' exercise, conducted by the Terrence Higgins Trust, examined average waiting times for appointments at sexual health clinics in November and December 2022. It found that waiting times for face-to-face appointments (available to book by telephone) "averaged 13 days, rising to 19 days in rural parts of England". It also found that face-to-face appointments were offered by 51% of sexual health clinics who were contacted by telephone.[32]

While the expansion of remote and online sexual health services has been welcomed, the Terrence Higgins Trust reported that such options "do not work for everyone". [33] The UKHSA points to evidence of inequality in the use of online services and notes that some people may encounter difficulties when trying to access STI testing using these services.[34] Similarly, the Office for Health Improvement and Disparities (OHID) recognised that some people "will be excluded or may be disadvantaged" by remote and online

29 UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 3

30 NICE, Quality statement 4: Access to sexual health services, February 2019, p35; see also British Association for Sexual Health and HIV (BASSH), Your guide to the Standards for the management of sexually transmitted infections (STIs) (PDF), January 2010

31 Terrence Higgins Trust, Over-stretched and under strain: A Mystery Shopper Approach to Access to Sexual Health Services in England, Scotland and Wales, 2023 (PDF), p21

32 Terrence Higgins Trust, Over-stretched and under strain: A Mystery Shopper Approach to Access to Sexual Health Services in England, Scotland and Wales, 2023 (PDF)

33 BASSH and the Terrence Higgins Trust, State of the Nation: Sexually Transmitted Infections in England, February 2020, p7

34 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024; Tamilore Sonubi and others, "STI testing, diagnoses and online chlamydia self-sampling among young people during the first year of the COVID-19 pandemic in England", International Journal of STD & AIDS, Vol 34 No 12, 2023, p841-853

approaches".[35] In its 'Integrated sexual health service specification', OHID says that a "mixture of face-to-face and online services is required to meet the needs of different population groups".[36]

Longer waiting times, and difficulties accessing appointments, have been linked to both reductions in GUM budgets and growing demand. The King's Fund, a health and social care charity, emphasised that "cuts to [...] GUM budgets" were leading to sexual health "clinics being closed, moved to less convenient locations or operating with reduced hours".[37]

Similar findings were reported by Terrence Higgins Trust and the British Association for Sexual Health and HIV (BASHH) in their 2020 State of the Nation report:

> Public health funding cuts have compromised service user access by facilitating service closures and staff cuts, both of which have contributed to longer waiting times and difficulty accessing appointments, as well as impacting on key preventative services such as outreach with communities.[38]

The Local Government Association and BASHH have also observed that the reduction in funding has coincided with rising demand for sexual health services, thereby placing pressure on existing services.[39]

2.2 Expenditure on sexual health services

Local authorities in England receive funding for sexual health services from central government through the Public Health Grant. The grant also covers services relating to other areas of public health, such as substance abuse, smoking and obesity, but the exact division of public health funding is determined by the local authority.

Public Health Grant allocations for the 2024/25 financial year amount to £3.6 billion.[40] This represents a real-terms increase of 1% compared with the previous year. However, when looking at longer-term trends, the value of the

35 Office for Health Improvement & Disparities, Integrated sexual health service specification, Produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency (PDF), 20 March 2023, p6

36 Office for Health Improvement & Disparities, Integrated sexual health service specification, Produced in partnership between the Office for Health Improvement and Disparities and the UK Health Security Agency (PDF), 20 March 2023, p6-7

37 Written evidence from The King's Fund submitted to the Health and Social Care Committee's sexual health inquiry (PDF), February 2019, p2

38 BASSH and the Terrence Higgins Trust, State of the Nation: Sexually Transmitted Infections in England, February 2020, p7

39 Local Government Association, STI surge: Sexual health services at breaking point due to rising demand, 19 January 2024; BASHH, FSRH and BASHH joint statement on the announcement of the public health grant 2024–2025, 7 February 2024

40 Department of Health and Social Care, Public health grants to local authorities: 2024 to 2025, 5 February 2024

grant is 20% lower in real terms than in 2015/16, when it was worth £4.5 billion in 2024/25 prices.[41]

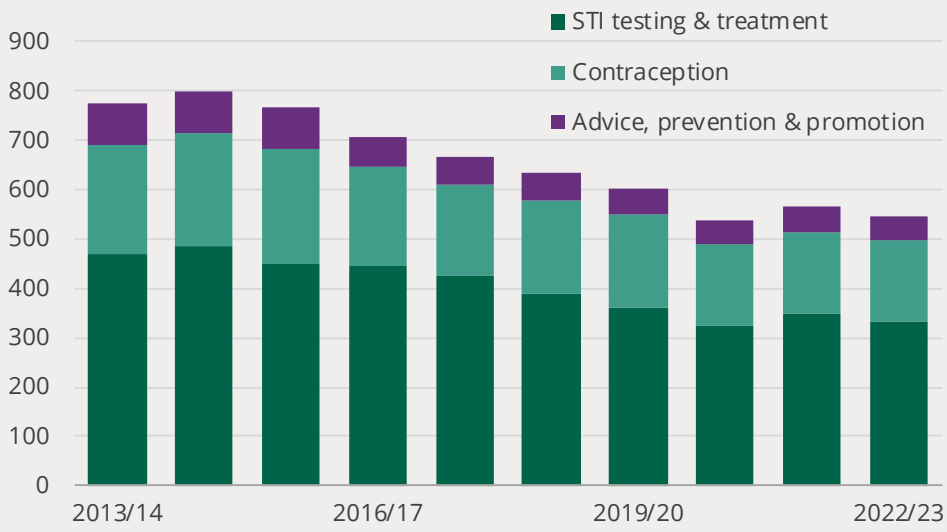
Local authority expenditure

As the real value of the Public Health Grant has reduced, so has spending on local authority-funded sexual health services.

English councils spent a total of £547 million on sexual health services in 2022/23, compared with £776 million in real terms (at 2022/23 prices) in 2013/14, when responsibility for public health was transferred from the NHS to local authorities (see section 2.1). This represents a 29% reduction in real terms spending, as shown in the chart below.

Local authority expenditure on sexual health services

£ millions, in real terms (2022/23 prices), England



Source: DLUHC, Local authority revenue expenditure and financing: Individual local authority outturn data (various editions); HM Treasury, GDP deflator, March 2024 (Quarterly National Accounts); Office for National Statistics, Mid-2022 population estimates, March 2024

Published details of local authority expenditure on sexual health services are broken down into three categories:

- STI testing and treatment
- contraception
- advice, prevention and promotion

[41] Department of Health and Social Care, Public health grants to local authorities (various editions); HM Treasury, GDP deflator, March 2024 (Quarterly National Accounts)

STI testing and treatment, and contraception are prescribed functions that local authorities are required by law to carry out, unlike sexual health advice, prevention and promotion which is a non-prescribed function.

Advice, prevention and promotion services, which make up the smallest share of sexual health expenditure, have had the largest cuts to funding, with spending down 40% since 2013/14. The prescribed functions have been slightly better protected; spending on STI testing and treatment has decreased by 29%, and spending on contraception by 26%.

2.3 Providers of sexual and reproductive health services

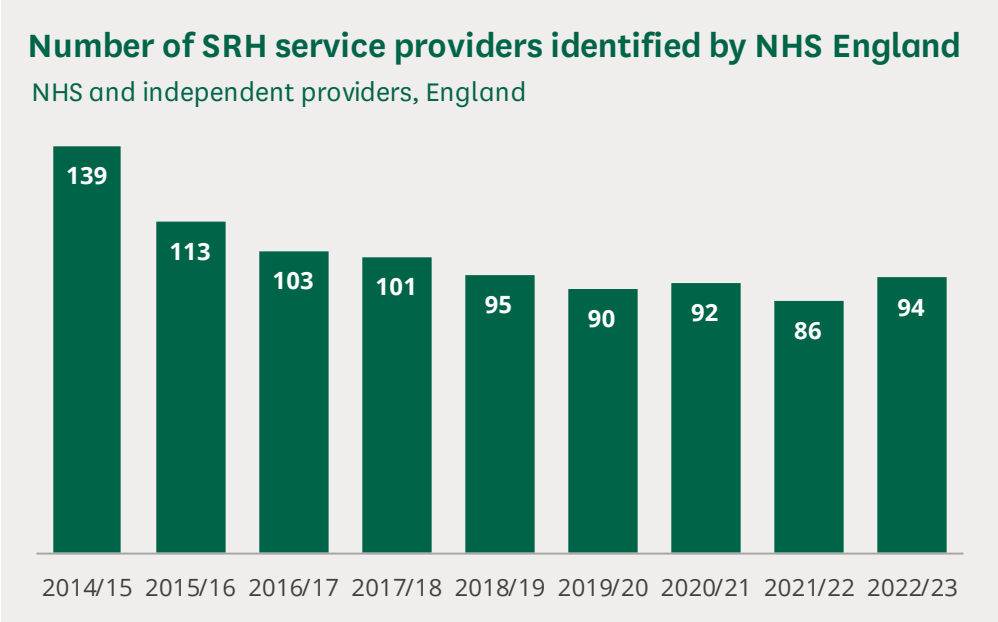
There is no centrally held register of organisations that offer sexual and reproductive health services, which makes it difficult to track changes in the number of service providers over time.

This is something highlighted by NHS England in relation to its Sexual and Reproductive Health Activity Dataset, which all providers of NHS sexual and reproductive health services are required to submit data to. NHS England says that "efforts are made each year" to update a list of organisations it expects to receive data from, but that it cannot be certain the dataset is complete.[42]

This list relates to providers of specialist sexual and reproductive health services only, rather than all sexual health service providers. Nonetheless, it is useful in providing some indication of the change in the number of providers.

The chart below shows a fall in the number of providers identified by NHS England since 2014/15.

[42] NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Data quality statement



Note: Includes providers who did not submit data for some years (one provider in 2020/21, six providers in 2021/22 and three providers in 2022/23).

Source: NHS Digital, Sexual and Reproductive Health (SRH) Services, England (Contraception) 2022/23, Data quality statement

3 Sexually transmitted infections (STIs)

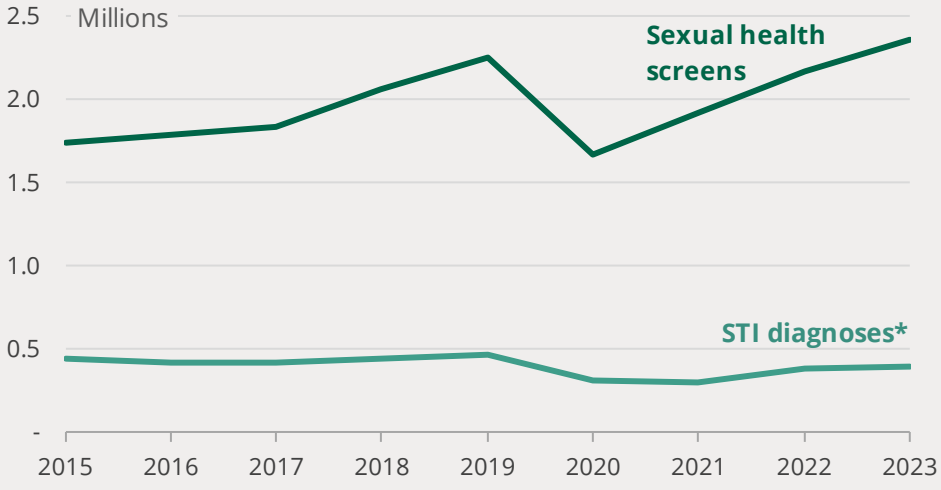
Sexually transmitted infections (STIs) are diseases, caused by bacteria, viruses, and parasites, that can be passed from one person to another through condomless sexual contact with an infected partner. Some STIs can also be transmitted to a baby during pregnancy, childbirth and breastfeeding.[43] Other routes of transmission include sharing needles.[44]

The prevention, diagnosis and treatment of STIs is vital to stop their onward transmission and to prevent the development of long-term health problems from undiagnosed and untreated STIs.

The UK Health Security Agency (UKHSA) publishes an annual data release on STI diagnoses and sexual health services provided in England.

In 2023, 2.4 million sexual health screens – diagnostic tests for chlamydia, gonorrhoea, syphilis or HIV – were carried out. The number of screens has recovered from a fall to 1.7 million screens in 2020 (the first year of the covid-19 pandemic), with online services helping facilitate more sexual health screens since. The number of screens in 2023 was 5% higher than in 2019 (pre-pandemic), when there were 2.3 million screens.

Sexual health screens and new STI diagnoses in England



*Surveillance of Mycoplasma genitalium and Shigella species infections began in 2015, therefore data from 2015 onwards is not directly comparable with previous years.

