

Sexual Health Needs Assessment

Oldham, Rochdale, Bury

12th June 2025

1. Introduction

What is a Health Needs Assessment?

Health Needs Assessments (HNA) assess how well the health and care needs of a local population are being met.⁽¹⁾ Regular HNAs are important as the needs of the population are ever-changing. This includes systematically reviewing trends in the supply and demand of services, as well as gathering a range of feedback. NHS, voluntary sector, and council-run services are all taken into consideration. This evidence helps to set priorities and recommend actions for improvement. HNAs are usually focused on a specific topic area or group, such as sexual health.

Existing local **Sexual Health Needs Assessments (SHNA)** include:

- [Young Peoples SHNA: Bury \(2023\)](#) ⁽²⁾
- [SHNA: Oldham Bury Rochdale \(2020\)](#) ⁽³⁾

What is sexual health?

Sexual health can be described as “...**a state of physical, emotional, mental and social well-being in relation to sexuality**”. ⁽⁴⁾ Rather than just focusing on illness, this emphasises the need for a positive and respectful approach to sexuality and sexual relationships. This SHNA encompasses a wide range of topics, including sexually transmitted infections (STIs) and reproductive health, and explores recent changes within Oldham, Rochdale, and Bury (ORB).

Sex: Biological status as male, female, or intersex, assigned at birth based on physical characteristics.	Gender Norms: The cultural roles, behaviours, activities, and attributes expected of people based on their sex.
Sexual Orientation: A person's sexual, physical, and/or emotional attraction to another person, or lack thereof.	Gender Identity: An individual's sense of self as a man, woman, transgender, non-binary, or other gender identity.

Table 1: Definitions related to sex, gender, and sexual orientation.^(5, 6)

Context

Sexual health affects everyone and therefore belongs on the national agenda. In 2024, **4.5 million consultations** were delivered by sexual health services in England. ^(7, 8) However, since 2013, **spending on local authority-funded sexual health services in England has been cut by 29%**. ^(7, 9)

In 2022, the Faculty of Sexual and Reproductive Health (FSRH) published the Hatfield Vision, outlining the stark challenges faced by sexual health services in the UK. ⁽¹⁰⁾ This was closely followed by the **Women's Health Strategy for England**, which set out the government's life course approach to improve the health of women and girls. ⁽¹¹⁾ Greater Manchester (GM)

responded in 2023 with its own action plan, with scope for GM-wide and locality-specific strategies.⁽¹²⁾

Pressure to prioritise sexual health continues to build. In 2024, the FSRH released a Manifesto calling on the incoming Government to take action.⁽¹³⁾ The evidence is clear: investing in sexual health is not only vital for the health and well-being of the nation, but also cost-effective. For example, **every £1 spent on contraceptive services is estimated to save £9** in the long run⁽¹⁴⁾.

The goal is to improve sexual health access, experience, and outcomes for all. However, it is also vital to address the persistent **health inequalities** that exist. Where you live, your age, ethnicity, economic background, sexual orientation, gender identity, religion, mental and physical health, or any protected characteristic should not be a barrier to your sexual health.

This aligns with the **Public Health Outcomes Framework (PHOF)**, which sets out a vision to:

- 1) Improve and protect the nation's health
- 2) Improve the health of the poorest, fastest⁽¹⁵⁾

The high-level outcomes are to increase healthy life expectancy overall, whilst reducing differences in **life expectancy and healthy life expectancy** between communities.

Sexual and reproductive health (SRH) plays a key role in this challenge. Prescribing of long-acting reversible contraceptives, under-18 conception rates, new STI diagnoses, and presentations with HIV at a late stage of infection are all indicators included in the PHOF. This SHNA analyses PHOF measures and other relevant data to assess local sexual health inequalities across ORB.



Spotlight on COVID-19

The COVID-19 pandemic was a challenging time for all health and care services, and SRH teams had to adapt to unpredictable circumstances. A reduction in SRH activity is captured in this report; for example, the data shows fewer contraception prescriptions during this time. In April 2020, the Association of Directors of Public Health (ADPH) published recommendations for the continuation of essential SRH services, acknowledging the potential short and long-term public health implications.⁽¹⁶⁾

SRH behaviours and expectations also shifted, and some of these changes have persisted post-pandemic. For example, although STI testing initially reduced, the pandemic subsequently accelerated the provision of online self-sampling.⁽¹⁷⁾ Online appointments have also increased significantly, rising from 2% in 2017 to 40% of SH clinic consultations following COVID-19.⁽¹⁷⁾ Although a rise in virtual services may improve accessibility for some, a lack of face-to-face appointments may potentially widen health inequalities, and therefore, services must be aligned with the needs of the local population.⁽¹⁷⁾

2. Demographics

Understanding the local population is vital to plan and adapt services to meet demand. This includes the capacity of service providers, which services to offer, and where to target interventions. This is particularly important for addressing inequalities. For example, across England, rates of new STI diagnosis remain consistently high in certain groups⁽¹⁷⁾:

- young heterosexuals aged 15 to 24 years
- black ethnic populations
- gay, bisexual and men who have sex with men (GBMSM)
- people residing in the most deprived areas

However, it is important to recognise that these groups are heterogenous, and individuals will vary widely in terms of sexual behaviour and risk. Intersectionality, which describes how characteristics interact, adds further complexity. This highlights the importance of working with service users with real life experience, and not just relying on statistics to design services.

Oldham, Rochdale and Bury

Oldham, Rochdale and Bury (ORB) have an estimated combined population of 671,362 people⁽¹⁸⁾. The population pyramid below shows the distribution of people in ORB by age and sex compared to England overall⁽¹⁹⁾. In keeping with national trends, there is a higher number of females in ORB, approximately 13,500 more than males.

Oldham, Rochdale & Bury

Percentage of population by Age (years) and Sex

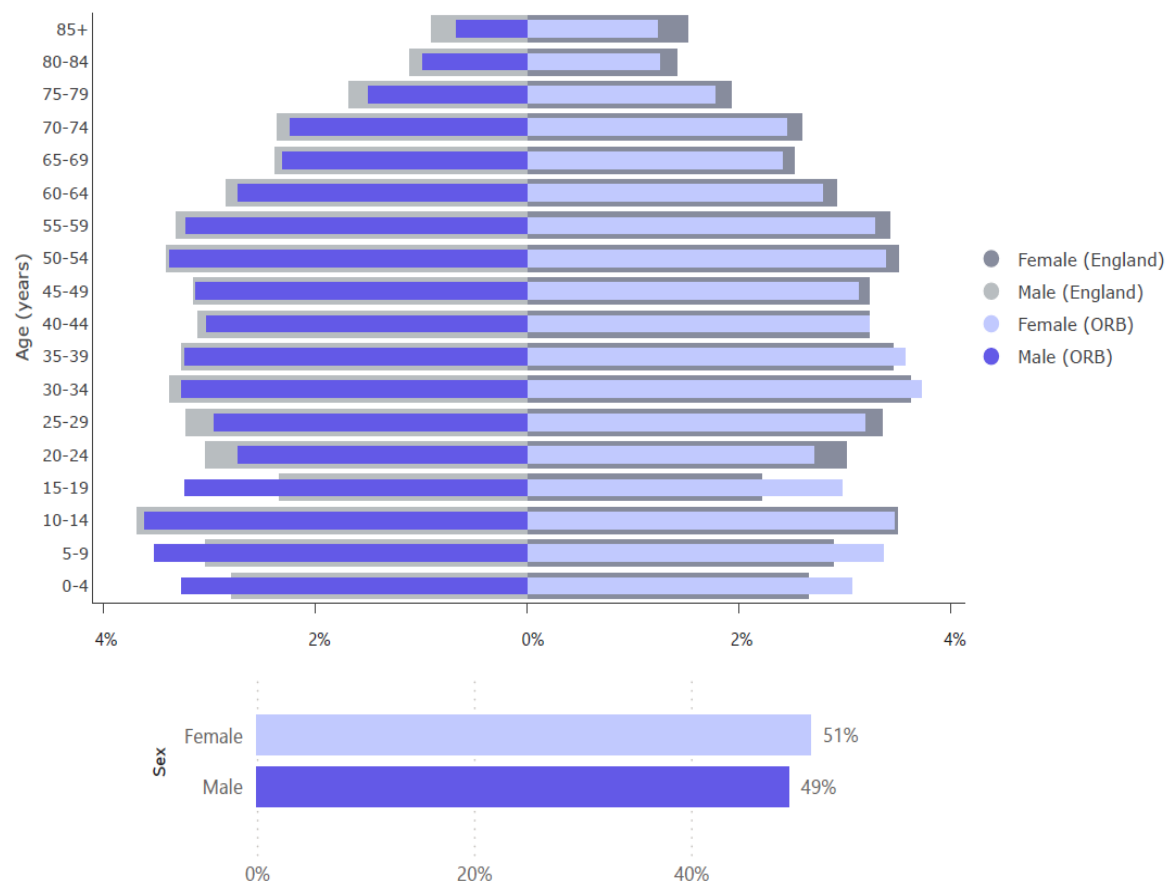


Figure 1.1: Oldham, Rochdale and Bury population pyramid based on 2021 census⁽¹⁹⁾.

Deprivation

Each of the 10 local authorities in GM have neighbourhoods among the most deprived in the country, measured by the 2019 Index of Multiple Deprivation (IMD)⁽²⁰⁾. This metric considers data related to income, employment, education, health, crime, barriers to housing and services, and living environment.

Rochdale and Oldham both rank within the top 10% most deprived local authorities in the country, whereas Bury is closer to the national average. Figure 1.2 shows IMD values across GM, and the map indicates deprivation across Bury, Rochdale and Oldham respectively (clockwise).

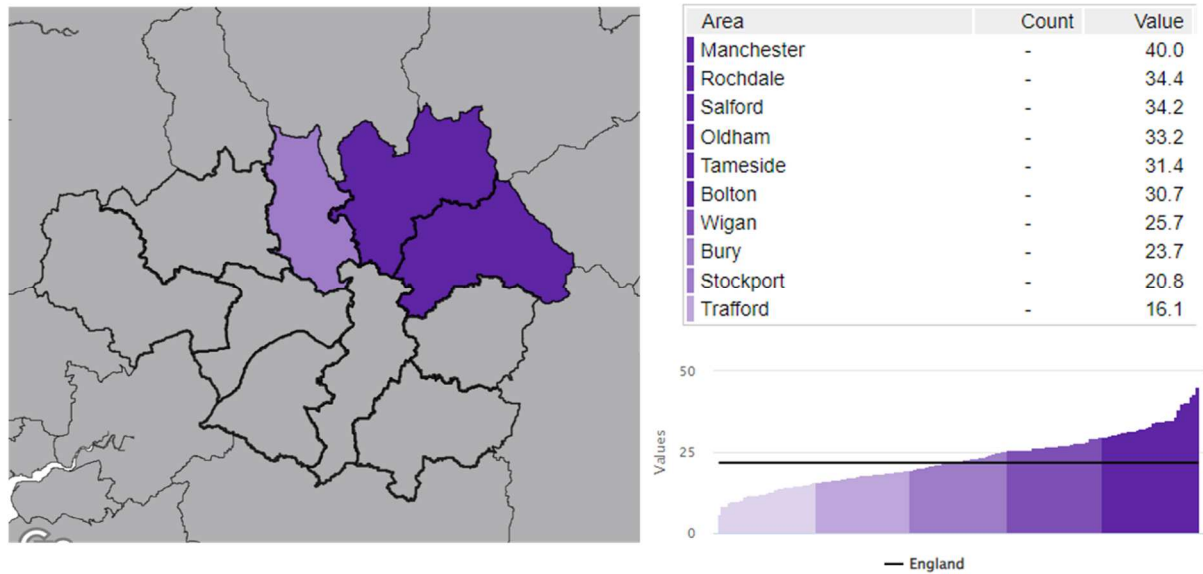


Figure 1.2: 2019 IMD score distribution for upper tier local authorities in England, map shaded by quintile for Oldham, Rochdale and Bury⁽²¹⁾.

Life expectancy

The graph below represents Life Expectancy (LE) and Healthy Life Expectancy (HLE) within ORB compared to England. LE across ORB is lower than average, and in keeping with national trends males have a shorter LE than females. The proportion of years expected to be lived in good health in Bury is similar to the national average, but considerably worse in Oldham and Rochdale. HLE is an important indicator of morbidity and reflects demand on health and care services.

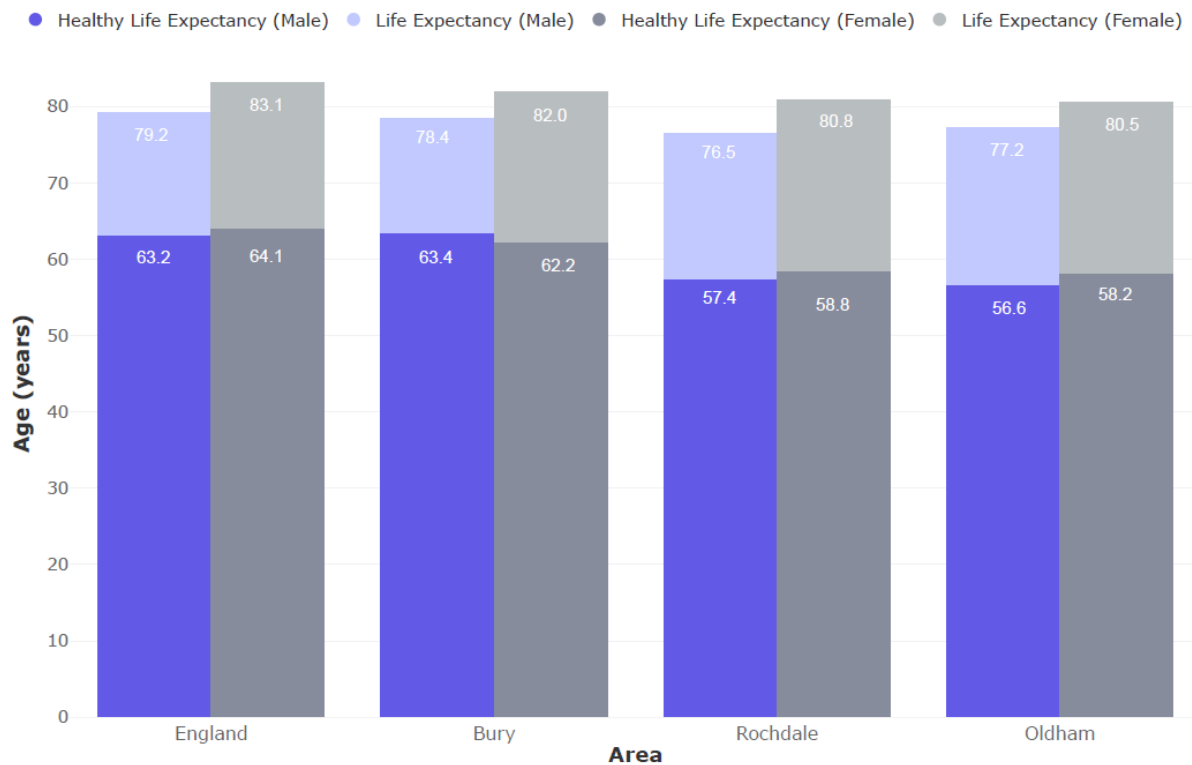


Figure 1.3: Life expectancy and healthy life expectancy by sex for ORB and England (2018-20)⁽²¹⁾

Oldham

Oldham's population was recorded as 242,100 in the 2021 census, and is expected to reach 261,000 by 2041.⁽²²⁾ Figures 1.4 and 1.5 demonstrated Oldham's relatively young population, with a higher proportion of residents aged under 20 compared to the national and GM averages. However, as the population ages, by 2041 the number of people over 65 years old is expected to increase by 30%. The majority of residents in Oldham identify as White ethnicity (68.1%), while the second largest group is Asian, Asian British or Asian Welsh (24.6%).

