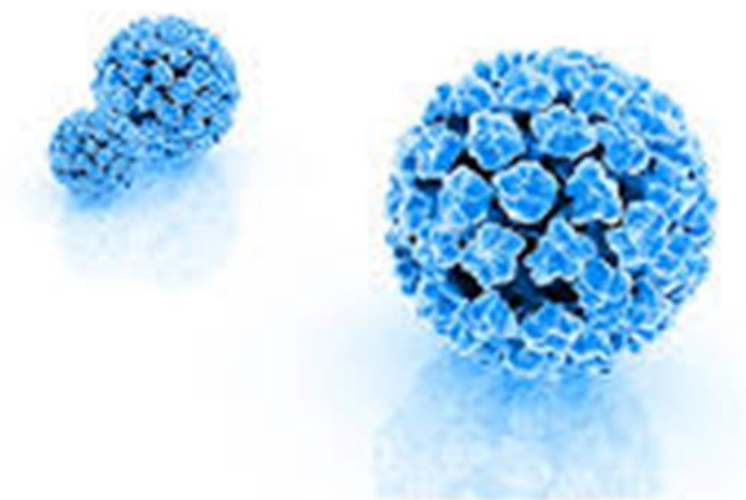


Sexually Transmitted Infection surveillance in Northern Ireland 2016

An analysis of data for the calendar year 2015



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This report aims to provide an overview of STI epidemiology in Northern Ireland by collating and analysing information from a number of sources. Although it reflects epidemiological trends over time, its main focus will be on data collected in 2015.

In order to prevent possible disclosure, where the number of any category of episodes in any one year is between one and four, this is reported either within a cumulative figure, or as an asterix. In addition, where the anonymised figure can be deduced from the totals, the next smallest figure will also be anonymised.

Summary points

In Northern Ireland Genito-Urinary Medicine (GUM) clinics in 2015

- New diagnoses of chlamydia decreased by 18%; 1,534 diagnoses in 2015 compared with 1,868 in 2014.
- New diagnoses of gonorrhoea increased by 3%; 619 in 2015 compared with 601 in 2014.
- New diagnoses of genital herpes simplex (first episode) decreased by 8%; 381 in 2015 compared with 415 in 2014.
- New diagnoses of genital warts (first episode) decreased by 14%; 1,746 in 2015 compared with 2,020 in 2014.
- New diagnoses of infectious syphilis increased by 17%; 76 in 2015 compared with 65 in 2014.

Surveillance arrangements and sources of data

KC60 returns

The most comprehensive source of surveillance data for sexually transmitted infections (STIs) in Northern Ireland is the statutory KC60 return each quarter from GUM clinics. This return records the numbers of new diagnoses for a range of STIs. Individual patients may contribute more than one diagnosis. For selected conditions, additional age, gender and sexual orientation information are provided. Regularly updated summary statistics are presented at: www.publichealth.hscni.net/directorate-public-health/health-protection/sexually-transmitted-infections.

Northern Ireland GUM clinics are in the process of migrating from KC60 to Sexual Health and HIV Activity Property Type codes (SHHAPT). As a result of the changes gonorrhoea and chlamydia are no longer categorised as complicated and uncomplicated. Therefore the way gonorrhoea and chlamydia are presented within the report has been amended and some figures are not directly comparable to data from previous years as annotated in the relevant figures.

There are two important limitations to KC60/SHHAPT data. Firstly, as data reflect only those diagnoses made in GUM clinics, it follows that accessibility of those services to the public, as measured by service capacity and geographic location of services, may influence the diagnostic rate of STIs. Thus, direct comparison of different regions, or indeed different time periods within the same region if service access should change, must be interpreted with caution.

Secondly, no residence-based data is collected. Given that the majority of new diagnoses originate from the GUM clinic at the Royal Victoria Hospital (the clinic that provides greatest access), the clinic location is not a useful proxy for patient residence.

Laboratory reporting

Laboratory data represent an important complementary source to clinician-initiated surveillance arrangements. Laboratory reporting of *Chlamydia trachomatis* in Northern Ireland is provided for 2006–2015 and *Neisseria gonorrhoeae* for 2015. Antibiotic susceptibility information for *Neisseria gonorrhoeae* isolates is provided for 2014–2015.

Enhanced syphilis surveillance

Enhanced surveillance arrangements for infectious syphilis in Northern Ireland have been in place since the outbreak was first recognised in September 2001. Based on anonymised, confidential reporting by GUM clinicians to the Public Health Agency (PHA), a range of demographic, clinical and risk factor data are collected on cases of primary, secondary and early latent stage syphilis.

1: Diagnoses provided in Northern Ireland GUM clinics in 2015

During 2015:

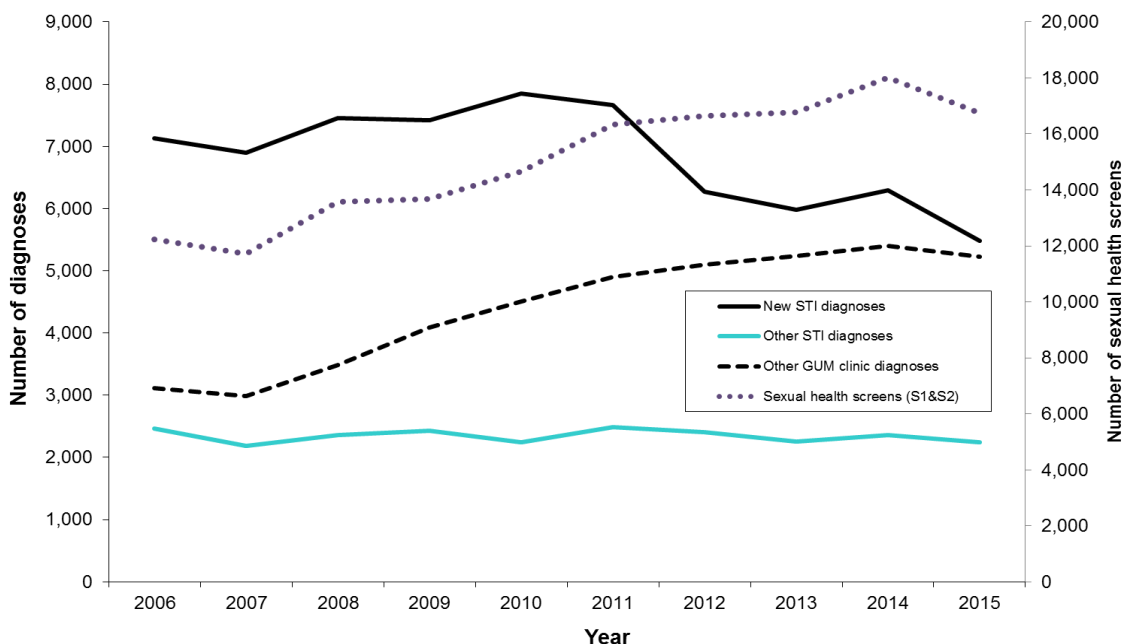
- 5,477 **new STI diagnoses** were made, a decrease of 13% compared with 2014 (6,292);
- 63% (3,447/5,477) of **new STI diagnoses** were in males;
- three types of infection accounted for 73% of **new STI diagnoses** – genital warts (first infections) (32%), chlamydia (28%) and non-specific genital infection (13%);
- 2,242 **other STI diagnoses** were made;
- 5,224 **other diagnoses** were made at **GUM clinics**.

Trends: 2006–2015

Between 2006 and 2011 the number of **new STI diagnoses** remained relatively stable. However, between 2011 and 2015, the numbers have decreased by 29% (Figure 1.1). The decrease in new STI diagnoses from 2011 must be interpreted with caution. This largely reflects a steep decline in new diagnoses of complicated and uncomplicated non-specific genital infection (NSGI) (Figure 1.2). This decrease is likely to be due to the change in test technology within GUM clinics, whereby the more sensitive dual platform PCR test for gonorrhoea and chlamydia has largely replaced the invasive urethral culture in asymptomatic patients¹. This has resulted in more detections of organisms with proven pathogenicity, particularly gonorrhoea and thus NSGI diagnoses have fallen (Figure 1.2).

