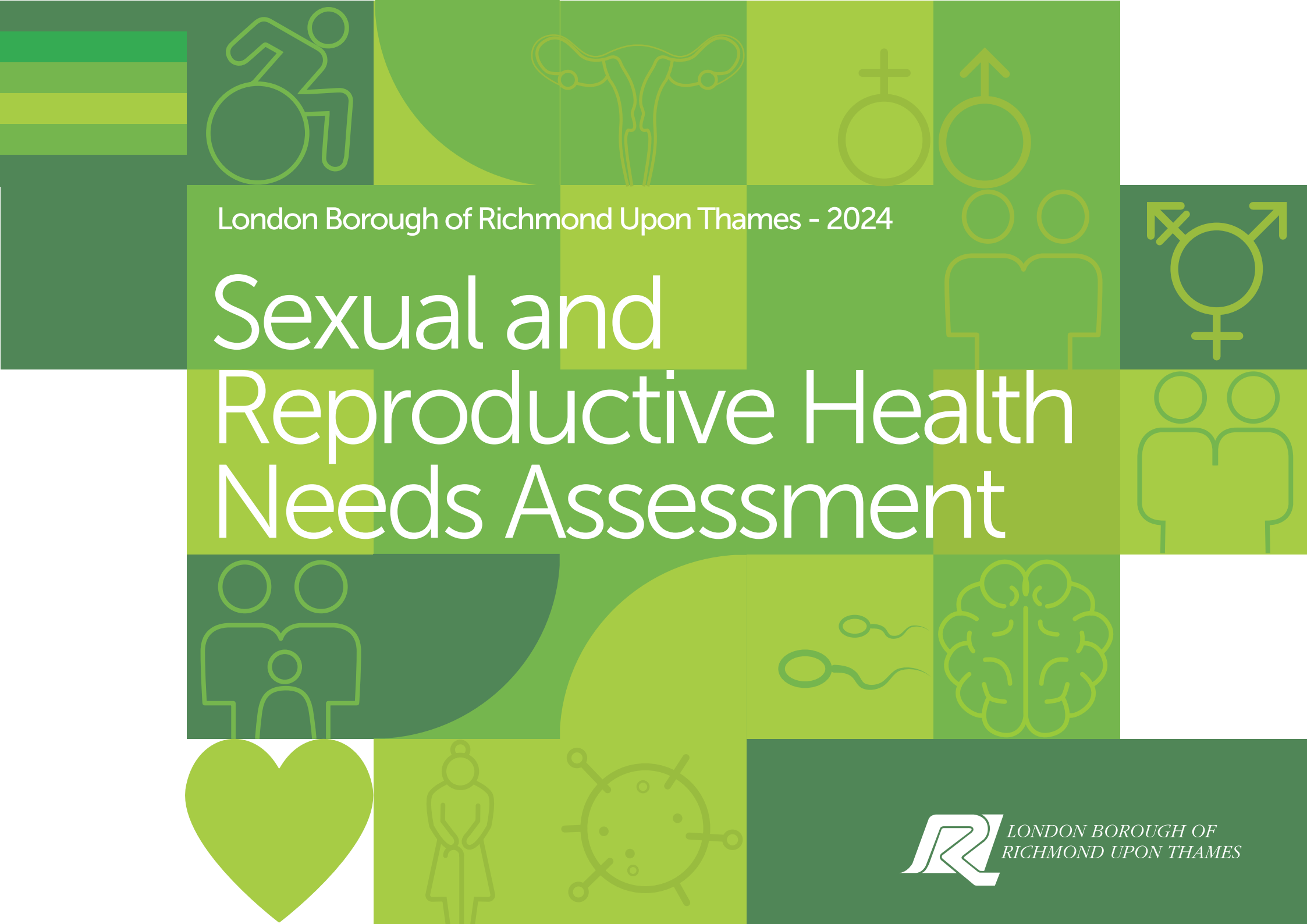
London Borough of Richmond Upon Thames - 2024

# Sexual and Reproductive Health Needs Assessment



LONDON BOROUGH OF RICHMOND UPON THAMES

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We are grateful to everyone who gave their time and generously shared their stories and experiences with us.

# Acronyms

| | |
|---|---|
| ART | Antiretroviral therapy |
| BJU | British Journal of Urology |
| BMJ | British Medical Journal |
| CASH | Contraceptive and Sexual Health |
| C-Card | Condom distribution scheme for young people |
| CCG | Clinical Commissioning Group |
| CLCH | Central London Community Healthcare NHS Trust |
| CNWL | Central and North West London NHS Foundation Trust |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPS | Crown Prosecution Service |
| CSA | Child Sexual Abuse |
| CSE | Child Sexual Exploitation |
| EHC | Emergency Hormonal Contraception |
| EINA | Equality Impact Needs Assessment |
| ELSA | English Longitudinal Study of Ageing |
| ESWRA | European Sex Workers Rights Alliance |
| FGM | Female Genital Mutilation |
| FSM | Free School Meals |
| GBL | γ-butyrolactone |
| GBMSM | Gay, bisexual and other men who have sex with men |
| GBV | Gender-based violence |
| GHB | γ-hydroxybutyrate |
| GiO | Getting It On |
| GP | General Practice |
| GUM | Genitourinary Medicine |
| HIV | Human Immunodeficiency Virus |
| HPV | Human Papillomavirus |
| HRBQ | Health Related Behaviour Questionnaire |
| HWBB | Health and Wellbeing Board |
| ICER | Incremental Cost-effective Ration |
| ICS | Integrated Care System |
| IMD | Index of Multiple Deprivation |
| ISH | Integrated Sexual Health |
| KRSCP | Kingston and Richmond Safeguarding Children's Partnership |
| LARC | Long-Acting Reversible Contraception |
| LGBTQ | Lesbian, Gay, Bisexual, Transgender or Questioning |
| LHPP | London HIV Prevention Programme |
| LSHP | London Sexual Health Programme |
| LSOA | Lower Layer Super Output Areas |
| MECC | Make Every Contact Count |
| MHCLG | Ministry for Housing, Communities and Local Government |
| Mpox | Previously known as Monkeypox |
| MSM | Men who have Sex with Men |
| Natsal | National Survey of Sexual Attitudes and Lifestyles |
| NCSP | National Chlamydia Screening Programme |
| NICE | National Institute for Health and Care Excellence |
| NHSBSA | NHS Business Services Authority |
| NSPCC | National Society of the Prevention of Cruelty to Children |
| OHID | Office for Health Improvement & Disparities |
| ONS | Office for National Statistics |
| PACT | Prescribing Analysis and Cost Tabulation |
| PHOF | Public Health Outcomes Framework |
| PHQA | Public Health Quality Assurance |
| PID | Pelvic Inflammatory Disease |
| PN | Partner Notification |
| PrEP | Pre-Exposure Prophylaxis |
| PSHE | Personal Social Health Economic |
| PWID | People Who Inject Drugs |
| QALY | Quality Adjusted Life Years |
| RCT | Randomised Control Trial |
| RoI | Return on Investment |
| RS(H)E | Relationships, Sex and (Health) Education |
| SDG | Sustainable Development Goals |
| SEND | Special Educational Needs and Disabilities |
| SHEU | School Health Education Unit |
| SHIG | Sexual Health Implementation Group |
| SHL.UK | Sexual Health London.UK |
| SMI | Severe Mental Illness |
| SRH | Sexual and Reproductive Health |
| SSW | Street Sex Worker |
| STI | Sexually Transmitted Infections |
| TiE | Theatre in Education |
| TNB | Transgender and Non-binary people |
| ToP | Termination of Pregnancy |
| UDM | User Dependent Method |
| UKHSA | UK Health Security Agency |
| VAWG | Violence Against Women and Girls |
| WHO | World Health Organisation |
| WSW | Women who have Sex with Women |

# Executive Summary

**Sexual and reproductive health is an important public health issue. Equitable access to sexual and reproductive health services is essential to improve the health and well-being of individuals and populations. The 2024 Sexual and Reproductive Health Needs Assessment (SRHNA) is a systematic and comprehensive evaluation of the current and future sexual and reproductive health needs of Richmond residents.**

The latest data on sexually transmitted infections (STIs) indicates that there has likely been an increase in STI transmission in the community that is beyond that of increased testing. STI prevention efforts need to include a range of measures. Proactive health promotion and high-quality health education can improve risk awareness and encourage safer sexual behaviour and testing. Consistent and correct condom use substantially reduces the risk of being infected with an STI and immunisation reduces the risk of infections. STI screening, open access to sexual health services for rapid STI diagnosis and treatment with robust contact tracing, allows earlier diagnosis and reduces the length of time that people can transmit to others[1]. There are also persistent inequalities in relation to reproductive health which further impacts on access to prevention and treatment interventions.

This SRHNA will be used to inform the development of the revised Sexual and Reproductive Health Strategy (2025-2030) and is expected to be used by stakeholders including commissioners and other providers of local sexual and reproductive health and related services.

The SRHNA recognises the interconnectedness and importance of sexual and reproductive health on physical, social, and mental well-being across the life course. This report highlights that certain groups are disproportionately affected by poor sexual and reproductive health outcomes or are underrepresented in service provision, and importantly also considers sexual and reproductive health in the broader context of other health issues such as mental health, substance abuse, homelessness, and the COVID-19 pandemic.

The assessment has been informed by engagement and collaboration with several different organisations including residents, safeguarding boards, community and voluntary sector partnerships, disabilities partnerships, crime prevention partners and young people's participation groups.

The SRHNA draws out six high level strategic priorities and 15 key recommendations that will inform the development of the forthcoming 2025-2030 sexual health strategy. Each recommendation has been mapped to the eight World Health Organisation intervention areas that promote positive **sexual (shown in blue) and reproductive (shown in orange)** health, suggested high level priority areas for the strategy (P1-6) and the life course approach (Start Well (SW), Live Well (LW) and Age Well (AW)). Specific attention is also given to those in underserved groups.

## High Level Strategic Priorities

Six high level strategic priorities are proposed by the sexual and reproductive health needs assessment steering group and will be further 'tested and refined' as the forthcoming strategy is developed.

1. RSE and sexual and reproductive health education through the life course, targeting disproportionately affected and underserved groups.
2. Improve prevention and rapid, targeted diagnosis and access to treatment for STIs and HIV.
3. Improve HIV prevention including the increased uptake of PrEP amongst underserved groups.
4. Increase reproductive choice and prevention of reproductive related ill-health.
5. Increase role of wider community in promoting positive sexual and reproductive health recognising links to emotional health and well-being.
6. Increase sexual health service provision and access for Richmond adults.

1 Spotlight on sexually transmitted infections in London: 2022 data - GOV.UK (www.gov.uk)

## Key Recommendations

1. Provide appropriate advice, information and training to parents & carers to enable early conversation that build a strong foundation for RSE and protective behaviours through the life-course.
   SW, P1
2. Strengthen support to schools, local teacher training programmes and youth and community services to build skills in the delivery of relationships and sex education, including how to access services and expand information on reproductive health (in-line with national guidance).
   SW, P1
3. Increase training for the wider workforce to build confidence and skills to engage residents in healthy discussions on sexual and reproductive health through the life course, including the identification of sexual harm or abuse.
   LW/AW, P1
4. Prioritise the expansion of access to contraceptive choices, particularly LARC through expanding online contraceptive services, integrating the new national pharmacy contraceptive service and expanding routine 'open' LARC availability in General Practice.
   LW, P4
5. Work towards standardisation of the pharmacy EHC offer across south west London ensuring EHC can be clearly accessed and promoted to high risk groups.
   LW, P4
6. Ensure that the forthcoming sexual and reproductive health strategy complements and strengthens existing crime prevention, VAWG and safeguarding strategies, recognising the links between sexual and domestic violence and poor sexual and reproductive health outcomes.
   SW, LW, P5
7. Increase the representation of ethnic minority and lower socio-economic groups in reproductive health services, specifically fertility, cervical screening and reproductive cancer prevention and treatment programmes.
   SW, LW, P4
8. Explore ways to improve access to menopause support including provision of HRT for ethnic minority groups.
   SW, LW, P4
9. Employ targeted STI prevention programmes that encourage consistent and correct condom use, STI related screening / testing programmes and take-up of STI related vaccinations.
   SW, LW, P2
10. Prioritise the provision of online and open access, adequately funded sexual health services for rapid STI diagnosis and treatment with robust contact tracing.
    SW, LW, P2, P3
11. Strive to achieve zero HIV transmission through targeted early diagnosis and identifying and enabling underserved groups to increase access to PrEP.
    LW, AW, P3
12. Explore and prioritise commissioning options that will increase access to open sexual health services for Richmond Adults.
    LW, AW, P6
13. Improve referral and access to both pre-conception and post-abortion contraceptive options via termination, perinatal, midwifery and 0-19 health services.
    SW, LW, P4, P5
14. Increase awareness of the link between sexual dysfunction, cardiovascular health, dementia and early death.
    LW, AW, P5
15. Increase the understanding and representation of underserved groups within our partnership approach to tackling inequalities in relation to sexual and reproductive health outcomes.
    SW, LW, AW, P1-5

# Introduction

## What is Sexual and Reproductive Health?

Sexual and reproductive health is an important public health issue with health, social and economic impacts that can affect the population across the life course. Experiencing good sexual and reproductive health is a fundamental aspect of human identity and life experience. The World Health Organisation's (WHO) current working definition of sexual health is described as:

"…a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled".[2]

Poor sexual and reproductive health can lead to a range of outcomes including STIs, HIV, unintended pregnancies, abortions and the psychological impacts of sexual coercion and abuse. Each of these can lead to long-lasting and costly impacts for both individuals and wider society with further impact on education, social and economic opportunities and longer-term health issues such as genital and liver cancers, pelvic inflammatory disease and poor maternity outcomes3. Poor sexual and reproductive health is not evenly distributed, with some communities disproportionately affected, including young people, GBMSM, people living in poverty, specific ethnic minority communities, and people living with HIV. Impacts, however, can be reduced through safer sex practices, regular testing and access to sexual health and reproductive services4.

The WHO also recognises that sexual health cannot be defined, understood or made operational without a broad consideration of both sexuality and sexual rights. The WHO working definition of sexuality is:

"…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."[5] (WHO, 2006a)

2 WHO (2006a) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva (updated 2010)
3 Department of Health (2001) The national strategy for sexual health and HIV.
4 Department of Health (2001) The national strategy for sexual health and HIV.
5 WHO (2006a) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva (updated 2010)

Sexual health cannot be achieved and maintained without respect for, and protection of, sexual rights which are intertwined with human rights.

"The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws"[6].

Human rights critical to sexual and reproductive rights include the rights to:

- equality and non-discrimination
- be free from torture or to cruel, inhumane or degrading treatment or punishment
- privacy
- the highest attainable standard of health (including sexual health) and social security
- marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- decide the number and spacing of one's children
- Information, as well as education
- freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights.

Reproductive health, according to the WHO, is closely allied to sexual health but both also have distinct components. Reproductive health has been defined as:

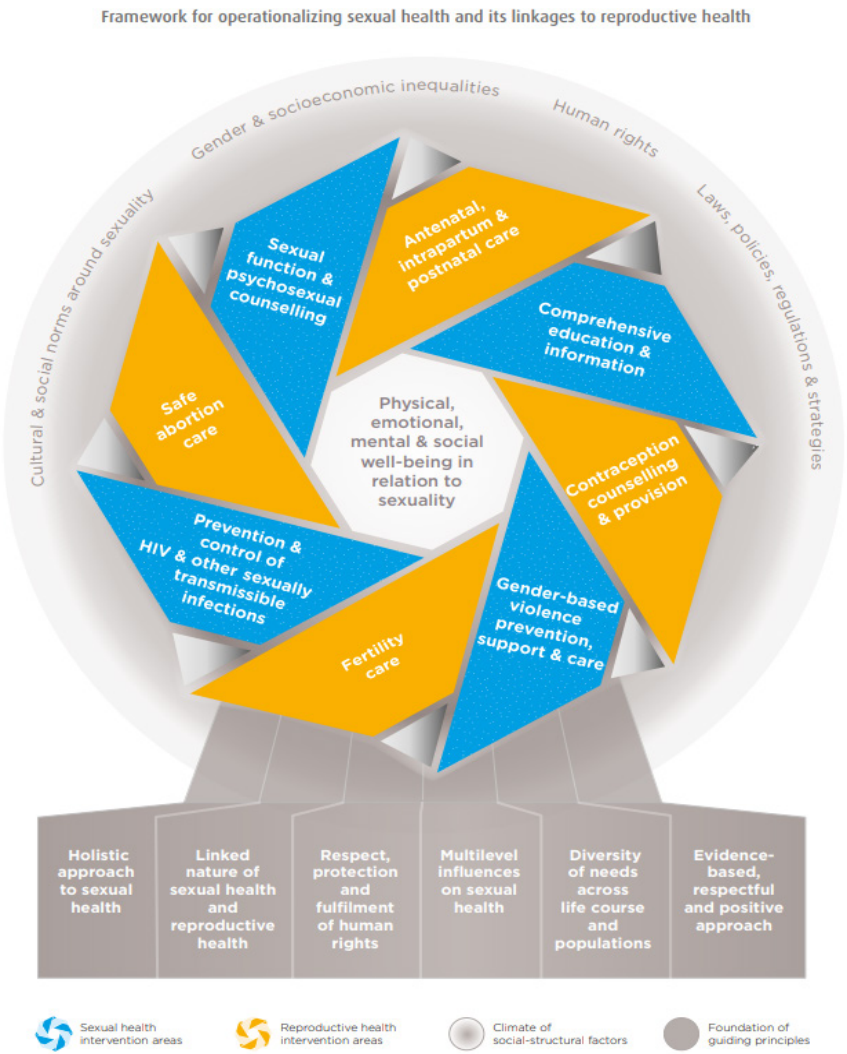
"…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so[7].

In 2017, the WHO developed a framework for operationalising sexual health and its linkages to reproductive health to create a rosette of sexual and reproductive health interventions (Figure 1). The eight intervention areas, four each for sexual health (blue ribbon) and reproductive health (orange ribbon), are of equal weight. More importantly, in a mutually supportive and protective arrangement, each intervention area enhances the impact of the others and, as a result, strengthens the attainment of sexual health as a whole8. The orange and blue ribbons support the central premise that good sexual and reproductive health in turn supports physical, emotional, mental & social well-being in relation to sexuality (as shown in the white centre of the framework).

6 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
7 https://www.who.int/westernpacific/health-topics/reproductive-health
8 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach

This needs assessment will adopt the WHO rosette framework to understand the sexual and reproductive health needs for the population of Richmond.

**Figure 1:**
**Framework for operationalising sexual health and its links to reproductive health**




Source: WHO (2017)

## Sexual and Reproductive Health Through the Life Course

A life course approach to health and well-being considers how biological (including genetics), social and behavioural factors throughout life and across generations act independently, cumulatively and interactively to influence health outcomes. A life course approach, set out by Michael Marmot in 2010, conceptualises both social and physical factors during gestation, childhood, adolescence and adulthood that affect chronic disease risk and health in later life. This approach provides a more comprehensive vision of health and its determinants[9]. It provides a framework that examines opportunities to intervene to improve health in later life and highlights the importance of services that focus on the needs of the individuals and groups at each stage of life.

Sexual and reproductive health is important throughout the life course, at every age and for every community, both as an independent aspect of health and for underpinning identity, personal wellbeing, and relationships.

**Early Childhood:** A life course approach to sexual and reproductive health can be considered from very early childhood. Positive parenting creates the social and emotional foundations on which healthy and safe relationships can be built, including setting personal boundaries and self-awareness that can prevent exploitation or abuse. The National Society of the Prevention of Cruelty to Children (NSPCC) Underwear Rule (Figure 2) is one such tool for parents and early years professionals to talk about sexual safety[10]. As children grow through childhood, age-appropriate universal Personal Health, Social and Economic (PSHE) education alongside Relationships and Sex Education (RSE) has been shown to increase knowledge, challenge attitudes and mould positive behaviours. Research findings in the Natsal-3 study, for example, demonstrated that experience of school based RSE correlated with better sexual and reproductive health, including less risk-taking behaviour, fewer STI diagnoses, unplanned pregnancies or sexual coercion[11].

9 Fair Society, Healthy Lives. The Marmot Review. Strategic Review of Health Inequalities in England Post 2010. London: The Marmot Review, 2010. http://www.instituteofhealthequity.org/projects/fair-society-healthylives-the-marmot-review
10 https://www.nspcc.org.uk/keeping-children-safe/support-for-parents/pants-underwear-rule/
11 Wellings K, Jones KJ, Mercer CH et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third TAKING A LIFE COURSE APPROACH TO SEXUAL AND REPRODUCTIVE HEALTH (CONTINUED) No.73 - 2011 7 No.82 - 2015 National Survey of Sexual Attitudes and Lifestyles (NATSAL-3). Lancet 2013; 382(9907): 1807-1816.

**Figure 2: NSPCC underwear rule**


Source: NSPCC (2023)

**School Years:** Evidence-based education in the classroom equips children to develop the knowledge and skills to grow into healthy adults seeking healthy relationships that are free from exploitation and abuse. The evidence of this led to the introduction of mandatory provision of Relationships, Sex and Health Education (RSHE) in 2020[12]. The curriculum guidance covers a range of related RSE topics including puberty, menstruation, consent, STIs, contraception, online safety, pornography, female genital mutilation (FGM), cancers, fertility, relationship violence and menopause. Supporting parents, teachers, and others to talk to children about sex and relationships encourages them to access early sexual and reproductive advice and health services[13]. The guidance is currently under review.

Creating safe environments for young people to develop their sexual identity is also key to enabling a healthy sexual and reproductive life in both the short and long term. The impact of bullying and discrimination on mental health and well-being can interact with sexual risk taking, particularly for lesbian, gay, bisexual, and transgendered young people14. Steps to tackle homophobia and transphobia in schools and beyond is a legal duty of public sector bodies, and an example of addressing the widespread discrimination experienced by the LGBTQ+ community, and of upholding their human rights.

**Working Years:** The working age population is a diverse group who may experience a range of significant life events from marriage, pregnancy, and parenting alongside physiological changes. For women, pregnancy, cervical cancer screening and menopause can present opportunities for healthcare professionals to recognise and support better sexual and reproductive health. For men, there are potentially fewer opportunities, however the NHS Health Check programme offers healthcare professionals an opportunity to raise the important risk of health issues such as impotence linked to chronic diseases like diabetes and cardiovascular diseases. Sexual and reproductive health for working-age adults bridges contraception, pregnancy, termination of pregnancy and diagnosis and treatment of STIs15. Specialised services focusing on psycho-sexual medicine and the response and support of those affected by sexual violence also play a key part in enabling positive sexual and reproductive health.

**Later Life:** The paradigm of sexual activity in later life is a period in which adults may become more socially isolated as they leave the workplace, develop impairments, or become bereaved. Although there is some evidence that sexual activity declines with age, there is also clear evidence that many adults remain sexually active well into old age16, adjusting and adapting to disability and disease to continue to enjoy fulfilling sex lives17. Research has suggested that although not all older people seek an active sex life, for those that do, sexual dysfunction can have a significant impact on mental health and well-being18. Sexual dysfunction is not an inevitability of ageing, for either gender, but rather a reflection of the burden of accumulated risk factors and immediate stressors19. Sexual activity in older life continues to carry a risk of STIs and yet it is an area that is under-researched and under-discussed in the medical discourse20.

As people age, they tend to have an increasing number of health problems. This is also true for people living with HIV, but evidence suggests people living with HIV experience more severe problems or problems at an earlier stage. One study of people over 50 living with

12 Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk)
13 Hadley A. The Teenage Pregnancy Strategy for England: Concerted effort can make a difference. Entre Nous 2014; 80: 28-29.
14 Promoting the health and well-being of gay, bisexual and other men who have sex with men. London: Public Health England, 2014.
15 WHO (2015): A life course approach to sexual and reproductive health, Entre Nous, The European Magazine for sexual and reproductive health. https://eeca.unfpa.org/sites/default/files/pub-pdf/Entre-Nous-82.pdf
16 Bretschneider J, McCoy N. Sexual interest and behaviour in healthy 80 to 102 year olds. Arc. of sexual behaviour 1988; 17(2):109-129.
17 Linday ST, Schumm P, Laumann EO et al. A Study of Sexuality and Health among Older Adults in the United States. N Engl J Med 2007; 357:762- 774.
18 2. Korfage IJ, Pluijm S et al. Erectile Dysfunction and Mental Health in a General Population of Older Men. J Sex Med 2008; 6(2): 505-512
19 . Laumann E, Das A, Waite E. Sexual Dysfunction among Older Adults: Prevalence and Risk Factors from a Nationally Representative U.S. Probability Sample of Men and Women 57–85 Years of Age. J Sex Med 2008; 5(10): 2300-2311.
20 Steckenrider J. (2023) The Lancet: Vol 4,Iss 3, E96-97, March 2023.

HIV found that just under two thirds were on treatment for other long-term conditions, and the number of these conditions was almost double what would have been expected in the general population at this age21.

**Different Population Groups:** Patterns of STIs, unwanted pregnancies and HIV infection vary across the life course and between groups. The data demonstrates that these remain issues for adults across their lives, with significant numbers of adults acquiring STIs and repeat terminations.

HIV infections, for example, continue to disproportionately affect gay, bisexual, and other men who have sex with men (GBMSM) and individuals from black and minority ethnic communities. HIV remains a stigmatised condition, often because people misunderstand the way it is transmitted and have misplaced fear about contracting the virus. One study found that a third of people living with HIV had faced discrimination, half of which occurred in a healthcare setting[22]. Many people living with HIV have concerns about residential and domiciliary care and what prejudices they may face[23].

Research shows that people with learning disabilities do not have as good or equal access to sex and relationship education or information as those without. Although some people with a learning disability may not be able to consent to having sex or a relationship, this is a minority[24]. Many people with a learning disability have the same aspirations for loving relationships as those without a learning disability.[25,26] When given sufficient and accessible sex and relationships education, many people with a learning disability can engage in safe, healthy, and happy personal and sexual relationships.[27]

Furthermore, research shows that people with physical disabilities have significant sexual and reproductive health disparities and higher rates of sexual distress when compared with the general population. There are specific sexual health concerns for men and women with physical disabilities and the approach to their care needs to be understood and managed appropriately[28].

21 Power, Lisa, Bell, Michael, Freemantle, Iriann. (2010). A national study of ageing and HIV, Joseph Rowntree Foundation.
22 Elford, J., Ibrahim, F., Bukutu, C. & Anderson, J. (2008). HIV-related discrimination reported by people living with HIV in London, UK. AIDS and Behavior, 12(2), pp. 255-264
23 https://www.nat.org.uk/sites/default/files/publications/NAT_Res_Dom_Care_Report_July_2015.pdf
24 www.mencap.org.uk
25 Bates, C., Terry, L., & Popple, K. (2017b). Partner selection for people with intellectual disabilities. ***Journal of Applied Research in Intellectual Disabilities***, 30(4), 602-611.
26 Whittle, C., & Butler, C. (2018). Sexuality in the lives of people with intellectual disabilities: A meta-ethnographic synthesis of qualitative studies. ***Research in developmental disabilities***, ***75***, 68-81.
27 Sinclair, J., Unruh, D., Lindstrom, L. and Scanlon, D. (2015) 'Barriers to sexuality for individuals with intellectual and developmental disabilities: a review,' ***Education and Training in Autism and Developmental Disabilities***, 50(1): 3-16.
28 Rowen.S, Stein S. Tepper M. (2015) Sexual Health Care for people with physical disabilities: Journal of Sexual Medicine; Mar;12(3):584-9.

## Why undertake a Sexual and Reproductive Health Needs Assessment?

A health needs assessment is a systematic process to assess the health problems facing a population[29]. This includes determining whether certain groups appear more prone to poor health than others and identifying any inequalities in terms of service provision. The aim is to maximise the health gain from available resources by identifying priorities for commissioning appropriate services and make recommendations for strategy.

The last sexual health needs assessment for Richmond was undertaken in 2018. It informed the production of a five-year sexual health strategy which was implemented in 2019 and will run to the end of 2024. The strategy provided an overview of sexual health in the borough and an outline of sexual health services at the time as well as the broad direction for improving sexual health outcomes, reducing inequalities, and promoting good sexual health. It focused on prevention, awareness, inequalities, and primary care commissioning. The strategy did not, however, provide commissioning recommendations for the integrated sexual health service which was commissioned in line with the London Sexual Health Transformation Programme; nor did it provide commissioning recommendations on services commissioned by NHS England and Improvement such as abortion services, sexual violence or acknowledge the compounding link between sexual and reproductive health. A strategy progress review conducted in 2022 recommended carrying out a new sexual health needs assessment to:

- Inform the commissioning of integrated sexual health services.
- Further understand the impact of COVID-19 on sexual health and inequalities.
- Inform strategy development beyond 2024.
- Inform the expansion of a future strategy to incorporate reproductive health.

Existing integrated sexual health services are commissioned until September 2024. Future commissioning will be informed by a comprehensive service review undertaken in partnership with the London boroughs of Wandsworth and Merton, as joint service commissioners. Findings from the review have informed this needs assessment.

## Aims and Objectives

The principle aim of the needs assessment is to provide the systematic evidence base to understand current and future sexual and reproductive health needs for the population of Richmond. Its main purpose is to inform the development of a sexual and reproductive health strategy for 2025 to 2030, related commissioning intentions and related policy direction to ultimately meet the sexual and reproductive health needs of Richmond residents. The objectives are to:

29 Kawachi I, (Ed) (2020) Assessing health needs | Oxford Handbook of Public Health Practice 4e | Oxford Academic (oup.com)

Gain greater understanding of sexual and reproductive health epidemiology across the life course for the population of Richmond.

- Describe the epidemiology of sexual and reproductive health in groups who experience disproportionately poorer sexual and reproductive health outcomes (young people, GBMSM, women who have sex with women (WSW), Black, Asian and minority ethnic groups).
- Identify levels of unmet need, particularly among vulnerable groups who have disproportionately poorer sexual and reproductive health outcomes or are underrepresented in service provision.
- Understand current provision and reach of the broad range of sexual and reproductive health services and the extent to which the council and partners meet national (and local) guidance in relation to the provision of sexual and reproductive health services.
- Understand sexual and reproductive health need in the context of other health issues including mental health, substance misuse, homelessness, and the impact of COVID-19.
- Understanding of well-being in the context of sexual health and sexuality.
- Establish potential service demand across the range of sexual and reproductive health services.
- Compare the borough's need and local service infrastructure with that at a regional and national level and with statistical neighbours.
- Make recommendations for future action in relation to service commissioning and strategy development.
- it acknowledges that there are limitations as to the extent of information an assessed need that can be included. The needs assessment acknowledges links between mental health and sexual health it is unable to provide detailed analysis of the range of mental health conditions in respect of sexual and reproductive health outcomes. Nor does the assessment contain analysis of the links between sexual and reproductive health and faith or religious perspectives, however, it does acknowledge that personal decisions will be made in the context of faith, religious and cultural beliefs.

## Methodology

This needs assessment will use a mixed methods approach to understand how Richmond is operationalising the WHO rosette framework for sexual and reproductive health:

- **Epidemiological:** consider the epidemiology of STIs and HIV, across the population, current service provision, and the return of investment on sexual and reproductive health interventions.
- **Comparative:** comparing service provision and access to services including STI, contraceptive, termination of pregnancy (ToP) and reproductive services between different populations and boroughs with a similar population.
- **Corporate:** eliciting the views of stakeholders including professionals and those who live, work, are educated or socialise in Richmond.

The needs assessment will incorporate both qualitative and quantitative methods of enquiry to closely examine need, understand current service configurations and identify opportunities and gaps in provision.

**Quantitative Analysis:**

- Analysis of national and local published sexual and reproductive health data.
- Analysis of sexual health and reproductive health provider service data.
- Incorporate the findings from the recent integrated sexual health integrated service review.
- Incorporate findings from related local resident and stakeholder surveys.
- Benchmark data against statistical neighbours.

**Qualitative Review:**

Broad consultation to identify trends; existing knowledge of and access to services; and identify gaps and opportunities:

- A desk-top literature review of related sexual and reproductive health policy and practice including a review of statutory guidance and legislative framework.
- Consultation with key stakeholders including:
- Service and non-service users across the life course.
- Service managers and Heads of Service (local authority and health partners),
- Community and voluntary sector, youth settings and various partnerships including, disabilities, crime prevention, safeguarding (adults and children), health, pharmaceutical, sexual health providers and mental health.
- Equality Impact Needs Assessment of the current strategy
- Review of provider service annual reports
- Review of existing related local strategies and needs assessments and their inclusion of sexual and reproductive health.

Information gleaned from consultations are weaved into the key relevant sections. Findings were drawn together and triangulated to test and assure with the needs assessment steering group and to make informed recommendations about future actions.

## Governance

To ensure the needs assessment is fully comprehensive and effective, the existing Sexual Health Implementation Group (SHIG) has provided the governance framework to oversee and advise its development. The Board appointed a 'steering group', co-ordinated by the Sexual Health lead, to carry out tasks required to agree the boundaries of, and conduct, the assessment. The group comprised key stakeholders to act as a sounding board to test emerging findings, formulate recommendations and develop strategic priorities. Membership of this group included:

- Consultant in public health
- Sexual health commissioner
- Public Health Senior Lead (sexual health)
- Public Health Senior Lead (primary care)
- Sexual health commissioning officer
- Sexual health GP lead
- Sexual health services provider representative
- Community and voluntary sector services representatives
- Data and analytics team
- Crime prevention team
- St George's reproductive services
- Children's safeguarding

## Core Data Sources

The core data sources used for this needs assessment are:

- Office for Health Improvement & Disparities (OHID) & UK Health Security Agency (UKHSA) Sexual and Reproductive Health Profiles
- Office for National Statistics (ONS) Birth and fertility rates
- NHS Business Services Authority (NHSBSA) Prescribing data
- ONS contraception and abortion data
- Summary Profiles of Local Authority Sexual Health (SPLASH)
- STI Surveillance System (GUMCAD).
- UKHSA HIV London annual data spotlight
- Local provider service data.
- SWL health insights dashboard

# Legislative and Policy Context

## Global, National and Regional Policy Context

This sexual and reproductive health needs assessment is guided by and set within the global, national and regional legislative and policy context which collectively identifies need, guides priority and funding decisions and drives improved health outcomes. The main goals, strategies and policies are acknowledged and considered herewith.

## Global

**Sustainable Development Goals**[30]**:** SDGs, adopted by the United Nations General Assembly in September 2015, were a universal call to action to end poverty, protect the planet, and ensure that, by 2030, all people enjoy peace and prosperity. The 17 SDGs are interrelated and include a goal for good health and well-being (SGD 3). Within this domain, countries have committed to ensuring that by 2030, there will be universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes (target 3.7). Target 3.3 also pledges to end AIDs, tuberculosis and other communicable diseases. These sustainable development goals are reflected within national policy commitments in England.

**Global health sector strategies on HIV, hepatitis and STIs 2022-30**[31]**:** The WHO calls for individual countries to build on achievements and lessons learned from previous global health sector strategies to create opportunities to leverage innovations and new knowledge for effective responses to HIV, viral hepatitis and STIs. It urges countries to define the populations that are most at risk and commit to actions that respond to the local epidemiological and health system contexts. Fundamentally, the strategies underline the critical role of the health sector in ending epidemics, recognising that a multisectoral 'Health in all Policies' approach is required to remove structural and systemic barriers to progress. It recognises that strong leadership coupled with innovative technologies and practices, financial investment and community engagement can reduce disease transmission, improve treatment outcomes and save lives. It requests that countries develop strategies putting people at the centre by organising services around people's needs rather than around diseases; emphasising that different populations have unique health needs and circumstances that require tailored approaches that respond to lived experiences. Recognising the historical context of disease prevention and treatments the WHO calls for disease specific roadmaps for each of HIV, viral hepatitis and STIs.

30 https://www.undp.org/sustainable-development-goals/good-health
31 WHO (2022) Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030

For HIV it urges countries to give greater attention to reducing HIV-related deaths, including by addressing tuberculosis (TB), cryptococcal meningitis, severe bacterial infections, and other comorbidities. For viral hepatitis the WHO urges expansion of universal access to the hepatitis B birth-dose vaccine to end infections in children, integrating viral hepatitis services into universal health coverage packages, simplifying, and decentralising service delivery, and improving coordination with other health areas such as those addressing cancer and maternal and child health care, supported by greater public and political awareness and adequate funding. For STIs the WHO urges increased funding and political commitment to re-energise prevention, reduction of stigma and increased access to awareness, screening, diagnosis and treatment. The collective health strategies look towards co-ordinated action across health and community systems and a swift response to the changing health and development context, recognising the spotlight put on disparities between populations and exacerbated by the COVID-19 pandemic. Finally, it calls for the elimination of stigma, discrimination and other structural barriers for key populations which exacerbate risk and prevent access to services.

**Fast Track Approach:** The Joint United Nations Programme on HIV / AIDS (UNAIDS) declared in 2015 that advances in science, accumulated implementation experience, political commitments, community activism, human rights advances, global solidarity, and attendant resources offered an historic opportunity to end the AIDS epidemic as a public health threat by 2030. At this time, UNAIDS set a 90-90-90 target for 2020: 90% of people living with HIV know their HIV status, 90% of people who know their status are receiving treatment and 90% of people on HIV treatment have a suppressed viral load so their immune system remains strong, and the likelihood of their infection being passed on is greatly reduced. Those on treatment with an undetectable viral load are unable to pass on the infection. In 2020 the world had made good progress to reach the 90-90-90 target but fell short of the goal. By the end of 2019, 81% of people living with HIV knew their HIV status, and more than two thirds (67%) were on antiretroviral therapy, and almost 59% of people living with HIV globally had suppressed viral loads. A more challenging 95-95-95 target has been set for 2030. The COVID-19 pandemic has further exacerbated progress, particularly in sub-Saharan Africa. The approach looks to implement focused, high-impact prevention; accelerated HIV testing; treatment and retention in care; anti-discrimination programmes; and an unwavering commitment to respect, protect and promote human rights and gender equality on a global scale.

## National

**National Sexual Health Strategy[32]:** The government set out its ambitions for improving sexual health in its publication, "A Framework for Sexual Health Improvement in England", which highlighted a commitment to an integrated model of service delivery to allow easy access to confidential, non-judgmental sexual health services (including contraception, abortion, sexually transmitted infections, health promotion and prevention) for everyone. This national strategy, set out in 2013, focussed largely on sexual health improvement and was limited in its understanding and integration of understanding reproductive services.

The 2019 All Parliamentary Health and Social Care Select Committee on Sexual Health confirmed that some progress had been made in terms of improving the nation's sexual health, including the reduction of some STIs and teenage conceptions. It also acknowledged, however, that cuts to spending on sexual health services had been severe with a 14% reduction in local authority spending on sexual health between 2014 and 2018[33] and an up to 35% reduction on health promotion activities. In response to the 'All Parliamentary' report, the government has agreed to the development of an updated sexual and reproductive health strategy[34]. A revised national strategy is yet to be delivered.

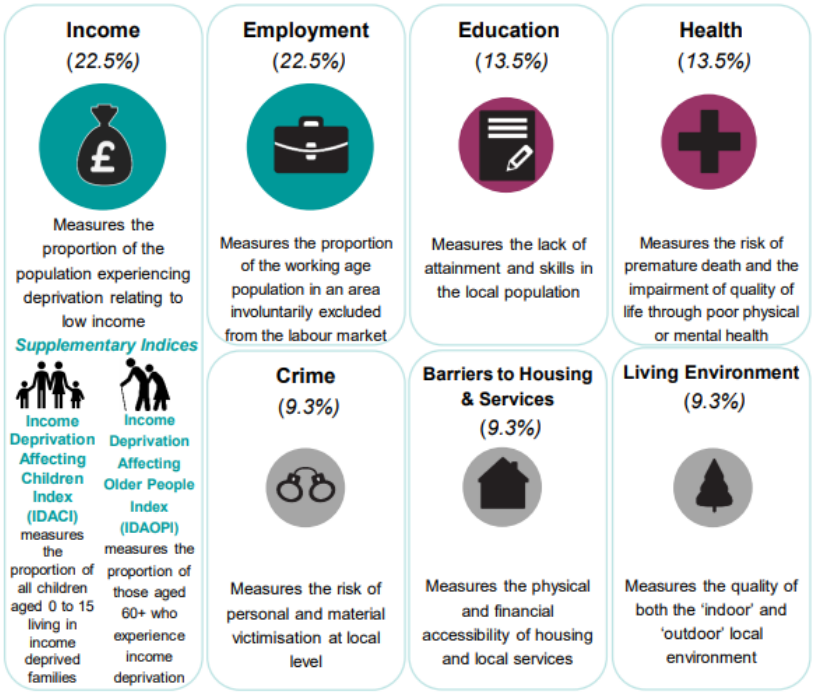
**Breaking Point: securing future sexual health services:[35]** In 2022 the Local Government Association published a report raising concerns over the reductions of long-term funding for sexual health services. It noted the following key concerns:

- Significant increase in the number of consultations at Sexual Health Services over the last 10 years.
- Number of screens and the overall number of services offered has increased, public awareness of STIs and contraception has grown.
- Local councils have been engaged in one of the biggest modernisation exercises in the history of public health, such as a rapid channel shift to online consultations, app, home testing and home sampling.
- Evidence from across the sector shows the capacity of councils to further innovate and create greater efficiencies is now limited.
- Unless greater recognition and funding is given to councils to invest in prevention services, a reversal in the encouraging and continuing fall in some STIs and more unwanted pregnancies is now a real risk as is their ability to respond to unforeseen challenges such as Mpox.
- Behavioural change has increased demand.

32 A Framework for Sexual Health Improvement in England - GOV.UK (www.gov.uk)
33 Sexual Health (parliament.uk)
34 Government Response to the Health and Social Care Committee report on Sexual Health - CP186 (publishing.service.gov.uk)
35 Breaking point: Securing the future of sexual health services | Local Government Association

**Core20PLUS5[36]:** Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach, initially focussed on adults, has been recently expanded to include children. Core20 looks to accelerate action for the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health:

**Figure 3: 7 domains of deprivation for the IMD**




Source: MHCLG (2019)

PLUS population groups are identified at a local level. Populations may include ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; and groups experiencing social exclusion such as people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

The approach also includes five clinical areas of focus which require accelerated improvement:

1. Maternity: Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): Ensure annual physical health checks for people with SMI to nationally set targets.
3. Chronic respiratory disease: A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.
5. Hypertension case finding: Optimising blood pressure and minimising the risk of myocardial infarction and stroke.

The five key clinical areas for reducing health inequalities in children include asthma, diabetes, epilepsy, oral health and mental health.

**Women's Health Strategy for England[37]:** In 2022, in recognition of disparities in health outcomes between men and women, the government produced the first Women's Health Strategy for England with some of the main priority areas linked to promoting positive reproductive health for women. Overlapping areas for action include:

- Menstrual health and gynaecological conditions
- Fertility, pregnancy, pregnancy loss and postnatal support
- Menopause
- Cancers (including reproductive cancers)
- Health impacts of violence against women and girls (including sexual violence)

Ambitions for the strategy include delivering on cross-cutting themes relating to information and awareness raising, improving access to services, promoting health in the workplace and education and training for health and care professionals. Following on from the Women's Health Strategy the government has provided additional funding for the establishment of 'Women's Health Hubs', which are understood as a model of care working across a population footprint as opposed to a physical place. Hub models aim to address fragmentation in service delivery to improve access, experiences and outcomes. Hubs reflect the life course approach to women's health, where care is not limited to interventions for a single condition, but instead is wrapped around the needs of an individual woman, which in some cases may be multiple needs.