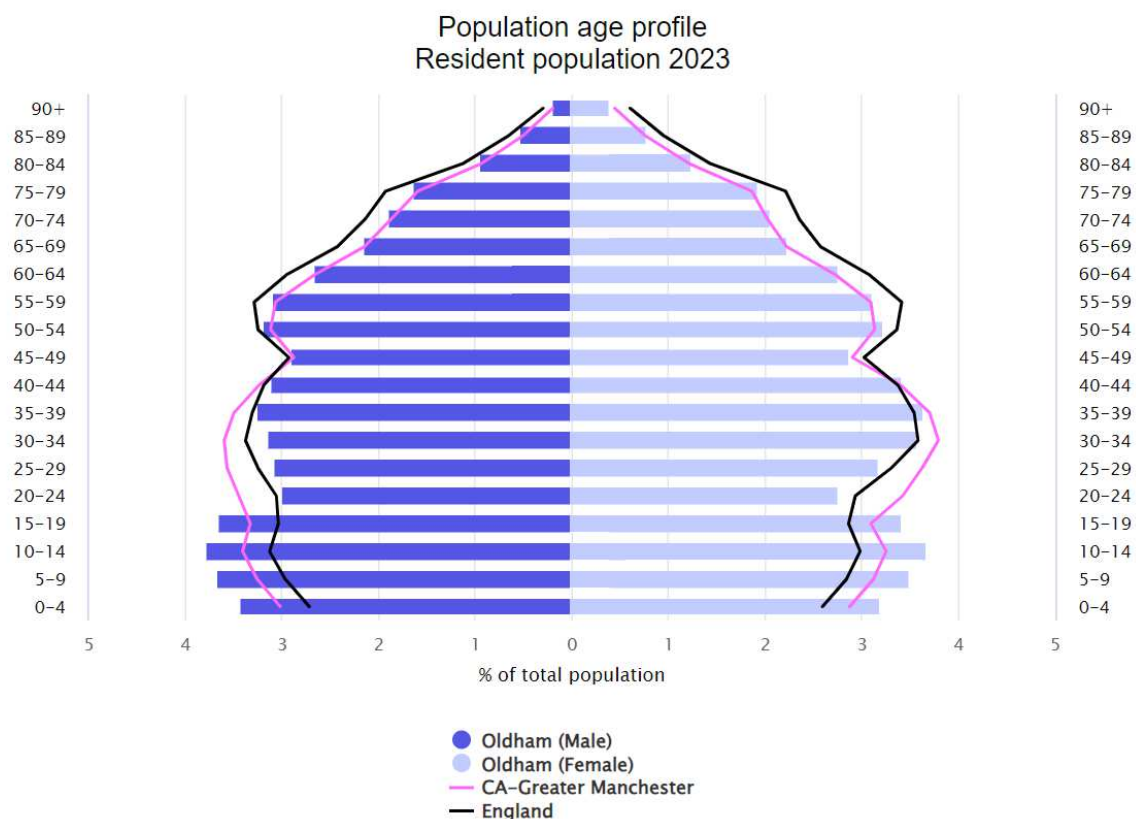


Figure 1.4: Population pyramid for Oldham ⁽²¹⁾

Oldham

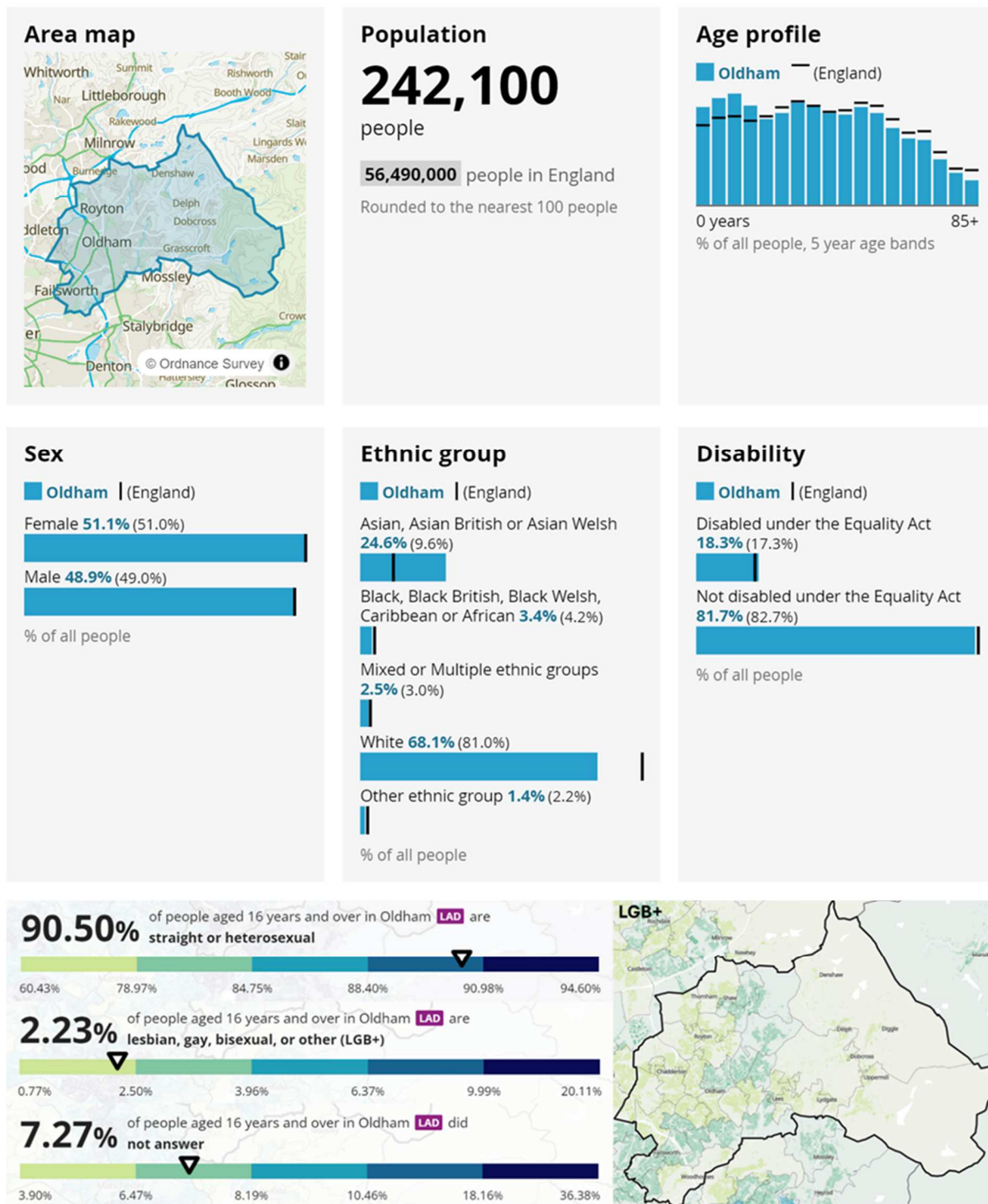


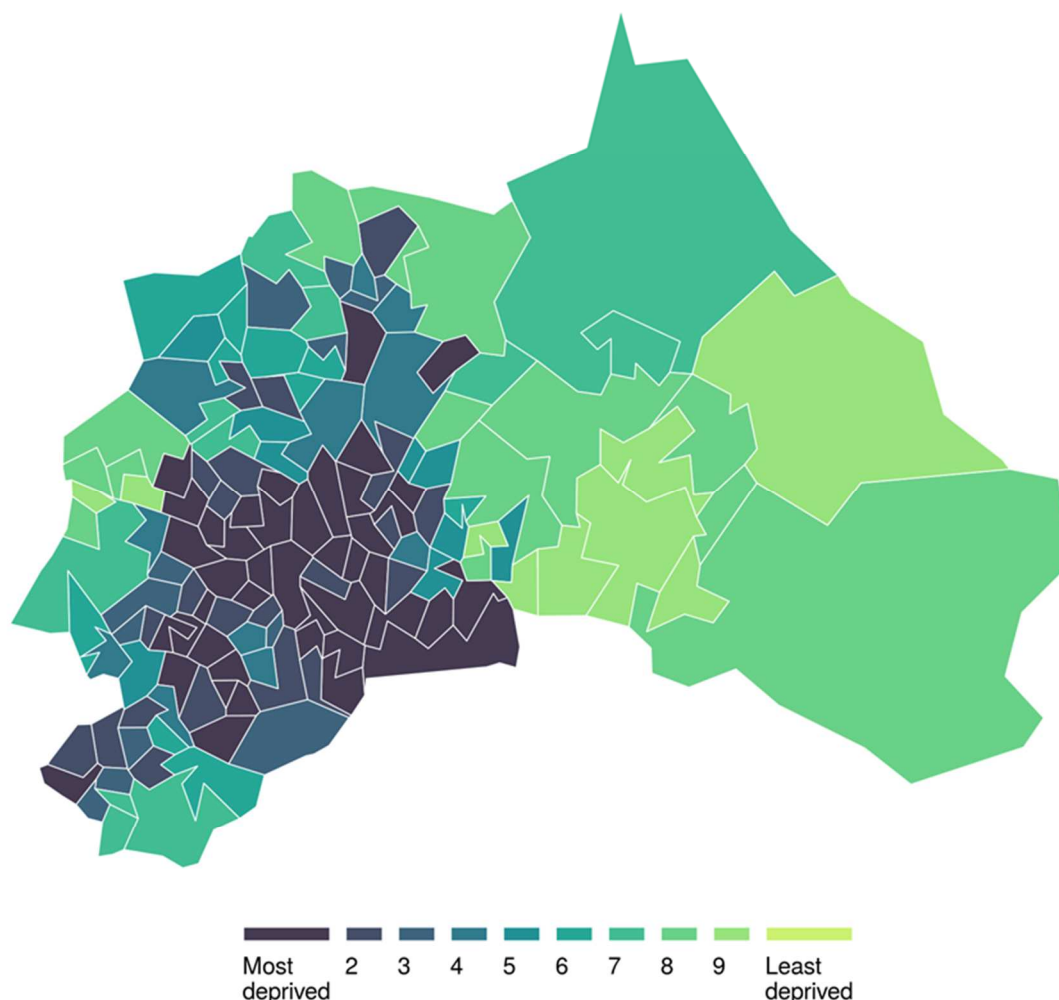
Figure 1.5: Demographic profile for Oldham: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. ⁽¹⁹⁾

Figure 1.6 displays deprivation across Oldham as measured by the IMD for 2019. Each area represents approximately 1,500 residents or 650 households, and therefore more densely populated areas appear smaller⁽²³⁾. Five of these small areas fall in the bottom 1% of overall IMD nationally. A 10-colour scale has been used to shade in each individual area according to

the level of deprivation. The lightest green represents the least deprived populations, and the darkest blue represents the most deprived.

Index of Multiple Deprivation, 2019

Lower-layer Super Output Areas in Oldham by decile



Source: English Indices of Deprivation (2019), MHC
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Figure 1.6: Indices of Multiple Deprivation within Oldham⁽²³⁾

Rochdale

Rochdale's population was recorded as 223,800 in the 2021 census, and similar to Oldham is predicted to grow over the coming decades, particularly within the older age groups⁽²⁴⁾. Figures 1.7 and 1.8 demonstrate that Rochdale also has a higher proportion of residents aged under 20 compared to the national and GM averages. Compared to Oldham, the proportion of ethnically Asian, Asian British or Asian Welsh residents in Rochdale is slightly lower (18.5%), but still higher than the national average (9.6%).

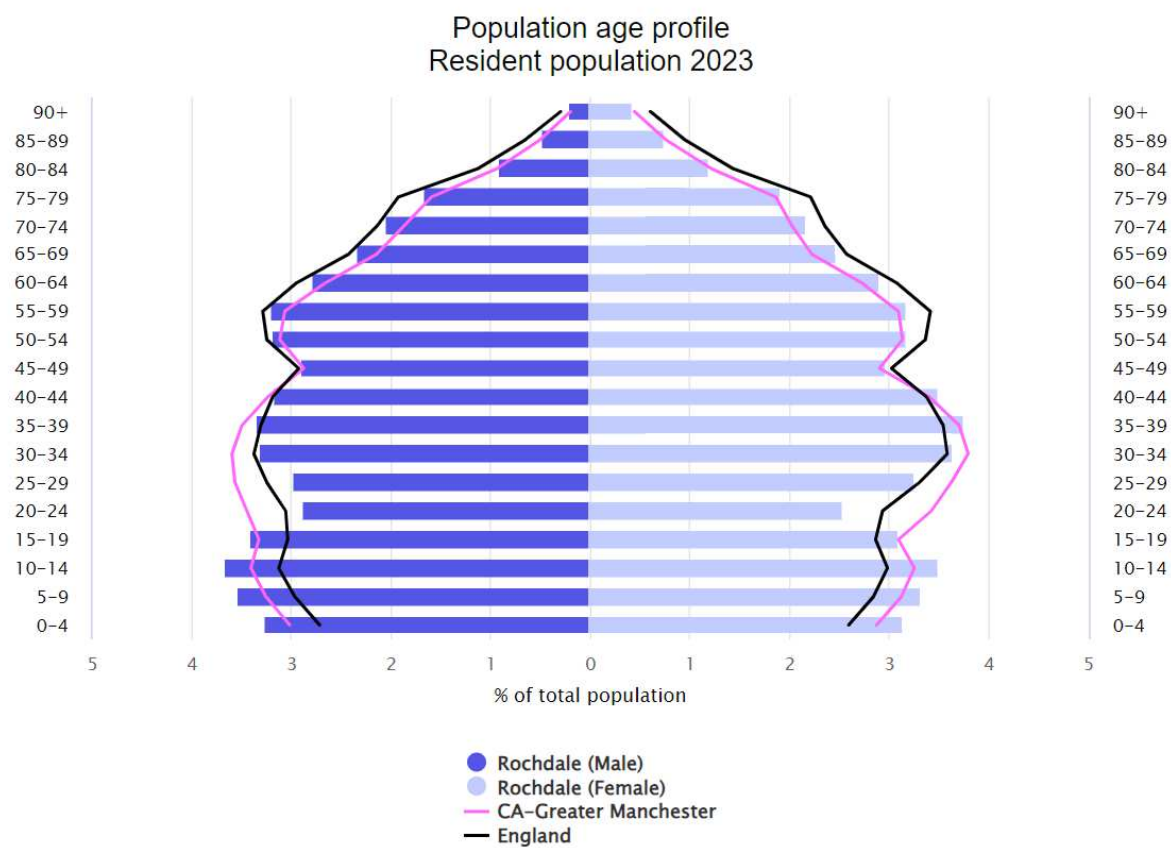


Figure 1.7: Population pyramid for Rochdale ⁽²¹⁾

Rochdale

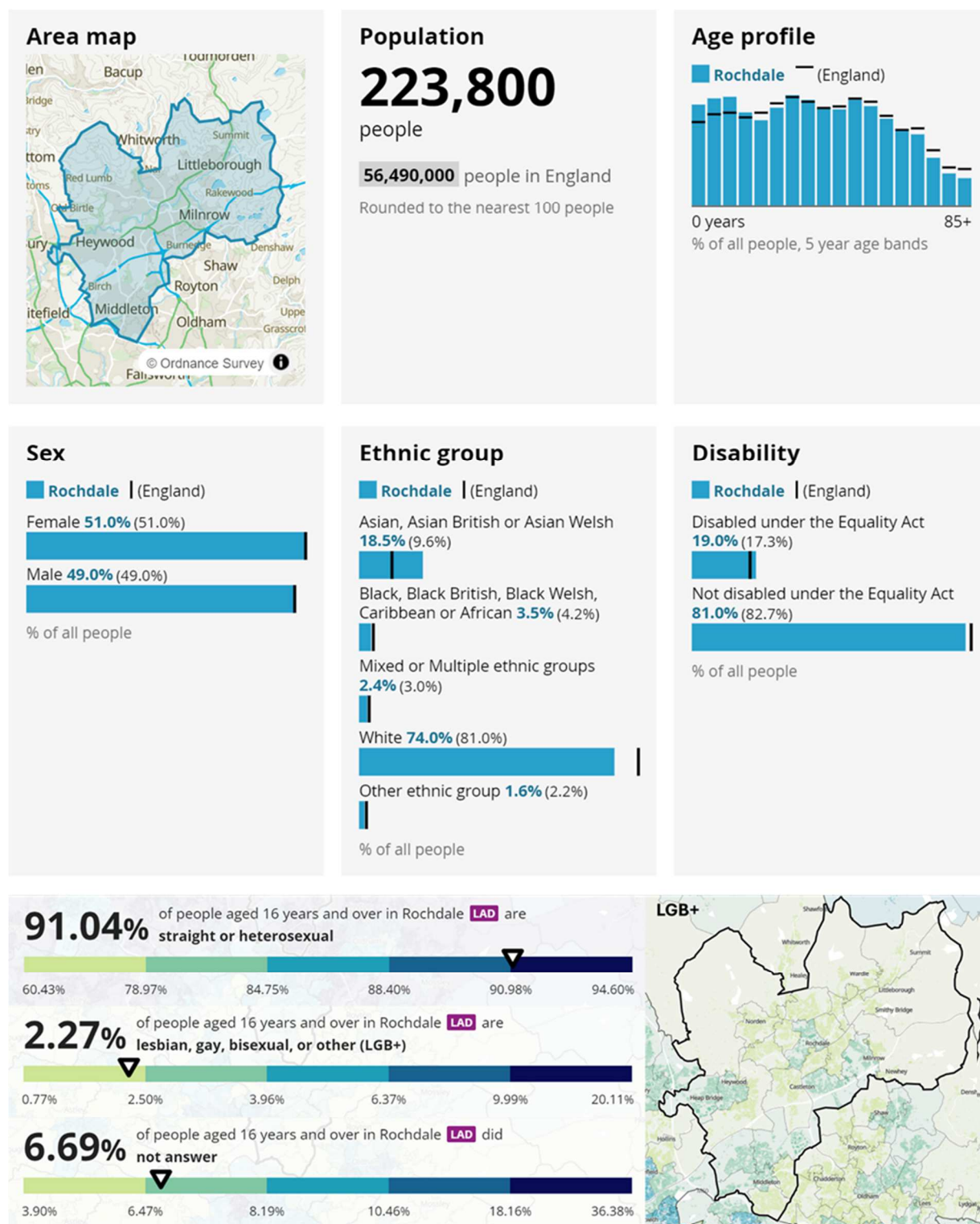


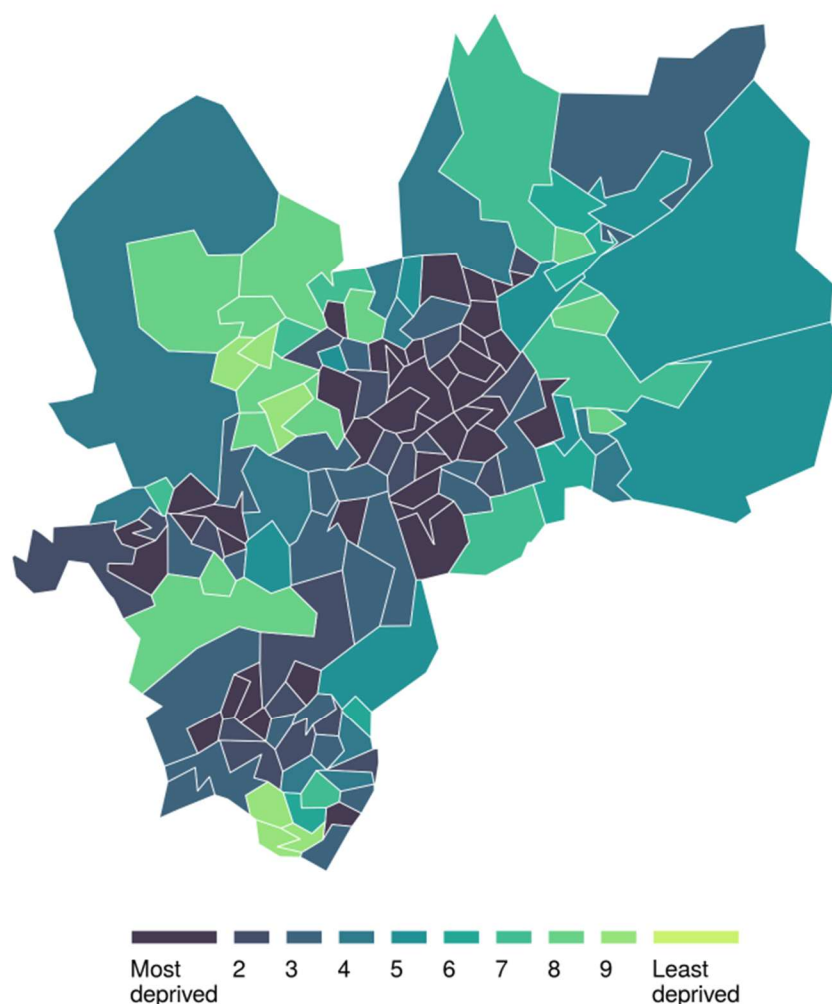
Figure 1.8: Demographic profile for Rochdale: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. ⁽¹⁹⁾

Figure 1.9 displays deprivation across Rochdale as measured by the IMD for 2019. The darkest blue zones belong to the 10% most deprived areas in England. Both Rochdale and Oldham are

amongst the top 20 local authorities in England with the highest proportion of neighbourhoods within this category.

Index of Multiple Deprivation, 2019

Lower-layer Super Output Areas in Rochdale by decile



Source: English Indices of Deprivation (2019), MHCLG
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Figure 1.9: Indices of Multiple Deprivation within Rochdale⁽²³⁾

Bury

Bury's population was recorded as 193,600 in the 2021 census, which is smaller than Oldham and Rochdale.⁽²⁵⁾ Although the population in Bury is predicted to grow over the next decade, it is projected to increase at a slower rate than the average for England. Figures 1.10 and 1.11 demonstrate that the distribution of ages in Bury is close to the national average, however a significantly smaller proportion of the population is ethnically Black, Black British, Black Welsh, Caribbean or African (1.9% vs 4.2%).