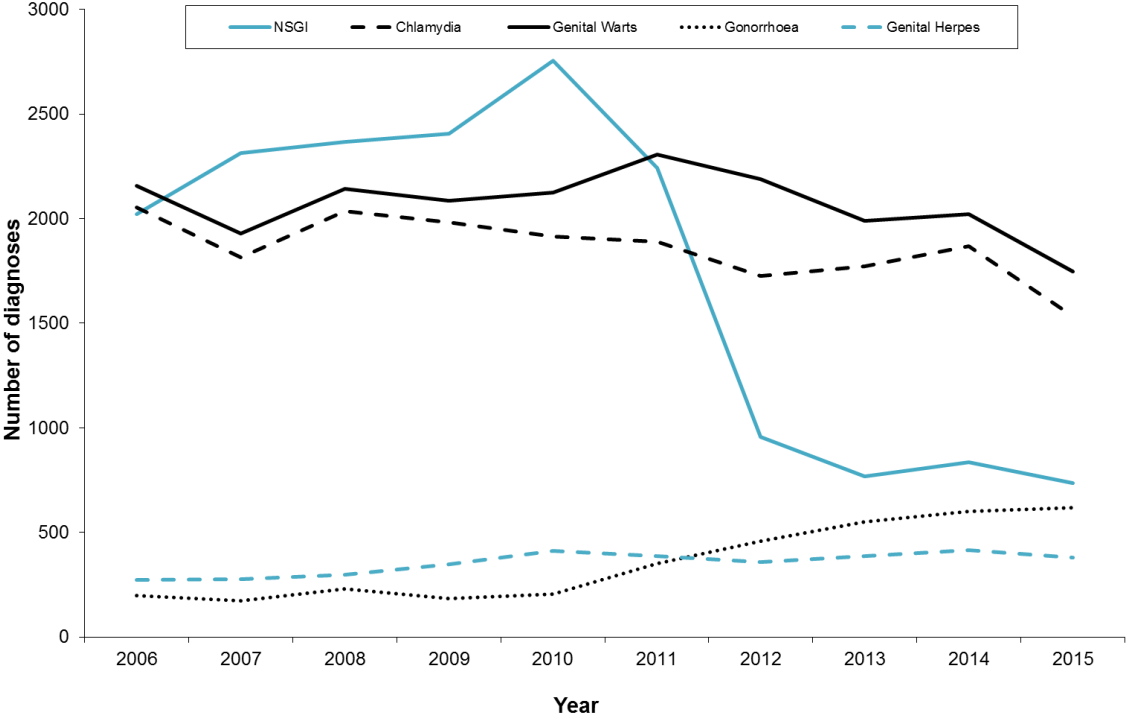
There has been a consistent increase in annual **other GUM clinic diagnoses** since 2007 with the number of **other STI diagnoses** remaining largely stable since 2006. An explanation of STI categories is provided in Appendix 1. The number of sexual health screens performed annually has also shown an increased trend. There was however a fall in 2015 (16,774) compared with 2014 (18,007).

Figure 1.1: Trends in diagnoses and sexual health screens made in Northern Ireland GUM clinics, 2006–2015



During 2006–2015, chlamydia infection, non-specific genital infection (NSGI) and genital warts (first infections) accounted for the highest proportion of new STI diagnoses (83%) made in Northern Ireland GUM clinics (Figure 1.2). Specific disease trends will be examined in chapters 2 to 6.

Figure 1.2: Trends in new diagnoses of STIs in Northern Ireland GUM clinics, 2006–2015



2: Chlamydia

Genital chlamydia is a bacterial infection caused by *Chlamydia trachomatis*. The infection is asymptomatic in at least 50% of men and 70% of women. In women, untreated infection can cause chronic pelvic pain and lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility. An infected pregnant woman may also pass the infection to her baby during delivery. Complications in men include urethritis, epididymitis and Reiter's Syndrome.

Consistent with elsewhere in the UK, chlamydia is the most common bacterial STI diagnosed in Northern Ireland GUM clinics.

Although there is currently no organised regional chlamydia testing programme in Northern Ireland, symptomatic testing is undertaken within primary care and sexual health services.

Diagnoses made in GUM clinics during 2015

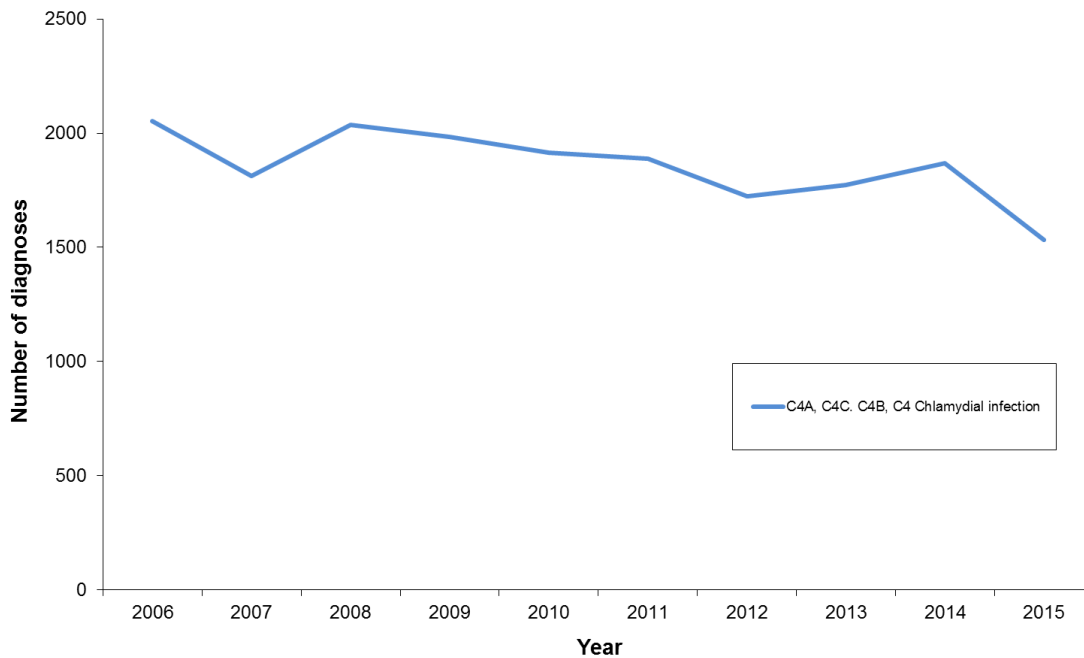
Chlamydial infection accounted for 28% (1,534/5,477) of all new STI diagnoses made in Northern Ireland GUM clinics during 2015.

- There were 1,534 new episodes of chlamydial infection diagnosed in Northern Ireland GUM clinics in 2015, compared with 1,868 in 2014.
- 856 (56%) of these were diagnosed in males.
- The highest rates of infection in both males and females were in the 20–24 years age group, accounting for 39% of male and 46% of female diagnoses.
- The rate of diagnoses in the 16–19 years age group is more than twice as high in females as in males.
- 14% (123/856) of the total male diagnoses occurred in men who have sex with men (MSM).

Trends: 2006–2015

Between 2006 and 2015, diagnoses of chlamydial infection decreased by 25%, from 2,053 diagnoses in 2006 to 1,534 in 2015 (Figure 2.1).

Figure 2.1: Diagnoses of chlamydia in Northern Ireland, 2006–2015



Age and gender trends: chlamydia

From 2012–2015, diagnostic rates in females were consistently highest in the 16–24 years age group, peaking between 20 and 24 years (Figure 2.2). In males, the highest rates were in the 20–34 years age group, again peaking between 20 and 24 years.