36 https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

37 https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england#menstrual-health-and-gynaecological-conditions

For example, hubs can provide management of contraception and heavy menstrual bleeding in one visit or integrate cervical screening with other aspects of women's healthcare such as long-acting reversible contraception (LARC) fitting or removal. Core services to bring into a hub model are suggested as38:

- Menstrual problems assessment and treatment, including but not limited to care for heavy, painful or irregular menstrual bleeding, and care for conditions such as endometriosis and polycystic ovary syndrome.
- Menopause assessment and treatment
- contraceptive counselling and provision of the full range of contraceptive methods including LARC fitting for both contraceptive and gynaecological purposes (for example, LARC for heavy menstrual bleeding and menopause), and LARC removal, and emergency hormonal contraception.
- Preconception care
- Breast pain assessment and care
- Pessary fitting and removal.
- Cervical screening
- Screening and treatment for STIs, and HIV screening.

**Towards Zero**[39]**:** The UK was one of the first countries to meet the UNAIDS 90-90-90 target. Furthermore, in line with global SDGs the government has committed to achieving zero new HIV infections, AIDS and HIV-related deaths in England by 2030. To achieve this the government set out an action plan for HIV comprising of four main objectives incorporating nine main actions:

- Equitable access and uptake of HIV prevention programmes
- **Action 1:** Investment in evidence-based national HIV prevention campaigns and prevention activities.
- **Action 2:** Investment in HIV Pre-Exposure Prophylaxis (PrEP) with support for access for key population groups
- Scaling up HIV testing in line with national guidelines.
- **Action 3:** Scaling up HIV testing, focussing on populations and settings where testing rates must increase.
- **Action 4:** Reduce missed opportunities for HIV testing and late diagnosis of HIV
- **Action 5:** Innovate and transform capacity and capability for effective partner notification (PN).
- Optimising rapid access to treatment and retention in care
- **Action 6:** Reduce the number of people newly diagnosed with HIV who are not promptly referred to care.
- **Action 7:** Boost support to people living with HIV to increase the number of people retained in care and receiving effective treatment.
- Improving quality of life for people living with HIV
- **Action 8:** Optimise the quality of life of those living with HIV.
- **Action 9:** Tackle stigma and improve knowledge and understanding across the health and care system about transmission of HIV and the role of treatment as prevention.

Towards Zero forms a part of the government's wider Sexual and Reproductive Health Strategy, which was expected in 2022, but currently paused. The HIV action plan provides the framework for both regional and local action in relation to HIV. There is an intention to update this action plan for 2025 and beyond as targets are met.

**Relationships and Sex Education (RSE)**[40]**:** The Department for Education published statutory guidance governing RSE in July 2019 under the Children and Social Work Act 2017. The guidance reinforces PSHE education delivered in schools by ensuring that all pupils in every school are consistently supported with the right information, skills and knowledge to enable them to keep safe and build their resilience as they journey into adulthood. The focus of the curriculum under the new guidance is about relationships in primary school, and sex and relationships in secondary school.

Children are taught through age-appropriate learning about families; friendship; caring and respectful relationships; the law; basic first aid; mental and physical well-being, including changes to their bodies as children grow up; and internet safety. Sex education is not statutory in primary schools however, the government makes it clear that schools should still provide a programme of age appropriate sex education.

Teaching about relationships also needs to meet the schools' duty (under the Equality Act 2010) to promote equality, helping to ensure that every child can grow up in an environment where they feel included. This means schools need to reflect and take into account different protected characteristics in relationships education, including disability, marriage and civil partnership, race, religion or belief, sex and sexual orientation. The statutory guidance is currently being refreshed with the intention for new guidance to be published in 2024.

38 https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-core-specification

39 Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025 - GOV.UK (www.gov.uk)

40 https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education

**The Teenage Pregnancy Prevention Framework (2018)[41]:** The evidence-base demonstrates that building knowledge, skills, resilience and aspirations of young people, and providing easy access to welcoming services, helps them to delay sex until they are ready to enjoy healthy, consensual relationships and to use contraception to prevent unplanned pregnancy. The national Teenage Pregnancy Prevention Framework and the Framework for Supporting Teenage Mothers and Young Fathers are legacy frameworks developed out of the success of the National Teenage Pregnancy Strategy (1999), which saw underage conception rates dramatically fall across England and Wales. The frameworks are designed to:

- Help local areas assess their local programmes to see what is working well.
- Identify any gaps in services.
- Strengthen the prevention and support pathways for all young people, young parents and their children.

Both frameworks provide an evidence-based structure for a collaborative whole system approach to prevent teenage pregnancies and support teenage parents.

## Regional

The London Sexual Health Transformation Programme was set up to develop a collaborative commissioning model for open access sexual health services, following the transfer of commissioning responsibilities from NHS Primary Care Trusts to local authorities in 2013. This included a template service specification which merged Genito-urinary medicine (GUM) and Contraceptive and Sexual Health (CASH) services into an integrated sexual health (ISH) service model of provision. The programme ended in 2017, with activities transitioning to the London Sexual Health Programme (LSHP), hosted by the City of London Corporation on behalf of all related authorities. The LSHP is a partnership of 31 London local authorities, including Richmond, that co-ordinates strategy and planning of sexual health services in the capital, and has included lead commissioning responsibility for the London-wide Sexual Health London. UK (SHL.UK)[42] since 2018. SHL.UK is London's sexual health e-service that provides free and easy access to self-sampling for STIs and HIV, routine contraception, emergency hormonal contraception (EHC), and signposting to local venues for people aged 16 and over who are residents in participating boroughs in London. The service provides testing for a range of sexually transmitted infections including chlamydia, gonorrhoea, HIV, syphilis, hepatitis B and hepatitis C via samples that can be collected at home. In some boroughs, service users can also access contraception and EHC.

Fast Track Cities[43]: London currently carries a high proportion of the national HIV epidemic, with 40% of the total of the new diagnoses in England in 2019 being made there. In 2018, London councils signed the Paris Declaration on Fast-Track Cities which is a global movement aiming to end HIV transmission by 2030. London is already leading the way in diagnosis and treatment, surpassing the global 95-95-95 target in 2017, but aims to be the first city in the world to end new cases of HIV and achieve zero preventable deaths and zero stigma by 2030. To reduce new rates the programme will look to establish a 'Getting to Zero' collaborative and provide additional funding in 2023 with the aim of:

Embedding a peer support network in all HIV clinics across London.

- Improving the quality of life and well-being of people living with HIV.
- Re-engaging people diagnosed with HIV who are no longer accessing care or treatment.
- To reduce stigma the programme looks to:
- Train people living with, affected by and at risk of HIV to enable the development of resilience, confidence and skills to tackle internal stigma.
- Create an 'HIV-friendly' charter or kitemark for organisations.

The London HIV Prevention Programme (LHPP) is London's flagship HIV public health awareness programme and has been supporting London's efforts to reduce HIV infections since 2014. It was established to provide a city-wide approach to HIV prevention.

The programme consists of three main elements:

**Public health information and marketing campaigns** on combination HIV prevention, under the brand 'Do It London' (delivered by Lambeth Council in partnership with commissioned advertising agencies)

**A free condom and lubricant distribution service** for GBMSM across Greater London (usually in bars, clubs, pubs, saunas and community sites - with the addition of home-delivery since March 2020, delivered by Central and North West London NHS Foundation Trust (CNWL) Freedoms Shop)

**Sexual health promotion outreach and rapid HIV testing** in commercial and community venues for GBMSM delivered by Metro, Spectra, Positive East, The Love Tank.

The LHPP is funded by all London boroughs with a proportional funding split based on diagnosed HIV prevalence. It is hosted, managed and commissioned by Lambeth Council on behalf of all London boroughs and governed by the LHPP Board.

41 Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
42 Sexual Health London • SHL.UK

43 Fast-Track Cities London: Helping end HIV by 2030 (fasttrackcities.london)

# Richmond Policy Context

## Richmond Sexual Health Strategy for 2019 to 2024

The sexual health strategy[44], developed following a rapid sexual health needs assessments in 2018, provides an overview of sexual health in the boroughs and an outline of sexual health services at the time. The strategy was further informed by engagement with a broad range of partners including commissioners, children's services, school health, the youth council, service providers, the voluntary sector, and the public. Through this consultation process, and an Equality Impact Needs Assessment (EINA), five strategic priorities were identified to drive forward the strategy:

**Priority 1:** Promote healthy sexual behaviour and reduce risky behaviour

**Priority 2:** Reduce STI rates with targeted interventions for at-risk groups

**Priority 3:** Reduce unintended pregnancies

**Priority 4:** Continue to reduce under-18 conceptions

**Priority 5:** Work towards eliminating late diagnosis and onward transmission of HIV

Through the five priorities, the strategy aimed to improve the sexual health of the whole population but was designed to have the greatest impact on vulnerable groups, who disproportionately experience inequalities in sexual health.

The strategy provides the broad direction for improving sexual health outcomes, reducing inequalities, and promoting good sexual health. It focuses on prevention, awareness, inequalities, and primary care commissioning. The strategy does not, however, provide commissioning recommendations for the ISH service. This was commissioned, at the time, in-line with the London Sexual Health Transformation Programme. Nor did it provide commissioning recommendations on CCG commissioned services for abortion, female genital mutilation and sexual violence and services commissioned by NHS England and Improvement. These elements were considered to be outside the scope of the strategy at the time. A strategy progress report conducted in 2022 and presented to the Richmond Health and Wellbeing Board (HWBB), demonstrated good progress had been made on the delivery of the strategy despite the disruption brought about by COVID-19. The strategic action plan to take the strategy to completion by the end of 2024 was updated accordingly.

Further discussions with strategic partners revealed a collective agreement to retain the existing time frame for the strategy with a view to developing a new and revised strategy from 2025 onwards. This would align with the start of the new ISH service contract and provide a mandate for sexual health service delivery for the provider of the contract. Other actions included:

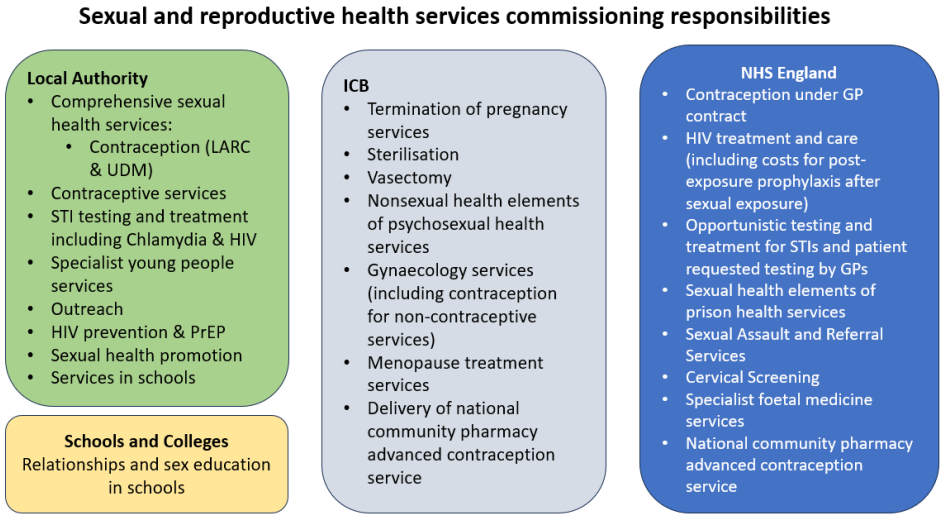
- Refreshing the strategy's EINA to ensure action plans continue to be equality driven and inform the development of any new strategy. This refresh subsequently identified the following vulnerable groups should be considered for this needs assessment:
  - Young fathers
  - People who are LGBTQ+
  - Migrant / refugee groups
  - People with learning disabilities and their carers
  - Older generations, including those in care homes, especially those being treated with HIV.
- Ensure the Pharmaceutical Needs Assessment (PNA) includes a reflection of sexual health service provision within pharmacies including workforce challenges.
- Scope out a new sexual health needs assessment which will:
  - Inform related ISH service specifications.
  - Inform strategy development beyond 2024.
  - Further understand the impact of COVID-19 on sexual health and inequality.
- Develop a new and expanded sexual health strategy that incorporates reproductive health.
- Ensure the new strategy builds on expanding sexual health education, is costed and is outcome focussed.

44 https://www.datarich.info/staying-healthy/sexual-health/sexual-health-strategy

## Local ISH service Provision and Review

The commissioning landscape for the provision of sexual and reproductive services is both complex and fragmented. To summarise, responsibilities for commissioning fall into three main groups:

### Figure 4: SRH commissioning responsibilities




Source: Adapted from A framework of sexual health improvement in England (2013)

Local authorities, through public health, across England from 2013 have held the responsibility for commissioning some sexual and reproductive health services. Within Richmond, the ISH is jointly commissioned by Wandsworth, Richmond, and Merton to Central London Community Healthcare NHS Trust (CLCH) who provide a comprehensive open access integrated Genito Urinary Medicine (GUM) and Contraceptive Advise and Sexual Health (CASH) sexual health service.

In October 2017, CLCH began providing an integrated hub and spoke sexual health service across the boroughs. The integrated model provides screening and treatment for STIs as well as contraception. The hub based near Clapham Junction Station in Wandsworth, provides the full range of sexual health services (levels 1-3; level 3 care being most specialist for complex cases); and spokes, located in Richmond and Merton, provide level 1 and 2 care. The service is open access and non-residents can attend.

**Services offered at the hub clinic include:**

- Long-acting reversible contraception (LARC)
- Emergency hormonal contraception
- Routine contraception
- C-Card condom distribution scheme for young people
- Chlamydia screening and treatment
- HIV treatment
- Pre-Exposure Prophylaxis (PrEP) and Post-Exposure prophylaxis (PEP) for HIV
- STI diagnosis and management
- Vaccination (Mpox, Hep A and Hep B)

The Local Authority also commission sexual health services including chlamydia screening and treatment, Emergency Hormonal Contraception (EHC) and LARC via primary care.

### Table 1: Overview of services currently commissioned

| | General practice | Pharmacies | ISH service |
|---|---|---|---|
| LARC | • | | • |
| EHC | | • | • |
| C-Card | | • | • |
| Chlamydia Screening & treatment | | • | • |
| HIV rapid testing | | | • |
| STI management & treatment | | | • |
| HIV testing | | | • |
| National community pharmacy advanced contraceptive service | | • | |

**Other services commissioned by Public Health include:**

- South West London Sexual Health and HIV Prevention Service for High Risk Groups, commissioned by Wandsworth Council on behalf of all South West London boroughs which participate in a varied mix of the following service elements:
  - Services for young people aged 24 and under
  - HIV prevention and support
  - Sex worker support service
  - Sexual health outreach, prevention and engagement
- 19 general practices providing LARC.
- 17 pharmacies providing emergency hormonal contraception (EHC) to females aged 13 years and over.
- 17 pharmacies accredited to provide chlamydia screening self-sampling kits of which 16 are also accredited to provide chlamydia treatment for uncomplicated chlamydia infections to 15–24-year-olds.
- 17 pharmacies offering the free condom distribution scheme (C-Card) to 15-24-year-olds.
- HIV and syphilis screening and testing through SH24.

A review of the locally commissioned ISH service was conducted in 2022 with a view to a recommissioned service being implemented from October 2024. The review suggested the following broad recommendations to be considered within recommissioning:

- Reconfigure the current hub and spoke model.
- Increase the number of hubs delivered by GP practices.
- Work with healthcare professionals to ensure that demand can be met via increased training and support.
- Enhanced promotion and signposting of sexual health services across the boroughs.
- Ongoing monitoring of sexual and reproductive health indicators to continue to evaluate the medium- and long-term repercussions of the COVID-19 pandemic.
- Increase engagement with young people, those aged over 45 and the LGBTQ+ community.

## Richmond Sexual Health Story

A comprehensive review of sexual health in primary care, conducted in 2020, provided an opportunity to increase equity of access to sexual health provision. Detailed recommendations are not duplicated here but included: [45]

- Rationalise sexual health provision in GP surgeries and pharmacies.
- Take action to optimise the effectiveness of services.
- Maximise the primary care offer for sexual health.
- Understand and respond to the demographic characteristics of service users.
- Undertake qualitative work to complement and contextualise the quantitative findings.
- Capitalise on opportunities that arise from the changing healthcare landscape.
- Optimise use of financial resource and expertise through cross-divisional spending. agreements between public health and commissioning and working collaboratively with councils across Southwest London.

## Richmond Pharmaceutical Needs Assessment[46]

All HWBBs have a statutory responsibility to publish and keep up to date a statement of needs for pharmaceutical services for their population every three years. This is called the Pharmaceutical Needs Assessment (PNA). The two-fold purpose of the PNA is to:

Support NHS England in their decision-making related to applications for new pharmacies, or changes of pharmacy premises and/or opening hours.

Support local commissioners in decisions regarding services that could be delivered by community pharmacies to meet the future identified health needs of the population.

45 Richmond Sexual Health Story (2020); Public Health Richmond and Wandsworth
46 https://www.richmond.gov.uk/media/rvwaihe1/richmond_pharmaceutical_needs_assessment_2023_2026.pdf

The latest PNA for Richmond was published in 2023 and provides an overview of the demographics and health and wellbeing needs of the Richmond population. It captures patients' and public's views of pharmacy services they access. It also assesses whether the current provision of pharmacies and the commissioned services they provide meet the needs of the Richmond residents and whether there are any gaps, either now or within the lifetime of the document, to June 2026. It assesses current and future provision with respect to:

- Necessary Services, i.e., current accessibility of pharmacies and their provision of Essential Services
- Other Relevant Services and Other Services including Advanced and Enhanced Pharmacy Services.

The PNA concluded there were no current gaps in the provision of essential, advanced, enhanced or other NHS pharmacy services for the lifetime of the PNA.

There were no specific recommendations in relation to sexual or reproductive health derived from the PNA, however, the needs assessment was published prior to the announcement of a national community pharmacy contraception advanced service.

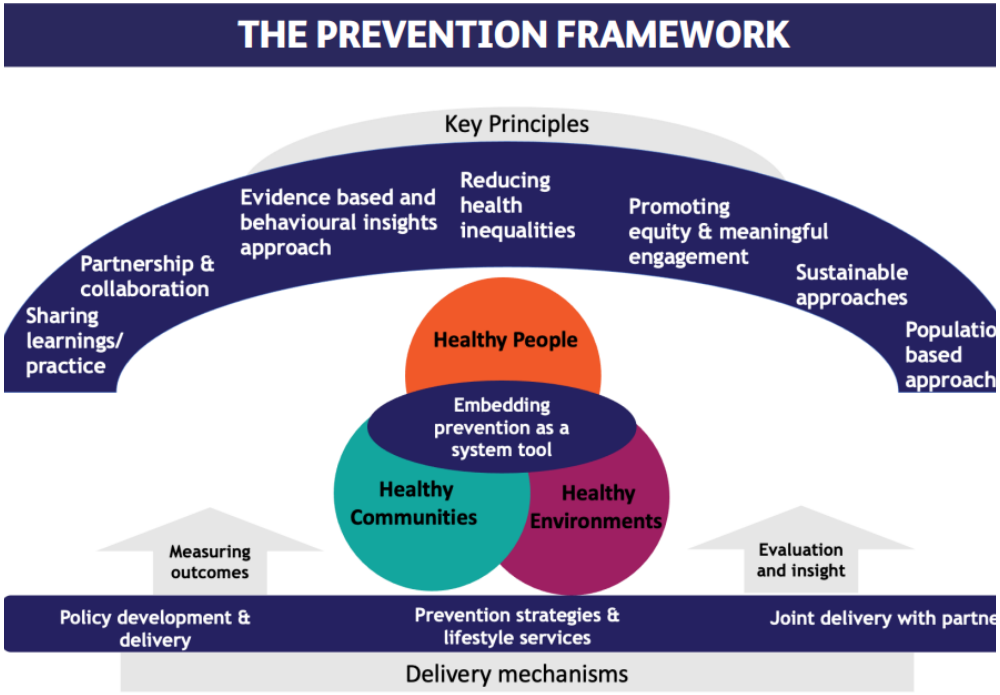
### Richmond Public Health Prevention Framework

The Richmond Sexual Health Needs Assessment now sits within the strategic prevention framework model adopted by Richmond Council[47]. This model has at its centre the aim of embedding prevention as a system delivery tool to promote health and to reduce health inequalities. It does this at three interconnecting levels within a system; people, community, and environment. The key objectives of the prevention framework are to:

- Deliver an evidence-based approach to prevention to support the wider Council to strengthen delivery of prevention through its work.
- Facilitate making the healthy choice, the easy choice.
- Support a tailored approach to prevention.
- Connect with policies and initiatives to enable prevention work to be sustainable.
- Create supportive communities and health-promoting environments.

The prevention framework was developed in the context of the COVID-19 pandemic and a shift to an Integrated Care System across the NHS, local authorities, voluntary sector and community partners locally. This shift significantly elevated prevention of ill-health and reducing health inequalities as key priorities across the health and care sector and encompasses action on the wider determinants of health.

**Figure 5: Richmond prevention framework**




Source: Richmond Council (2022)

## Richmond Demography

### Population

As an outer London borough Richmond comprises of eighteen wards covering an area of 22.2 square miles and is in the top 20% of most densely populated areas of English Local Authority areas but is the 5th least densely populated of London's 33 Local Authority areas. The borough, as the second smallest of the outer London boroughs, contains five main town centres - Richmond, Twickenham, East Sheen, Teddington and Whitton - and was home to 195,300 residents at the 2021 census[48]. Comparative census data from 2011 indicates that the population grew by 4.4%, which was smaller than the overall growth of 7.7% across London. The proportion of Richmond population in all age groups above 40 is substantially higher than London average (35) in 2021 and the average (median) age of residents has increased by three years, from 38 to 41 years since the last census.

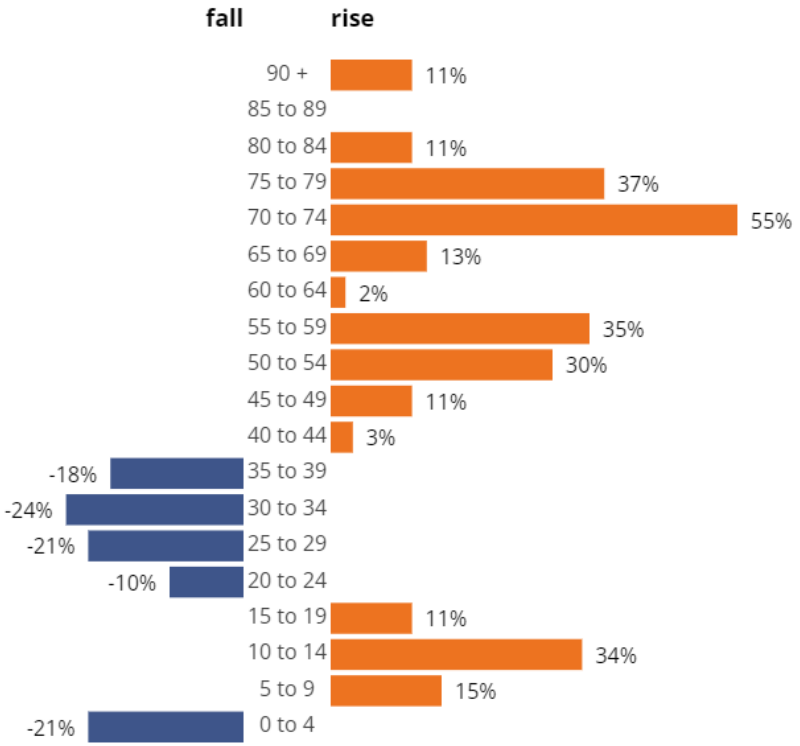
47 www.richmond.gov.uk/council/how_we_work/policies_and_plans/adult_strategy/framework_for_prevention

48 ONS 2011-21 comparative data: accessed 7th September 2023: www.ons.gov.uk/visualisations/censusareachanges

## Age & Gender

The age demography of Richmond is changing. Since the 2011 census there has been an increase of 24.9% of people aged 65 and over, with those in the 70-74 age bracket seeing the highest increase of 55%. Young people in the age brackets 20 to 39 have decreased while those age 15 and under have increased by 6.1% in total:

**Figure 6; Population change (%) by age group in Richmond, 2011 to 2021**




Source: ONS, visualisations (2023)

Greater London Authority population projections[49] show that by 2030, the borough is likely to see a small decrease of 0.4% in the overall population from the estimated figure in 2023 of 198,007 to 197,544 by 2030. Age demography, however, will change over this time with an estimated 15.6% decrease in the number of children aged under 15 but a steady increase of 7% for those in the 15-24 age bracket (an estimated additional 1500 young people). In 2021 there were an estimated 18,026 people aged 15 to 24 in Richmond.

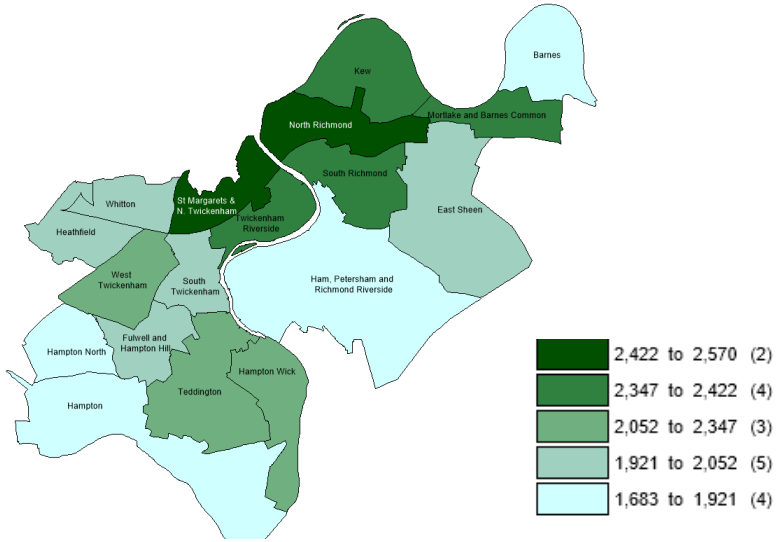
49 https://apps.london.gov.uk/population-projections/: Accessed 7th September 2023

Simultaneously the numbers of 25–44-year-olds, those with the greatest demand on sexual and reproductive health services, will fall by 9% from approximately 50,000 to 45000 residents, but an estimated increase of 2.9% and 12.9% in the 45-64 and 65-79 age brackets respectively. The greatest increase in Richmond will be seen in the 80+ population which will increase 38% (an additional 3500 residents).

Changes in local demography, coupled with socio-economic change, can of course impact on service demand. As users of sexual and reproductive health services are most likely found within the 15- to 45-year-old age range an increase in demand for chlamydia screening and STI testing could be predicted for young people aged up to 24, but there may be a decreasing demand for sexual and reproductive services from those aged 25 to 45. When stratified by sex, there appears to be a steady increase of young women aged 15 to 24 until 2030, but this is likely to fall again from 2030 onwards to below 2011 levels by 2041. The numbers of females aged 16-45 will, however, fall from 36,437 (in 2023) to 34,442 by 2030, a 5.5% decrease, and continue to fall thereafter, indicating a possible reduced demand for reproductive services when looking at population estimates alone. There could, however, potentially be an increase of demand for sex and relationships training and wider knowledge for an increasing number of professionals working with the increasingly older populations.

Figure 7 shows the distribution of females aged 15-45 (considered to be at childbearing age) in Richmond. The map indicates that the demand for contraceptive services is likely to be greater in the northern wards of the borough.

**Figure 7: Distribution of female population aged 15-45, 2020**



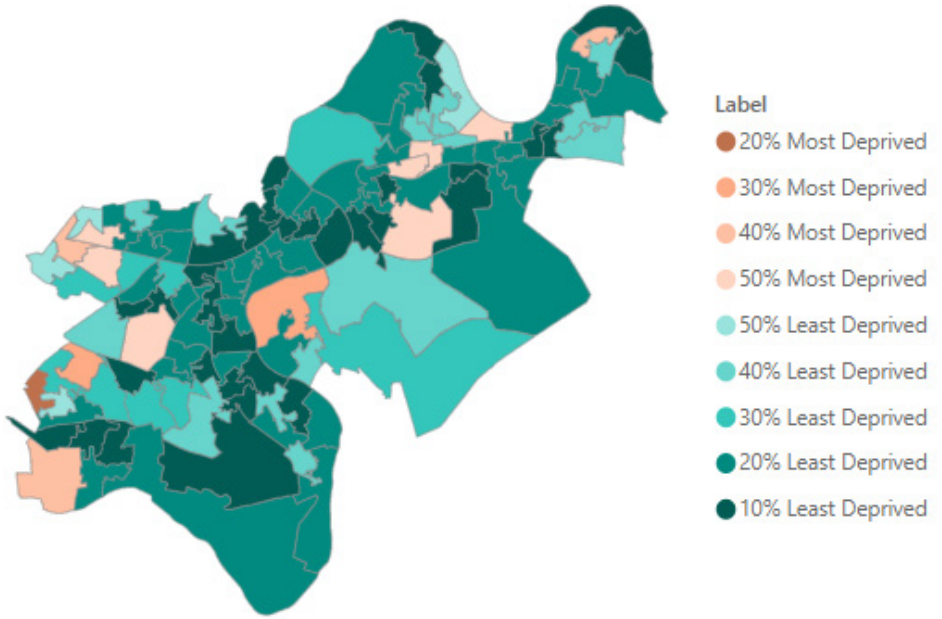

Source: Richmond and Wandsworth Health Intelligence team (2022).

## Deprivation

Richmond maintains a rank within the 10% least deprived Local Authorities in England between 2015 and 2019 and remains the least deprived London borough (ranking 238th). In London, Richmond is within the 50% least deprived boroughs across all indices of deprivation. Almost 90% of Lower Layer Super Output Areas (LSOA) in Richmond fall within the 50% least deprived nationally. Richmond more deprived LSOAs are dispersed throughout the borough (Figure 8) but those that are ranked as relatively more deprived since 2015 (moving down IMD deciles) tend to be in the north of the borough. 11% of residents live within the 50% most deprived LSOAs nationally in 2019, a smaller proportion than London where over 60% of the population live in the 50% most deprived LSOAs in England.

The LSOA ranking the highest amongst the 10% most deprived in London was in Hampton North. It also had a high proportion of LSOAs amongst the most deprived nationally and regionally. At the other end of the spectrum, South Twickenham had no LSOAs that ranked amongst the 50% most deprived nationally, regionally and locally, while Twickenham Riverside ward had the most LSOAs in the less deprived decile[50].

**Figure 8: LSOA Deprivation level in Richmond, 2019**




Source: DataRich (2019)

50 https://www.datarich.info/indices-of-deprivation-2019/#ward: Accessed 7th September 2023

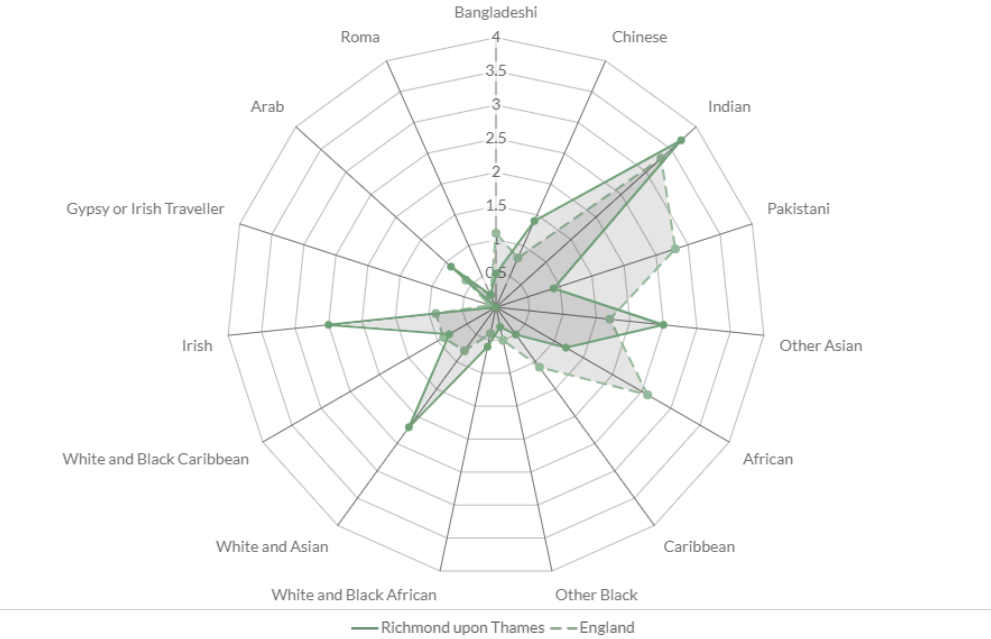
## Ethnicity

Sexual and reproductive health outcomes can be closely linked with ethnicity, with people from some ethnic backgrounds having disproportionately poorer outcomes. Richmond is the least ethnically diverse population of all the London boroughs with only 19.5%[51] of the population describing themselves as non-white. In 2021, 5.5% of Richmond residents identified their ethnic group within the "Mixed or Multiple" category, up from 3.6% in 2011[52]. The 1.8 percentage-point change was the largest increase among high-level ethnic groups in this area. The following was breakdown can be discerned from the 2021 census[53]:

- 8.9% describe themselves as Asian, Asian British or Asian Welsh (compared to 20.7% in London and 9.6% across England.
- 1.9% describe themselves as Black, Black British, Black Welsh, Caribbean or African (compared to 13.5% in London and 4.2% across England).
- 3.3% describe themselves as being of 'other' ethnic group (compared to 6.3% in London and 2.2% across England).
- The Black Asian and Minority Ethnic population is slightly younger, with 26.3% of children aged 19 and under who describe themselves as Black, Asian and Minority Ethnic, compared to 19.5% in the whole population.
- Figure 9 demonstrates the ethnic breakdown of non-white population in comparison to England as a whole.

51 www.trustforlondon.org.uk/news/census-2021-deep-dive-ethnicity-and-deprivation-in-london
52 https://www.ons.gov.uk/visualisations/censusareachanges
53 https://www.datarich.info

**Figure 9: Percentage of population by ethnic group, 2021**

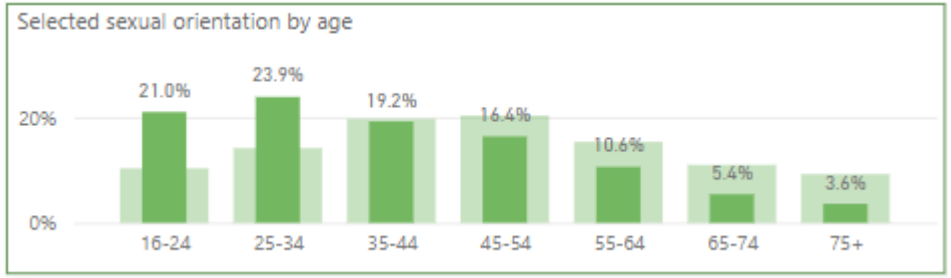



Source: DataRich (2021)

## Sexual Orientation & Gender Identity

Data from the 2021 census estimates that 3.4% of the population (5,238) aged 16+ are LGBTQ+. The graph below compares the percentage of LGBTQ+ people in each of the different age cohorts with the population of the borough in the age group. For example, 10.2% of the borough are aged 16 to 24 (light green) and within this age bracket 21% of the 3.4% are aged 16 to 24 (dark green).

**Figure 10: Selected sexual orientation by age, Richmond**




Source: DataRich (2021)

Latest 2021 census data has identified that 0.1% (n=226) of Richmond residents specify that their gender is different from that registered at birth, but do not specify a particular gender. 0.1% (n=137) identify as Trans women and 0.1% (n=113) identify as Trans men. A further 0.1% (134) identify as other gender identity.

### Key Findings

The population of over-45s is expected to increase in Richmond over the next ten years while those in the 25 to 40 age bracket will decrease and reduce demand on contraceptive and reproductive services, but there is likely to be an increase in the 15 to 24 aged population thereby altering the demand on sexual and reproductive services.

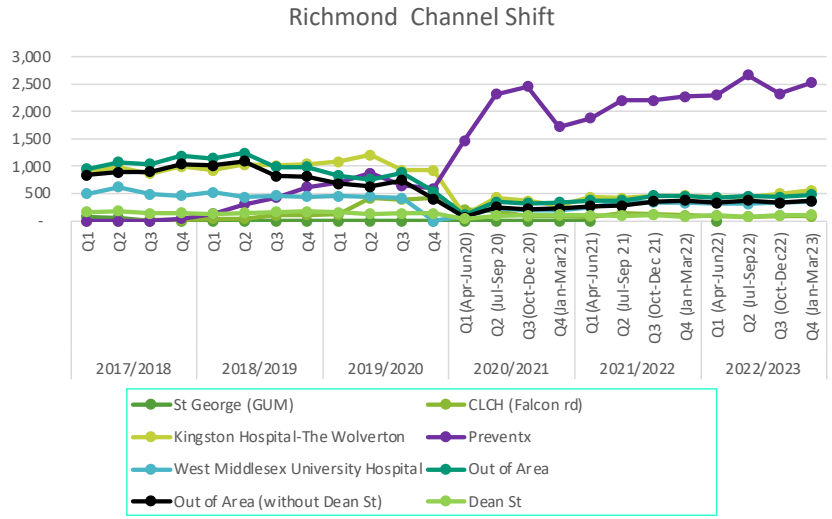
- Increased capacity may be needed for chlamydia, STI testing and contraceptive services over the lifetime of the next strategy.
- Additional training and skill development for those working with increasing older populations will be necessary.
- Access to contraceptive services for women should be focussed for those living in the north of the borough.

# The Impact of COVID-19 and Mpox on Sexual Health

Non-acute healthcare services were halted during the nationwide lockdown to limit the spread of COVID-19. This impacted sexual and reproductive healthcare services as well as face to face GP consultations. Within Richmond, sexual health services provided an online service for STI testing sending out self-sampling kits via post. Nationwide, an initiative to provide emergency hormonal contraception via mail was also in place. Despite this, gaps in sexual and reproductive healthcare provision were evident, especially with regards to access to LARC, asymptomatic STI testing and specialist HIV care. This needs assessment clearly demonstrates the impact of COVID-19 related shutdowns on the diagnosis and treatment of STIs, particularly during 2020 and 2021 at the height of the pandemic and further restrictions to re-opening sexual health services as the Mpox infection became apparent. Dips in the diagnosis of all STIs, chlamydia, gonorrhoea, syphilis and HIV testing coverage are all demonstrated in the section on Prevention & Control of HIV and other STIs.

The London Sexual Health Transformation Programme instigated a 'channel shift', increasing the use of online services for appropriate groups. The pandemic undoubtedly expediated this shift and it is now an integral part of the service offer. Local data on the extent of the channel shift is clearly demonstrated in the graph below, where the purple line showing the numbers of clients accessing Preventx (the providers of SHL.UK) had started to grow with the launch of the service in 2018 but then increased substantially during the lockdown period from March to December 2020.

**Figure 11: Number of Richmond clients accessing SRH services, 2017 to 2023**




Source: Adapted from GUMCAD (2023)

The COVID-19 pandemic forced local councils to engage in huge modernisation exercises, namely the prompt shift to online consultations, home testing and sampling. This was especially seen within sexual health services across England. Despite this, according to a report by the Local Government Association in 2022, reductions to the public health grant and local authority funding in general suggest the capacity for councils to innovate and increase efficiency within sexual health services may be nearing its end[54]. On the other hand, the economic climate and pressure on resources is prompting the exploration of new methods to better deliver outcomes that are more cost-effective.

It has been reported that, nationally, unplanned pregnancies during the pandemic period more than doubled[55]. Access to contraception during lockdown, especially LARC, was challenging. Factors beyond the restriction of sexual and reproductive health (SRH) services during the pandemic need also to be considered. These include fear, misinformation and restrictions in movement influencing choices. England did see a significant shift towards telemedicine and remote prescriptions (for example for the progesterone only pill and combined oral contraceptive pill for up to a year rather than the usual 3 to 6 months). Women in more deprived areas may have been disproportionately affected by the lockdown. Local LARC data captured in Figure 23 clearly shows dips in 2020 and early 2021 which correspond with health service lockdowns.

Studies and surveys to understand the impact of COVID-19 on sexual behaviour and access to sexual and reproductive health services were carried out by Natsal, during and preceding the pandemic. Results were compared with pre-pandemic behaviours where possible. A web-panel survey of over 6600 18-59-year-olds was carried out in March-April 2021 and compared to pre-pandemic population and surveillance data. The analysis showed that among the 5,733 participants reporting sexual experience ever, over two-thirds reported one or more sexual partner(s) in the year following lockdown (women 71·8%; men 69·9%), and a median of 2 occasions of sex per four weeks. Compared with Natsal-3[56], less sexual risk behaviour (lower reporting of multiple partners, new partners, and new condomless partners) was reported. Reduced risk was also included among participants reporting same-sex behaviour. Similar reporting of HIV testing and STI-related service use was found, but reduced reporting of chlamydia testing; fewer reported pregnancies, of which a smaller proportion were unplanned; less reported abortion; and increased sexual dissatisfaction and distress. Compared with trends in surveillance data over the previous decade, lower than expected use of STI related services, lower levels of chlamydia testing and fewer conceptions and abortions were noted[57].

54 Local Government Association (2022); Breaking point: Securing the future of sexual health services
55 Impact of the SARS-CoV-2 pandemic on access to contraception and pregnancy intentions: a national prospective cohort study of the UK population (bmj.com)
56 https://www.natsal.ac.uk/natsal-survey/natsal-3
57 Mitchel. K. R. Et al (2022)Sexual and Reproductive Health in Britain During the First Year of the COVID-19 Pandemic: National Population Survey (Natsal-COVID Study): The Lancet, Pre-print.

In 2021, 6.9% of women and 16.2% of men reported unmet need for condoms because of the pandemic. This was more likely among participants aged 18–24 years, of black or black British ethnicity, and reporting same-sex sex (past 5 years) or one or more new relationships (past year). Chlamydia and HIV testing were more commonly reported by younger participants, those reporting condomless sex with new sexual partners and men reporting same-sex partners. This was a very similar distribution to 10 years previously (Natsal-3). However, there were differences during the pandemic, including stronger associations with chlamydia testing for men reporting same-sex partners; with HIV testing for women reporting new sexual partners; and with cervical screening among smokers. The study suggests that differential access to key primary and secondary STI/HIV prevention interventions continued during the first year of the COVID-19 pandemic. However, there was no strong evidence that differential access has changed during the pandemic when compared with 2010–2012. While the pandemic might not have exacerbated inequalities in access to primary and secondary prevention, large inequalities persisted, typically among those at greatest STI/HIV risk[58].

**Key findings**

**The COVID-19 pandemic, which was then followed by Mpox clearly reduced the capacity to deliver testing and diagnosis opportunities and some behaviour change in sexual behaviours was seen. The pandemic, however, created an opportunity to increase online service provision which has continued post-pandemic.**

- There is now an increased appetite for online sexual health services. This approach should be utilised in relation to expanding the provision of contraception online.