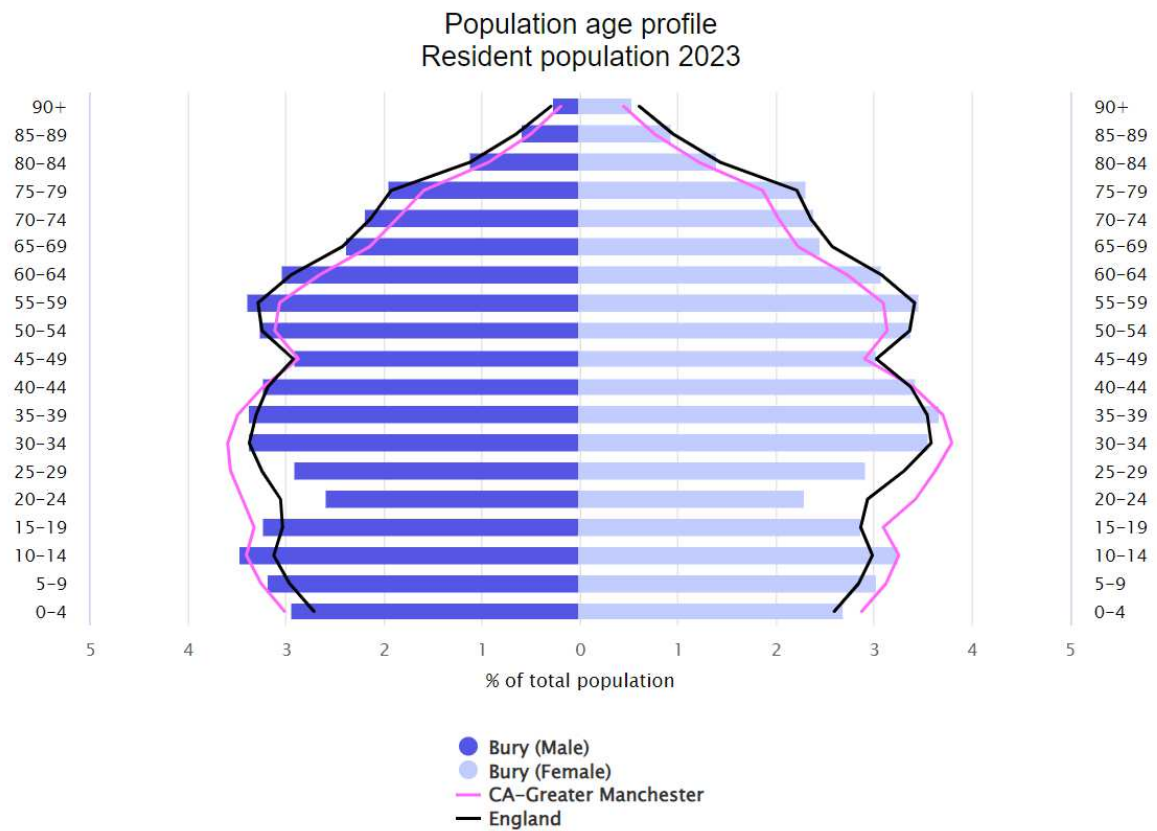


Figure 1.10: Population pyramid for Bury ⁽²¹⁾

Bury

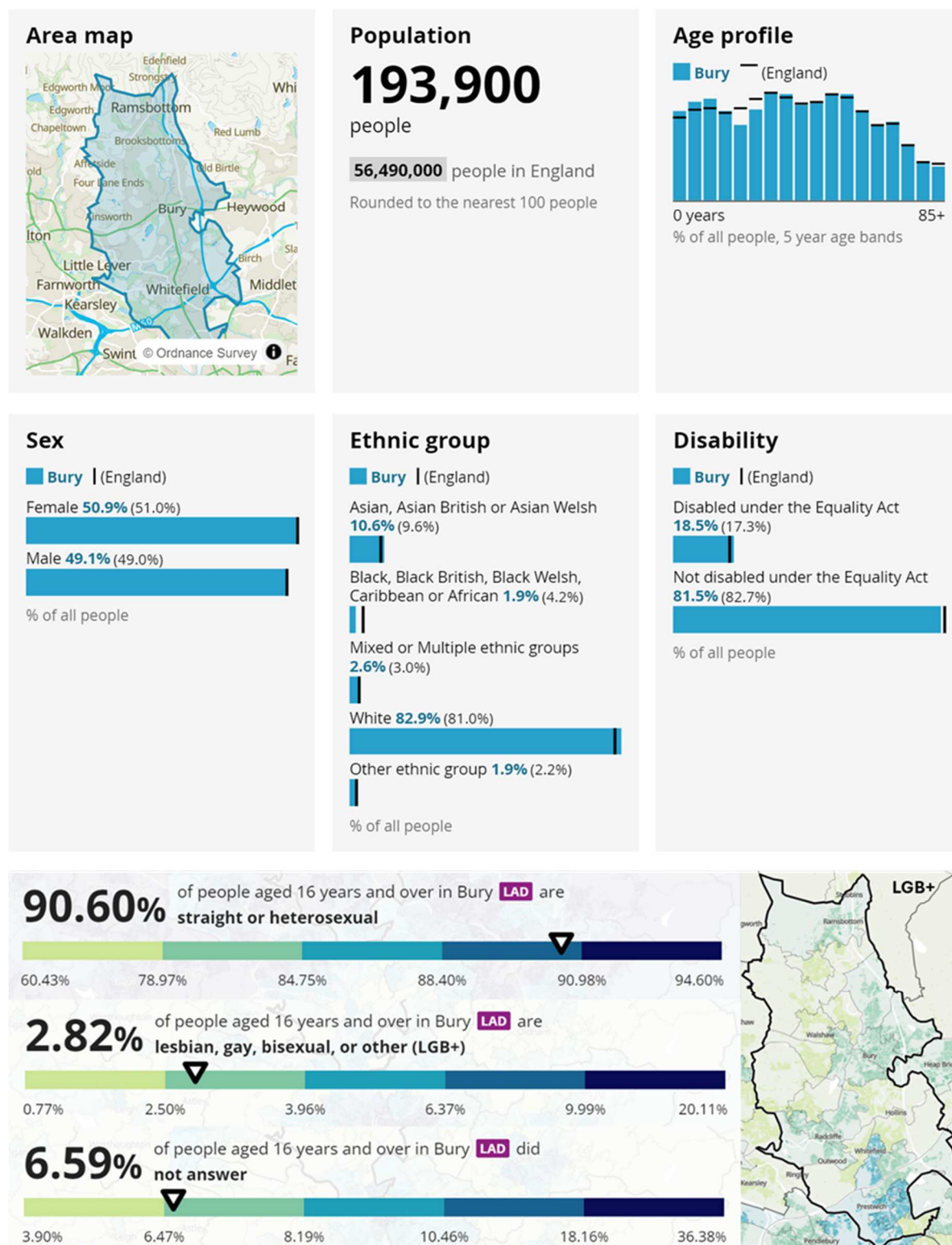


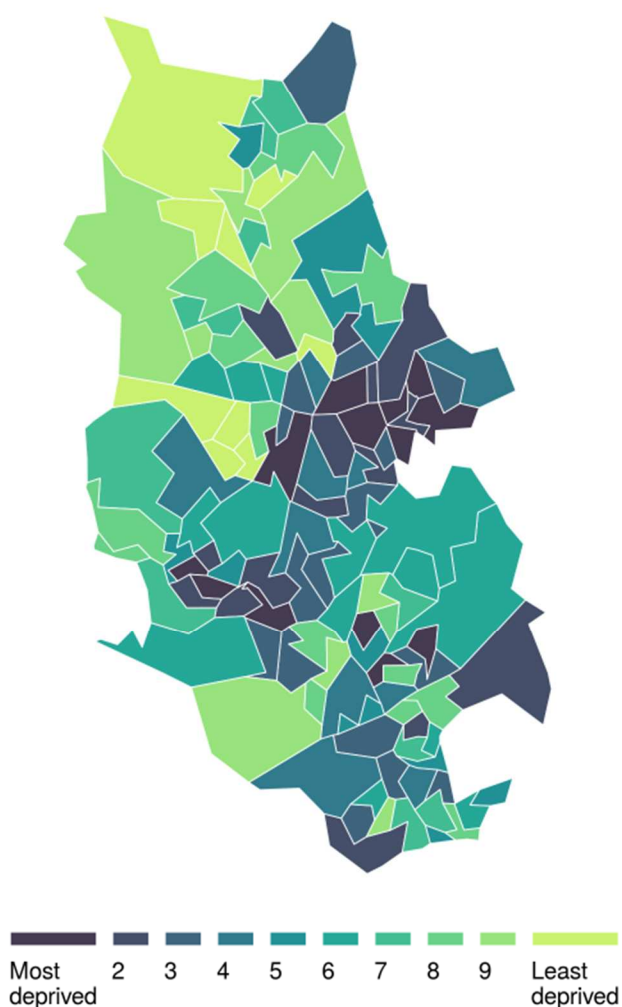
Figure 1.11: Demographic profile for Bury: local authority boundaries, and population by size, age, sex, ethnic group, disability and sexual orientation. ⁽¹⁹⁾

Figure 1.12 displays deprivation across Bury as measured by the IMD for 2019. Out of the 10 local authorities that make up GM, Bury is the 8th most deprived, as shown in Figure 1.2. ⁽²¹⁾

However, Bury is still slightly more deprived than the national average, as the North of England is generally has higher rates of deprivation than the South.

Index of Multiple Deprivation, 2019

Lower-layer Super Output Areas in Bury by decile



Source: English Indices of Deprivation (2019), MHCLG
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Figure 1.12: Indices of Multiple Deprivation within Bury⁽²³⁾

3. Sexually Transmitted Infections

Sexually transmitted infections (STIs) are infections that are spread primarily through person-to-person sexual contact. A challenge for sexual health services is that many STIs are asymptomatic. Therefore, people may not know they have an STI, so they will not seek treatment and may inadvertently pass on an STI to others. However, even without any symptoms, STIs have the potential to cause significant harm, both to the reproductive system, sometimes leading to infertility, and to all other body systems. An additional challenge is the stigma associated with STIs, which can act as a barrier to people accessing services.

In light of these challenges, plus the wide range of STIs and people affected, the public health response is complex.⁽²⁶⁾ Categorising actions into primary, secondary, and tertiary prevention is a helpful way to simplify this. These strategies adapt according to the time, place, person, and STI.

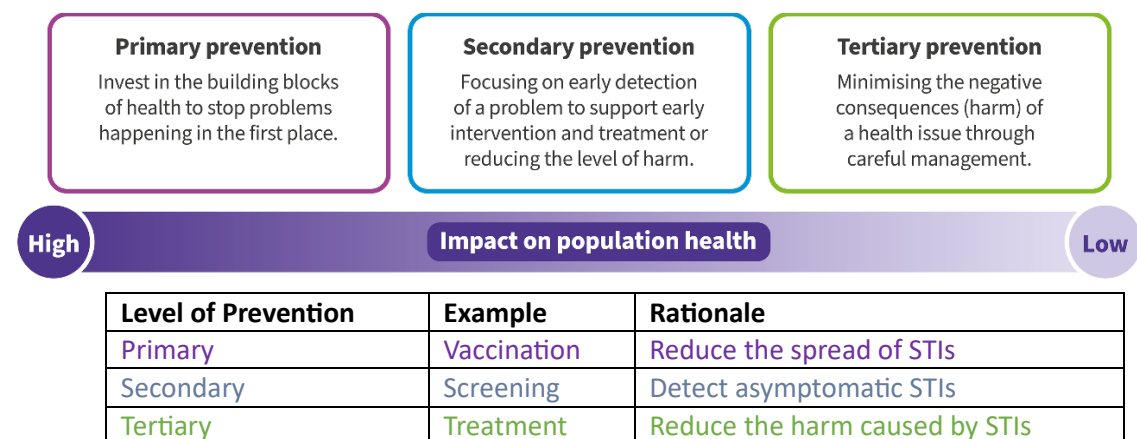


Figure 2.1: Examples of the 'three levels of prevention'.⁽²⁷⁾

The UK Health Security Agency (UKHSA) is the government agency responsible for public health protection across England, including threats from infectious diseases such as STIs.⁽²⁸⁾ Historically, their main goal was to reduce the prevalence of STIs, focusing on reducing the number of infections. However, not only are STI rates increasing, but so are their harmful effects.⁽¹⁷⁾

In October 2024, UKHSA published the 'STI Prioritisation Framework' to assist the planning and provision of local sexual health services, which has been applied to this SHNA.⁽¹⁷⁾ This framework shifted towards preventing adverse health outcomes caused by STIs, focusing on reducing health inequalities. The first step in the framework is to take a closer look at the local disease burden. The following chapter looks at STI trends in ORB and places a spotlight on key emergent themes.

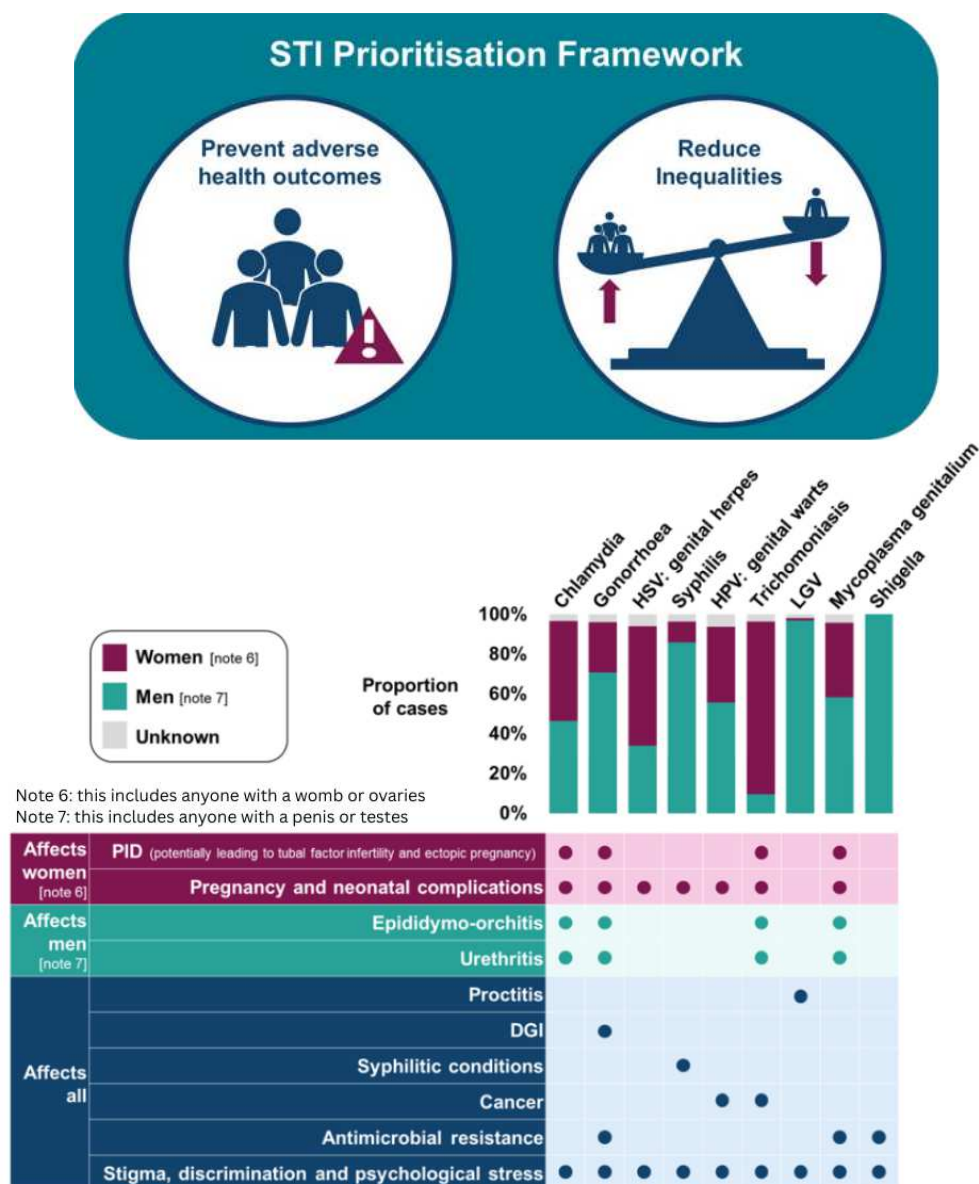


Figure 2.2: Vision of the STI Prioritisation Framework and summary of STI-related adverse health outcomes by pathogen (DGI = Disseminated gonococcal infection). ⁽¹⁷⁾

Background

Rates of new STI diagnoses vary by age, gender, ethnicity, sexual orientation, geographical location, and socioeconomic status. For example, the highest rate of new STIs amongst women is between 15 and 24 years old, whereas for men, rates peak between 20 and 29.⁽²⁹⁾ Diagnoses of new STIs are higher in older men than older women, and bacterial STI diagnoses specifically are more common amongst GBMSM and people of black ethnicity.⁽²⁹⁾

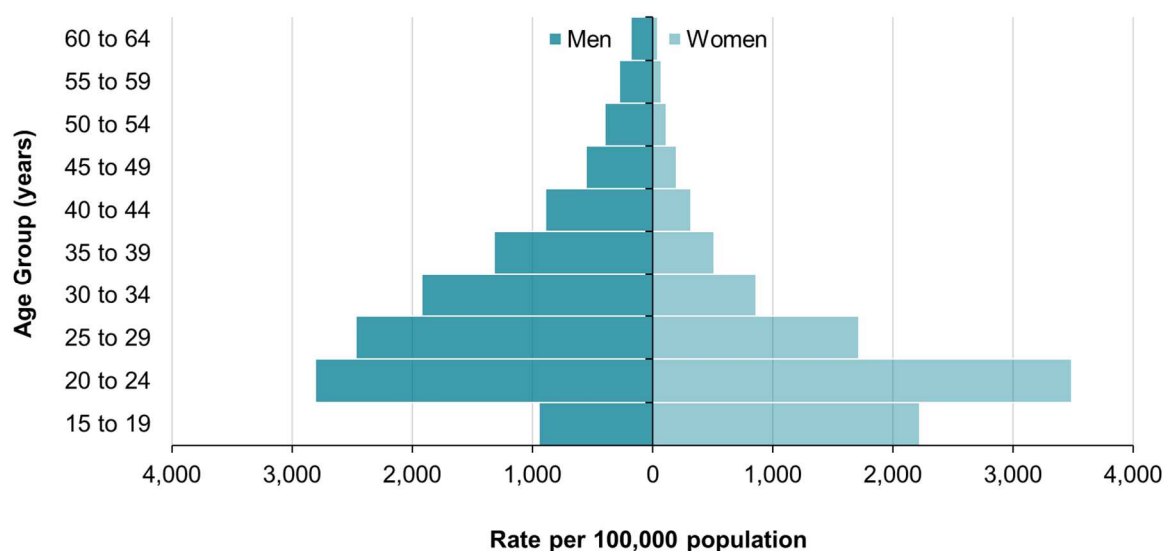


Figure 2.3: Rates of new STI diagnoses by gender and age group: England, 2023.⁽²⁹⁾

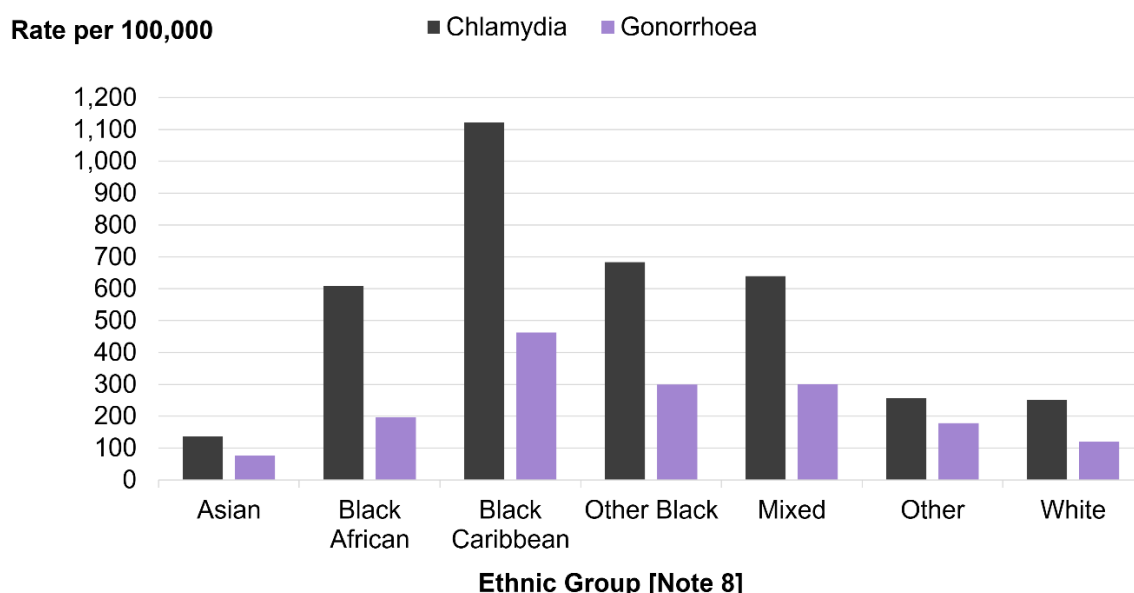


Figure 2.4: Rates of chlamydia and gonorrhoea diagnoses among England residents accessing SH services by ethnicity, 2023 (note 8: the ethnic categories above are as specified by the Office for National Statistics).⁽²⁹⁾

The rate of STI diagnoses in ORB has been consistently lower than the English average for the last decade. However, not everyone with an STI will get tested, and therefore, disease prevalence is likely to be significantly higher than the figures presented. In keeping with national trends, the number of STIs diagnosed in ORB in 2024 decreased compared to the previous year.⁽⁸⁾

Figure 2.6 shows that STI testing rates are below average in ORB, potentially leading to a sizeable burden of undetected disease.⁽²¹⁾ There was a pronounced dip in STI testing towards the start of the COVID-19 pandemic, but subsequently rates have recovered and continued to rise.

