Document Front Sheet

Name and date of meeting: London Sexual Health Steering Group- 13 November 2006	
Title of document: London Sexual Health Promotion Strategy- draft	Agenda item: 3.1 Attachment: B
Aims: To discuss and endorse the draft London Sexual Health Promotion Strategy	
Summary: This is London's first Sexual Health Promotion Strategy. It was developed by a multi-agency steering group and this is the penultimate draft of the strategy. There are 5 High Impact Sexual Health Promotion Changes that have been endorsed by the steering group meeting of 6 November 2006. It is being referred to the following for endorsement: - London Sexual Health steering group - NHS London - Government Office for London - GLA/ London Assembly - London Councils - Sexual Health Networks - Sexual Health Voluntary Groups - PCT Directors of Commissioning.	
Actions: The London Sexual Health Steering Group is asked to: - Comment on the draft Strategy - Discuss implementation issues - Endorse the strategy.	
Author and Date: Hong Tan- Nov 2006 *Director of London Sexual Health Programme*	

Item B.1
Draft 4 - October 2006

Sexual Health Promotion Framework for London:

5 High Impact Changes for Sexual Health Promotion in London

Contents:

Foreword

5 High Impact Changes

Introduction

The Case for Sexual Health Promotion in London

Evidence Base for Sexual Health Promotion

High Impact Change 1

High Impact Change 2

High Impact Change 3

High Impact Change 4

High Impact Change 5

Achieving the Changes – Next Steps

Supporting Resources

Participants of London Sexual Health Promotion Steering Group

Supporting Appendices available at: www….

1. Sexual Health Needs in London
2. Evidence of Effectiveness of Sexual Health Promotion

Foreword – to add

5 High Impact Changes for Sexual Health Promotion in London

1. Provide strong regional strategic and local leadership and partnerships on sexual health promotion across London.

2. Improve commissioning of sexual health promotion that is based on evidence of effectiveness, and supports delivery of public service agreements and targets.

3.Target priority groups for sexual health promotion appropriately and effectively:

- Children and Young People
- Gay/Bisexual/Men who have sex with men
- Black and Minority Ethnic Communities
- Sex Workers
- Offenders in London Prisons

4. Promote safer sex through improved access to condoms and contraception

5. Develop a co-ordinated approach to targeted, evidence based communications and campaigns to promote behaviour change.

Introduction

Aims
The main goal of this Framework is to strengthen regional and local commitment to an evidence-based, co-ordinated approach to sexual health promotion, which enables appropriate interventions to target specific communities at risk, and reduce sexual health inequalities across London.

It sets out why sexual health promotion should be a priority for London and what makes the city different and challenging. It identifies 5 high impact changes for London, which if addressed will make a significant difference to sexual health inequalities in the capital.

This is a developing tool to support regional and local action. It aims to be useful, relevant and robust, and makes a strong case for sexual health promotion in London in a climate of change in the NHS and beyond.

Background
The Framework is supported/ endorsed by….(to confirm with SHA, GLA,GOL….) It was developed by a London-wide Sexual Health Promotion Steering Group, chaired initially by the Prof. Sue Atkinson Regional Director of Public Health to August 2006, and subsequently by Dr Anne Mackie, Health Strategy Co-ordinator. It has been developed in response to one of the priorities set in the London Wide Sexual Health Framework, 2004.

What is sexual health promotion?
Sexual health has been described as 'an important part of physical and mental health….essential elements of good sexual health are equitable relationships and sexual fulfilment, with access to information and services to avoid the risk or unintended pregnancy, illness or disease' (DH 2001).

Sexual health promotion aims to improve the positive sexual health of the general population and reduce inequalities in sexual health. It has been defined as
'any activity which proactively and positively supports the sexual and emotional health and well-being of individuals, groups, communities and the wider public and reduced the risk of HIV transmission' (DH 2003).

Sexual health promotion encompasses a wide range of settings and methodologies, both direct with communities, groups and individuals; and indirect with professionals, agencies and service providers; and encompasses the wider social, economic and political factors that impact on and shape sexual health.

At a regional level the Mayor and GLA, Government Office for London, Association of London Government, Strategic Health Authority and Regional Public Health Group-London, Councils, pan-London Voluntary agencies and media and private sector all have a role in promoting good sexual health. At a local level Local Authorities, schools and colleges, Primary Care Trusts, primary care, GUM clinics and other clinical services, the Voluntary and Community Sector all have a role to play in commissioning and delivering services. Faith groups, local media and retailers and hospitality industry also have a role in promoting sexual health.

Policy context
The policy context for sexual health promotion is set out in a range of strategies including the National Strategy for Sexual Health (DH 2001), the public health White Paper Choosing Health (DH 2004), the Teenage Pregnancy Strategy (SEU 1999), and Every Child Matters: Change for Children.

A wide range of resources are available to support the promotion of good sexual health. Key documents are set out on page XXXXX

Principles and Values

Sexual health promotion should be grounded in a positive and holistic model of sexuality and sexual health, and encompass the following:

- *Respect:* no place for any form of discrimination or judgemental attitudes and need to respect choice and lifestyles.

- *Equity and diversity*: need to affirm diversity and address systematic inequalities in sexual health amongst different communities.

- *Community involvement*: individuals, groups and communities actively involved in assessing needs, developing and delivering sexual health promotion services.

- *Whole person approach*: addressing social and psychological factors determining behaviour and enabling people to develop practical skills to take control over their lives.

- *Choice and access*: ensure sexual health promotion is accessible to all, takes account of particular needs, offers diversity of provision (including open access), clear and appropriate information about sexual health.

- *Evidence and Evaluation*: sexual health promotion must be based on evidence of what works, and/or include robust evaluation.

- *Genuine partnership:* especially between communities, PCTs and Community and Voluntary Sector

- *Confidentiality*: this is vital within sexual health promotion, dealing with a range of sensitive and stigmatising issues.

The Case for Sexual Health Promotion in London

A unique world city
London is a unique world city. It has a population of 7.5 million, however, it also has 1 million daily commuters and over 13 million tourists every year. It has a young population, which is set to increase significantly over the next 10 years. It is highly ethnically diverse, with 40% from an ethnic minority group, 90 different ethnic groups and 300 different languages spoken. It is home to many refugees and asylum seekers, and has a highly mobile population (20-40% turnover on GP lists annually). These unique characteristics are significant factors in patterns of sexual health in London

Wide inequalities
Within London there are wide inequalities in the broader determinants of health, including deprivation, social exclusion, discrimination and educational attainment. These all have a significant influence on sexual health, and reflect wide inequalities in patterns of sexual health across London. Tackling these wider aspects need to be part of a holistic approach to health promotion across the capital

Sexual health needs
Peter Trail to add…Sexual health need in London is increasing with high levels of teenage pregnancy, high numbers of pregnancy terminations, increasing diagnoses of sexually transmitted infections and increasing numbers of HIV diagnoses. 1 in 5 diagnoses of Chlamydia are in London this rises to 1 in 3 reported incidences of Gonorrhoea and half of the diagnoses of HIV.. Appendix 1. sets out detailed needs assessment data.

Access to services
The capital's sexual health services are coming under increasing pressure caused by growing numbers of people requiring diagnostic and treatment services. Adequately resourced and effective sexual health promotion services can contribute to reducing pressure on service access and support the delivery of sexual health targets including the priority for achieving 48 hour access to GUM services, which is one of the top six NHS service priorities for 2006/07.

The economic case
There is a strong economic case for investing in sexual health promotion. A recent report into the health economics of sexual health, which included sexual health promotion and prevention, stated that investment in sexual health interventions is good value for money and in many cases cost-saving. It concluded that 'a PCT or other commissioning organisations is actually allocating resources inefficiently if it does not invest (or indeed disinvests) in sufficient of these services to cover the relevant population adequately' (DH 2005).

Evidence Base for Sexual Health Promotion

A summary of current available literature on best practice and cost effectiveness of sexual health promotion is attached in Appendix 2. It focuses on the findings of a number of recent reviews of reviews. Key findings are summarised below:

Types of Interventions which are likely to be most effective:

- **Small group discussion sessions** in which a variety of media are used e.g. video, slides, posters etc are effective. These sessions are delivered to small groups of individuals usually from the same peer group and are facilitated in some way.
- **Some types of partner notification** are effective in newly detecting infections. Provider referral (the use of third parties – usually health service personnel to notify partners) is more effective than patient referral. Patient referral can be enhanced by the provision of contact slips providing additional information for the index patient and their partners.
- **Individual risk counselling** can be effective. This usually takes place in clinics and aims to improve knowledge and awareness of sexual risks as well as identifying triggers and associated risk reduction strategies.
- **School based sex education** can be effective and is more effective if begun before the onset of sexual activity. This may encompass a diversity of methods (e.g. videos, didactic lessons, role play) and of content (e.g. focus on HIV or pregnancy) delivered by a variety of providers (e.g. peers, teachers, nurses)
- **Contraception**: greater access to full range of contraceptive methods (including longer acting methods and access to emergency contraception) is beneficial.