Source: Data provided by the UKHSA, National STI surveillance data, GUMCAD

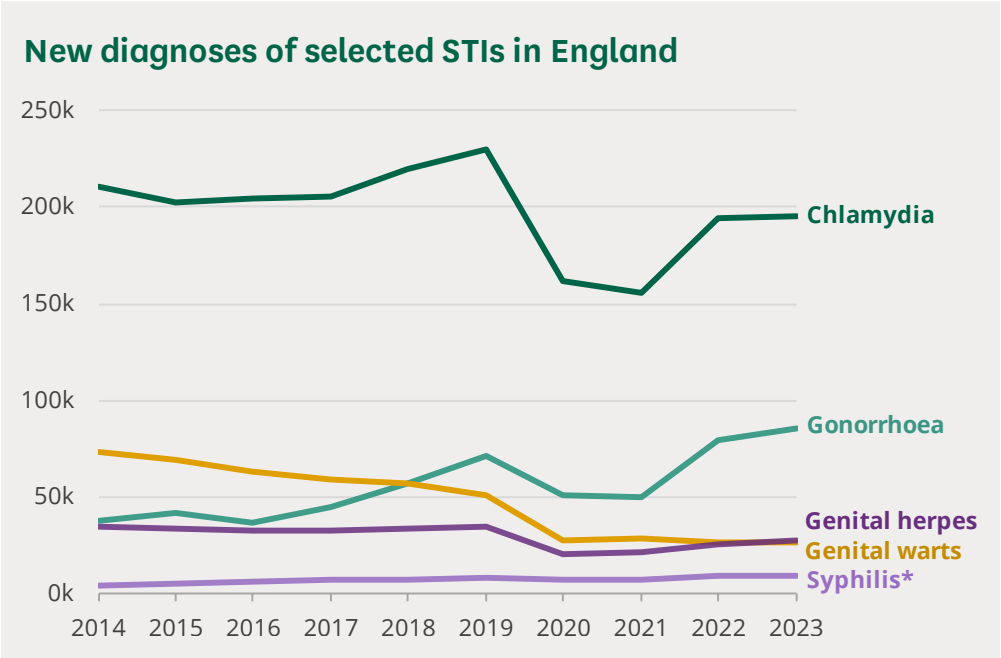
[43] World Health Organization, Sexually transmitted infections (STIs), accessed 29 April 2024
[44] US National Cancer Institute, Sexually transmitted infection, accessed 29 April 2024

The number of new STI diagnoses (rounded to the nearest 1,000) increased from 311,000 in 2020 to 402,000 in 2023, but remained 14% lower than in 2019 (pre-pandemic), when there were 468,000 diagnoses.

When looking at longer term trends over the last 10 years, the number of sexual health screens has increased, while the number of new STI diagnoses has decreased.

3.1 Common STIs

The most commonly diagnosed STIs in 2023 were chlamydia (49% of all new STI diagnoses), gonorrhoea (21%), first episode genital herpes (7%) and first episode genital warts (7%), as shown in the chart below.[45]



*Includes diagnoses of infectious syphilis (primary, secondary, early latent stages) only.

Source: Data provided by UKHSA, National STI surveillance data, GUMCAD

Increase in gonorrhoea and syphilis

Over the last 10 years, there has been a decrease in the number of new diagnoses of many STIs, but gonorrhoea and syphilis have increased.

Gonorrhoea is an STI caused by the bacterium Neisseria gonorrhoeae and is transmitted through condomless sex. The bacterium primarily affects the urethra, endocervix (entrance to the womb), rectum and in some instances

[45] Some STIs, including genital warts and genital herpes, may involve recurrent outbreaks.

the throat and eyes.[46] Syphilis is also a bacterial STI, caused by the bacterium Treponema pallidum.

In its annual report on STIs and chlamydia screening in England, the UK Health Security Agency (UKHSA) noted that diagnoses of gonorrhoea and syphilis have continued to follow this increasing trend, exceeding the high levels reported in 2019 before the covid-19 pandemic.[47] This suggests a genuine increase in transmission in the community, rather than simply an increase in testing following the resumption of sexual health service provision.

In 2023, there were around 85,000 diagnoses of gonorrhoea, up from 37,000 in 2014 – a 129% increase. Infectious syphilis diagnoses increased by a similar proportion (+114%), from 4,400 in 2014 to 9,500 in 2023.

The number of gonorrhoea diagnoses in 2023 was the highest since records began in 1918, while the number of syphilis diagnoses was the highest reported since 1948.[48]

Gonorrhoea and antibiotic resistance

Gonorrhoea is treated with antibiotics. Over time, however, gonorrhoea has developed resistance to certain antibiotics. The UKHSA reported in 2023 that the bacteria that causes gonorrhoea (N. gonorrhoeae) "has developed some level of resistance to all classes of antibiotics recommended for treatment including ceftriaxone, which is regarded as the 'last-line' therapy".[49] Thus, if ceftriaxone does not work, there are no other treatment options for empirical first-line monotherapy.[50] Guidance from the UKHSA says that "the Consultant Microbiologist at UKHSA will provide treatment advice for these cases where ceftriaxone has not worked" though adds that "alternative treatment options are limited".[51]

The chief medical officer for England, Professor Sir Chris Whitty, has described gonorrhoea as "one of the most highly drug-resistant organisms we have".[52]

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46 NICE, Definition | Background information | Gonorrhoea, March 2024; NHS, Gonorrhoea, September 2021

47 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024

48 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024

49 UKHSA, Antibiotic-resistant gonorrhoea: staying well while travelling, July 2023

50 European Centre for Disease Prevention and Control, Response plan to control and manage the threat of multi- and extensively drug-resistant gonorrhoea in Europe, October 2019 update (PDF), p1. An empirical monotherapy or treatment refers to starting a single course of antibiotics before identification of the infecting microorganism and its antibiotic susceptibility.

51 UKHSA, Managing incidents of ceftriaxone-resistant Neisseria gonorrhoeae in England, 21 November 2022

52 Q7, Women and Equalities Committee, Oral evidence: Prevalence of STIs among young people, HC 463, 24 January 2024

Cases of gonorrhoea with resistance to ceftriaxone are monitored and responded to by the UKHSA.[53] Nine cases of ceftriaxone-resistant N. gonorrhoeae were detected in the UK between December 2015 and September 2021. In the six months between December 2021 and June 2022, however, 10 additional cases were identified.[54] Left untreated, gonorrhoea can cause pelvic inflammatory disease, ectopic pregnancy (when a fertilised egg implants itself outside of the womb, typically in a fallopian tube) and infertility.

While there is less concern about antibiotic resistance in syphilis, its effects (if untreated) may seriously damage the brain, heart and other organs and can be life-threatening.[55] A Library briefing provides more general background on Antimicrobial resistance.

The Department of Health and Social Care (DHSC) is currently considering whether to add Treponema pallidum (syphilis) and Neisseria gonorrhoeae (gonorrhoea) infections to schedule 2 of the Health Protection (Notification) Regulations 2010. Both causative agents were considered as part of a wider consultation, run by the DHSC in 2023, which sought views on updating the 2010 regulations to include an additional 12 causative agents.

This move would place "a statutory duty on all diagnostic laboratories that test human samples in England to notify UKHSA" if they identify these agents in a sample. The DHSC maintains that this would strengthen "surveillance capabilities for infectious diseases", which it states, is "key to detecting outbreaks and understanding outbreak progression and trends".[56]

Syphilis Action Plan

In response to the increase in syphilis diagnoses, Public Health England (PHE) published an action plan in June 2019. It focused on addressing four factors to control and prevent syphilis:

1. Increase testing frequency of high-risk MSM [men who have sex with men] and re-testing of syphilis cases after treatment.

2. Deliver partner notification to BASHH [British Association for Sexual Health and HIV] standards.[57]

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53 See, for example UKHSA, Antimicrobial resistance in Neisseria gonorrhoeae in England and Wales Key findings from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP 2021), data to June 2022, published November 2022 (PDF)

54 UKHSA, Antibiotic-resistant gonorrhoea: staying well while travelling, July 2023

55 NHS, Syphilis, 25 May 2022

56 DHSC, Health Protection (Notification) Regulations 2010: proposed amendments, July 2023

57 BASHH partner notification standards are presented in its Syphilis 2015 guideline, last updated 9 July 2019. The guideline emphasises that all patients should have partner notification discussed at diagnosis, with "epidemiologic treatment" offered for asymptomatic contacts (meaning that antibiotic treatment is administered to contacts when a diagnosis is considered likely but before it is confirmed by laboratory tests).

3. Maintain high antenatal screening coverage and vigilance for syphilis throughout antenatal care.

4. Sustain targeted health promotion.[58]

In a progress update published in 2021, PHE reported that testing frequency for syphilis in MSM had increased: "80% of those attending SHS [sexual health services] in 2018 were tested for syphilis at least once in the following year, and 33% tested more frequently". It added, however, that testing frequency and uptake were still not meeting "recommended standards".[59] PHE also reported that the partner notification ratio[60] was increasing for MSM (from 0.33 in 2011 to 0.65 in 2019) but had decreased in heterosexual people, from 1.0 in 2016 to 0.85 in 2019.[61]

Decrease in genital warts

There has been a steep decline in genital warts diagnoses over the past decade, from around 77,000 in 2013 to 26,000 in 2023.[62] This can be largely attributed to the national human papillomavirus (HPV) immunisation programme.[63] Infection with HPV is associated with genital warts, as well as certain types of cancer, including cervical cancer.

A school-based HPV vaccination programme to help protect against cervical cancer has been offered to girls aged 12 to 13 since 2008, and to boys of the same age since 2019.[64] As a result, the largest proportional decline in cases has been among younger age groups.

Between 2019 and 2023, rates of first-episode genital warts diagnosis among young women aged 15 to 19 decreased by 76% (from 76 to 18 per 100,000 population). In young men of the same age, rates fell by 77% (from 61 to 14 per 100,000 population).[65]

The HPV vaccination programme was disrupted in the 2019–20 and 2020–21 academic years due to school closures during the covid-19 pandemic. HPV vaccine coverage for the first dose in 2019–20 was 59% in girls aged 12 to 13

58 PHE, Syphilis: Public Health England action plan, June 2019, p5

59 PHE, Tracking the syphilis epidemic in England, February 2021, p24

60 "The PN ratio compares the number of attendances at SHS in a calendar year made by patients reported as a notified contact of a sexual partner diagnosed with syphilis, and the number of infectious syphilis diagnoses made in the same calendar year. A value of 1.0 is the target, which indicates that for every index case one partner has been notified and attended SHS".

61 PHE, Tracking the syphilis epidemic in England, February 2021, p44

62 UKHSA, Sexually transmitted infections (STIs): annual data tables (various editions), Table 1

63 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2022 report [Archived], 25 October 2023

64 UKHSA, Information on the HPV vaccination from September 2023, updated 26 September 2023

65 UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 2

(compared with 88% in 2018–19) and 54% in boys of the same age (this was the first year the vaccine was offered to this group).[66]

Coverage among 12-to-13-year-olds improved in 2020–21; 77% of girls and 71% of boys received their first dose of HPV vaccine. Since then, vaccine coverage has not recovered to pre-pandemic levels. Coverage for the first dose in 2022–23 was 71% in girls aged 12 to 13 and 65% in boys of the same age.[67]

3.2 Groups at greater risk of infection

Data on STI diagnosis indicates that young people; gay, bisexual and other men who have sex with men; and people from Black Caribbean ethnic backgrounds have disproportionately high rates of certain STIs.

As noted above, treatment of some STIs, particularly gonorrhoea, is becoming much more challenging because of increasing resistance to antibiotics.

Young people aged 15 to 24

Young people aged 15 to 24 experience the highest rates of new STI diagnoses. In the latest STI/chlamydia screening annual report, UKHSA suggested this may be due to higher rates of partner change among this age group.[68]

Between 2021 and 2022, the largest increase in new STI diagnoses was among young people aged 15 to 24. This was driven by an increase in new cases of gonorrhoea, which doubled from 14,700 to 30,000 among this age group. However, in 2023 cases of gonorrhoea among 15- to 24-year-olds remained stable and there was a 2% decrease in diagnoses of all new STI diagnoses among this group compared with the previous year.[69]

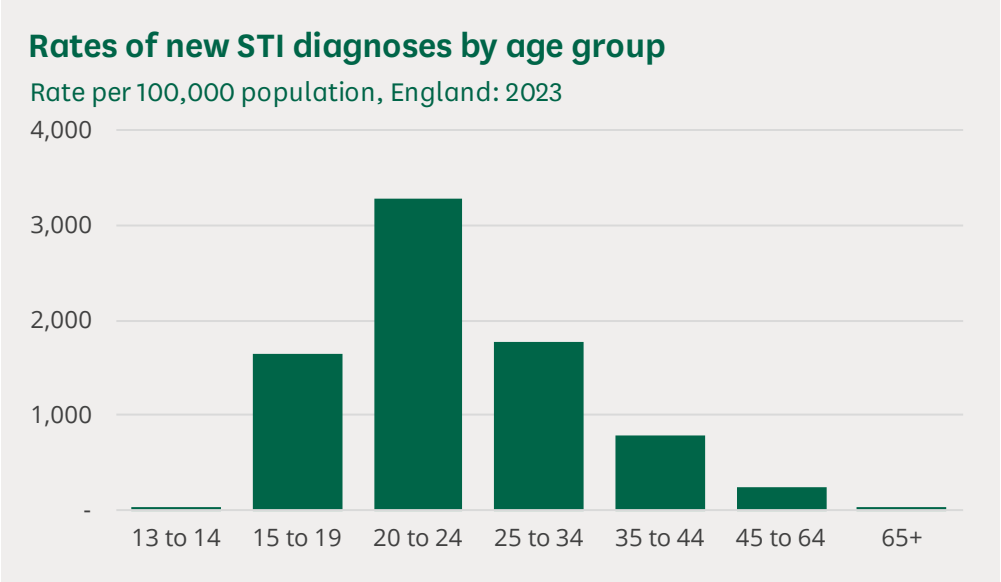
The chart below provides a more detailed breakdown of STI rates by age group. This shows that diagnosis rates for all STIs in 2023 were highest among young people aged 20 to 24, followed by people aged 25 to 34, with slightly lower rates seen among those aged 15 to 19.