New STI diagnoses (excluding chlamydia aged <25)

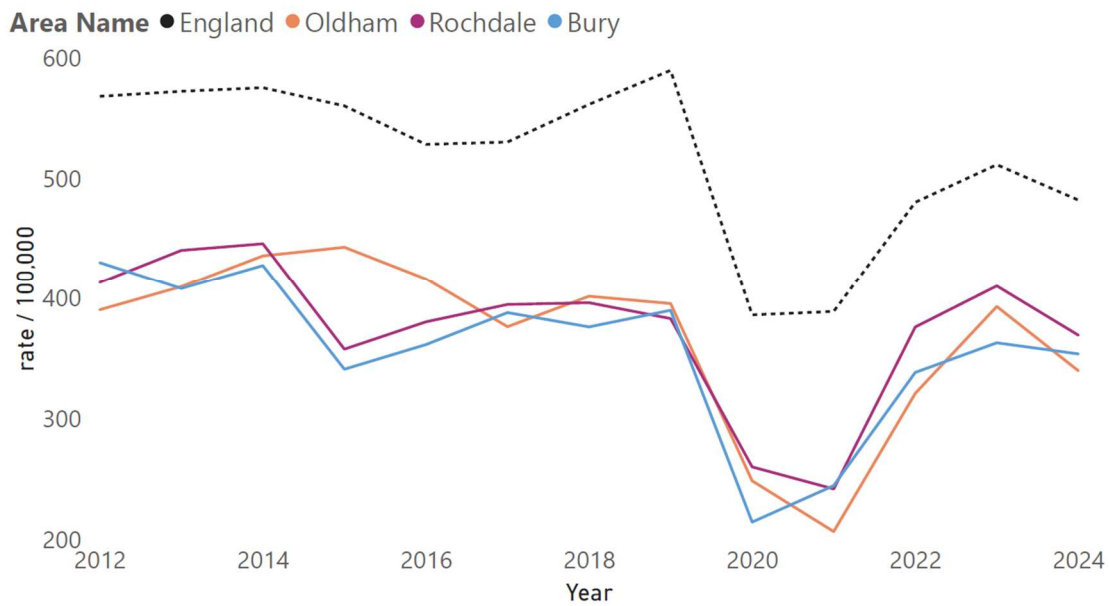


Figure 2.5: New STI diagnoses (excluding chlamydia <25) per 100,000. ⁽²¹⁾

STI testing (excluding chlamydia aged <25)

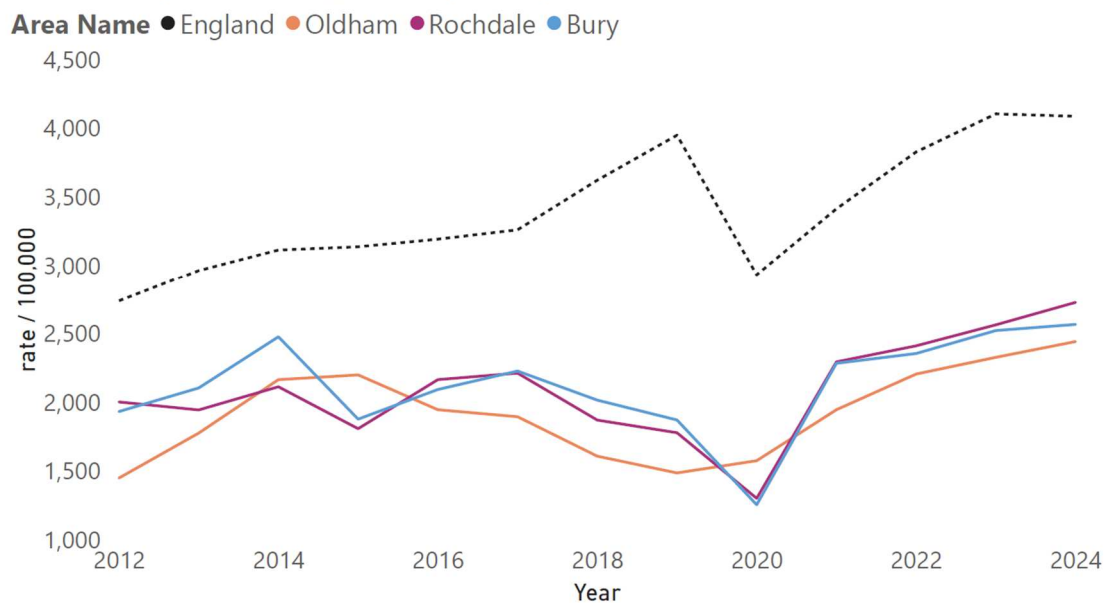


Figure 2.6: STI testing rate (excluding chlamydia <25) per 100,000. ⁽²¹⁾

Chlamydia

Chlamydia is the most common STI in England, and represented 46.3% of new STI diagnoses in 2024.⁽⁸⁾ This explains the exclusion of chlamydia detection from certain statistical reports, specifically under 25 years, as the high rates would eclipse the rest of the data. Comparing Figure 2.7 to Figure 2.8 demonstrates the discrepancy between different age groups. In Oldham, for example, the overall diagnostic rate peaked at just over 600, whereas for 15 to 24-year-olds the peak was closer to 5,000. Chlamydia detection peaks in the early 20s for both men and women; however, rates are higher amongst women before the age of 25 and amongst men subsequently.⁽²⁹⁾

Chlamydia diagnosis

Area Name ● England ● Oldham ● Rochdale ● Bury

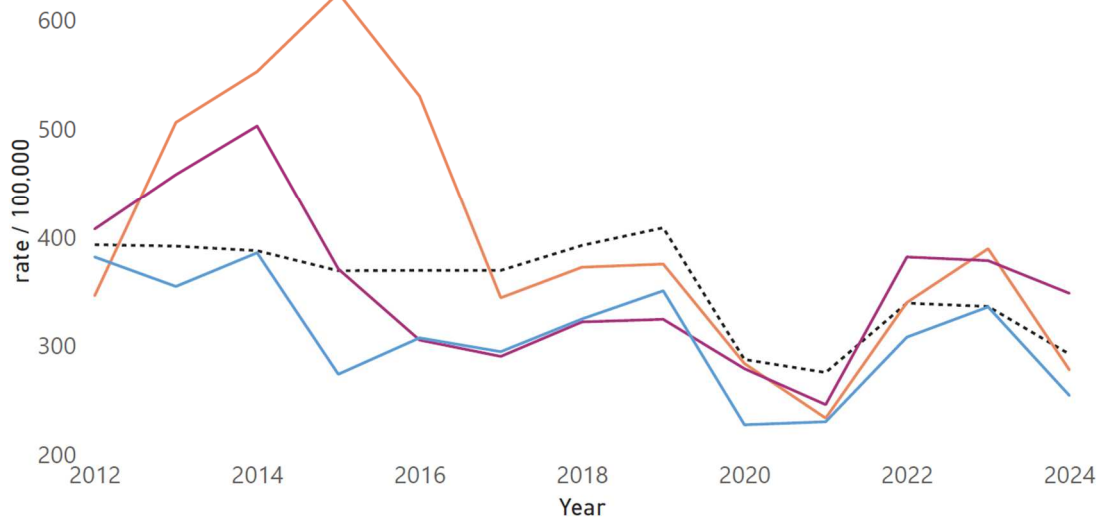


Figure 2.7: Chlamydia diagnostic rate per 100,000 persons. ⁽²¹⁾

Chlamydia detection (aged 15 to 24)

Area Name ● England ● Oldham ● Rochdale ● Bury

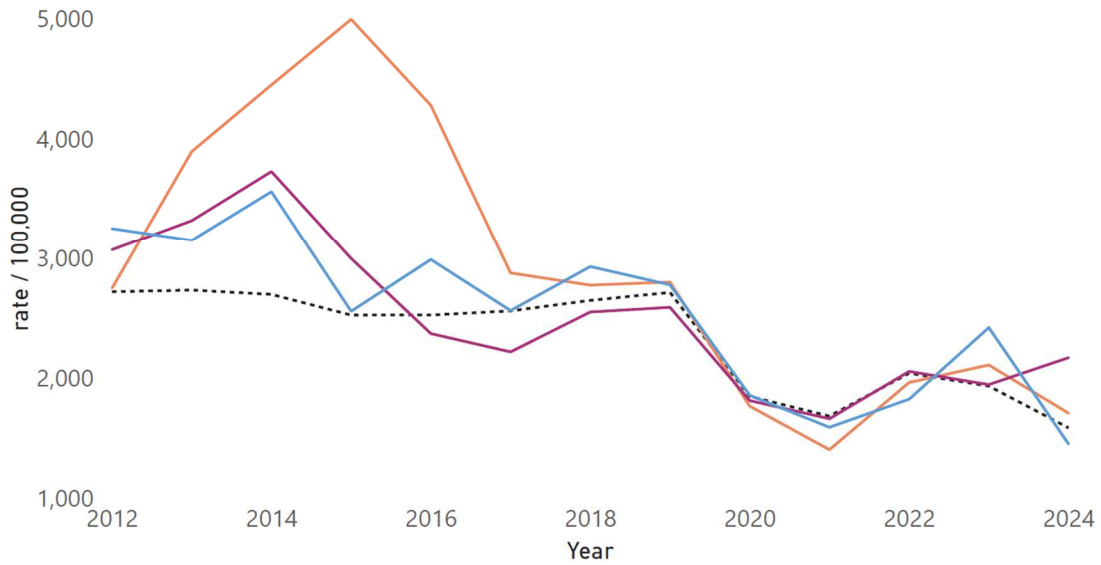


Figure 2.8: Chlamydia detection rate per 100,000 persons aged 15 to 24. ⁽²¹⁾

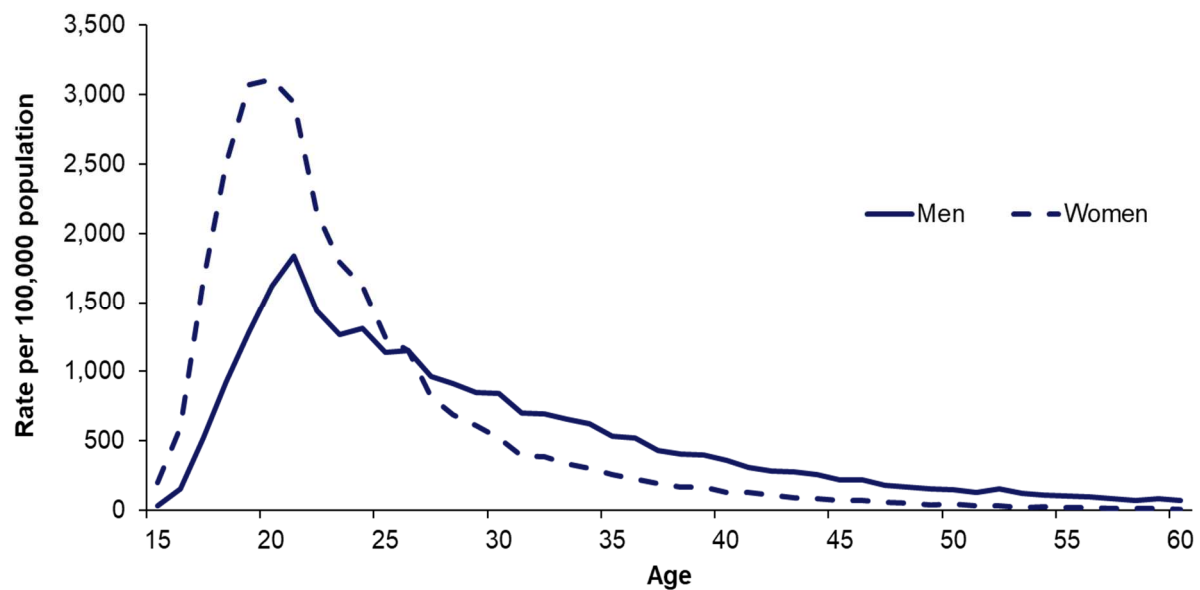


Figure 2.9: Rates of chlamydia diagnoses by gender and age, England, 2023.⁽²⁹⁾

Spotlight- changes to the National Chlamydia Screening Program



Chlamydia can be treated with antibiotics; however, many people never experience any symptoms and therefore do not seek help. An untreated chlamydia infection can have serious consequences, such as Pelvic Inflammatory Disease (PID) in women, which can negatively impact fertility.

⁽³⁰⁾ Early detection and treatment can reduce long-term harm; therefore, screening for asymptomatic cases is an important public health measure.⁽³¹⁾

First rolled out in 2003, the National Chlamydia Screening Program (NCSP) was initially offered opportunistically to women and men under 25 years of age.⁽³²⁾ In 2021, the NCSP criteria were restricted to women, changing focus to reduce reproductive harm from untreated infections.

⁽³⁰⁾ This aligns with the STI Prioritisation Framework's shift towards prevention of adverse health outcomes.

For these guidelines, 'women' refers to cisgender women, transgender men, non-binary (assigned female at birth), and intersex people with a womb or ovaries.⁽³⁰⁾ Men are still able to get tested if they report symptoms or sexual contact with a partner diagnosed with chlamydia, but are no longer proactively offered a test without a clear indication.⁽³⁰⁾ The policy change also focused on strengthening partner notification, re-testing, and reducing time to treatment for all.⁽²⁹⁾

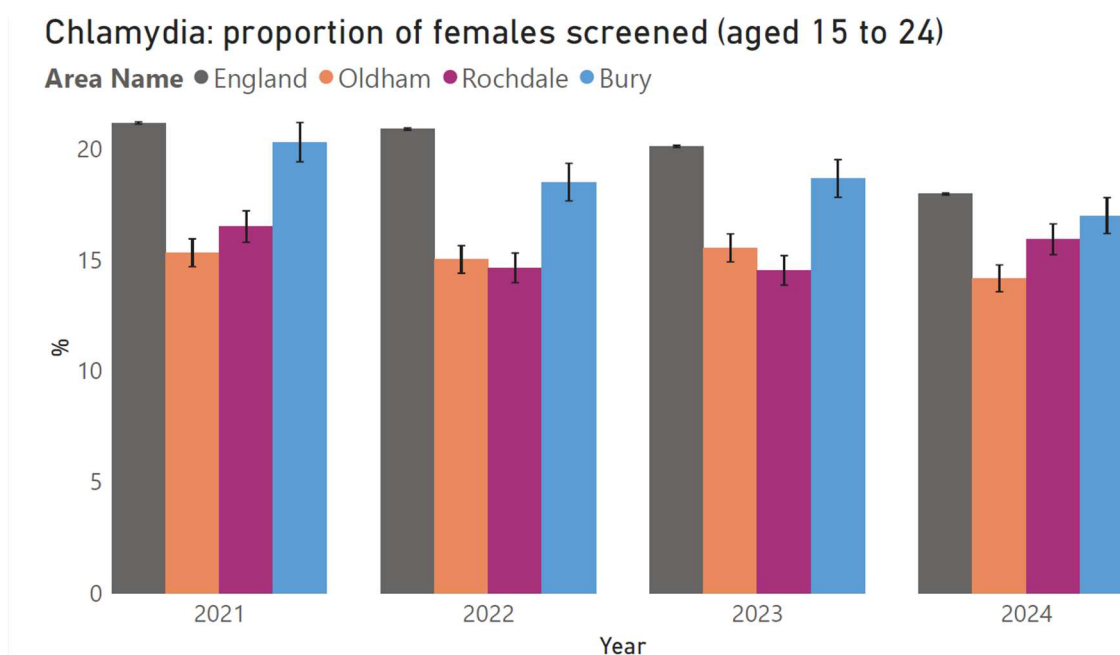


Figure 2.10: Chlamydia proportion of females aged 15 to 24 screened.⁽⁸⁾

Nationally, there was a 10.7% decrease in the number of chlamydia tests amongst 15 to 24-year-old women between 2023 and 2024, and therefore, more work needs to be done to improve NCSP uptake.⁽⁸⁾ This is particularly important as the programme contributes to reducing health inequalities. Although test coverage is relatively similar based on deprivation, detection rates are highest amongst young women living in the most deprived areas of England, as demonstrated by Figure 2.11.⁽²⁹⁾

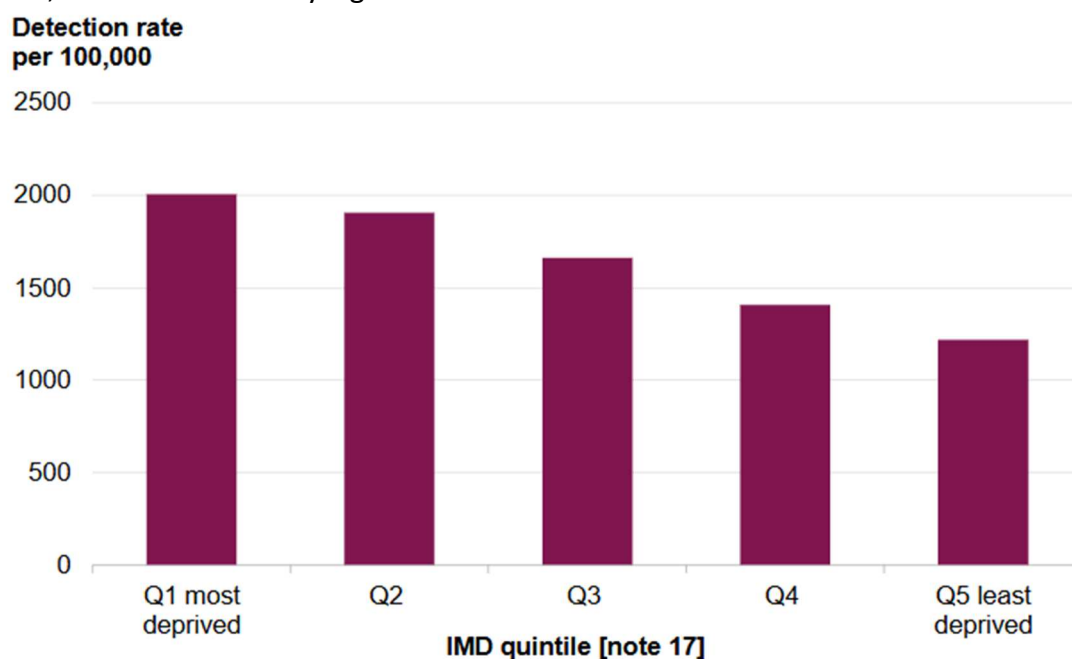


Figure 2.11: Chlamydia detection rates among women aged 15 to 24 years by IMD quintile, 2024, England (Note 17: IMD is based on the location of residence of the person tested)⁽⁸⁾

Local data shows significant variation in detection rates within ORB, some of which may be related to deprivation, alongside many other factors such as accessibility of testing, attitudes, and awareness.⁽³¹⁾

