CHAPTER 5: Sexual health

- The average age of first heterosexual intercourse is 16.
- Among women aged 16-49, the lowest levels of contraceptive use are found in the 16-19 year olds. Two thirds of heterosexual 16-19 year olds are ‘at risk’ of pregnancy (ie, have a sexual partner) but approximately one in ten of those with a partner does not use contraception.
- Both GPs and community contraceptive services are important sources of information for young people aged 15-24. In 2013/14, 22% of those aged 16-19 had visited a community contraceptive clinic.
- In 2013 the reported rate of conceptions in the under-18 age group was at its lowest since 1969 but the UK still has a relatively high rate of birth among 15-19 year olds compared with other countries.
- Of those young people having intercourse, the majority report using some kind of contraception. For the younger age group the most common method used is condoms. By early adulthood young women are more likely to use the oral contraceptive pill.
- The highest rates of sexually transmitted infections are among those aged 15-24. Those under 25 accounted for 63% of all new Chlamydia diagnoses in 2014.
- In 2013 there were 736 new HIV diagnoses among those aged 15-24. A total of 643 under-15s were receiving care for diagnosed HIV infection, together with 2,699 young people aged 15-24.
Sexual health

Developing a sexual identity is a key task of adolescent development. Staying safe, healthy and happy through the process is important. As a result, the sexual health and behaviour of young people is a huge topic in adolescent public health, with important ramifications for wellbeing, education and service provision. There is a lot that we know, but this is also a topic where there are many challenges in collecting regular, robust information.

In policy terms, there have been some significant changes. In England, the Teenage Pregnancy Strategy ran from 1999-2010. Under-18 conception rates fell from 44.8 per 1,000 in 1999 to 34.2 in 2010, a reduction of 23.7% over the course of the strategy. The reduction accelerated after 2008, with further reductions down to 24.5 conceptions per 1000 women aged 15-17 by 2013 (Office for National Statistics, 2015). As teenage pregnancy is a complex issue requiring a multifaceted approach, the steeper decline in the later stages of the strategy is likely to be due to a combination of factors. These might include the increasing priority in local areas following the midcourse review, an increase in under-18s choosing more effective long acting reversible contraception (LARC) methods and the cumulative impact of the Strategy’s longterm prevention programme.

Following the change of Government in 2010, in England the continuing priority of teenage pregnancy was signalled by including the under-18 conception rate as an indicator in a new Public Health Outcomes Framework (Department of Health, 2012). Further reduction in the under-18 conception rate is also one of eight objectives in the Department of Health’s Framework for Sexual Health Improvement in England (Department of Heath, 2013), which restates the Strategy’s evidence base. However, this has not been accompanied by detailed guidance to inform local implementation of effective prevention and there is no target or performance management of local progress. No central funding was retained after 2010 for national actions to support local areas and the previous structures and access to expertise at all government levels, which supported the Strategy implementation, have been disbanded.

In Scotland the Scottish Government held an inquiry into teenage pregnancy published in 2013, noting that although rates were in decline, they still remained high in the European context. The inquiry made a number of recommendations including calling for a new strategy for Scotland (Scottish Parliament, 2013).

Sexual activity

The third National Survey of Sexual Attitudes and Lifestyle (Natsal-3) reported in 2013, providing information about sexual behaviour of adults aged 16-74 (ie, over the age of consent) in Great Britain. The youngest age group in the published data are 16-24 year olds, and Chart 5.1 summarises the main findings about the sexual experiences of this age group as reported in 2012. The results confirm the fairly consistent finding that the average age of first heterosexual intercourse is 16 years, and that nearly one third of both men and women reported first heterosexual intercourse before they turned 16. This still means that the majority do not have sex until after 16.
The patterns of sexual activity in Chart 5.1 are notably similar for men and women, although the men aged 16-24 reported an average of 6.5 sexual partners compared to the women, who reported 5.2, and men were more likely to report a new sexual partner in the last year. A significant proportion of both genders reported new partners in the last year and this is important when we consider how best to ensure they have the sexual health advice that they need.

For information about people under 16, one of the main sources of data on young people’s reports of their sexual behaviour remains the Health Behaviour in School Aged Children (HBSC), which collected data for England, Scotland and Wales in 2014. Chart 5.2 presents the data on the proportions of 15 year olds in the English survey who reported experience of sexual intercourse in the HBSC report, and compares this to the rates reported in the previous sweeps in 2002, 2006 and 2010. We can see that one quarter of boys and one fifth of girls reported having had sexual intercourse by this age, and that this proportion has been falling over the last decade.
It is interesting to compare the HBSC trends and those reported in Natsal-3. HBSC trends indicate a decline in 15 year old sex from 2002 onwards. However, Natsal-3 found that the proportion reporting first heterosexual intercourse before age 16 years increased in successive birth cohorts (Mercer et al, 2013). It is not clear how we account for the trends seen in HBSC, nor the different picture suggested in Natsal-3, although it is worth noting the surveys are very different in methods.