66 Public Health England, Human papillomavirus (HPV) vaccination coverage in adolescent females and males in England: academic year 2019 to 2020, October 2020, p2

67 UKHSA, Human papillomavirus (HPV) vaccination coverage in adolescents in England: 2022 to 2023, 23 January 2024

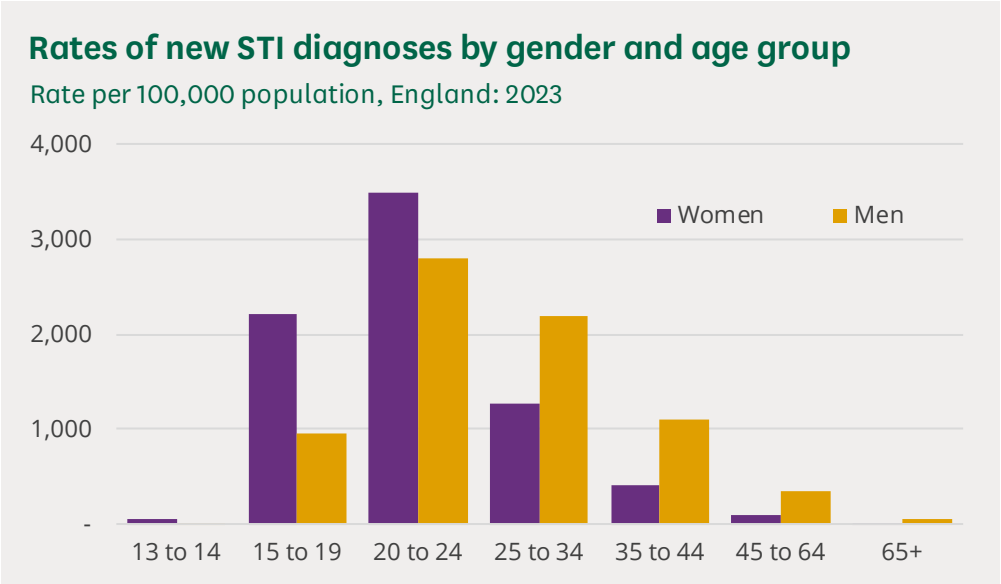
68 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024

69 UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 2



Source: UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 2

The chart below shows the same data broken down additionally by gender. This shows that in younger age groups women are more likely to be diagnosed with an STI than men.



Source: UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 2

This trend then reverses in older age groups, with men over the age of 25 more likely than women of the same age to be diagnosed with an STI.

UKHSA suggests this may be due to sexual mixing between younger women and older men. It highlights research by University College London which shows that around one third of heterosexual partnerships involve an age gap

of five years or more, with men the older partner in most cases, which can increase the STI risk for younger women.[70]

National Chlamydia Screening Programme

Chlamydia is a sexually transmitted infection caused by the bacterium 'Chlamydia trachomatis'. It occurs in both men and women; in 2023 there were around 91,000 diagnoses of chlamydia in men, in England, and 98,000 diagnoses in women.[71] In most cases, people with chlamydia do not notice any symptoms and they are therefore unaware that they may have it. If left untreated, chlamydia can lead to chronic pelvic pain, ectopic pregnancy and infertility. In rare cases, it can result in inflammation of the testicles.[72]

The National Chlamydia Screening Programme (NCSP) was introduced in England, in phases, from 2003.[73] The initial aim of the programme was to prevent the onward transmission of chlamydia through early detection and treatment.

The NCSP began by offering opportunistic testing to sexually active young people under the age of 25 years, without symptoms, in a variety of settings. Opportunistic testing involves offering a test (in this instance for chlamydia) when a young person comes into contact with health services for an unrelated matter. It is different from screening programmes for other conditions (such as bowel cancer) where those at a greater risk of the condition are systematically targeted and formally invited, usually via a letter, to take a test at regular intervals.

The NCSP recommended testing annually or after sex with a new partner (whichever was more frequent).[74]

In June 2021, the primary aim of the NCSP changed to reducing the reproductive harm of untreated chlamydia infection in young women. This change followed a review of the programme by Public Health England (PHE). It was made on the grounds that the "harmful effects of chlamydia occur predominantly in women and other people with a womb or ovaries" and that opportunistic screening should therefore focus on this group so that the "programme will be better able to maximise the health benefits".[75]

PHE emphasised that anyone needing a chlamydia test would still be able to access one, but that men "will not be proactively offered a test unless an

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70 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024; Rebecca S Geary and others, "Sexual mixing in opposite-sex partnerships in Britain and its implications for STI risk: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)", International Journal of Epidemiology, Vol 48, 2019, p228

71 UKHSA, Sexually transmitted infections (STIs): annual data, Table 2, 17 July 2024

72 NHS England, Chlamydia, last updated 1 September 2021

73 National Audit Office, Young people's sexual health: the National Chlamydia Screening Programme (PDF), 12 November 2009, HC 963, p5

74 PHE, Opportunistic Chlamydia Screening of Young Adults in England. An Evidence Summary (PDF), April 2014 (withdrawn June 2021)

75 PHE, Changes to the National Chlamydia Screening Programme (NCSP), June 2021

indication has been identified, such as being a partner of someone with chlamydia or having symptoms". [76] Chlamydia testing as part of routine sexual health screens, for people of any gender and at any age, remained unchanged.

The chlamydia detection rate is a Public Health Outcomes Framework indicator (see section 1.1) and UKHSA recommends that local authorities should be working towards a minimum detection rate of 3,250 diagnoses per 100,000 women aged 15 to 24 years. In 2023, the detection rate was well below target at 1,962 per 100,000 population.[77] An increased detection rate is a sign of improved control of chlamydia infection in the population.[78]

The shift away from testing all those who are sexually active and under the age of 25, towards a focus on sexually active women and other people with a womb or ovaries in this age group, was criticised by several organisations. The Royal College of Obstetricians and Gynaecologists and the Faculty of Sexual and Reproductive Healthcare both told the Women and Equalities Committee in 2024 that the change "risked shifting responsibility away from men and could bias public perception that chlamydia is a sexually transmitted infection primarily affecting and transmitted by women". [79]

In its 2024 report on the prevalence of sexually transmitted infections in young people and other high risk groups, the Women and Equalities Committee recommended that the government should review whether the change in focus of the NCSP had been effective. While the government has yet to respond to the committee's report, the then Health Minister, Lord Markham, stated in March 2024 that the NCSP's change in approach was "based on the scientific advice and evidence we have received that [it] is the best use of resources".[80]

Gay, bisexual, and other men who have sex with men

Gay, bisexual, and other men who have sex with men (GBMSM) have disproportionately higher rates of bacterial STIs (chlamydia, gonorrhoea and syphilis) compared with heterosexual men and women.

The number of diagnoses of each of these STIs among GBMSM has more than doubled over the last decade (between 2013 and 2023).[81] In 2023, GBMSM accounted for 80% of syphilis diagnoses in men and 67% of gonorrhoea diagnoses.[82]

76 PHE, Changes to the National Chlamydia Screening Programme (NCSP), June 2021

77 UKHSA, National chlamydia screening programme (NCSP): annual data, June 2024, Table 1

78 Office for Health Improvement and Disparities, Public Health Outcomes Framework, Chlamydia detection rate per 100,000 aged 15 to 24 (female) – indicator definition and supporting information

79 Women and Equalities Committee, The prevalence of sexually transmitted infections in young people and other high risk groups, Fifth Report of Session 2023–24, HC 463, March 2024, para 64

80 HL Deb, 19 March 2024, c193

81 Data provided by the UKHSA, National STI surveillance data, GUMCAD

82 UKHSA, Sexually transmitted infections (STIs): annual data tables, 4 June 2024, Table 2

In oral evidence to the Women and Equalities Committee, Dr Claire Dewsnap suggested that more frequent STI testing may play a role in increased diagnoses within this group. Professor Sir Chris Whitty also suggested that part of the increase in STIs in the GBMSM community may be due to reduced concern about HIV due to the effectiveness of available treatment, leading to fewer precautions being taken than may have been the case previously.[83]

A joint publication from the Terrence Higgins Trust and the British Association for Sexual Health and HIV emphasised the importance of considering the wider structural context in which these trends occur, and how that context may "impact higher STI rates, drive behaviours, and restrict access" to services. It added, however, that there is a very limited amount of research in this area:

> [...] high rates of syphilis and gonorrhoea among MSM are taking place within the context of a society which assumes heteronormativity. And yet, when looking for explanations of these trends, the focus of evidence is on behaviours, with little research on the impact of, for instance, homophobia.[84]

People from Black Caribbean ethnic backgrounds

When looking at new STI diagnoses among broad ethnic groups, people from Black ethnic backgrounds tend to have the highest diagnosis rates. However, rates vary between Black ethnic groups.

As shown on the chart below, people from Black Caribbean ethnic backgrounds had the highest diagnosis rates of many common STIs in 2023, while people of Black African ethnic backgrounds had relatively lower rates.

UKHSA reports that there are "no unique clinical or behavioural factors" to explain the disproportionately high rates of STIs in this group. It says that the disparities are therefore "likely influenced by underlying socio-economic factors and the role they play in the structural determinants of the health of this community".[85]

STI rates in different ethnic groups are also influenced by the age structure of each group. STI rates are highest among younger age groups, meaning ethnic groups with a higher proportion of young people would be expected to have higher rates.[86] Minority ethnic groups in England tend to have a younger age composition compared with the general population, which may in part explain higher STI rates.[87]

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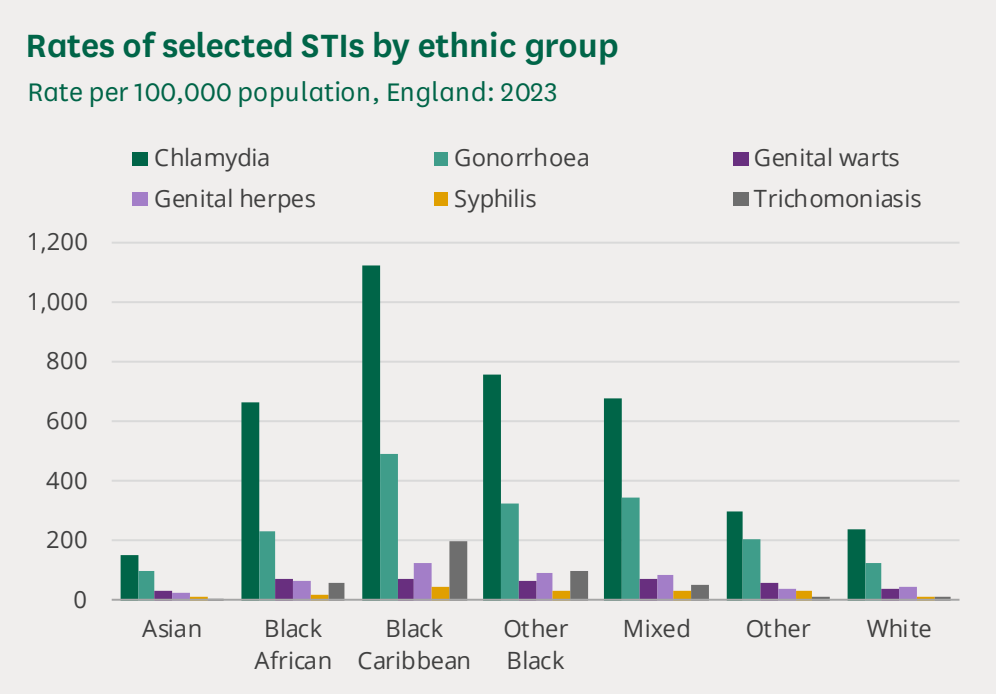
83 Women and Equalities Committee, The prevalence of sexually transmitted infections in young people and other high risk groups (oral evidence), HC 463, 2023-24, Q35

84 BASSH and the Terrence Higgins Trust, State of the Nation: Sexually Transmitted Infections in England, February 2020, p18

85 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2023 report, 4 June 2024

86 As above

87 Office for National Statistics, Ethnic group by age and sex, England and Wales: Census 2021, 23 January 2023



Note: Data is presented by disaggregated ethnic groups for people from Black ethnic backgrounds to highlight the variability in rates of the most common STIs among the ethnic group. People of Asian, Mixed, White and other ethnicities are presented as aggregated ethnic groups for comparison.