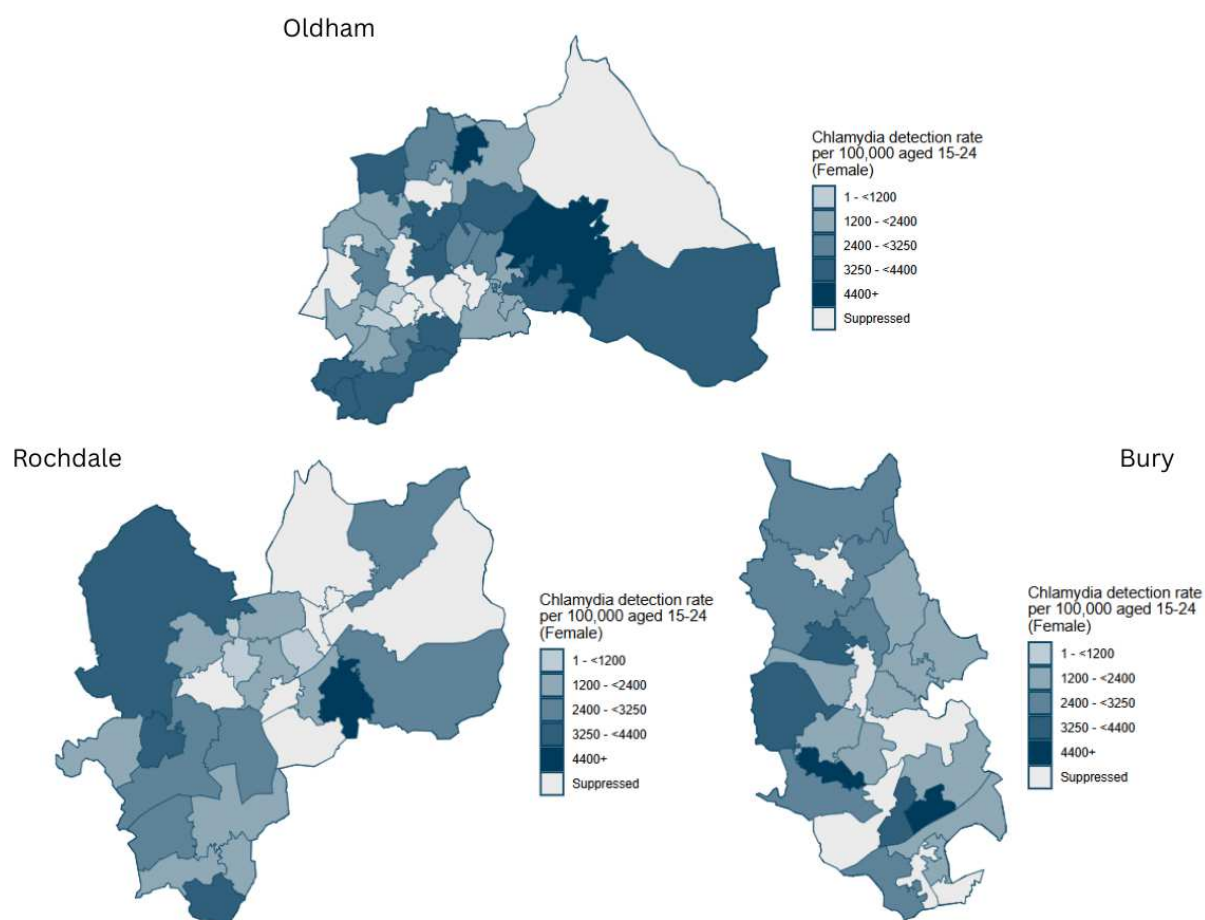


Figure 2.12: Map of chlamydia detection rate per 100,000 females aged 15 to 24 in Oldham, Rochdale, and Bury by Middle Super Output Area, 2023. ⁽³¹⁾

Gonorrhoea

Gonorrhoea rates in England more than doubled over the last decade.⁽²¹⁾ This trend has been mirrored within ORB, however, local rates remained below the national average.⁽²¹⁾ The number of gonorrhoea diagnoses in England amongst men has consistently stayed 2 to 3 times higher than amongst women.⁽²⁹⁾ Figure 2.14 shows that the excess cases in men can be attributed to persistently high rates after age 20, when corresponding rates in women drop dramatically.⁽²⁹⁾

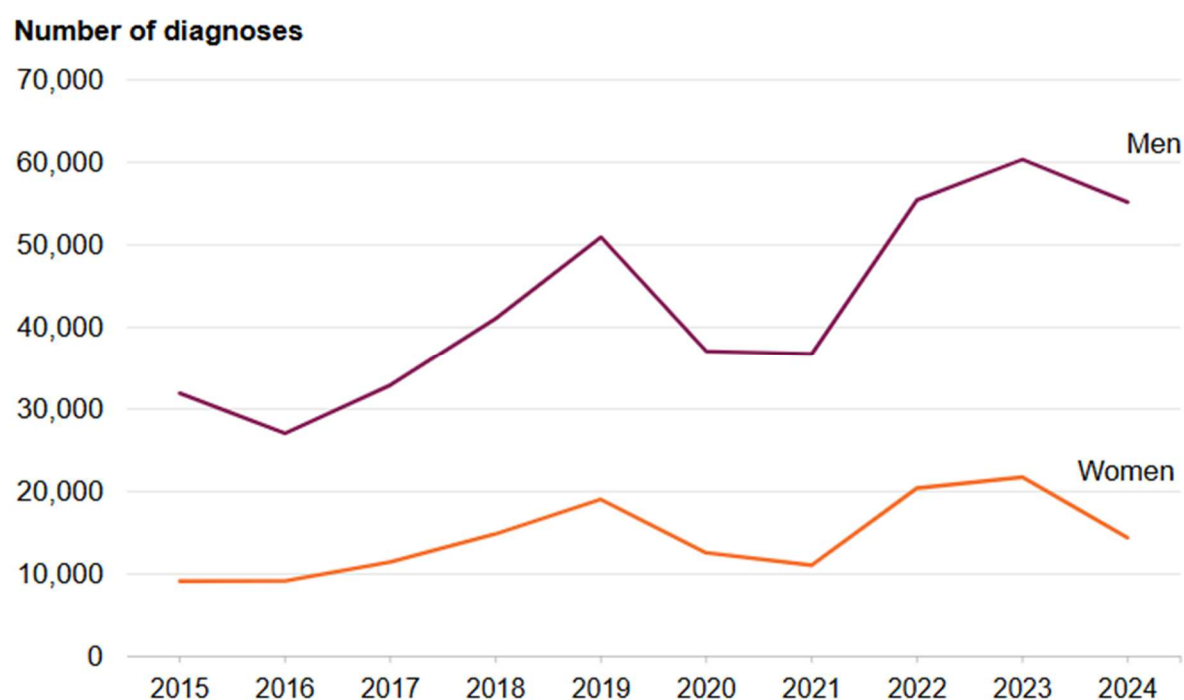


Figure 2.13: New gonorrhoea diagnoses by women and men among England residents accessing SH services, 2015 to 2024.⁽⁸⁾

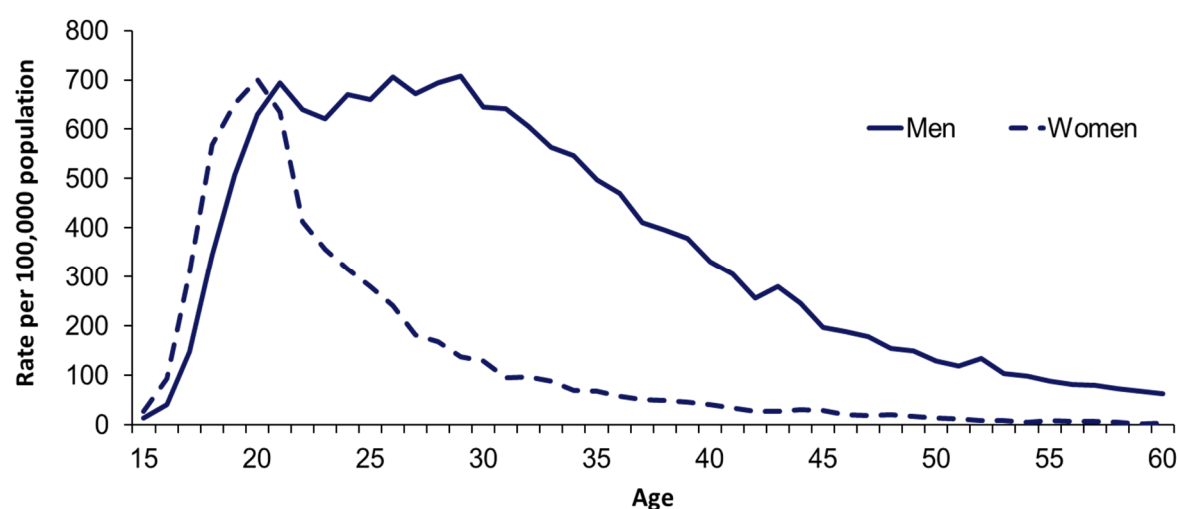


Figure 2.14: Rates of gonorrhoea diagnoses by gender and age, England, 2023.⁽²⁹⁾

In 2023, the rate of gonorrhoea diagnoses increased by 7.5% in the general population and 9.4% amongst GBMSM, reaching the highest number since records began in 1918.⁽²⁹⁾ Gonorrhoea remained the second most commonly diagnosed STI in England in 2024, accounting for 19.7% of STI diagnoses.⁽⁸⁾ However, the total number of gonorrhoea diagnoses decreased by 15.9%, with the greatest reduction seen in the 15-24 age group of 36.3%.⁽⁸⁾ It is too soon to know whether this trend will continue, meanwhile antibiotic resistance is a growing at an alarming rate.⁽⁸⁾

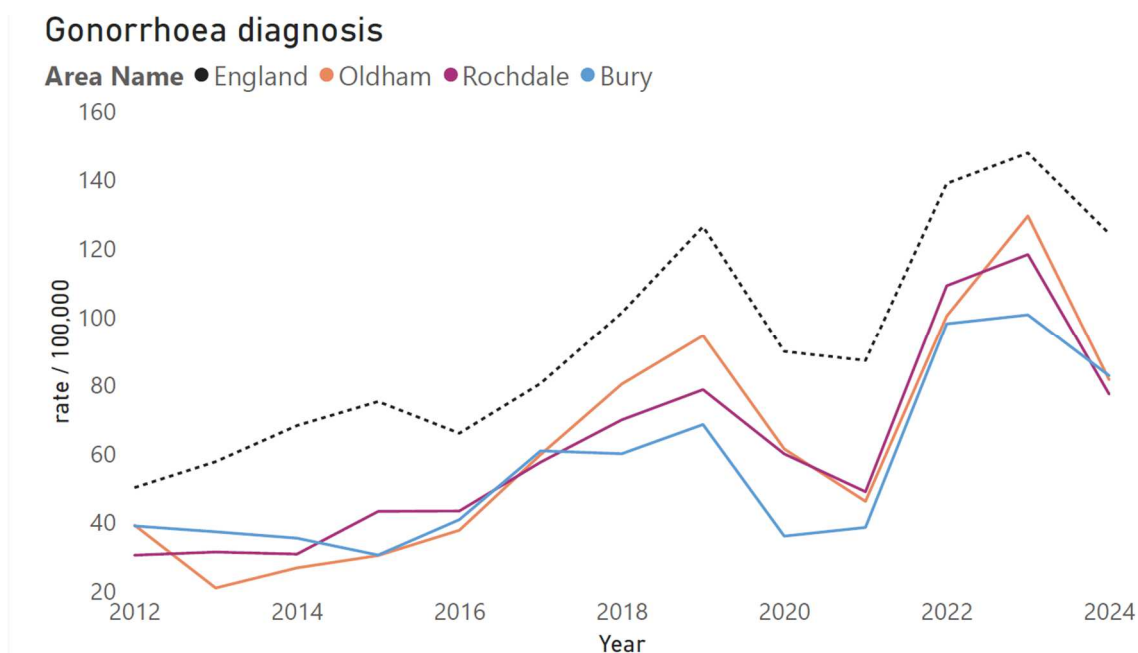


Figure 2.15: Gonorrhoea diagnostic rate per 100,000. ⁽²¹⁾

Gonorrhoea diagnoses

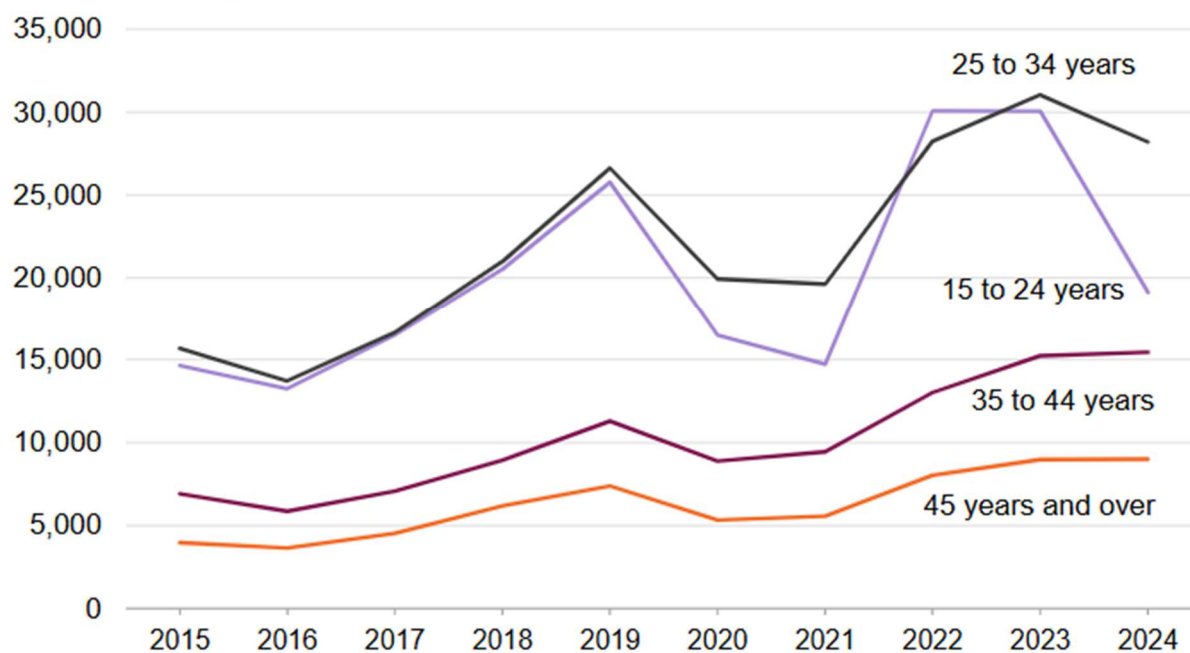


Figure 2.16: Number of gonorrhoea diagnoses by age group, 2015 to 2024. ⁽⁸⁾



Spotlight- Super gonorrhoea & vaccination

Gonorrhoea is associated with significant morbidity globally, including reproductive complications such as pelvic inflammatory disease and infertility, and severe neonatal eye infections that may lead to blindness.^(33, 34)

Gonorrhoea can be transmitted even if an infected person experiences no symptoms, and also increases the risk of HIV transmission 5-fold.^(33, 34)

The WHO has considered *Neisseria gonorrhoea* a high-priority pathogen since 2017 due to increasing antibiotic resistance, and highly resistant strains have been dubbed 'super gonorrhoea'.⁽³³⁻³⁵⁾ UKHSA have already reported 14 cases of ceftriaxone-resistant gonorrhoea

in the first 5 months of 2025, which is greater than the number of cases reported for the whole of 2024 (13 cases).⁽³⁶⁾ A significant challenge posed by *Neisseria gonorrhoeae* is reinfection. Natural infection is not protective, therefore, repeated reinfection with gonorrhoea is common.^(29, 33) Figure 2.18 shows that reinfection is disproportionately high amongst GBMSM.

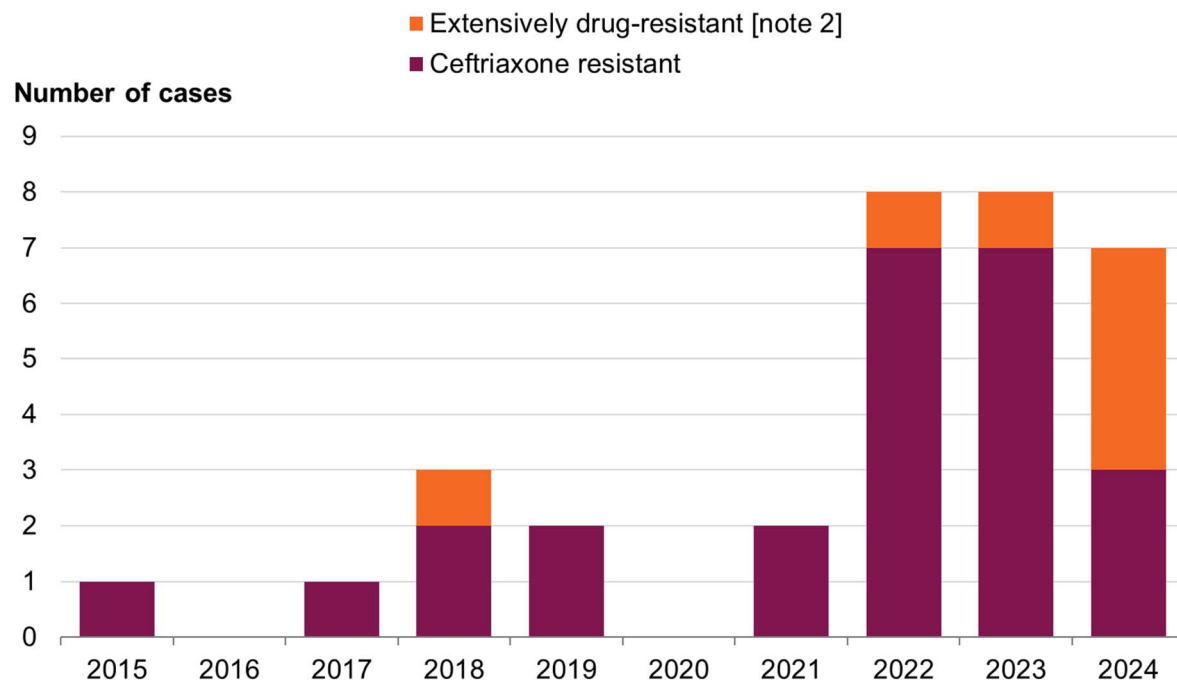


Figure 2.17: Number of confirmed cases of infection with ceftriaxone-resistant *N. gonorrhoeae* in England, January 2015 to August 2024. (Note 2: Extensively drug-resistant (XDR) infections are resistant to both first and second-line treatment options and to other antibiotics.)⁽³⁷⁾

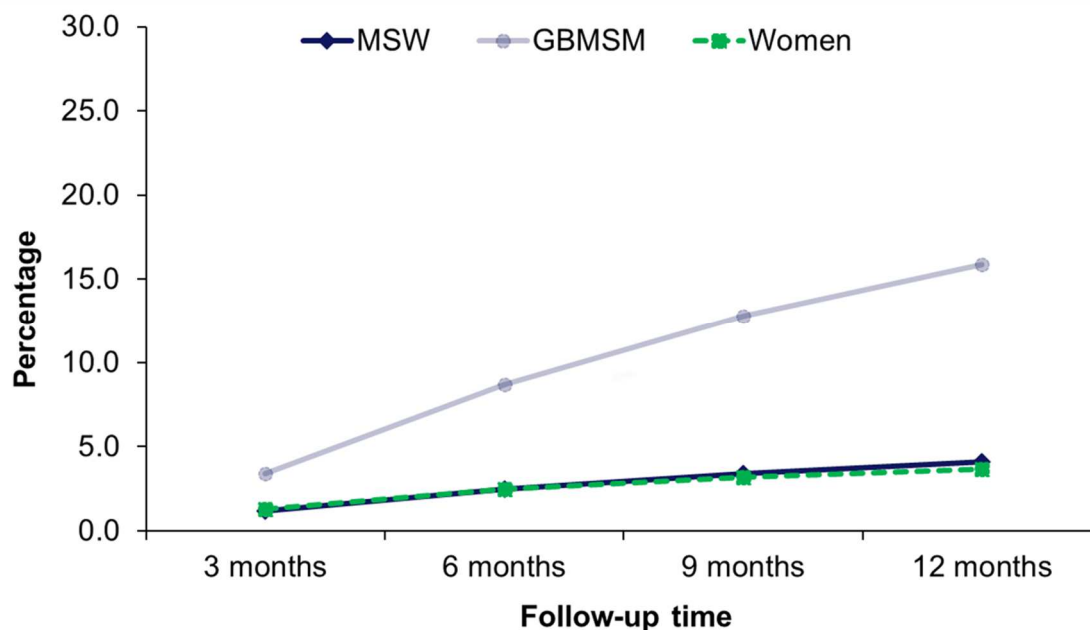


Figure 2.18: Repeat infection with gonorrhoea, England, 2019 to 2023.⁽²⁹⁾

In 2023, the Joint Committee on Vaccination and Immunisation (JCVI) advised a targeted vaccination program to reduce infections within high-risk groups.⁽³³⁾ The proposed vaccine 4CMenB was not specifically designed to prevent gonorrhoea and is administered as a routine childhood vaccination to prevent meningococcal disease.⁽³³⁾ As the intended target, *Neisseria meningitidis* is closely genetically related to *Neisseria gonorrhoea*, the vaccine offers 40% protection against gonorrhoea.^(8, 33)