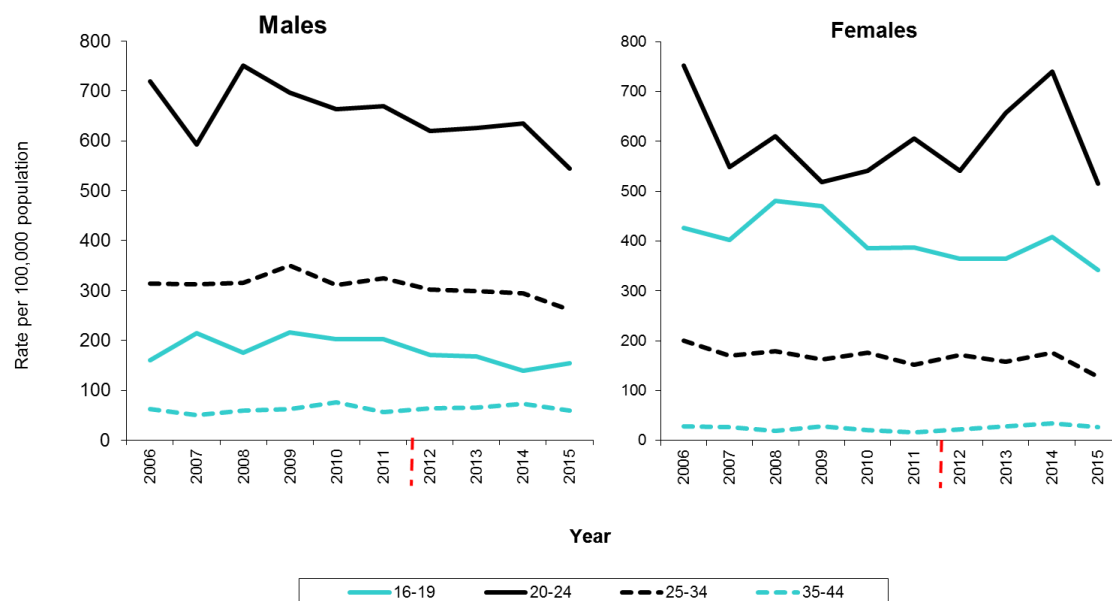
Diagnostic rates in those under 25 years of age were consistently higher in females, with rates in those aged 25 years and over consistently higher in males. Diagnostic rates in females aged over 24 years decrease due to changes in sexual behaviour, as well as decreased susceptibility.

Diagnoses in those under 16 years of age accounted less than 1% (23/6,895) of all diagnoses made during the period 2012–2015.

Diagnoses in the 45+ years' age group accounted for 3% (206/6,895) of all diagnoses made during the period 2012–2015.

The proportion of male chlamydia diagnoses attributed to MSM has ranged from 6% in 2006 to 17% in 2014, with 14% being attributed to MSM in 2015.

Figure 2.2: Rates of chlamydial infection in Northern Ireland, by gender and age group, 2006–2015



Footnote: Rates have been re-calculated from 2012 to include KC60 code C4B – Complicated chlamydia

Genital chlamydia trachomatis laboratory reporting, 2006–2015

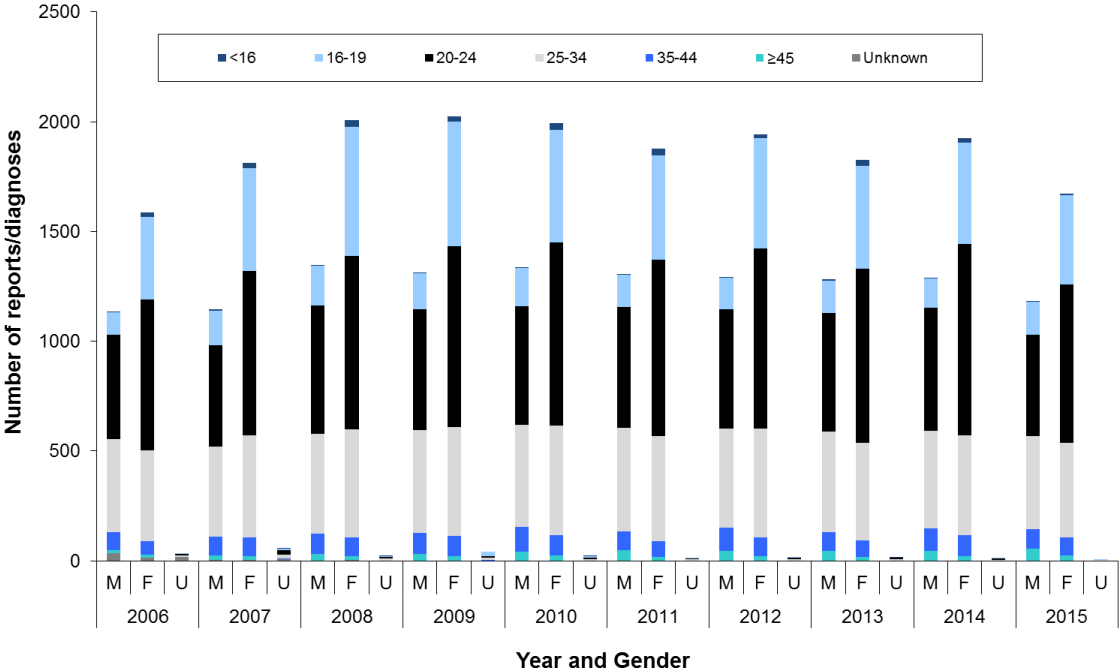
During 2015, 2,864 laboratory confirmed cases of genital chlamydia trachomatis were reported, a decrease of 11% compared with 2014. GP specimens accounted for 36% (1,028/2,864) of cases reported during 2015 (Table 2.1). Between 2006 and 2015, confirmations from GP specimens increased by 43%.

Referral Source	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	TOTAL
GP Number (%)	720 (26.1)	894 (29.7)	979 (29.0)	1025 (30.3)	1124 (33.5)	1096 (34.3)	1207 (37.1)	1102 (35.2)	1093 (33.9)	1028 (35.8)	10,268
Other	2,036	2,121	2,396	2,353	2,231	2,104	2,044	2,023	2,130	1,836	21,274
Total	2,756	3,015	3,375	3,378	3,355	3,200	3,251	3,125	3,223	2,864	31,542

Table 2.1: Referral source of genital *Chlamydia trachomatis* specimens, 2006–2015

Higher numbers of diagnoses are consistently reported in females, accounting for 58% (1,674/2,864) of all cases reported by laboratories during 2015. The majority (68%; 12,723/18,672) of female cases reported in the period 2006–2015 were aged between 16 and 24 years. Between 2006 and 2015 females accounted for 80% of the diagnoses made by a GP. Males accounted for between 38% and 41% of cases reported annually since 2006. The majority of male cases reported since 2006 were in the 20–34 years age group (Figure 2.3). Information on gender was missing for 1% of cases reported during the period 2006–2015.

Figure 2.3: Laboratory reports of genital *Chlamydia trachomatis*, by age and gender, 2006–2015



3: Gonorrhoea

Gonorrhoea is a bacterial STI caused by *Neisseria gonorrhoeae*. Untreated, gonorrhoea can enter the bloodstream or spread to the joints, and in women it can cause pelvic inflammatory disease, ectopic pregnancy and infertility. An infected pregnant woman may pass the infection to her baby during delivery.