Interventions that have been identified as cost effective:

Cost-saving Interventions – Interventions which save money to health care funders at the same time as producing health benefits such as reduced mortality or improved quality of life:

- Free condom provision for medium and high risk groups (mainly men who have sex with men (MSM) and sex workers).
- Condom subsidy or tax reduction schemes
- Outreach health promotion and safe sex programmes for high risk groups (mainly MSM and sex workers) and hard to reach groups.
- Provision of AIDS risk reduction messages in gay bars.
- Safer sex skills training session/cognitive behavioural intervention for MSM.
- Peer-leader interventions for MSM.
- High quality integrated Sex and Relationships Education (SRE)
- Needle exchange provision to prevent HIV in injecting drug users.

Above averagely cost-effective Interventions compared with current NHS expenditure:

- Behavioural HIV risk reduction sessions for high risk women.
- Partner notification.

Averagely cost-effective Interventions compared with current NHS expenditure (most NHS interventions are in this category):

- 1-day cognitive-behavioural HIV risk reduction intervention in male adolescents.

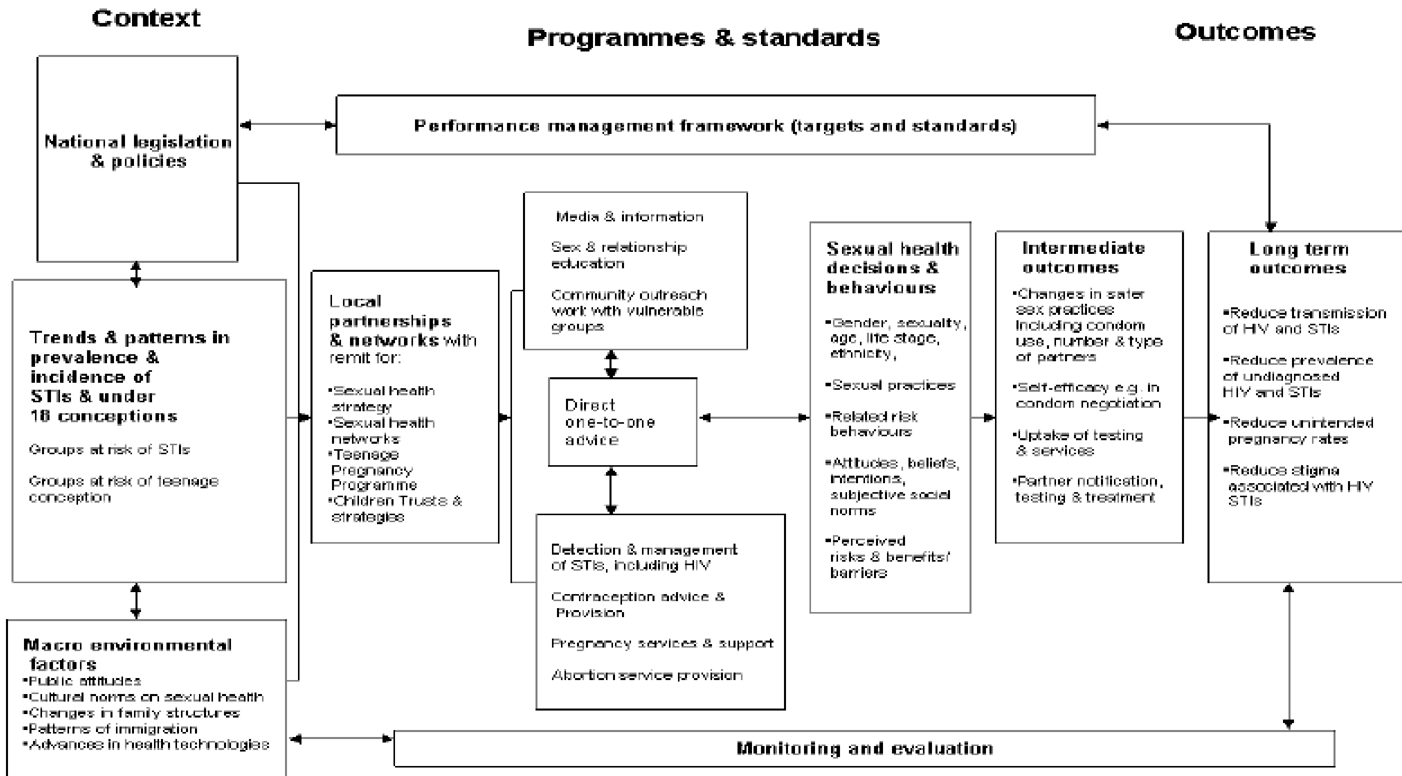
- Interventions based on individualised risk assessment and counselling, peer education, optional HIV testing, and referrals to needed healthcare services, for gay and bisexual male adolescents.
- Use of condoms only 20% of the time by MSM – ie only when condom use is high are condoms cost-saving in this group – in that case condoms are hugely cost-saving.

Gaps in Evidence base
There are significant gaps in the UK evidence base on sexual health promotion. Much of the available evidence is based on international research and may not be directly transferable to the UK. A significant gap, (given the level of cultural diversity in) London is the evidence about effective interactions for Black and Minority Ethnic communities.

NICE Sexual Health Interventions Framework
Forthcoming guidance from the National Institute of Health and Clinical Excellence (NICE) guidance will go some way towards filling gaps in the evidence base. NICE have also set out a useful Interventions framework: (currently seeking permission to use:).

National Institute for Health and Clinical Excellence

Figure 1 **Sexual Health Interventions Framework**



STIs: synopsis March 2006 Page 6 of 24

5 High Impact Changes for Sexual Health Promotion in London

Rationale
Five high impact changes for Sexual Health Promotion are outlined below. These are relevant to regional and local stakeholders and have the potential to make a significant change to sexual health and inequalities in London. They are based on evidence of sexual health needs and evidence of effectiveness of interventions. It is recognised that the evidence base is not complete and where there are significant gaps in evidence this is highlighted.

The 5 high impact changes are immediate priorities for London, and have emerged from significant debate about competing needs. It is recognised that in order to focus, some potential priorities have not been included.

In addition, there are cross-cutting themes that relate to London that will need to shape the actions, including:

- Diversity issues in London
- The inequalities issues of vulnerable communities in London.
- The transient and mobile nature of Londoners
- London as a world city and in particular with its wealth of night-time economy

1. Provide Strong London Strategic and Local Leadership and Partnerships on Sexual Health

Rationale/evidence:

- To increase awareness and action on sexual health promotion.
- To provide better joined up working at regional level – SHA/GLA/GOL
- To promote a unified, evidence-based co-ordinated approach across London, which allows for appropriate local interventions to target specific communities at risk.

Key actions:

1.1 A London Sexual Health Champion should be appointed by the GLA, GOL, SHA, ALG and partners to provide strategic leadership on sexual health. This will involve raising the profile and awareness of sexual health challenges in London. Other roles include co-ordinating a high level Sexual Health Summit and Board to meet on an annual basis to account for delivery of the London Sexual Health Promotion Strategy, the London Sexual Health Framework, Choosing Health Sexual Health, Teenage Pregnancy Strategy and other targets.

1.2 Local Authorities, PCTs, Trusts, Children's Trusts, Schools, Colleges should ensure there is a local "Sexual Health Champion" at a senior executive level to provide key leadership to improving sexual health. This will include new or current local Sexual Health Strategic Partnerships.These will be asked to develop action plans to take forward the London work. These partnerships should work with the Children and Young People's strategic partnership and Teenage Pregnancy Partnership Boards. They should ensure that there is an annual statement on the Sexual Health of the local population and key actions to improve this in the annual public health report from the PCT.

1.3 Local Strategic Partnerships should align local priorities and integrate sexual health promotion with mainstream planning. this will involve supporting commissioning that involves community in actively addressing the wider determinants of good sexual health such as self esteem and access to young-people friendly services. This should include integrating sexual health promotion work and LSPs should carry out an audit of appropriate settings for this work by March 2008.

1.4 Local Strategic Partnerships (LSP) should include Sexual Health Promotion and Sexual Health targets within Local Area Agreements (LAA) and consider this during the review and refresh process (e.g. reduction in teenage conceptions, access to 48 hr GUM, roll out of Chlamydia screening and 70% access to termination of pregnancy within 10 week gestation). Examples of best practice in getting Sexual Health targets included in LAAs will be shared across London.

2. Improve Commissioning of Sexual Health Promotion services that is based on evidence of effectiveness and supports effective delivery of public service agreements and targets

Rationale/evidence:

- Better commissioning and use of contestability will enable people to remain well and better deliver sexual health service targets.
- To strengthen use of current evidence base in informing commissioning and service delivery. This should include proper evaluation of local prevention projects to contribute to evidence base
- To refocus work on communities at greatest risk
- To integrate health promotion work across community and clinical settings
- Better partnership working with PCTs and CVS; better understanding and value of CVS

Key actions

2.1 A Pan-London Sexual Health Promotion/HIV prevention consortium should be explored with PCTs and be formed across statutory partners by April 2007. This will add value and reduce duplication in commissioning for those services that can be contracted across London e.g. condoms, Pan-London HIV prevention programmes. This consortium will be accountable to PCTs via the proposed London Commissioning Board.