58 Dema. E et al (2022) How did the COVID-19 pandemic affect access to condoms, chlamydia and HIV testing, and cervical cancer screening at a population level in Britain? (Natsal-COVID): BMJ: Vol 99, Issue 4, 261-267

# Sexual and Reproductive Health Need

## Antenatal, Intrapartum & Postnatal Care

Pregnancy, childbirth and the first six weeks after childbirth are critical times for maternal and newborn survival. Good quality antenatal, intrapartum, and postnatal care are vital to reducing adverse outcomes of pregnancy, labour and delivery, and to optimising the well-being of women and their infants. Maternal health service provision includes postpartum contraception and diagnosis and treatment of STIs.

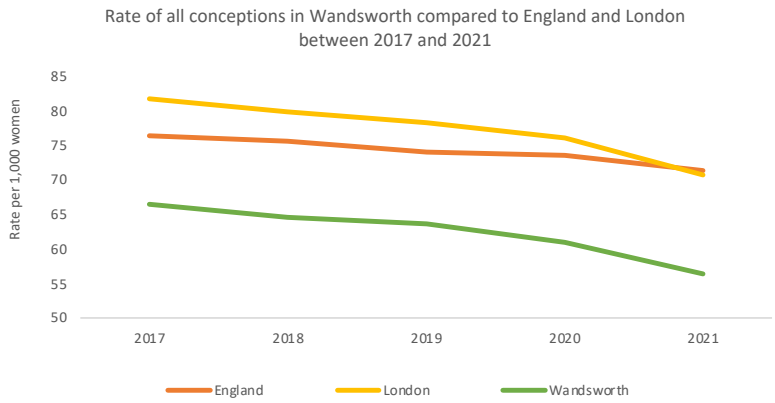
### Conceptions and Births

The number of annual conceptions in Richmond fell from a high of 2852 in 2017 to a low of 2422 in 2021 representing a 15% decline. The number of conceptions reduced each year, except for 2020 in which there was a small increase in conceptions.

The rates of annual conceptions in Richmond have been consistently lower than the rate of conception for England and London from 2017 to 2021. Whilst the average rate of annual conceptions between 2017 and 2021 in England and London was 72.3 and 77.4 per 1,000 women respectively, in Richmond the average rate of annual conceptions was 70.7 per 1,000 women.

England and London have consequentially seen reducing rates of conceptions over the last 5 years, but this was smaller than that seen in Richmond over the same time period. The number of conceptions in England only decreased by 2.7% and the number of conceptions in London reduced by 8.7%, compared to a 15% decline in Richmond.

**Figure 12: Number of conceptions in Richmond**




Source: ONS conception data (2021)

Latest data for England demonstrates that there were a total of 577,046 live births in 2022, a 3.13% decrease from 595,948 in 2021 and a 20.3% decrease over the 10 year period since 2012, when numbers stood at 694,241. In London there were 106,696 live births in 2022, a 3.8% decrease from 110,961 and a 20.5% decrease over the last 10 years from 134186. The number remains in line with the recent trend of decreasing live births observed before the COVID-19 pandemic.[59] In Richmond, however, there were 1827 live births in 2022, a 16% decrease from 2120 in 2021 and a 59.6% decrease since 2012 when there were 2916 live births in Richmond. This indicates that the number of live births in Richmond is declining substantially faster than both England and London trends.

In 2022, there were 2276 stillbirths in England, a decrease of 175 (6.3%) from 2451 in 2021 and a rate of 3.9 per 1000 live births in 2022. This is slightly higher than the rate observed before the coronavirus pandemic in 2019 (3.8). In London there were 481 stillbirths in 2022 and a rate of 4.2 per 1000 births compared to a rate of 4.4 per 1000 in 2019. In Richmond the still birthrate was 1.6 per 1000 live births in 2022. This has dropped from a rate of 1.8 per 1000 in 2019. Richmond remains the borough with the lowest stillbirth rate compared to other London boroughs.

Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. In England in 2021 there were 3789 perinatal deaths (deaths occurring as either a stillbirth, or within 7 days of life), a crude perinatal mortality rate of 6.3 per 1000 live and stillbirths. This compared to 6.3 per 1000 in London and 5.6 in Richmond. The neonatal mortality rate for England in 2021 stood at 2.9 per 1000 live births, 2.4 per 1000 for London and 1.9 for Richmond. Perinatal mortality rates in 2019 were slightly lower at 6.1 per 1000 for England but the same for London at 6.3 per 1000 but lower in Richmond at 3.7 per 1000.

The neonatal mortality rate for England in 2021 stood at 2.9 per 1000 live births, 2.4 per 1000 for London and 1.9 for Richmond. In 2019, the year preceding the pandemic, neonatal mortality for England stood at 2.9 per 1000, London 2.8 per 1000 and for Richmond at 2.8 per 1000

## Maternal Health

Maternal health indicators for Richmond are relatively good in comparison to London and England averages, though there are indications that trends over the most recent five points are getting worse for smoking.

**Table 2: Key maternal health indicators 2020-2022**

| Indicator | England (%) | London (%) | Richmond (%) |
|---|---|---|---|
| Low birthweight of term babies (2021) | 2.8 | 3.3 | 2.3 > |
| Baby's first fed breastmilk (2021/2022) | 71.7 | 87.7 | 93.5 |
| Smoking status at time of delivery (2021/2022) | 9.1 | 4.5 | 5.5 ^ |
| Under 25s abortion after a birth (2021) | 26 | 19.5 | 12.8 > |

Source: OHID Fingertips public health profiles (2023)

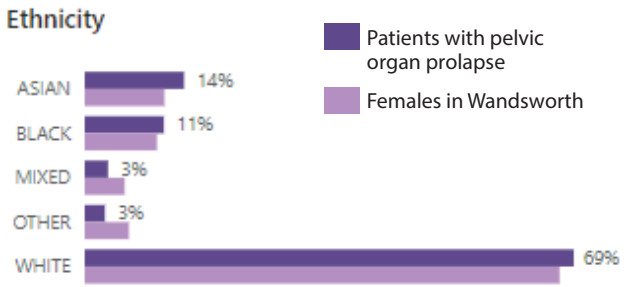
The percentage of abortions to women aged under 25 who have previously had a birth can indicate awareness of post-partum contraception need at a local level and can be used to help identify post-natal contraception needs within an area. The current rate for 2021 may indicate that Richmond has relatively good access to post-partum contraception for this age group.

In October 2023 the government announced a new National pelvic health service to support and inform women who experience trauma during childbirth. Roughly 1 in 3 women experience urinary incontinence 3 months after pregnancy, and around 1 in 7 experience anal incontinence 6 months after birth. One in 12 women report symptoms of pelvic organ prolapse, which is when one or more of the organs in the pelvis slip down from their normal position and bulge into the vagina. These distressing issues can affect women's ability to work, their sexual and social relationships, and their mental health.

In Richmond there are currently 475 residents diagnosed with pelvic organ prolapse. When compared with the percentage of females in the population there is an under-representation of Asian and those in mixed ethnicity groups, while White females are over-represented.

59 www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthsummarytablesenglandandwales/2022

**Figure 13: Richmond patients with pelvic organ prolapse by ethnicity**




Source: SWL Health Analytics (2024)

A national service specification for perinatal pelvic health services was published in October 2023 and additional national funding of over £11 million has been promised from April 2024. The new national service aims to:

- Ensure all women are offered a self-assessment of their pelvic health as early as possible in pregnancy - and by 18 weeks at the latest.
- Educate all women on the risk of safeloor dysfunction and birth injuries and preventative action they can take to reduce this risk.
- Provide additional support to those at higher risk of pelvic health problems.
- Reduce NHS waiting times - one of the Prime Minister's 5 pledges - and minimise administrative barriers to treatment.
- Allow affected women to access appropriate physiotherapy assessment and personalised treatment.

## Teenage Pregnancy

Teenage parents and their children experience poorer health, educational and economic outcomes, and inequalities. High rates of teenage pregnancy are most often associated with low educational attainment, disengagement from school, economic deprivation, and poor mental health. Young people at increased risk of teenage pregnancy and early parenthood include children of teenage mothers, those who are looked after, use substances, are involved in crime, are at risk of or experience child sexual exploitation, or who may go missing from home or care.

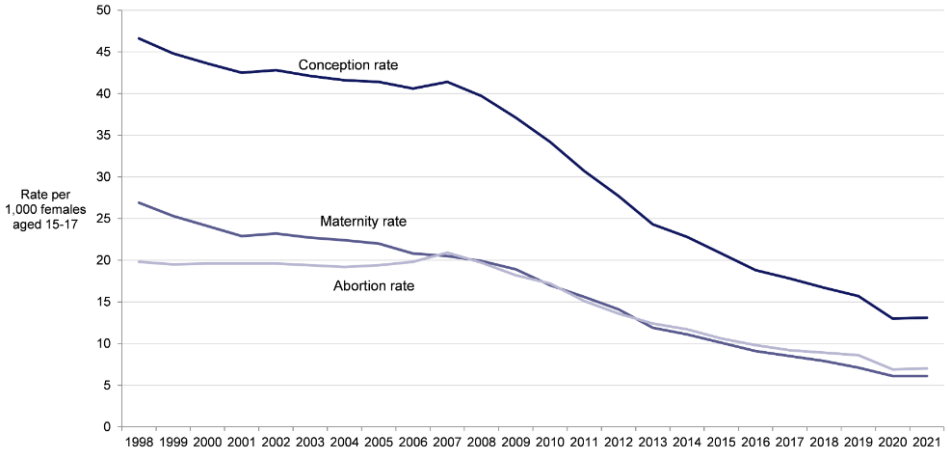
Compared with mothers aged 20 or over, there is a 30% higher rate of stillbirth, 60% higher rate of infant mortality and 30% higher rate of low birthweight amongst babies born to mothers under the age of 20. They also have a 63% higher risk of living in poverty and are 22% more likely to live in poverty by the age of 30. Almost 60% of mothers involved in serious case reviews had their first child under the age of 21 and they have a higher chance of subsequent unplanned conceptions. Other health outcomes that are more common in teenage mothers:[60]

- They are twice as likely to smoke before pregnancy and three times more likely to smoke throughout.
- They are a third less likely to start breastfeeding and half as likely to be breastfeeding at 6-8 weeks.
- They have higher rates of poor mental health for up to three years after the birth.
- They are three times more likely to experience postnatal depression.
- Babies of teenage mothers are 1.9 times more likely to die from sudden unexpected death in infancy (SUDI).
- It is twice as likely for their children to be hospitalised for gastro-enteritis or accidental injury.
- At age 5 their children are 4 months behind on spatial ability, 7 months behind on non-verbal ability and 11 months behind on verbal ability.

Annual 2021 conception data for England shows there has been an overall 72% reduction in the under-18 conception rate since the 1998 baseline. The current rate in England is 13.1 per 1000 young women under the age of 18. The 2021 conception rate for under-16s now stands at 2.1 for all England and showed a slight increase from 2.0 per 1000 13–15-year-olds in 2020. Both under-18 and under-16 rates are now at the lowest level since records began in 1969[61]:

60 Public Health England (2019) A framework for supporting teenage mother & young fathers
61 Data - Teenage Pregnancy Knowledge Exchange | University of Bedfordshire (beds.ac.uk)

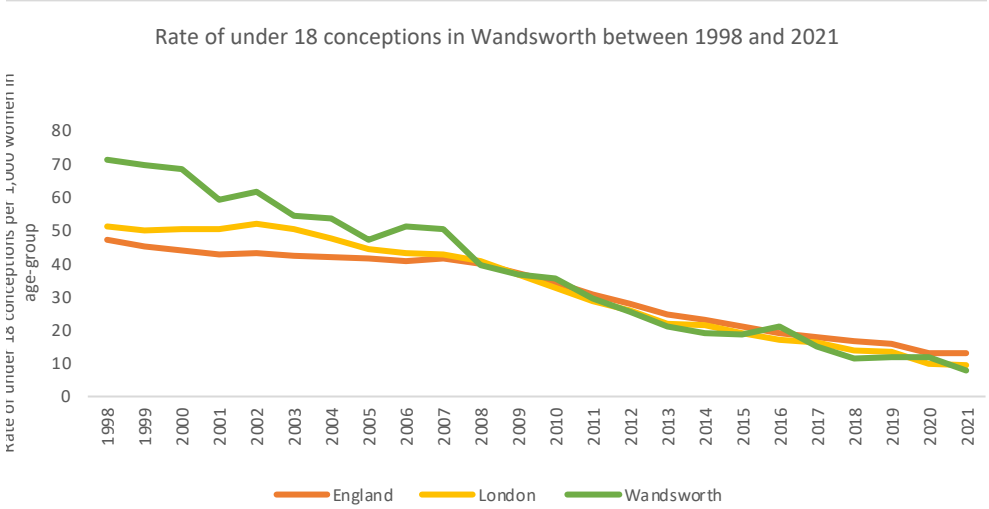
**Figure 14: England under 18 conception, maternity and abortion rates 1998 - 2021**




Source: Teenage Pregnancy Knowledge Exchange (2022)

Declining rates have also been seen in Richmond with the under-18 conception rate dropping 62.8% from 1998 to 2021. The 2021 rate in Richmond is now 9.6 per 1000 young women under the age of 18:

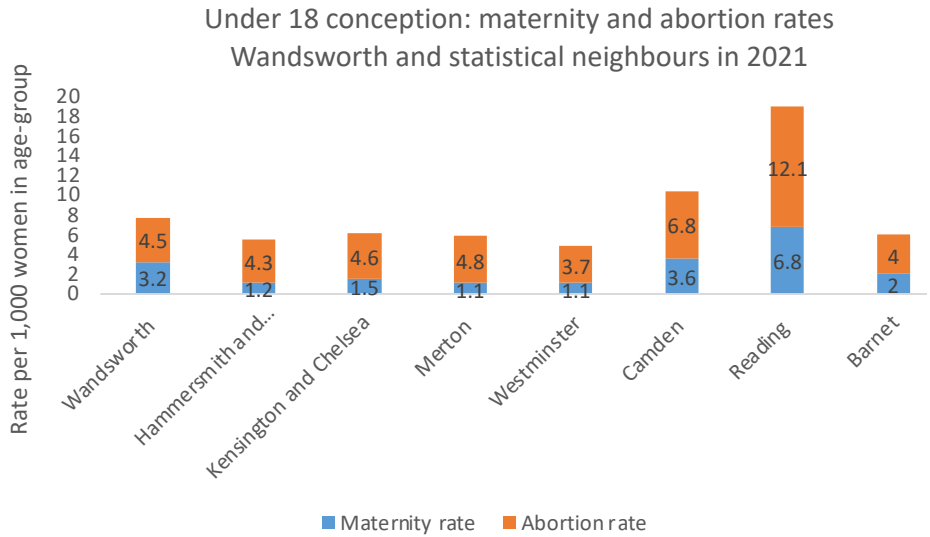
**Figure 15: Under 18 conception rate 1998 to 2021**




Source: ONS Conception rates (2021)

The under-18 conception rate in Richmond in 2021 was second highest compared to its statistical neighbours. The proportion of conceptions leading to abortion was 69%, compared to 53.4% for England and 62.1% for London indicating that Richmond would benefit from increasing preventive measures to reduce abortions.

**Figure 16: Richmond under 18 maternity and abortion rates**

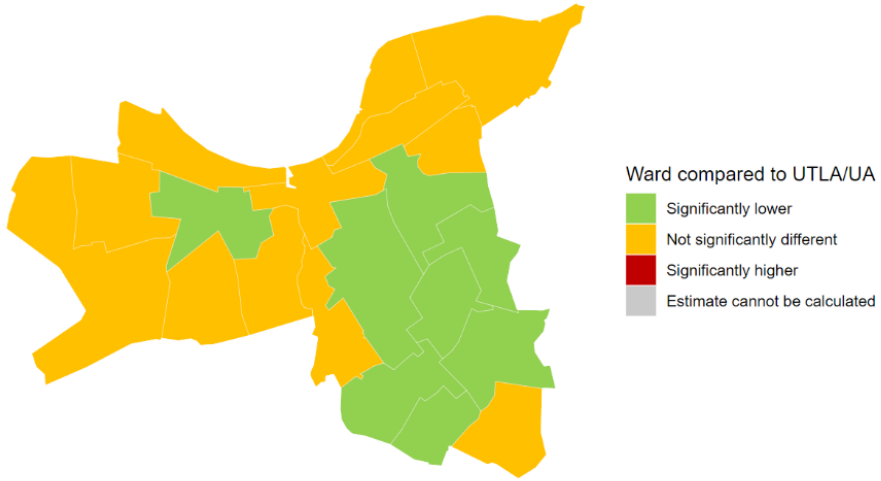



Source: ONS Conception rates (2021)

Aggregated ward conception data for 2017-19[62] can indicate where services need to be located to ensure those more likely to become pregnant can access contraceptive services or antenatal support. All but the four wards of Hampton North, West Twickenham, Heathfield, and South Richmond have significantly lower rates compared to England rates. Hampton North is the only ward with a significantly higher rate when compared to England. When comparing rates across the whole borough Hampton North and Heathfield are the only two wards with significantly higher rates than the borough as a whole.

62 ONS have confirmed they will no longer be producing under 18 ward conception level data. This is the latest available ward level data.

**Figure 17: Aggregated under 18 conception rates by ward compared to borough rates (2017-2019)**



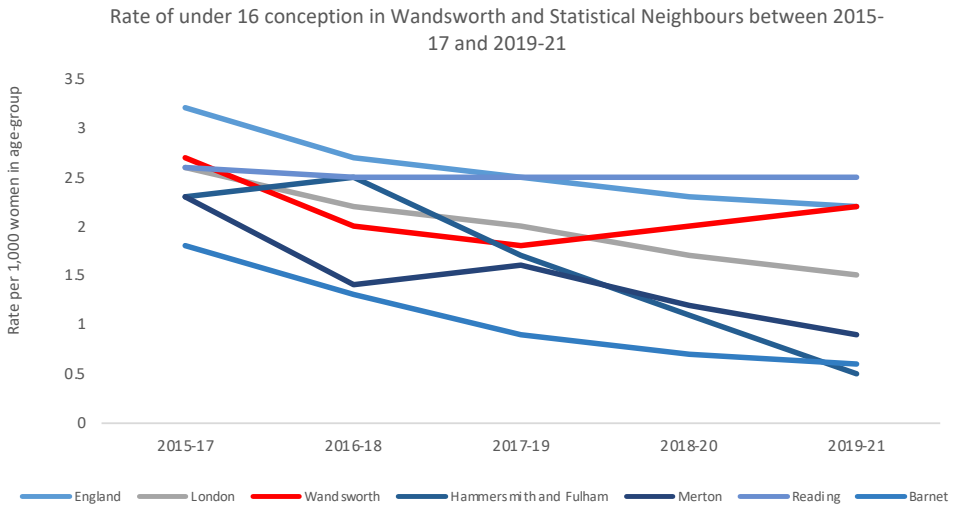

Source: ONS Conception statistics (2021)

The numbers and rates of under-16 conceptions in Richmond is low and data is therefore aggregated to protect anonymity. Between 2015-17 and 2019-21, the average rate of under-16 conceptions in Richmond was 1.3 per 1,000 women in the age group. The rate in Richmond (2019-21) was slightly lower than in London (2.0 per 1,000 women in age-group), and Richmond saw lower rates than England (2.58 per 1,000 women in age-group). In this period Richmond saw 8 young women aged under 16 became pregnant, all them chose to abort their pregnancies.

A general trend of decline in the rate of under-16 conceptions can be observed at national, regional and local levels. Richmond saw the greatest decline to its rate of under-16 conceptions, falling year-on-year from a high of 2.1 conceptions per 1,000 women in the age group to 0.7 conceptions per 1,000 women in the age group in the same time frame.

Across the period, the rate of under-16 conceptions in Richmond was lower than in England and London year-on-year. The declining rate of under-16 conceptions in Richmond was also observed in England, London, and most statistical neighbours. However, Richmond saw one of the greatest overall declines in the rate of under-16 conceptions. As a result, the rate of under-16 conceptions in Richmond fell from the highest rate among its statistical neighbours to one of the lowest rates.

**Figure 18: Under 16 conception rates 2015-2021**




Source: ONS conception data (2023)

The percentage of under-16 conceptions leading to an abortion in Richmond fluctuated over the between 2015-17 and 2017-19 the percentage declined each year, falling from 68.4% in 2015-17 to 50% in 2017-19. The percentage of under-16 conceptions leading to an abortion has since increased each year to 71.4% and 100% in 2018-20 and 2019-21 respectively. It is noted that the overall numbers of under-16 conceptions in Richmond are low and the percentage of these which led to an abortion is likely to see greater fluctuations.

The teenage pregnancy prevention framework63 is clear that supporting young fathers will also positively protect the health of both mother and child. It also notes that young fathers are more likely than older fathers and other young men to;

- have been subjected to violent forms of punishment at home and are twice as likely to have been sexually abused.
- have pre-existing serious anxiety, depression and conduct disorder
- have poor health and nutrition.
- drink, smoke and misuse other substances with one in six young men under the age of 25 accessing drug and alcohol services are young fathers.

63 Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)

**Key Findings:**

The number of births continue to decline in Richmond and there is relatively good access in post-partum contraception, but maternal health deteriorated during the pandemic and will take time to recover.

- Local services should take advantage of the new funding for pelvic health announced by the government and strategic approaches aligned.

The continued decline in under 18 conceptions is welcomed but progress needs to be maintained, particularly as Richmond has higher percentages of pregnancies leading to abortion than its statistical neighbours and under 18s in North Hampton and Heathfield wards fair worse than the rest of the borough.

- Prevention programmes should continue to focus on younger age groups to ensure under 18s, particularly in higher rate wards have clear pathways to services should they be identified.
- Provide appropriate advice, information and training to parents & carers to enable early conversation that build a strong foundation for RSE and protective behaviours through the life-course.

# Comprehensive Education and Information

Comprehensive education and information involve the provision of accurate, age-appropriate and up-to-date information on physical, psychological and social aspects of sexuality and reproduction, as well as sexual and reproductive health and ill health. Accurate information can address gaps in knowledge, dispel misconceptions and build comprehensive understanding, as well as foster empowerment, positive attitudes and values, and healthy behaviours.

School based education targeting increased condom use, reduced STIs and unplanned pregnancies has, when delivered as part of a health-based curriculum, shown to have an incremental cost-effective ratio of £4,965 where benefits are assumed to last 5 years or more after the intervention. The education programme showed a 9.36% increase in condom use, which provided an additional 0.156 Quality Adjusted Life Years (QALYs) and £934 cost savings from reduced transmission of chlamydia and associated complications, such as pelvic inflammatory disease and ectopic pregnancy[64].

## Relationships and Sex Education

Relationships and sex education has long since been a hallmark of sexual health intervention and prevention programmes with a particular focus on RSE for children and young people. In 2020 this became enshrined within statutory guidance on the provision of RSE in schools[65]. Moves to improve the quality of RSE within school settings were affected by school closures during the pandemic with implementation of the RSE guidelines postponed until September 2021. Curriculum changes are therefore still in their infancy and will take time to embed. The mandated RSHE guidance (currently under review) asserts that by the end of secondary school pupils should have covered the following topics (among others):

- How to recognise the characteristics and positive aspects of healthy one-to-one intimate relationships, which include mutual respect, consent, loyalty, trust, shared interests and outlook, sex and friendship.
- The concepts of, and laws relating to, sexual consent, sexual exploitation, abuse, grooming, coercion, harassment, rape, domestic abuse, forced marriage, honour-based violence and FGM, and how these can affect current and future relationships.
- That they have a choice to delay sex or to enjoy intimacy without sex.
- That all aspects of health can be affected by choices they make in sex and relationships, positively or negatively, e.g. physical, emotional, mental, sexual and reproductive health and well-being.
- The facts about the full range of contraceptive choices, efficacy and options available.
- How the different STIs, including HIV, are transmitted, how risk can be reduced through safer sex (including through condom use) and the importance of and facts about testing.
- About the prevalence of some STIs, the impact they can have on those who contract them and key facts about treatment.
- How the use of alcohol and drugs can lead to risky sexual behaviour.

How to get further advice, including how and where to access confidential sexual and reproductive health advice and treatment.

Locally, a health-related behaviour survey conducted across Richmond primary and secondary schools with over 4800 pupils in 2022 has indicated the current state of knowledge, attitudes and behaviours regarding relationship and sexual health. Some key findings include[66]:

64 https://www.gov.uk/government/publications/health-economics-evidence-resource

65 https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education

66 https://www.richmond.gov.uk/media/25980/ryps_relationships_sexual_health_report_2022.pdf

**Key findings at primary school**

- 8% of boys and 21% of girls said they worry 'quite a lot' or 'a lot' about puberty and growing up. This compared to 18% of boys and 26% of girls in the School Health Education Unit (SHEU) nationwide reports.
- Only 48% of primary pupils said they feel they know enough about puberty and growing up, this reaches 61% by year 6.
- Among Year 6 pupils, boys are less likely than girls to be having conversations about puberty and growing up (Table 3).
- In Richmond, 82% of year 6 pupils said their school covers the topic of puberty and growing up 'fairly' or 'very' well and 70% said their school covers the topic of healthy relationships 'fairly' or 'very well'.

**Table 3: Year 6 pupils who said who has talked with them about puberty and growing up**

| Year 6 | Boys | Girls |
|---|---|---|
| Parents/carers ***(56% of Young carers)*** | **55%** | **81%** |
| Teachers, in lessons | **67%** | **79%** |
| Friends | **16%** | **37%** |
| Brothers, sisters, other close relations | **12%** | **18%** |
| School nurse | **3%** | **5%** |
| No-one | **13%** | **2%** |

Source: School Health Education Unit (2022)

**Key findings at secondary school**

- 19% of pupils said they worry about relationships and 11% worry about having sex/ first having sex.
- 25% of Year 10 boys and 43% of Year 10 girls said that they think most young people start having sex before the age of 16, however, only 12% of Year 10 boys and girls said that they have had, or are currently in, a sexual relationship.
- 77% of pupils in Richmond felt that their curriculum covers relationships and consent 'fairly' or 'very well'.
- 35% of boys and 32% of girls in year 10 said their main source of information about sex and relationships were from school lessons (Table 4)
- 13% of boys compared to 29% in the wider study and 23% of girls compared to 23% in the wider study said that they know where they can get condoms free of charge.
- Only 13% of Year 10 pupils identified that there is a special sexual health or contraception and advice service for young people available locally.
- A quarter (25%) of Year 8 pupils and 59% of Year 10 pupils correctly identified that HIV/ AIDS can be treated but not cured. This compared to 20% and 46% in the wider SHEU co-hort respectively.
- Only 19% of year 10 pupils could correctly identify that chlamydia could be both treated and cured and 17% correctly identified that HPV can be treated but not cured.
- Year 10 pupils expressed that RSE lessons had helped them to learn most about consent, followed by, sex and the law, but less about contraception for both boys and girls (Table 5)

**Table 4: Richmond year 10, main source of information about sex and relationships, 2022**

| Year 10 | Boys | | Girls |
|---|---|---|---|
| School lessons | **35%** | School lessons | **32%** |
| Friends | **18%** | My parents/carers | **20%** |
| My parents/carers | **11%** | Internet/mobile phone | **19%** |
| Internet/mobile phone | **10%** | Friends | **17%** |
| Porn | **9%** | TV, films | **4%** |

Source: School Health Education Unit (2022)

**Table 5: Percentage of Year 10 pupils who said RSE has helped them understand 'quite a lot', or 'a lot' about:**

| Year 10 | Boys | Girls |
|---|---|---|
| Consent | 67% | 73% |
| Healthy relationships | 55% | 58% |
| Sex and the law | 64% | 60% |
| Contraception | 42% | 47% |
| Sexually transmitted infections (risks and how to avoid them) | 57% | 45% |
| Puberty and growing up | 56% | 61% |
| Resisting pressure | 48% | 57% |

Source: School Health Education Unit (2022)

Some statistically significant differences in self-reported behaviours in relation to relationships and sexual health exist between potentially vulnerable groups and the rest of the year group in year 8 and year 10 pupils:

Year 8 pupils in single parent families are more likely to have seen pornography (33% vs. 23%).

- Year 10 young carers are more likely to have had sex (27% vs. 11%).
- Year 10 LGBTQ+ pupils are more likely to have had sex (24% vs. 11%).
- Year 10 pupils on free school meals (FSM) are less likely to always use a condom when having sex (23% vs. 41%)

These results indicate there is more work needed to embed and further improve RSE in both primary and secondary schools in the borough. A similar survey was conducted in 2014 revealing both positive changes in knowledge but a drop in awareness of service provision:

- 25% (16% in 2014) of Year 8 pupils and 59% (48% in 2014) of Year 10 pupils correctly identified that HIV can be treated but not cured.
- 27% (29% in 2014) of pupils in year 10 responded that they know where they can get condoms free of charge.
- 9% (20% in 2014) of pupils in year 10 responded that there is a special sexual health or contraception and advice service for young people available locally, while 76% (72% in 2014) said they 'don't know'.

Comparisons with 2014 should be read in the context of changes to local provision and COVID-19 disruptions when year 10 would have been in year 8 during lockdown and may not have received RSE provision.

## Reproductive Health Education

Reproductive health education is perhaps even less well covered at primary and secondary age. At key stages 1 and 2, the national curriculum for science includes teaching about the main external body parts and changes to the body as it grows from birth to old age, including puberty. At key stage 3 and 4, it includes teaching about human reproduction. The new mandatory RSE curriculum asserts that by the end of secondary school pupils should know:

- The facts about reproductive health, including fertility, and the potential impact of lifestyle on fertility for men and women and menopause.
- The facts around pregnancy including miscarriage.
- That there are choices in relation to pregnancy (with medically and legally accurate, impartial information on all options, including keeping the baby, adoption, abortion and where to get further help).

Interestingly, there is currently no provision in the mandatory RSHE guidance that covers the prevention of reproductive illnesses, including cancers and when or where to seek help for symptoms.

Opportunities for comprehensive sexual and reproductive health education beyond school-age are rarer and would largely lie within the realm of opportunistic health contacts such as through Make Every Contact Count (MECC) interventions and national or local health promotion communications, vaccination, or screening campaigns.

## Period Poverty

Period poverty in the UK is increasing. A poll of 2060 UK adults, conducted by ActionAid, estimated that approximately one in four (28%) struggle to afford period products and one in five (19%) reported being unable to afford products at all since the start of 2022, with some having to cut back on food and groceries to be able to buy them. One in 10 used a foodbank to obtain free products. The survey suggested that the number of UK women and people who menstruate who are struggling to afford period products has risen from 12% to 21% from 2021 to 2022[67]. This amounts to an estimated 2.8 million people experiencing period poverty and approximately 10,000 women aged 13 to 50 in Richmond. Anecdotally, schools report an increase of girls accessing free period products in Richmond schools. Of those struggling to buy products 80% used other substitutes including toilet paper, socks, newspaper or other products[68]. Using unhygienic alternatives brings further increased risks for urogenital infections such as urinary tract conditions and bacterial vaginosis[69].

Those surveyed reported that period poverty and associated stigma around periods led to school and work absences and the avoidance of exercise or socialising, with 14% missing work and, 13% missing school or university or college. 39% missed sport or exercise and 25% missed socialising with friends while on their period. Of those who avoided or missed some activities 32% did so because they didn't feel comfortable wearing uniform, kit or clothing required for the activity. 7% missed activities because they feared being bullied or teased. 64% missed these activities because of period side effects including fatigue and anxiety.

Despite efforts in recent years to improve openness about periods and reducing social stigma 'period positivity' appears to be in decline. The ActionAid survey found that 22% of young women and people who menstruate (aged 18-24) felt embarrassed during their period, a rise from 8% in 2022. Of those who reported feelings of anxiety, embarrassment or shame, 12% said this was because of jokes made about their period by a partner, friends, colleagues or parents. 30% said it was because people would see them taking sanitary products to the toilet, and 58% said it was because of fear of leaking onto their clothes.

## RSE Confidence in the Workforce

The delivery of relationships and education across the life course is largely reliant on the confidence and expertise of the health and social care sector workforce to relay information and knowledge to local residents. In 2022 a short consultation on sexual health knowledge and confidence of the workforce was undertaken across Richmond and the neighbouring borough of Wandsworth. In total 114 individuals completed the survey. This was considered an above average response to a consultation by the consultation team.

Of those working in services covering Richmond only half had received some form of sexual health training in the last three years. Of those identifying themselves as working with services covering both boroughs or more than one borough 60% had received some form of sexual health training in the previous 3 years.

Respondents came from a range of professional backgrounds with the largest group (38%) coming from the community and voluntary sector followed by 15% from the targeted health sector (adults, such as those in mental health, substance misuse or learning disabilities services) and 10% from children's social care services such as children who are looked after, or children in need:

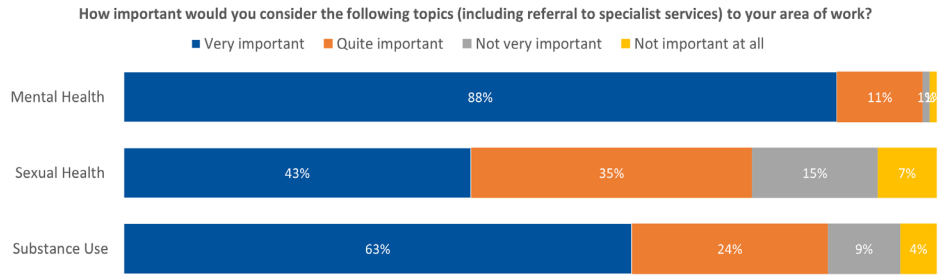
Of those describing themselves as working predominantly in adult related services (n=75) 57% had not received any sexual health training in the last 3 years and 29% had received a basic level.

Of those working in the community and voluntary sector (n=42) 38% mainly worked with adults yet almost two thirds (60%) had not received any training in sexual health in the last 3 years.

67 https://www.actionaid.org.uk/blog/2023/05/26/cost-living-uk-period-poverty-risen
68 https://plan-uk.org/media-centre/dramatic-increase-in-girls-cutting-back-on-essentials-to-afford-period-products#:~:text=Amidst%20the%20worst%20cost%20of,since%20the%20start%20of%202022.
69 Das P, Baker KK, Dutta A, et al. Menstrual Hygiene Practices, WASH Access and the Risk of Urogenital Infection in Women from Odisha, India. PLOS ONE. 2015;10(6):e0130777

**Importance of sexual health:** 78% of respondents thought that sexual health was quite or very important to their role while 22% thought not very important or not important at all.

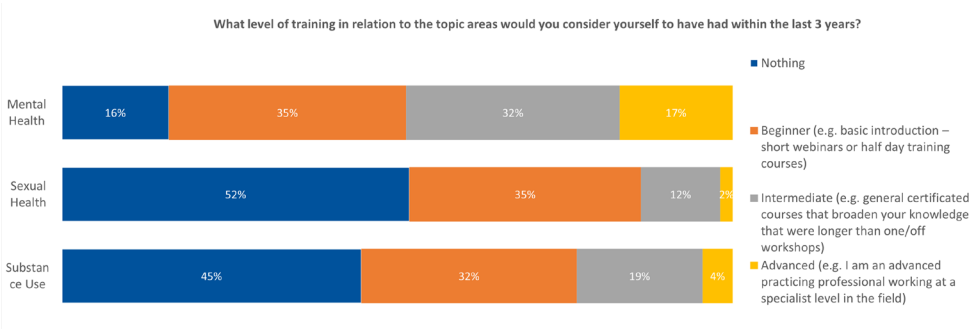
### Figure 19: Importance of sexual health to respondent's role




Source: Richmond and Wandsworth councils training needs analysis (2022)

Over half the respondents, however, had not received any training in relation to sexual health over the last three years and 35% had received only a basic introduction such as a short webinar or half-day training event. These results show the importance of sexual health but a substantial training need for our local workforce in relation to even a basic level of understanding with regard to sexual health. The graph below shows better provision of training in mental health and substance use.

### Figure 20: Level of training received in last 3 years



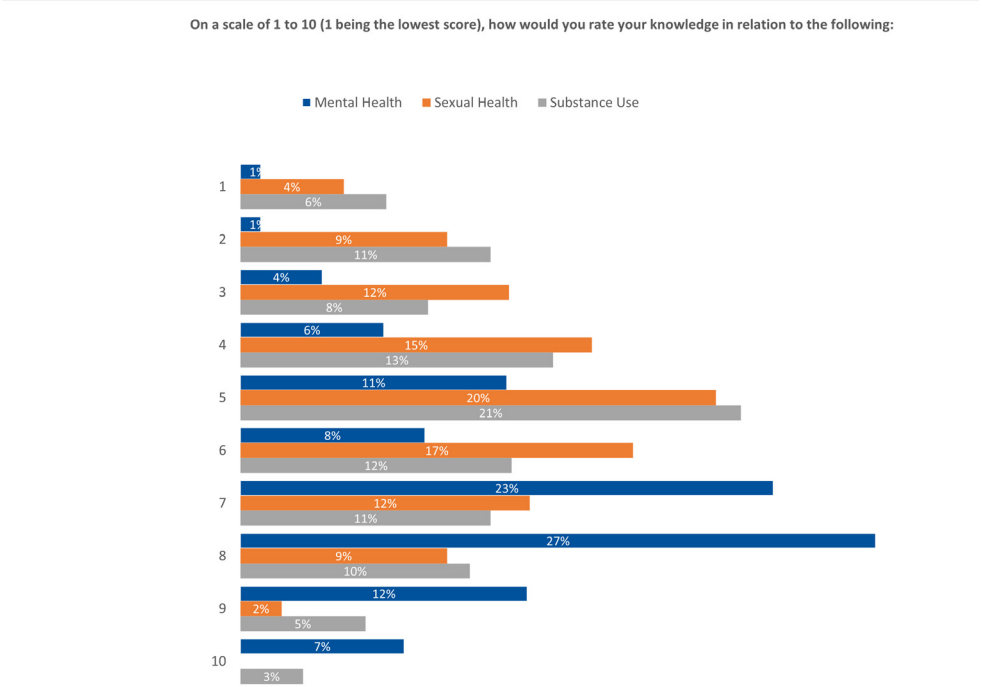

Source: Richmond and Wandsworth councils training needs analysis (2022)

Of those describing themselves as working predominantly in children's related services (n=39) less than 5 did not consider sexual health as being very important to their role, yet 30% had not received any sexual health training in the last three years.

Of those working in the community and voluntary sector over half (54%) described sexual health as being either quite or very important to their role, but 60% had not received training in the last 3 years.

**Knowledge and confidence rating:** When asked to rate their knowledge of sexual health 60% rated themselves as a 5 or lower in terms of their knowledge of the subject. Of those working in services primarily identified as children's services 44% rated their knowledge as a 5 or lower. Of those primarily working with adults, 69% rated themselves as a 5 or lower.

### Figure 21: Sexual health self-reported knowledge rating



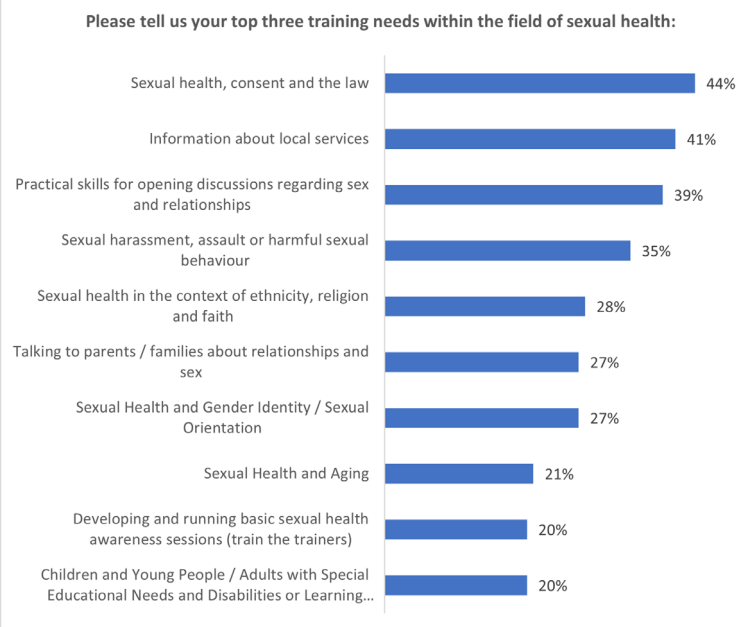

Source: Richmond and Wandsworth councils training needs analysis (2022)

When asked to rate their confidence in relation to opening discussions about sexual health 60% rated their confidence as a 5 or lower. One quarter of respondents rated themselves as a 3 or lower in terms of knowledge of sexual health while 30% rated themselves as 3 or lower in relation to confidence to start discussions. This suggests that there is a need to increase confidence across the workforce. 49% of those working in children's related services, compared to 66% of those working primarily in adult related services scored themselves a rating of 5 or lower.

This may indicate that the focus of work on sexual health over the last 20 years, since the inception of the teenage pregnancy strategy, may have focussed attention on sexual health training for those working with children and young people. Almost 40% of all respondents did not know or were not sure how to access sexual health services. This indicates that further work is needed to promote sexual health services to stakeholders.

**Top 3 training needs:** Respondents were asked to identify their top 3 training needs in the field of sexual health. Consent and the law, information about local services and practical skills were the most pressing needs for the workforce. This suggests that there is a need for some basic sexual health knowledge, confidence and skills training for the general workforce. 35% of respondents identified a training need in relation to 'sexual harassment, assault or harmful sexual behaviour'. This was followed by sexual health in the context of ethnicity and religion or faith (28% of respondents), followed by 'talking to parents / families' and 'sexual health in relation to gender identity or sexual orientation' (both 27% of respondents).

### Figure 22: Sexual health top three training needs




Source: Richmond and Wandsworth councils training needs analysis (2022)

The training needs analysis demonstrated a clear need to increase access to both basic sexual health awareness training, defined as introductory short-courses, and intermediate courses covering subjects in depth. At a minimum, all training courses should cover consent and the law, information about local services and practical skills for introducing difficult conversations and increasing confidence in delivery. Future sexual health training focusing on topics including sexual harassment, ethnicity & religion, talking to parents, and sexual orientation and gender identity should also be offered.

**Key Findings:**

While the new RSHE statutory guidance and any planned updates are welcomed, young people experience variations in how it is delivered in schools. Areas to develop include:

- Encouraging schools to ensure boys feel included in conversations about puberty and growing up.
- Open conversations about pornography - what it is and isn't.
- Activities that focus on perception versus reality in relation to young people's sexual behaviour.
- Information on STI prevalence, prevention, testing and treatment including contraception options for young people.
- Information about where and how to access the full range of young people's services including that sexual health services are ***free and confidential.***
- Information on reproductive health through the life course including where / when to seek help.
- Awareness of period poverty and schemes to address these.

Continue to support schools and local teacher training programmes need continued support to implement the national RSHE guidance including forthcoming updates.

There is a clear training need around sexual and reproductive education for the wider workforce. Particularly in relation to consent and the law, information about services and the development of practical skills to enable the workforce to engage residents in healthy discussion around sexual and reproductive health, including action to reduce period poverty.

# Contraception Counselling & Provision

Contraception is the intentional prevention of pregnancy by artificial or natural means. A range of modern contraceptive methods, commodities and services should be accessible, acceptable, available and affordable, and they should be provided without coercion by skilled providers in settings that meet standards for quality of care[70].