Diagnoses made in GUM clinics during 2015

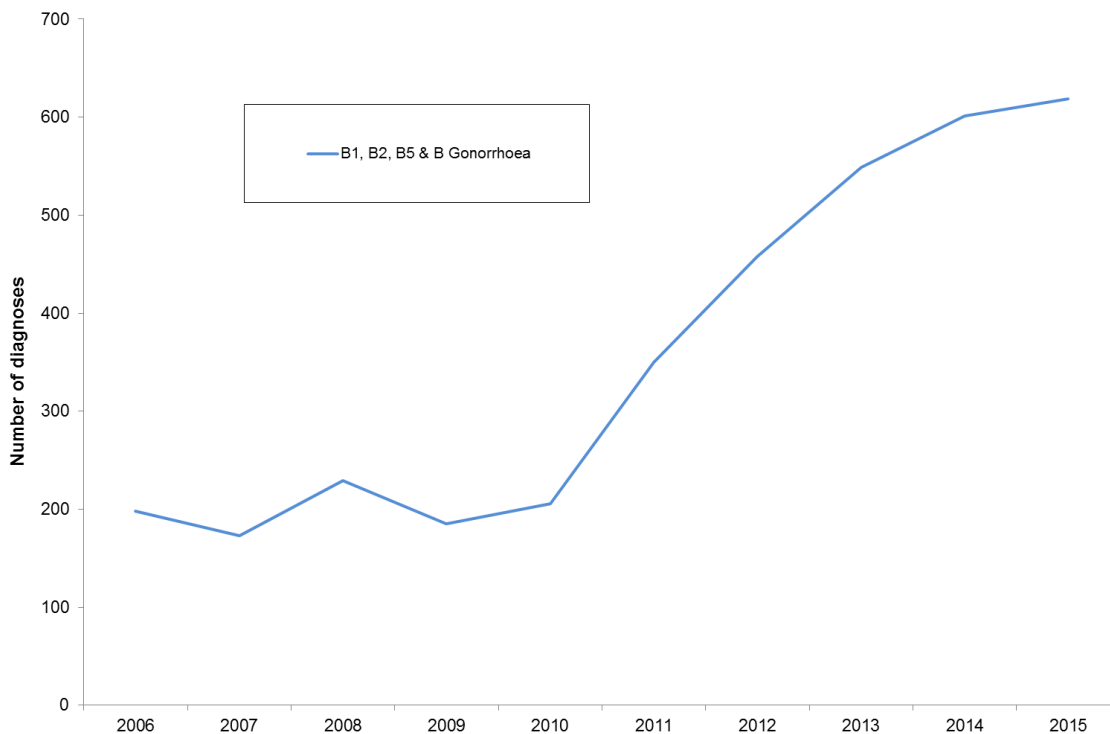
Gonorrhoea accounted for 11% (619/5,477) of all new STI diagnoses made in Northern Ireland GUM clinics during 2015.

- There were 619 new episodes of gonorrhoea diagnosed in Northern Ireland GUM clinics in 2015, compared with 601 in 2014, an increase of 3%.
- 483 (78%) of these were diagnosed in males.
- The highest diagnostic rates in both men and women were in the 20–24 years age group.
- 71% of female diagnoses were in the 16–24 years age group and 24% were in the 25–34 years age group.
- 40% of male diagnoses were in the 16–24 years age group and 38% were in the 25–34 years age group.
- 64% (308/483) of male diagnoses were attributed to MSM.

Trends: 2006–2015

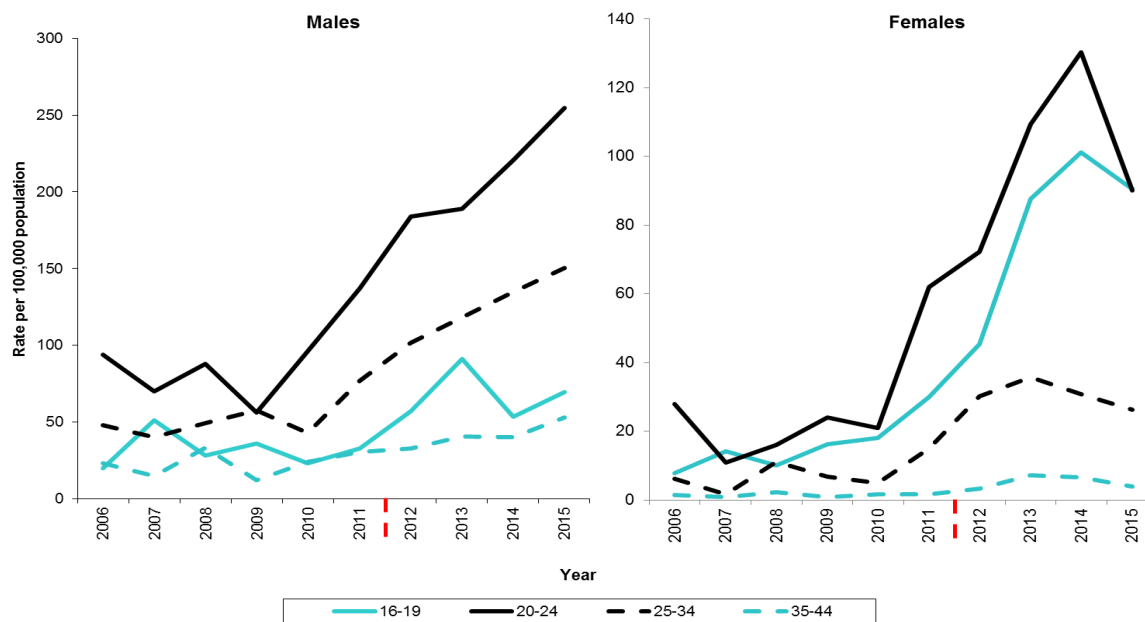
The annual number of diagnoses of gonorrhoea has shown very little change between 2006-2010. However diagnoses rose dramatically between 2010 and 2014 with a 192% increase; 601 diagnoses in 2014 compared with 206 in 2010 (Figure 3.1). The number of diagnoses in 2015 (619) is the highest ever recorded in Northern Ireland. However the rate of increase has slowed with the annual percentage increase (3%: 619 in 2015 compared with 601 in 2014) the lowest since 2010. The proportion of male diagnoses attributed to MSM ranged from 24% in 2006 to 64% in 2015.

Figure 3.1: Diagnoses of gonorrhoea in Northern Ireland, 2006–2015



Age, gender and sexual orientation trends: gonorrhoea

Figure 3.2: Rates of gonorrhoea in Northern Ireland, by age group, 2006–2015

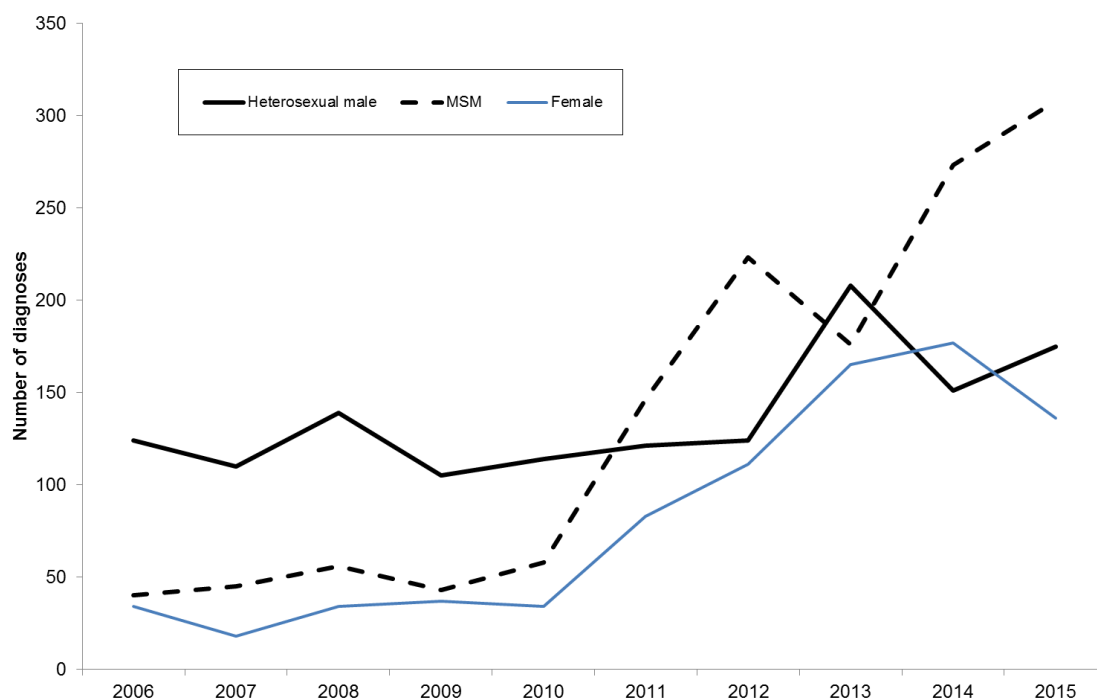


Footnote: Rates have been re-calculated from 2012 to include KC60 code B5 Complicated gonorrhoea

In males, the highest diagnostic rates have consistently been in the 20–34 years age groups (Figure 3.2). From 2012–2015, fewer than 10 diagnoses were made annually in males aged under 16 years. Males aged 45 years and over accounted for 10% (159/1,638) of all male diagnoses during the period 2012–2015.