Source: UKHSA, Sexually transmitted infections (STIs): annual data tables, 25 October 2023, Table 2

3.3 Variations in STI diagnosis in local areas

Local-level data shows that STI rates are highest among people living in urban areas, particularly those living in London. UKHSA explains "that this largely reflects the areas of higher deprivation and the distribution of the core groups of the population who are at greatest risk of infection".[88]

Around 128,000 new STIs were diagnosed in London residents in 2023, accounting for nearly one third of all new STIs in England (32%).[89]

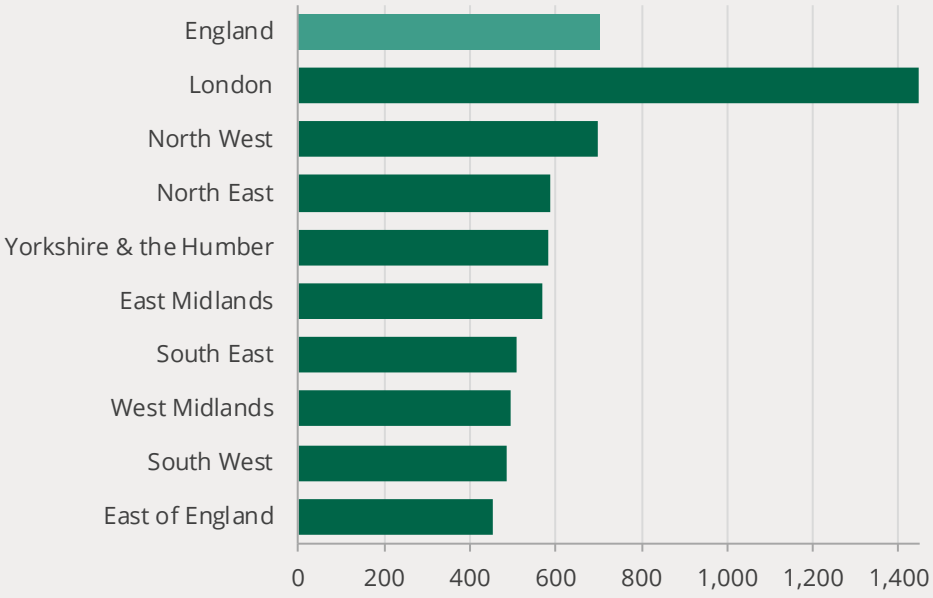
The rate of new diagnoses of STIs in London (1,448 per 100,000 population) was more than twice as high as in England overall (704 per 100,000 population), and more than three times as high as the East of England, which was the region with the lowest rate (453 per 100,000 population). High STI rates in the capital skew national figures, with all other English regions of England reporting lower rates than the England average.

88 UKHSA, Sexually transmitted infections (STIs): annual data tables, England STI slide set 2022, notes to slide 36

89 UKHSA, Sexually transmitted infections (STIs): annual data tables, 25 October 2023, Table 2

Rates of new STI diagnoses by region

Rate per 100,000 population, England: 2023



Source: UKHSA, Sexually transmitted infections (STIs): annual data tables, updated 4 June 2024, Table 2

There is also substantial variation within London, with higher diagnosis rates in inner London boroughs compared with suburban boroughs. For example, in 2023, rates of gonorrhoea in Lambeth (1,295 per 100,000 population) were 13 times higher than in Sutton (103 per 100,000 population).[90]

In 2023, the 10 local authorities in England with the highest rates of gonorrhoea and syphilis were all inner London boroughs, as were eight of the 10 local authorities with the highest rates of chlamydia.[91]

[90] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

[91] Including the City of London. Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles

4 HIV

Human immunodeficiency virus (HIV) weakens a person's immune system and their ability to "fight everyday infections and disease".[92] HIV does this by destroying certain white blood cells (known as 'CD4 cells') that tackle infection.[93]

HIV is a sexually transmitted infection (STI). Since there is a lot of data, and associated policy, on HIV, it is considered separately from other STIs in this briefing. The UK Health Security Agency (UKHSA) also reports HIV data separately from other STIs.

Some groups of people are at higher risk of becoming infected with HIV. They include:

- people with a current or previous partner with HIV
- men who have condomless sex with men
- people who inject drugs and share equipment
- people who have received a blood transfusion, transplant or other risk-prone procedures in countries that do not have strong screening for HIV.[94]

HIV is treated using antiretroviral medicines (sometimes called antiretroviral therapy – ART). These stop the virus replicating in the body and allow the immune system to repair itself and prevent further damage. The aim of HIV treatment is for the affected person to have an 'undetectable viral load', meaning the level of HIV in the body is too low to be detected by a test.[95] Having an undetectable viral load not only helps to improve the health of the person living with HIV, it also reduces the risk of HIV transmission; this is sometimes referred to as 'undetectable=untransmittable' (U=U).[96]

While there is currently no cure for HIV, ART is effective and can enable people with HIV to live a long and healthy life. If a person living with HIV is not on ART, they are at a higher risk of developing infections and 'acquired immunodeficiency syndrome' (AIDS).[97] The NHS emphasises that, "with an

92 NHS, HIV and AIDS, April 2021
93 World Health Organization, HIV, accessed 29 April 2024
94 NHS, HIV and AIDS - Causes, April 2021
95 NHS, HIV and AIDS – Treatment, April 2021
96 US Centers for Disease Control and Prevention About HIV, January 2024
97 US Centers for Disease Control and Prevention, HIV Basics, June 2022

early diagnosis and effective treatments, most people with HIV will not develop any AIDS-related illnesses and will live a near-normal lifespan".[98]

4.1 HIV testing

Almost 1.2 million people were tested for HIV in England's sexual health services in 2022. The positivity of these tests was 0.1%, meaning around 1 person tested positive for every 1,000 people tested.[99]

The number of people tested was lower than in 2019, when 1.3 million people were tested, but had recovered partially from a fall in 2020 (during the first year of the covid-19 pandemic) to 927,000 people tested. The rise between 2020 and 2021 was almost entirely accounted for by a rise in people tested via internet services.[100]

Among gay, bisexual, and other men who have sex with men, the number of people tested in 2022 was the highest ever reported. However, HIV testing levels among heterosexual men and women has not recovered to 2019 levels (pre-pandemic).[101]

4.2 HIV diagnosis

The number of newly diagnosed cases of HIV in England showed a declining trend between 2014 and 2021, before increasing by 22% in 2022 – up from 3,118 new cases in 2021 to 3,805 in 2022.

This increase was largely explained by a rise in cases which were first diagnosed abroad, which increased by 69% from 805 in 2021 to 1,361 in 2022 (see chart below). These infections were likely acquired abroad and therefore do not reflect a rise in transmission in England.[102]

UKHSA reports that most people diagnosed in England in 2022 who were first diagnosed abroad were linked to care shortly after their arrival in England, which helps to ensure good health outcomes and to prevent onward HIV transmission. Furthermore, 87% of those previously diagnosed abroad were virally suppressed at the time of their England diagnosis, which UKHSA says indicates access to treatment abroad.[103]

98 NHS, HIV and AIDS, April 2021

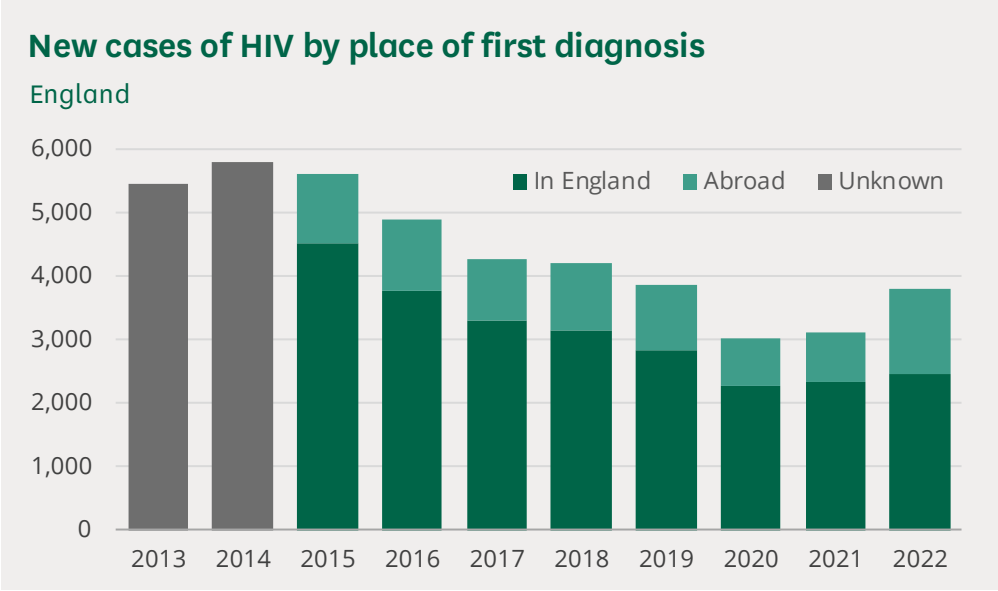
99 Source: UKHSA, HIV: annual data tables – HIV testing in England data tables, October 2023, Table 1

100 UKHSA, HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2023 report, updated 6 October 2023

101 As above

102 UKHSA, HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2023 report, updated 6 October 2023

103 As above



Note: Reliable data on new cases of HIV by place of first diagnosis is only available from 2015 onwards.

Source: UKHSA, HIV: annual data tables – country and region data tables, October 2023

In 2022, there were 2,444 people in England who were diagnosed with HIV for the first time, up from 2,313 the previous year. The government's ambition is to reduce the number of cases first diagnosed in England to under 600 by 2025, and to eliminate HIV transmission altogether by 2030.[104]

Just under half (44%) of people first diagnosed in England in 2022 had a 'late diagnosis', which means that they are estimated to have been unaware of their infection for at least three to five years. This increases the likelihood of potential onward transmission, serious illness and death.[105]

Transmission routes

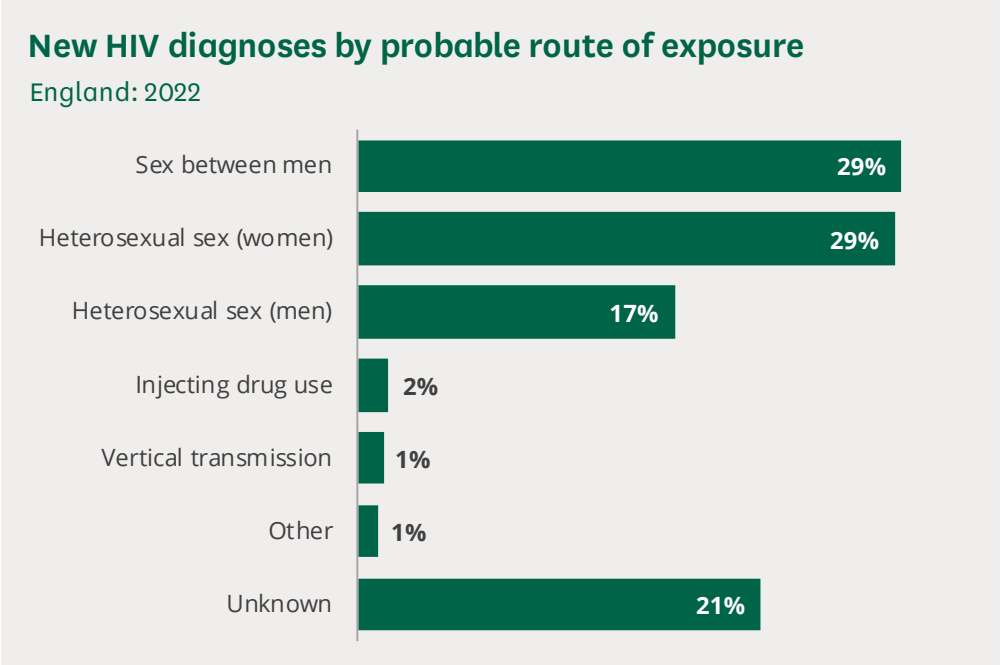
Sexual contact is the most common HIV transmission route, as shown in the chart below: in 2022, 74% of newly diagnosed cases were acquired in this way. Men exposed through sex between men accounted for 29% of cases, while women exposed through heterosexual contact accounted for 29%, and men exposed through heterosexual contact made up 17%. Other probable routes of exposure included injecting drug use (2%) and vertical transmission from parent to infant (1%). The probable route of exposure was unknown for 21% of cases.[106]

Cases of HIV transmission through sex between women are very rare and are included in the 'other' category by UKHSA, rather than being presented as an individual category.

104 Department for Health and Social Care, Towards Zero: HIV Action Plan for England 2022 to 2025, updated 21 December 2021

105 UKHSA, HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report [Archived], updated 1 December 2022

106 UKHSA, HIV: annual data tables – New HIV diagnosis in England data tables, October 2023, Table 1a



Source: UKHSA, HIV: annual data tables – New HIV diagnosis in England data tables, October 2023, Table 1a

When comparing probable routes of HIV exposure among people who were first diagnosed in England and those first diagnosed abroad, there was a similar distribution of diagnoses by most transmission routes. However, a higher proportion of cases diagnosed abroad involved women exposed through heterosexual contact (38% compared with 23% of those first diagnosed in England). Vertical transmission was also more common among people first diagnosed abroad (3% compared with 0.5% of those first diagnosed in England).[107]

A much higher proportion of cases first diagnosed in England had no stated transmission route (28% compared with 10% of those diagnosed abroad).