Contraception is one of the most cost-effective health-care interventions, preventing unintended pregnancies and abortions (as well as related complications of unsafe abortions). A cost-benefit analysis of the return of investment on contraception demonstrates that for every £1 invested £11.09 is saved from averting the outcomes of unplanned pregnancies (terminations, antenatal and maternity care)[71]. It also contributes to reducing maternal and neonatal mortality, and enhancing newborn and child health. Prevention of unintended pregnancy through contraception also enables more educational opportunities for girls, thereby improving their socioeconomic status and overall well-being.

A new national Pharmacy Contraception Service (PCS) commenced in spring 2023[72]. The aim of the PCS is to offer people greater choice and access when considering starting or continuing their current form of oral contraception. The service supports the role community pharmacy teams can play to help address health inequalities by providing wider healthcare access in their communities and signposting service users to local sexual health services. It also aims to create additional capacity in primary care and sexual health clinics (or equivalent) to support meeting the demand for more complex assessments. Pharmacies can also register for the NHS Pharmacy Contraception advanced service for the ongoing supply of oral contraception. From December 2023 the service expanded to give people the option of being able to have a confidential consultation with a community pharmacist to request a prescription of the contraceptive pill for the first time directly from their pharmacist, rather than from their GP or sexual health clinic. The PCS is currently being rolled out in South West London, including among Richmond pharmacies. Support for this scheme should be encouraged.

## Long Acting Reversible Contraception (LARC)

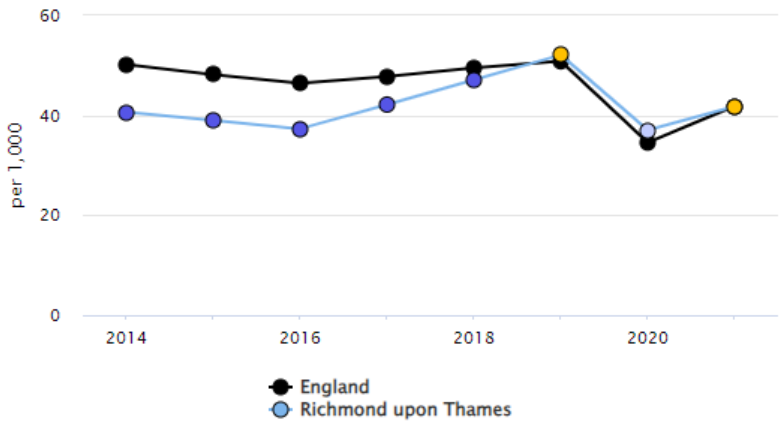
The National Institute for Health and Care Excellence (NICE) Clinical Guideline[73] advises that LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years depending on the type of product. Furthermore, individuals opting to switch from an oral contraceptive pill to a LARC method of contraception reduces reliance on user dependent methods (UDMs), thereby increasing reliability and saves approximately £29 per year per woman (£143 over 5 years) through avoided unplanned pregnancies. Furthermore, every £1 invested in a LARC method of contraception saves £13.42 in averted outcomes[74]. The incremental cost-effectiveness ratio[75] of implant (most effective LARC method) versus IUD (cheapest LARC method) was £13,206 per unintended pregnancy averted for 1 year of use but gradually decreased as years of intended use increased, with slight increases at 4, 7, 10 and 13 years (owing to high implant reinsertion costs incurred in those years, which increased the average annual cost of implant and hence its incremental average annual cost over IUD). At 15 years of contraceptive use, implants dominated IUD[76]. Switching from an oral contraceptive pill to a LARC method is estimated to save £29 per woman per year (£153 over 5 years) through avoided unplanned pregnancies[77]. Overall, the estimated economic value of contraceptive services has been calculated as £9 saved for every £1 spent. These are costs saved from pregnancies that are averted, over a ten-year period[78].

Women can access contraception through both sexual health services and general practice. The prescribing rate per 1000 females in Richmond is 41.8, and is the third highest in London, compared to a London rate of 30.4 and is the same as the England rate of 41.8 per 1000 females. The Richmond rate is currently showing a downward trend in LARC prescriptions, but is starting to increase to pre-pandemic levels:

70 Smith R, Ashford L, Gribble J, Clifton D. Family planning saves lives, 4th edition. Washington (DC): Population Reference Bureau; 2009 (http:// www.prb.org/pdf09/familyplanningsaveslives.pdf, accessed 13 June 2017).
71 Bayer HealthCare. Contraception Atlas. 2013.
72 https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/nhs-pharmacy-contraception-service/

73 G30 https://www.nice.org.uk/guidance/cg30
74 https://www.gov.uk/government/publications/health-economics-evidence-resource
75 The difference in the change in mean costs in the population of interest divided by the difference in the change in mean outcomes in the population of interest. It provides the 'extra cost per extra unit of outcome', which can be compared to other interventions.
76 cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence (NICE) clinical practice guideline | Human Reproduction | Oxford Academic (oup.com)
77 Local health and care planning menu of preventative interventions (publishing.service.gov.uk)
78 Contraceptive services: estimating the return on investment - GOV.UK (www.gov.uk)

**Figure 23: Total prescribed LARC excluding injections per 1000 females**




Source: OHID, Fingertips public health data (2022)

Females aged 15-34 years are the largest proportion of those accessing SRH services in England, followed by those who were 20-24 years of age. During 2020/21, 1500 female's resident in Richmond accessed SRH services for contraception. 30% of contacts at SRH services were for contraception for Richmond residents (Figure 25). Intrauterine systems and subdermal implants were the most prescribed LARC with oral pills the most commonly prescribed form of UDM. Latest data available for 2021 indicates that the LARC prescribing rate in SRH services is 15.4 per 1000 resident Richmond females, which compares with 19.8 per 1000 in London and 16.1 per1000 for England. Though there was a dip in rates in 2020 due to the pandemic, there has been no significant change over the last 5 years.

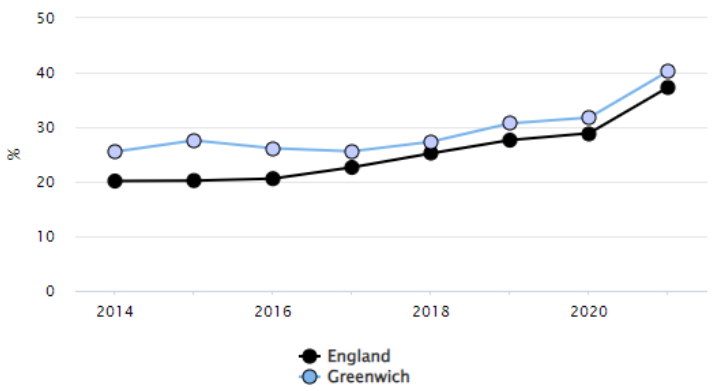
**Table 6: Main methods of contraception prescribed to Richmond residents at ISH services**

| Contraceptive Method prescribed | Richmond (number of prescriptions) |
|---|---|
| Total (main method in use) | 1200 |
| **Total: LARC** | **700** |
| IU device | 100 |
| IU system | 300 |
| Implant | 200 |
| Injectable | 0 |
| **Total: User dependent** | **500** |
| Oral (pill) | 300 |
| Male: Condom | 100 |
| Patch | 0 |

Source: Summary Profiles of Local Authority Sexual Health (2022)

An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. The percentage of under 25-year-old women attending SRH services who chose LARC (excluding injections) in Richmond is 40.2%, which is higher than London (33.8%) and England (37.3%). Trends have been increasing over the last 5 years:

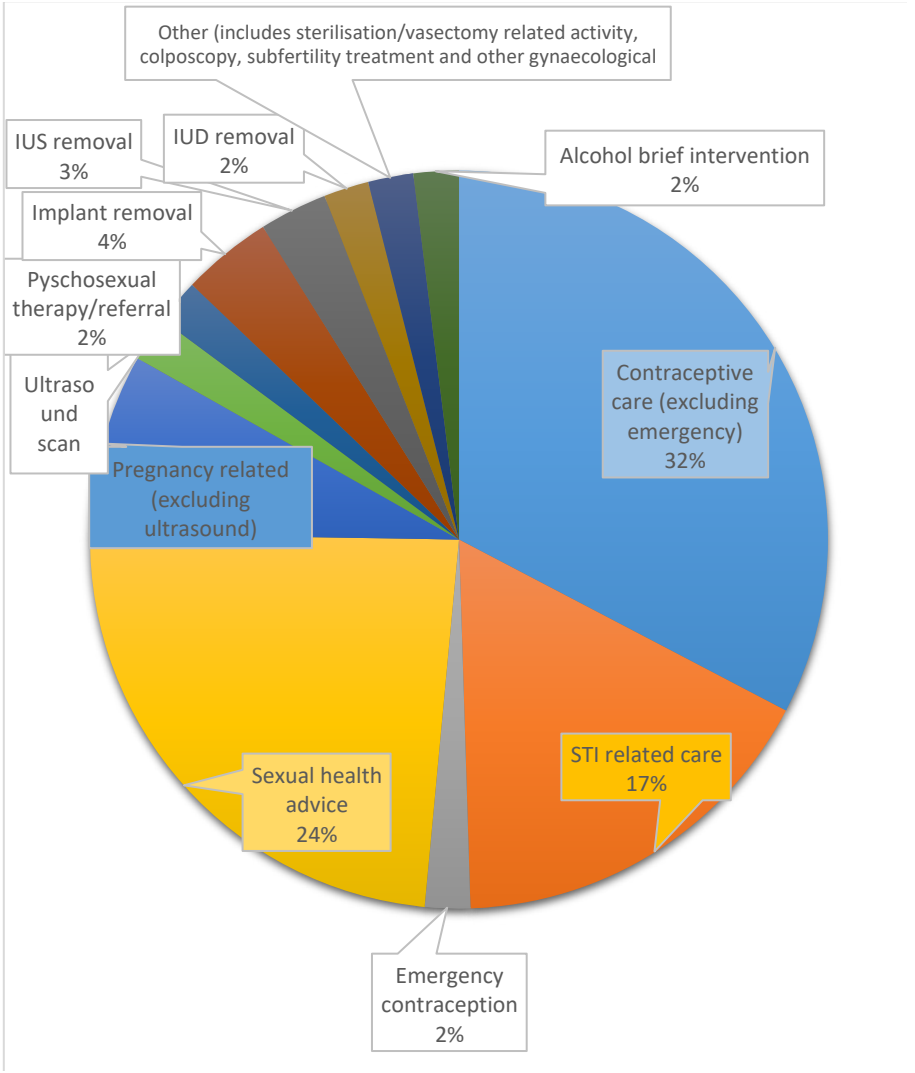
**Figure 24: Under 25s who choose LARC excluding injections at SRH services (%)**




Source: OHID, Sexual and Reproductive Health Profiles (2023)

The percentages of women over the age of 25 who are choosing LARC at SRH services has also increased for borough residents and now stands at 62.7% in comparison with 50.6% across London and 53.4% for England. Consequently, decreases in the percentage of SRH users choosing UDM contraception, including injections and hormonal short-active contraceptives, have been seen over the last few years. For Richmond residents, for example, the percentage of women choosing user-dependent methods of contraception at SRH services has decreased from 1469 (70.3%) in 2014 to 805 (50.2%) in 2020.

**Figure 25: Proportion of SRH service contacts by service activity in Richmond (2020/21)**




Source: NHS Digital Sexual and Reproductive Health Services (2022)

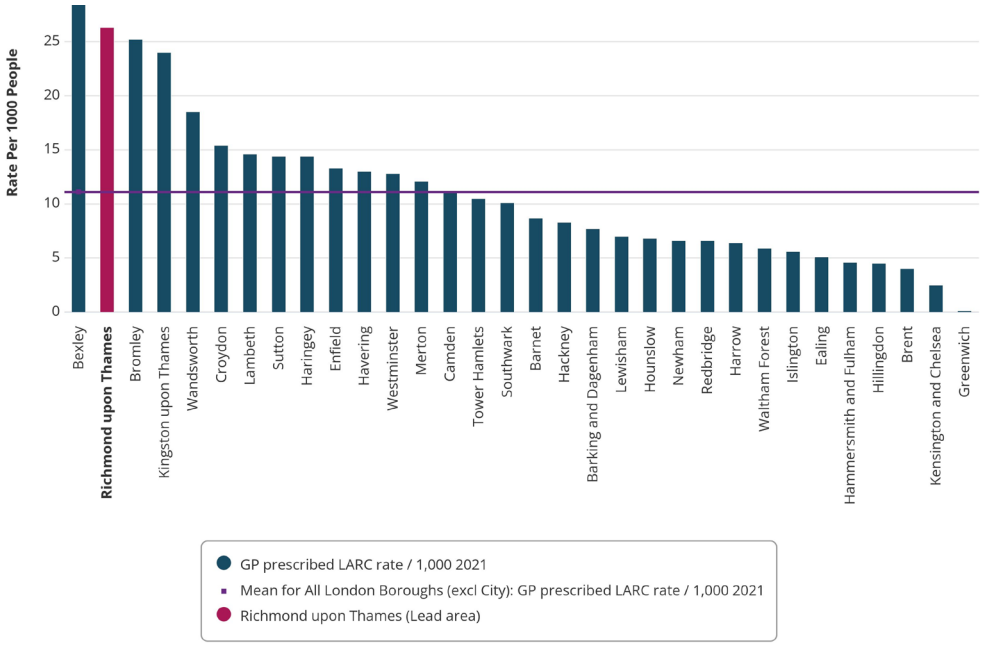
Prescribing Analysis and Cost Tabulation (PACT) data provides information on prescription contraception from general practice. PACT data excludes the following:

- prescriptions that were not collected (i.e. not dispensed)
- data from community sexual and reproductive health services
- pharmacies and young people's services
- contraception provided within general practice where devices are bought by a local authority or community SRH service.

The data should be interpreted with caution as the total count of prescriptions does not equate to the number of women who have received each contraceptive method. This is an issue seen often with methods that require prescribing more than once annually.

In 2021, Richmond was ranked 2nd out of London local authorities for the rate of GP prescribed LARC with a rate of 26.3 per 1,000 women aged 15 to 44 years of age; in contrast to 11.1 per 1000 in London and 25.7 per 1000 for England.

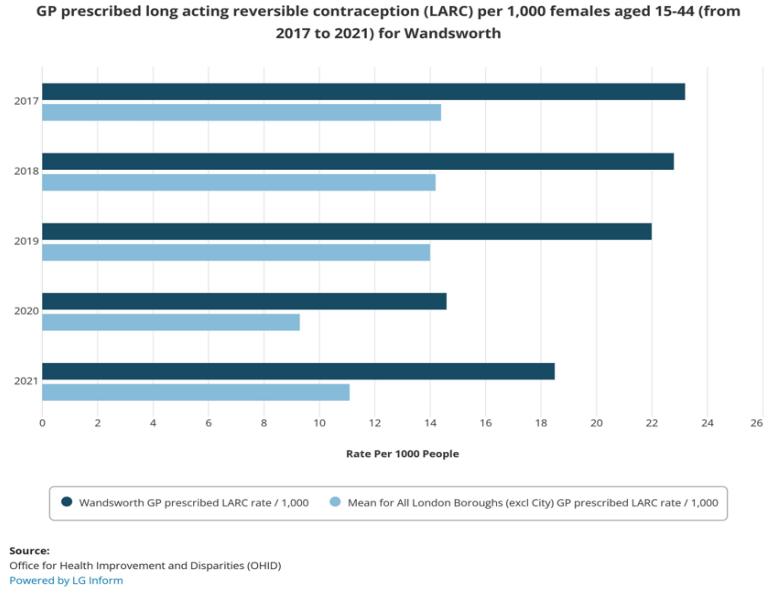
### Figure 26: GP prescribed LARC per 1000 females (2021)




**Source:**
Office for Health Improvement and Disparities (OHID)
Powered by LG Inform

Figure 27 illustrates the rate per 1,000 women aged 15 to 44 years of LARC (excluding injections) prescribed in a primary care setting between 2017 and 2021 in Richmond compared to all London boroughs. A clear dip was evident in 2020, most likely due to the COVID-19 pandemic and the reduced accessibility of LARC due to lockdown measures imposed on non-acute healthcare services.

### Figure 27: GP prescribed LARC per 1000 females (2017-2021)



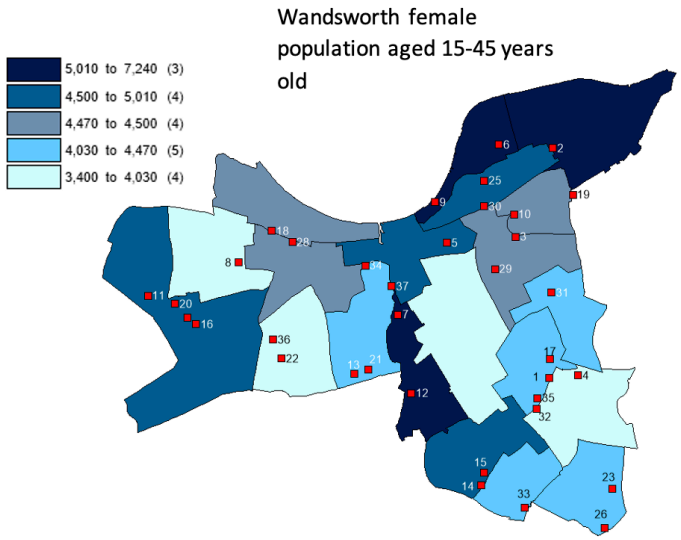

**Source:**
Office for Health Improvement and Disparities (OHID)
Powered by LG Inform

Source: Richmond and Wandsworth Health Intelligence Team (2022)

The maps below show a relatively good distribution of GP practices offering LARC compared to the distribution of child-bearing females aged 15 to 45 by ward for Richmond (Figure 28) and against ward deprivation scores (Figure 29). North Richmond ward may benefit from increased LARC provision.

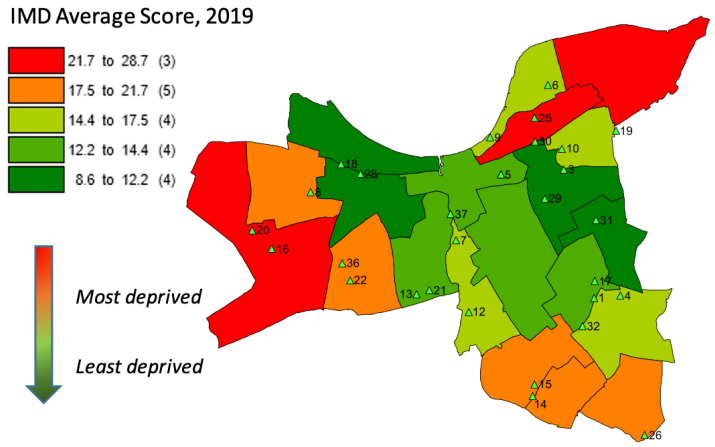
| | Trading Name |
|---|---|
| 1 | Cross Deep Surgery |
| 2 | The York Medical Practice |
| 3 | Woodlawn & Oak Lane Medical Centres |
| 4 | The Partners Broad Lane |
| 5 | The Hampton Medical Centre |
| 6 | The Park Road Surgery |
| 7 | Kew Medical Practice |
| 8 | Seymour House & Lock Road Surgery |
| 9 | Parkshot Medical Richmond |
| 10 | Glebe Road Surgery |
| 11 | Richmond Medical Group |
| 12 | Sheen Lane Health Centre) |
| 13 | The Essex House |
| 14 | Hampton Hill Medical Centre |
| 15 | Hampton Wick Surgery |
| 16 | Thameside Medical Practice |
| 17 | The Green Surgery & Fir Road Surgery |
| 18 | Richmond Lock Surgery |
| 19 | The Acorn Practice |

**Figure 28: GPs offering IUD/IUS & female population**




Wandsworth female population aged 15-45 years old

**Figure 29: GPs offering IUD/IUS and Index of Multiple Deprivation (IMD) scores**




IMD average score 2019

## Emergency Hormonal Contraception

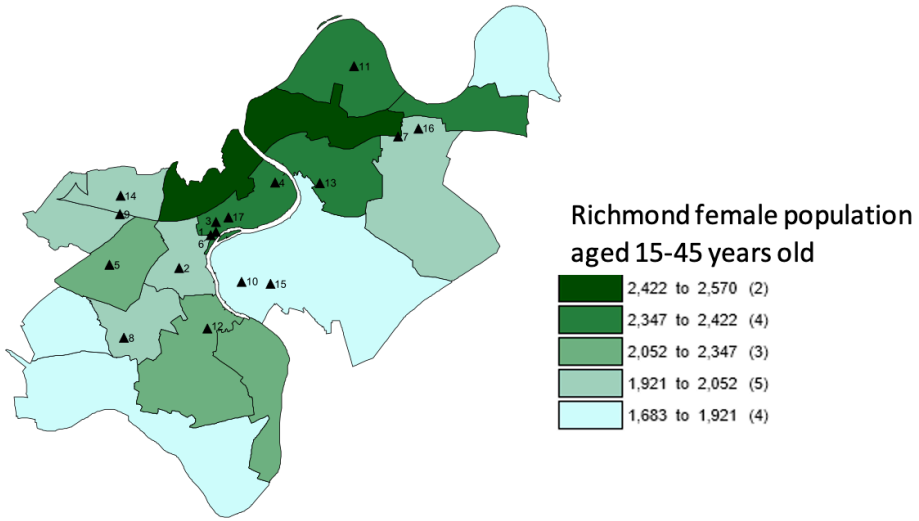
Pharmacies in Richmond are commissioned to provide postcoital contraception to females aged 13 years and over. In 2020/21 100 females in Richmond were prescribed emergency hormonal contraception (EHC). This equated to 200/1000 women aged 16 to 54.

There are currently 17 pharmacies in the borough contracted to provide EHC and this was found to be a sufficient offer within the latest pharmaceutical needs assessment[79]. Nurses and pharmacists can supply EHC to females of all ages under a Patient Group Direction (PGD). The two wards in Richmond with the highest population of females of child-bearing age (St. Margaret's/North Twickenham and North Richmond) do not have pharmacies that offer EHC.

| ID | TRADING NAME |
|---|---|
| 1 | Boots - 3-5 King Street |
| 2 | Brightlife Chemist |
| 3 | C Goode Pharmacy |
| 4 | Charles Harry Pharmacy |
| 5 | Crossroads Pharmacy |
| 6 | Day Lewis |
| 7 | Dumlers Pharmacy |
| 8 | Health On The Hill |
| 9 | Percy Road Pharmacy |
| 10 | Kanset Pharmacy |
| 11 | Kew Pharmacy |
| 12 | Kirby Chemist |
| 13 | Nima Pharmacy |
| 14 | Minal Pharmacy |
| 15 | Pharmacare |
| 16 | Spatetree Pharmacy |
| 17 | Twickenham Pharmacy |

79 https://www.richmond.gov.uk/media/rvwaihe1/richmond_pharmaceutical_needs_assessment_2023_2026.pdf#page=106&zoom=100,92,97

**Figure 30: Pharmacies offering EHC and female population aged 15-45 years**




Source: Richmond and Wandsworth Health Intelligence Team (2022)

The Local Government Association highlights a number of case studies from councils across the country that have implemented local schemes to increase access to contraceptive services. Some of these are highlighted in Appendix One.

**Key Findings:**

There has been a steady increase in provision of contraception, particularly LARC, although this was hampered by the pandemic. There is an appetite from the local population to continue to increase access to contraceptive choices. This can be achieved through:

- Supporting Richmond to switch on the online contraceptive service offered by other London boroughs.
- Ensure the new national advanced pharmacy contraception service is integrated into the local sexual and reproductive health offer.
- Standardisation and harmonisation of the EHC pharmacy offer including IT platforms across all 6 SW London boroughs to support:
  - EHC cost supply
  - Population health management
  - Service harmonisation
- Borough EHC training and accreditation across the 6 boroughs needs to be standardised, with guides to sexual health provision across each borough, safeguarding leads contacts and local training, and more multi-disciplinary engagement with Community pharmacy.
- Continue to encourage and enable LARC accessibility through general practice as routine practice, though provision in the North of the borough needs to be increased. Enable women to access LARC from GPs other than their own practice, if not already available or known about, could be explored.
- Develop streamlined pathways for LARC between providers.
- Increase number of LARC fitters at a local level, though recognising this is hampered by workforce issues.

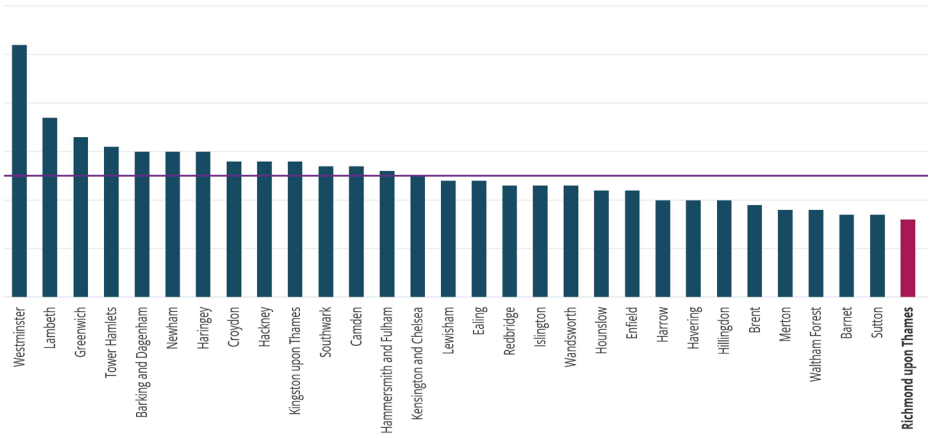
# Gender-based Violence Prevention, Support & Care

Gender-based violence (GBV) can take many forms, including physical, sexual and emotional. GBV has previously been defined as male violence against women, but in recent years, the term has been used to include violence that is based on gender identity or sexual orientation. [80] Health sector interventions to address GBV include: early identification through clinical inquiry; first-line support and response; treatment and care for intimate partner violence and sexual assault (e.g. emergency contraception, presumptive treatment for STIs, post-exposure prophylaxis for HIV, mental health care).

## Sexual Assault, Exploitation and Abuse

Internationally, the UN reports that an estimated 1 in 3 women experience physical or sexual violence during their lifetime[81]. These rates vary across cultures, age, gender and sexual identity. However, what is consistent is that the majority (83% in the UK[82]) will not report sexual assault and/or sexual exploitation. It is highly probable, however, that many will attend mainstream sexual health services for crisis STI screening or emergency contraception. Questions about sexual health, including consent and sexual violence are vital in helping to identify patients who have experienced sexual assault, especially where individuals are hesitant to divulge details, or unaware of the definition of sexual assault. Recorded instances of sexual offences per 1000 population in Richmond for 2021/22 were 1.6 and have increased from 1.4 in 2017/18[83]. Richmond is currently the third lowest borough for sexual offences across the capital (2.5/1000).

**Figure 31: Sexual offences per 1000 population, Richmond 2021/22**




Education for girls of secondary school age, economic empowerment of women, work on changing perceptions of masculinity and social norms, and home visiting programmes to reduce child maltreatment are all important complementary interventions outside the health sector[84]. Freedom from violence supports safer sexual relationships, reduces the risk of STIs, enables access to contraception and maternal health care, and increases access to needed health care, including sexual health and reproductive health care.

Data from the 2022 Richmond Health Related Behaviour Questionnaire (HRBQ) showed the following:

- 4% of pupils said they had been pressured to share images of themselves and 2% said that naked or semi-naked images of themselves had been shared without their consent.
- 10% of boys and 7% of girls in Year 10 said they have been intentionally physically harmed and 1% of boys and 6% of girls in Year 10 said they have been sexually harmed or harassed.
- 65% of Year 10 boys and 45% of Year 10 girls said they have viewed pornographic images (videos, pictures online/social media or in a magazine/photographs), compared to 58% and 38% respectively in other areas conducting the same survey.
- Year 10 transgender pupils are more likely to experience controlling partner behaviour than non-transgender pupils (40% vs 22%).
- Year 10 LGBTQ+ pupils are more likely to have experienced controlling partner behaviour (30% vs. 22%).

A 2023 survey conducted by Women's Aid found that children and young people were more likely to agree they had unhealthy perceptions of relationships if they had been exposed to pornography/nudity. Over half (51%) of those exposed to nudity/pornography agreed with the statement 'the most important thing in a relationship is to make your partner happy, no matter what', compared with 37% not exposed. Similarly, 11% of those exposed to nudity/pornography disagreed that 'it is important to talk with your partner about whether you are ready to have sex' compared with just 4% of these who had not been exposed[85].

80 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
81 Press Release: Devastatingly pervasive: 1 in 3 women globally experience violence | UN Women – Headquarters
82 Violence against Women and Girls and Male Position Factsheets - Home Office in the media (blog.gov.uk)
83 Violent crime - sexual offences per 1,000 population in Richmond upon Thames | LG Inform (local.gov.uk)
84 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
85 Influencers and Attitudes: How will the next generation understand domestic abuse? (womensaid.org.uk)

When asked about their experiences within relationships with a past or current boyfriend or girlfriend year 10 pupils reported the following:

**Table 7: Year 10 pupils said YES to the following experiences in a past or present relationship:**

| Year 10 | Boys | Girls |
|---|---|---|
| Was angry or jealous when I wanted to spend time with friends (12%) | 12% | 13% |
| Kept checking my phone (8%) | 7% | 7% |
| Used hurtful or threatening language to me (6%) | 5% | 9% |
| Made me do something I didn't want to do (5%) | 5% | 6% |
| Asked me to send them photos or videos of a sexual nature (6%) | 4% | 9% |
| Threatened to tell people things about me (5%) | 4% | 7% |
| Put pressure on me to have sex or do other sexual things (4%) | 2% | 6% |

Source: SHEU Survey, Richmond (2022)

When asked about the quality of RSE lessons in Richmond schools 42%, of pupils, compared to 37% in other areas conducting the survey, said that their RSE lessons have helped them 'quite a lot' or 'a lot' to understand grooming and sexual exploitation; and 15%, compared to 19% in the wider survey, said they have helped them understand FGM (female genital mutilation). 54% of boys and 63% of girls said that if they were worried about anything happening in a romantic relationship, they could get some help. More worryingly, 14% of pupils said they could not get help.

Data drawn from the Kingston and Richmond Safeguarding Children's Partnership (KRSCP) indicates that around 6% of children that are assessed by children's social care are at risk of child sexual exploitation. In 2022/23 5.6% (89 of 1590 children assessed) were at risk of CSE in Richmond. This compares to national levels of approximately 3% and may indicate the level of attention afforded in Richmond to identification of the issue[86].

A recent needs assessment conducted by the VAWG partnership for Richmond[87] noted that girls affected by criminal exploitation are often hidden from services for various reasons including grooming, exploitation or not considered as a risk when presenting at health services. However, females experience higher incidences of rape and higher rates of sexual abuse than males through criminal exploitation[88]. This is not always picked up when presenting to health services and would benefit from further awareness raising for health staff, including those in sexual health services[89].

A survey of more than 3000 UK adults conducted by the Crown Prosecution Service (CPS) found that while the public's accurate understanding of rape has grown over the last 20 years there are still significant false beliefs and misconceptions[90].

- Only 39% accurately identified that most rapists know their victim.
- Only 17% of those surveyed recognised few offenders use physical violence.
- Only a third of respondents correctly identified that women rarely make up rape allegations (36% got this right)
- There was a significant lack of understanding around what is meant by reasonable belief of consent by the suspect, with 49% of people saying they were unsure or did not know what it meant.

The response of 18-24-year-olds in upholding views based on false assumptions and misconceptions was particularly striking:

- Only half recognised that it can still be rape if a victim doesn't resist or fight back (53% got this right)
- Less than half recognised that being in a relationship or marriage does not mean consent to sex can be assumed (42% got this right, compared to 87% of people aged 65 and above)
- Less than half recognised that if a man has been drinking or taking drugs, he is still responsible if he rapes someone (46% got this right)
- Young people were also far less likely to understand that if a person says online they want to meet up and have sex, that doesn't mean they have to have sex when they meet (28% of 18-24-year-olds got this right, compared to 54% of people overall)
- Overall, two thirds (62%) of respondents recognised that even if no physical force is involved a person might not be free and able to consent to sex; but this dropped to 40% when young people were asked, compared with 74% of over 65s.

86 KRSCP 2023/24 Richmond Safeguarding Quality Assurance Dataset

87 Violence Against Women and Girls Needs Assessment 2023, Richmond
88 Gang Activity, Youth Violence and Criminal Exploitation Affecting Children (proceduresonline.com)
89 Three priorities to support girls and young women affected by serious violence and exploitation - Redthread
90 More to do to tackle rape misconceptions and lack of understanding of consent, CPS survey finds | The Crown Prosecution Service

Some local NHS services have recently signed up to a new Sexual safety in healthcare organisational charter to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace[91]. Signatories to the charter commit to a zero-tolerance approach, adapt key principles and actions that work towards eradicating sexual harassment and abuse in the work place. The charter could potentially be used as a model for other organisations to follow.

## Child Sexual Abuse

Child sexual abuse (CSA) is associated with adverse physical and mental health in childhood and beyond into adulthood. Survivors report impacts on mental health and well-being ranging from anxiety, depression, eating disorders, sleep disruption, post-traumatic stress to personality disorders. Physical health conditions including gastrointestinal, gynaecological and reproductive health can also be an issue. Furthermore, sexual abuse can affect children's psychosexual and psychosocial development and attachment, with impacts on sexual functioning as well as relationships in both adolescence and adulthood[92].

The Centre of Expertise on CSA estimates that at least one in ten children in England and Wales are sexually abused before the age of 16, however, the number of cases recorded is far below this estimate[93]. Local authority child protection data in England for 2021/22 recorded concerns about CSA in 33,990 assessments of children. This is a 15% increase on the previous year and is likely to be the result of heightened awareness of concerns following campaigns such as Everyone's Invited; increased focus on risks of hidden harms during COVID-19 lockdowns; and greater priority given to identifying these concerns as children became visible to services again post-lockdowns. Regardless of the rise in identification, there continues to be a large gap between the estimates of prevalence of child sexual abuse in England and Wales and the levels of identification and response recorded in official data where an increase of only 3% in the total number of sexual abuse assessments has been seen. This represents the highest level of identified concerns of CSA since 2014/15. Across England in 2021/22 2520 children were placed on child protection plans under the primary category of sexual abuse, representing 4% of the total number of child protection plans[94]. End of year figures for the percentage of children on a child protection plan under the primary category of sexual abuse for Richmond in 2021/22 was 5% and in 2022/23 was 3%[95].

In December 2023 the government announced a national review of multi-agency safeguarding practice in relation to the identification, assessment, and response to child sexual abuse within the family environment. This review will consider challenges, identify effective strategies, and understand what the current system can do to create effective conditions for effective practice and build professional confidence. The findings are likely to be published in summer 2024[96].

With low workforce confidence regarding sexual health and increases in work absences due to period poverty it can be extrapolated that a healthier approach to discussing sexual and reproductive health would raise confidence to enable professionals to spot the signs of and respond to sexual harm and abuse. The Centre of Expertise on CSA recently launched a CSA response pathway highlighting good practice when there are concerns that a child or young person is being or has been sexually abused. It aims to bring clarity to professionals' responsibilities and actions at key points to meet children's needs for safety and support and address their wider well-being[97].

## Female Genital Mutilation

Female Genital Mutation (FGM) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. It comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women and causes severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths[98].

The practice of FGM is recognised internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against girls and women. It is nearly always carried out by traditional practitioners on minors and is a violation of the rights of children. While there are many immediate complications of FGM including severe pain, infections and in some cases death, there are long-term physical complications including urinary, vaginal, menstrual, sexual and reproductive problems and increased risks of complications in childbirth. FGM is also recognised to bring long-term psycho-social problems including depression, anxiety, post-traumatic stress disorder and low self-esteem[99].

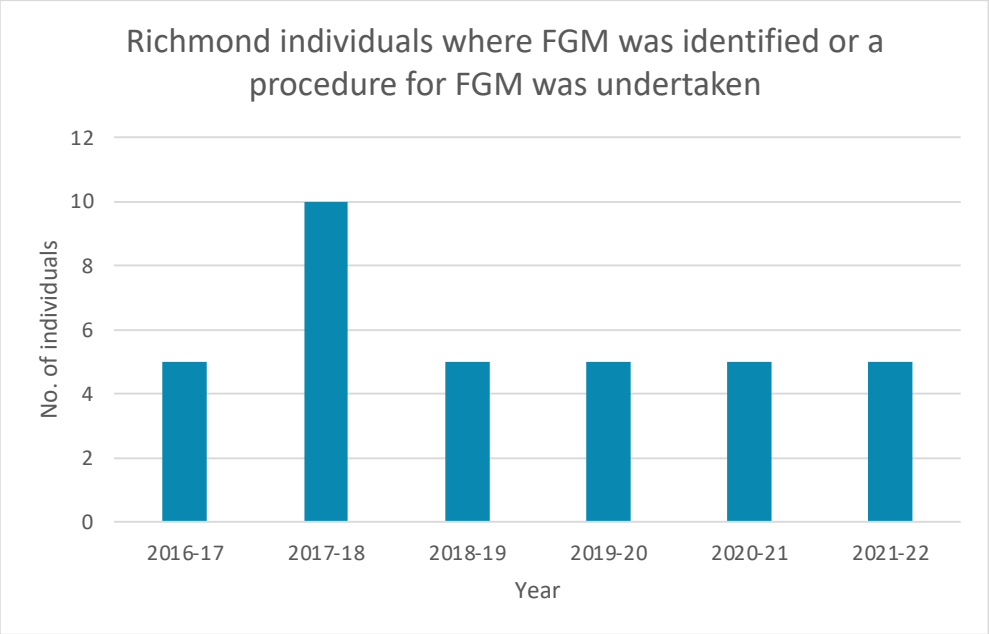
FGM has been illegal in the United Kingdom (UK) since 1985, with the law being strengthened in 2003 to prevent girls travelling from the UK and undergoing FGM abroad[100]. 30,335 women and girls who had undergone FGM have been seen at NHS services in England between April 2015 and March 2022, where FGM was relevant to their attendance. Not all information is

91 NHS England » Sexual safety in healthcare – organisational charter
92 https://www.csacentre.org.uk/research-resources/key-messages/impacts-of-child-sexual-abuse/
93 Child sexual abuse in 2021/22: Trends in official data (csacentre.org.uk)
94 Centre of expertise on child sexual abuse (2023) Child sexual abuse in 2021/22 Trends in official data
95 KRSCP annual dataset (2023)
96 Terms of reference - national review by the child safeguarding practice review panel into child sexual abuse within the family environment (publishing.service.gov.uk)
97 https://csapathway.uk/index.html
98 Female genital mutilation (who.int)
99 The Consequences of Female Genital Mutilation on Psycho-Social Well-Being: A Systematic Review of Qualitative Research - PMC (nih.gov)
100 Female Genital Mutilation (FGM) - April 2021 to March 2022 - Report.pdf (digital.nhs.uk)

known about every case of FGM, but where information about when FGM took place is known, most of these women and girls were under 18 when it took place. Only 42.4% of cases have a known geographical area where FGM was undertaken, of these 84.7% took place in Africa and 9.8% in Asia[101].

NHS digital produces an annual experimental dataset that captures the extent of women known to be affected by FGM. The dataset is a repository for individual level data collected by health care providers in England, including acute hospitals, mental health providers and GPs. In England, there were 5,620 individual women and girls who had an attendance where FGM was identified in the period April 2021 to March 2022. Individuals refers to all patients in the reporting period where FGM was identified or a procedure for FGM was undertaken. Each patient is only counted once (values between 1 and 7 are represented as 5 and all values greater than 7 are rounded to the nearest 5). Figures for Richmond indicate that numbers identified are very low, perhaps reflecting the ethnic profile for the borough.

**Figure 32: Richmond individuals where FGM was identified or a procedure for FGM was undertaken**




Source: NHS Digital (2022)

**Key Findings:**

Recorded instances of sexual offences in Richmond have been steadily increasing. Freedom from violence supports safter sexual relationships, reduces risk of STIs and enables access to sexual and reproductive health care. The HRBQ for Richmond indicates a number of key concerns experienced by young people in their early relationships, with some groups experiencing controlling partner behaviour more than others. There is a need to:

- Enable schools and youth services to support children and young people to understand the differences between healthy and unhealthy relationships.

There is a clear link between sexual and reproductive health strategies and existing violence prevention strategies, particularly Violence Against Women and Girls (VAWG) strategies and safeguarding partnerships. Some areas for further consideration in both strategies could be:

- Support and enable schools and youth services to support children and young people to understand the differences between healthy and unhealthy relationships.
- Workforce training to enable conversations about sexual health to build confidence to enable professionals to spot the signs of and respond to sexual harm and abuse.
- Refocus attention on identification and understanding of FGM post pandemic.
- Continue to support theatre in education programmes in schools and related resources to raise awareness of CSE and sexual harm / harassment.

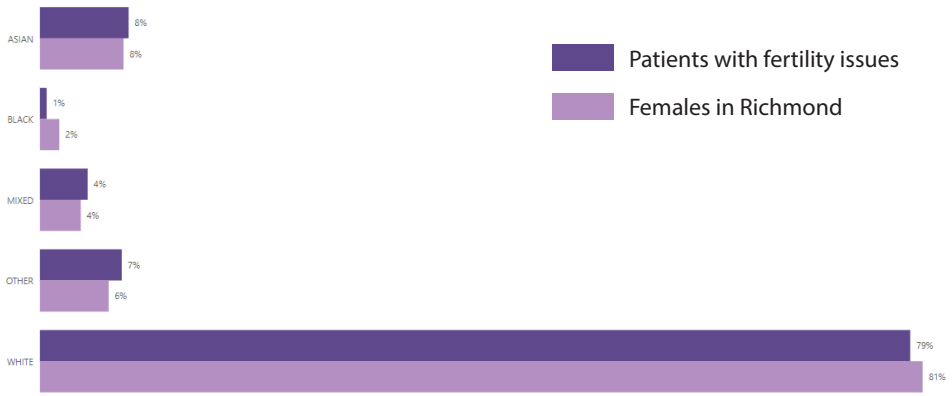
## Fertility & Reproductive Care

Failure to become pregnant after 12 months of regular, unprotected sexual intercourse is defined as infertility. In addition to the psychosocial impact on individuals of not being able to have children, the effects of infertility can be far-reaching. Inability to have children might result in marital discord, be grounds for divorce, or lead to ostracism from the family or community. Gender Based Violence (GBV) is also more likely among individuals and couples suffering from unwanted childlessness or involuntary infertility. Interventions for fertility care range from improved fertility awareness to advanced medical technologies, including assisted reproductive technologies, such as in-vitro fertilization (IVF). Offering fertility care also provides an important opportunity to engage men, who are generally less willing to access health services or discuss issues related to sexual and reproductive health.

Access to fertility care however, is easier for some ethnic groups and those in higher socio-economic groups. Of Richmond's 105,286 females aged 18 or over, 288 were captured through SWL health analytics as having fertility issues.