Trends in age-specific diagnostic rates in females have been less obvious due to small number variation. The increases in 2012 and 2013 have clearly mostly affected the 16-19, 20-24 and 25-34 age groups (Figure 3.2).

Figure 3.3: Number of diagnoses of gonorrhoea by sexual orientation in Northern Ireland, 2006-2015



The increase in diagnoses since 2010 has largely affected MSM and females. There has been a much smaller though still generally upward trend in heterosexual males. In 2015 there was a 13% increase (308 in 2015 compared with 273 in 2014) among MSM.

Interpretation of the increase in diagnoses is made difficult by the introduction across Northern Ireland of combined chlamydia and gonorrhoea PCR testing in both GUM and community settings since 2010. The increase in numbers of people tested, and the increased sensitivity of the test compared with traditional culture methods, particularly at extra genital sites, may at least partly explain the increase seen in both the heterosexual and MSM population.

Neisseria gonorrhoeae laboratory reporting, 2012–2015

During 2015, 626 laboratory confirmed diagnostic episodes of *Neisseria gonorrhoeae* (all anatomical sites) were reported. Of those 477 were male and 147 were female (the gender was unreported in two cases). GP referred specimens accounted for 13% (81/626) with the majority of specimens 81% (504/626) received from a GUM clinic.

Effective treatment of gonorrhoea has been compromised by the ability of *Neisseria gonorrhoeae* to develop resistance to successive antimicrobial agents.² Ongoing monitoring of antimicrobial resistance in Northern Ireland is important to ensure that first line treatments for gonorrhoea remain effective, as patterns of resistance can change rapidly. During 2015, laboratories reported antibiotic susceptibility data for 221 isolates.

Current treatment guidelines recommend the use of a one-off dose of a combination of oral azithromycin and intra-muscular ceftriaxone and that treatment should be followed by a test of cure. By combining antibiotics in this way it is hoped the development of resistance to either component will be slowed. (Table 3.1).

Table 3.1: *Neisseria gonorrhoeae* antibiotic susceptibility reported activity for antibiotics, 2014–2015

Antibiotics	Susceptible		Resistant (%)		Indeterminate		Total specimens Reported	
	2014	2015	2014	2015	2014	2015	2014	2015
Azithromycin	17	41	2 (11%)	0	0	0	19	41
Cefixime	0	0	0	0	0	0	0	0
Cefotaxime	0	0	0	0	0	0	0	0
Ceftriaxone	181	206	0	1 (0.5%)	0	0	181	207
Ceftizoxime	2	5	0	0	0	0	2	5
Cefuroxime	3	0	0	0	0	0	3	0
Cephalexin	0	0	0	0	0	0	0	0
Ciprofloxacin	132	153	33 (20%)	48 (24%)	0	0	165	201
Doxycycline	114	114	32 (22%)	53 (32%)	0	0	146	167
Nalidixic Acid	0	0	0	0	0	0	0	0
Penbritin	0	0	0	0	0	0	0	0
Penicillin	32	23	134 (80%)	184 (88%)	1	2	167	209
Spectinomycin	0	0	0	0	0	0	0	0
Erythromycin	0	0	0	0	0	0	0	0
Tetracycline	0	9	0	5 (31%)	0	2	0	16

Note: There may be variation in laboratory antibiotic susceptibility testing methodology in Northern Ireland. This has not been assessed. Due to the increase in high level azithromycin resistant strains seen in Great Britain since 2015, it is now recommended that all microbiology labs include azithromycin in their testing panels.

4: Genital herpes

Genital herpes is caused by the herpes simplex virus (HSV), of which there are two distinct subtypes. HSV2 is almost exclusively associated with genital infection. Historically, HSV1 has mainly been associated with oral infection, but the proportion of genital herpes attributed to HSV1 in the UK is increasing. Genital herpes infection may facilitate HIV transmission, can cause severe systemic disease in those with impaired immunity, and can be potentially fatal to neonates.

Diagnoses made in GUM clinics during 2015

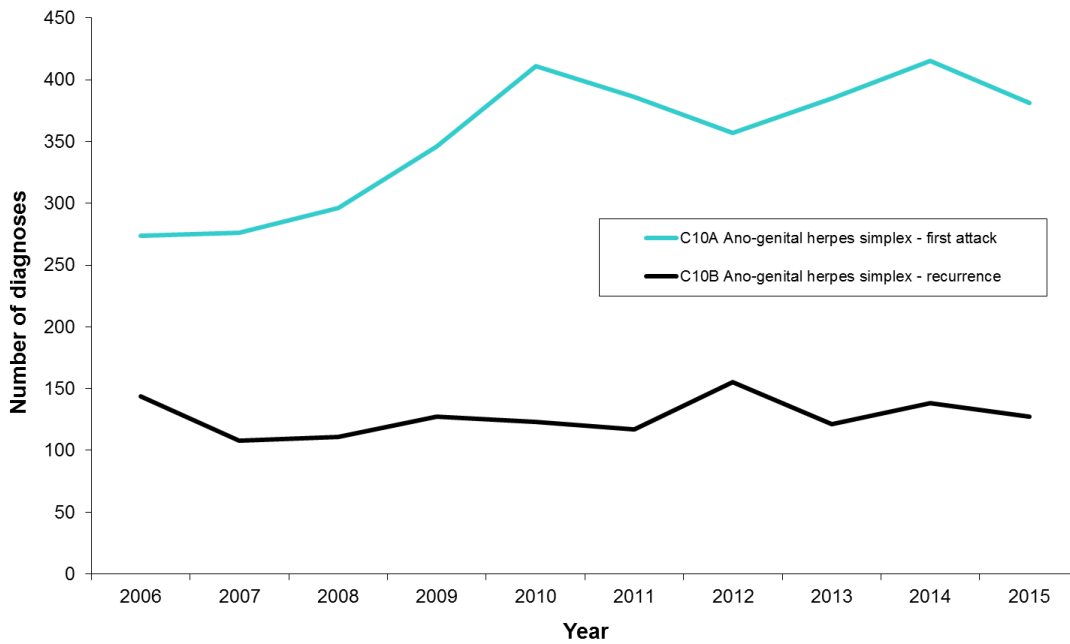
Genital herpes (first episodes) accounted for 7% (381/5,477) of all new STI diagnoses made in Northern Ireland GUM clinics during 2015.

- There were 508 episodes (first infections and recurrent infections) of genital herpes diagnosed in Northern Ireland GUM clinics in 2015.
- 317 (62%) of these were diagnosed in females.
- 381 (75%) of the total attendances for herpes in 2015 were for treatment of first infection and 127 (25%) were for treatment of recurrent infection.
- 26% of male diagnoses (50/191) and 24% (77/317) of female diagnoses were recurrent infections.
- The highest diagnostic rates of first infection in men were in the 20-34 years age group and in women were in the 16-24 years age group.
- Diagnostic rates of first infection in most age groups were higher in females. The diagnostic rate in 16–19 year old females was over 7 times higher than in males of the same age.
- 14% (20/141) of male first diagnoses occurred in MSM.