Men exposed through sex between men

The number of diagnoses among gay, bisexual and other men who have sex with men (GBMSM) fell in consecutive years between 2014 and 2020, but has since plateaued.[108] UKHSA says the fall in diagnoses together with high and sustained numbers testing for HIV indicates that HIV transmission continues to decline among this group.[109]

The largest fall was among GBMSM from White ethnic backgrounds, among whom the number of new diagnoses reduced by 75% between 2014 and 2022, from 2,312 to 517. However, this ethnic group still accounted for half of new

[107] UKHSA, HIV: annual data tables – New HIV diagnosis in England data tables, October 2023, Tables 2a and 3

[108] UKHSA, HIV: annual data tables – key population data tables, October 2023

[109] UKHSA, HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2023 report, updated 6 October 2023

diagnoses among GBMSM in 2022. A slower rate of decrease was seen for all other ethnic groups.[110]

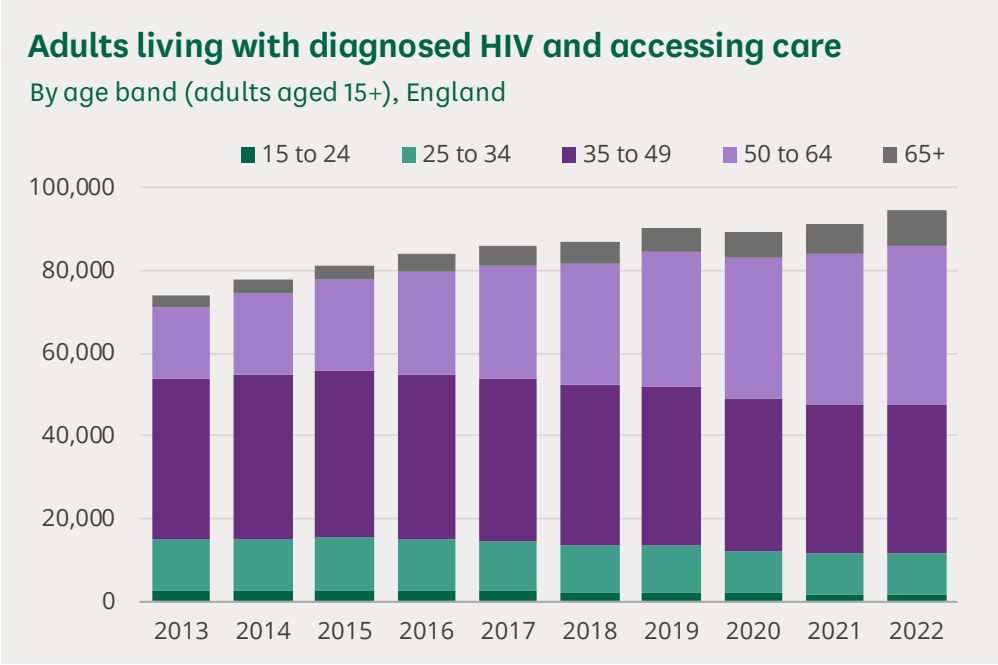
Men and women exposed through heterosexual sex

Among people who acquired HIV through heterosexual contact, the number of new cases almost halved between 2014 and 2020, from 2,142 to 1,116. The number of diagnoses then rose slightly in 2021 before increasing by 31% in 2022 to 1,731. This was largely driven by an increase in diagnoses among women exposed through sex with men.[111]

People from Black African ethnic backgrounds accounted for half (50%) of new diagnoses acquired through heterosexual contact in 2022, up from 41% in 2021.[112]

4.3 People living with HIV

In 2022 there were around 94,400 people living with diagnosed HIV infection and accessing care in England. Numbers have tended to increase year on year over the past decade, rising by 27% since 2013 (74,200 people).



Source: UKHSA, HIV: annual data tables – New HIV diagnosis in England data tables, October 2023, Table 4

As illustrated by the chart above, the age profile of those receiving HIV care in 2022 reflects an ageing population living with HIV. The proportion of people

110 UKHSA, HIV: annual data tables – key population data tables, October 2023
111 UKHSA, HIV: annual data tables – key population data tables, October 2023
112 As above

with diagnosed HIV who were aged 50 or over increased from 27% in 2013 to 50% in 2022. UKHSA attributes this to the success of HIV treatment in increasing the life expectancy of people living with HIV.[113]

In each of the past 10 years, men have consistently made up around two thirds of those living with HIV in England.[114]

In 2022, it was estimated that there were 4,500 people in England living with undiagnosed HIV. This is equivalent to around 5% of all people thought to be living with HIV in England.[115]

4.4 HIV prevention

Medicines are available to people who are at higher risk of contracting HIV. These can be taken before or after condomless sex to reduce the risk of HIV transmission.

The risk of transmitting HIV can also be reduced by using male or female condoms and lubricant during sex, and by not sharing needles and other injecting materials during drug use.

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) describes a practice where an HIV-negative person takes antiretroviral medication to reduce the likelihood of acquiring HIV from a partner. PrEP can be taken every day or, alternatively, 'on-demand', immediately before and after sex. PrEP is a prescription medication. It is available as tablets that contain two medicines; tenofovir disoproxil and emtricitabine. People at higher risk of acquiring HIV can obtain PrEP from sexual health clinics.[116]

People who are considered at substantial risk of HIV and would therefore benefit from PrEP are described as 'having a PrEP need'. In 2022, 10% of HIV negative people who attended specialist sexual health services in England (excluding people accessing reproductive care only) were defined as having a PrEP need, up from 7% the previous year.[117]

113 UKHSA, HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2023 report, updated 6 October 2023

114 UKHSA, HIV: annual data tables – New HIV diagnosis in England data tables, October 2023, Table 4

115 UKHSA, HIV Action Plan monitoring and evaluation framework 2023 report, 1 December 2023

116 NHS, About Pre-Exposure Prophylaxis (PrEP), March 2023; NICE, Recommendations | Reducing sexually transmitted infections | Guidance, June 2022

117 UKHSA, HIV: annual data tables – PrEP need and use data tables, October 2023

The proportion of HIV negative people defined as having a PrEP need was highest among GBMSM attending sexual health services at 69%, compared with 2% of heterosexual men, and 1% of heterosexual and bisexual women.[118]

Of those with PrEP need, 71% (86,000) initiated or continued PrEP in 2022, compared with 70% (62,000) in 2021. GBMSM with PrEP need were most likely to initiate or continue PrEP (74%), whereas heterosexual men (35%), and heterosexual and bisexual women (36%) were less likely.[119]

Post-exposure prophylaxis (PEP)

PEP uses antiretroviral medications to help stop people becoming infected with HIV if they think they have been exposed to the virus. PEP is not guaranteed to work. It must be started within 72 hours (and ideally within 24 hours) of coming into contact with the virus and taken every day for one month to be effective.[120]

The National Institute for Health and Care Excellence (NICE) recommends that PEP should only be taken following occupational exposure (such as within a health or social care setting) or following potential sexual exposure to HIV. For example, PEP could be offered to an HIV-negative "sexual partner of a person known to have HIV, to prevent infection after sex without a condom or where the condom has split".[121]

In 2022, around 8,400 people received PEP in England. This is a 3% increase compared with the previous year, but a 30% decrease compared with 2019 (before the covid-19 pandemic), when 12,000 people received PEP.[122]

4.5 HIV Action Plan for England 2022-25

In January 2019, the government committed to achieving zero new transmissions of HIV in England by 2030.[123] This commitment is in line with the Joint United Nations Programme on HIV/AIDS (UNAIDS) target "to end the AIDS epidemic as a public health threat by 2030" and is aligned with UN Sustainable Development Goal (SDG) 3.3.[124]

An independent HIV Commission was established in July 2019 to make recommendations on how to meet the government's 2030 target. The work of

118 As above. Figures for women who have sex exclusively with women have not been included as this group represents a small proportion of the total (less than 1%), meaning figures may be misleading.
119 As above
120 NHS, HIV and AIDS - Treatment, April 2021; Terrence Higgins Trust, PEP (post-exposure prophylaxis for HIV), February 2023
121 NICE, Scenario: Post-exposure prophylaxis, May 2021
122 UKHSA, HIV: annual data tables – PEP activity data tables, October 2023
123 Department of Health and Social Care, Let's pledge to do our part to end HIV, 30 January 2019
124 Goal 3 targets: Health - United Nations Sustainable Development, accessed 3 July 2024; UNAIDS Strategy 2016-2021, accessed 10 July 2024

the commission was supported by the Terrence Higgins Trust, National AIDS Trust and Elton John AIDS Foundation, and a final report was published on World AIDS Day 2020.

Towards Zero: HIV Action Plan for England 2022 to 2025 was published a year later, in December 2021, by the DHSC. It sets out how the government intends to achieve the UNAIDS target as well as the recommendations presented in the HIV Commission's report. The government accepted the commission's "interim ambition of an 80% reduction in new infections, and reductions in AIDS diagnoses and HIV-related deaths by 2025", with the action plan outlining the required actions to meet the ambition.

The actions are grouped according to four key objectives:

1. Ensure equitable access and uptake of HIV prevention programmes.
2. Scale up HIV testing in line with national guidelines.
3. Optimise rapid access to treatment and retention in care.
4. Improve quality of life for people living with HIV and address stigma.[125]

The plan also lists three key milestones to reach by 2025:

1. To reduce the number of people first diagnosed in England by 80% from 2,860 in 2019 to under 600.
2. To reduce the number of people diagnosed with AIDS within 3 months of HIV diagnosis from 219 in 2019 to under 110.
3. To reduce the number of deaths from HIV/AIDS in England from 230 in 2019 to under 115.[126]

HIV Action Plan: Annual update to Parliament

In June 2023, the government published its first annual update to Parliament on the HIV Action Plan. It stated that the number of new HIV diagnoses first made in England (not including diagnoses made abroad) had fallen by 32% between 2019 and 2021. The number of people diagnosed with AIDS also fell by 21% over the same period.

In addition, the government announced that it had met the Joint United Nations Programme on HIV/AIDS (UNAIDS) '95-95-95 target' for both 2020 and 2021 where:

- 95% of all people living with HIV are aware of their status.
- 95% of those aware of their status are on antiretroviral treatment (ART).

125 DHSC, Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025, December 2021

126 As above

- 95% of those on ART achieve viral load suppression (meaning that they have good clinical outcomes and cannot transmit HIV to another person).

While emphasising these developments, the update was also clear that progress towards ending HIV transmission in England was unevenly distributed across different groups and geographical regions. For example, it highlighted that while there has been a "sustained fall in new HIV diagnoses in gay, bisexual and other men who have sex with men (GBMSM) in London" there has not been the same fall among GBMSM outside London.[127]

PrEP and the action plan

Objective 1 of the action plan is to "ensure equitable access and uptake of HIV prevention programmes". As part of this objective, the government stated that it would "invest in HIV PrEP and develop a plan to drive innovation in PrEP delivery to improve access for key groups including provision in settings outside of sexual and reproductive health services".[128]

A Roadmap for meeting the PrEP needs of those at significant risk of HIV was published by the government in February 2024. The roadmap acknowledges that there are currently significant differences in both PrEP need and uptake by population group:

> [...] for example, heterosexual women are much less likely to have their need identified at a clinical consultation at a specialist SHS [sexual health service] and to start and continue using HIV PrEP than gay, bisexual and other men who have sex with men (GBMSM).[129]

Five 'action areas' are identified in the roadmap:

- Funding of sexual health services and HIV PrEP
- Tackling inequalities in PrEP access, uptake and use
- Promoting awareness of PrEP among key groups
- Improving access pathways in specialist sexual health services
- Improving access pathways in other settings.

Progress made in implementing these actions is due to be reviewed in 2025.

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127 Department of Health and Social Care, HIV Action Plan: annual update to Parliament, June 2023

128 Department of Health and Social Care, Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025, December 2021

129 Department of Health and Social Care, Roadmap for meeting the PrEP needs of those at significant risk of HIV, 21 February 2024

4.6 HIV Action Plan for England 2025-30

The Labour Party 2024 general election manifesto committed to commissioning a new HIV action plan for England for 2025-30.[130] The government subsequently confirmed that it aims to publish a new plan by summer 2025.[131] The Terrence Higgins Trust, National AIDS Trust and the Elton John AIDS Foundation have worked together to organise a series of events, and a call for views (which closed on 30 September 2024), on the new action plan.[132]

130 Labour Party Manifesto 2024, July 2024, PDF, p106

131 PQ HL2546 [on HIV Infection: Screening], 18 November 2024

132 How can a new HIV Action Plan achieve the 2030 goals and support everyone to live well with HIV? | Terrence Higgins Trust, July 2024

5 Reproductive health

Reproductive health affects both men and women; it includes "pregnancy-related health, some aspects of sexual health and health unrelated to pregnancy".[133] The World Health Organization (WHO) defines reproductive health as:

> [...] a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.[134]

The British Medical Association (BMA) notes that the WHO's definition frames reproductive health as a "positive state associated with well-being" but adds that the reproductive health of a population is "typically measured by pregnancy related 'morbidity' outcomes such as rates of abortion or repeat abortion and teenage pregnancy".[135]

5.1 Contraception

Contraception, sometimes referred to as 'birth control', is the use of medicines, devices, procedures or surgery to prevent pregnancy. There are different types of effective contraception that work in different ways:

- Barrier methods, such as condoms and diaphragms or caps, work by stopping sperm from either entering a woman's body or from entering the uterus.
- Hormonal methods include oral contraceptives, contraceptive injections, implants and patches, as well as vaginal rings. These contain either progestogen, or a combination of progestogen and oestrogen, and prevent pregnancy by stopping the ovaries releasing an egg each month.
- Surgical methods involve procedures that permanently stop eggs meeting sperm (female sterilisation) or permanently stops sperm

133 S Mann and J Stephenson, Reproductive health and wellbeing – addressing unmet needs (PDF), British Medical Association, August 2018, p1

134 WHO, Reproductive health, accessed 10 June 2024

135 S Mann and J Stephenson, Reproductive health and wellbeing – addressing unmet needs (PDF), British Medical Association, August 2018, p2. Morbidity means having a physical or mental health condition or disease.

travelling from the testes to the penis (male sterilisation, also known as a vasectomy).[136]

Prescriptions for contraceptives are automatically exempt from prescription charges. Contraception is also available for free from sexual health clinics, some GP surgeries and some young people's services.[137] Since December 2023, it has also been possible for some pharmacies to prescribe contraceptive pills without the person first needing to see or contact a GP or nurse.[138]

Access to free contraception, however, varies across England. Public Health England reported in 2018 that "one-third of women are unable to access contraception from their preferred source".[139] Freedom of information requests made in the same year showed that 49% of local authorities had reduced, or planned to reduce, the number of sites providing contraceptive services in their area.[140]

More recently, in 2022, the Women's Health Strategy for England published by the Department of Health and Social Care (DHSC) acknowledged that "women can struggle to access basic services such as contraception". One of the government's "10-year ambitions", set out in the strategy, is that "all women who want contraception are able to access their preferred type of contraception in a convenient way".[141]

Contraception can also be purchased; for example, condoms can be bought in pharmacies, supermarkets and online, while emergency contraception (contraception used after unprotected sex to prevent pregnancy) can be bought from pharmacies.