In May 2025, the NHS announced the world's first vaccine program to protect against gonorrhoea.^(8, 38) The nationwide rollout is due to commence in September 2025, and some SH services will begin vaccinations in early August.⁽⁸⁾ Eligible patients will include GBMSM with a recent history of multiple sexual partners. To maximise the public health impact, people will also be offered mpox, hepatitis A and B and HPV vaccinations when attending their appointment.⁽³⁶⁾ Analysis suggests that if high uptake of the vaccine is achieved and sustained, up to 100,000 cases of gonorrhoea could be averted, saving the NHS £7.9 million over 10 years.^(36, 39)

Human Papilloma Virus

Of the 100-plus types of Human Papilloma Virus (HPV) that infect the skin and mucous membranes, the majority are self-limiting and do not cause any symptoms.⁽⁴⁰⁾ However, certain strains, such as 16 and 18, persist and can increase the risk of HPV associated cancers. This includes some mouth and throat cancers, cancers of the anus and genital areas, and up to 99% of cervical cancers.^(40, 41) Safe sex practices, such as condom use, cannot completely prevent the risk of infection, as HPV can spread via skin-to-skin contact.⁽⁴²⁾

The current HPV vaccine has been shown to prevent 90% of cervical cancer cases, and cervical screening saves approximately 5,000 lives a year.⁽⁴³⁾ In November 2023, NHS England committed to eliminating cervical cancer by 2040.⁽⁴³⁾ As the incidence of cervical cancer is 65% higher in the most deprived compared to the least deprived quintile, core to NHS England's ambition is achieving equitable uptake of screening and vaccination.⁽⁴³⁾

The HPV vaccine has been offered routinely to all girls in year 8 since September 2008, incorporating year 8 boys from September 2019.⁽⁴⁰⁾ The programme was also extended to include GBMSM in the preceding April.⁽⁴⁰⁾ Figure 2.19 reflects the increase in HPV vaccination coverage upon including boys and the drop in vaccination rates in response to COVID-19, which is yet to recover to pre-pandemic levels.⁽²¹⁾

In September 2023, the routine schedule (with certain exceptions) changed from two doses to one, as emerging evidence demonstrated equal effectiveness.⁽⁴⁴⁾ To mitigate inequalities in uptake, from December 2024, clinicians in specialist SH services have also been able to use the national stock to vaccinate eligible individuals opportunistically.⁽⁴¹⁾

HPV vaccination coverage for one dose (12 to 13 year old)

Area Name ● England ● Oldham ● Rochdale ● Bury

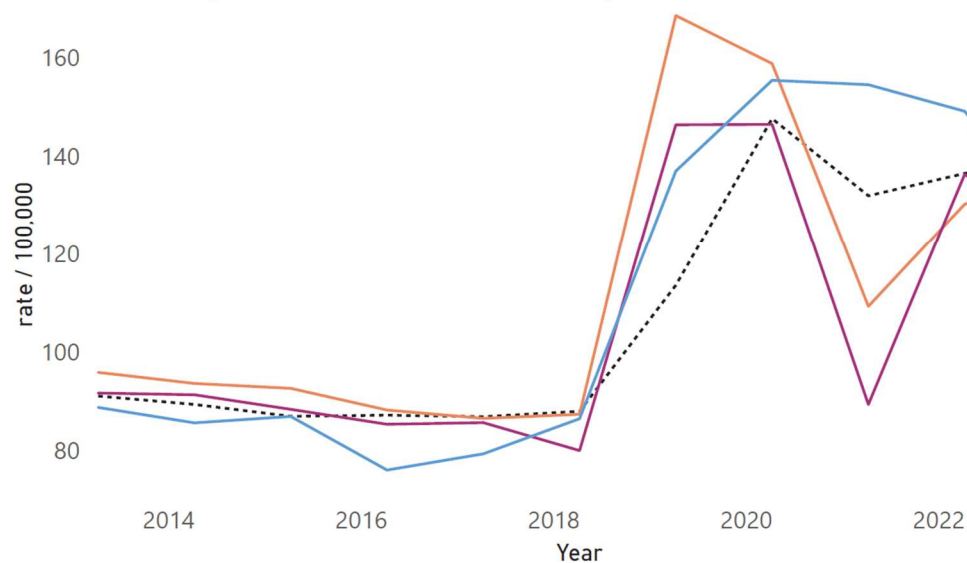


Figure 2.19: Population HPV vaccination coverage for one dose (12 to 13 years old) % females. (21)

Genital warts

In 2023, the first episode of genital warts represented 6.5% of STI diagnoses in England, and the total number of diagnoses has remained relatively stable since 2020.⁽²⁹⁾ Over the last decade, new diagnoses of genital warts have remained more common amongst men than women.⁽²⁹⁾ The quadrivalent HPV vaccine protects against HPV 6 and 11, which are the main causes of genital warts.⁽²⁹⁾ The protective effect of HPV vaccination is particularly evident in younger age groups who have been offered the vaccine since the national programme began.⁽³¹⁾

Genital warts diagnosis

Area Name ● England ● Oldham ● Rochdale ● Bury

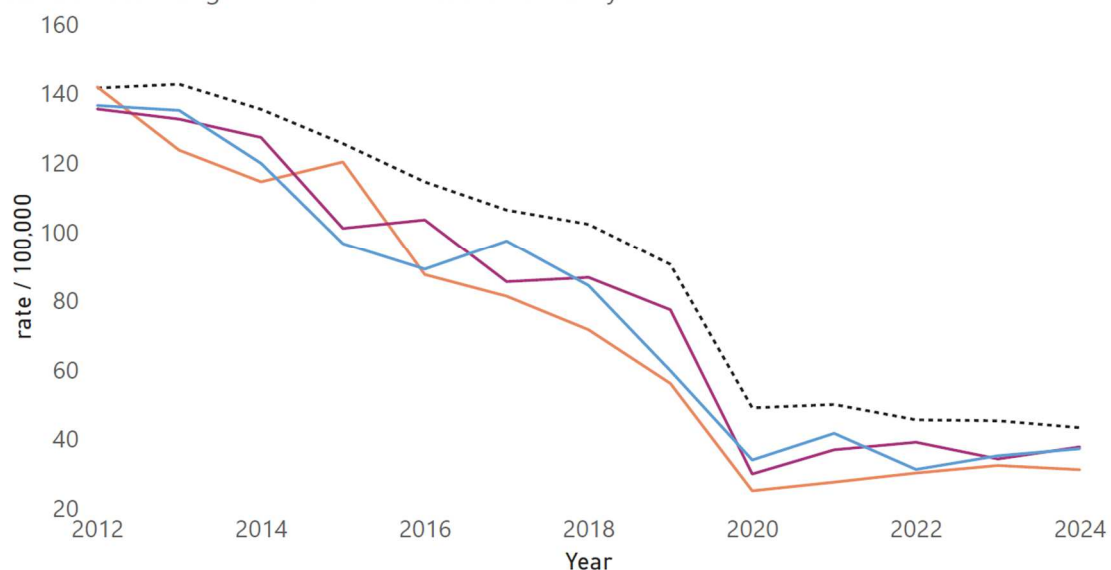


Figure 2.20: Genital Warts diagnostic rate per 100,000. (21)

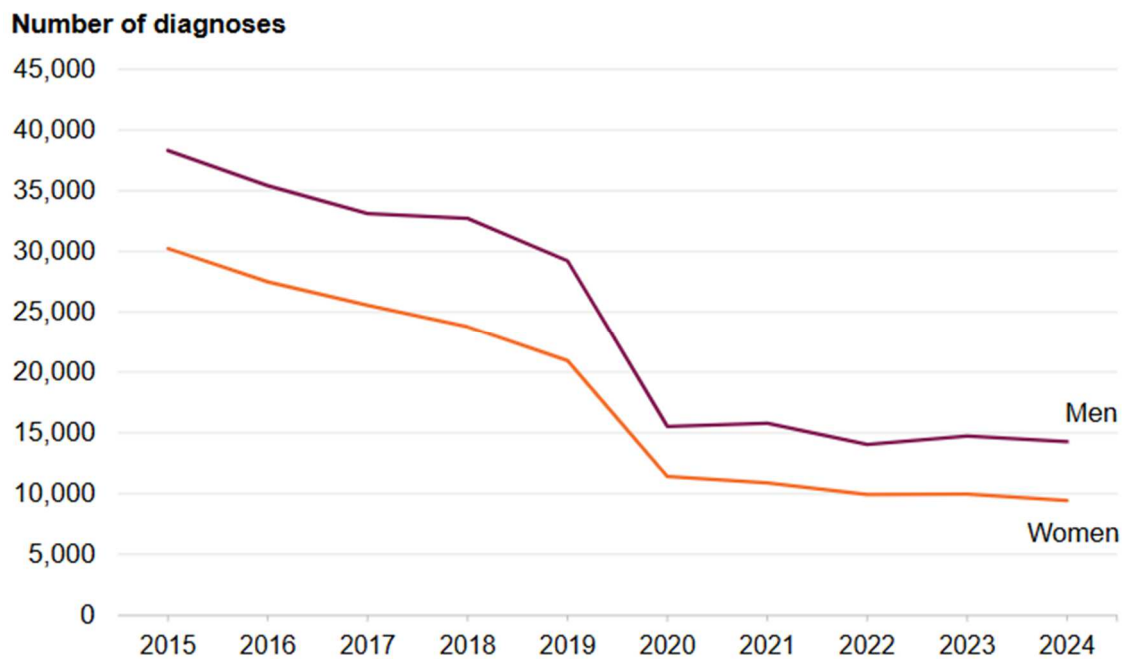


Figure 2.21: New diagnoses of genital warts (first episode) by women and men among England residents accessing SH services, 2015 to 2024.⁽⁸⁾

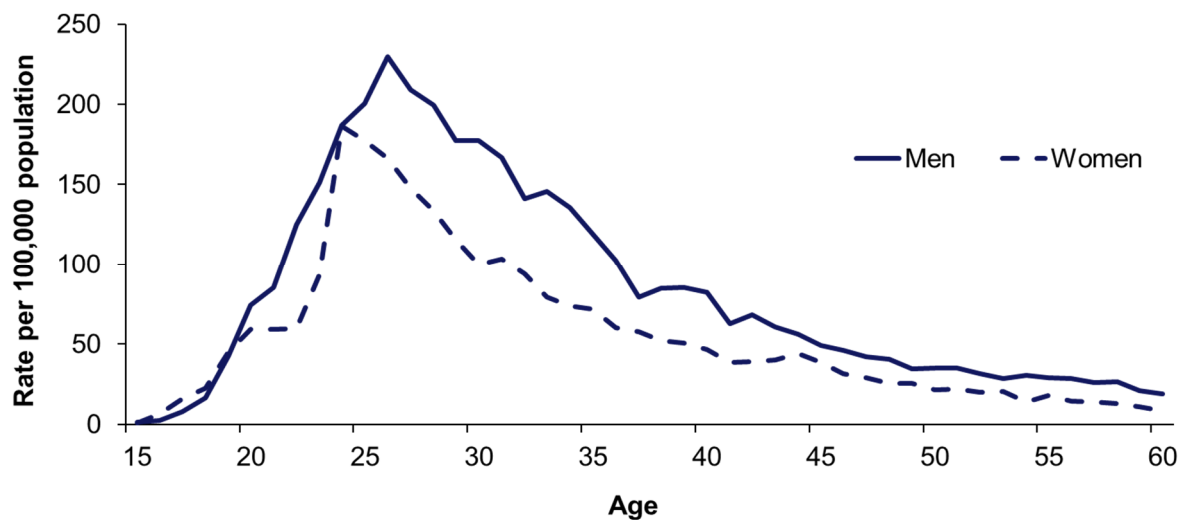


Figure 2.22: Rates of genital warts (first episode) diagnoses by gender and age: England, 2023.⁽²⁹⁾

Genital Herpes

Genital herpes, caused by the Herpes Simplex Virus (HSV), is England's most common ulcerative STI. ^(3, 45) HSV type 1 primarily causes oral herpes but can also cause genital infections, whereas type 2 HSV is associated with genital infection almost exclusively.⁽⁴⁵⁾ Many HSV infections are asymptomatic, however, they may cause systemic disease in the immunosuppressed.⁽⁴⁵⁾ Compared to other STIs, testing for genital herpes has recovered relatively slowly since the disruption of 2020, remaining lower than pre-pandemic rates. ⁽³¹⁾ As HSV can lie dormant and reactivate several times a year, individuals may frequently return

for antiviral treatment to reduce the severity and duration of symptoms. ^(3, 46) New diagnoses of genital herpes are most common amongst young women and those identifying as heterosexual. ^(3, 29)

Genital herpes diagnosis

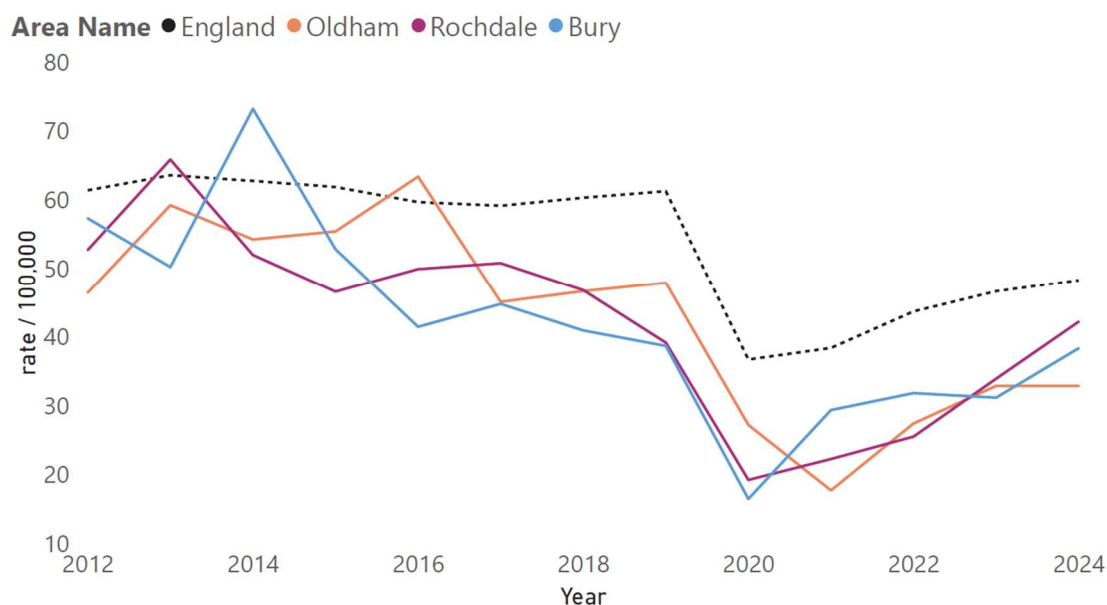


Figure 2.23: Genital herpes diagnostic rate per 100,000. ⁽²¹⁾

Number of diagnoses

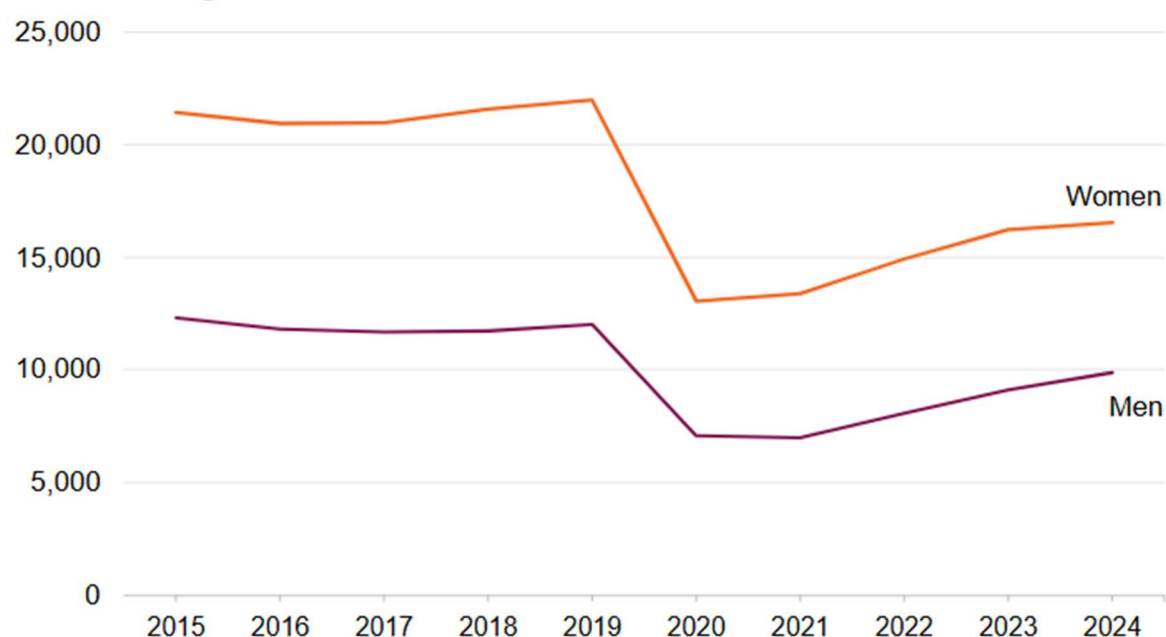


Figure 2.24: New diagnoses of genital herpes (first episode) by women and men among England residents accessing SH services, 2015 to 2024. ⁽⁸⁾

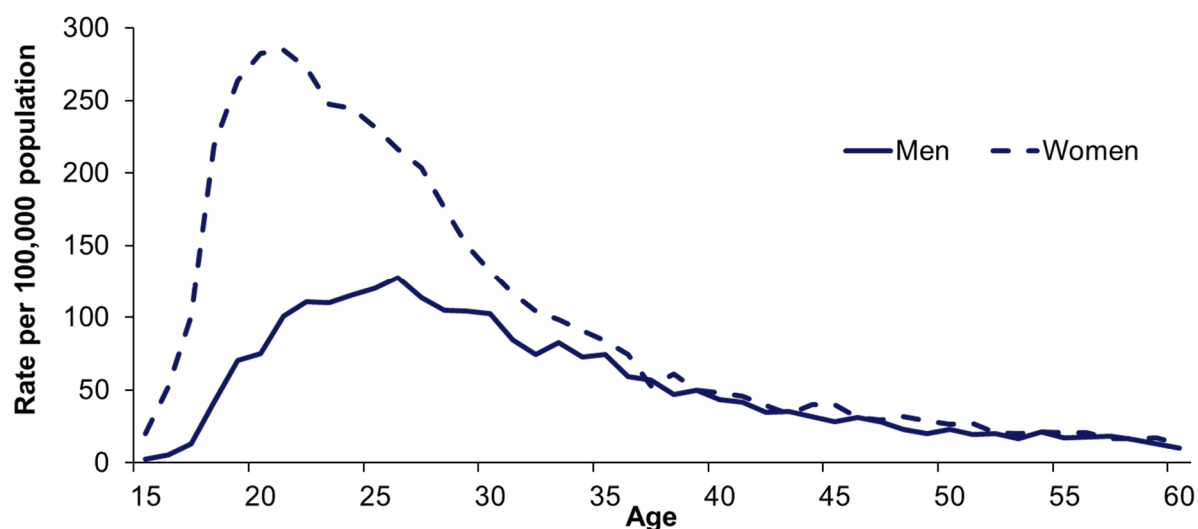


Figure 2.25: Rates of genital herpes (first episode) diagnoses by gender and age: England, 2023.⁽²⁹⁾