101 Female Genital Mutilation (FGM) - April 2021 to March 2022 - Summary.pdf (digital.nhs.uk)

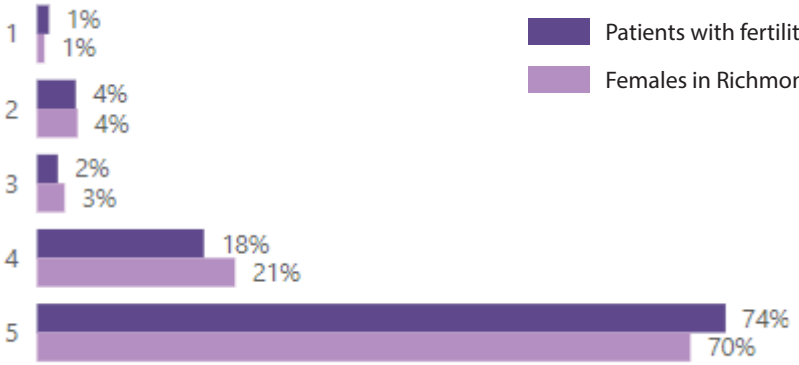
Figure 33: Richmond residents with fertility issues by ethnicity




Source: SWL Health Analytics (2023)

The figure below demonstrates that those in higher socio-economic groups may be more likely to seek out support with fertility issues in the borough.

**Figure 34: Richmond females with fertility issues by deprivation**




Source: SWL Health Analytics (2023)

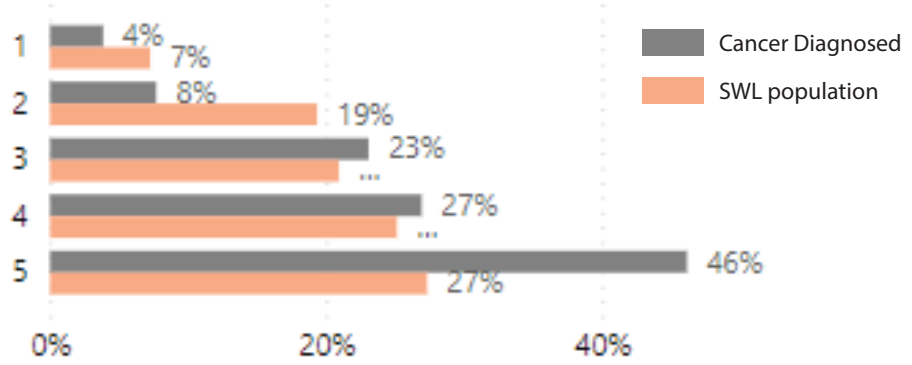
## Reproductive Cancers

Reproductive health through the life course can be measured through the prevalence of a variety of reproductive related cancers. SWL health insight data has been gathered for gynaecological cancers including cervical cancer and prostate cancer for men.

Across the UK, around 3200 new cervical cancers are diagnosed each year, accounting for 2% of all new cancer cases in females. The incident rate is highest in females aged 30 to 34 and around 9% are diagnosed in females aged 75 and over. Cervical cancer rates have however, decreased by 25% since the 1990s, but incidence rates are 65% higher in the most deprived quintile compared to the least and are lower in the Asian and Black ethnic groups, compared with the White ethnic groups. Yet, 99.8% of cervical cancers in the UK are preventable.[102]

In Richmond, cervical cancer is most common during the reproductive years, with 38% of women diagnosed in the 19-49 age group. 97% of the 31 women with a cancer diagnosis in Richmond were White and 50% of them were in the highest deprivation quintile, those in lower socio-economic groups were under-represented compared to the SWL population.

**Figure 35: Richmond cervical cancer by deprivation**

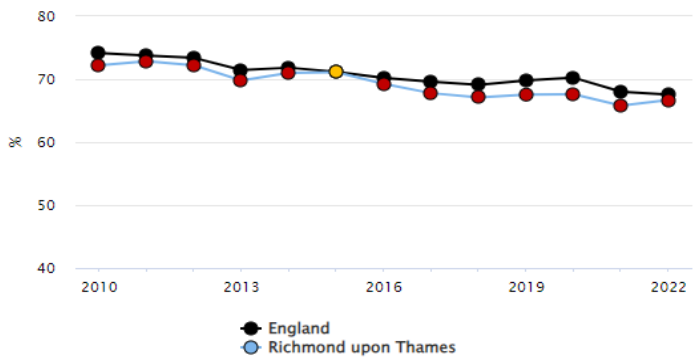



Source: SWL Health Analytics (2023)

Cervical screening coverage of 65.5% for 25-to-49-year-olds and 72.3% of 50-to-64-year-olds in Richmond (2022) is well below the national target of 80% coverage for population[103] and shows downward trends for both age groups.

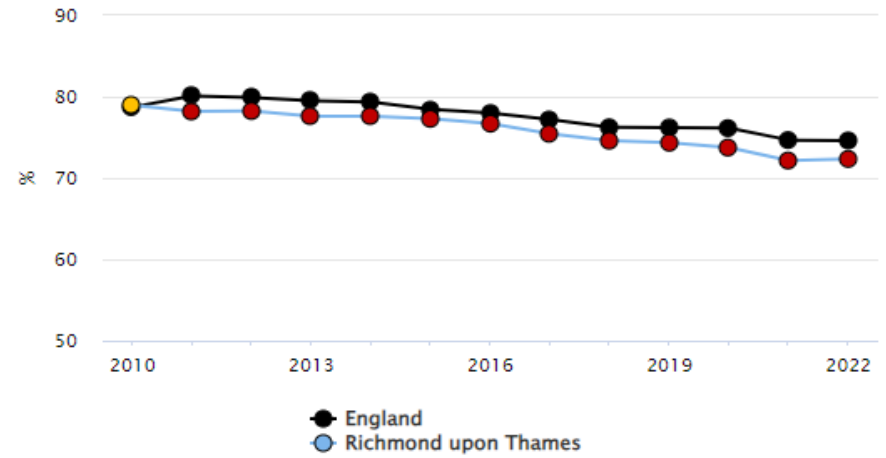
102 https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/cervical-cancer#heading-Zero
103 https://www.gov.uk/government/publications/be-clear-on-cancer-first-national-cervical-screening-saves-lives-campaign/cervical-screening-uptake

**Figure 36: Richmond cancer screening coverage (aged 25 to 49))**




Source: OHID, Public Health Profiles (2022)

**Figure 37: Richmond cervical cancer screening (aged 50 to 60 years)**




Source: OHID, Public Health Profiles (2022)

This demonstrates that more needs to be done to increase screening uptake at both national and local levels.

Gynaecological cancers include ovarian, uterine, vaginal, vulval. Cancer Research UK summarises the incidence, death, survival and prevention rates of a range of cancers. The information is captured in the table below:

**Table 8: UK gynaecological cancers, key statistics (2016-18)**

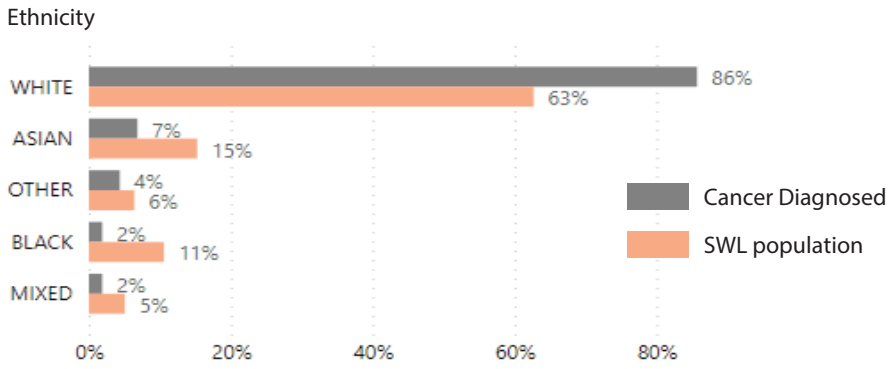
| Type of Cancer | New cases / year | Deaths | Survival rate (for 10 years or more) | Preventable estimate | Deprivation (% difference between lowest and highest quintile) |
|---|---|---|---|---|---|
| Cervical | 3197 | 853 | 51% | 99.8% | 65% |
| Ovarian | 7495 | 4142 | 35% | 11% | Similar |
| Uterine | 9703 | 2543 | 72% | 34% | 17% |
| Vaginal | 250 | 110 | unknown | 75% | 88% |
| Vulval | 1372 | 469 | 58% | 69% | 74% |

Source: Cancer Research UK (2023)

A similar demographic picture can be discerned for other gynaecological cancers diagnosed in Richmond as is found in cervical cancers[104]. Diagnosis of some reproductive cancers increase with age, only 8% of diagnosis occurring in the 19-49 reproductive age years meaning possible implications for sexual and reproductive health education as women age. Gynaecological cancers are again, more likely to be diagnosed among the White population and under diagnosed in Black, Asian, and other ethnic groups:

104 Population Health Management - South West London ICS

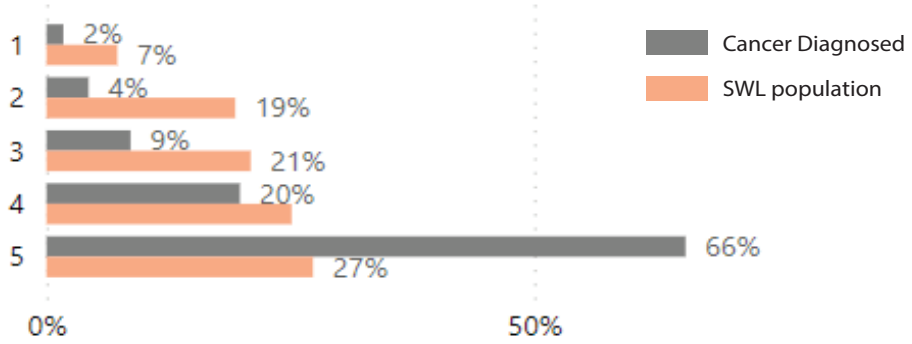
**Figure 38: Richmond gynaecological cancer diagnosis by ethnicity**




Source: SWL Health Analytics (2023)

Clear disparities in diagnosis are also seen for deprivation:

**Figure 39: Richmond gynaecological cancer diagnosis by Deprivation**

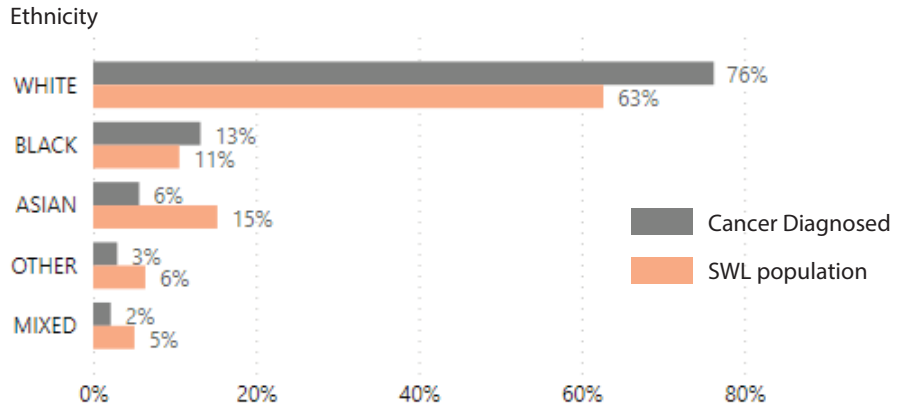



Source: SWL Health Analytics (2023)

Very little information is available regarding male reproductive health. Cancer Research UK[105] estimates that prostate cancer is the most common cancer in males and there are around 52,300 new cases in the UK every year, with incidence rates being highest in males aged 75 to 79. Incidence rates have also increased by almost half (48%) since the early 1990s and are projected to increase by a further 15% from 2023 to 2025[106]. Prostate cancer is most often linked to aging. Within Richmond, 73% of prostate cancer diagnosed were to people aged 65+, 26% aged 50 to 64 and only 1% aged 19 to 49. In England (2013-2017) incidence rates for prostate cancer were lower in the Asian ethnic group and in people of mixed or multiple ethnicities, but higher in the Black ethnic group, compared with the White ethnic group, in males. Black males in Richmond are at greatest risk.

105 Our research by cancer type (cancerresearchuk.org)
106 https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/prostate-cancer#heading-Zero

**Figure 40: Richmond prostate cancer diagnosis by ethnicity**




Source: SWL Health Analytics (2023)

In males in the UK, testicular cancer is the 17th most common cancer, with around 2,400 new cases every year and highest among males aged 30 to 34. Testicular cancer rates have increased by more than a quarter (27%) since the 1990s but are projected to fall by 6% from 2023 to 2025. Incidence rates are lower in the Asian ethnic group compared with the White ethnic group.

Cancers of the male reproductive tract include penile, prostate and testicular cancers. Cancer Research UK summarised their incidence, death, survival and prevention rates:

**Table 9: UK Male reproductive cancers, key statistics (2016-18)**

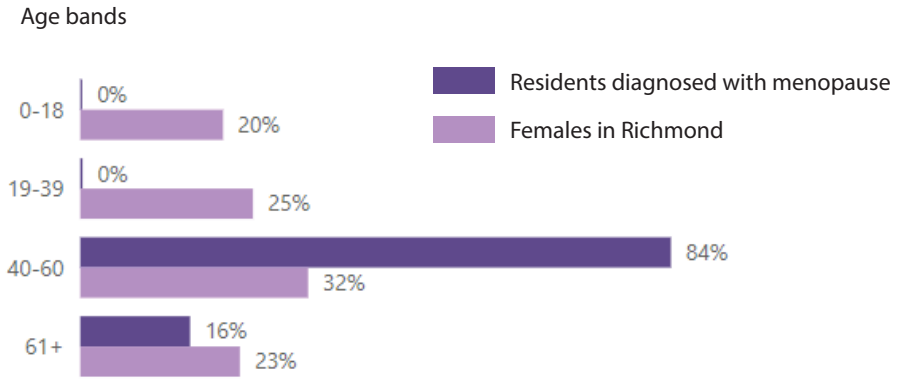
| Type of Cancer | New cases / year | Deaths | Survival rate (for 10 years or more) | Preventable estimate | Deprivation (% difference between lowest and highest quintile) |
|---|---|---|---|---|---|
| Penile | 699 | 154 | 68% | 63% | 52% |
| Prostate | 52,254 | 12,039 | 78% | Not known | 17% lower |
| Testicular | 2354 | 65 | 91% | Not known | 16% lower |

Source: Cancer Research UK (2023)

## Menopause

The menopause affects anyone who has periods. It is usually a natural symptom of aging, marking the end of fertility. Symptoms begin with perimenopause and the menopause is considered to have taken place once periods have stopped for 12 months. The menopause usually affects women between the ages of 45 and 55 but can also happen earlier or following surgery to remove the ovaries or uterus. Symptoms can include anxiety, mood swings, hot flushes and irregular periods which can continue for a considerable time before and after periods cease. These symptoms can have a big impact on health (including sexual health), life, relationships and work. Southwest London Health analytics data estimates that in Richmond there are currently 4021 patients diagnosed with menopause, with the majority diagnosed between 40 to 60 years:

**Figure 41: Ages of Richmond residents diagnosed with menopause**




Source: SWL Health Analytics (2023)

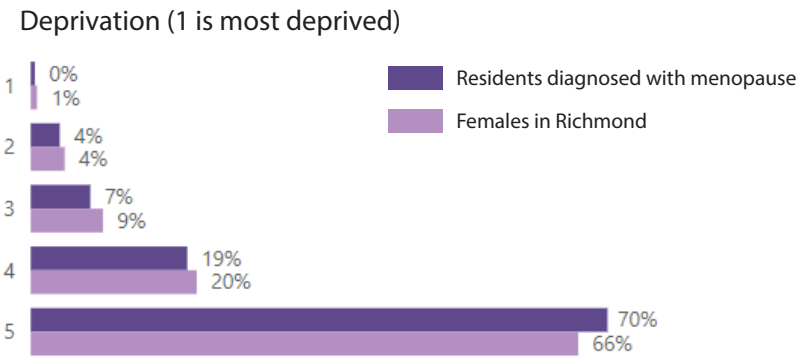
While all women living beyond the age of 60+ will eventually go through the menopause there is clear disparity in relation to who will seek help for or be diagnosed with menopause. White women for example, are more likely to be diagnosed than Black or Asian women:

**Figure 42: Ethnicity of Richmond residents diagnosed with menopause**


Source: SWL Health Analytics (2023)

Females in the most deprived cohort were over-represented as were those in cohort 4 suggesting a clear disparity in access to menopause help and support compared with those in higher socio-economic groups.

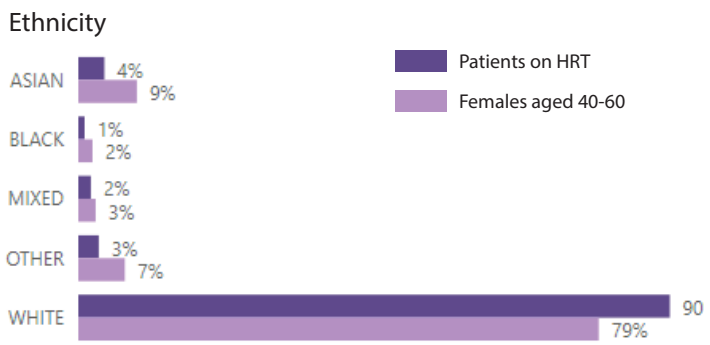
**Figure 43: Richmond females diagnosed with menopause by deprivation indicator**




Source: SWL Health Analytics (2023)

Looking at Richmond females aged 40 to 60 that are receiving hormone replacement therapy (HRT) for menopause or other symptoms White females are more likely to receive treatment than all other ethnic groups.

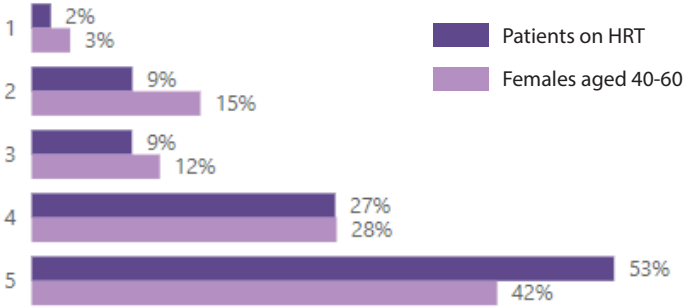
**Figure 44: Richmond residents on HRT aged 40-60 by ethnicity**




Source: SWL Health Analytics (2023)

Disparities are further played out when deprivation is considered for those on HRT. 0% of those on HRT are within the most deprived quintile compared to 71% in the least deprived quintile.

**Figure 45: Richmond patients aged 40-60 on HRT by deprivation**




Source: SWL Health Analytics (2023)

Key Findings:

Those in lower socio-economic groups and some ethnic groups may be less likely than those in higher socio-economic or White ethnicities to seek support for fertility issues.

- Development / delivery of a fertility awareness campaign targeting groups with lower uptake.

There has been a steady decline in uptake of cervical cancer screening and low diagnosis of other reproductive related cancers in Black, Asian and mixed ethnicity groups and those living in areas with higher levels of deprivation.

- Increase awareness of the importance of accessing cervical screening programmes
- Ensure education with regard to reproductive diseases is factored in to RSE and sexual and reproductive health education through the life course.
- Consider the development of MECC modules in relation to reproductive health (if not already nationally available)

There are clear disparities in relation to access to menopausal support and care, including the provision of HRT as women age.

- Ensure the sexual and reproductive health strategy aligns to the developing women's health hub.
- Ensure education with regard to the menopause is embedded within sexual and reproductive health education through the life course, including access to MECC modules.

## Prevention & Control of HIV and other STIs

STIs are caused by pathogens, such as bacteria and viruses, that can be transmitted through sexual contact (oral, anal, vaginal) as well as through other mechanisms, such as mother-to-child transmission. Common STIs include chlamydia, gonorrhoea, syphilis, trichomoniasis, herpes simplex virus (HSV), human papillomavirus (HPV), HIV and some types of viral hepatitis. More recently, outbreak associated viral infections, such as Mpox, which are primarily transmitted through vectors or physical contact, have been identified as also sexually transmissible.

Many STIs can occur without noticeable symptoms[107]. Left untreated, they can have short- and long-term psychological, social and financial effects on individuals, in addition to effects on overall health, fertility and sexuality[108]. STIs can be prevented through delaying sexual activity, use of condoms, vaccination to prevent HPV and hepatitis B, circumcision to reduce HIV transmission, and pre- and post-exposure HIV prophylaxis. STIs can be controlled through early identification and treatment, appropriate case management, improving health care-seeking behaviour, partner notification, and preventing and managing complications (e.g. pelvic inflammatory disease).

STIs are an important public health problem, particularly in London. London has the highest rate of new STIs of all the regions in England, with a rate of 1,397 diagnoses per 100,000 population, twice as high as the rate of 694 per 100,000 in England. More than 120,000 new STIs were diagnosed in London residents in 2022 (122,912), accounting for nearly one third of new STIs in England (31%).

Overall, men continue to have higher rates of new STIs than women (1,901 and 863 per 100,000 residents, respectively) and where country of birth was known, 57% of London residents diagnosed with a new STI in 2022 (excluding chlamydia diagnoses reported via CTAD) were UK-born[109].

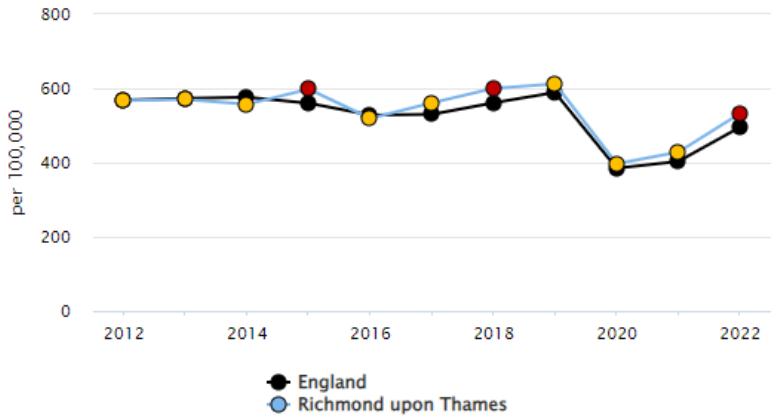
The number of new STIs diagnosed in London residents increased by 21% between 2021 and 2022. While the number of genital warts diagnoses decreased by 3%, rises were seen in the other major STIs:

- gonorrhoea by 36%
- chlamydia by 19%
- genital herpes by 16%
- syphilis by 8%.

Gonorrhoea increased in all age groups, however, the highest rates were among those aged 20 to 24 years, and 25 to 34 years. While the overall number of new STIs diagnosed in London in 2022 was 18% lower than the pre-COVID-19 pandemic year of 2019, the numbers of gonorrhoea and syphilis diagnoses in 2022 exceeded those reported in 2019 [110]. Although the number of sexual health screens rose in London between 2021 and 2022, the rise in STI diagnoses outpaced the rise in testing. In addition, there was an increase in STI test positivity. These trends may reflect better targeted testing of people more likely to have an STI, or more likely, an increase in transmission.

Overall, Richmond enjoys relatively good sexual health outcomes. The total number of all new STIs diagnosed in Richmond in 2022 was 1309; a rate of 670 per 100,000 residents which is lower than the London rate of 1397 per 100,000 and marginally better than the England rate of 694 per 100,000. Overall rates in Richmond have seen a downward trend on the five most recent points. This is also seen within the STI diagnosis rate when chlamydia is excluded.

**Figure 46: New STI diagnosis (excluding chlamydia aged under 25) per 100,000**

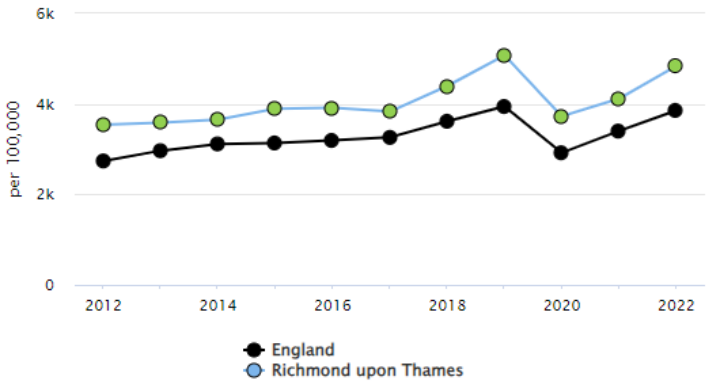



Source: OHID, Sexual and Reproductive Health Profiles (2023)

In 2022, a rate of 532 per 100,000 population of new STIs (excluding chlamydia) were diagnosed in Richmond; this is considerably lower than London rates of 1171 per 100,000. STI testing rates (excluding chlamydia) in 2022 stood at 4844 per 100,000 population which is half that of the London rates of 8662 and lower than England rates of 3856 per 100,000 meaning that Richmond population has lower access to STI testing than other London boroughs and there has been no significant change in trends over the five most recent points.

107 An STI is diagnosed in a young person every 4 minutes in England - GOV.UK (www.gov.uk)
108 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
109 Spotlight on sexually transmitted infections in London: 2022 data - GOV.UK (www.gov.uk)
110 Spotlight on sexually transmitted infections in London: 2022 data - GOV.UK (www.gov.uk)

**Figure 47: STI testing rate (exclude chlamydia aged under 25) per 100,000**




Source: OHID, Sexual and Reproductive Health Profiles (2023)

There is also a clear link between prevalence of STIs and deprivation. Just under 60% of all new STI diagnoses were among people living in the least deprived areas in the borough.

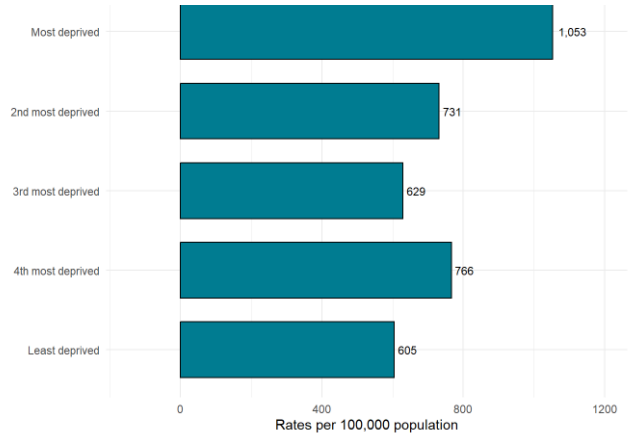
**Table 10: New STIs by deprivation, Richmond 2022**

| Deprivation category | Number | % |
|---|---|---|
| Most deprived | 15 | 1.2 |
| 2nd most deprived | 65 | 5.1 |
| 3rd most deprived | 120 | 9.3 |
| 4th most deprived | 305 | 23.7 |
| Least deprived | 780 | 60.7 |

Source: Summary Profiles of Local Authority Sexual Health (SPLASH) report supplement (2023)

When looking at STI rates per 100,000 population by deprivation higher rates in the third most deprived population can be seen:

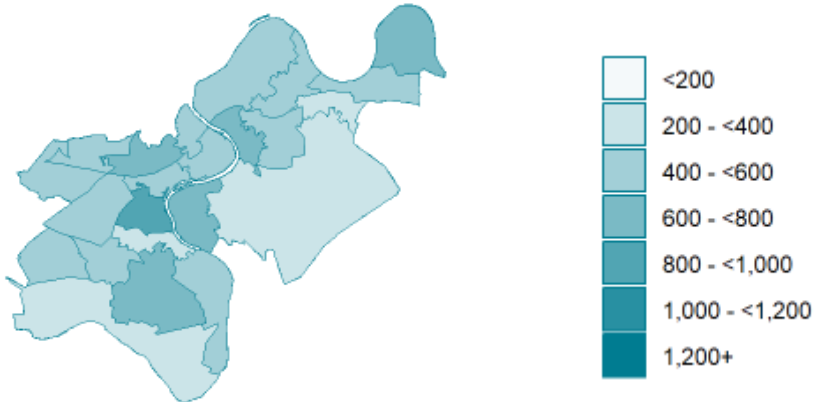
**Figure 48: Rates per 100,000 population of new STIs by deprivation category in Richmond, 2022**




Source: SPLASH reports UKHSA (2023)

New STI diagnoses across the borough of Richmond by middle super output areas per 100,000 population indicates higher prevalence across wards in the north of the borough.

**Figure 49: New STI diagnosis per 100,000 population, 2022**




Source: SPLASH reports UKHSA (2023)

Reinfection with an STI is a marker of persistent high-risk behaviour identification of new infections can be a consequence of regular testing which can be interpreted as a positive choice. Nationally, from 2016 to 2020, 6.7% of women and 9.6% of men became re-infected with a new STI within 12 months. In Richmond, an estimated 5.0% of women and 9.6% of men presenting with a new STI at a SHS became re-infected with an STI within 12 months. An estimated 11.4% of 15- to 19-year-old women and 11.7% of 15- to 19-year-old men presenting with a new STI during the five-year period from 2016 to 2020 became re-infected with a new STI within 12 months in Richmond. In England, 10.9 % of 15- to 19-year-old women and 9.8% of 15- to 19-year-old men became reinfected with a new STI within 12 months.

## Genital Warts

Genital warts are the most common viral STI diagnosed in the UK and are caused by strains of the human papillomavirus (HPV). They can be very uncomfortable but are easily treated. The numbers of first episodes of genital warts have been declining since the introduction of the National HPV immunisation programme targeting children aged 12 to 13 (year 8) and GBMSM aged under 45. In 2022, 65.1 per 100,000 genital warts were diagnosed in Richmond which is a downward trend on the previous five points and is lower than London (80.0) but remains higher than England (46.1) rates. HPV vaccination coverage across the UK decreased by 7% in year 8 girls and 8.7% in year 8 boys in 2021 to 2022 when compared to the previous academic year, which suggests coverage still remains below pre-pandemic levels[111]. Richmond has historically seen low take-up of vaccination programmes.

The latest data for uptake of the Human Papillomavirus (HPV) vaccine, from academic year 2021/22. In 2021/22, shows that 77.3% of girls and 75.4% of boys in year 8 received their first dose of the vaccination[112]. 81% of girls and 80.3% of boys in year 9 received their second dose. Take up in Richmond across all indicators was higher than the London average (61.6%).

Data[113] indicates that uptake of the HPV vaccine is declining in the borough. Uptake of the first vaccine dose for both boys and girls in 2021/22 was lower than in the previous academic year, and uptake in 2020/21 was lower than the average annual uptake in the years preceding the COVID-19 pandemic. This decline in uptake of the HPV vaccine has been seen across London.

Delivery of the first HPV vaccine dose in 2019/20 was severely disrupted by the COVID-19 pandemic. This resulted in no girls in Richmond receiving either a first or second dose of the HPV vaccine and only 7.4% of boys received their first dose. From September 2023 the vaccine programme moved to a single dose only schedule[114].

## Chlamydia

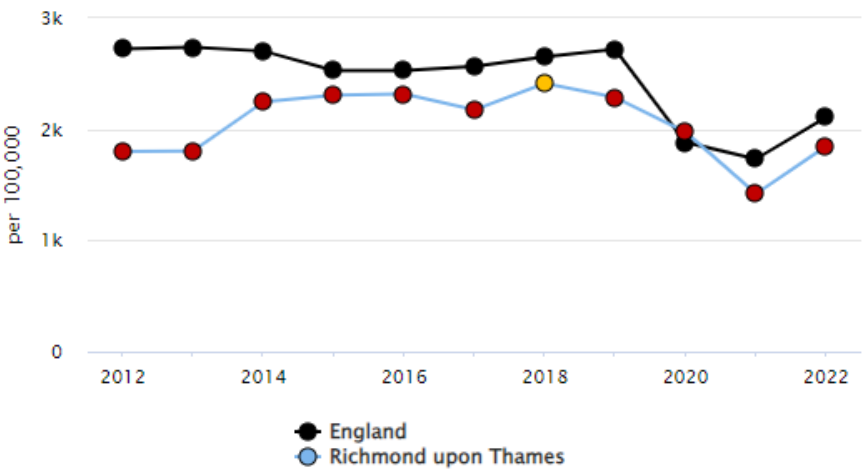
Chlamydia is a common STI that can occur in both men and women[115]. Caused by the bacteria Chlamydia trachomatis, it is easily treated with antibiotics. If not treated, however, it can cause serious problems, including infertility, ectopic pregnancy and pelvic inflammatory disease (PID). In pregnant women, it can also cause premature birth. Correct and consistent use of condoms during sex is the most effective way to prevent chlamydia.

In 2022, the crude diagnostic rate of chlamydia in Richmond of 266 per 100,000 population is much lower than London (588) and trends have shown a decrease over the five most recent points, which is encouraging[116]. The diagnostic rate per 100,000 people aged 25 and over is 250 (n=520) and has decreased over the last five points. The diagnostic rate and numbers for those aged under 24 is not currently available.

The chlamydia detection rate among under 25-year-olds is a measure of chlamydia control activity aimed at reducing the incidence of reproductive sequelae of chlamydia infection and interrupting transmission[117]. An increased detection rate is indicative of increased control activity. The UKHSA recommends that local authorities should be working towards achieving a detection rate of at least 3,250 per 100,000 female population aged 15 to 24. The recommendation was set at a level that would encourage a high volume of screening and diagnoses, be ambitious but achievable, high enough to encourage community screening, rather than in specialist sexual health clinics only and be likely to result in a continued chlamydia prevalence reduction. Chlamydia Detection rates among the female population in Richmond stands at 1847/100,000 females at 15 to 24. Trends have been getting worse over the five most recent points. When benchmarked against national rates Richmond stands in the 'red' zone of less than 2400/100,000 female population, meaning much more could be done to both detect and prevent chlamydia in the local female population.

111 https://www.gov.uk/government/news/concern-over-drop-in-hpv-vaccine-coverage-among-secondary-school-pupils
112 https://fingertips.phe.org.uk/search/hpv#page/1/gid/1/pat/15/ati/502/are/E09000032/iid/92319/age/206/sex/1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
113 https://fingertips.phe.org.uk/search/hpv#page/1/gid/1/pat/15/ati/502/are/E09000032/iid/92319/age/206/sex/1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1
114 HPV vaccination programme moves to single dose from September 2023 - GOV.UK (www.gov.uk)
115 Chlamydia - NHS (www.nhs.uk)
116 Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
117 https://fingertips.phe.org.uk/profile/SEXUALHEALTH

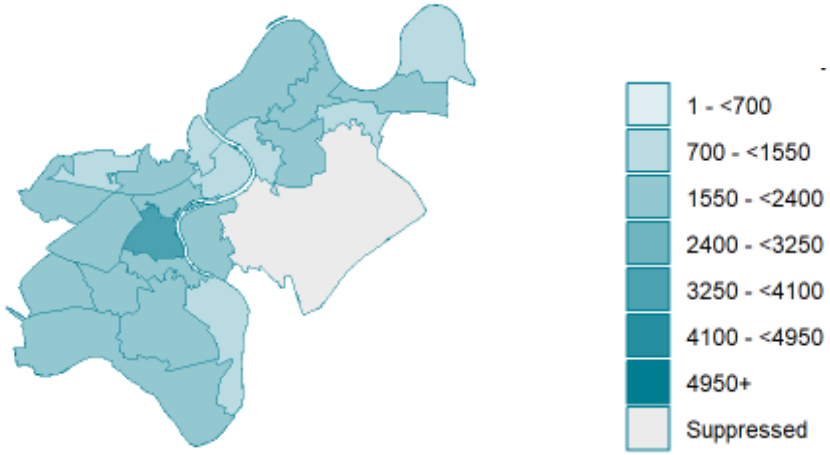
**Figure 50: Chlamydia detection rate per 100,000 aged 15 to 24 (Female)**




Source: OHID, Sexual and Reproductive Health Profiles (2023)

Chlamydia detection rates per 100,000 in Richmond in 2020 are highest toward the East of the borough, this could indicate the ease of access to testing in those areas. Areas with detection rates lower than 2400 should therefore be the focus for targeted chlamydia screening.

**Figure 51: Chlamydia detection rates per 100,000 15–24 year olds, Richmond 2022**



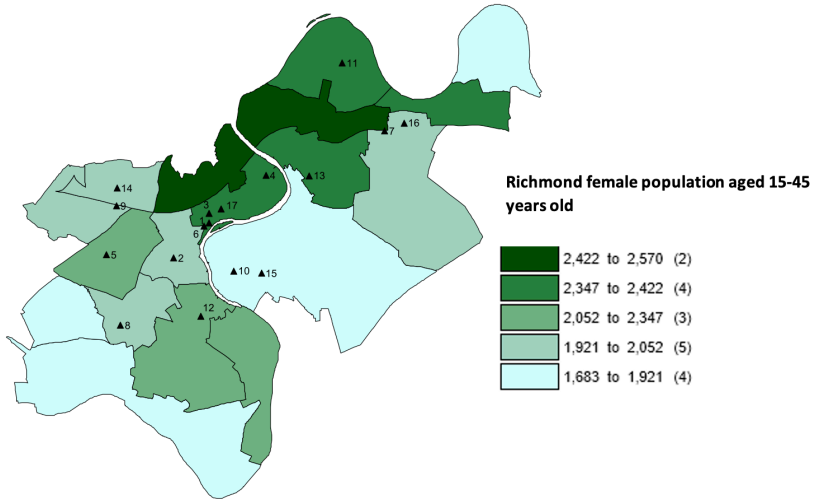

Source: SPLASH reports UKHSA (2023)

Another indicator that enables understanding of chlamydia screening and chlamydia diagnoses in a local area is the admission rate for PID. PID is a clinical syndrome referring to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy, infertility and chronic pelvic pain. Chlamydia is a cause of both PID and ectopic pregnancy. PID can be treated in both primary care and outpatient settings but may lead to the need for hospital admission. Ectopic pregnancy usually results in hospital admission. It is anticipated that high chlamydia screening coverage should lead to increased diagnosis and assuming successfully treated should lead to a decrease in PID and consequentially lower ectopic pregnancy[118].

In Richmond the PID admission rate per 100,000 in 2021/22 was 147.7 which compared favourably to that of London at 196.8 and 224.4 for England. The ectopic pregnancy rate for Richmond for 2021/22 was 80.5 per 100,000 compared to 92.2 for London and 90.6 for England. Trends over the last few years are unfortunately not currently available.

In Richmond, 16 pharmacies offer chlamydia screening and treatment as part of the National Chlamydia Screening Programme and this was found to be a sufficient offer within latest the pharmaceutical needs assessment.[119]

**Figure 52: Pharmacies in Richmond offering chlamydia screening and treatment against female population aged 15-45 years**




Source: Richmond Pharmaceutical Needs assessment 2023)

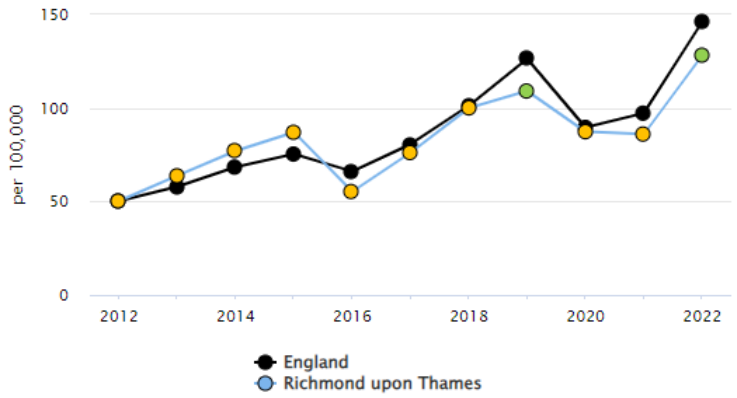
118 Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
119 https://www.richmond.gov.uk/media/rvwaihe1/richmond_oloeutical_needs_assessment_2023_2026.pdf#page=106&zoom=100,92,97

## Gonorrhoea and Syphilis

Gonorrhoea and syphilis infection are indicators of risky sexual behaviour. Untreated gonorrhoea can lead to complications such as long-term pelvic pain, pelvic inflammatory disease, ectopic pregnancy and infertility in women. However, people infected will often have no symptoms, especially for infections in the throat, vagina or rectum, meaning people are less likely to consider the need for testing. Provisional national data released in September 2023 indicates that the rate of gonorrhoea diagnosis from January to September 2022 was 21% higher than that reported in the same period in 2019 and higher than that reported over the same period in each of the last three years[120]

There has been no significant increases in Richmond over the last five points measured however, trends in general can be seen to be increasing and this increase is likely to not solely be a result of increased testing. The rate of gonorrhoea diagnoses was 128 per 100,000 compared to 146 per 100,000 in England and 383 in London, which marks this as favourable (green) in comparison to other London boroughs. With lower access to sexual health services in Richmond, however, this may indicate that prevalence is higher than may seem:

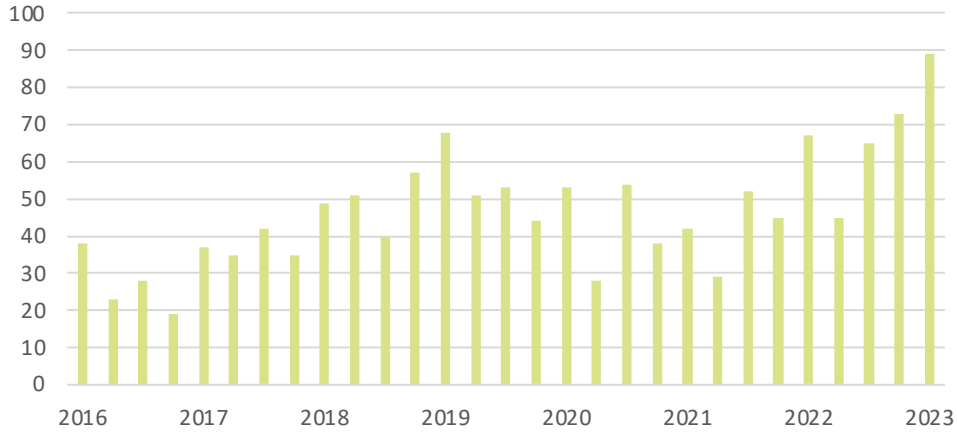
**Figure 53: Gonorrhoea diagnostic rate per 100,000**




Source: OHID, Sexual and Reproductive Health Profiles (2023)

Latest provisional quarterly data for local authorities denotes a continuing upward trend temporarily impacted by the pandemic.

Figure 54; Gonorrhoea diagnosis numbers (2016-2023)




Source: UKHSA HIV/STI Data Exchange (2023)

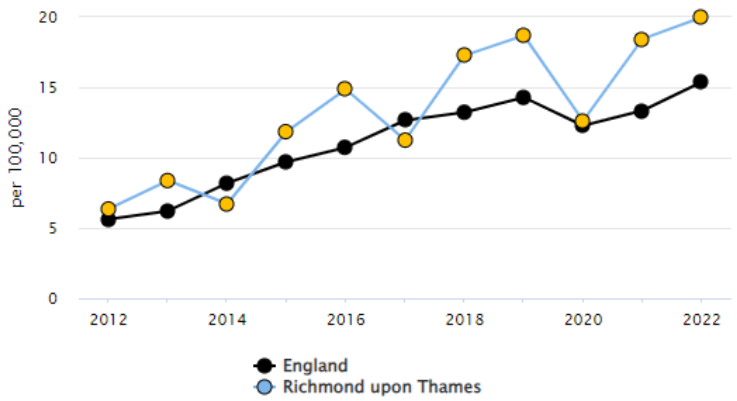
In Richmond residents, an estimated 3.1% of women and 8.2% of men diagnosed with gonorrhoea at a sexual and reproductive health service between 2016 and 2020 became reinfected within 12 months. Nationally, an estimated 4.1% of women and 11.2% of men became reinfected with gonorrhoea within 12 months. Increases in rates of gonorrhoea are particularly concerning due to the growing rise of antibiotic resistant strains[121].