Trends: 2006–2015

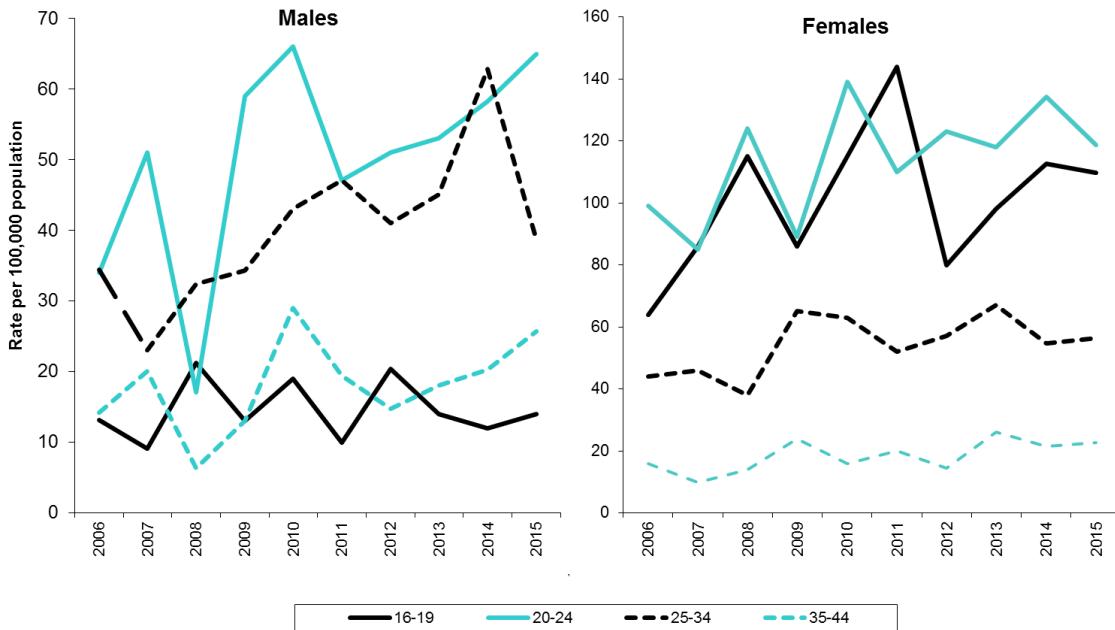
Annual numbers of first diagnoses of genital herpes increased each year from 2008-2010 with numbers remaining similar from 2011 to 2015. (Figure 4.1).

Figure 4.1: Diagnoses of genital herpes in Northern Ireland, 2006–2015



Age and gender trends: genital herpes (first episode)

Figure 4.2: Rates of diagnosis of genital herpes (first episode) in Northern Ireland, by age and gender, 2006–2015



Diagnostic rates in females were consistently highest in the 16–24 years age group. In males, the highest diagnostic rates were in the 20–34 years age group (Figure 4.2).

Males under 20 years of age accounted for 6% (75/1,229) of all male diagnoses of genital herpes (first episode) made during the period 2006–2015, with diagnoses in the 45+ years age group accounting for 11% (136/1,229).

Females under 16 years of age accounted for 1% (27/2,298) of all female diagnoses made during the period 2006–2015, with diagnoses in the 45+ years age group accounting for 7% (161/2,298).

5: Genital warts

Genital warts are caused by human papillomavirus (HPV). More than 90 HPV types have been identified, of which approximately one third are sexually acquired. Although around 20 different types of HPV have been linked to cervical cancer, these particular types are less frequently linked to genital warts.

HPV vaccine for girls was introduced as a school-based programme in Northern Ireland in 2008/09. Until September 2012 the vaccine used protected against the oncogenic types 16 and 18, but not those types causing genital warts.³ From September 2012 onwards, the vaccine used is protective against types 6 and 11, accounting for 90% of genital warts⁴. In September 2014 the HPV immunisation programme changed from a three dose to a two dose schedule.

Diagnoses made in GUM clinics during 2015

Genital warts (first episodes) accounted for 32% (1,746/5,477) of all new STI diagnoses made in Northern Ireland GUM clinics during 2015.

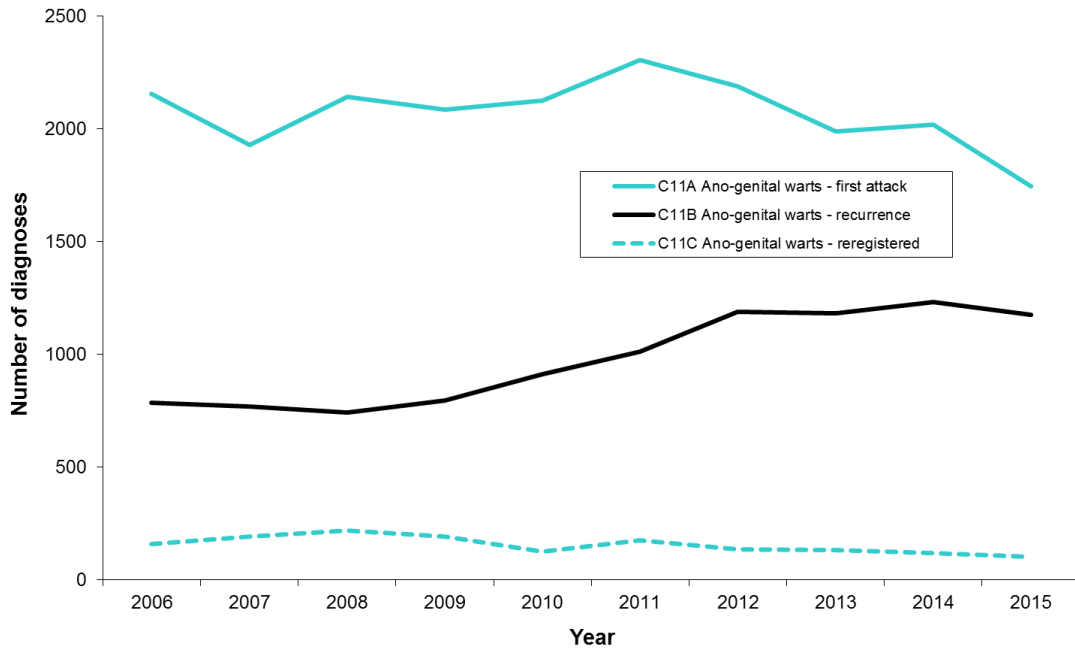
- There were 2,922 episodes (first infections and recurrent infections) of genital warts diagnosed in Northern Ireland GUM clinics in 2015.
- 1,805 (62%) of these were diagnosed in males.
- 1,746 (60%) of the total attendances for genital warts in 2015 were for treatment of first infection and 1,176 (40%) were for treatment of recurrent infection.
- 44% of male diagnoses (789/1,805) were recurrent infections, compared with 35% (387/1,117) of female diagnoses.
- The highest diagnostic rates of first infection in both men and women were in the 20–24 years age group.
- 36% of male diagnoses and 35% of female diagnoses of first infection were in the 20–24 years age group.
- The diagnostic rate in females aged 16–19 years (259/100,000) were almost twice that of males the same age. However, diagnostic rates in those aged over 19 years were higher in males.
- 9% (89/1,016) of male first diagnoses occurred in MSM.