Syphilis

Syphilis is one of the least common STIs in England, and a small decrease or increase in diagnoses can dramatically affect local trends.⁽²¹⁾ The national picture is less impacted by small fluctuations and shows a steady increase in syphilis rates since 2020, and 2024 saw the largest annual number of syphilis diagnoses since 1948.^(8, 29) This included an increase in acute infections and late-stage complications of syphilis.⁽⁸⁾

Approximately 76% of infectious syphilis diagnoses are among GBMSM, however, recent statistics show a larger proportional rise in syphilis amongst heterosexual men and women.^(8, 29, 47) London is a geographical hotspot for syphilis, although outbreaks and clusters have also occurred in Brighton and Manchester.⁽⁴⁸⁾ The UKHSA has published a Syphilis Action Plan to address this increase, focusing on more frequent testing, partner notification, and raising awareness.^(29, 48)

Syphilis diagnosis

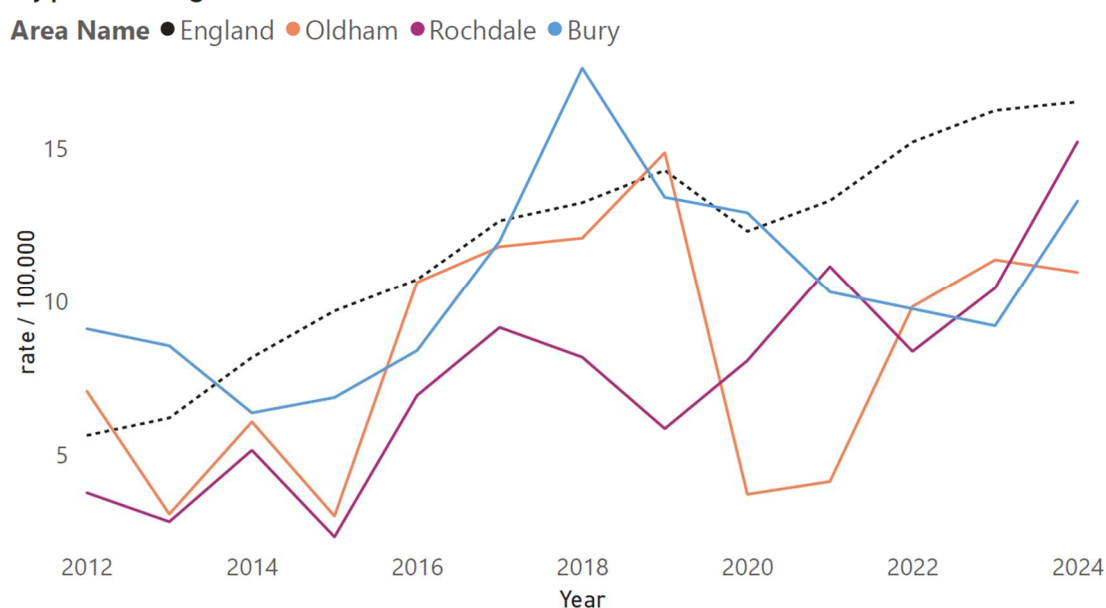


Figure 2.26: Syphilis diagnostic rate per 100,000.⁽²¹⁾

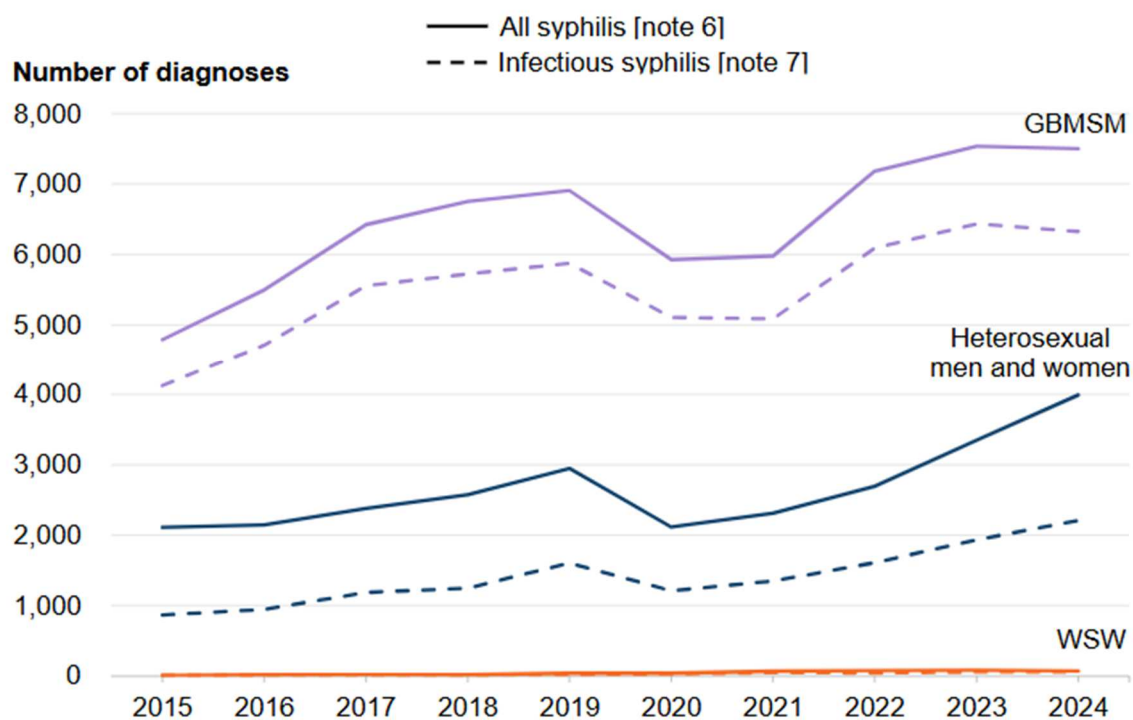


Figure 2.27: Number of diagnoses of syphilis among England residents accessing SH services, 2015 to 2024 (WSW = women who have sex with women. Note 6: includes infectious syphilis and late stage and complications of syphilis. Note 7: includes diagnoses of primary, secondary, and early latent syphilis.) ⁽⁸⁾

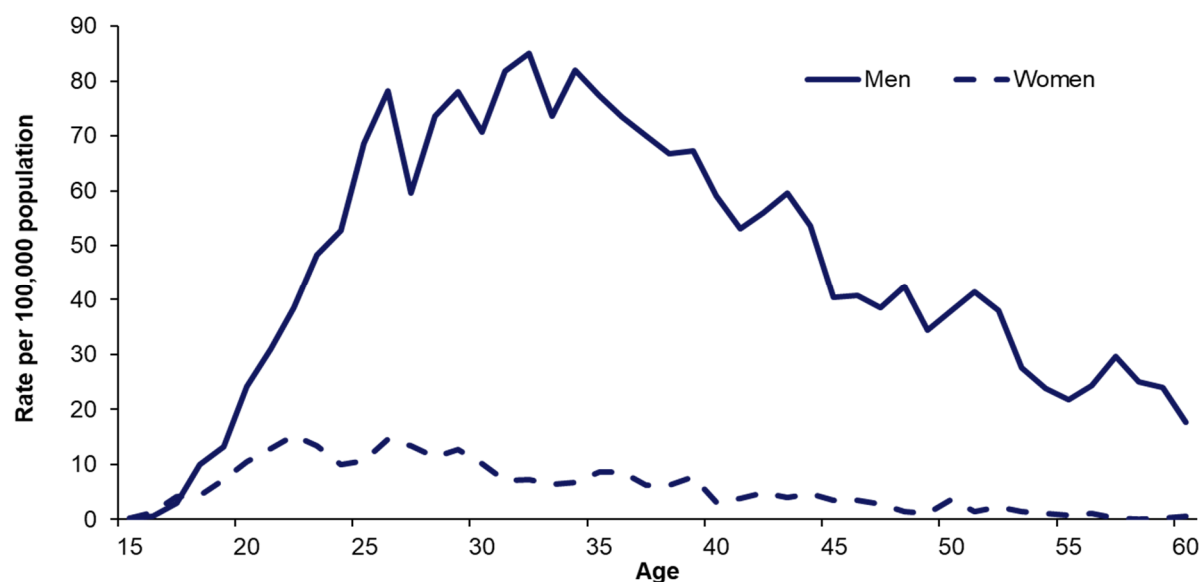


Figure 2.28: Rates of infectious syphilis (including primary, secondary and early latent diagnoses) by gender and age, England, 2023. ⁽²⁹⁾



DoxyPEP

A potential strategy to combat the rise in bacterial STIs, such as syphilis, is doxycycline as post-exposure prophylaxis (DoxyPEP). It is recognised that many patients choose to take antibiotics such as doxycycline before and/or after a sexual interaction to reduce the risk of STI transmission. However, in 2017, PHE and the British Association for Sexual Health and HIV (BASHH) published a joint statement that did not endorse the use of DoxyPEP for STIs. This recommendation was reaffirmed by UKHSA in 2021 due to the potential for antibiotic resistance to develop in STIs and other bacteria, posing a significant public health risk.^(49, 50) However as research continues to emerge, the consensus around DoxyPEP may shift.⁽⁵¹⁾

Sexually transmitted Shigella

Shigellosis is an emerging STI within England that was recently added to Fingertip's SRH Profiles in June 2023.⁽³¹⁾ Cases of sexually transmitted shigellosis increased by 13% in 2024 and there was a corresponding increase in extensively drug-resistant isolates.⁽⁵¹⁾ As it presents with fever, abdominal pain, and diarrhoea, which may be bloody, many patients present to the GP or A&E rather than SRH services.⁽³¹⁾ Most cases resolve without any intervention, however, complications may lead to hospital admission. Surveillance suggests that transmission is commonly associated with Chemsex (sexualised drug use) or multiple casual sexual partners amongst GBMSM.⁽³¹⁾ However, intelligence indicates that only a minority of GBMSM are aware of Shigella and the associated risks, precautions and treatments.⁽³¹⁾

Sexually transmitted Shigella spp. / adult males

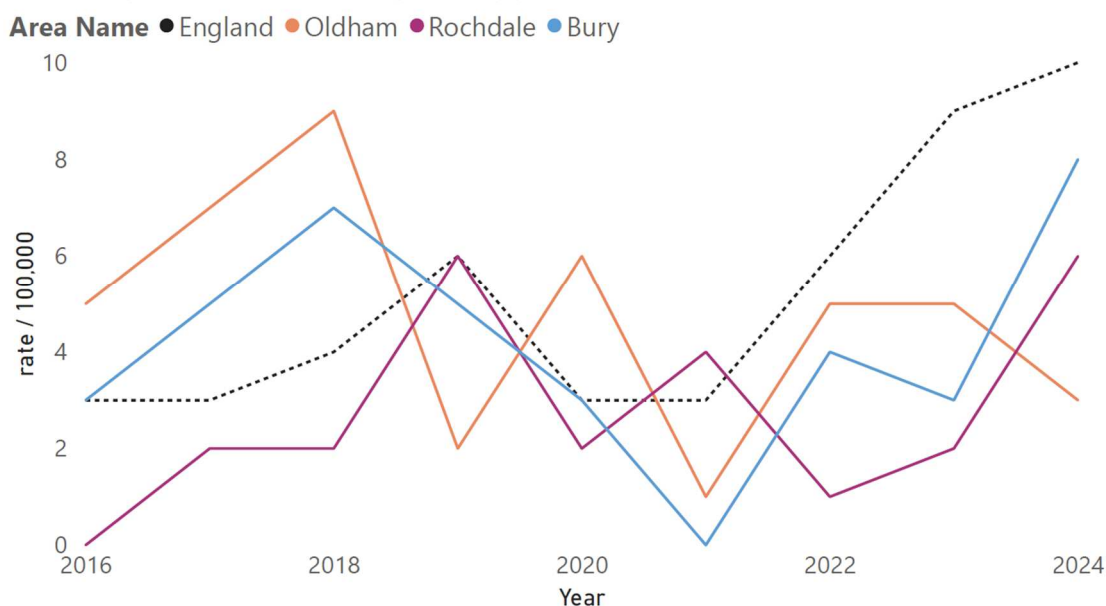


Figure 2.29: Rates of sexually transmitted Shigella in adult males⁽²¹⁾



Mpox

Mpox is caused by infection with the MPXV virus, which may be spread by close contact with lesions, respiratory droplets, contaminated material (such as bedding) or bodily fluids.⁽⁵²⁾ Therefore, sexual contact is a high-risk activity for MPXV transmission. Historically, mpox cases in England were rare and mostly linked to travel to countries where the virus was endemic.⁽⁵²⁾ An international outbreak in May 2022 led to sustained transmission in the UK, mainly affecting GBMSM. In response, targeted vaccination was offered to those at highest risk of mpox, including GBMSM and workers at risk of occupational exposure.⁽⁵²⁾

Number of mpox cases

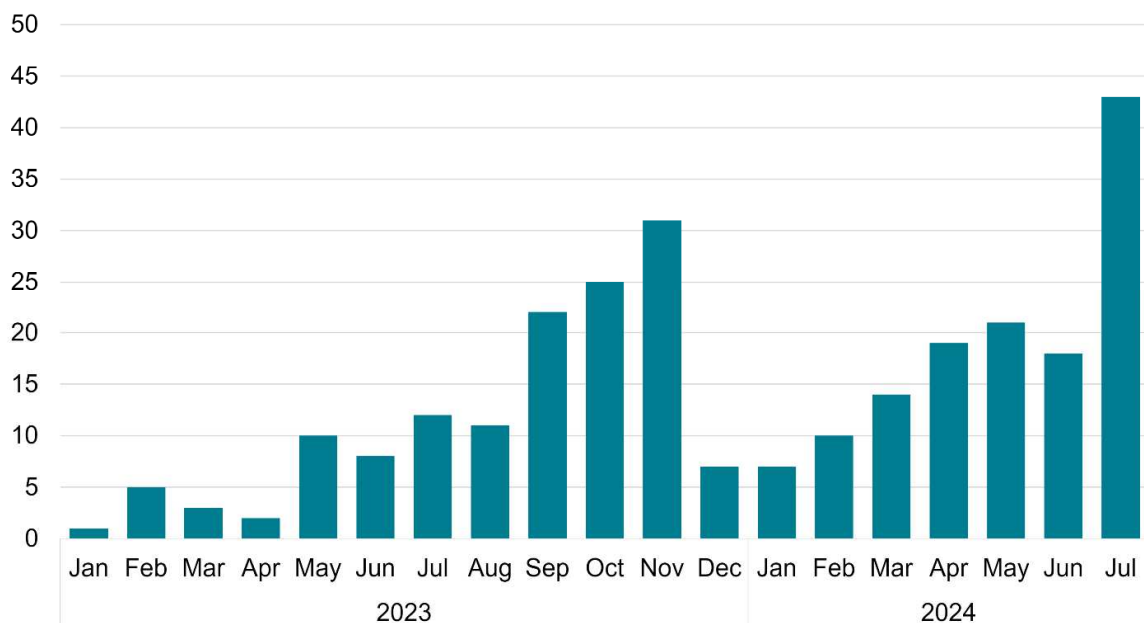


Figure 2.30: Mpox figures England.⁽⁵³⁾

The national offer for reactive mpox vaccination ended in summer 2023.⁽⁵⁴⁾ However, due to clusters of locally transmitted cases, vaccination continued in London and Manchester. In November 2023, the JCVI recommended that a routine mpox vaccination strategy be developed nationwide. From February 2025, every region in England has been able to offer the mpox vaccine to residents at increased risk⁽⁵⁵⁾.

However, limited vaccine supply has resulted in logistical challenges.⁽⁵⁶⁾ As a temporary measure, SH services have used a much lower intradermal dose of the vaccine as a 'dose sparing' technique.⁽⁵⁶⁾ This has allowed healthcare professionals to vaccinate a greater number of at-risk patients in the short term.⁽⁵⁶⁾ As vaccine supply stabilises, clinics will return to offering full intramuscular doses.

Human Immunodeficiency Virus (HIV)

HIV is associated with significant mortality, morbidity and healthcare costs. HIV diagnosed prevalence is increasing across ORB in line with the national picture, which is likely due to the improved life expectancy of people living with HIV.^(3, 31) People diagnosed promptly with HIV and who start anti-retroviral therapy (ART) early can expect near-normal life expectancy. Challenges remain, however, in the form of high rates of late HIV diagnoses and stark health

inequalities associated with HIV outcomes. GM is enrolled as a 'Fast Track City', an international initiative to end new cases of HIV by 2030, and has exceeded expectations.⁽⁵⁷⁾ Collectively, GM has achieved the '95:95:95' target (see Figure 2.31) 9 years ahead of schedule.⁽⁵⁷⁾