Like gonorrhoea, syphilis symptoms are often hard to notice, can take up to three weeks to appear after infection and can change over time with symptoms disappearing but individuals remaining infectious. If left untreated syphilis can cause serious and life-threatening problems including heart failure, seizures, memory problems and dementia. It can also cause nerve problems, joint, skin and liver problems but these may not appear for many years after infection. Syphilis can also be passed on during pregnancy increasing the risk of miscarriage, prematurity and stillbirth[122].

Syphilis is also seeing a resurgence across the UK, with rates in England in 2022 increasing 15% on the previous year. Rates of syphilis in Richmond in 2022 were are at 20.0 per 100,000 which is below the London level of 44.9 but below the England level at 15.4. While trends over the last five points have not seen an overall increase there remains a need to increase prevention efforts.

121 Antibiotic-resistant strain of gonorrhoea detected in London - GOV.UK (www.gov.uk)
122 Syphilis - NHS (www.nhs.uk)

**Figure 55: Syphilis diagnostic rate per 100,000**

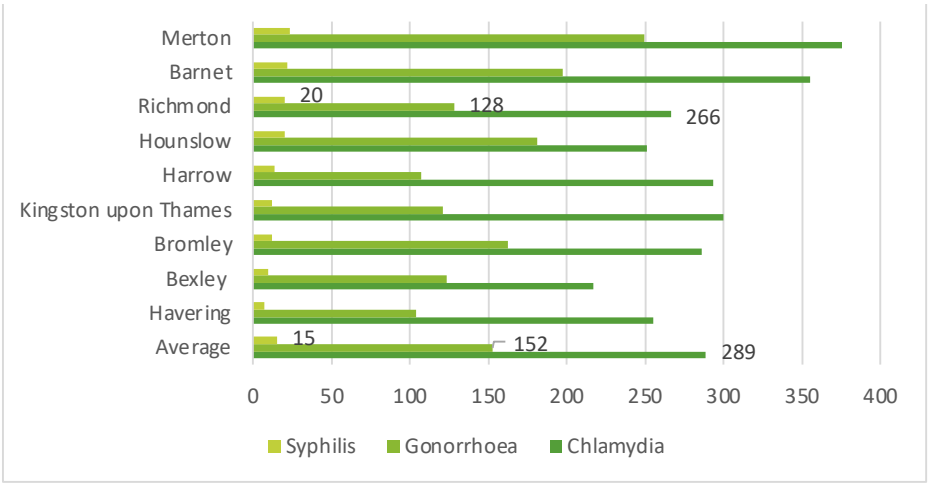



Source: OHID, Sexual and Reproductive Health Profiles (2023)

## STIs Compared

When comparing the three main bacterial STI diagnostic rates with statistical neighbours it can be discerned that Richmond rates in 2022 were similar to the average for chlamydia and gonorrhoea but ranks the third highest for syphilis. This perhaps indicates that there is greater need for both prevention and treatment services to be made available to its local population.

**Figure 56: Statistical neighbour comparisons for STIs**




Source: OHID, Sexual and Reproductive Health Profiles (2022)

Modelling of cost-effectiveness of self-sampling interventions for bacterial STIs (chlamydia, gonorrhoea and syphilis) have been deemed by NICE as highly cost effective through various Randomised Control Trials (RCTs). Additional costs generated by higher volumes of tests requested generate considerable additional QALYs as well as some downstream savings from preventing complications and secondary infections[123].

## Trichomoniasis

Trichomoniasis is a curable bacterial STI mostly affecting people aged 15 to 49 years. In women it can cause vaginal discharge, itching and painful urination but typically no symptoms in men. Up to half of all people will not develop any symptoms at all, though they can still pass on the infection[124]. The WHO has set a new global priority to reduce trichomoniasis by 50% by 2030[125]. England trends have been decreasing over the last five years with rates currently at 13.1 per 100,000, but rates across London are higher at 32.5 per 100,000. Richmond, in comparison, has lower than London and England rates, but has seen no significant change over the last 5 years, but rates are lower at 9.7 per 100,000 than ten years ago when rates in 2012 were 7.9 per 100,000.

## HIV

HIV (human immunodeficiency virus) is a virus that damages the cells in the immune system, weakening the body's ability to fight everyday infections and disease. AIDS (acquired immune deficiency syndrome) is the name used to describe a number of potentially life-threatening infections and illnesses that happen when the immune system has been severely damaged by the HIV virus. AIDS itself cannot be transmitted from one person to another, but the HIV virus can. Currently, there is no cure for HIV, but there are very effective drug treatments that enable most people with the virus to live a long and healthy life. With an early diagnosis and effective treatment, most people with HIV will not develop any AIDS-related illnesses and will live a normal lifespan.

The number of HIV diagnoses in England rose by 22% from 3,118 in 2021 to 3,805 in 2022. Most of this increase is attributable to people previously diagnosed abroad, a 69% increase from 805 in 2021 to 1,361 in 2022. The number of HIV diagnoses first made in England rose by 6% from 2,313 in 2021 to 2,444 in 2022, but variation between population groups remains[126].

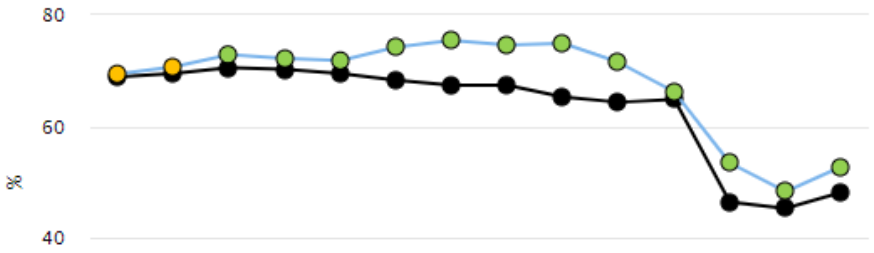
Early diagnosis of HIV has been shown to be cost effective with a cost per life year gained of £1776. Early diagnosis provides better outcomes for combination antiviral therapy providing a cost per life year gained of £4,639. Furthermore, cost-savings accrue due to prevented onward

123 NG221 Evidence review C: effectiveness, acceptability and cost effectiveness of strategies to improve uptake of STI testing (nice.org.uk)
124 https://www.nhs.uk/conditions/trichomoniasis/
125 WHO (2022) Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030
126 https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report

HIV transmission and reduced, expensive late diagnosis[127]. Universal HIV testing has been shown to not be cost-effective under the NICE cost-effective threshold. This outcome does not change with less frequent testing (every two to three years)[128].

New HIV testing, diagnosis, treatment and care data was released in October 2023. HIV testing data for Richmond varies between being statistically significantly similar or better than the England range, demonstrating reasonable access to HIV testing in the borough. 58.2% of those eligible for an HIV test in Richmond received one compared with 54% for London and 48.2% for England. A dip in testing coverage, however, can be seen because of the pandemic closures.

**Figure 57: HIV testing coverage, Richmond total**




Source: OHID, Sexual and Reproductive Health Profiles (2023)

Tuberculosis (TB) is the leading cause of death among people living with HIV (PLHIV). HIV targets the immune system and weakens people's defence systems against infections, leading to an increased risk of TB. PLHIV have up to 20 times higher risk of developing active TB compared to those without HIV infection[129]. Though numbers of TB notifications are small in Richmond at 14 in 2021, all of them (100%) were offered an HIV test.

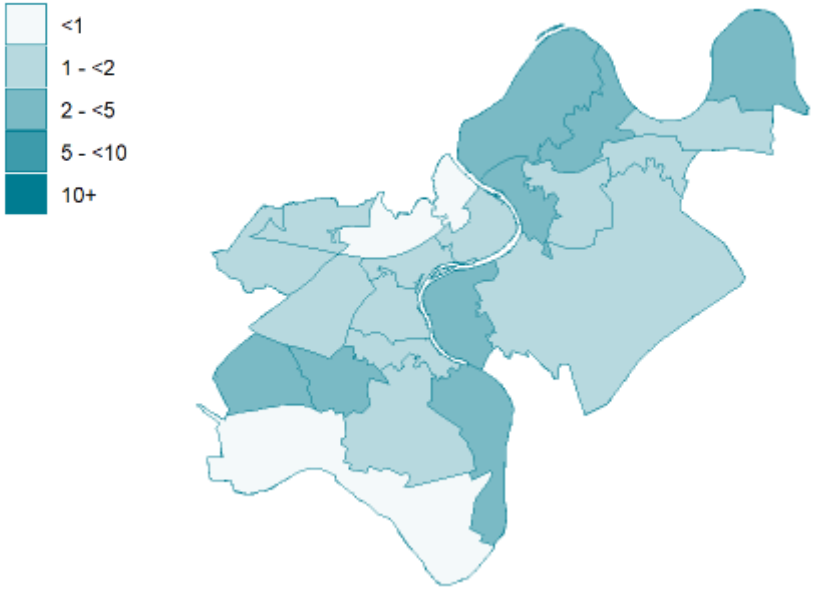
The HIV prevalence rate (rate of people aged 15 to 59 seen at HIV services in the UK) for Richmond in 2022 was 2.06 per 1000 which puts Richmond into an amber rating, indicating a need to increase HIV testing. This compares to a rate of 5.29 for London and 2.34 for England[130]. In 2022, an estimated 315 Richmond residents were living with HIV, which represents a rate of 4.34 per 1,000 population. Richmond's rates were similar to the London average of 1.61 per 1000 population but remained higher than England as a whole (1.67 per 1,000 population). In 2017, NICE defined high HIV prevalence local authorities as those with a diagnosed HIV prevalence of between 2 and 5 per 1,000 and extremely high prevalence local authorities as those with a diagnosed HIV prevalence of ≥5 per 1,000 people aged 15 to 59 years[131]. Richmond is therefore now classed as a low prevalence area.

13 residents in Richmond were newly diagnosed with HIV in 2022 with a rate of new HIV diagnosis per 100,000 population among people of all ages of 6.7 compared to 15.5 in London and 6.7 in England. Nationally there has been a declining trend of new HIV diagnosis[132]. The decrease highlights the success of combination HIV prevention which includes condom provision, PrEP, expanded HIV testing and prompt initiation of treatment after diagnosis. HIV prevalence across the borough is shown below.

127 The Cost-Effectiveness of Early Access to HIV Services and Starting cART in the UK 1996–2008 | PLOS ONE
128 Expanded HIV Testing in Low-Prevalence, High-Income Countries: A Cost-Effectiveness Analysis for the United Kingdom | PLOS ONE
129 HIV and Tuberculosis (who.int)
130 Public health profiles - OHID (phe.org.uk)
131 NICE guideline NG60 (2016) HIV testing: increasing uptake among people who may have undiagnosed HIV
132 Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

HIV diagnosis disproportionately affects GBMSM and some Black and minority ethnic groups. First HIV diagnoses made in England among GBMSM fell by 8% from 784 in 2021 to 724 in 2022. A 3% drop was observed in GBMSM living in London (252 to 244), with a 10% decline (532 to 480) among GBMSM living outside London. Trends in new diagnoses varied by ethnic group with the steepest fall in men of white ethnicity (17% from 508 to 420) between 2021 and 2022 but rises were observed among men of Asian (17% from 75 to 88) and mixed or other ethnicity (25% from 71 to 89). Among heterosexual men and women living in London, diagnoses rose by 14% from 284 in 2021 to 325 in 2022[133]. Further analysis of HIV demographics is contained within the disproportionately affected groups section of this report. Further analysis of HIV demographics is contained within the disproportionately affected groups section of this report.

**Figure 58: Diagnosed HIV prevalence per 1000 residents, 2022**




Source: SPLASH reports UKHSA (2023)

Late diagnosis (CD4 count less than 350 cells per mm3 within 91 days of diagnosis) is the most important predictor of HIV-related morbidity and mortality and is a key component of evaluating the success of HIV testing efforts. Care costs for late-stage HIV diagnosis have been estimated at £12,800 per annum per patient whereas care costs for early diagnosis have been estimated as £10,500[134].

At 25.0%, Richmond just tips into the NICE amber zone for late diagnosis, which is between 25% to 50% indicating more can be done to diagnose HIV at an earlier stage. In 2019, among those diagnosed in England, those diagnosed late had more than a 7-fold increased risk of death within a year of diagnosis[135] compared to those diagnosed promptly.

PrEP is a drug taken by HIV-negative individuals before they have sex to stop them acquiring HIV[136]. As part of a combination approach to HIV prevention, the roll out of routine PrEP commissioning began in England in the autumn of 2020. A new indicator for determining the PrEP need in a local population was added to public health profiles in 2022. It assesses the proportion of all HIV negative people accessing specialist sexual health services who are at substantial HIV risk, and therefore could benefit from receiving PrEP. In Richmond 490 individuals are identified as having a PrEP need and, current coverage is 12.6%. This is lower than the London coverage of 17.2% but above that of England at 9.7%. The proportion of individuals accessing specialist sexual health services with a PrEP need that start or continue PrEP in Richmond however, is 76.3%.

From 2020-22, the vast majority (92.0%) of newly diagnosed patients in the borough were put on antiretroviral treatment (ART) within 91 days of their diagnosis. Successful ART decreases a person's viral load, thereby significantly reduces the risk of future transmission and transforms HIV from a fatal infection to a chronic but manageable condition. The percentage of ART coverage in people accessing HIV care for Richmond is encouraging and stands at 97.5%, which exceeds the target of 95% of those receiving treatment to have viral load suppression.

HIV transmission does not occur when a patient's viral load is undetectable (VL ≤200 copies/ml) on ART, also known as Undetectable = Untransmittable (U=U). 98.7% of people accessing HIV care in Richmond have an undetectable viral load.

133 https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2023-report#conclusion
134 The Cost-Effectiveness of Early Access to HIV Services and Starting cART in the UK 1996–2008 | PLOS ONE
135 UK Health Security Agency (UKHSA). HIV testing, new HIV diagnoses, outcomes and quality of care for people accessing HIV services: 2021 report. 2020.
136 What is PrEP? – HIV Prevention England

**Key Findings**

This needs assessment recognises that there are concerning increases in the rise of STIs in recent years, which have been more significant across London than in other areas of the country. This increase is believed to be over and above the increase in testing capability. Some groups are more disproportionately affected than others and prevention activities, including access to testing and treatment should be targeted accordingly.

- Continue to support and emphasise HPV vaccination programmes in schools.
- Enhance chlamydia detection programmes through broadening chlamydia screening offer where possible – including encouraging more pharmacies in the north of the borough to offer chlamydia screening.
- Target testing for gonorrhoea and syphilis on undiagnosed individuals such as through partner notifications and promoting online testing programmes.
- Ensure awareness of full range of BBVs, including trichomoniasis are captured within RSHE and sexual and reproductive health education programmes.

Low diagnosis rates and low testing rate for STIs in Richmond highlights the lack of local sexual health clinics. Increasing local access to sexual health spoke services is critical to improving testing rates especially for Young People and GBMSM.

There is recognition that there is reasonable access to HIV testing in the borough, but this was hampered by the pandemic. Efforts to diagnose HIV as early as possible should be increased. This includes identifying and enabling underserved groups to increase access to PrEP.

- Continue to offer HIV and syphilis online screening and testing service through SH24
- Target HIV testing at high prevalence groups and those more likely to be diagnosed late
- Target PrEP uptake to relevant groups and in particular underserved groups
- Increase awareness of U=U
- Explore expanding provision of testing opportunities in general practice – with a view to rolling out an offer similar to that provided in Kingston

The Local Government Association highlights a number of case studies from councils across the country that have implemented local schemes to increase uptake of STI and HIV testing services. Some of these are highlighted in Appendix One.

## Safe Abortion Care

Where services are legal, readily accessible and available, abortions are generally safe. Safe abortion care includes provision of information; counselling; provision of medical and/or surgical abortion; recognition and management of complications from unsafe abortion; provision of postabortion contraception, when desired; and having in place referral systems for all required higher-level care. There is also evidence to suggest that women who have undergone an abortion experience an 81% increased risk of mental health problems, and nearly 10% of the incidence of mental health problems was shown to be attributable to abortion[137]. A 30-year longitudinal study carried out in New Zealand also suggests abortion may be associated with a small increase in risk of mental disorders. However, other pregnancy outcomes were not related to increased risk of mental health problems[138]. This suggests that women accessing abortion services may need additional mental health support.

Between 2014 and 2021 rates of abortion in Richmond remained consistently lower than in London and England. The total abortion rate per 1000 females has remained stable over the last 5 years and at 15.2 per 1000 is lower than London rate of 20.9 and England at 19.2 per 1000

### Total Abortion Rates

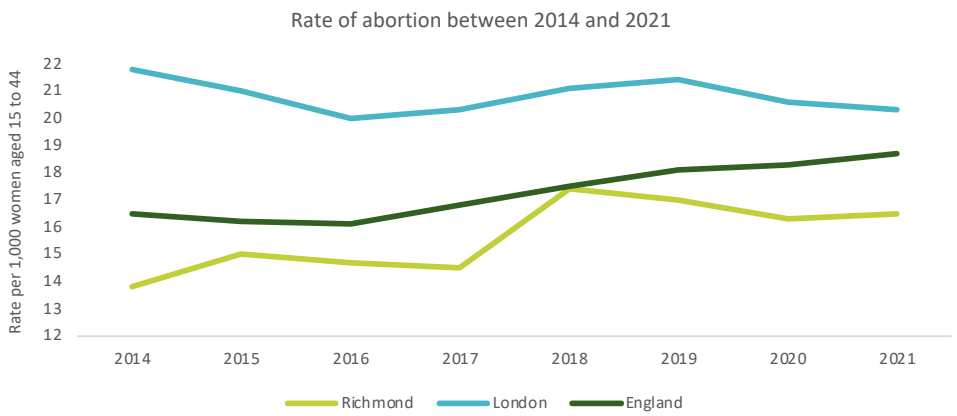
Nationally, the rate of abortions has increased year on year since 2015, and in 2021 the rate reached an all-time high of 18.6 per 1000 women aged 15 to 44. The same trend has not been observed in London. By contrast, the rate of abortion in London has declined over the past eight years.

.Like in England, a general trend of increase was also observed in Richmond. Between 2014 and 2018, the rate of abortion in Richmond increased from 13.8 per 1,000 women to 17.4 per 1000 women aged 15 to 44. A slight reduction in rate was observed between 2019 and 2021. In 2021, the rate of abortion was 16.5 per 1000 women aged 15 to 44.

137 Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009 | The British Journal of Psychiatry | Cambridge Core

138 Abortion and mental health disorders: evidence from a 30-year longitudinal study | The British Journal of Psychiatry | Cambridge Core

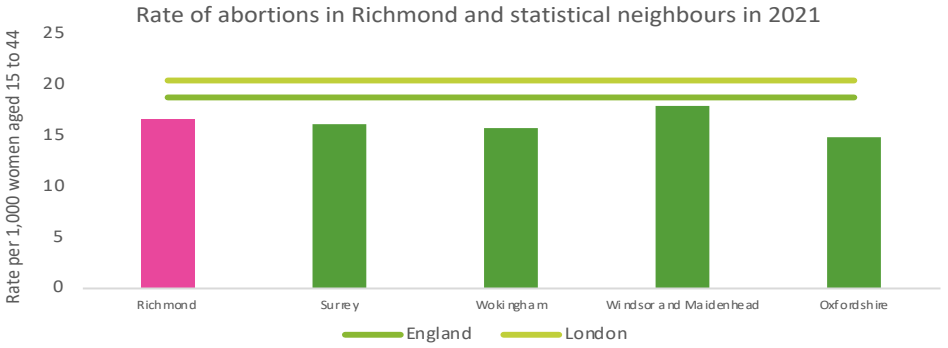
### Figure 59: Rates of abortion 2014 to 2021




Source: OHID, abortion statistics, England and Wales (2021)

In 2021, the rate of abortion in Richmond was 16.5 per 1000 women aged 15 to 44. This was lower than the average rate for both England and London, as well as the rate of abortion in Windsor and Maidenhead. The rate of abortion in Richmond was slightly higher than the rate of abortion in Surrey, Wokingham and Oxfordshire although this was not statistically significant.

### Figure 60: Rate of abortion Richmond and statistical neighbours (2021)



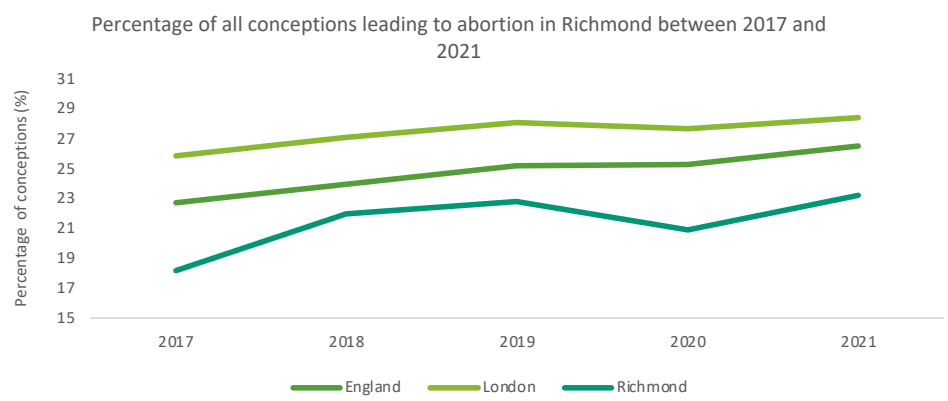

Source: OHID, abortion statistics, England and Wales (2021)

Between 2017 and 2021, the percentage of conceptions leading to abortion increased in

Richmond. The percentage of conceptions leading to abortion in Richmond increased from 18.2% to 23.3%. An increase in the percentage of conceptions leading to abortion was also observed in England and London. This may indicate a national increase in unplanned pregnancies, and therefore unmet needs in contraceptive care and services.

Richmond saw a reduced percentage of conceptions leading to abortion in 2020, followed by an increased rate in 2021. This decrease in 2020 was not observed in England, and was minimal in London.

### Figure 61: Conceptions leading to abortion 2017 to 2021

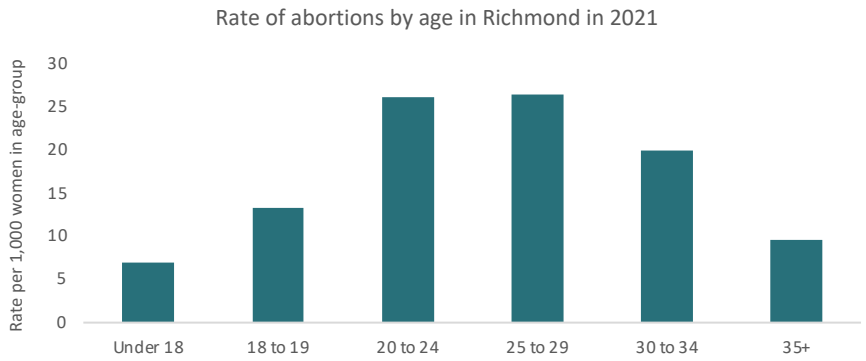



Source: OHID, abortion statistics, England and Wales (2021)

## Abortion by Age

In 2021, the rate of abortions in Richmond was highest in the 20 to 24 age group (26.2 per 1,000 women aged 15 to 44) and 25 to 29 age group (26.4 per 1,000 women aged 15 to 44). The lowest rate of abortions was in the under-18 age group (6.9 per 1,000 women aged 15 to 44).

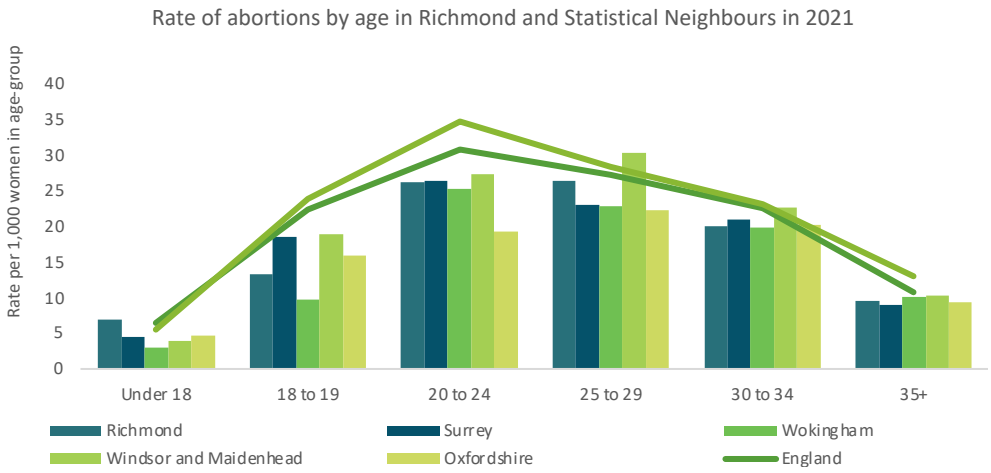
**Figure 62: Rate of abortion by age (2021)**




Source: OHID, abortion statistics, England and Wales (2021)

In 2021, the rate of under-18 abortions in Richmond was 6.9 per 1000 women which was higher than in England (6.5), London (5.5) and all statistical neighbours, which averaged 4.1 per 1000. Yet, the rate of abortions in Richmond within the 18 to 19 age group was 13.3 per 1000 which was lower than the rate in England (22.4) and London (23.9) and most statistical neighbours which averaged to 15.8 per 1000. The rate of abortions among the 20 to 24 age group was 26.4 per 1000 in Richmond which was lower than the England (30.9) and London (34.8) average, but in line with statistical neighbours (24.6 on average). The rate of abortions among the 25 to 29 at 26.4 per 1000 was slightly higher than statistical neighbours, with the exception of Windsor and Maidenhead (30.3); For age groups aged 30+ Richmond was similar to other statistical neighbours.

**Figure 63: Rate of abortion by age in Richmond and its statistical neighbours (2021)**




Source: OHID, abortion statistics, England and Wales (2021)

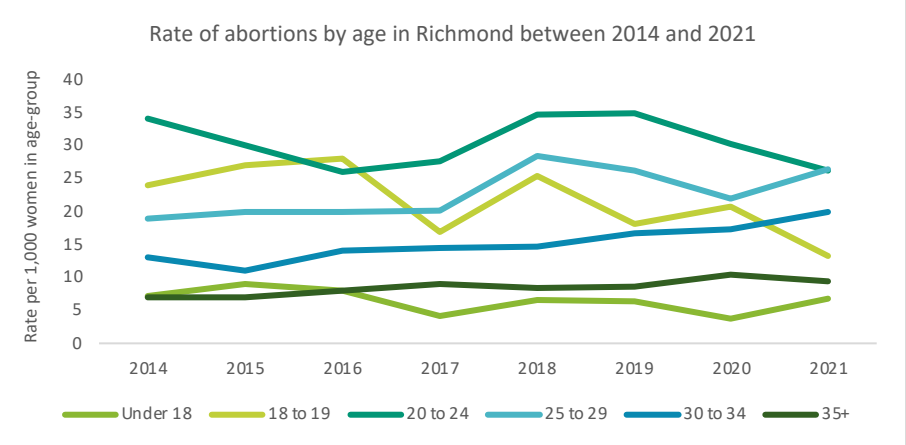
All age groups in Richmond saw fluctuating rates of abortion between 2014 and 2021. These fluctuations are likely to be a result of the small number of abortions occurring within the borough.

Whilst the under-18, 18 to 19 and 20 to 24 age groups saw a general trend of decline in abortion rates over the period, the 25 to 29, 30 to 34, and 35+ age groups saw a general increase in trends.

The COVID-19 pandemic impacted the rate of abortions for most age groups in Richmond. In 2020, with the exception of the 18 to 19 and 30 to 34 age groups, all other groups saw reduced rates of abortion. This is likely a consequence of restricted access to abortion services, as well as the exodus of young people aged 18 to 29 from London over the height of lockdown periods.[139]

139 London's population changes during the COVID-19 pandemic – London Datastore

**Figure 64: Rate of abortion by age (2014 to 2021)**




Source: OHID, abortion statistics, England and Wales (2021)

The largest increases in abortion rates in Richmond by age are now among women aged 30 to 34 which have increased by 47% from 13.6 per 1000 in 2016 to 20.0 per 1000 in 2021. This may indicate that, while strategies to increase access to contraception and sexual health services have had an impact on the women aged 20 and under, women aged over 25 should be included within targeted prevention interventions.

**Table 11: Changes in the Richmond abortion rate by age, 2016 to 2021**

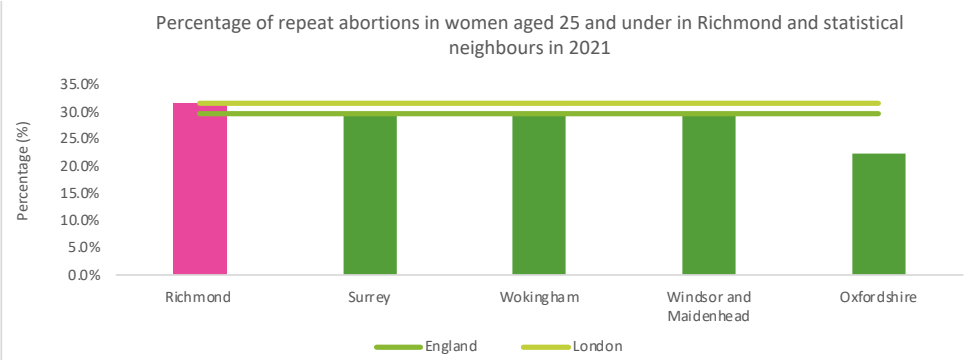
| | Under 18 | 18-19 | 20-24 | 25-29 | 30-34 | 35 + |
|---|---|---|---|---|---|---|
| 2016 | *7.9* | *28.4* | *26.2* | *19.6* | *13.6* | *8.2* |
| 2021 | 6.9 | 13.3 | 26.2 | 26.4 | 20.0 | 9.5 |
| % -/+ | -13% | -53% | 0% | 34% | 47% | 16% |

Source: OHID, abortion statistics, England and Wales (2021)

## Repeat Abortions

In Richmond, just under one-third (31.5%) of women aged <25 undergoing an abortion in 2021 had one or more previous abortions. This was in line with London (31.6%), but slightly higher than England (29.7%). Richmond also had a higher percentage of repeat abortions than all statistical neighbours, which averaged 28.5%.

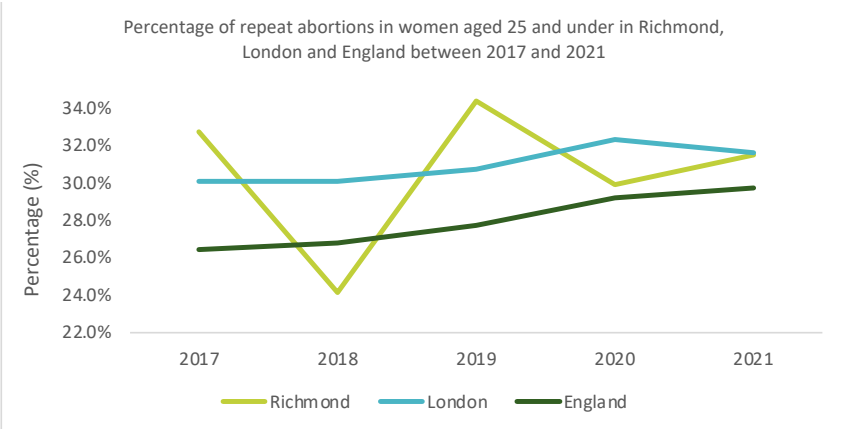
**Figure 65: Repeat abortions in women under 25 and statistical neighbours**




Source: OHID, abortion statistics, England and Wales (2021)

A general increase was also observed in the five year repeat abortion trend in London and England. In Richmond, the percentage of repeat abortions in women aged 25 and under over the period fluctuated massively year-on-year. This is inconsistent with the trend in Richmond, London, and England. This may be due to low numbers of abortions in the borough.

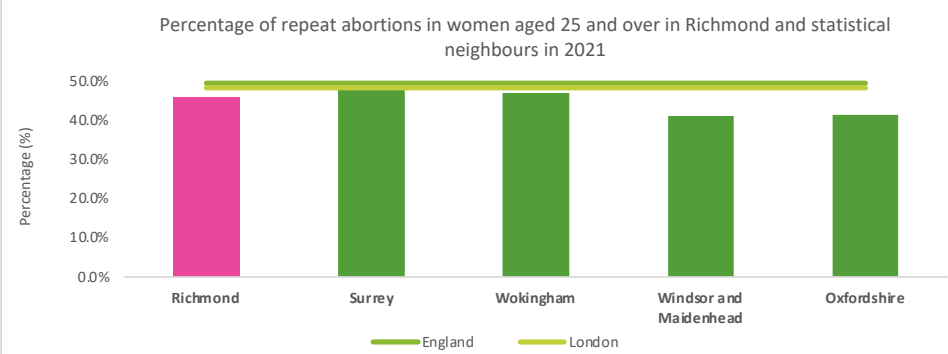
**Figure 66: Percentage of repeat abortions (2017 to 2021)**




Source: OHID, abortion statistics, England and Wales (2021)

In Richmond, almost half (45.9%) of women aged 25 and over undergoing an abortion in 2021 had one or more previous abortions. This was lower than the percentage of repeat abortions in London (48.4%) and England (49.6%). Compared to statistical neighbours, the percentage of repeat abortions was lower than in Surrey and Wokingham, but higher than in Oxfordshire and Windsor and Maidenhead.

### Figure 67: Repeat abortions and statistical neighbours (2021)

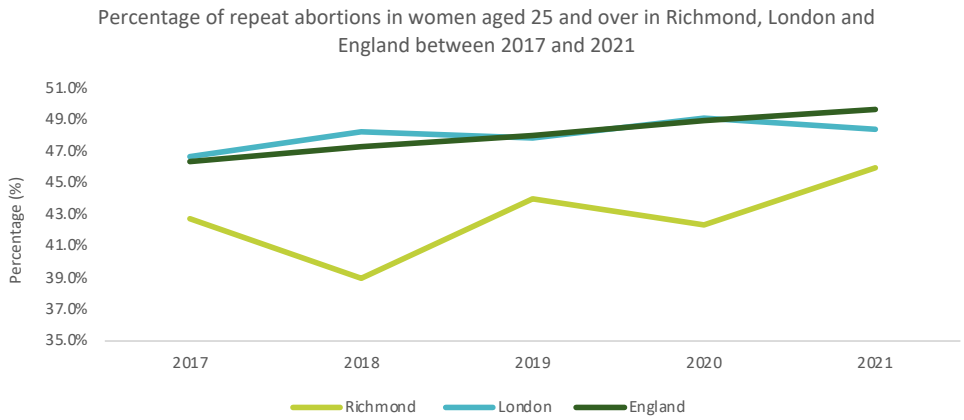



Source: OHID, abortion statistics, England and Wales (2021)

Between 2017 and 2021, the percentage of repeat abortions in women aged 25 and over in Richmond was consistently lower than in London and England. Whilst the average percentage of repeat abortions in women aged 25 and over in London and England was 48%, in Richmond it was 42.8%. All areas saw a general trend of an increased percentage of repeat abortions within this age group over this period. This may indicate unmet needs in contraceptive care and services across the country. Repeat abortions can also be an indication of domestic abuse and/or exploitation.[140] Professionals need be aware of this link to ensure people at risk are identified and enabled to seek help.

However, the percentage of repeat abortions in women aged 25 and over in Richmond saw greater fluctuations than in London and England. This might be due to low numbers of abortions in the borough.

### Figure 68: Repeat abortions from 2017 to 2021

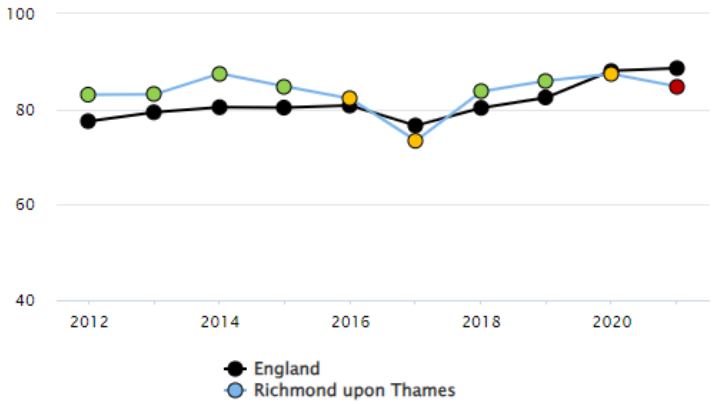



Source: OHID, abortion statistics, England and Wales (2021)

## Early Abortions

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion at an early stage of pregnancy, is also cost-effective and an indicator of service quality. The percentage of abortions performed under 10 weeks in Richmond (84.8%) is similar to 2012, is the lowest of all London boroughs and is below that of for both England (88.6%) and London (88.8%). Richmond rates are now statistically worse than London and this likely indicates that more could be done to ensure Richmond residents get equal access to abortion services.

### Figure 69: Abortions under 10 weeks (%)



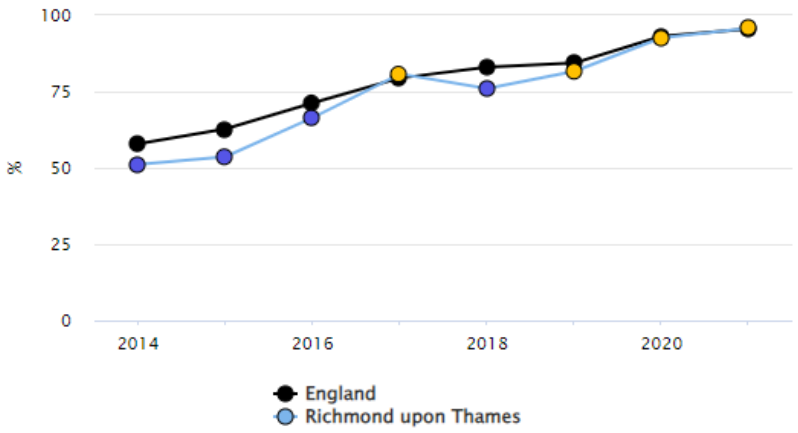

Source: OHID Fingertips, Sexual and Reproductive Health Profiles (2023)

140 Domestic Abuse Statutory Guidance (publishing.service.gov.uk)

Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve instrumentation or the use of anaesthetics[141]. Medical abortions are also cheaper. The percentage of medical abortions performed under 10 weeks demonstrates local transparency on the extent of medical and surgical services available to women and will thus be an indicator of patient choice. A very low or a very high percentage of medical abortions compared to other areas could be an issue for concern.

The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall percentage of abortions performed at under ten weeks gestation. However, women may prefer a surgical abortion under local or general anaesthesia/conscious sedation for a variety of reasons such as wishing to avoid the experience of going through an induced pregnancy loss; intrauterine contraception can be fitted at the same time; and only one visit is required to the provider site (medical abortions typically require two trips). There is also a new manual vacuum aspiration (MVA) technique which is a quicker and cheaper surgical procedure that does not require an anaesthetic[142], [143]. In Richmond, 95.8% abortions under 10 weeks were medical compared to 94.0% for London and 95.5% for England, this was the third highest in London.

**Figure 70: Abortions under 10 weeks that are medical (%)**




Source: OHID Fingertips, Sexual and Reproductive Health Profiles (2023)

**Key Findings:**

The total abortion rate has remained stable over the last five years, though the percentage of conceptions leading to abortion has increased possibly indicating an increase in unplanned pregnancies and a possible unmet need in contraceptive services and care.

Increases in abortion rates for women aged 25 to 29 may indicate a need to target prevention to older women.

- Continue to ensure EHC / contraception is available to women over the age of 24 and is widely advertised.

Increases in repeat abortions can indicate a lack of access to good quality contraceptive care.

- Increase availability of online contraception services
- Improve referral to contraceptive provision post abortion

## Sexual Function and Psychosexual Counselling

Sexual function represents the complex interaction of various physiological, psychological, physical and interpersonal factors[144]. Poor sexual function or sexual dysfunction are syndromes that comprise a cluster of ways in which adults may have difficulty experiencing personally satisfying sexual activities. Identifying and addressing sexual concerns and difficulties, as well as offering treatment for sexual dysfunction and disorders, are critical components of sexual health care. Psychosexual counselling provides patients with both support and specific information or advice relating to their sexual concerns; this can facilitate a return to satisfying sexual activity. Such treatment focuses on making adjustment to sexual practices or to enhance methods of coping with a sexual event or disorder. Pharmacotherapies may also be part of the treatment.

Sexual health need changes throughout the life course for women and men. The onset of the menopause and decreases in testosterone in later life can impact on sexual functioning but, due to ongoing stigma, this is often not talked about or explored in depth. Studies into the prevalence of sexual dysfunction estimate that it is highly prevalent, affecting about 43% of women and 31% of men. Hypoactive sexual desire disorder has been reported in approximately 30% of women and 15% of men in population-based studies. Sexual arousal disorders, including erectile dysfunction in men and female sexual arousal disorder in women, are found in 10% to 20% of men and women respectively, and is strongly age-related in men. A 2021 Pharmacy Direct survey of 2000 UK adults found that almost half (48%) said they experienced erectile dysfunction with 12% saying they always experience erectile dysfunction[145].

141 https://fingertips.phe.org.uk/search/medical%20abortion
142 Blaylock R, Makleff S, Whitehouse KC, et al. BMJ Sex Reprod Health Published Online First: [2021]. doi:10.1136/bmjsrh-2021-201242
143 Abortion statistics, England and Wales: 2021 - GOV.UK (www.gov.uk)

144 WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
145 https://pharmacydirectgb.co.uk/erectile-dysfunction-statistics-facts-figures-in-the-uk-in-2021/#:~:text=Erectile%20dysfunction%3A%20key%20statistics%20of,equivalent%20of%2016.5%20million%20people.

A review of studies published in the BJU found that erectile dysfunction is linked with increased risks of cardiovascular disease, dementia, and early death and affects up to one in five men (4.3 million men) across the UK. Early detection may help improve the quality of life in affected men and indicate when interventions may be warranted to support early identification of cardiovascular disease and consideration of treatment to prevent premature death[146].

Orgasmic disorder is relatively common in women, affecting about 10% to 15% in community-based studies. In contrast, premature ejaculation is the most common sexual complaint of men, with a reporting rate of approximately 30% in most studies. Finally, sexual pain disorders have been reported in 10% to 15% of women and less than 5% of men. Sexual dysfunction disorders have been found to impact significantly on interpersonal functioning and overall quality of life in both men and women[147]. While psychosexual counselling is offered as part of the integrated sexual health service, it accounts for only 1% of service activity in Richmond. The psychosexual service is accessed by just under 170 people each year with those aged 21-30 accessing more than other aged groups, perhaps indicating a greater openness to disclose concerns alongside reflecting the general user age of the service.

Sexual difficulties are common in patients with neurological disorders and can affect different areas of sexual function including desire, arousal, orgasm, and ejaculation. Reviews of studies into sexual functioning demonstrate that advances in structural and functional neuroimaging have contributed to a greater understanding of the neural pathways involved in the regulation of sexual functions options for managing sexual dysfunction in men and women, however, remain poor. Research into different domains of sexual dysfunction is likely to lead to additional therapeutic strategies in the future[148].

**Key Findings:**

**Sexual dysfunction disorders have been found to impact significantly on interpersonal functioning and overall quality of life in both men and women. Sexual dysfunction in men may indicate other risks in relation to cardiovascular disease, dementia and early death.**

- Ensure sexual dysfunction in men is included within sexual and reproductive health education, heart health and dementia awareness campaigns. Including where and when to get help.