2.2 London commissioners should aim to ensure that there is a reduction in the rate of growth of STIs and undiagnosed HIV **by 10% over 3 years (HPA (2005) data shows increases in London by X%** This will use prevalence of gonorrhoea, Chlamydia and HIV (transmitted in the UK?) as proxy indicators for performance measures in the London Sexual Health Performance balanced scorecard.

2.3 London partners should commission evidence based Sexual Health promotion services to inform, educate, advise and train skills for good sexual health in individuals and targeted communities, specifically BME/African Caribbean communities as well as and early access to appropriate testing and screening of STIs.

2.4 A Sexual Health promotion Commissioning Template for PCTs should be developed to support commissioning in 07-8. This will identify good practice in commissioning of Sexual Health Promotion including an appropriate set of Sexual Health Promotion performance measures. Monitoring will be co-ordinated at PCT- and London-levels as needed.

2.5 London should implement current best practice in commissioning with a "compact" with voluntary sector partners for 07-8 contracts.

3. Target priority groups for sexual health promotion appropriately and effectively:

3.1 Children & Young People

Rationale/evidence

- To create the right environment for Sex and Relationship Education (SRE) as a core part of the curriculum provided for all children.
- Provision of good quality SRE from foundation stage –a progressive programme within Personal, Health and Social Education (PHSE) as an integral and valued part of the curriculum.
- Young people from BME groups are more likely to experience teenage pregnancy; Repeat abortion/teenage pregnancy is a feature of teenage pregnancy rates –suggesting prevention messages are not getting through.

Key Actions

3.1. 1 Work with key partners to ensure that London schools achieve healthy schools status in line with national targets and work towards enhancing SRE within the PHSE theme. This should include supporting training for professionals and work with partners such as the NBC Sex Education Forum and the forthcoming 'Subject Association for PHSE', which will provide a national framework. This work will also target marginalised/looked after children and young people who may also access services in non-school settings, Connexions and Youth services.

3.1.2 Engage the private sector e.g. partners such as London First (business group for London) to integrate Sexual Health with their work in colleges, universities, entertainment, media and retail settings e.g. Responsible Drinking charter for bars in universities/colleges. There is a need to link with the Drug Action team work on substance misuse/sexual health.

3.1.3 The GLA should lead on using its networks to promote active involvement of Young people in sexual health promotion by March 2008. Young People's groups/focus groups (such as London Youth Parliament, and others) will be asked to advise on appropriate and the most effective ways to engage young people. This will include best ways to promote peer education, use of internet and websites to signpost information and services and how to get "Sexual Health role models".

3.2 Black and Minority Ethnic Communities

Rationale/evidence

- Target work to support the needs of BME communities, particularly African and Caribbean communities with regard to HIV
- Work with communities of faith, not just faith leaders (NB Faith is an issue for more than BME communities).
- This is an under-developed area of work
- There is a need to link to the Teenage pregnancy toolkit and deep-dive work across 8 boroughs in London.

Key actions:

3.2.1 Commissioning Pan-London Sexual Health Promotion/HIV prevention targeting African and African Caribbean communities should be a priority for 07-8. The HIV prevention sub-group of the HIV consortium will carry out this work on behalf of London PCTs for April 2007.

3.2.2 To increase evidence base in some areas- resources will need to be identified and agreed. Evidence from current PCT projects will inform potential London pilots or roll out as appropriate. In particular, there is limited evidence of effective sexual health promotion in some areas e.g. African Caribbean communities but learning will be collated from best practice.

3.2.3 Roll out learning from the forthcoming London Teenage Pregnancy BME Toolkit (due 2007). As part of developing evidence base this will focus on identifying effective interventions in working with BME communities on teenage pregnancy.

3.3.Gay Men/MSM:

Rationale/evidence

- Continue targeted work with Gay & Bisexual/MSM who are at greater risk of HIV infection/sexual ill health.
- Sexual health promotion with HIV prevention integrated
- Greater utilisation of community testing as a health promotion tool
- Engage HIV positive men in health promotion

Key actions

3.3.1 Pan-London Sexual Health Promotion/HIV prevention services for Gay Men/MSM will be tendered for April 2007 by the HIV prevention sub-group of the HIV consortium on behalf of London PCTs. This should complement appropriate local action plans.

3.4 Sex workers

- To be completed and to note specific work is needed with asylum seekers/refugees some of which are HIV positive? Need to link with London implementation of the government's "Paying the Price"strategy.

3.5 Offenders in London prisons

- Sexual Health release pack should be developed, piloted and available for 07-8.
- To be completed.

4. Promote safer sex through improved access to condoms and contraception

Rationale/evidence

- To expand London-wide programme of free/low cost condoms
- Contraception services are cost effective and cost saving
- To develop shared or model protocols/guidelines for condom distribution/outreach etc.
- To improve access to contraception - especially for teenagers and improved access to emergency contraception
- Young people are highly mobile - important to have pan-London young people friendly branding.

Key Actions:

4.1 Pan- London procurement of condoms will add much value by reducing costs of condoms. This will be in place for 07-8 led by a PCT on behalf of London with targeted local distribution systems and appropriate messages for TP/STI/HIV prevention. It will include Implementing "pay for condom provision at cost" for key groups by April 2007.

4.2 A Condom Card (CCard) Scheme should be implemented across London for target groups by April 2008

4.3 PCTs will be asked to consider improving access to contraception as part of the London Contraception Plan (see reference) and for this to be prioritised for 2007-8 commissioning. This will target teenagers linking in with the London Teenage Pregnancy Strategy.

5. Develop a co-ordinated approach to targeted, evidence based communications and campaigns to promote behaviour change.

Rationale/evidence:

- Joined-up media across London (not PCT/TPU/CBO level) to reduce duplication
- Build on evidence base about communications and social marketing approaches
- Targeted, culturally sensitive messages.

Key Actions

5.1 A Sexual Health communications group (with GLA, London Assembly, GOL, NHS London, London Councils should be formed by April 2007 to scope and develop a communications strategy to steer London Sexual Health Promotion work. This will link to current media work (e.g. CHAPS, African HIV Policy Network) and will lever in public and private resources to add value to London events organised by e.g. the Mayor and partners such as Transport for London. Specific work should include London work to support national campaigns and events e.g. Sexual Health Week.

5.2 Targeted London Sexual Health media campaigns should be promoted, based on evidence of effectiveness and targeted at priority groups. This could include and add value to: Freshers' Week, Sexual Health Week, and existing Annual Events, e.g. Mayor's Annual Events and Festivals, World AIDS Day.

5.3 Media training and briefings to support local and London partners on communicating sexual health issues should be developed for 07-8.

Achieving the Changes – Next Steps

This framework has been developed at a time of significant change within the NHS and beyond. It is recognised that this has made developing the framework challenging and that there are still uncertainties about the priorities of the new Strategic Health Authority 'NHS London'.

However, there is a commitment from partners involved that the 5 High Impact Changes will be taken forward in 2007/08 and beyond.

It is intended that these priorities are evolving and to be reviewed on annual basis to inform annual action plans.

An Action Plan for 2007/08 will be developed by ----------?

Monitoring?

Supporting Resources - to edit – advice needed…

Title	Web link	Audience	Summary
Sexual Health Policy Context			
Better Prevention, better services, better sexual health: The national strategy for Sexual Health and HIV (2001)/Implementation Plan (2002) DH	www.dh.gsi.gov	Policy makers, commissioners, providers	Sets out the national strategy for Sexual Health. See Chapter 3. Better Prevention.
Choosing Health: Making Healthier Choices Easier (2004)/Delivering Choosing Health: making healthier choices easier (2005) DH	www.dh.gsi.gov.uk	Policy makers, commissioners, providers	Public Health White Paper sets out commitments to improve health and tackle health inequalities including sexual health.
Sexual Health Guidelines/Toolkits			
Effective Sexual Health Promotion: A toolkit for PCTs and others working in the field of promoting good sexual health (2003), DH.	www.dh.gsi.gov.uk	PCTs, Local Authorities, NHS and CVS Providers	Provides a 'route map' for sexual health promotion across a range of settings including tools and practical strategies.
Effective Commissioning of Sexual Health and HIV Services: A sexual health and HIV Commissioning toolkit for Primary Care Trusts and Local Authorities (2003), DH.	www.dh.gsi.gov.uk	Commissioners and others responsible for leading sexual health	Provides a summary of recommended key aims, goals and standards for PCTs and Local Authorities in relation to sexual health and HIV.
Recommended Standards for Sexual Health Services (2005) MedFASH/DH	www.medfash.org.uk	Commissioners and NHS funded Service providers	Guidance for all settings providing NHS funded sexual health services including general practice, hospital and community-based clinics, pharmacies, voluntary and independent sector organisations. See Standard 2. Promoting Sexual Health
Health Economics of Sexual Health: A Guide for Commissioning and Planning (2005) DH	www.dh.gov.uk	Commissioners and planners in NHS and local government	Sets out evidence on cost effectiveness of sexual health including health promotion and sex education.
Children & Young People			
Social Exclusion Report on Teenage Pregnancy setting out Teenage Pregnancy Strategy (1999) Social Exclusion Unit	www.dfes.gov.uk/teenagepregnancy	Local Authorities, PCTs, CVS	Sets out Government Strategy on Teenage Pregnancy including national targets.
Teenage Pregnancy Next Steps: Guidance for Local Authorities and PCTs on Effective Delivery of Local Strategies (2006) DfES	www.dfes.gov.uk	Local Authorities, PCTs, CVS	Sets out lessons learnt since the Teenage Pregnancy Strategy was launched, including findings from in-depth reviews carried out by the Teenage Pregnancy Unit.
Sex & Relationship Education	www.dfes.gsi.gov	Schools,	Provides information on