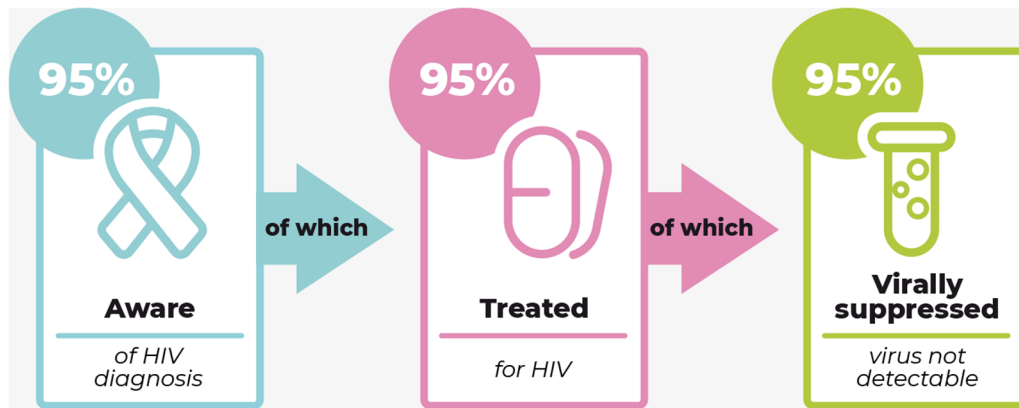


Figure 2.31: UNAIDS 95:95:95 target ⁽⁵⁸⁾

HIV diagnosed prevalence

Area Name ● England ● Oldham ● Rochdale ● Bury

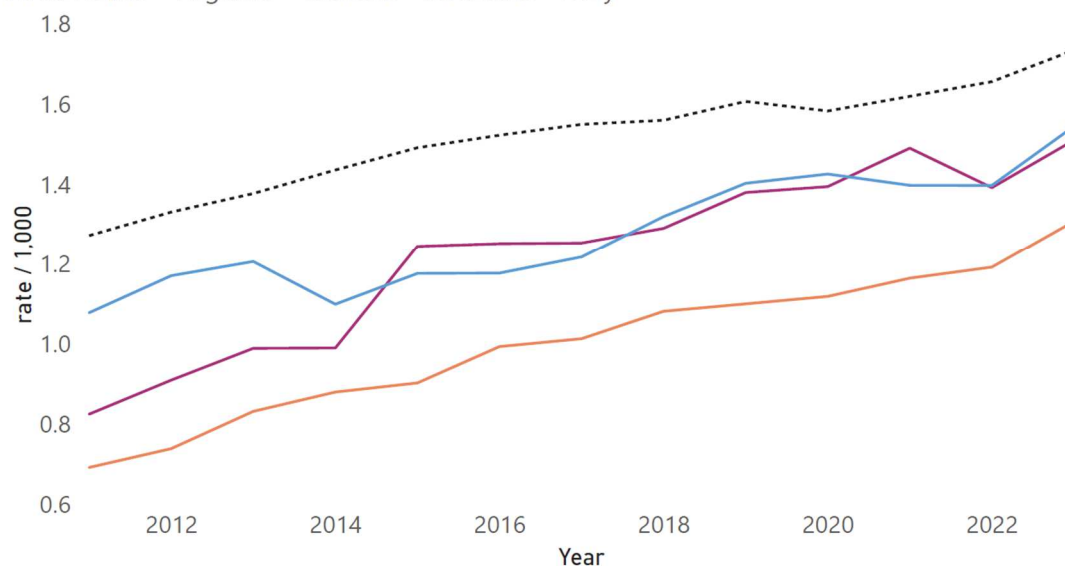


Figure 2.32: HIV diagnosed prevalence rate. ⁽²¹⁾

New HIV diagnosis

Area Name ● England ● Oldham ● Rochdale ● Bury

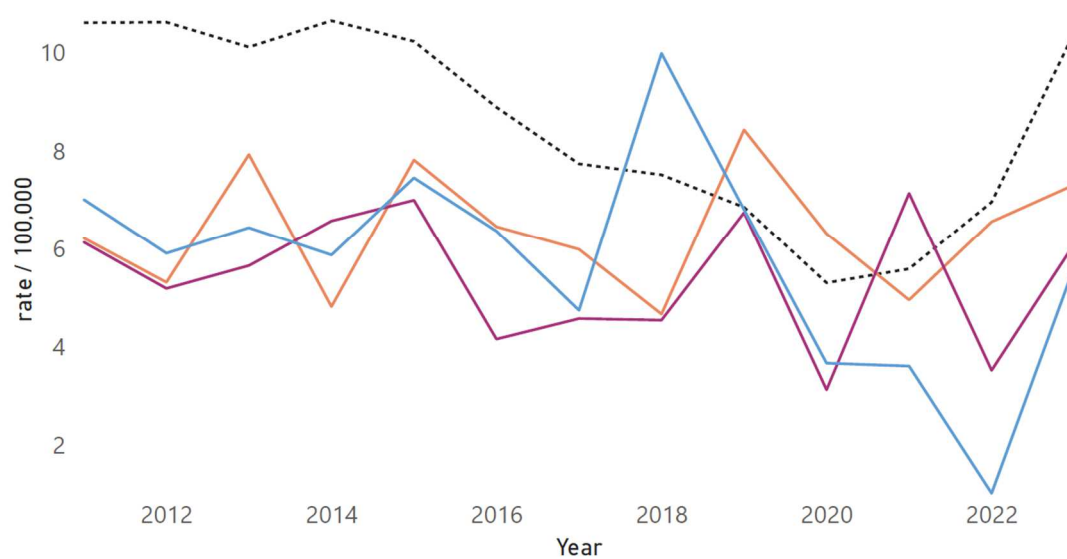


Figure 2.33: New HIV diagnosis rate. ⁽²¹⁾

HIV late diagnosis in people first diagnosed with HIV in the UK

Area Name ● England ● Oldham ● Rochdale ● Bury

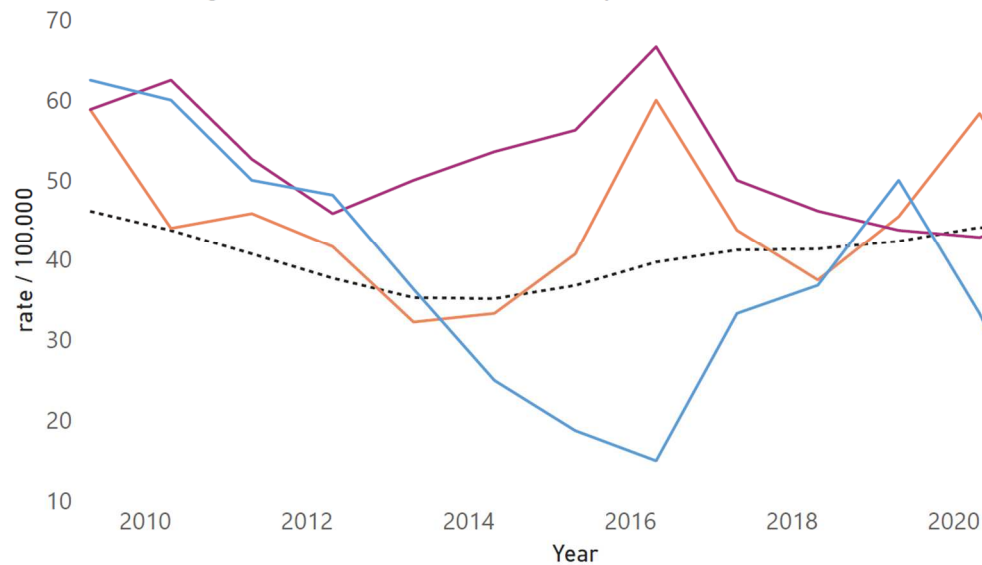


Figure 2.34: HIV late diagnosis in people first diagnosed with HIV in the UK- 3 year combined. ⁽²¹⁾

HIV testing

Area Name ● England ● Oldham ● Rochdale ● Bury

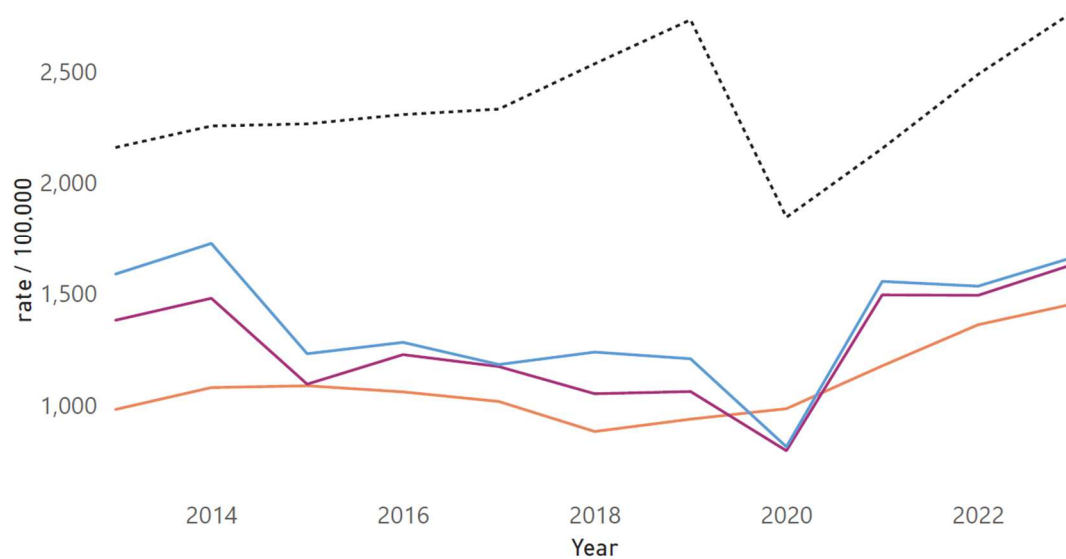


Figure 2.35: HIV testing coverage. ⁽²¹⁾



Spotlight: Opt-Out Testing for Blood-Borne Viruses (BBV)

As part of the strategy to reduce HIV transmission, an opt-out BBV testing programme has been rolled out nationally. Anyone over the age of 16 who is already having a blood test at a participating ED is eligible for HIV, Hepatitis B and Hepatitis C testing.⁽⁵⁷⁾ The first wave included 34 EDs across the country, and due to high local prevalence, 4 of these sites were based in GM. Within ORB, in March 2025, the Royal Oldham Hospital and Fairfield General Hospital commenced the scheme.

PRELIMINARY RECOMMENDATIONS

1. Share the STI Prioritisation Framework amongst stakeholders to align common goals
2. Promotion of NCSP with a focus on women in areas of socio-economic deprivation
3. Implementation of a comprehensive 4CMenB vaccination to prevent gonorrhoea
4. Targeted strategy to increase the uptake of HPV vaccination to pre-pandemic levels
5. Educate professionals to monitor and counsel service users regarding DoxyPEP
6. To establish and expand routine mpox vaccination as the national supply increases
7. Campaign to raise awareness of Shigellosis amongst the GBMSM community
8. Continue the promotion and implementation of opt-out HIV testing across ORB

4. Reproductive Health

PENDING- this chapter will feature in the final report

5. Services

Not only do ORB work together to provide SRH services, but there is also widespread collaboration across GM. This has led to 'cross-charging' agreements between the 10 local authorities, which help integrate the SRH services by facilitating open access. These contracts are regularly reviewed to ensure cost effectiveness and fairness across the boroughs. This chapter will focus on recent changes in ORB, encompassing pharmacies, GPs, specialist SRH and midwifery services, and vital third-sector organisations.

Pharmacies

Community pharmacies are a cornerstone of health and well-being in our local communities. They are often more accessible due to their longer opening hours, convenient locations, and the ability to walk in without an appointment. The three core SRH services traditionally offered by community pharmacies have been:

1. Advice and signposting

Pharmacies have hyperlocal knowledge about the services in their area and can provide general sexual health advice, as well as items such as condoms and lubrication for safer sex.

2. Chlamydia Screening & Treatment (CST)

In community pharmacy settings, screening is now only proactively offered to women, unless there is an indication, such as being symptomatic or a partner of someone with chlamydia.⁽³⁰⁾

3. Emergency Hormonal Contraception (EHC)

Community pharmacies in ORB offer EHC to women who request emergency oral contraception following unprotected sexual intercourse or potential contraception failure, within 72 hours.

Advanced Pharmacy Contraception



Progesterone Only contraceptive Pills (POP) have been available for purchase over-the-counter from pharmacies without a prescription since 2021.⁽⁵⁹⁾

From Spring 2023, pharmacies have also been able to register for the ongoing monitoring and supply of oral contraception as part of an NHS initiative.^(60, 61)

From December 2023, this NHS service was extended to include the initiation of oral contraception, subject to a confidential consultation with a specially trained pharmacist.^(60, 61)

This service aims to improve access and provide greater choice for patients who do not need to be registered with a GP. Patients can access a Combined Oral Contraceptive (COC) or the POP free of charge, provided they satisfy the medical eligibility criteria.

In March 2025, the Department of Health and Social Care (DHSC) announced a significant expansion to the Pharmacy Contraception Service (PCS).⁽⁶²⁾ The change aims to reduce

regional variation and provide more equitable access by commissioning EHC supply and consultations nationally.⁽⁶²⁾

General Practice

GPs provide a wealth of SRH advice alongside LARC and are a key point of access to refer to specialist SRH services. The graph below shows a downward trend in the rate of LARC prescribed by GPs in ORB over the last decade. This decline could be due to several factors, such as changing attitudes towards contraceptive choices. However, long waiting lists suggest that access is also a barrier.

GP prescribed LARC excluding injections

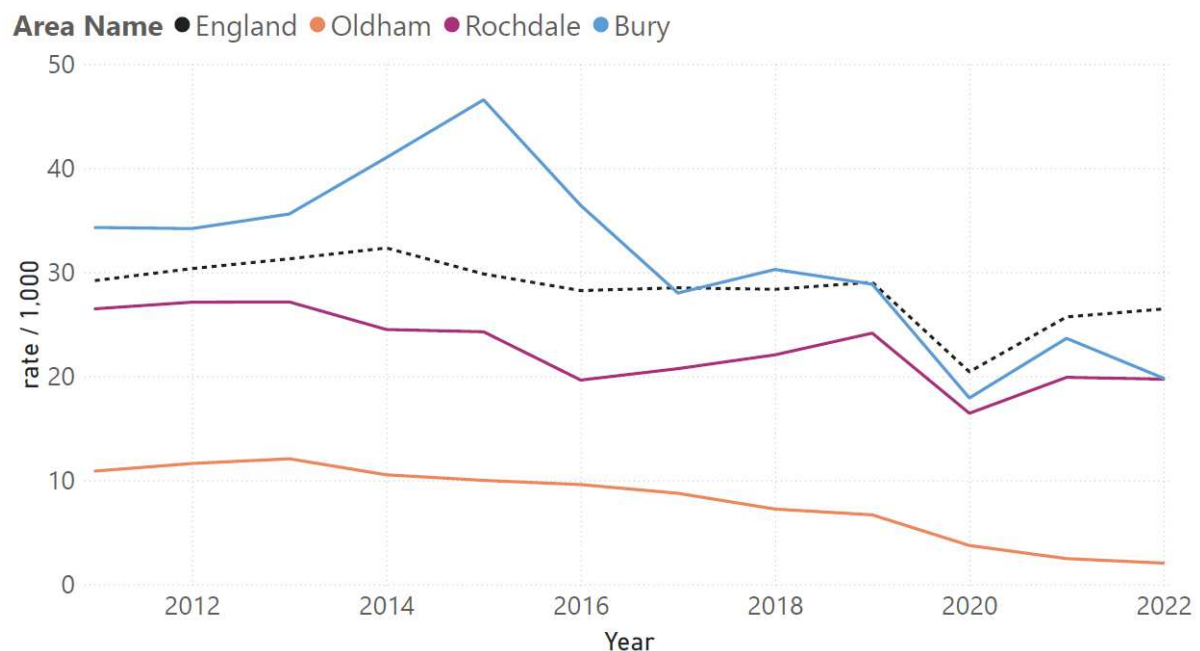


Figure 4.1: GP prescribed LARC (excluding injections) / 1000 ⁽²¹⁾

Long-Acting Reversible Contraception



There is a variety of LARC methods to choose from, offered by different primary care and specialist SRH providers. LARC was highlighted as an issue of national concern in a 2023 Primary Care Women's Health Forum report, "[On the brink- The reality of LARC provision in primary care](#)".⁽⁶³⁾ Funding challenges, training and workforce issues, and reduced capacity have led many GP practices to cease or consider stopping the provision of LARC fitting in practice across the country.

Case study: General Practice

Bury has historically reported higher rates of GP-prescribed LARC (excluding injections) than Rochdale, Oldham, and England, as shown by Figure X. However, the number of practices in Bury offering LARC decreased by almost 50% in five years. As of May 2024, approximately 160 women were waiting for a coil, and 68 women were waiting for contraceptive implants in Bury. Bury's Public Health team has worked with HCRG to improve access to LARC in the short term and sustainably increase long-term LARC capacity in primary care. This involves highlighting training support, reviewing, and proposing amendments to the delivery model.

By October 2024, the list of women awaiting a coil fitting had reduced significantly to around 60. Despite this improvement, there was still a 3-month waiting list, and only 8 out of 26 GP practices in Bury were signed up to deliver LARC. As a result, 44% of Bury's population had no access to LARC within primary care, leading many women to seek routine LARC within specialist SRH services.

Specialist SRH services

Case study: Women's Health Hubs

In addition to supporting individual GP practices, ORB Public Health Teams have been working with local integrated care boards (ICB) to develop [women's health hubs](#) (WHH).⁽⁶⁴⁾ WHHs integrate women's health services in the community by bringing together healthcare professionals across a population footprint. By pooling expertise and resources, the WHH model aims to improve access to and experiences of care. This, in turn, will help to reduce health inequalities and improve women's health outcomes.

In October 2024, the Bury GP Federation opened a WHH in Prestwich. Held weekly on Sunday afternoon, the hub takes LARC referrals from any Bury GP practice that does not offer LARC. A similar Borough-Wide Primary Care Service is based in Littleborough, Rochdale.

The aim was to expand the service so that every Primary Care Network (PCN) in ORB has a WHH. However, recent governmental reports suggest the existing funding and operational model may be subject to change.⁽⁶⁵⁾ ORB and GM will adapt to continue working towards integrated community SRH services that reflect the life course approach to women's health.

Case study: Midwifery Services

ORB has recently worked with midwifery services to introduce LARC into the Royal Oldham Hospital. The aims of the service are to:

- Prevent unplanned pregnancy at a time when women are more likely to get pregnant
- Increase access to LARC at a time when it's convenient for women
- Support vulnerable people to access contraception when they may not ordinarily access sexual health services

Midwives will provide information about all contraceptive methods' suitability, risks, and possible side effects, failure rates to all women at 28 weeks of gestation. Women who are under the care of the Rochdale and Oldham Midwifery Enhanced Service (ROMES) will be offered implants before leaving the post-natal ward or being booked into a clinic.⁽⁶⁶⁾

Bury women may also access Bolton or North Manchester Foundation Trusts for maternity care. Bury Public Health and HCRG are working with both organisations to link women to either Bury Primary Care or SRH services for their post-natal contraceptive needs. In addition, they are exploring training opportunities for midwives working with Bury women to provide post-natal contraception via a contraceptive implant, particularly to the most vulnerable women.

Sexual Health Hubs

Throughout ORB, most community SRH services are delivered by HCRG Care Group, which rebranded in December 2021 from its former name, Virgin Care. HCRG partners with the NHS and SH:24, an online sexual health service, to form 'The Sexual Health Hub'. ^(67, 68)



Figure 4.2: Sexual Health Hub logo for ORB⁽⁶⁷⁾

A Sexual Health Hub is based in each locality, offering a mix of bookable and walk-in appointments:

- The Integrated Care Centre, Sexual Health Oldham, OL1 1NL
- Nye Bevan House, Rochdale, OL11 1DN
- Townside Primary Care Centre, 1 Knowsley Place, Bury, BL9 0SN

All of the Sexual Health Hubs offer a comprehensive range of services, including:

- Sexual health advice and guidance
- Express STI testing with no appointment needed
- Fittings for LARC
- Injectable contraception
- Oral contraception
- Emergency contraception – coils and pills
- Testing and treatment for STIs
- Condoms and lubricant
- PrEP (Pre-exposure prophylaxis) HIV prevention medication
- PEP – (Post-exposure prophylaxis) emergency HIV prevention medication
- HIV treatment and care
- Partner notification
- Hepatitis B vaccination
- HPV vaccination
- Psychosexual counselling (by GP referral)

The following community clinics can also offer appointments for asymptomatic screening and most forms of contraception:

- Failsworth Primary Care Centre, Ashton Road West, Failsworth, M35 0AD
- Middleton Health Centre, F1, Middleton Way, Middleton, M24 4EL
- Redbank GP, Radcliffe Primary Care Centre, 69 Church St W, Radcliffe, M26 2SP

Every week, one of the hubs offers Saturday appointments. HCRG has created signposting videos that walk service users through a visit to the Oldham and Bury hubs.



Figure 4.3: What to Expect: Oldham Integrated Sexual Health Service video. ⁽⁶⁷⁾

PaSH Partnership

PaSH is a collaboration of partners who are “Passionate about Sexual Health across GM”, comprising BHA for Equality, George House Trust, and the LGBT Foundation⁽⁶⁹⁾. The partnership delivers interventions to meet the changing needs of people at greatest risk of acquiring HIV, newly diagnosed with HIV, and living longer term with HIV. PaSH is commissioned across all 10 GM localities and aims to empower people to practice safer sex, whilst raising HIV awareness and improving access to services.


<div><div>The PaSH  Partnership</div><div>Passionate about Sexual Health across Greater Manchester</div><div>  </div></div>		
<u>BHA for Equality</u>	<u>George House Trust</u>	<u>LGBT Foundation</u>
Free & confidential sexual health services for Black, Asian, and Minority Ethnic communities. ⁽⁷⁰⁾	Free & confidential support, advice, and advocacy services for people living with HIV. ⁽⁷¹⁾	Providing advice, support, and resources for LGBT people to take control of their sexual health and wellbeing. ⁽⁷²⁾

Figure 4.4: The PaSH Partnership organisations

Manchester Action on Street Health

MASH provides vital, confidential, and non-judgmental support to female sex workers across ORB.⁽⁷³⁾ Key areas of focus include sexual health, substance misuse, and safety. Recognising the severe health inequalities and social challenges faced by sex workers, MASH takes a trauma-informed and compassionate approach, ensuring access to essential services while advocating for safer working conditions.

Through strong partnerships with organisations like Turning Point, local Community Safety teams, Mental Health Services, and Sexual Health Services, MASH offers tailored support in various settings. In Oldham and Rochdale, assistance is available for both street and sauna-based sex workers, while in Bury, services are provided exclusively through saunas. In Q3 of 2024, MASH supported more than 80 ORB residents.



Figure 4.5: Manchester Action on Street Health

6. Engagement

- Qualitative data collected- analysis pending



Figure 5.1: Qualitative feedback survey poster designed by Voice-2-Voice Workers

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