There is no single data set that captures all contraception provision across all services in England. NHS Digital publishes data on contraceptive activity taking place at dedicated sexual and reproductive health (SRH) services in England. Data on contraceptive prescribing in GP practices is supplied by the Prescription Services Division of the NHS Business Services Authority. Both datasets show a recent decline in prescriptions for contraception, particularly during the covid-19 pandemic.[142]

Limited data is available on services provided in hospital out-patient clinics, or contraception purchased at pharmacies and in other retail settings.

136 NHS, Methods of contraception, accessed 3 July 2024
137 NHS, Where to get contraception, February 2024
138 Find a pharmacy that offers the contraceptive pill without a prescription - NHS
139 PHE, Health matters: reproductive health and pregnancy planning, June 2018
140 BBC News, Women 'struggling to access contraception', September 2018
141 Department of Health and Social Care, Women's Health Strategy for England, June 2022
142 NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, September 2023

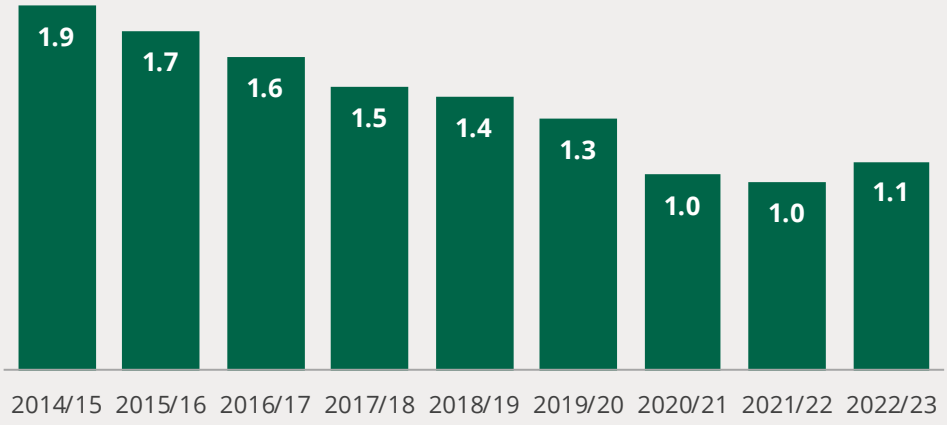
Contraception accessed through specialist SRH services

In the 2022/23 financial year, there were 1.1 million contacts made with SRH services in England for contraception-related reasons. This is an 11% increase on the previous year (when 964,000 contacts were made), although there has otherwise been a general declining trend since 2014/15 (1.9 million contacts), as shown in the chart below.

A 'contact' is a record of activity at a SRH service; it does not provide a count of the number of contraceptive items provided. It is also possible for the same person to access SRH services on multiple, separate occasions, in which case each occasion would count as an individual contact.

Contraception-related contacts with SRH services

England (millions)



Note: Data is not available prior to 2014/15 because of changes in data collection methods.

Source: NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 1

In 2022/23, 97% of people contacting SRH services for contraception-related reasons were female.[143] 4% of the female population (aged 13 to 54) were in contact with SRH services for contraception-related reasons that year, down from 7% in 2014/15.[144]

NHS Digital observes that the likelihood of a person using SRH services will be influenced by the availability of such services in their local area.[145]

Prescriptions dispensed in the community

Prescriptions for contraceptives are written primarily by GPs and non-medical healthcare prescribers, such as nurses and pharmacists. This does not

143 NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 2a

144 As above, Table 2b

145 As above, Part 1: Contacts with Sexual and Reproductive Health Services

include contraceptives provided by SRH services, except in instances when a prescription item is unavailable directly from the service.

In 2022, 7.4 million contraceptive prescriptions were dispensed in the community. The number of contraceptive prescriptions has fallen in the last 10 years, from 8.9 million in 2012.[146]

Methods of contraception

Contraceptive methods are classified as either user dependent or long acting reversible contraception (LARC). User dependent methods of contraception include condoms and the contraceptive pill. LARC is defined as contraceptive methods that require administration less than once per cycle or month, and include the non-hormonal copper coil (the IUD), the hormonal coil (the IUS), the contraceptive injection and the hormonal implant.

LARC has been promoted as a reliable method of contraception as it "removes the risk of pregnancy due to missed doses, or incorrect use, which can occur with other contraceptive methods".[147] In its LARC clinical guideline, NICE states that "LARC methods may have a wider role in contraception" and that their "increased uptake could help to reduce unintended pregnancy".[148]

LARC is also considered a "highly cost-effective public health intervention" by Public Health England (PHE). In July 2021, PHE estimated a 'return on investment' (ROI) of £48 for every £1 invested in LARC in primary care.[149]

Contraception accessed through specialist SRH services

The chart below shows that while the overall number of women and girls using SRH services for contraception has decreased in recent years, the proportion of those choosing LARC has increased.

Of the 473,000 women and girls using SRH services in 2022/23 for whom a method of contraception was recorded, 55% were using LARC, while the remaining 45% were using a user dependent method. LARC is most popular among older age groups.[150]

146 NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 13

147 Healthwatch Greenwich, Young People and Contraceptive Use. Knowledge and Awareness of Long Acting Reversible Contraception (LARC) (PDF), 2023

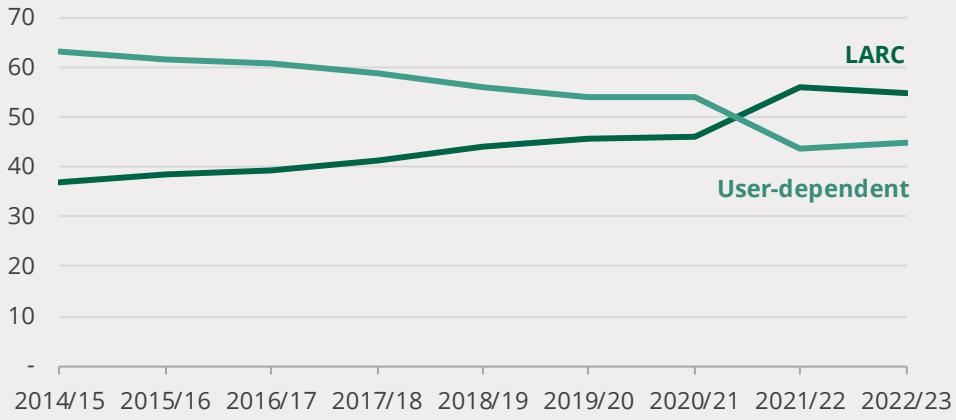
148 NICE, Long-acting reversible contraception. Guidance. updated July 2019

149 PHE, Contraception return on investment tool - maternity and primary care settings, July 2021, p5

150 NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 7

Uptake of user-dependent and long-acting reversible contraceptives (LARC) at SRH services

Percentage of women for whom a main method of contraception is recorded

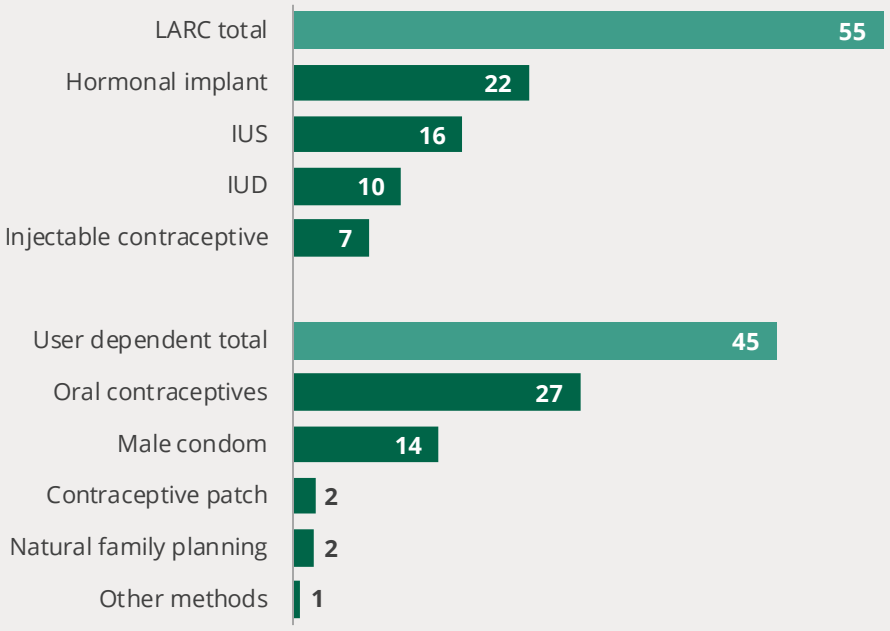


Source: NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 6

When looking at specific contraception methods, the chart below shows that oral contraceptives are the most popular. However, the proportion of women accessing these as their main method of contraception at SRH services has decreased from 45% in 2014/15 to 27% in 2022/23.

Main method of contraception in SRH services in England

% of women using SRH services for contraception



Source: NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 6

Prescriptions dispensed in the community

Between 2012 and 2019 (pre-pandemic), the number of prescriptions for LARC decreased from around 1.3 million to 1.2 million, before falling to 1.0 million in 2020. Although there has been a partial recovery since, the number of prescriptions for LARC has not returned to pre-pandemic levels (1.1 million prescriptions were issued in 2022).[151]

Over the same period, the number of prescriptions for user dependent methods (almost all of which are for oral contraceptives) has fallen steadily from around 7.3 million in 2012 to 6.2 million in 2022.[152]

These figures relate to the number of prescribed items, rather than the number of people being prescribed contraception.

Emergency contraception

In the last 10 years, the number of emergency contraceptives provided by SHR services in England has decreased from around 132,000 in 2012/13 to 83,000 in 2022/23. This fell to a low of 46,000 in 2020/21 due to restrictions to service provision in response to the covid-19 pandemic, but numbers have since returned to pre-pandemic levels.[153]

The number of emergency contraceptives provided to people under the age of 16 by SHR services has also fallen, as has the proportion of all emergency contraceptives provided to people of this age. In 2022/23, 1,822 emergency contraceptives were provided to under 16s, representing 2% of total emergency contraception. This is down from 11,810 in 2012/13 (9% of total).[154]

Oral contraceptives made up 91% of emergency contraception provided in 2022/23, while IUDs accounted for the other 9%.[155]

The number of prescriptions for emergency contraception dispensed in the community has fallen steadily from 230,000 in 2012 to 74,000 in 2022.[156]

These figures do not represent the full extent of emergency contraception provided in England. Emergency contraception has been available to purchase without prescription since 2001 (by women aged 16 and over). It is unclear whether the fall in provision in SRH services and primary care is because demand is increasingly being met in retail settings, or if this represents a genuine decline in the use of emergency contraception.

151 NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2022/23, Table 13
152 As above, Table 13
153 As above, Table 9a
154 As above, Table 9a
155 As above, Table 9a
156 As above, Table 13

5.2 Conception

The Office for National Statistics (ONS) publishes annual statistics on conceptions to residents in England and Wales. Here a conception is defined as a pregnancy that leads either to a maternity (birth of a live-born or stillborn child) or an abortion. ONS conception statistics do not include miscarriages.

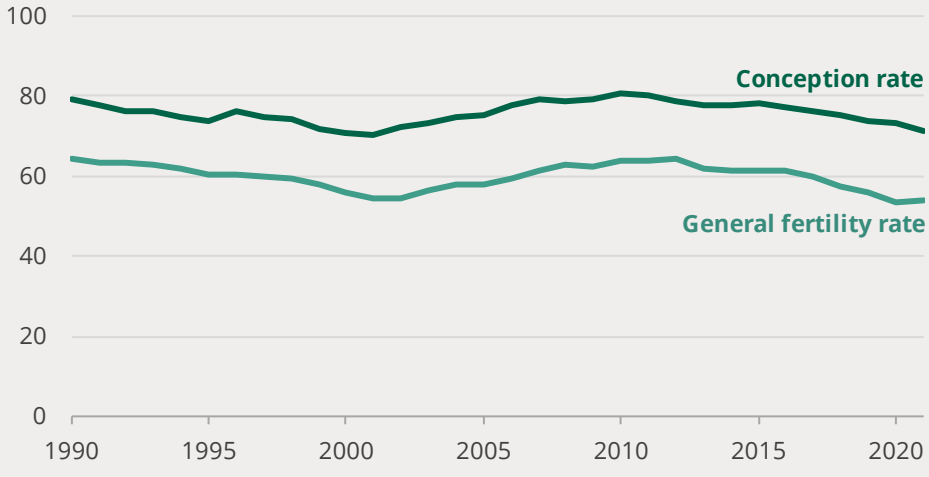
The latest data is for 2021, when the number of conceptions rose for the first time in six years, from around 818,000 in 2020 to 825,000 in 2021.