Trends: 2006–2015

The number of annual diagnoses of first infections of genital warts has shown little variation between 2006 and 2011. There has been a significant decline, however, since 2011 (Figure 5.1). The decline in diagnostic rates has been greatest in females aged 16-19 years (48%) followed by females aged 20-24 years (32%) (Figure 5.2). There have been smaller declines in diagnostic rates in males aged 16-19 years (29%) and 20-24 years (20%). There has been no significant change to diagnostic rates in other age groups in either sex. It is likely that this pattern in females is at least partly explained by an

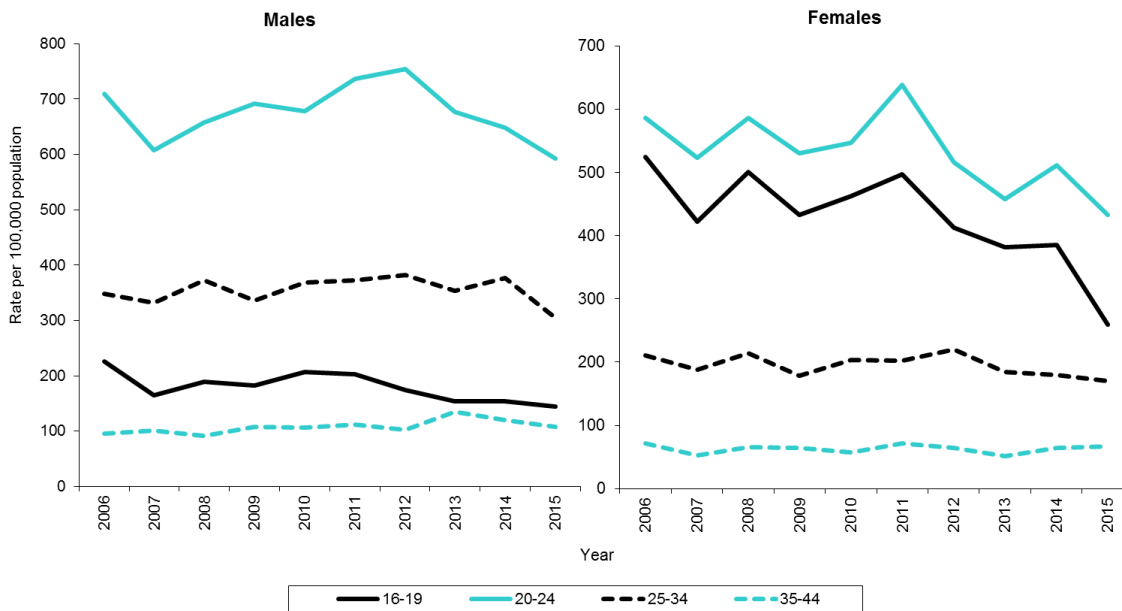
unexpected direct protective effect from the bivalent vaccine introduced in 2009, with a smaller indirect effect being seen in males⁵.

Figure 5.1: Diagnoses of genital warts in Northern Ireland, 2006–2015



Age and gender trends: genital warts (first episode)

Figure 5.2: Rates of diagnosis of genital warts (first episode) in Northern Ireland, by age and gender, 2006–2015



Between 2006 and 2015, diagnostic rates have been consistently highest in 20-24 year old males and females, followed by 16-19 year old females and 25-34 year old males. Individuals under 16 year old accounted for 0.4% (88/20,690) of diagnoses (first episode) made during 2006-2015, while the 45+ year age group accounted for 6% (1,235/20,690).

During 2006-2015, the proportion of male diagnoses attributed to MSM ranged from 2% in 2006 to 10% in 2012, with 9% in 2015.

6: Syphilis

Syphilis is a bacterial infection caused by the spirochete *Treponema pallidum*. Its importance lies in its ability to promote both the acquisition and transmission of HIV, and in the potential for serious or even fatal consequences if left untreated. Late syphilis can cause complications of the cardiovascular, central nervous and mucocutaneous systems. Infectious syphilis in pregnant women can cause miscarriage, stillbirth or congenital infection.

Northern Ireland has, in common with elsewhere in the UK and Europe, experienced a marked increase in infectious syphilis since 2000. In the decade prior to 2000, on average only one case of infectious syphilis per year was reported.

Diagnoses made in GUM clinics 2015

During 2015:

- 45 new episodes of primary and secondary syphilis were reported;
- 75% (30/40) were diagnosed in MSM;
- 31 additional episodes of early latent syphilis were also reported;

Enhanced surveillance 2015

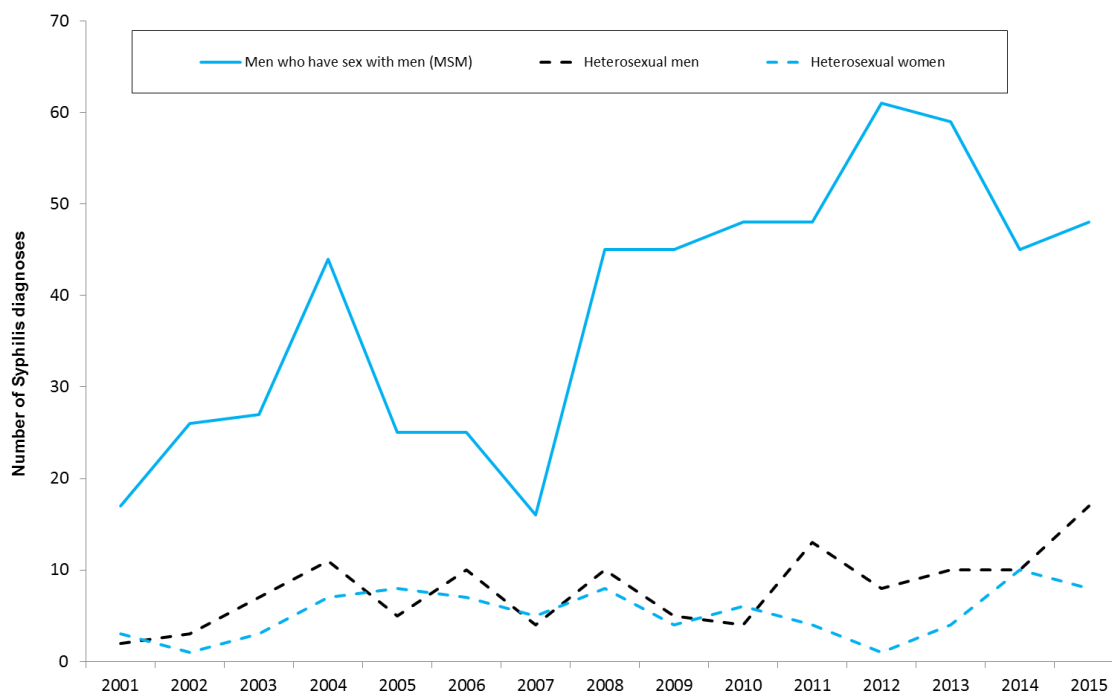
Information from enhanced surveillance arrangements is available for 70 cases:

- 64 episodes occurred in Northern Ireland residents and, in 44 episodes, syphilis was likely to have been acquired through exposure within Northern Ireland;
- 19% (13/70) also reported as being HIV positive;
- diagnosed co-infections also included chlamydia, gonorrhoea, genital warts and herpes;
- 39% (27/70) reported having had one sexual partner in the three months preceding diagnosis;
- the highest number of reported sexual partners of any one individual in the preceding three months was 8;

Trend information

Infectious syphilis is now endemic within Northern Ireland. Annual numbers of new diagnostic episodes have been consistently highest in MSM (Figure 6.1). Following an annual decrease from 2004 to 2007, numbers have increased from 2008 with a further increase again in 2015. Numbers in females and heterosexual males have remained relatively constant, although in 2015 there was an increase in heterosexual males with 17 diagnoses made compared with 10 in 2014.