Guidance, (2000) DfES	.uk	teachers & those supporting teachers	law relating to SRE, policy, teaching and learning and curriculum content.
Personal, Social & Health Education and Citizenship at Key Stages 1&2; and 3&4 (2000) Qualification & Curriculum Authority.	www.nc.uk.net	Schools, teachers & those supporting teachers	Provides a PHSE curriculum framework. SRE is encompassed within 'developing a healthy, safer lifestyle, and developing good relationships'.
SRE in Schools (2002) Ofsted	www.ofsted.gov.uk	Schools, teachers & those supporting teachers	Provides summary of guidance and an overview of current provision of SRE in schools with recommendations.
Looking for a School Nurse (2006) Dfes/DH	www.teachernet.gov.uk	School Nurses and Managers	See Section 1. Why have a School Nurse?
School Nurse Practice Development Resource Pack (2006) DfES/DH	www.teachernet.gov.uk	School Nurses and Managers	See policy drivers and page 24 on Sexual Health
BME Groups			
HIV and AIDS in African Communities: A framework for better prevention and Care (2005) NAT/AHPN/DH	www.dh.gov.uk	NHS, Local Government, CVS providers	Framework was developed to set out standards and goals set out in the National Sexual Health Strategy concentrating on services for African Communities.
GBT/MSM			
Making it Count: a collaborative planning framework to reduce the incidence of HIV infection during sex between men (2003) Sigma/ The Field Guide: applying making it Count to health promotion activity (2003) THT	www.tht.org.uk	Planners, commissioners and service providers	Framework and practical guide to HIV prevention and health promotion with Gay and bisexual men.
Prisons			
Health Promoting Prisons: A Shared Approach (2002) HO/DH	www.dh.gov.uk	Prison Service/NHS	Strategy setting out an agenda for future developmental work with prisons.
Sex Workers			
To add			
Condoms/Contraception/Abortion			
The Economics of Sexual Health (2005) fpa	www.fpa.org.uk	Regional leaders and sexual health commissioners	Review of economic evaluations of contraception and abortion services and models for increasing access.
Guidance on long acting contraceptive methods ( ) NICE		Regional leaders and health commissioners	
Early Abortion: promoting real choice for women (2003) fpa	www.fpa.org.uk	Health Commissioners	Review and recommendations about early abortions.
RCOG guidance on abortion Services	To add		

London Resources			
London-Wide Framework for Sexual Health (2004) NWL SHA	?	PCTs, NHS commissioners and providers	Sets out
Forthcoming: London Teenage Pregnancy Strategy (2006) GOL/RPHG			
Choosing Health: A briefing on sexual health in London (2005) LHO	www.lho.org.uk	Regional leaders, service commissioners and providers	Sets out London data and evidence on sexual health and sexual health promotion.
Improving Young People's Sexual Health: tackling the sexual health crisis in London (2005) London Assembly	www.london.gov.uk	Policy makers and service development a from all organisations	Sets out findings from a scrutiny of Access to Sexual Health Services for young people focusing on education, information and advice.
Other?			

Participants of London Sexual Health Promotion Steering Group

Anne Mackie (chair)	London SHA
Sue Atkinson, Chair to August '06	Regional Public Health Group
Paul Ward	Terence Higgins Trust
Eunice Kyalo	Hammersmith and Fulham PCT
Heema Shukla	North West London Hillingdon NHS
Rachel Wells	SWLHA
Susie Daniel	Brook London
Bernard Forbes	UK Coalition
Alistair Hill	Croydon PCT
Mark Creelman	Kensington & Chelsea PCT
Bryan Teixeira	Naz Project
Anne Weyman	FPA
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Julia Groom	Public Health group
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Dorinda Thirlby	SWAGNET/Queen Mary's Hospital
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Amanda Killoran	NICE
Fraser Serle	Health First
Su Everett	RCN Sexual Health Forum
Sarah Smart	London Healthy Schools, GOL DCL
Claire Smith	Prison Health Team, NWL SHA
Amanda Cranston	Merton & Sutton PCT
Kathy Elliott	North Central London Strategic Authority
Simon Barton	BASHH
Tanya Procter	Regional Teenage Pregnancy co-ordinator
Formerly Mary Rogers- to August '06	

Item B.2

APPENDIX 2

A Review of the Literature on the Costs and Effectiveness of Sexual Health Promotion Interventions

1. Introduction

This paper reviews the literature on the costs and effectiveness of sexual health promotion interventions. It starts by setting out the national targets with regard to sexual health, provides a brief background on strategies for improving sexual health and pulls together and summarises the findings of a number of reviews of reviews which have been undertaken over the last few years with regard to the current evidence on the effectiveness and costs of sexual health promotion interventions. The paper then makes recommendations on the principles that need to be taken into account in implementing a London wide sexual health promotion strategy.

2. National Sexual Health Targets

In July 2001, the Department of Health published the first National Strategy for Sexual Health and HIV (Department of Health, 2001). This set out five main aims:

- Reduce transmission of HIV and Sexually Transmitted Infections (STIs) with a national goal of a 25% reduction in newly acquired HIV and gonorrhoea infections by 2007,
- Reduce prevalence of undiagnosed HIV and STIs,
- Reduce unintended pregnancy rates,
- Improve health and social care for people with HIV,
- Reduce stigma associated with HIV and STIs.

Sexual behaviour is a major factor determining the incidence of STIs, HIV and unintended pregnancy rates. The second National Survey of Sexual Attitudes and Lifestyles shows that there have been notable changes in sexual behaviours since the first survey in 1990. These include a greater number of lifetime partners, lower median age at first intercourse, a greater proportion of the sample with concurrent partnerships and a greater proportion with two or more partners in the past year who did not use condoms consistently. However, there has also been an increase in the proportion who use condoms at first intercourse. (HIV Prevention: A Review of Reviews, Health Development Agency, 2003, page 1).

3. Strategies for reducing exposure

There are a number of strategies for reducing exposure to STIs, HIV and for reducing the unintended pregnancy rate. These are briefly set out in the Health Development Agency Reviews and include increased condom use, reduction in partners, abstinence, and screening and treatment. Sexual behaviour is therefore a key factor in reducing exposure. Sexual behaviour may be influenced by a number of personal and structural determinants of risk including:

- low self esteem,
- lack of skill in using condoms,
- lack of skills to negotiate safer sex eg to say no to sex without condoms,
- lack of knowledge about the risks of different sexual behaviours,
- availability of resources such as condoms or sexual health services,

- the opinions of peers and social pressures,
- attitudes (and prejudices) of society, which may affect access to services.

Interventions ultimately aim to influence sexual behaviour (and hence incidence) by addressing these determinants. They can be delivered at different levels:

- Individual eg partner notification, risk counselling,
- Group eg group work, school sex education,
- Community eg community development campaigns,
- Socio political eg legislation, resource allocation, professional development.

For most individual and populations there will be multiple determinants of risk. Some interventions are delivered across several levels and aim to address a range of these determinants simultaneously.

4. Summary Of Findings

This paper focuses on pulling together the findings of a number of reviews of reviews which have been undertaken recently. Reviews of reviews have the benefit of bringing together the evidence from different reviews of effectiveness to highlight the available evidence and any gaps or discrepancies. Appendices 1 to 9 provide a summary of the reviews that have been analysed for this paper and set out the recommendations arising from each review. These findings suggest that successful health promotion interventions should incorporate the elements set out below.

Types of Interventions which are effective

The reviews suggest that the types of intervention set out below are likely to be most effective.

- **Small group discussion sessions** in which a variety of media are used eg video, slides, posters etc are effective. These sessions are delivered to small groups of individuals usually from the same peer group and are facilitated in some way.

- Some types of **partner notification** are effective in newly detecting infections. Provider referral (the use of third parties – usually health service personnel to notify partners) is more effective than patient referral. Patient referral can be enhanced by the provision of contact slips providing additional information for the index patient and their partners.

- **Individual risk counselling** can be effective. This usually takes place in clinics and aims to improve knowledge and awareness of sexual risks as well as identifying triggers and associated risk reduction strategies.

- **School based sex education** can be effective and is possibly more effective if begun before the onset of sexual activity. This may encompass a diversity of methods (eg videos, didactic lessons, role play) and content (eg focus on HIV or pregnancy) delivered by a variety of providers (eg peers, teachers, nurses).