However, while there was an uptick in the number of conceptions, the chart below shows that the conception rate continued to decline, from 73.4 per 1,000 women of childbearing age (typically defined as ages 15 to 44) in 2020 to 71.5 per 1,000 population in 2021.[157] The data suggests that this is the lowest overall conception rate seen since 2001, when there were 70.3 conceptions per 1,000 women of childbearing age, although the ONS cautions that "this may be an effect of the differences in population estimates used".[158]

The conception rate peaked in 2010, when there were 80.5 conceptions per 1,000 women of childbearing age, and has decreased fairly steadily since. The general fertility rate, which measures the number of live births in a year per 1,000 women of childbearing age, has generally followed a similar trend.

Conception and fertility rates for women of childbearing age

Rate per 1,000 women aged 15 to 44, England and Wales: 1990 to 2021



Source: ONS, Conceptions in England and Wales dataset, 30 March 2023, Table 1a; ONS, Births in England and Wales: summary tables, 23 February 2024

[157] ONS, Conceptions in England and Wales dataset, 30 March 2023, Table 1

[158] ONS, Conceptions in England and Wales: 2021, 30 March 2023

The percentage of conceptions leading to legal abortions has increased fairly steadily over the past 10 years, reaching a record high in 2021 when over a quarter (26.5%) of conceptions led to abortions, up from 20.8% in 2011.[159]

Under-18 conception

The Department of Health's 2013 Sexual Health Strategy (PDF) has an ambition to "continue to reduce the rate of under-16 and under-18 conceptions" on the grounds that there is a higher risk of poor outcomes for both teenage parents and their children. The department stated that:

- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60% higher.
- Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child.[160]

In May 2018, Public Health England and the Local Government Association jointly published a Teenage Pregnancy Prevention Framework (PDF). Its aim is to enable areas to assess their local programmes "to see what's working well [and] identify any gaps" in services.[161] The framework cites the importance of relationship and sex education delivered in schools and its role in both delaying first sex and reducing the likelihood that "young women [are] pregnant by 18 and [...] experience an unplanned pregnancy in later life".[162]

Reducing the rate of under-18 conceptions is also one of the 66 indicators in the Public Health Outcomes Framework (PHOF) which highlights trends in public health across local authorities in England.

The chart below shows conception rates for girls under the ages of 16 and 18 in England and Wales between 1990 and 2021.

The rate of under-18 conceptions fluctuated but ultimately decreased during the first two decades shown, from a peak of 47.7 conceptions per 1,000 girls in 1990, before falling year-on-year between 2007 and 2020 from 41.6 to 13.1 conceptions per 1,000 girls (a 69% decrease). In 2021, there was a small increase to 13.2 conceptions per 1,000 girls.

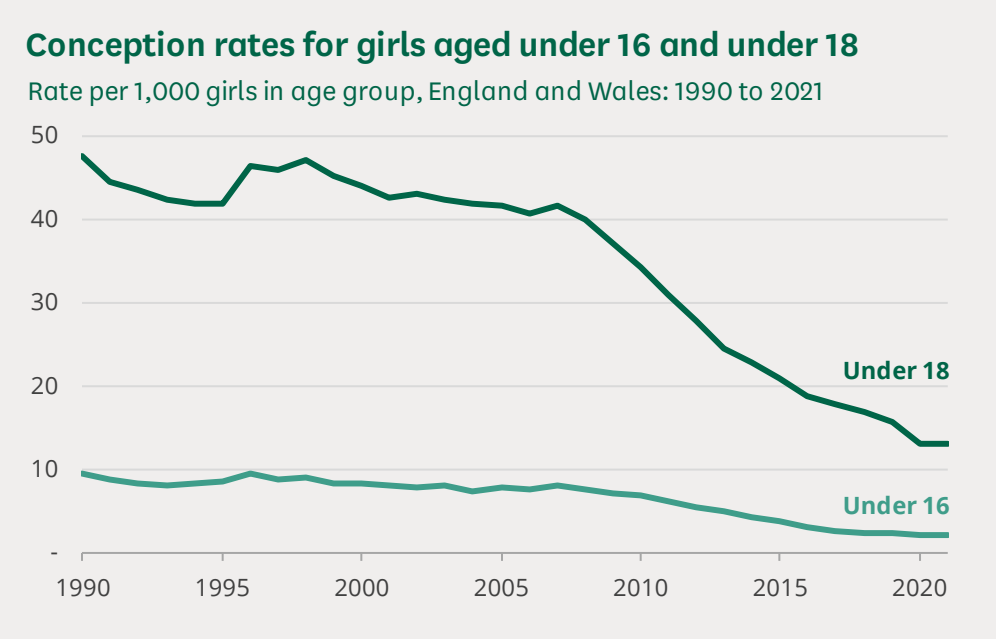
159 ONS, Conceptions in England and Wales: 2021, 30 March 2023

160 Department of Health, A Framework for Sexual Health Improvement in England (PDF), March 2013, p38

161 Public Health England and the Local Government Association, Teenage Pregnancy Prevention Framework (PDF), May 2018, p2

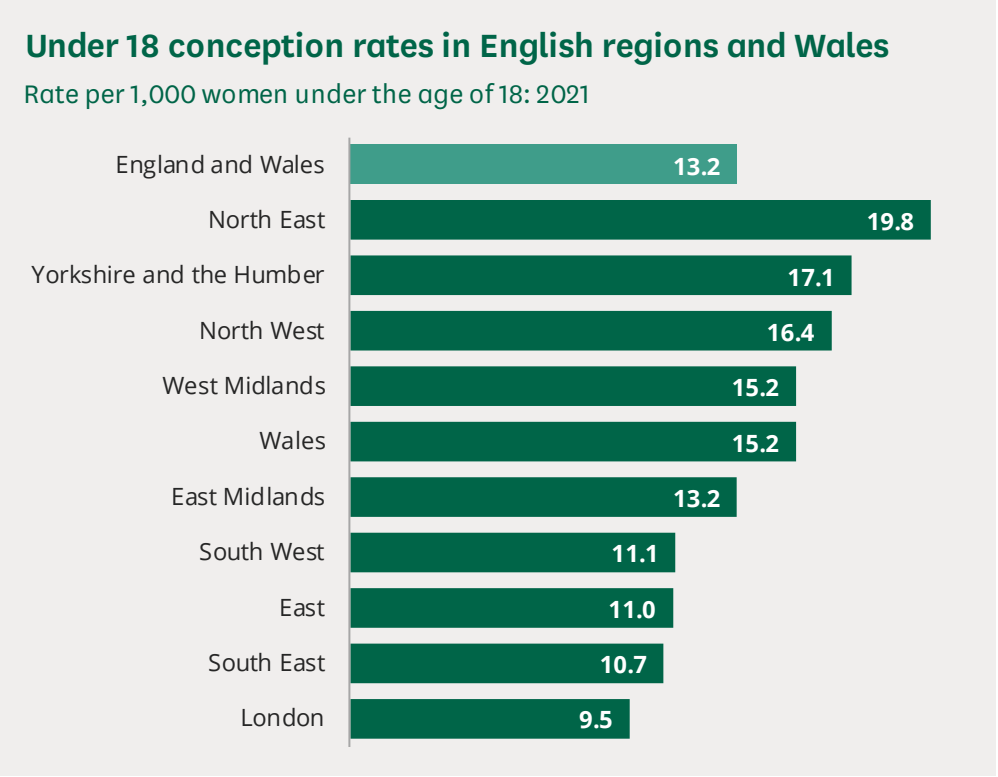
162 Public Health England and the Local Government Association, Teenage Pregnancy Prevention Framework (PDF), May 2018, p16. Under the Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019, there is a statutory requirement for all secondary schools to teach relationships and sex education.

The rate of under-16 conceptions followed a similar trend, decreasing from 9.5 to 2.1 conceptions per 1,000 girls between 1990 and 2021.



Source: ONS, Conceptions in England and Wales dataset, 30 March 2023, Table 1

The chart below shows that, in English regions and in Wales, rates of under-18 conception are highest in northern regions and lowest in London and the southeast regions. The same pattern is evident when comparing under-16 conception rates.



Source: ONS, Conceptions in England and Wales dataset, 30 March 2023, Table 4

The largest decrease in under-18 conception rates in the last 10 years has been in London, where rates were nearly three times higher in 2011 at 28.7 conceptions per 1,000 population. The North East has had the smallest percentage decrease, although rates have still almost halved over this period from 38.4 conceptions per 1,000 population.[163]

In 2021, more than half of under-18 conceptions led to abortions (53%). This figure was highest in London (62%) and lowest in the East Midlands (45%).[164]

5.3 Abortion

Abortion is a medical intervention to end a pregnancy. A medical abortion involves taking two different medicines (mifepristone and misoprostol) to end the pregnancy, usually one or two days apart. A surgical abortion involves an operation to remove the pregnancy from the womb. Both medical and surgical abortions can only be carried out under the care of an NHS hospital or a licensed clinic.

The Abortion Act 1967 (as amended) provides that abortions carried out in accordance with the conditions in the 1967 act will not be criminal offences under the Offences Against the Person Act 1861 and the Infant Life (Preservation) Act 1929. Abortion is thus lawful in England, Scotland, and Wales provided the criteria in the Abortion Act 1967 are met. The 1967 act never extended to Northern Ireland, though abortion was decriminalised in Northern Ireland in October 2019 and medical and surgical abortions are available.

In most cases, abortions can be performed up to 24 weeks of pregnancy. There are grounds in the 1967 act for abortions to take place after 24 weeks, for example if the:

- "termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman" [165] or if;
- "continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated" [166] or if;
- "there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped".[167]

163 ONS, Conceptions in England and Wales dataset, 30 March 2023, Table 6
164 As above, table 4
165 Section 1(1)(b) Abortion Act 1967
166 Section 1(1)(c) Abortion Act 1967
167 Section 1(1)(d) Abortion Act 1967

Early medical abortion

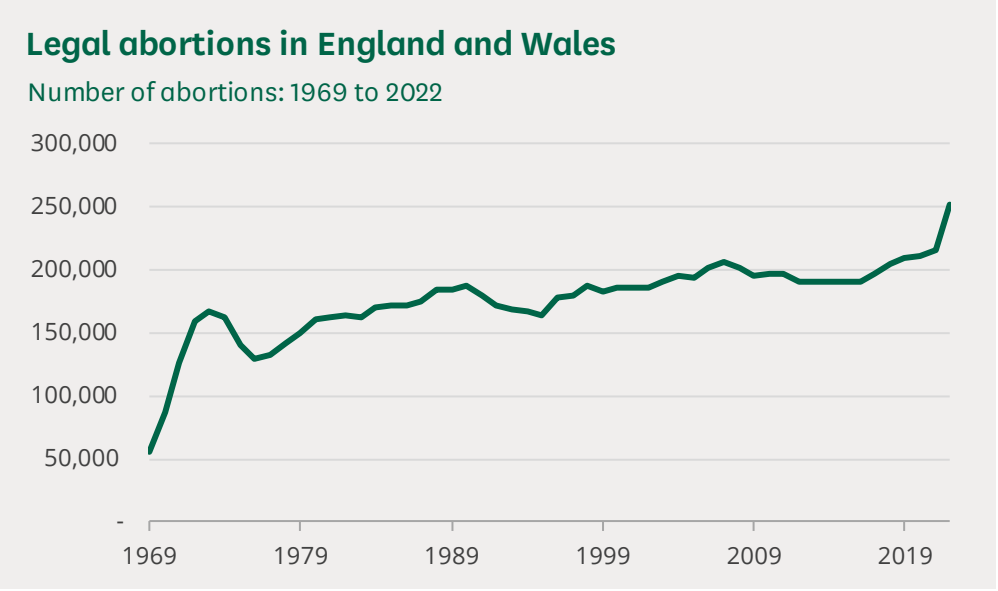
The 1967 act was further amended by Section 178 of the Health and Care Act 2022 (and the Abortion (Amendment) Regulations 2022). This permits early medical abortion, where the pregnancy has not exceeded nine weeks and six days, to take place at home, providing certain conditions are met. The 2022 regulations extend to England and Wales; they made permanent a temporary measure that was introduced during the covid-19 pandemic.

The regulations allow both tablets for early medical abortion (mifepristone and misoprostol) to be taken at home, without the need to attend a hospital or clinic first. The same medical consultation requirements remain but can be provided via a video link, over the telephone or by other electronic means. Further information is provided in the Library briefing on Early medical abortion at home during and after the pandemic.

Abortions carried out in England and Wales

The Office for Health Improvement and Disparities (OHID) publishes abortion statistics for England and Wales.

There were 252,000 legal abortions carried out in England and Wales in 2022, which is the highest number ever recorded (see chart below). This was a 17% increase on the previous year, when there were 215,000 abortions.



Note: The Abortion Act came into effect in April 1968, meaning 1969 is the first full year for which data is available.