As these data suggest, adolescence and early adulthood is a time of developing sexual identity. Overall, national statistics obtained in the Integrated Household Survey suggest that 1.6% of UK adults identify their sexuality as gay, lesbian or bisexual. In the 16-24 age group the rates are slightly higher; 2.7% report being gay, lesbian or bisexual, and a further 8% say they do not know, refuse to answer the question, give no response or state ‘other’ (Office for National Statistics, 2014). These figures are likely to be underestimates as many people will not feel ready to reveal their sexual identity in a survey.

Finally, there is concern about sexual exploitation and unwanted sexual attention in this age group. Finding representative, robust data on these topics is particularly challenging. Official estimates of the numbers of young people who are trafficked or are victims of sexual exploitation are very low, because so few cases become subject to official proceedings. However, Natsal-3 provided important data on rates of non-consensual sex in the 2014 survey. Respondents answered questions about whether anyone had made them have sex against their will. In the 16-24 year old group (1,700 young people), 16.4% reported that someone had attempted to have non-consensual sex with them, and 6.9% reported they had experienced non-consensual sex. In one quarter of the cases, the young people had told the police (Macdowall et al, 2013). The median age for the whole sample (aged 16-74) to report non-consensual sex was 18 in women and 16 in men. The majority of the perpetrators were reported to be family, friends or current intimate partners. The Natsal-3 researchers concluded that this kind of sexual experience is mainly one that happens at a young age, and is strongly associated with poor health (physical and mental), risk behaviours such as binge drinking, and abortion and pregnancy before age 18. Natsal-3 also showed that young women who cited school as the main source of sex and relationship education were less likely to report having non-consensual sex, although this did not apply to young men.
Use of contraception

The majority of young people use contraception during heterosexual sexual intercourse, but rates are still not as high as for older age groups. The most recent ONS general population survey on contraception and sexual health among women was undertaken in 2008/09 (Lader, 2009) and has not been updated since. In the absence of new data, Chart 5.3 shows the use of contraception by age among women at that time, demonstrating the lowest levels of contraceptive use among those aged 16-19. Lader estimated that 64% of those aged 16-19 were ‘at risk’ of pregnancy (ie, had a heterosexual sexual relationship and were not protected), so the finding that only 57% were using any methods of contraception suggests that approximately one in ten were not protected. In addition, some of those using contraceptives may not be doing so properly or on every occasion. Use of contraception is important both for preventing conception and also for protecting against sexually transmitted infections (STIs). The English Sexual Health Framework (DH, 2013) specifically aims to increase knowledge and awareness of all methods of contraception for all ages.

![Chart 5.3: Use of contraception by women in the UK, by age, 2008/9](source)


NB Figures for 16-19 are unreliable and should be treated as indicative, not definitive.
Data on contraceptive use by those aged 15 is available from the Health Behaviour in School Aged Children. Of those who had had sexual intercourse, the majority (85%) reported using some kind of contraception. Use of condoms at last intercourse was the most common method in this younger age group, used by 61% of the boys and 57% of the girls. The contraceptive pill was the second most common method, followed by the morning after pill or another method (Brooks et al 2015).

The 2008/9 ONS survey of women also illustrated the numbers using family planning services (during the five years prior to interview) and the ways in which the reported behaviour of the 16-19 year olds differed from those aged 20-24, as demonstrated in Chart 5.4. Approximately half of the younger age group had used at least one service and these tended to be either their own GP or a community contraceptive clinic. Two thirds of those aged 20-24 had used contraceptive services and the GP or practice nurse was the most popular choice.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>16-19</th>
<th>20-24</th>
<th>All 16-49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not use a service</td>
<td>49</td>
<td>32</td>
<td>45</td>
</tr>
<tr>
<td>Community contraception clinic</td>
<td>27</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>GP or practice nurse</td>
<td>26</td>
<td>53</td>
<td>45</td>
</tr>
<tr>
<td>Chemist or pharmacy</td>
<td>10</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Walk in centre</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Somewhere else</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>


NB Percentages sum to more than 100 as respondents could use more than one type of service

More up to date data on the preferred type of contraception is available from nationally collated information about those who chose to attend community contraceptive clinics. These include contraceptive and sexual health clinics run by voluntary organisations such as Brook. It excludes contraceptive services provided by outpatient clinics and general practitioners. Overall, in 2013-14, young people aged 16-19 were the age group most likely to have visited community contraceptive clinics (HSCIC, 2014), as demonstrated in Chart 5.5.
It can be seen from the data illustrated in Chart 5.6 that the most common type of contraceptive for all young women attending clinics remains oral contraceptives, followed by the male condom. Use of the male condom is highest in the youngest age groups and is overtaken by the oral pill in those aged 15 and above. However, long acting reversible contraceptives, such as IU devices, injectable contraceptives and implants, account for approximately one fifth of those aged over 15 years; a significant proportion that has increased over the last five years.