Features of effective interventions

The reviews suggest that successful interventions are likely to have the features set out below.

- **Successful interventions are likely to be multi faceted and include a number of different components such as skills development, motivation building and attitude change as well as the provision of factual information.** Personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences and practical skills, all play an important part in the ability to change behaviour.

- **Basic accurate, factual information should be provided about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.** Basic accurate information is particularly important in the area of sexual health because of reticence in discussing sexual behaviour and the misconceptions that prevail about the transmission of STIs. Good knowledge of sexual risks is a key health promotion aim for STI programmes.

- **Interventions should incorporate theoretical models of behavioural change, or components of these models.** Wong (1995) suggests that underlying all behavioural change models are two fundamental theories:
  a) for behaviour to change individuals must recognise the problem, be motivated to act and have the knowledge and skills to perform the action and
  b) to increase the likelihood of action, barriers in the social environment must be removed or overcome and support or reinforcement provided wherever possible. A number of behaviour change models have been empirically tested and have shown positive results with respect to their application for sexual health promotion interventions (McKay, 2000). These are described in more detail in the HDA HIV review (2003, pp 87 to 90).

- **Interventions should incorporate specific behavioural skills training eg how to use condoms.** It is unlikely that sexual health interventions will have the desired impact on sexual behaviour without also addressing skills such as safer sex negotiation and condom use. Behavioural skills training is particularly important because of its effect on self efficacy – peoples' beliefs about their ability to carry out a chosen health behaviour and how much effort they will need to invest in the face of difficulties and resistance (Wong 1995). Interventions therefore need to build the individuals' sense of competency and teach them the required skills, for instance using role play to practice safer sex (eg condom use or refusal).

- **Interventions should be appropriate to the target population in terms of age, gender, sexual experience and culture.** This requires the appropriate use of needs assessment about the particular determinants of risk for the target population ie their knowledge, beliefs, skills, attitudes, peer norms etc. For example the issues relating to young women and condom use require a different approach from those relating to young men.

- **Peer educators or community opinion leaders are more likely to be effective.** In particular some adolescents may be more comfortable receiving information from peers rather than adults, and peers may also have added credibility because of their perceived recent experience of the issues under discussion. The evidence however is tentative as some reviews have suggested that the competence of the provider to facilitate learning in groups is the important factor. Comfort with the subject matter may also be important.

- **Interventions should be of an appropriate duration.** Multiple intervention sessions should be used to provide reinforcement as it takes time to change long established sexual risk taking behaviour.

- **Initiatives should emphasise risk reduction (eg promoting condom use or reduction in number of partners) rather than promotion of abstinence only.** Telling people not to have sex is unlikely to be an effective intervention.

- **Initiatives should provide access to a full range of contraceptive methods, including longer acting methods (such as the IUD, IUS and implants).**

All reviews note that the full range of interventions is not represented in the literature. A gap in the evidence therefore cannot necessarily be taken to imply ineffectiveness. Instead it means that there is insufficient or no review level evidence either to support or discount the effectiveness of an intervention.

Cost Effectiveness

The National Strategy for Sexual Health and HIV (Department of Health, 2003, page 11) notes that poor sexual health costs the country a lot of money and that improving sexual health has significant potential for the better use of finite resources. The Strategy states that economic costs go far beyond the costs of diagnosing and treating the infections themselves. Left untreated STIs can have long term effects on health for example, chlamydia can result in pelvic inflammatory disease, which can lead to ectopic pregnancy and infertility. Other consequences of poor sexual health identified in the Strategy (Department of Health 2003 p.7) include:

- HIV
- Cervical and other genital cancers
- Hepatitis, chronic liver disease and liver cancer
- Recurrent genital herpes
- Bacterial vaginosis and premature delivery
- Unintended pregnancies and abortions
- Psychological consequences of sexual coercion and abuse
- Poor educational, social and economic opportunities for teenage mothers.

The National Strategy for Sexual Health notes that the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. Cost modelling by the University of Newcastle shows that the cost of contraceptive services could be reduced by over £500m over the next 15 years if services better reflected the preferences of women by decreasing prescription of the combined pill with a parallel increase in the prescriptions of a number of other methods particularly implants and the IUS (FPA, 2005, p.10).

The National Strategy for Sexual Health states that the average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000 and the monetary value of preventing a single onward transmission is estimated to be somewhere between £0.5 million and £1 million in terms of individual health benefits and treatment costs (Department of Health, 2003, p 11).

McKay (2000) indicates that the high costs associated with outcomes such as HIV infection point to the high probability that appropriately targeted interventions

addressing these outcomes are not only likely to be cost effective but are also likely to be cost saving. Pinkerton et al (1998) conclude that most HIV/STI sexual risk reduction strategies are cost effective and many are cost saving. They also consider the greater societal savings from preventing STIs in adolescents compared with adults: the reductions in life expectancy for the reproductive health consequences for women (eg PID, ectopic pregnancy) and more opportunity for ongoing transmission. The HDA (2004) concluded that there is tentative review level evidence to conclude that STI prevention interventions are cost effective, and can be cost saving.

One 1999 paper (King Spooner) argues that HIV prevention programmes are more cost effective if targeted at HIV positive people. "Preventive interventions with positive individuals are likely to have a greater impact on the epidemic, for an equivalent input of cost, time, resources, than preventative interventions focused on negative individuals. A change in the risky behaviour of an HIV positive person will, on average, and in almost all affected populations, have a much bigger impact on the spread of the virus than an equivalent change in the behaviour of an HIV negative person." (Quoted in Cairns G 2005 page 3).

A rapid economic review of one to one interventions to reduce the transmission of STIs and reduce the rate of under 18 conceptions (still in draft form) has been undertaken by NERA on behalf of the National Institute for Health and Clinical Effectiveness (2006). The report's authors conclude that a range of studies suggest that the cost effectiveness of certain interventions may be clearly established. Economic modelling shows that the provision of emergency contraception is cost saving. Education counselling in one to one sessions with visual aids and the provision of contraception for under 18 year olds can be cost saving in terms of pregnancies avoided and can lead to a higher use of contraception. With regard to partner notification the cost per infection averted in index patients is relatively low particularly for syphilis and gonorrhoea, however, effectiveness is less for HIV patients. A summary of the findings of this review are set out in Appendix 7.

A summary of the literature on the health economics of sexual health produced by the Department of Health (2005) looks at the cost effectiveness of different sexual health interventions. Cost effectiveness is defined as the ratio between the cost incurred and the benefit produced. Quality Adjusted Life Years have been used as the cost effectiveness measure where available as they take into account quality as well as duration of life gained. This measure enables the comparison of interventions which improve quality of life with those that extend life. In this paper interventions are classified into four categories which are set out below. These categories represent the synthesis of a literature search and the output of a consensus meeting which was held on 12th April 2005 involving key researchers and workers in this area, including GUM clinicians and PCT commissioning and public health staff. It should be noted that the report does not provide any further detail about how the various conclusions have been reached.
The symbol ☺ indicates consensus statements from the meeting, whilst the numbers in brackets relate to the literature references. The references are provided in Appendix 5.

Cost-saving Interventions – Interventions which save money to health care funders at the same time as producing health benefits such as reduced mortality or improved quality of life.

- Free condom provision for medium and high risk groups (mainly men who have sex with men (MSM) and sex workers) ☺ (1,2,3,4,5,6,7,8,9).
- Condom subsidy or tax reduction schemes (6,10,11).

- Outreach health promotion and safe sex programmes for high risk groups (mainly MSM and sex workers) and hard to reach groups ☺ (3,12,13,14,15).
- Provision of AIDS risk reduction messages in gay bars (12).
- Safer sex skills training session/cognitive behavioural intervention for MSM (3,5,16,17,18,19).
- Peer-leader interventions for MSM ☺ (3,5,17,20).
- High quality integrated Sex and Relationships Education (SRE) ☺ (12) - includes especially *Safer Choices* School Programme evaluation (a 2-year multi component education programme in US high school students) (21).
- Needle exchange provision to prevent HIV in injecting drug users ☺ (22,23,24).

Above averagely cost-effective Interventions compared with current NHS expenditure - Less than £100 per Quality Adjusted Life Year (QALY).

- Behavioural HIV risk reduction sessions for high risk women (17,19,25)
- Partner notification ☺ (14)

Averagely cost-effective Interventions compared with current NHS expenditure (most NHS interventions are in this category) - £100 to £10,000 per Quality Adjusted Life Year

- 1-day cognitive-behavioural HIV risk reduction intervention in male adolescents (26).
- Intervention based on individualised risk assessment and counselling, peer education, optional HIV testing, and referrals to needed healthcare services, for gay and bisexual male adolescents (27).
- Use of condoms only 20% of the time by MSM – the message here is that only when condom use is high are condoms cost-saving in this group – in that case condoms are hugely cost-saving (6).

At upper end of cost-effectiveness, but within current NHS range of expenditure – £10,000 to £30,000 per Quality Adjusted Life Year

No interventions were included in this category.