Figure 6.1: Number of infectious syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001-2015

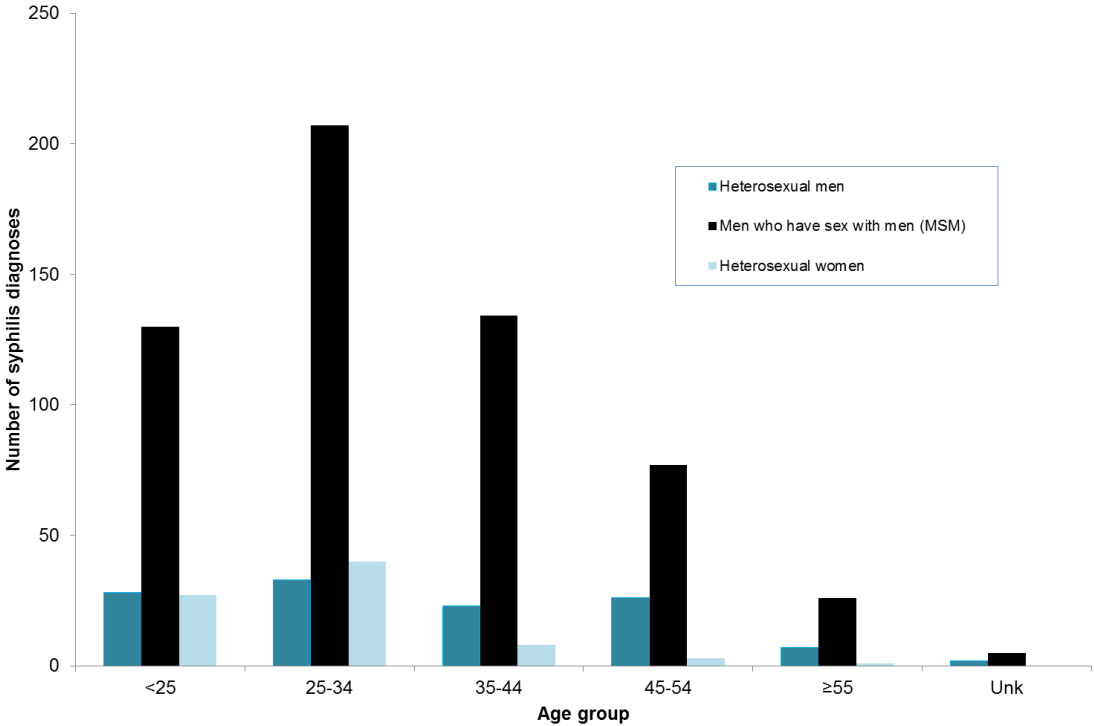


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from KC60 for 2011- 2015

Age and sexual orientation

Analysis of cumulative data by age and sexual orientation shows the highest number of episodes in heterosexual females was in the 25–34 years age group (51%; 40/79). In MSM, the highest number of episodes was in the 25–44 years age group (59%; 341/579). In heterosexual males, diagnoses were more evenly spread across the age bands, with those aged 25+ years accounting for 75% (89/119) of diagnoses. Information on age was missing for seven episodes (Figure 6.2).

Figure 6.2: Age distribution of syphilis diagnoses in Northern Ireland, by gender and sexual orientation, 2001–2015

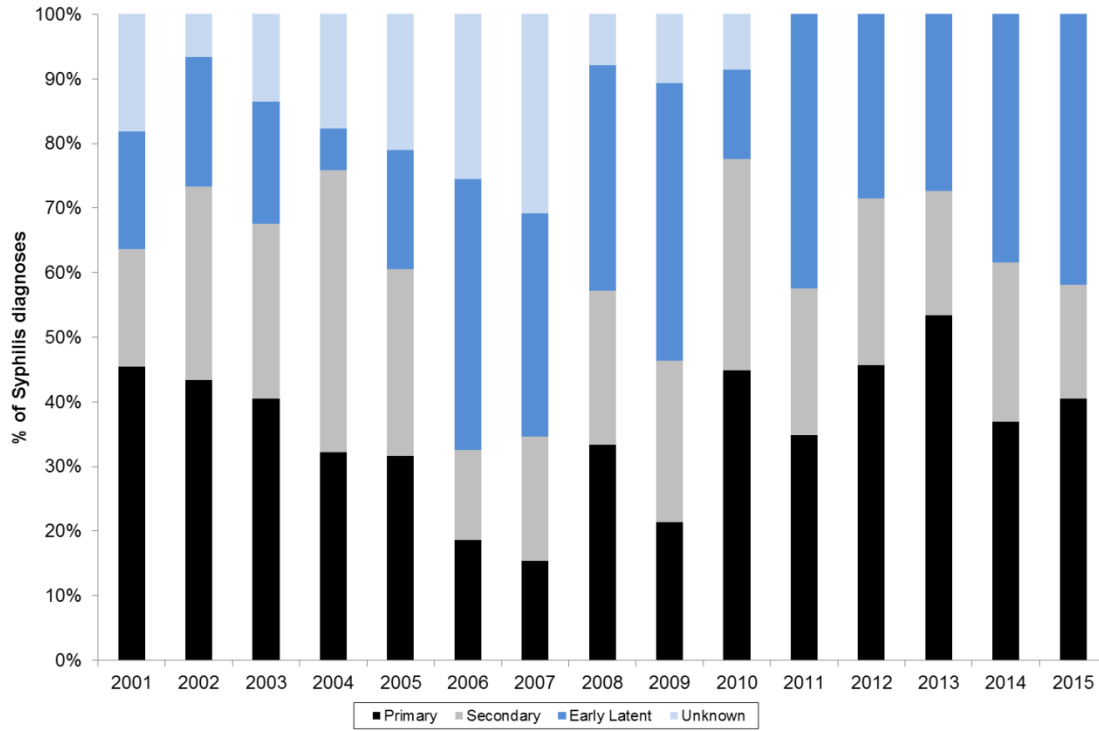


Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from KC60 returns for 2011 -2013

Stage of disease

Since 2001 the majority of diagnoses have been made at the primary or secondary stage of disease, although there has been some significant year to year variation. Interpretation is difficult also due to variation in the extent to which stage is unknown. Over the past 5 years the percentage of diagnoses of primary and secondary syphilis had ranged from 58% to 73%. This suggests there is still a significant lack of awareness of the signs and symptoms of infectious syphilis in the affected population.

Figure 6.3: Stage of disease, by year of diagnosis



Note: Data derived from enhanced syphilis arrangements from 2001-2010 and from KC60 returns for 2011-2015

7: Summary and conclusions

Although 2015 saw a 13% decrease in annual numbers of new STI diagnoses made in Northern Ireland GUM clinics this masks an increase in diagnoses of gonorrhoea and infectious syphilis.

Between 2010 and 2015, diagnoses of gonorrhoea have tripled. This has largely been driven by an increase in MSM and females. In 2015 there was a further increase albeit to a much smaller degree (3%). Although the rise in diagnoses coincides with the introduction of more sensitive PCR testing the continued increase is also likely to represent increased transmission.

The highest diagnostic rates of the common STIs occur in 16-24 year old females and 20-34 year old males. People aged 16-34 year old account for 82% of new STIs.

MSM are at disproportionate risk of contracting some STIs accounting for 75% of male syphilis, 64% of male gonorrhoea, 14% of male herpes and 14% of male chlamydia infections. Safer sex messages should continue to be promoted to the general population, young people and MSM. The risks to health of unprotected casual sex, both within and outside Northern Ireland, need to be reinforced.

Individuals can reduce their risk of acquiring or transmitting an STI by:

- Always using a condom when having sex with casual and new partners;
- Getting tested if at risk, as these infections are frequently asymptomatic;
- MSM having unprotected sex with casual or new partners should have an HIV/STI screen at least annually, and every three months if changing partners regularly;
- Reducing the number of sexual partners and avoiding overlapping sexual relationships.

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Appendix 1: STI groupings

New STI diagnoses
Chlamydial infection (uncomplicated and complicated)
Gonorrhoea (uncomplicated and complicated)
Infectious and early latent syphilis
Genital herpes simplex (first episode)
Genital warts (first episode)
New HIV diagnosis
Non-specific genital infection (uncomplicated and complicated)
Chancroid/lymphogranuloma venereum (LGV)/donovanosis
Molluscum contagiosum
Trichomoniasis
Scabies
Pediculus pubis
Other STI diagnoses
Congenital and other acquired syphilis
Recurrent genital herpes simplex
Recurrent and re-registered genital warts
Subsequent HIV presentations (including AIDS)
Ophthalmia neonatorum (chlamydial or gonococcal)
Epidemiological treatment of suspected STIs (syphilis, chlamydia, gonorrhoea, non-specific genital infection)
Other diagnoses made at GUM clinics
Viral hepatitis B and C
Vaginosis and balanitis (including epidemiological treatment)
Anogenital candidiasis (including epidemiological treatment)
Urinary tract infection
Cervical abnormalities
Other conditions requiring treatment at a GUM clinic



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