Source: OHID, Abortion statistics for England and Wales: 2022, Table 1

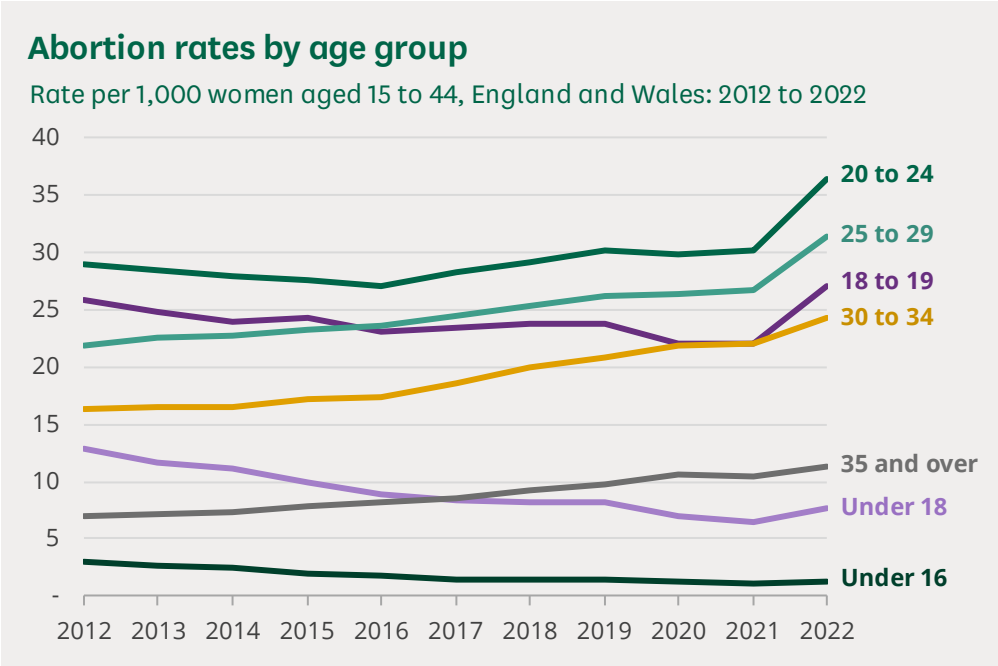
The vast majority of abortions were for residents in England and Wales (251,000 in 2022).[168] From this point onwards, figures provided in this briefing relate to abortions for England and Wales residents only.

41% of women undergoing abortions in 2022 had had one or more previous abortions. This represents a decrease from 43% in 2021, although the proportion had been increasing steadily for decades prior to this (25% of women undergoing abortions in 1992 had had one or more previous abortions).[169]

Abortions by age

Abortion rates are calculated per 1,000 women of childbearing age, which is typically defined as ages 15 to 44.

The chart below shows the change in abortions rates by age group between 2012 and 2022. This shows that abortion rates have increased for all groups over this period, except for under 18s. When looking at data broken down by single year of age, this shows that abortion rates have in fact increased for women of all ages 19 and above.[170]



Source: OHID, Abortion statistics for England and Wales: 2022, Table 3b

168 In Scotland, there are no independently run abortion clinics (such as those run by the British Pregnancy Advisory Service (BPAS) or MSI Reproductive Choices); abortions are only provided by NHS health boards. At the time of writing, NHS health boards in Scotland were not providing abortions after 20 weeks gestation. BPAS reported in July 2023 that in 2022, "65 women travelled from Scotland to England to access abortion care that is not provided within Scotland". Since summer 2017, the government has also funded abortion care in Great Britain "for women ordinarily resident in Northern Ireland". This provision remains in place despite the decriminalisation of abortion in Northern Ireland. In 2022, there were 172 abortions for residents of Northern Ireland in England and Wales.

169 Department of Health, Abortion Statistics, England and Wales: 2002 [Archived], Table 3

170 OHID, Abortion statistics for England and Wales (2022 and 2012 editions), Table 4a

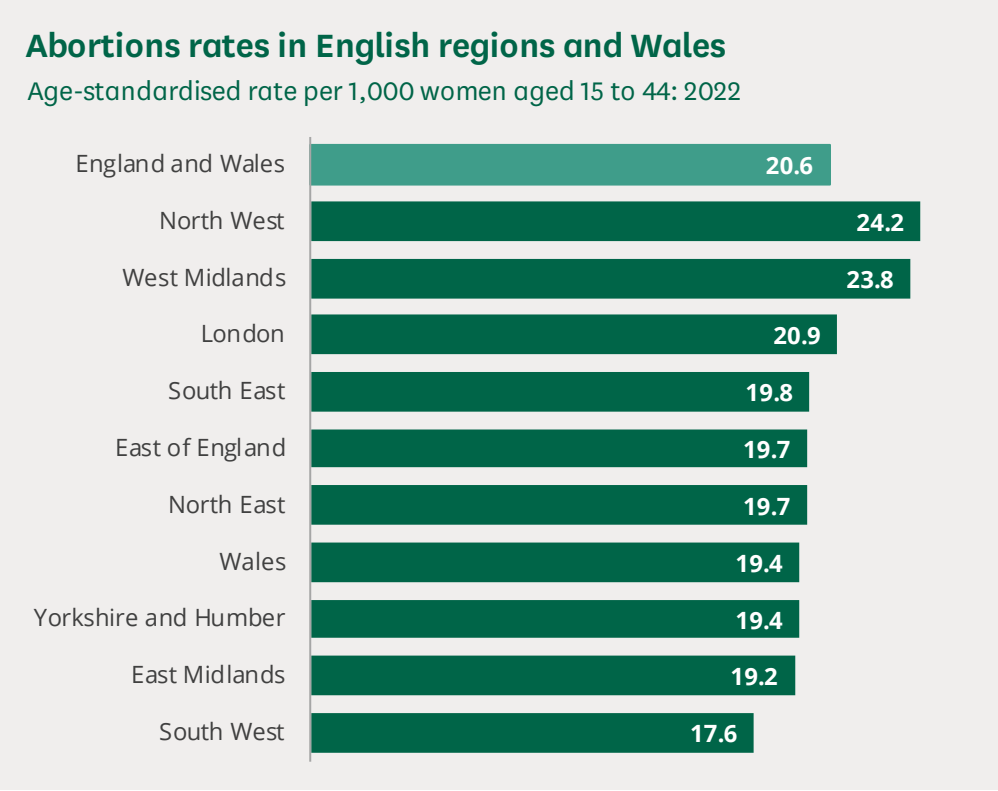
Since 2012, abortion rates have consistently been highest among women aged 20 to 24 and lowest among girls under the age of 16. The largest increases over this period have been among women aged 25 and over.

While abortion rates for women and girls under the age of 20 have shown a generally declining trend, there was an uptick in 2022 compared with the previous year.

Abortions by area of residence

The chart below shows age-standardised abortion rates in English regions and in Wales in 2022. Age standardised rates are adjusted to take into account differences in age structure to enable comparison between different populations.

Abortion rates were highest in the North West (24.2 per 1,000 women aged 15 to 44) and the West Midlands (23.8 per 1,000 population). Rates in London (20.9 per 1,000 population) were similar to the England and Wales average (20.6 per 1,000 population), while rates in all other regions and in Wales were below average. The lowest rates were in the South West region (17.6 per 1,000 population).



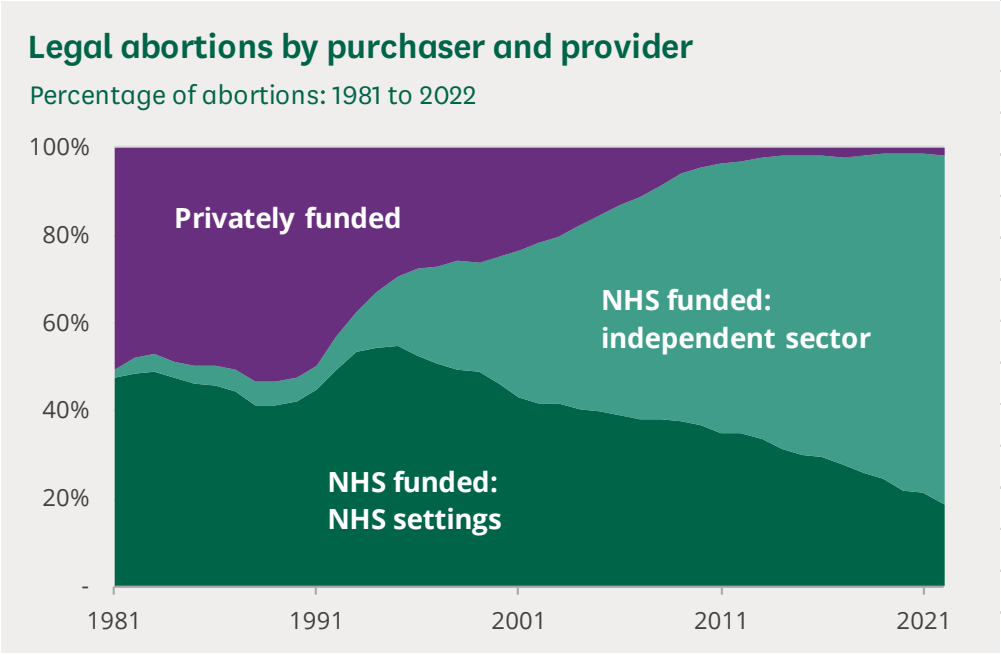
Source: OHID, Abortion statistics for England and Wales: 2022, Table 10d

The local authorities with the highest abortion rates were situated in the Midlands and the north of England: Knowsley (36.2 per 1,000 population), Wolverhampton (32.6 per 1,000 population), Sandwell (31.7 per 1,000 population), Halton (30.7 per 1,000 population) and Middlesborough (29.9 per 1,000 population).

Abortion provision and funding

In 2022, 98% of abortions in England and Wales were NHS funded, with 19% provided in NHS settings, while 80% took place in the independent sector under NHS contract.[171] The remaining 2% of abortions were privately funded.[172]

The proportion of abortions delivered by independent NHS-funded providers has increased in almost every year since this information was first collected, from 2% in 1981 to 80% in 2022, while the proportion of private abortions and abortions in NHS settings has reduced (see chart below).



Source: Source: OHID, Abortion statistics for England and Wales: 2022, Table 1

Medical abortions involving the use of medicines accounted for 86% of total abortions in 2022, with surgical abortions making up the remaining 14%.[173]

There has been an upward trend in medical abortions since 1991, when mifepristone was first licensed for use in the UK, which has increased further since the covid-19 pandemic when measures were introduced permitting early medical abortions to take place at home, without the need to first attend a hospital or clinic.[174]

Taking both medicines (mifepristone and misoprostol) at home is now the most common procedure, accounting for 61% of abortions in 2022, while

[171] The main independent providers are the British Pregnancy Advisory Service (BPAS), Marie Stopes International (MSI) and the National Unplanned Pregnancy Advisory Service (NUPAS).
[172] Percentage figures do not sum to 100 due to rounding.
[173] OHID, Abortion statistics for England and Wales: 2022, Table 3a
[174] OHID, Abortion statistics, England and Wales: 2022 (commentary), 23 May 2024

taking one or both medicines in a hospital or clinic has become less common.[175]

5.4 Cervical screening

'Screening' involves testing an otherwise healthy group of people for a disease or condition, before they are showing any symptoms. Its aim is to improve health outcomes by detecting and treating disease at an early stage.

Cervical screening is one of 11 NHS population screening programmes available in England. The cervix is the opening to the uterus (womb). The NHS cervical screening programme aims to prevent cervical cancer by taking a small sample of cells from the cervix and testing them for a virus called human papillomavirus (HPV).

Cancer Research UK notes that 'high-risk' HPV can cause cervical cells to become abnormal and can develop into cancer over time (though not all cell changes will develop into cancer).[176] Cervical screening is thus not a test for cancer but rather a test for high-risk HPV. The NHS notes that HPV is spread through close "skin-to-skin contact of the genital area" as well as from sex and sharing sex toys.[177]

In England, cervical screening is currently offered to people aged 25 to 64 who are registered as female with their GP.[178] The first invitation to eligible people is sent at 24.5 years of age. People aged 25 to 49 years receive an invitation every three years and people aged 50 to 64 years receive an invitation every five years. People aged 65 and over will only be invited again if a recent test was abnormal.

Coverage for cervical screening refers to the proportion of those eligible who have received a test within the recommended time-period.

In the 2022/23 financial year, approximately 16 million people in England were eligible for cervical screening, of which 11 million had been screened within the appropriate period. This equates to a coverage rate of 68.7%. Total coverage has fallen since the start of the pandemic, from 72.2% in 2019/20.[179]

Coverage varies across different regions in England, ranging from 61.3% in London to 72.5% in the North East in 2022/23.[180]

175 As above

176 Cancer Research UK, About Cervical Screening, September 2023

177 NHS, Human papillomavirus (HPV), May 2022

178 Public Health England (PHE) noted that "trans men (assigned female at birth) do not receive invitations if registered as male with their GP, but are still entitled to screening if they have a cervix", see PHE, Cervical screening: programme overview, March 2021

179 NHS Digital, Cervical Screening Programme, England 2022-2023, 23 November 2023, Table 1

180 As above, Table 11

Uptake differs between the eligible age groups. In 2022/23, 65.8% of the eligible population aged between 25 to 49 had been screened within the recommended period, compared with 74.4% of those aged 50 to 64.[181]

[181] As above, Table 1

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