From this exercise the reviewers concluded that there is evidence and consensus that investment in sexual health interventions is good value for money and in many cases cost saving. They concluded that 'A Primary Care Trust or other commissioning organisation is actually allocating resources inefficiently if it does not invest (or indeed disinvests) in sufficient of these services to cover the relevant population adequately' (Department of Health, 2005 p. 8).

Summary and Recommendations

This paper provides a summary of the literature with regard to best practice and cost effectiveness of sexual health promotion. It sets out in summary form:

- The types of interventions which have proved to be successful in the literature
- The features of successful interventions and
- A summary of the literature on the cost effectiveness of specific interventions.

It is recommended that the findings as set out in the literature are used as the basis for the provision of a cost effective sexual health promotion strategy within London.

Amanda Cranston
Public Health Directorate, Sutton and Merton PCT
31st May 2006 (Updated 24th August 2006)

APPENDIX 1

Teenage pregnancy and parenthood: a review of reviews, February 2003, Health Development Agency

This document is a review of reviews and focussed on interventions to prevent teenage pregnancy and improve outcomes for teenage parents.

Interventions which can be effective in preventing teenage pregnancies

- School based sex education particularly when linked to contraceptive services can delay sexual activity and reduce pregancy rates.
- Community based (eg family or youth centres) education, development and contraceptive services can be effective in reducing pregnancy rates,
- Youth development programmes which develop young peoples education, vocational skills, interpersonal skills and confidence may increase contraceptive use and reduce pregnancy rates,
- Family outreach: including teenagers' parents in information and prevention programmes can be effective.

Features of effective interventions and programmes

- Based on theory with clear behavioural goals and outcomes,
- Focussed on improving contraceptive use and at least one other behaviour likely to prevent pregnancy and/or STI transmission,
- Provide long term services and or interventions,
- Are tailored to meet the needs of recipients with age group and family background taken into account,
- Are targeted towards local high risk groups,
- Provide clear and unambiguous information and messages,
- Use participatory and inclusive teaching methods,
- Provide interventions and services which are accessible in terms of opening hours, location and level of information provided to young people,
- Use staff who have been trained and are committed to the programme and to working with young people and who will respect young peoples' confidentiality,
- Provide information and education before young people become sexually active,
- Focus on both young women and young men,
- Encourage a local culture in which discussion of sex, sexuality and contraception is permitted,
- Include interpersonal skills development – such as negotiating and refusal skills - and allow young people to practice these skills,
- Utilise key opportunities – eg if an adolescent uses a clinic service and receives a negative pregnancy test - for education and information,
- Work with teenage 'opinion leaders' and peer group influences,
- Ensure that interventions are age appropriate,

- Join up services and interventions aimed at preventing pregnancy with other services for young people and work in partnership with local communities.

Cost Effectiveness

Good evidence was found by the reviewers to indicate that effective contraceptive services are highly cost effective in preventing teenage pregnancy. However, information on the cost effectiveness of other types of intervention was not identified.

Appendix 2

HIV Prevention: A review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission, March 2003, Health Development Agency

This is a review of reviews which focussed on the priority populations for the sexual transmission of HIV in the UK, namely men who have sex with men (MSM), African communities, commercial sex workers and people with HIV. It also covers HIV voluntary counselling and testing with all populations. It does not include clinic based interventions other than voluntary counselling and testing.

1. Men who have sex with men

1.1 Interventions which can be effective in preventing the sexual transmission of HIV in MSM

- There is evidence that community level interventions involving peers and opinion leaders can be effective in influencing sexual risk behaviours in MSM.
- There is evidence that cognitive behavioural group work, focusing on risk reduction, sexual negotiation, communication skills training and rehearsal (eg through role play) can be effective in influencing sexual risk behaviours.

1.2 Features of effective interventions and programmes for MSM

- Interventions should be placed within the broader context of men's lives, addressing the range of factors which influence risk at both the personal level (eg knowledge and skills) and the structural level (eg discrimination towards gay men and gay community norms towards condoms)
- Interventions should be tailored and targeted to specific sub populations of men who have sex with men, for instance black gay men and working class gay men
- Interventions should be multi component (using small group work), focussing on risk reduction, sexual negotiation and communication skills training and rehearsal (eg through role play or identifying 'triggers')
- Interventions delivered at the community level (particularly peer led) can be effective in influencing the sexual risk behaviours for commercial sex workers.

2. Commercial Sex Workers (CSW)

There is tentative review level evidence to conclude that interventions delivered at the community level (particularly peer led) can be effective in influencing the sexual risk behaviours for CSWs, however, the reviewers were of the opinion that it is not possible to transfer these findings to the UKs CSW population.

3. African Communities in the UK

There is sufficient review level evidence to conclude that small group interventions delivered at the community level can be effective in influencing the sexual risk behaviours of black and minority ethnic women, however, the reviewers considered that it was not possible to transfer these findings to the UKs African population.

4. People with HIV

There is no review level evidence to either support or discount the effectiveness of any interventions with people with HIV. (See Note 1 below).

5. HIV Voluntary Counselling and Testing

For all target level populations other than MSM and CSWs the review level evidence shows that a positive diagnosis can influence risk behaviour in some individuals. The recommendation of the reviewers is that VCT should be targeted only at high risk individuals who are likely to test sero positive.

6. Cost Effectiveness

None of the review papers in this review had any details about cost effectiveness for any of the UKs priority populations. The reviewers were therefore unable to form any conclusions about the cost effectiveness of any HIV preventions with these populations.

Note 1

Since the publication of the HDA review a meta analysis has been undertaken by Crepaz et al (2006) which demonstrates that heath promotion interventions targeting People Living With HIV (PLWH) are effective in reducing unprotected sex (odds ratio (OR), 0.57; 95% confidence interval (CI) 0.40–0.82) and decreased the acquisition of sexually transmitted diseases (OR, 0.20; 95% CI, 0.05–0.73). Interventions with the following characteristics significantly reduced sexual risk behaviours:

- based on behavioural theory;
- designed to change specifically HIV transmission risk behaviours;
- delivered by health-care providers or counsellors;
- delivered to individuals;
- delivered in an intensive manner;
- delivered in settings where PLWH receive routine services or medical care;
- provided skills building, or
- addressed issues related to mental health, medication adherence, and HIV risk behaviour.

Appendix 3

Prevention of Sexually Transmitted Infections (STI's): a Review of Reviews into the Effectiveness of Non Clinical Interventions, January 2004, Health Development Agency

This document is a review of reviews and focusses on interventions to reduce STIs. It covers partner notification and health promotion/educational interventions.

Summary of Findings

Types of Interventions which can be effective:

The reviewers concluded that there is **sufficient** evidence to state that the interventions set out below can be effective;

- Small group work. These discussion sessions are delivered to small groups of individuals usually from the same peer group and are facilitated in some way.
- Some types of partner notification can be effective in newly detecting some STIs. This is the process whereby the partners of patients diagnosed with an STI are informed of their potential exposure to infection and thus the need to visit a health service for curative and preventative treatment. There are three types of partner notification: a) Provider referral uses third parties - usually health service personnel to notify partners. b) Patient referral is where health service personnel encourage index patients to notify their partners). c) Contract referral (or conditional referral) refers to health service personnel encouraging index patients to notify their partners, with the understanding that health service personnel will notify those partners who do not visit the health service by an agreed date.
- Provider referral is more effective than patient referral.
- Patient referral can be improved by simple forms of patient assistance such as a reminder telephone call.

The reviewers concluded that there is **tentative** review level evidence that the interventions set out below are effective.

- Individual risk counselling by professionals may be effective. This usually takes place in clinics and aims to improve knowledge and awareness of sexual risks as well as identifying triggers and associated risk reduction strategies.
- School based sex education can be effective and is possibly more effective if begun before the onset of sexual activity. School based sex education may encompass a diversity of methods (eg videos, didactic lessons, role play) and content (eg focus on HIV, pregnancy, abstinence,) delivered by a variety of providers (eg peers, teachers, nurses). Some school programmes go beyond education and have links to clinics or provide condoms. However, there is insufficient evidence to support or discount the effectiveness of school based interventions linked to clinical services and or the provision of condoms in schools.
- Partner notification by patient referral can be improved by patient education and counselling.

Features of effective interventions

The reviewers concluded that there is **sufficient** review level evidence to conclude that interventions are more likely to be effective if they include the features set out below.

- Basic accurate information should be provided through clear unambiguous messages.
- Interventions should incorporate appropriate behavioural skills (particularly safer sex negotiation skills).
- Interventions based upon theoretical models of behaviour are more likely to be effective.
- Interventions should be appropriately targeted and tailored, making use of needs assessment or formative research.
- Multi component interventions which address a range of personal and structural determinants of risk are more likely to be effective than single component interventions.

The reviewers concluded that there is **tentative** review level evidence to conclude that interventions are more likely to be effective if they include the features set out below.

- Peer educators or community opinion leaders should be used.
- Interventions should emphasise risk reduction (eg promoting condom use or reduction in number of partners) rather than promotion of abstinence only.