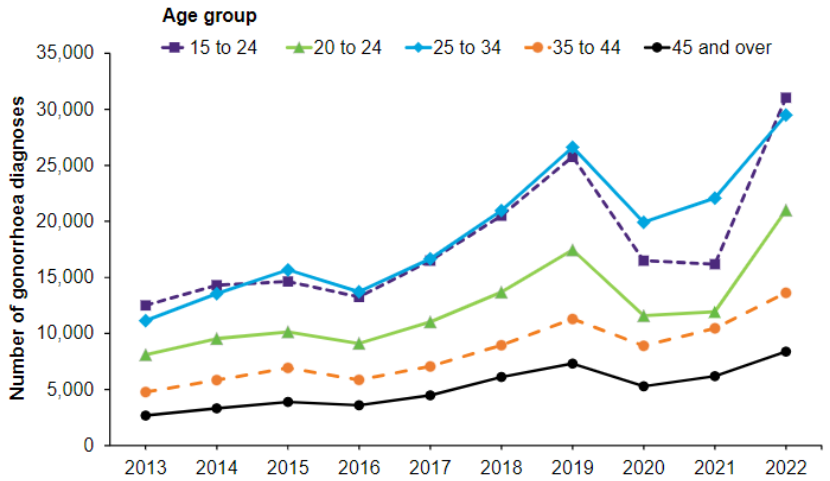
146 https://www.kcl.ac.uk/news/the-global-prevalence-of-erectile-dysfunction
147 Rosen RC. Prevalence and risk factors of sexual dysfunction in men and women. Curr Psychiatry Rep. 2000 Jun;2(3):189-95. doi: 10.1007/s11920-996-0006-2. PMID: 11122954.
148 Approach and management to patients with neurological disorders reporting sexual dysfunction - The Lancet Neurology

# Disproportionately Affected Groups

## Young People

Young people aged 15-24 years are at high-risk of STIs. This may be due to higher rates of partner change among those aged 16 to 24 years[149]. Young women may be more likely to diagnosed with an STI due to disassortative sexual mixing (when partnerships form between higher and lower risk people by age and gender)[150], [151]. Compared to 2021, the number of new STI diagnoses in 2022 among 15-to-24-year-olds increased by 26.5% (129,938 to 164,337), largely due to the near doubling of cases of gonorrhoea over the same period (91.7% increase from 16,191 to 31,037:

**Figure 71: Number of gonorrhoea diagnoses by age group, 2013 to 2022**

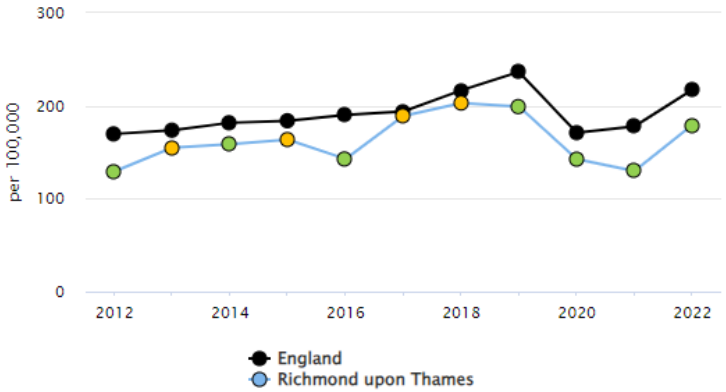



Source: GUMCAD STI and CTAD Chlamydia Surveillance Systems (2023)

In 2022 41.4% of diagnoses of new STIs made in SRH services and non-specialist SRH services in Richmond residents were in young people aged 15 to 24 years old. This compares to 45.7% in England. The prevalence and diagnosis of chlamydia is also higher in young people compared to those over 25.

In Richmond in 2022 the chlamydia diagnostic rate amongst all ages was 266 per 100,000. However, when only considering those in the population aged 25 years old and over, the chlamydia diagnostic rate is lower at 179 per 100,000. A general upward trend in this diagnostic rate over the last 10 years can be seen. This could be due to both an increase in chlamydia infections, increasing awareness and subsequent screening and testing among older groups. Richmond rates are significantly better than the England rate of 217 per 100,000. This may indicate the lack of access to sexual health services for adults in Richmond, masking the actual prevalence in the population. A dip during the COVID-19 pandemic would suggest reduced access to screening due to service closures during the pandemic.

**Figure 72: Chlamydia diagnostic rate per 100,000 aged 25 years and older**




Source: OHID Fingertips, Sexual and Reproductive Health Profiles (2023)

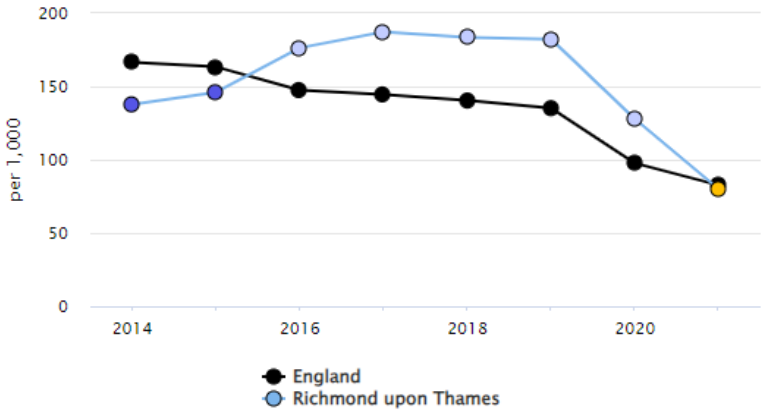
However, the number and rate of under 25s attending specialist contraceptive services has been falling nationally, across London and this trend is mirrored in Richmond. Attendance indicators provide commissioners and service providers with a measure of young peoples' access to specialist contraceptive services. The unique individuals view helps identify the degree of success regarding targeting this age group for each sex. In Richmond the rate for 2021 was 80.1/1000 females compared to 102.3 for the London region and 82.6/1000 for England.

149 Mercer CH, Tanton C, Prah P, Erens B and others. 'Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)'. The Lancet. 2013; volume 382: pages 1781 to 94

150 Geary RS, Copas AJ, Sonnenberg P, Tanton C and others. 'Sexual mixing in opposite-sex partnerships in Britain and its implications for STI risk: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)'. International Journal of Epidemiology. 2019; volume 48: pages 228 to 242

151 Doherty IA, Schoenbach VJ, Adimora AA. Sexual mixing patterns and heterosexual HIV transmission among African Americans in the southeastern United States. J Acquir Immune Defic Syndr. 2009 Sep 1;52(1):114-20. doi: 10.1097/QAI.0b013e3181ab5e10. PMID: 19506485; PMCID: PMC2741169.

**Figure 73: Under 25s attending specialist contraceptive services / 1000 females**




Source: OHID Fingertips, Sexual and Reproductive Health Profiles (2023)

The reduction in attendance at sexual health services has been in the most part intentional to reduce the numbers of people attending for routine and non-complex STI testing. This has been coined as 'channel shift' to increase the numbers of people accessing online self-testing services. Access to online services are more likely used by young people.

Consultation with professionals working with young people conducted as part of the ISH service review in Richmond pulled out key themes in relation to restricted access, knowledge and perception of sexual health largely fuelled by social media.

Current service location of the main hub at Falcon Road was felt to be a barrier to some young people, particularly those who can't access due to gang related issues and young people unable to travel to Clapham junction for fear of parents finding out. The telephone service was felt to be a barrier as young people are less likely to use phone calls to book appointments and unwilling to wait for long phone messaging systems. There still remains some concerns in relation to whether the service is confidential but increased opportunities for online services was felt to be beneficial. Improving sexual health outreach in schools such as through school health services providing STI screening, testing, condoms and contraception was felt to be a way forward but would need support from schools and their governors. Involving young people in the development of sexual health services was felt to be key to ensuring young people went on to use services. Consultation with young people across both Richmond and Wandsworth revealed their priorities for improving access to sexual health services would include:

- Young people focussed sexual health walk-in services.
- On-site provision of school and college based sexual health services.
- Assurance that sexual health services are FREE and CONFIDENTIAL
- Teachers trained in the delivery of RSE.
- Information on where, when and how to access sexual health support.
- More information on sexual and reproductive health through the life course.
- Online provision of STI testing and contraception.
- Interactive chat health websites for young people to ask questions in real-time.
- Promotion of Gettingiton young people's website.

A young people's review conducted by Spectra in 2022 found a preference for young people to access support in non-clinical settings. Integrating a service offer into other settings used by young people is being trialled and supported by the young people's service, but is dependent on service capacity, and the receptiveness of existing service providers working with young people, including colleges, and targeted services.

In terms of knowledge and perception of sexual health professionals working with young people cited young people's reluctance to use condoms due to both reduction in pleasure and peer pressure not to use them. Misinformation in social media was thought to be a barrier to improving sexual health knowledge. Social media campaigns combatting misinformation were therefore seen to be crucial to combat this.

Key Findings:

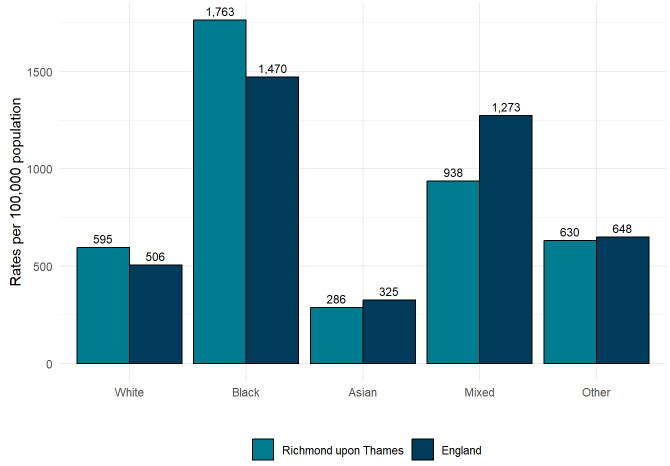
Young people aged 25 and under are disproportionately affected by poor sexual health outcomes. Enabling access to sexual health services, particularly for young people at greater risk than others is key to a successful strategy. The significant distance to Falcon Road services from Richmond is a key issue for young people being able to access appropriate treatment. Top priorities identified by young people should be included within the next strategy.

## Black and Minority Ethnic Groups

Some Black and minority ethnic groups are disproportionately affected by both STIs and HIV. In 2022, there was a total of 36,747 diagnoses of new STIs among people of Black ethnicity (9.4% of the total number of new STI diagnoses) in England. In London, although only 9% of new STIs are in black Caribbean residents, they have the highest rate: 2,857 per 100,000, which is twice the rate seen in the white ethnic group. However, compared to other ethnic groups, the black Caribbean ethnic group also saw the largest fall in its diagnosis rate when 2022 is compared to 2019. The rate of 2,857.3 per 100,000 black Caribbean population was 29% lower than in 2019, but 12% higher than in 2021. The white ethnic group in London has the highest number of new STI diagnoses: 61,201 (56%) and a new STI diagnosis rate of 1,293.6, 14% lower than in 2019 but 24% higher than in 2021[152].

In Richmond rates of STIs in White and Asian ethnic groups are higher when compared with England, but lower for Black, mixed and other ethnic groups.

**Figure 74: New STIs by ethnic group per 100,000 population in Richmond and England 2022**

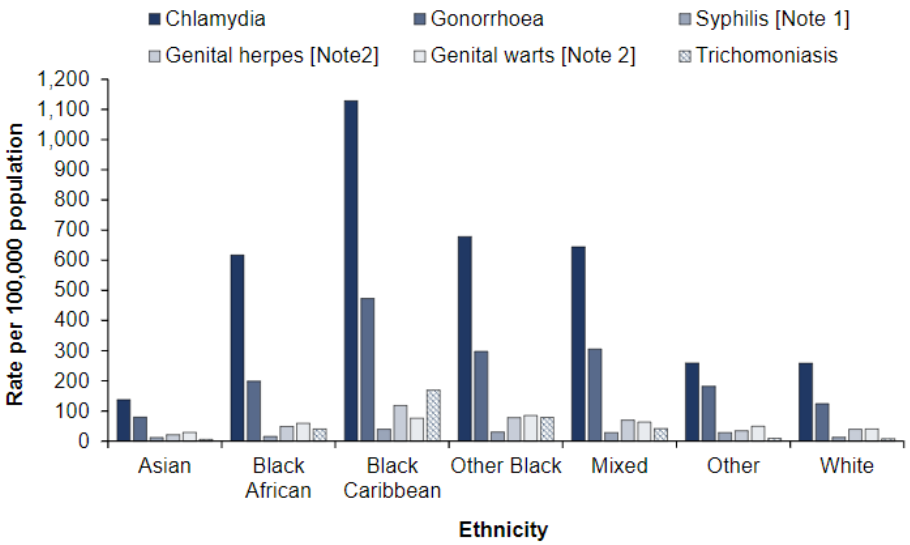



Source: GUMCAD STI Surveillance System (2023)

Overall, STI diagnosis rates were highest among those of Black ethnicity although this varied between the different Black ethnic groups. In 2022, people of Black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, infectious syphilis, trichomoniasis, and genital herpes, while people of Black African ethnicity had relatively lower rates of STIs.[153]

152 Spotlight on sexually transmitted infections in London: 2022 data - GOV.UK (www.gov.uk)
153 Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)

**Figure 75: Rates of selected STI diagnoses among England residents accessing sexual health services by ethnicity and STI, 2022**



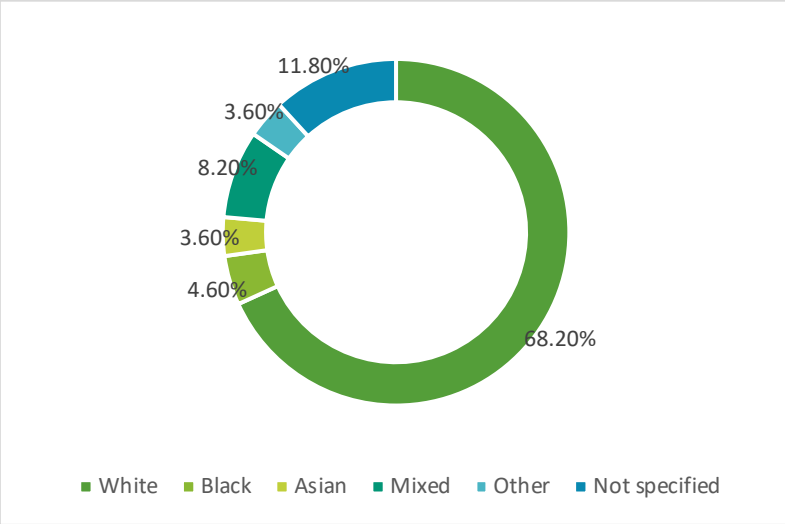

Source: UKHSA STI and Chlamydia Screening report (2023)

National research found, when compared to all other ethnic groups, there were no unique clinical or behavioural factors explaining the disproportionately high rates of STI diagnoses amongst people of Black Caribbean ethnicity. This ethnic disparity in STIs is therefore likely influenced by underlying socio-economic factors and the role they play in the structural determinants of the health of this community[154].

There is over representation of new STI diagnoses amongst those of Black ethnic compared to the local population in Richmond. In the 2021 census, 1.9% of people described themselves as Black, Black British, Black Welsh, Caribbean or African whereas 4.6% of STI diagnosis were in Black ethnic groups.

154 Bardsley M, Wayal S, Blomquist P, Mohammed C and others. 'Improving our understanding of the disproportionate incidence of STIs in heterosexual-identifying people of black Caribbean heritage: findings from a longitudinal study of sexual health clinic attendees in England'. Sexually Transmitted Infections. 2022; volume 98: pages 23 to 31.

**Figure 76: Proportion of STI diagnosis by ethnicity in Richmond, 2020/21**

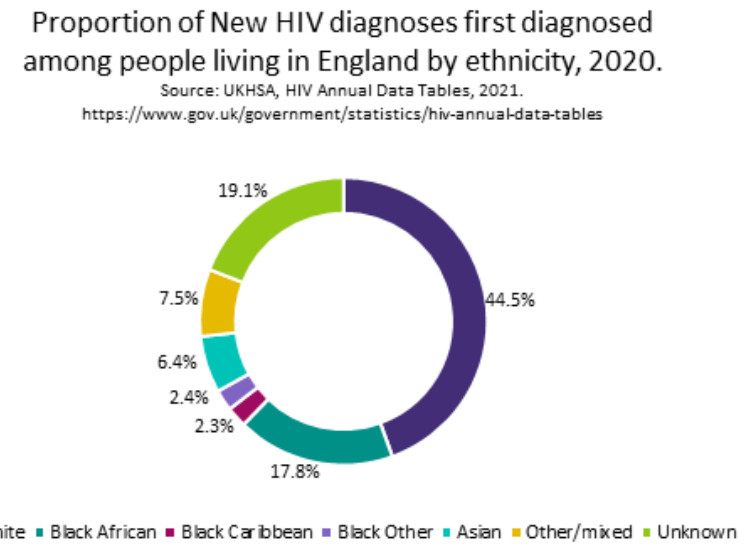



Source: GUMCAD STI Surveillance System (2023)

Where recorded, 25.6% of new STIs diagnosed in Richmond residents in 2020/21 were in people born overseas. A similar trend can be seen for HIV prevalence. While there is limited local data available, local characteristics are thought to mirror the regional picture.

For those living in England there were a total of 1,987 new HIV diagnoses in 2020. Where ethnicity was known, the majority were White (44.5%) or Black African (17.8%).

**Figure 77: Proportion of new HIV diagnoses among people living in England by ethnicity**




Source: Summary Profiles of Local Authority Sexual Health (SPLASH) report supplement (2023)

A study carried out in America demonstrated that expanding HIV testing with disproportionately affected groups, including Black populations resulted in a return of $1.95 for every $1 invested[155].

Consultation with mainly south Asian older women conducted as part of the ISH service review provided valuable insights into the cultural challenges of engaging in sexual health conversations. While participants were initially reluctant to talk about sexual health as they did not feel it was any longer relevant to their lifestyles, they agreed that open conversations would be helpful for encouraging younger generations, over whom they have influence, to seek advice and support. Some key themes emerged through the conversation:

Sexual and reproductive health was generally seen a taboo subject, but there were lessons to be learned from mental health, HIV and cancers, which are now more widely accepted topics of conversation. This change came about due to television programmes and wider advertising.

Participants felt that their first point of call for any health issue would be their GP and they would feel comfortable talking about reproductive health with a GP of the same gender. However, some expressed embarrassment about seeking support for help with thrush, for example.

155 Return on Public Health Investment: CDC's Expanded HIV Testi... : JAIDS Journal of Acquired Immune Deficiency Syndromes (lww.com)

The group felt that older generations would benefit from information and adverts about sexual health and relationships in the later years to normalise the discussion. For example, they cited the work that Lady Diana had done to change attitudes toward reduce stigma around HIV. TV programmes such as 'Embarrassing Bodies' have helped both younger and older generations to gain knowledge about different infections and diseases, encouraging people to seek help. These programmes are important to encourage conversations. Information and education on sexual and reproductive health would be helpful for older generations from different ethnic backgrounds and would be more acceptable if linked to conversations about bladder health.

The group felt specifically that if older generations knew more about sexual and reproductive health they would be in a better position to guide and influence younger generations to help keep them safe. Younger generations would also be in a better position to teach older generations about societal changes such as being more accepting of LGBTQ+ people. Familial pressure of older generations for younger generations to produce grandchildren could also be relieved through older generations developing an understanding about conception, fertility and choice.

Key Findings

Black, minority ethnic groups are disproportionately affected by poor sexual health, with the black Carribbean community fairing particularly worse. Prevention programmes should be targeted to reach these communities. This may be strengthened through:

Engaging and training health champions from these groups to raise awareness of sexual and reproductive health.

Continue to offer online targeted STI and HIV testing as well as walk-in clinics.

Sexual and reproductive health education

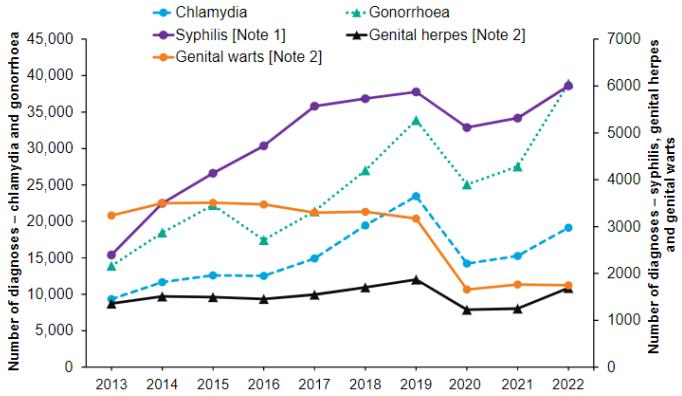
Black African women should be prioritised for increased rates of HIV testing and access to PrEP.

## Gay, Bisexual and other Men who have Sex with Men (GBMSM)

### STIs

Nationally, the number of bacterial STI diagnoses among GBMSM increased from 2013 to 2019 before dropping in 2020. In keeping with the recovery of sexual health service provision and increased STI testing in 2021 and 2022, there were increases in bacterial STI diagnoses amongst GBMSM over this period: gonorrhoea increased 41.3% (27,545 to 38,923), chlamydia increased by 25.3% (15,267 to 19,129) and infectious syphilis increased 12.9% (5,316 to 6,003).

**Figure 78: Diagnoses of selected STIs among GBMSM accessing sexual health services**




Source: UKHSA STI and Chlamydia Screening report (2023)

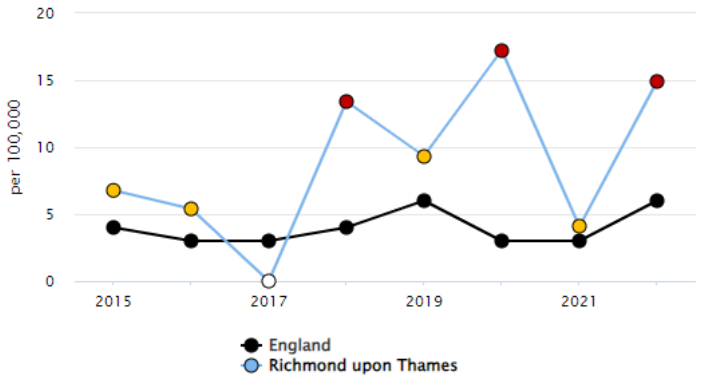
The estimated new STI diagnosis rate for GBMSM London residents in 2022 was 21,133.3 per 100,000, 15 times higher than the rate observed for Londoners as a whole. However, this rate for GBMSM is likely to be an overestimate, due to under-reporting of gay and bisexual sexual orientations in the census, from which the denominator is derived. Where gender and sexual orientation are known, GBMSM account for 49% of London residents diagnosed with a new STI (excluding chlamydia diagnoses reported via CTAD), 86% of cases diagnosed with syphilis and 73% of cases diagnosed with gonorrhoea. The number of new STIs diagnosed in GBMSM in London in 2022 was 31% higher than in 2021, and over this period there was a 39% increase in gonorrhoea and 14% increase in syphilis diagnoses[156].

There have also been increases in less frequently reported STIs such as lymphogranuloma venereum (LGV) (82.8%, from 570 in 2021 to 1,042 in 2022)[157], as well as an increase in cases of shigellosis and recent outbreaks in 2022 of extensively drug-resistant Shigella sonnei and S. flexneri[158]. Shigella is a gut infection that causes diarrhoea (sometimes mixed with blood),

156 Spotlight on sexually transmitted infections in London: 2022 data - GOV.UK (www.gov.uk)
157 Trends of Lymphogranuloma venereum (LGV) in England: 2019 2020, Public Health England
158 Thorley K, Charles H, Mitchell H, Jenkins C and others. 'Sexually transmitted Shigella spp. in England – data up to quarter 2, 2022' 2022, UK Health Security Agency

stomach cramps and fever. It is caused by bacteria found in faeces. Sex that may involve anal contact or contact with faeces is one way that the infection can spread. There is evidence of a rebound in sexual mixing among GBMSM between 2020 and 2021, and this is likely to have contributed to the rise in STIs within this population in 2022[159]. In Richmond, the rate of Shigella at 14.9 per 100,000 males in 2022 was significantly higher than the England rate of 6.0 per 100,000 males and has increased since 2015. Numbers in Richmond are small (11 people in 2022), as a result fluctuations in rates will be greater:

**Figure 79: Sexually transmitted Shigella spp. per 100,000 adult male population**




Source: OHID Fingertips, Sexual and Reproductive Health Profiles (2023)

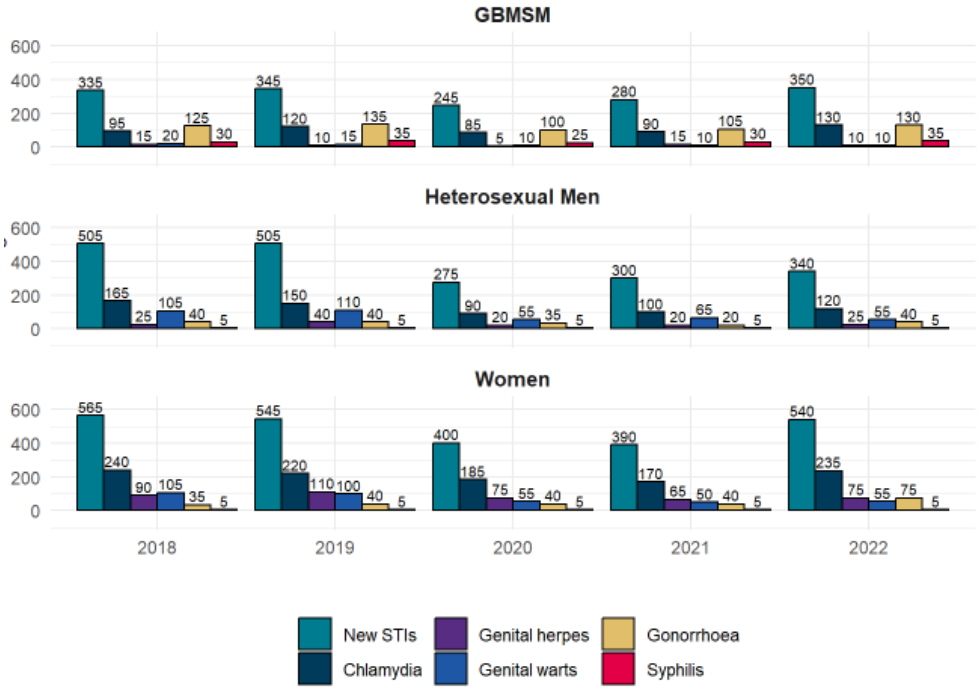
There is an absence of analysis of data on changes in sexual behaviour amongst GBMSM connected to the increase in STI diagnosis. It is important to recognise that access to PrEP, and use of ART by GBMSM living with HIV has changed the landscape of choices for individual harm reduction strategies. Going back to before the HIV epidemic condoms were not widely used amongst GBMSM and STIs were seen as an acceptable inconvenience by some. Recognising that the threat of HIV is not perceived in the same way it was in the 1980s and 1990s is key to choosing effective STI prevention strategies. Medical interventions e.g. vaccination, PrEP, U=U and regular testing are key to supporting this community. Getting STIs diagnosed and treated in a timely manner is key if infection rates are realistically expected to be controlled. Addressing service access needs to STI treatment services for GBMSM is key to this strategy alongside exploring international trials of preventative treatment for bacterial infections.[160]

The National HPV Vaccination Programme for GBMSM aged up to and including 45 years attending specialist sexual health services and HIV clinics started across England in April 2018 following a two-year pilot[161]. From the pilot start in 2016 to the end of 2022, the reported data shows 34.8% of eligible attendees have started their HPV vaccine course, and of these, 54.9% have received at least two doses. Very few GBMSM (0.9% in 2022) have not accepted the vaccine when offered it.

In May 2022, an international outbreak of Mpox was detected, with cases reported concurrently from many countries where the disease is not endemic. The outbreak has involved mainly, but not exclusively, GBMSM. Over 3,500 individuals were diagnosed in England during 2022.

In people where sexual orientation was known, 28.5% of new STIs in Richmond residents in 2020 were among GBMSM. This compares to 27.1% in England. Numbers of new STIs among heterosexual men, GBMSM and women are shown below:

**Figure 80: Number of new STIs, chlamydia, genital herpes, genital warts, gonorrhoea and syphilis in heterosexual men, MSM and women in Richmond, 2018-2022**




Source: GUMCAD STI Surveillance System (2023)

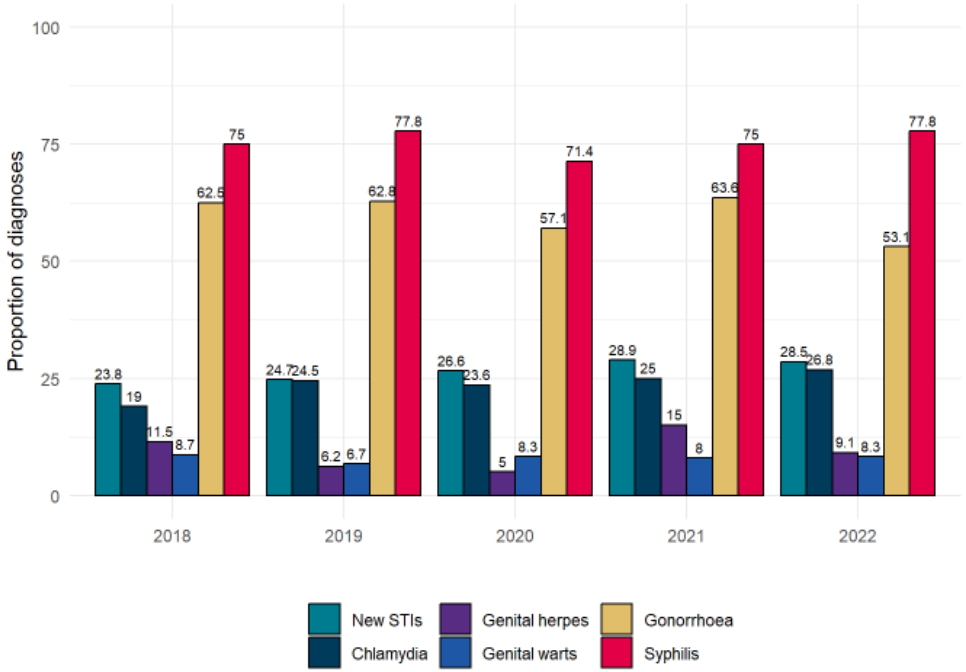
159 Brown JR, Reid D, Howart AR, Mohammed H and others. 'Sexual behaviour, STI and HIV testing and testing need among gay, bisexual and other men who have sex with men recruited for online surveys pre/post-COVID-19 restrictions in the UK'. Sexually Transmitted Infections. 2023;

160 https://www.bhiva.org/PrEP-guidelines

161 'HPV vaccination programme for men who have sex with men (MSM)' 2022, UK Health Security Agency

The proportions of new STIs that were diagnosed in MSM in Richmond for 2018-2022 show that the prevalence of syphilis and gonorrhoea were particularly high for MSM in comparison to other STIs.

**Figure 81: Proportion of new STIs, chlamydia, genital herpes, genital warts, gonorrhoea, and syphilis that are diagnosed in MSM in Richmond, 2018-2022**




Source: GUMCAD STI Surveillance System (2023)

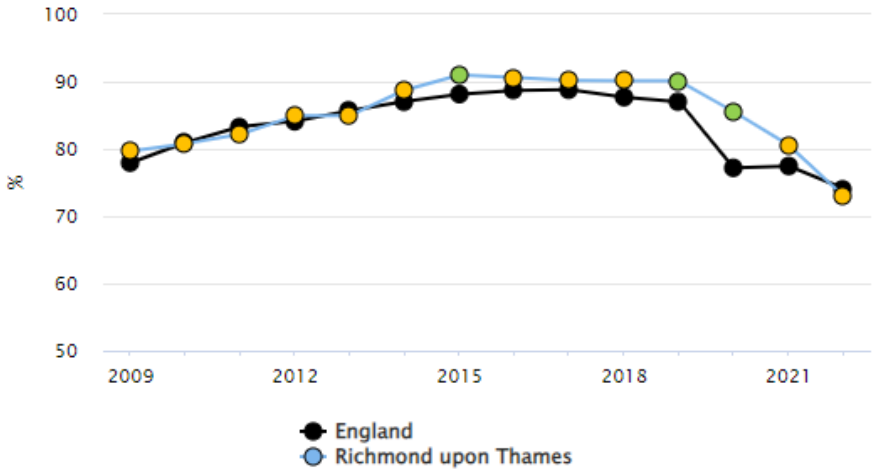
## HIV

GBMSM are disproportionately affected by HIV. It is therefore important to ensure that access to testing and diagnosis is prioritised for these groups. A return-on-investment study of a large-scale American HIV testing programme which expanded HIV testing for disproportionately affected groups, including GBMSM, demonstrated an RoI of $1.95 for every $1 invested[162]. Under the Initiative, 2.7 million persons were tested for HIV, leading to a newly diagnosed HIV positivity rate of 0.7%, and an estimated 3381 HIV infections were averted.

Other targeted annual HIV testing programmes have been shown to be cost-effective. Providing annual testing only to GBMSM, people who inject drugs (PWID) and people form HIV-endemic countries, and one-time testing for all other adults, prevents 4-15% of new infections over a 10-year period, leading to as much as £17,000/QALY gained. If programmes are augmented with increased ART accesses £26,000/QALYs can be gained[163]

New testing data was released in October 2023 by OHID which captures coverage. In Richmond, the number of persons tested for HIV out of those considered eligible for an HIV test when attending specialist sexual health services shows that testing has decreased over the last five years, following England trends:

**Figure 82: HIV testing coverage among, gay, bisexual and other men who have sex with men, 2009-2022**




Source: OHID Sexual and Reproductive Health Profiles (2023)

Currently 73.0% (n=422) of those considered eligible for a test receive one in Richmond, this is lower than both London (73.3%) and England (74.1%). The HIV late diagnosis rate for GBMSM in 2022 was 33.3% though numbers are disclosed due to small numbers but this is higher than London at 29.4% and similar to England's 34.2%. This may demonstrate there is a need to improve access to HIV testing and diagnosis in Richmond for this population.

UKSHA data presented to HIV CEOs in January 2024 highlights that there has been an increase in the proportion of GBMSM non-UK born new diagnoses for HIV in the last 5 years. The number of HIV tests per year has, however, recovered since the Covid-19 pandemic for GBMSM. 50%

162 Return on Public Health Investment: CDC's Expanded HIV Testi... : JAIDS Journal of Acquired Immune Deficiency Syndromes (lww.com)

163 Expanded HIV Testing in Low-Prevalence, High-Income Countries: A Cost-Effectiveness Analysis for the United Kingdom | PLOS ONE

of people living with HIV in England are now over 50 years old, and a significant proportion of these will be GBMSM. GBMSM are more likely to have a need for PrEP identified.

BHIVA guidance on PrEP[164] recommends that it is offered to HIV-negative MSM and trans women who report condomless anal sex in the previous 6 months; and ongoing anal sex and HIV-negative individuals having condomless sex with partners who are HIV positive, (unless the partners have been on ART for at least 6 months and their viral load is less than 200 copies/ml). In addition, the following sexual behaviour/sexual-network individuals are considered higher risk:

- Reporting condomless sex with partners of unknown HIV status, particularly condomless sex or with multiple partners
- Engaging in chemsex or group sex.
- Reports anticipated untrue high-risk sexual behaviour.

The high STI rates amongst MSM are indicative of unprotected condomless sex and should be used as opportunities to engage GBMSM in discussions around the use of PrEP as well as future STI screening needs. The purpose of PrEP is to avoid new HIV diagnosis, and this has been reflected in a reducing rate of new HIV diagnosis amongst MSM. Given this is targeted at people not using condoms it is not surprising perhaps that STI rates are increasing. Involving GBMSM who are using PrEP and GBMSM living with HIV in meaningful discussions about the purpose of sexual health promotion interventions is key to identifying strategies to keep reducing HIV incidence, but also address the increasing diagnosis of STIs.

Richmond contributes to the LHPP which offers targeted multi-media campaigns and sexual health promotion programmes across the capital. This year the campaign was delivered to key populations such as GBMSM, Black Heritage communities and Latin American MSM. High-profile advertising was distributed across a range of channels including radio, YouTube, Spotify, and Google as well as key sites such as London Underground. An outreach team also conduct targeted sexual health promotion including condoms, STI screening, point of care testing and events in venues that attract GBMSM and people from black heritage backgrounds and other minoritised ethnicities. This includes delivery of work at a priority venue in Richmond. Approximately 1% of point of care testing for GBMSM carried out across the capital as part of this initiative are for Richmond residents.

## LGBTQ+

The evidence that LGBTQ+ people have disproportionately worse health outcomes and experiences of healthcare is both compelling and consistent. The National LGBT survey[165], with over 108,000 responses, described a situation where LGBT+ communities face discrimination, felt their specific needs were not being met, had poorer experience and had major concerns about accessing healthcare that should be a right for all.

- at least 16% of survey respondents who accessed or tried to access public health services had a negative experience because of their sexual orientation, and at least 38% had a negative experience because of their gender identity.
- 27% of respondents had accessed sexual health services in the 12 months preceding the survey. A further 2% had tried but were unsuccessful. Most respondents said they had been easy or very easy to access (74% said this); but 26% said they had not been easy to access.
- 51% of survey respondents who accessed or tried to access mental health services said they had to wait too long, 27% were worried, anxious or embarrassed about going and 16% said their GP was not supportive.
- 80% of trans respondents who accessed or tried to access gender identity clinics said it was not easy, with long waiting times the most common barrier.

The national survey noted that comments made about the NHS often focussed on the NHS not having a full understanding of LGBT specific issues such as access to PrEP. Locally, 2022 HRBQ survey of Richmond pupils found the following for young people in year 10 who identified as LGBTQ+:

- Year 10 LGBTQ+ pupils are more likely to have had sex (17% vs. 12% non-LGBTQ+).
- Year 10 LGBTQ+ pupils are more likely to have experienced controlling partner behaviour (30% vs. 22%).
- 61% of secondary pupils said their school covers sexuality 'fairly' or 'very' well. 46% of LGBTQ+ pupils said this.
- 54% said they feel lonely some of the time. This compared with only 27% of pupils who were non-LGBTQ+.
- 63% said they worry about more than five issues (such as' school lessons, friends, parents, internet, pornography) 'quite a lot' or 'a lot'. This is higher than the 30% pupils who were non-LGBTQ+.

On the positive side, they are also more likely to have correctly identified that HIV/AIDS can be treated but not cured, suggesting their attention and/or exposure to HIV and sexual health related issues may be greater than that of non-LGBTQ+ young people.

164 https://www.bhiva.org/PrEP-guidelines

165 National LGBT Survey: Summary report (publishing.service.gov.uk)

Consultation with LGBTQ+ youth groups carried out as part of the ISH service review revealed the most important current issues for this group was access to the female condom and the lack of support services for LGBTQ+ young people, particularly those who were Trans. The most important elements of a sexual health service for engaging LGBTQ+ young people were reported to be non-judgemental practice, open access services that have static opening times, services not provided in a clinical setting such as hospitals and services that were led by other LGBTQ+ young people. They confirmed that the fear of parents finding out that they may have used a service remained a barrier to them accessing in the first place, as did shame and embarrassment in attending. Young LGBTQ+ people suggested they should be involved in the development and commissioning of sexual health services to ensure providers were young people friendly. The promotion of sexual health services and provision through e-resources were favourable to this group:

"Nobody wants to be seen picking up leaflets on STIs or condoms because of shame, but if it's sent as e-copies as part of other resources (RSE and other PSHE information sent to everyone) people will read it at their own time and those who need the services can know where to get support without everyone knowing."

Other suggestions for promoting services included the use of QR codes in private spaces such as toilet cubicles and anonymous boxes in youth clubs, schools or other community settings so young people can raise questions and have them addressed as themes within RSHE lessons. PSHE lessons in school were felt not to be specific enough for LGBTQ+ young people to have their concerns raised and there was an over-emphasis on information about STIs but limited information on what to do if you need support.

**Key findings**

Increases in STIs among GBMSM, in particularly gonorrhoea and syphilis is significant and is likely not to be solely a reflection of increased and regular testing but of behaviour change in the context of PrEP. The rise of antibiotic resistant bacteria adds a challenge to this. Targeted prevention (including PrEP), testing and treatment programmes are shown to be effective.

The low proportion of high-risk individuals accessing PrEP is an area of concern especially given the social mixing of GBMSM beyond geographic boundaries.

GBMSM using PrEP and those living with HIV need to be engaged in strategy development for GBMSM's sexual health. Continuing to promote access to PrEP for all relevant GBMSM remains a priority as does understanding how those using PrEP do so, in relation to sexual risk taking.

Discrimination continues to be felt by LGBTQ+ people and this can impact on wellbeing which in-turn impacts on sexual and reproductive health, including access to sources of support. LGBTQ+ people should therefore be involved in service commissioning to ensure their particular needs are met.

## Underserved groups

It is well known that certain groups have a higher probability of being affected by poor sexual health. There is a lack of local data, however, on the impact of poor sexual health on other marginalised groups. Additional research is required to better comprehend their specific needs and how these can be met in the future.

### Transgender & Non-binary People

Transgender and gender-nonconforming individuals experience significant socioeconomic and stigma-related disadvantages. Sexual health morbidity and unmet need is therefore likely to be significant, yet there is a lack of national data on STI rates among transgender and non-binary (TNB) populations. A study compared the sexual health outcomes of TNB and cisgender users of London's online sexual health service. Of 119,329 users registered with the e-service between May 2019 and December 2019, 504 (0.42%) identified as TNB with 302 TNB users requesting 463 kits and 78.4% (363/463) of kits returned. STI and HIV test positivity rates were 5.5% syphilis, 4.8% chlamydia, 3.4% gonorrhoea and 0.7% HIV positive for TNB individuals. HIV prevalence amongst TNB individuals was 4.3%. 19.9% of TNB individuals engaged in chemsex, group sex, or fisting and were more likely to engage in sex work. High positivity rates of HIV and STIs and significant levels of high-risk sexual activity were observed amongst TNB individuals. Given TNB often have complex healthcare needs, some of which cannot be met entirely online, physical clinics must work collaboratively with e-services to support and protect this marginalised population[166].

Data for Richmond individuals using the on-line sexual health services showed that of 54 kits requested by non-binary, trans-male, trans-female and other individuals, 48 were returned, a 88.8% return rate. This compares to a return rate of 79% for those identifying as either male or female[167].

It is also known, however, that TNB people are more likely to use drugs and alcohol, smoke, be diagnosed with HIV or other sexually transmitted infections, and experience depression or attempt suicide. Many also experience discrimination within the health care system[168]. The HRBQ conducted among schools in Richmond in 2022 indicated that 4% of year 6 and 6% of years 8 and 10 pupils (approximately 41 young people in year 10) said their gender is different to the gender they were assigned at birth. Boys were also more than twice as likely to say their gender is different to the gender they were assigned at birth than girls.[169] Further analysis confirms that Year 10 transgender pupils are more likely to have experienced controlling partner behaviour; 40% vs. 22% of non-transgender identifying individuals[170]. A sex worker

166 Beyond the binary: sexual health outcomes of transgender and non-binary service users of an online sexual health service - Sara Day, Joanna Smith, Sean Perera, Sophie Jones, Ryan Kinsella, 2021 (sagepub.com)
167 SHL, Preventx reporting data
168 Hayon R. Gender and Sexual Health: Care of Transgender Patients. FP Essent. 2016 Oct; 449:27-36. PMID: 27731969
169 SHEU (2022) Richmond Young People's Survey Findings from the 2022 survey; A themed report for relationships and sexual health
170 SHEU (2022) Richmond Young People's Survey Findings from the 2022 survey; A themed report for relationships and sexual health

needs assessment carried out in Richmond in 2022 indicated that through an analysis of sex worker adverts approximately 6% of sex workers identified as transgender.