<table>
<thead>
<tr>
<th>Contraceptive Type</th>
<th>All Ages</th>
<th>Under 15</th>
<th>15</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptives</td>
<td>47</td>
<td>41.7</td>
<td>45.7</td>
<td>50.1</td>
<td>53.5</td>
<td>54.2</td>
</tr>
<tr>
<td>Male condom</td>
<td>18.2</td>
<td>36.2</td>
<td>29.2</td>
<td>22.9</td>
<td>17.2</td>
<td>14.4</td>
</tr>
<tr>
<td>Implant</td>
<td>12.9</td>
<td>12.4</td>
<td>13.1</td>
<td>13.1</td>
<td>13.9</td>
<td>14.4</td>
</tr>
<tr>
<td>Injectable contraceptive</td>
<td>8.9</td>
<td>5.6</td>
<td>8</td>
<td>9.4</td>
<td>10.2</td>
<td>9.6</td>
</tr>
<tr>
<td>Interuterine devices/system</td>
<td>9.1</td>
<td>0.4</td>
<td>0.5</td>
<td>0.9</td>
<td>1.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>


NB ‘Intrauterine devices/system’ includes the coil and a hormonal contraceptive inserted into the uterus.
NB ‘Other’ includes female condom, contraceptive patch, cap, diaphragm, and other methods.
Considering how important community clinics are for the younger age group, it is interesting to note the majority of respondents in the Exeter Schools Unit annual survey did not know if there was a ‘special birth control service for young people available locally’. The low awareness may be because a minority are sexually active, but it is important that young people know in advance of need so that they access help early. The results suggest the need to improve promotion of local services and access to them. Chart 5.7 shows that, among the 15 year olds in the survey, only one third of both boys and girls indicated they were aware of such services. However, as Balding and Regis (2014) note, the majority (66%) of 14-15 year olds in the survey did know where to get free condoms.

![Chart 5.7](https://example.com/chart5.7.png)

*Source: Balding and Regis (2014) Young people into 2014. Exeter Schools Health & Education Unit (SHEU)*
Research shows that young people receiving good quality sex and relationships education at school are more likely to use condoms and other forms of contraception when they first have sex (Kirby, 2007). Natsal asked about sources of information about sex while growing up, and the data suggest those who reported their main source of information had been at school were less likely to have an unplanned pregnancy (Wellings, 2013). School was also the preferred source of information about sex when growing up: Chart 5.8 shows that both young men and young women aged 16-24 reported that they would particularly have liked more information from schools, their parents and health professionals. There are interesting gender differences; young women would prefer information from their mothers, young men from their fathers.

Conception and birth

Teenage conception rates provoke continuing debate. Data collection improved in England during the Teenage Pregnancy Strategy. The establishment of the Teenage Pregnancy Unit in England in 1998 and cross-government support was pivotal to giving the topic a high profile. The leadership and national guidance also assisted professionals in reducing rates of teenage pregnancy and improving support for young parents. In 2013 the reported number of conceptions in the under-18 age group in England and Wales was the lowest since 1969 (ONS, 2015), at a figure of 24,306. The rate of under-18 conceptions for 2013 was also the lowest since records began in 1969 at 24.5 pregnancies per 1,000 women, compared to 47.1 in 1969. The rate has thus nearly halved (although there is considerable variation between local authorities). Charts 5.9 and 5.10 illustrate how this rate (per 1,000 females aged 15-17) has fallen since the late 1990s, both in England and Wales and in Scotland. In addition, in England and Wales, the proportion of under-18 conceptions that result in an abortion has remained fairly stable since the mid-2000s and in 2013 stood at 50.7% (ONS, 2015), although the proportion varies considerably between regions, from 42% in North East to 64% in London.