Cost effectiveness of interventions

The reviewers found that partner notification is cost effective and that patient referral is more cost effective than contract or provider referral.

With regard to the cost effectiveness of other interventions the reviewers looked at the evidence in a number of the reviews. For example McKay (2000) cites two studies of behaviourally effective interventions that have also been shown to be cost effective by other reviews; one focussed on HIV prevention, the other addressing HIV/STIs and pregnancy prevention. McKay indicates that the high cost associated with outcomes such as HIV infection point to the high probability that appropriately targeted interventions addressing these outcomes are not only likely to be cost effective but are also likely to be cost saving.

Pinkerton et al (1998) has estimated the net cost of preventing one HIV infection as $195,000 (at 1998 US costs). Costs associated with treating other STIs are estimated: $100 for gonorrhoea: $650 for syphilis; pelvic inflammatory disease $200 for outpatient, $10,000 for hospitalisation, $9,000 for ectopic pregnancy and $925 for infertility. Pinkerton at al also concluded that most HIV/STI sexual risk reduction interventions are cost effective and many are cost saving.

In considering that different adolescents are at varying degrees of risk from HIV/STI transmission Pinkerton et al conclude that "targeted' interventions that address the sexual risk behaviours of high risk young people are likely to be highly cost effective,

provided that they are well designed and include cognitive behavioural components found to be effective at inducing sexual risk reduction behaviour changes.' Pinkerton et al conclude that interventions should be targeted at 'high risk youth' to maximise cost effectiveness. High risk groups can be identified as runaways, homeless, drop outs, youths in detention, those having a history of sexual abuse, increased use of drugs and alcohol and exchanging sex for money food and shelter.

In contrast, school based programmes are likely to be relatively less cost effective because of the low average risk among adolescent populations attending school.

Dehne and Snow (1999) also found that interventions focussing on high risk populations tend to be more cost effective than those among low risk populations even if additional costs for outreach and extra effort to motivate staff are taken into account.

In the light of the above evidence the reviewers concluded that there is tentative review level evidence to conclude that STI prevention interventions are cost effective, and can be cost saving.

APPENDIX 4

Shepherd J, Weston R, Peersman G, Napuli IZ. Interventions for encouraging sexual lifestyles and behaviours intended to prevent cervical cancer. The Cochrane Database of Systematic Reviews 1999

The objective of this review was to determine the effectiveness of health education interventions to promote sexual risk reduction behaviours amongst women in order to reduce transmission of Human Papilloma Virus (HPV) one of the major risk factors for cervical cancer. These include interventions to promote the use of condoms for sexual intercourse (especially early intercourse amongst young women), sexual partner reduction and negotiated safer sex strategies.

Effective Interventions

- Health education interventions in which factual information on transmission and prevention is presented alongside skill development and motivation building can achieve short term increases in reported condom use for intercourse.
- Successful interventions are based upon socio- psychological models of behaviour.
- Successful interventions paid attention to gender issues in the negotiation of safer sex. The researchers concluded that interventions need to be sensitive to local culture and context in order to enable women to identify with the health education messages. Furthermore, interventions which acknowledge and address power imbalances in relationships are also crucial especially where assertiveness skills are taught. Some of the interventions reviewed in this study took into account specific cultural and gender factors which have an impact upon womens' abilities to engage in risk reduction behaviour.
- Successful interventions employed peer educators and used multiple intervention sessions.
- Evidence suggests that small group discussion sessions led by peer educators in which a variety of media are used eg video, slides posters etc can be effective.
- Women should be informed about the fact that sexual risk reduction protects against a variety of diseases/conditions including gonorrhoea, chlamydia, infertility, pelvic inflammatory disease and ultimately cervical carcinoma. All of

the studies reviewed in this report promoted sexual risk reduction in the context of STIs (most notably HIV) and made no mention of cervical cancer. The reviewers considered that it is possible that the inclusion of cervical cancer may provide a greater incentive for behaviour change and may also avoid the promotion of mixed messages.

- Interventions should be ongoing or at least sustained over longer periods of time in order to support women to sustain sexual risk reduction and to provide reinforcement, a tenet of Banduras' Social Learning Theory (Bandura 1990). Furthermore, over time women may change sexual partners and sexual behaviour is strongly influenced by partner type eg regular and casual partners). Thus long term interventions are needed to support women to negotiate sexual risk reduction through periods of partner change.

APPENDIX 5

Draft Contraceptive advice and provision for the prevention of under 18 conceptions and STIs : A rapid review, Centre for Research in Primary and Community Care, University of Hertfordshire on behalf of the National Institute for Health and Clinical Excellence.

Scope of Review

The rapid review considered interventions which provided:

- Information provision,
- Advice,
- Condom provision,
- Counselling,
- Cognitive behavioural therapy and
- Activities that increase self confidence, self esteem, and skills development.

The effectiveness of one-to-one interventions for the prevention of under 18 conceptions

Pregnancy - There was insufficient evidence to say whether one-to-one interventions with people under the age of 18 can prevent conceptions, although an RCT of health services support for adolescent mothers found the service helped reduce repeat pregnancies among this group.

Contraceptive Use - There is weak evidence that one-to-one interventions can improve contraception use among adolescents. There is evidence from two good quality studies that adolescents were more likely to use emergency contraception if given an advance supply. Provision of advanced emergency contraception did not appear to lead to an increase in unprotected sex.

Condom use - Of 10 RCTs only two found a significant increase in condom use in the intervention group compared to a control.

Duration of intervention – There is weak evidence that multi session one to one interventions for teenage mothers may increase effective contraception use and prevent repeat pregnancies.

The majority of the evidence was US-based and therefore its applicability in a UK context is difficult to determine.

The effectiveness of one-to-one interventions for the reduction of STIs (including HIV)

Reduction in STIs - Fifteen studies evaluated the effect of one-to-one interventions on the spread of STIs. However, many of these were small and underpowered, and the evidence was mixed. One large, good quality RCT showed that 2 and 4 sessions of counselling in a clinic setting can reduce the risk of STIs. A large study with MSM led to a 15.7% reduction in rates of HIV infection, but this was not statistically significant.

Condom Use - Twenty-three studies measured condom use. Overall, there was weak evidence that one-to-one STI/HIV interventions can increase condom use – and the effect decreases over time.

Unprotected sex -The evidence is conflicting on whether or not such interventions reduce the likelihood of unprotected sex. However, a large good quality RCT found a 13.9% reduction in unprotected sex in MSM after a 10 session intervention.

Reduction in sexual partners/abstinence - There was weak evidence that they do not reduce the number of sexual partners or help promote abstinence. However, the studies included in the review had the main aim of promoting sexual behaviour rather than promoting abstinence.

Sexual health related knowledge - Evidence is mixed on whether one to one interventions can improve sexual health related knowledge.

Theory based interventions - There is some evidence that theory based interventions are more likely to be effective than a more didactic educational control in preventing STIs.

Sex Workers - No studies evaluated one to one interventions that were targeted specifically at sex workers. There is some evidence from a (+) study that one to one interventions can reduce the number exchanging sex for drugs or money, and from a (++) study that a two session one to one counselling intervention can reduce STIs in those who exchanged sex for drugs or money. However, further research is needed with this group.

Prisoners/probationers - Evidence for one to one interventions with prisoners is sparse. One to one counseling may increase condom use and reduce sexual risk behaviours but more research is needed.

People with HIV – There is insufficient evidence to say whether one to one counselling interventions have an effect on STIs or condom use in people living with HIV.

Draft results of a rapid review of evidence for the effectiveness of partner notification for sexually transmitted infections including HIV, Department of Social and Preventative Medicine, University of Berne, Switzerland and Centre for Sexual Health and HIV Research, Royal Free and University College Hospitals Medical School, London, UK on behalf of the National Institute for Health and Clinical Effectiveness.

There are three primary approaches to partner notification. These are:

- **Patient Referral** – where the index patient accepts full responsibility for informing partners of the possibility of exposure to a sexually transmitted infection and for referring them to the appropriate services. Patient referral can be assisted by counselling from a health professional or by using contact slips (printed material that index patients give to their sex partners advising the partner to seek medical care).
- **Provider referral** – Where the health professional takes responsibility for confidentially notifying partners of the possibility of their exposure to sexually transmitted infection.
- **Contract (conditional) referral** - Where the provider and the index patient agree that the index patient will notify the partners within a specified time period. It is further agreed that the provider will complete the notification process for partners, but only notify those partners if not reached within the agreed time period.
- **Accelerated partner therapy** – This is the treatment of partner(s) of index patients without an intervening personal assessment by a health care provider. Accelerated partner therapy can be implemented in several ways. Usually, doctors provide index patients with drugs or prescriptions intended to be delivered to the partner(s).

The authors of the review note that the evidence of the effect that different types of partner notification have on the incidence or prevalence of STIs in index patients – and in terms of the number of partners contacted, tested and treated – is mixed and overall findings are difficult to summarise. Some adverse outcomes are identified when partners are notified. Issues of acceptability and implementation include fear of stigma and violence.