![Chart 5.9](source: ONS, Conception Statistics, England and Wales, 2013)

**Rate per 1000 females aged 15-17**

- **Source:** ONS, Conception Statistics, England and Wales, 2013 » Download data
Conception rates among the under-16s are low but of considerable concern. **Charts 5.11 and 5.12** again present the trends for England and Wales and Scotland. England and Wales demonstrate a similar trend as the under-18s, with a downward fall (apart from an unexplained spike in 2007). The proportion resulting in a termination of pregnancy is higher for the under-16s than for the older age group, at 62% (ONS, 2015). The trends in Scotland do not reflect such a clear trajectory and have remained fairly constant since 1998.
Conception rates are not available for Northern Ireland, but we can look at the number of live births in the 15-19 age group since 1998. These figures are shown in Chart 5.13 which show there has been a decline here too, with a reduction from 28 births per 1,000 young women in 1998 to 15.7 per 1,000 in 2013.
Looking at international rates, comparable conception data are not available for other European countries, but comparisons can be made for birth rates per 1,000 women aged 15-19. **Chart 5.14** plots the births per 1,000 young women aged 15-19 in the UK in 2013 and the average for a selection of other countries. The data are collected at the age the mother gives birth, not adjusted for age of conception, so these data are not directly comparable to the under-18 conception data published annually by ONS. The UK birth rate among women aged 15-19 was higher than many other countries.

**Source:** Unicef Office of Research (2013) Child wellbeing in rich countries: Innocenti Report Card 11 » Download data
Sexually transmitted infections

As well as pregnancy, sexual behaviour carries the possibility of sexually transmitted infections (STIs). Public Health England data on the number of STI diagnoses in England make it clear that the highest rates of infection are among those aged 15-24. Indeed it is estimated that those under 25 accounted for 63% of all new Chlamydia cases in 2013 (Public Health England, 2015).

Chart 5.15 demonstrates that the 20-24 age group is most at risk of STIs for both genders. Among women, the second age group at risk is 15-19 but in males it is the 25-29s (PHE, 2015). Under the age of 24, rates are higher in young women than young men. Helping all young people to protect themselves is a major public health issue, but the higher rates in young women indicate that particular attention needs to be paid to health promotion strategies directed at them.
Chart 5.16 presents the rates of selected STI diagnoses, per 100,000 population, for young people in the UK in 2015 by gender and age. Chlamydia is clearly the most frequent STI diagnosis, followed by genital warts, herpes and Gonorrhoea. Syphilis is rare.

<table>
<thead>
<tr>
<th></th>
<th>Chlamydia</th>
<th>Gonorrhoea</th>
<th>Herpes</th>
<th>Syphilis</th>
<th>Genital warts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>15-19</td>
<td>881</td>
<td>101</td>
<td>40</td>
<td>4</td>
<td>208</td>
</tr>
<tr>
<td>20-24</td>
<td>1799</td>
<td>330</td>
<td>162</td>
<td>22</td>
<td>765</td>
</tr>
<tr>
<td><strong>WOMEN</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 15</td>
<td>136</td>
<td>10</td>
<td>8</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>15-19</td>
<td>2651</td>
<td>166</td>
<td>216</td>
<td>2</td>
<td>476</td>
</tr>
<tr>
<td>20-24</td>
<td>2692</td>
<td>161</td>
<td>332</td>
<td>3</td>
<td>632</td>
</tr>
</tbody>
</table>


Improvements in screening and diagnosis have meant that more STI cases are identified now than previously, so untangling the underlying trends is complicated. England’s National Chlamydia Screening Programme, launched in 2003, has diagnosed well over half a million infections in 15-24 year olds. Modelling by the former Health Protection Agency (now Public Health England) suggested that it has ‘probably decreased the prevalence of Chlamydia among sexually active under-25 year olds’ (HPA, 2012).
In addition, changes to PHE data collection methods in 2012 make comparisons with earlier years difficult. **Chart 5.17** illustrates both these points. The data for Chlamydia diagnoses by age group and gender are presented from 2003 to 2013. In 2008 the rates go up exponentially as data from community services were included as well as data from genitourinary clinics (GUM). As we can see from the increase in the figures in 2008, the largest proportion of the diagnoses are actually made in the community clinics so it does not make sense to look at the trends without including these data. The data for 2012 and 2013 stand separate from the trend lines because PHE introduced further changes to data collection methods and the results are not comparable to those for 2003-2011. Overall, there has been an increase in diagnoses between 2008 and 2009 and a levelling out or slight decline since then. It is worth noting that PHE Chlamydia screening policy is to achieve a diagnostic rate of 2,300 per 100,000 15-24 year olds in order to find the infection, treat and bring down prevalence.

Rates of acute STI diagnoses vary by the Index of Multiple Deprivation; for example, Health Protection Agency (now Public Health England) data for London residents in 2011 showed that the acute STI rate for people living in the most deprived areas of London was 3.4 times higher than for those living in the least deprived areas (Health Protection Agency, 2012). As we have seen, people with STIs are more likely to be young people than other age groups.

Finally, in 2013 there were 736 new HIV diagnoses among those aged 15-24 years, and 643 under-15 were receiving care for diagnosed HIV infection, together with 2,699 15-24 year olds (Public Health England, 2014). This is important as one of the Public Health Outcomes Framework sexual health indicators is late diagnosis of HIV.
References