The effectiveness of partner notification for gonorrhoea, Chlamydia, and non gonococcal urethritis

There is evidence from four large randomised control trials that **accelerated partner therapy** plus additional information for partners reduces persistent or recurrent infections in women and in men diagnosed with gonorrhoea or c. trachomatis by approximately 5% compared to patient referral (either minimal or supplemented by contact card).

There is evidence from one large randomised controlled trial that **patient referral** supplemented by additional information about infection for index patients and partners reduces persistent or recurrent infections in men by approximately 5% when compared to minimal patient referral.

There is evidence from one large randomised controlled trial that accelerated partner therapy plus additional information for partners does not reduce persistent or recurrent infections in men diagnosed with gonorrhoea or c. thrachomitis when compared to **enhanced patient referral** that included providing index patients and partners with additional information about the infection.

There is evidence from one randomised controlled trial that patient referral supplemented by additional education for index patients diagnosed with gonorrhoea is not more effective in terms of partners tested when compared to **patient referral with contact slips.**

There is weak evidence from two randomised controlled trials that giving index patients diagnosed with C. thrachomitis **sampling kits** for their partners can increase the number of partners who get tested when compared to getting the partners to visit their doctor for testing.

There is evidence from two randomised controlled trials that **accelerated partner therapy** increases the number of partners who get treated in patients diagnosed with Chlamydia or gonorrhoea compared to minimal patient referral and patient referral supplemented by additional information for partners.

There is evidence from one randomised controlled trial that patient referral for patients with Chlamydia conducted in general practice is at least as effective in terms of partners who get treated when compared to referring patients to a specialized health service.

Three small studies provide some indication that partner notification for patients with C. thrachomatis infection in special clinics for younger patients (eg teenage pregnancy units) is comparable to partner notification done in specialist settings if initiated by a health advisor.

Two small studies indicate that **specialised health professionals other than physicians** situated in specialised settings might be more effective in eliciting partners of patients diagnosed with gonorrhoea or Chlamydia when compared to non specialized health professionals.

Two small retrospective chart reviews and one observational study suggest that partner notification in men who have sex with men diagnosed with gonorrhoea might be less effective than **partner notification in heterosexual men.**

The effectiveness of partner notification for syphilis

There is weak evidence from one large randomised controlled trial that contract referral for patients with syphilis is at least as effective as provider referral where the provider tries to notify the partners in person.

One large observational study indicates that partner notification is comparable in patients diagnosed with syphilis under and over 19 years with respect to partners tested and partners testing positive.

One large observational study indicates that provider referral for men who have sex with men diagnosed with syphilis in the USA results on average in 0.5 treated partners per index patient.

Stratified analysis from one large randomised trial indicate that partner notification for syphilis in African – Americans is at least as effective as in white patients in regard to numbers of partners contacted and numbers of partners treated.

Stratified analysis from one large randomised trial indicates that partner notification in prisoners is less effective when compared to patients in sexually transmitted disease clinics in regard to numbers of partners treated.

The effectiveness of partner notification for HIV

There is insufficient evidence to say whether provider referral is superior to patient referral in patients with HIV.

One large prospective study suggests that results for contract or provider referral for HIV are not different in patients under or over 25 years of age.

Four observational studies from the USA indicate that there may not be large differences in the results of partner notification of black and white patients diagnosed with HIV.

Four observational studies on partner notification of intravenous drug users elicit higher numbers of partners compared to other patients. Subsequently, more partners get tested. There is no indication that the proportion of partners who got tested is lower in intravenous drug users compared to other patients.

Adverse effects of partner notification

Two observational studies report that some patients with syphilis or HIV experienced emotional abuse or negative emotional reactions and physical violence when notifying their partners.

Acceptability of and barriers to partner notification

Two qualitative studies indicate that fear of gossip, stigma and violence (especially in women) can be a barrier to partner notification for gonorrhoea or Chlamydia.

APPENDIX 7

Draft rapid economic review of interventions to reduce the transmission of Chlamydia and other sexually transmitted infections and to reduce the rate of under 18 conceptions, especially amongst vulnerable and at risk groups, NERA Economic Consulting on behalf of the National Institute for Health and Clinical Excellence.

The rapid economic review found that even when relatively substantial amounts of literature existed there was a wide range of reasons that made application to the development of UK guidance problematic. These issues included difficulties in translating international evidence to UK settings and the fact that much of the literature does not develop outcome based measures in terms such as cost per QALY which UK policy making would ideally be based on,

HIV - Overall reviews of HIV interventions suggest that group based activities may be more cost effective. There is little on other one to one interventions to tackle HIV in the majority of reviews.

The review concludes that there is evidence that interventions designed explicitly to act upon the transmission of HIV (eg Post Exposure Prophylaxsis (PEP) and condom prescribing) are highly cost effective in the most at risk populations and circumstances but are subject to very great cost differentials which the authors note makes it very difficult to rely heavily on this evidence base for a UK policy making context.

Syphilis- The review notes that although the available evidence tends to support the view that screening for syphilis and associated interventions (eg partner notification) may achieve results at reasonable cost, the limited amount of literature and potential doubts about its UK applicability make it difficult to rely heavily on this conclusion.

Herpes – There is a lack of cost per QALY information which makes direct consideration of this evidence problematical.

Non disease specific studies – these studies considered the cost of condom distribution and the pharmacist prescribed emergency contraception. The general nature of these interventions and the limited amount of literature make it difficult to extend firm conclusions, although the evidence clearly supports the potential for such interventions to be highly cost effective.

Further economic modeling

Provision of emergency contraception -The review authors undertook some further economic modeling to look at the provision of emergency contraception including that provided by pharmacists as well as contraception provided in advance. The analysis suggested that pharmacy provision is relatively cheap (£6.01 per person with 268 taking it per 1,000 people) and avoids later pregnancies (£1,490 per normal delivery with 21 pregnancies averted per 1,000 people). Overall this analysis suggest that this intervention is cost saving.

Education and Counselling – The review authors undertook some further economic modeling looking at education and counselling in one to one sessions with visual aids and the provision of contraception for under 18 year olds. The resulting analysis suggested that if a practice nurse is just as effective as a GP in delivering the intervention then it can be cost saving overall in terms of pregnancies avoided and can lead to a higher use of contraception which could impact on STIs.

Partner Notification – Further economic modeling showed that the cost per infection averted in index patients in four studies was relatively low (£600 per reinfection averted in index patients even in the most expensive scenario) However the effectiveness of partner notification for HIV patients is less certain than for syphilis and gonorrhoea because partners are not cured and intervention with high risk partners may not necessarily reduce further transmissions.

Summary

In summary the authors noted that the cist effectiveness of certain interventions may be clearly established. In other cases (particularly concerning HIV and depending, in part, on the populations considered) there is less certainty about cost effectiveness in a UK environment.

APPENDIX 8

The Economics of Sexual Health, Nigel Armstrong, Caroline Davey and Cam Donaldson

The two main aims of this research were to assess the existing literature on the economics of contraception and abortion services and to model the economic impact of changes in contraception and abortion services (the latter is not included in this summary as it does not relate to sexual health promotion).

Key findings drawn from the review are as follows;

- Contraception services result in reduced cost and increased benefit overall,
- There is evidence that greater access to a full range of contraceptive methods, including longer acting methods (such as the IUD, IUS and implants), is beneficial and can lead to a reduction in unwanted pregnancies,
- There is evidence that access to emergency contraception (EC) (both the emergency contraceptive pill and the IUD) is beneficial.

The second part of the research models the costs and benefits of changing the NHS supply of contraceptive methods in order to better reflect the preference of women. Based on a comparison between current and ideal profiles it is estimated that current supply does not meet the demand for longer term reversible contraceptive methods. It is therefore estimated that in order to provide the ideal profile across the NHS as a whole there would need to be a large decrease (-27%) in prescriptions of the combined pill, and a parallel increase in prescriptions of a number of other methods particularly implants (+9%) and the IUS (+8%), in order to better meet women’s preferences. The cost implications of these changes is a net saving to the NHS of over £500m over 15 years.

In the light of these findings the authors draw the following conclusions:

- All PCTs should review their contraception data in the light of this evidence and take steps to improve services as a matter of urgency,
- PCT Chief Executives need to consider their budgets as a whole and must recognise that investing in contraception services will result in savings in other areas,
- That PCTs should provide more training, resources and support to service providers to ensure that a fuller range of contraceptive methods is provided to meet women's needs, in particular training within general practice (where the majority of contraceptive care is given) on the insertion of implants, the IUD and the IUS.
- PCTs should provide more and better information to women to enable them to make an informed choice about the contraceptive method that best meets their needs.

APPENDIX 9

Health Economics of Sexual Health: A Guide for Commissioning and Planning, Nick Payne, Sexual Health Team and Rachel O'Brien Analytical Team, Department of Health, September 2005.

This paper sets out to categorise different interventions in terms of how cost effective they are. The findings of this paper are set out in the main report. Set out below are the literature references which have been used by the authors of the report to inform the categorisation which is set out in the main body of the text.

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