The sexual health outcomes for those who have undergone gender reassignment locally are not known. There is no relevant routine national monitoring data for gender reassignment status. Sexual health providers only collect rudimentary data on clients' gender identification. However, commissioners are aware that transgender people are at higher risk of contracting HIV and STIs compared to the general population and are subject to stigma and transphobia which may prevent them from accessing sexual health services. TNB people have been identified as a priority population group within the new SWL service contract for high-risk groups.

The SWL service contract for high-risk groups includes counselling, social groups, peer mentoring and advocacy services for trans people. In addition, trans people are a target group of targeted work for sexual health outreach prevention and education. Spectra provides peer led counselling, social groups, peer advocacy, and peer mentoring to the trans community. It incorporates relevant sexual health interventions into this work.

The provider separately leads a trans-advocacy network of support agencies and through this enables clients to access gender re-assignment services including a gender GP, Clinic Q and Clinic T, as well as support through a peer-led holistic Trans Empowerment Programme delivering counselling, mentoring, social groups and workshops, which is available to Richmond residents.

The local service model is relatively clinically focussed and would benefit from the inclusion of peer-led holistic trans empowerment services. Spectra's participation and leadership of the Trans Learning Partnership means that locally there is access to broader research regarding the needs of this community group other than sexual health. Engagement in Spectra's Trans Empowerment Programme delivering counselling, mentoring, social groups and workshops delivers services to more trans adults in London than any other service, furnishing clear evidence of issues and needs[171].

**Key Findings**

Trans people are a marginalised and often underserved group and are at higher risk of poor sexual and mental health outcomes.

- Funding for local bespoke Trans services, including peer-led holistic trans empowerment services, should be considered to better develop the support available to trans people from local service providers.

171 https://www.the-tlp.org.uk/

## Women who have Sex with Women

The sexual and reproductive health inequalities faced by GBMSM are well documented. However, the sexual and reproductive health needs of women who have sex with women (WSW) are poorly understood and frequently overlooked. Research into the sexual health of WSW is limited[172] and this group has frequently been perceived as low risk for sexually transmitted infections (STIs)[173].

Newly released data from the UK Health Security Agency, however, shows that rates of chlamydia diagnoses have increased 144% from 90.6 per 100,000 in 2018 to 221.8 per 100,000 in 2022. Over the same period, similar patterns are seen for gonorrhoea and herpes, rising from 51.2 to 174.6 per 100,000 and 45.7 to 124.1 per 100,000 respectively[174]. Furthermore, despite evidence that bisexual women are twice as likely to develop cervical cancer, WSW have typically not been the focus of cervical screening initiatives[175].

172 Gaps in sexual health research about women who have sex with women. A scoping review - ScienceDirect
173 Sexually transmitted infections and risk behaviours in women who have sex with women | Sexually Transmitted Infections (bmj.com)
174 Sexually transmitted infections (STIs): annual data tables - GOV.UK (www.gov.uk)
175 HSC0057 - Evidence on Health and social care and LGBT communities (parliament.uk)

There are a number of factors that are likely to be contributing to increasing rates of STI diagnoses, poor outcomes in other aspects of sexual and reproductive health, and limited understanding of the needs of WSW. These include:

- **Misinformation:** A parliamentary enquiry into health and social care and the LGBT community was told that many women who exclusively have sex with women had been told incorrectly by healthcare professionals that they do not need to be screened for cervical cancer.[176]
- **Lack of perceived risk:** Women themselves, as well as the healthcare professionals looking after them, may perceive their risk of contracting STIs as low.[177]
- **Poor access to services:** Lesbian and bisexual women have been found to be much less likely to go for cervical screening than heterosexual women.[178] This may, in part, be related to having been told that they do not need to be screened.
- **Heteronormative attitudes towards health promotion:** Despite WSW, including those who exclusively have sex with other women, being at risk of STIs, primary prevention initiatives focus on the use of condoms, with little reference to dental dams.[179]
- **Discrimination:** The aforementioned parliamentary enquiry heard evidence that a large proportion of frontline workers in health and social care did not consider a person's sexual orientation to be relevant to their needs.

It is clear that more needs to be done to understand and adequately address the sexual and reproductive health needs of WSW. This should include:

- Improved training for healthcare staff to increase their understanding of the sexual and reproductive health needs of WSW and reduce misinformation.
- More health promotion initiatives focused on the sexual and reproductive health needs of WSW and incorporation of specific messaging into broader campaigns on women's and LGBTQ+ sexual and reproductive health.
- Better representation of WSW in sexual and reproductive health research.
- Ensuring that healthcare services are LGBTQ+ inclusive, with the specific needs of WSW explicitly addressed.

The Richmond VAWG needs assessment[180] also identified LGBTQ+ people as facing discrimination in accessing local services. Additionally, there is evidence that suggests LGBTQ+ experience higher rates of sexual violence, often linked to their LGBTQ+ identity. The Galop LGBT study also highlights the lack of understanding around WSW and sexual violence in these relationships[181].

**Key findings:**

The sexual and reproductive health needs of women who have sex with women (WSW) are poorly understood and frequently overlooked. More needs to be done to understand and adequately address the sexual and reproductive health needs of WSW:

- Improve training for health care staff
- Health prevention campaigns targeting WSW
- Ensuring health care services are LGBTQ+ inclusive, with the specific needs of WSW addressed.

## People Using Substances

There has long been a recognised link between substance use and sexual behaviour in Britain, particularly among young people. An analysis of the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) conducted in 2016 explored associations between reporting frequent binge drinking, recent drug use or multiple substance use, and key sexual risk behaviours and adverse sexual health outcomes.

Men and women reporting frequent binge drinking or recent drug use were more likely to report unprotected first sex with more than 1 new partner; first sex with their last partner after only recently meeting; emergency contraception use within the last year; and sexually transmitted infection diagnosis/es in the past 5 years. Associations with sexual risk were frequently stronger for those reporting multiple substance use, particularly among men.[182] Richmond has the highest admission rates for alcohol specific conditions for under 18s of all the London boroughs (36.4 per 100,000) and is higher than the London average of 14.3 per 100,000 (2018-21).[183] Rates of hospital admissions due to substance misuse for 15 to 24 year olds at 62.4 per 100,000 are also higher than London averages of 56.5 per100,000 (2018-21). This may indicate a higher prevalence of a risk factor that is associated with sexual risk-taking behaviours in Richmond.

The word "Chemsex" is used to describe intentional sex under the influence of psychoactive drugs and is most associated with GBMSM. It refers particularly to the use of mephedrone, γ-hydroxybutyrate (GHB), γ-butyrolactone (GBL), and crystallised methamphetamine. These drugs are often used in combination to facilitate sexual sessions lasting several hours or days

176 Health and Social Care and LGBT Communities - Women and Equalities Committee - House of Commons (parliament.uk)
177 A hidden population: What are the sexual health needs of women who have sex with women? By Siobhian Moores - Faculty of Sexual and Reproductive Healthcare (fsrh.org)
178 Health and Social Care and LGBT Communities - Women and Equalities Committee - House of Commons (parliament.uk)
179 State of The nation Report.pdf (tht.org.uk)
180 Violence against Women and Girls Needs Assessment, Richmond 2023
181 Galop-LGBT-People-Sexual-Violence-April-2022.pdf
182 Khadr SN, Jones KG, Mann S, et al: Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey: BMJ Open 2016;6:e011961. doi: 10.1136/bmjopen-2016-011961
183 https://fingertips.phe.org.uk/profile/child-health-profiles

with multiple sexual partners[184]. Qualitative studies show that users report using psychoactive substances to reduce inhibitions, increase pleasure and to manage negative feelings, such as a lack of confidence and self-esteem, internalised homophobia, and stigma about their HIV status[185]. A quantitative study conducted in south London suggested that chemsex is practiced by a minority of GBMSM yet barriers to accessing services exist. To this end sexual health services have developed specific chemsex clinics.

Mephedrone and crystal meth can create a powerful psychological dependence, with GHB/GBL creating a dangerous physiological dependence. Mental health effects may require treatment and can become permanent.[186] Some users will need drug treatment to support detoxification, particularly from GHB/GBL..[187]

Amongst GBMSM a range of substance use patterns have been identified developing a range of subgroups of drug using behaviours.[188] These include:

- Those using poppers only.
- Club-drug users: young men consuming MDMA, cocaine, amphetamine, cannabis and amyl nitrite, but not methamphetamine.
- Chem users: men reporting chemsex related drugs (methamphetamine, ketamine, GHB and methedrine), the group reporting the highest rate of employment, suggesting a high level of functioning.
- Polyvalent users: reporting a wide range of reported substances, a high prevalence of chemsex drugs and higher risk behaviour.

Men in the last two groups predominantly lived in big cities. Whilst some studies have found higher rates of depressive mood or anxiety symptoms in MSM engaged in chemsex this is not the case in all studies.

Needle exchange services are also an important intervention that can help prevent HIV. A study of the cost-effectiveness of needle-exchange programmes in the US determined that $3.48 dollars was saved on every dollar spent on needle exchange programmes in preventing HIV spread[189].

184 Bourne A, Reid D, Hickson F, Torres-Rueda S, Weatherburn P. Illicit drug use in sexual settings ('chemsex') and HIV/STI transmission risk behaviour among gay men in south London: findings from a qualitative study. Sex Transm Infect 2015 Jul 9

185 Bourne A, Reid D, Hickson F, Torres-Rueda S, Weatherburn P. The Chemsex study: drug use in sexual settings among gay & bisexual men in Lambeth, Southwark & Lewisham. 2014. www.sigmaresearch.org.uk/chemsex.

186 Novel Psychoactive Treatment UK Network. Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances. 2015 http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf.

187 Stuart D. Sexualised drug use by MSM: background, current status and response. HIV Nurs2013 Spring:6-10.

188 https://law-journals-books.vlex.com/vid/substance-use-and-chemsex-879945731

189 Syringe Exchange in the United States: A National Level Economic Evaluation of Hypothetical Increases in Investment | AIDS and Behavior (springer.com)

There are strong examples of linked sexual health with drug or alcohol interventions and services from across Europe that could be drawn upon locally.[190]

**Key Findings:**

**Using alcohol and substances is associated with poorer sexual health outcomes. Chemsex was found to be practiced by a minority of GBMSM, but larger proportions of GBMSM regularly use substances recreationally including when having sex. There remains barriers to accessing services for those that do.**

- Specific chemsex clinics within sexual health services may be an appropriate solution if not already provided.
- Sexual health services need to be able to discuss the different types of substances used by GBMSM and their different impacts on sexual risk taking.
- Substance misuse services (adults and young people services, including those offering needle exchange) should provide information, signposting and/or STI testing wherever possible.

## People who are Homeless or Rough Sleeping

It is well known that people experiencing homelessness face significant health inequalities and have poorer health outcomes than the general population, including a higher number of diagnoses of physical and mental health conditions compared with the general population[191].

Individuals who experience homelessness face disproportionately poor reproductive health and pregnancy outcomes, and a higher risk of STIs. Precarious living conditions contribute to poor uptake and engagement with SRH services for this population. Substance misuse and sex work can also co-exist in this cohort. People who experience rough sleeping have a significantly increased prevalence of TB, HIV and Hepatitis B & C, compared to general population[192]; and 3 out of 10 female rough sleepers experience sexual violence[193].

The Covid-19 pandemic and current cost of living crisis have contributed to a growing number of women finding themselves homeless and moving into street-based sex work due to financial instability. Engagement is low due to their working hours, lack of phone contact and difficulties travelling to SRH services.

190 EuropeanResponsesGuide2017_BackgroundPaper-Sexual-health-and-drug-use.pdf

191 The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit. Debra Hertzber and Sophie Boobis (October 2022) available at: Unhealthy_State_of_Homelessness_2022.pdf (kxcdn.com)

192 Beijer U, Wolf A, Fazel S. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis. Lancet Infect Dis. 2012 Nov;12(11):859-70. doi: 10.1016/S1473-3099(12)70177-9. Epub 2012 Aug 20. PMID: 22914343; PMCID: PMC3494003

193 Institute of Health Equity, Evidence review: Housing and Health inequalities in London https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf

Data from an extensive homeless health audit[194] by Homeless Link, represents the views of 3,555 people experiencing homelessness between 2018-2021 across the UK. Of the 3,555 people responding, 71% male and 29% female. 93% were UK residents, and 89% identified as White. Most respondents were between 18 and 45 years old. This research found that 24% had had a sexual health check in the year prior to the audit. A recent homelessness health needs assessment conducted in 2022 for Richmond also identified that 4% self-reported being at risk of or experiencing sexual abuse or exploitation. This suggests that there should be improved links between homelessness services and sexual health.

**Key Findings:**

**It is well known that people experiencing homelessness face significant health inequalities and have poorer health outcomes than the general population, including poorer sexual health outcomes and higher risk of STIs:**

- People working with homeless or rough sleepers to sign-post to sexual health services.
- Exploration of an outreach service offer for this vulnerable group.

## Sex Workers

Sex workers are a highly marginalised and stigmatised group who carry an extremely high burden of unmet health need. They experience multiple and interdependent health and social problems and extreme health inequality. Research shows that the main barriers in providing healthcare to sex workers were services being inflexible, under-resourced and not trauma informed[195]. A sex worker needs assessment for Richmond was conducted in 2022[196] to inform the commissioning and development of a sex worker support service as part of the new SWL service for high-risk groups.

During the development and mobilisation of the Sex Worker Support Service a range of scoping exercises and community participation groups were undertaken to further clarify the needs of the sex worker community. This review provided further insight into the sex worker community in the borough and found:

- 543 online sex worker profiles were found on 3 different online advertising platforms (Adultwork, Vivastreet and Sleepyboy), within 1 mile of Wandsworth postcodes.
- 150 trans and MSM workers were identified.

While there are limitations of using these platforms for estimates, they provide a useful proxi-indicator to identify the prevalence of sex work in an area. However, this is likely to be an underestimation as some sites require official forms of identification verification, which precludes undocumented migrants, those with concerns they may risk losing statutory benefits and those at risk of partner violence or being 'outed' to their community or employed payment, from using such sites.

Sex workers using online advertising platforms often hide their actual identity (age, gender, ethnicity, locations of residence or work) on these sites for marketing or safety reasons. And some adverts may be placed to be more visible to wealthier clients.

Sex workers offering 'outcalls' either independently or with agencies often work in, and advertise their work in, multiple locations (including internationally) to increase work opportunities, to engage in multiple types of sex work, or to avoid criminalisation or other regulations.

There are currently no licensed Sexual Entertainment Venues (SEVs) in Richmond. Residents engaging in stripping or erotic dancing therefore travel to other boroughs to work in SEVs but offer private entertainment in-borough. Research in the borough did not find any evidence of street sex work in Richmond, but one brothel has been identified in Richmond. And no 'Sex on Premises' venues were identified indicating that the nature of sex work in the borough is largely through independent indoor sex workers. Spectra also collected examples of hidden or incidental sex work, and MSM workers were less likely to identify with the term 'sex worker'.

- The peer-led sex worker community participation review conducted by Spectra highlighted the following key challenges for sex workers in the borough:
- Widespread barriers for sex workers in accessing local support, housing, health and community care services and other support networks.
- Limited success of services in engaging and supporting sex workers.
- Sex worker concerns about privacy and data sharing leading to criminalisation, deportation, or other consequences for their personal safety and well-being.
- Avoidance of use of services in the same area as residence.
- Access further hampered by those with disabilities.
- Fear that providing feedback or complaints about a service either directly or to regulators may jeopardise their care or lead to further negative consequences.
- Lack of awareness by professionals and provision of suitable safer sex and harm reduction supplies including latex free condoms and menstrual sponges.
- A lack of access to PrEP
- Stigmatisation and discrimination and lack of awareness of sex work and appropriate health care, which led to:
  - A lack of trust in health and well-being services.
  - Avoidance in accessing health and well-being services.
  - Decreased levels of disclosure of sex work to health and well-being services.

194 Unhealthy State of Homelessness, 2014 https://homelesslink-1b54.kxcdn.com/media/documents/Unhealthy_State_of_Homelessness_2022.pdf
195 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8840502/
196 Spires (2022) Richmond and Wandsworth Sex Worker Needs Assessment (unpublished)

Research conducted by the European Sex Workers Rights Alliance (ESWRA) indicates that one of the major barriers shown to influence sex workers' access to health care is stigma. For example, when sex workers disclose their occupation to health care providers they may experience discrimination, denial of care, disrespectful and abusive language and treatment, confidentiality breaches and a lower quality of care[197].

Sex workers in Richmond shared that where services stipulated, they are sex worker friendly it was clear they had not had training on how to encourage sex workers to feel confident to disclose their identity. This resulted in some judgemental attitudes leading to sex workers not, therefore disclosing enough information to be then given access to PrEP for example. They also shared that they perceived that services did not care enough to listen to them and therefore preferred to share feelings about their experiences with other sex workers. The reputation and trust of a service amongst sex worker peers was a key motivator for sex workers to use one service over another. Sex worker specific services, however, were usually seen as positive and helpful, but were less likely to be accessed by sex workers who are at high risk of harm if their sex worker status was to be disclosed without permission or discovered by a family member, friend or partner. Sex worker specific sexual health services were expected to provide services and supplies that were not available at most other sexual health services:

- Results certificates
- Same day treatment for reactive tests
- Drop-in services
- Signposting and information about other sex worker only services
- Community support
- A wider variety of safer sex supplies

Net reach and communication to online work profiles via aps used by sex workers were felt to be intrusive and disrespectful by the sex workers consulted, and some felt it indicated a lack of understanding of sex work by any service and that such services could prevent more of a risk to their safety. This means sex worker services need to use alternative platforms as community notice boards such as WhatsApp, set up to protect individual identities.

Sharing information or working with the police, was seen by sex workers a strong reason to avoid using a service or disclosing sex work to a service. Migrant workers were concerned about sharing personal information with services. Incidents of negative experiences resulting in or coinciding with police welfare checks, raids, evictions or the involvement of social services are shared across the sex worker community and recalled years after any incident.

- When asked what they would change about local support services, sex workers placed importance on:
- Consistency and clear service definitions, with genuinely sex worker inclusive pathways and safeguarding protocols.
- Clarity on what services mean when they advertise 'supports sex workers' and to whom those services are available.
- Easily accessible information about how to get support and what was being offered.
- Training and awareness raising for staff on the needs of sex workers and how to support them, including maintaining confidentiality.
- Provision of clear information about what personal information is required to access services and in what circumstances information would be shared and with whom.
- Sensitivity with regard to passing information on to either police or immigration – particularly without their consent.
- Consistency of service workers to avoid repetition of storytelling and to promote trust in services to enable support to be received.

Mutual aid and community care was consistently raised by people Spectra consulted as a key form of support that sex workers relied upon, often in place of services. Trusted peers were found to individually and collectively provides resources, funds and safety information to one another, in spaces where they could also connect with people with shared experiences and feel secure to speak more openly with than they would to support staff in services who do not share the same status.

**Key findings**

The needs and experiences of sex workers are complex and often hidden. The new sex worker service is welcomed and key to ensuring the needs of this very vulnerable group are understood and responded to. There is more that can be done with mainstream services to ensure this group is included in service development and delivery:

- Training for health and social care professionals to highlight key issues for this group, including the need to safeguard over need to report.
- Training healthcare professionals to better identify and understand needs of sex workers.
- Ensure provision of safer sex harm reduction supplies including latex free condoms and menstrual sponges.

197 https://www.eswalliance.org/two_pairs_of_gloves_sw_experiences_stigma_discrimination_healthcare_europe

## Refugees and Asylum Seekers

Refugee and asylum-seeking women are often physically, socially and psychologically vulnerable, owing to past experiences[198,199]. They have a range of social and sexual health needs, which can include suffering from the consequences of FGM, sexual violence and exploitation, or STIs due to inadequate contraceptive use[200]. These women have been highlighted in clinical guidelines as a disadvantaged group needing enhanced maternity care[201]. Evidence shows that refugee and asylum-seeking women have a significantly higher rate of maternal mortality and incidence of stillbirths than White British women.[202,203] This is primarily due to migrant women not engaging with sexual and reproductive health services, or receiving inadequate care, which exacerbates existing problems.[204]

Migration, the asylum process and resettlement are a complex and distressing, with many experiencing a history of torture, rape and trafficking coupled with lack of funding for food, clothes and transport to health appointments[205]. They are vulnerable to further exploitation and often lack knowledge in relation to entitlements and navigation of foreign health services. Late presentations in care further exacerbate poor treatment outcomes and health complications. Poor health literacy often means refugees and asylum seekers have low or no conceptual knowledge of screening programmes such as cervical screening.

Cultural norms and expectations can also have an impact on refugees and asylum-seekers accessing sexual health services. Sociocultural characteristics, health status and health-seeking behaviours have been linked by researchers[206,207]. A qualitative study with Eritrean and Sudanese migrant women, for example, demonstrated a good level of knowledge regarding contraception; however, women reported a taboo in discussing sexual health issues with their family or partners. The women suggested that men lacked contraceptive knowledge and should be involved in sexual health education[208]. Language has also been identified as a key barrier for refugees and asylum-seekers accessing health care services.[209]

Some refugees and asylum seekers will be fleeing from persecution due to their LGBTQ+ or HIV status which is important to recognise and will also have a lower understanding of available services in London. 2% of asylum claims in the UK during 2022 included sexual orientation as part of the basis for the claim. This is down from 7% in 2016 and 2017. The grant rate of application in 2022 was 72%. The National AIDS Trust continues to publish research from migrant Peer Experts living with HIV in the UK on the diverse needs of all migrants living with HIV including those with insecure migration status, highlighting that in 2019 61% were first diagnosed in the UK. 41% of migrants living with HIV identifying as gay and bisexual men were born in Europe, whilst 68% of heterosexual migrants living with HIV were born in Africa[210,211].

At a South West London level an estimated 20% of HIV support service users are currently asylum seekers.

198 Sudbury H. & Robinson A. (2016), Barriers to sexual and reproductive health care for refugee and asylum-seeking women; BMJ, Vo 24, Issue 4
199 Feldman RLondon: Maternity Action and Refugee Council; 2013
200 Wilson R, Sanders M, Dumper H. London: Family Planning Association; 2007
201 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. 2010. http://www.nice.org.uk/guidance/cg110
202 Lewis G. London: Confidential Enquiry into Maternal and Child Health; 2007
203 Gardosi J, Madurasinghe V, Williams M, Malik A, Francis A Maternal and fetal risk factors for stillbirth: population based study. BMJ. 2013; 346 https://doi.org/10.1136/bmj.f108
204 Raleigh VS, Hussey D, Seccombe I, Hallt K Ethnic and social inequalities in women's experience of maternity care in England: results of a national survey. J R Soc Med. 2010; 103:(5)188-98 https://doi.org/10.1258/jrsm.2010.090460
205 Sudbury H. & Robinson A. (2016), Barriers to sexual and reproductive health care for refugee and asylum-seeking women; BMJ, Vo 24, Issue 4
206 Carroll J, Epstein R, Fiscella K, Volpe E, Diaz K, Omar S Knowledge and beliefs about health promotion and preventive health care among somali women in the United States. Health Care Women Int. 2007; 28:(4)360-80
207 Henderson S, Kendall E, See L The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically diverse communities: a systematic literature review. Health Soc Care Community. 2011; 19:(3)225-49 https://doi.org/10.1111/j.1365-2524.2010.00972.x
208 Rogers C, Earnest J A cross-generational study of contraception and reproductive health among Sudanese and Eritrean women in Brisbane, Australia. Health Care Women Int. 2014; 35:(3)334-56 https://doi.org/10.1080/07399332.2013.857322
209 National Institute for Health and Care Excellence. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. 2010. http://www.nice.org.uk/guidance/cg110
210 www.nat.org.uk/sites/default/files/publications/FINAL%20HIV%20and%20migration%20report%20June%202021.pdf
211 www.gov.uk/government/statistics/immigration-system-statistics-year-ending-june-2023/asylum-claims-on-the-basis-of-sexual-orientation-2022

**Key findings**

**Refugees and asylum seekers are already a very marginalised group and are less likely to be familiar with local health care and prevention services. There is a need to ensure outreach in relation to sexual and reproductive health is in place and is accessible in a variety of languages. This may include:**

- Work in partnership with services supporting refugees, asylum seekers and migrants.
- Ensuring the high-risk sexual health service and HIV services are in operation within venues where refugees either reside or frequent.
- Training for workers and community groups on the sexual and reproductive health needs of refugee and asylum-seeking support services.

## People with Disabilities

Research shows that people with physical disabilities have significant sexual and reproductive health disparities and higher rates of sexual distress when compared with the general population. There are specific sexual health concerns for men and women with physical disabilities and approach to their care needs to be understood and managed appropriately[212].

Research shows that people with learning disabilities do not have as good or equal access to sex and relationship education or information as those without. Although some people with a learning disability may not be able to consent to having sex or a relationship, this is a minority[213]. Many people with a learning disability have the same aspirations for loving relationships as those without.[214,215] When given sufficient and accessible sex and relationships education, many people with a learning disability are able to engage in safe, healthy and happy personal and sexual relationships.[216] Having a partner can also replace the potential need for support staff in later life[217].

Discrimination is further exacerbated for people who have a learning disability and also identify as LGBTQ+. Some even conceal their sexuality to avoid expected negativity.[218] Family members and support staff may also not acknowledge their identities or relationships[219]. While many support workers can be instrumental in helping those with learning disabilities to build intimate relationships many also report a lack of guidance on what they can and cannot do or say. Tensions between enabling positive relationships and protecting against abuse or exploitation are also particularly challenging[220].

Access to appropriate relationships and sex education is equally as important for those with learning and other disabilities as those without, yet information and support may be lacking or can be insufficient[221]. Consequently, they are at higher risk of negative sexual experiences, contracting STIs or unwanted pregnancies[222]. Relationships and sex education content throughout life, therefore, requires adaptation to ensure it is both appropriate and accessible[223].

Consultation with local adults with learning disabilities confirmed that the ability to make friends with each other was a very important skill to develop, and helped them to develop more meaningful personal relationships. This can start with giving each other respect and allowing others to speak and to listen to what they are saying. The group expressed the importance of knowing when, how and who to report when something that has happened doesn't feel right.

The group gave examples of people that can help to talk to about sex and relationships, but were less clear about specific sexual health services or location:

- Nurse, friends, carers, parents, workers at the centre,
- Information online (but not all of it good)
- C-card scheme and where to get condoms
- Hospitals / doctor
- Importance of seeking and getting support from peers and in group chats.

212 Rowen T.S, Stein S. Tepper M. (2015) Sexual Health Care for people with physical disabilities: Journal of Sexual Medicine; Mar;12(3):584-9.
213 www.mencap.org.uk
214 Bates, C., Terry, L., & Popple, K. (2017b). Partner selection for people with intellectual disabilities. ***Journal of Applied Research in Intellectual Disabilities***, 30(4), 602-611.
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218 Rushbrooke, E., Murray, C., & Townsend, S. (2014). The experiences of intimate relationships by people with intellectual disabilities: A qualitative study. ***Journal of Applied Research in Intellectual Disabilities,*** 27(6), 531-541.
219 Harflett, N., & Turner, S. (2016). Supporting people with learning disabilities to develop sexual and romantic relationships. National Development for Inclusion (NDTI).
220 Maguire, K., Gleeson, K., & Holmes, N. (2019). Support workers' understanding of their role supporting the sexuality of people with learning disabilities. ***British Journal of Learning Disabilities***, ***47***(1), 59-65.
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222 Baines, S., Emerson, E., Robertson, J., & Hatton, C. (2018). Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. ***BMC public health***, ***18***(1), 667.
223 Dukes E and McGuire BE (2009) Enhancing capacity to make sexuality-related decisions in people with an intellectual disability. ***Journal of Intellectual Disability Research*** 53(8): 727–734.

Participants confirmed they had been involved in sessions on consent, personal boundaries, harassment, friendships, healthy and unhealthy relationships, sexual health (condoms and contraception) in both school and through continuous learning opportunities. There was clear examples of where the lessons or one to one sessions had had a positive impact on appropriate behaviour. For example, learning when interest in another person can become obsessive or perceived as harassment and harmful.

The young adults gave examples of the tendency of parents / carers to over protect them when friendships develop further and that they may not be able develop these relationships outside of the learning environment. Another example was given demonstrating the vulnerability of young adults with learning disabilities in relation to sexual harm / abuse, the trauma of which impacts on relationships through life, including safety when travelling alone. Strategies for keeping safe while travelling on the bus, for example, such as having a phone to hand, sitting near the driver, travelling with a friend, and not talking to strangers. However, stranger danger messages were also seen as having a negative impact when it came to seeking help when feeling threatened or unsafe in a public space. Several of the participants reported incidences of being bullied by others.

The group thought that while lessons on sex and relationships were important, they could be very embarrassing but expressed a need and wish to learn more and to ensure this is repeated to both to keep them safe but also to enable them to enjoy respectful and developing relationships.

Actions for the strategy would be to enhance ability of parents/carers and professionals to enable uncomfortable conversations in relation to sex education throughout life to enable people with learning disabilities to enjoy safe relationships and seek advice, information and supplies as needed. This includes supported one to one or group trips to sexual health services, and sexual health services delivering awareness sessions in adult learning centres.

- Consultation with professionals working with people with learning disabilities was conducted as part of the ISH service review[224]. The following key points were raised:
- Access to sexual health services for people with disabilities is a challenge, especially for those who have a hidden disability. People with learning disabilities will have less access to sex education, will be more stigmatised and have less opportunities for safe sex.
- Increase promotion of sexual health services and relationships, and sex education to people with learning disabilities and to carers and professionals working with them.
- Support to enable people with LD to maintain relationships and engage in safe sexual activity where wanted.
- Adapt sexual and reproductive health information and education to meet needs of young people with complex needs, predominantly learning disabilities and autism, there is only very low-level basic conversations around sexual and reproductive health.
- A balanced approach to safeguarding issues, which can often be over-played with the intention to protect people with disabilities from harm but can prevent healthy relationships developing.
- Improve knowledge and skills of sexual health staff regarding how to engage with older people with learning disabilities.
- Support people with learning disabilities to use sexual and reproductive products including period hygiene products.
-

**Key Findings:**

When given sufficient and accessible sex and relationships education, many people with a learning disability are able to engage in safe, healthy and happy personal and sexual relationships and have a right to do so. Having a partner can also replace the potential need for support staff in later life.

- Increase promotion of sexual health services, RSE and sexual and reproductive health education to people with learning disabilities and to carers and professionals working with them.
- Support people with learning disabilities to use sexual and reproductive products including period hygiene products.

224 Merton, Richmond and Wandsworth Integrated Sexual Health Service Review (2023) (Unpublished).

## Older People

The term 'older people' largely refer to people in age categories above the aged 50 cohort, but additional considerations is also given specifically to those entering care homes or are cared for by family members.

It is repeatedly reported that heterosexual and LGBTQI+ older people are less likely to disclose sexual concerns and difficulties which increases the risks for STIs. Older people are often absent from policies and healthcare providers describe difficulties in commencing conversations around their sexual health and sexual history. Efforts by healthcare providers to recognise sexuality in older age and provide older people with the opportunity to open up regarding their sexual health and experiences is required. There is also a lack of awareness around the abuse of older people especially around sexual violence and it not being recognised in older people in health services[225] .

Research from The University of Manchester[226] shows that 54% of men and 31% of women over the age of 70 are still sexually active. With a third of these men and women having frequent sex, meaning at least twice a month. According to the data from the latest wave of the English Longitudinal Study of Ageing (ELSA), the most frequent problems reported by sexually active women related to becoming sexually aroused (32%) and achieving orgasm (27%). While for men it was erectile difficulties (39%) and their chronic health conditions and poor self-rated health that affected their sexual health in comparison to women. For men there is more concern around their sexual activities and functions than women and these concerns only increased with age.

This is the first time that the research from the ELSA has included people over the age of 80 demonstrating that the sexual health needs of older people has been overlooked possibly due to common misconceptions about sex, sexuality, and sexual or intimate relationships[227]. Such common misconceptions include[228]:

**Older adults are neither sexually active nor interested in sex, so there is no reason to ask them about their sexual health.**

- In England, 86% of men and 60% of woman aged 60-69 are sexually active, as were 59% of men and 34% of women aged 70-79 years, with 31% of men and 14% of women aged 80 or older[229].
- Despite social awkwardness, or unwillingness to talk about this topic with older residents, there is still a strong interest in engaging in sexual activity amongst those aged 65-80 years, with two thirds of people in this age group saying they were interested in sex and over 50% saying sex was important to their quality of life, as reported in the American Association of Retired Persons' Healthy Aging poll[230].

**Assuming that the term sex refers only to partnered sex and intercourse. This is not the reality for many older adults who adapt their sexual activity due to erectile dysfunction, vaginal dryness, arthritis, mobility limitation, effects of medication, or serious health conditions.**

- Sexual activity is more than penetrative sex and can be expressed in various forms of physical and emotional intimacy, as part of what those involved consider as having sex, this can include oral sex, kissing, fondling, and solo sex (masturbation).

**Older adults are not at risk of STI's and therefore there is no need to ask about their sexual history or discuss their sexual behaviours.**

The generation that is now aged 65 and older had no sex education at school, at a time when many STIs were unheard of; therefore, this generation doesn't usually opt for protection when having sex. In 2022[231] the rates for Chlamydia in England for men aged 65 and over had increased from 7.4 to 12 per 100,000 since 2021 and in London it increased from 19.9 to 30.5. STI rates in women aged 65 and over are also but not as fast as in men. Therefore, there are fewer diagnoses overall. According to the UK Health Security Agency (UKHSA), between 2020-2022 there has been an increase in rates for both men and women aged 65 and over in London and in England for Chlamydia, Gonorrhoea, Herpes, and Warts with an increase in Syphilis for men. This shows there is a need for increased STI testing and sexual health education for older people.

225 SARSAS Briefing Paper Jan20_9307.indd
226 Love and intimacy in later life: study reveals active sex lives of over-70s (manchester.ac.uk)
227 Sexual activity of older adults: let's talk about it - The Lancet Healthy Longevity
228 Sexual activity of older adults: let's talk about it - The Lancet Healthy Longevity
229 Sexual Health and Well-being Among Older Men and Women in England: Findings from the English Longitudinal Study of Ageing - PubMed (nih.gov)
230 NPHA-Sexual-Health-Report_050118_final.pdf (umich.edu)
231 UK Health Security Agency, National STI surveillance data 2022: Table 2

**Barriers to Good Sexual Health**

To build appropriate services that cater to the needs of this population, barriers and challenges that older residents, carers, service managers, families and other stakeholders face or envisage need to be considered. These could include[232]:

1. Cultural and societal views and beliefs toward sexual health.
2. Stigma, embarrassment, and discrimination
3. Lack of education, training, and confidence of health care providers
4. Quality of relationships between patients and health professionals.

Cultural and societal views and beliefs around sexual health have developed and changed over the past 60 years within the UK[233]. Changes in behaviour appear to be greater in women than men, whether this is due to willingness to report their experiences or to engage in new experiences[9]. Such changes reported in the latest National Surveys of Sexual Attitudes and Lifestyles (NATSAL) include increased numbers of partners and greater likelihood of same-sex experience across all ages and sexual activity continuing into later life[9].

To help combat stigma, embarrassment, and discrimination that older adults face regarding sex and relationships, the University of Sheffield developed the UK's first ever Sexual Rights Charter[234] Lead researcher, Dr Sharron Hinchliff has said "A third of over-70s have sex at least twice a month but they face huge barriers particularly when it comes to seeking advice about sexual health."[12] This Sexual Health Charter aims to transform the conversation around ageing and sexuality and is designed to help GPs, health care professionals, service providers and the community to develop inclusive practices and policies that stop stigma and discrimination towards older people regarding their sexual health. The Charter[235] provides a range of materials to help educate and train the healthcare professionals that work directly with this age group and is accompanied with training to upskill and inform staff to improve sexual health literacy for professionals and patients.

In addition, sexual health problems can be a sign of other undiagnosed conditions, medication side effects, or an indication of an STI, all of which can be treated Improvements in the sexual health can also result in other mental, physical, and emotional health benefits[236237238].

The focus of the current Richmond sexual health strategy on young people has been effective, however, there is a need to ensure this is not delivered at the cost of other age groups. There are no strong health promotion activities, for example, for those coming out of long-term relationships who may be seeking new partners and who may engage in condomless sex due to the absence of pregnancy risk.

The COVID-19 pandemic is thought to have aggravated the aforementioned health inequalities, especially with regards to the move towards online based services and telemedicine; digital poverty being a factor especially amongst older residents and the homeless.

Some older people will be in care homes. With increased age there can be additional challenges in relation to decreased, mobility, increase frailty and reduced access to transport to health care services.

Consultation carried out as part of the ISH service review revealed a lack of sexual health services for older adults (retired plus) and their difficulty accessing reproductive and sexual health services due to poor mobility and transport links. There was a general impression that as people age, they are less likely to be sexually active and therefore have a reduced need for targeted service provision. Older residents reported that they were more likely to access general practice for help and support with sexual and reproductive health; and some felt that older people would be unlikely to seek help due to embarrassment. To overcome this, education was felt to be key, particularly in relation to enabling men to understand that sexual dysfunction can indicate other health issues such as cardiovascular health and vice versa. Considering sexual health alongside other health conditions was felt to be a positive way to address sexual health concerns.

Services that were welcoming and provided alongside other primary health care services such as a specialist sexual health GP within a Primary Care Network hub, were thought to be the most effective. Online services were thought to be beneficial as they can be accessed without embarrassment, but not all older people were comfortable using such services or had online access. Emphasis on sexual and reproductive health related training and campaigns targeting for older people were felt to be a gap and needed increasing, particularly for people entering care homes.

Furthermore, challenges related to older people identifying as LGBTQ+ and those with HIV entering care homes, for individuals themselves, other residents, families and staff, were not sufficiently addressed and education and training was felt to be key for breaking down barriers. Sexual health and the impact of dementia was also felt to not be fully understood. Older people who have been using HIV treatment for much of their lives are now starting to access care homes. Further consideration of their needs and the ability of care homes to ensure care and treatment is non-judgmental is required.

With a now ageing population, it is vital that providers of sexual health and older people's services understand the needs of older people in their boroughs across various settings: living at home, supported living and in care homes. Information on sexual health advice and services needs to be developed specifically to include the needs of older people.

232 Barriers to older adults seeking sexual health advice and treatment: A scoping review - PubMed (nih.gov)
233 Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal) - The Lancet
234 UK's first ever Sexual Rights Charter launched to tackle aged based discrimination | Healthy Lifespan Institute | The University of Sheffield
235 Education & training – A Sexual Rights Charter for Older Adults (agesexandrights.com)
236 STIs in older people (ageuk.org.uk)
237 Sexual Activity is Associated with Greater Enjoyment of Life in Older Adults - PubMed (nih.gov)
238 Lack of sexual activity in older adults linked to health problems (news-medical.net)

**Key Findings:**

Sexual health for older people has been generally dismissed as older people are thought to be less sexually active. Opportunities to discuss sexual health into the later years need to be considered, particularly with carers / social care professionals working where older generations are entering care homes who may have an HIV status to enable continued care and treatment.

- Training on sexual health in later life for health, social care and community and voluntary sector service professionals.
- Development of a local sexual and reproductive health charter for older residents
- Provision of information about sex for older people
- Encouragement of local policy in care home establishments that promote access to private and personal space and confidentiality for residents.
- Consideration of sexual health sessions for older people within existing clinic sessions, or within general practice.

## Stakeholder Consultation

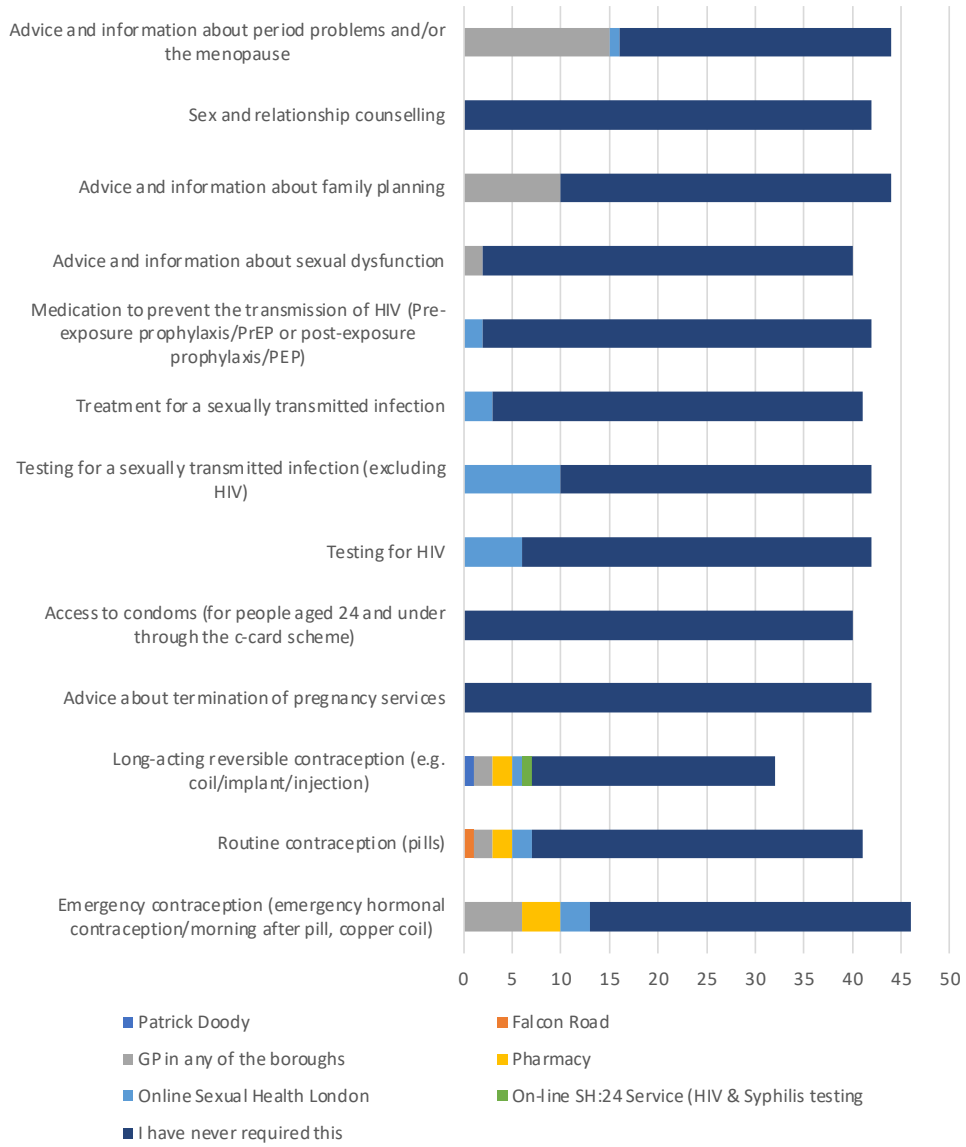
A residents' survey, wider staff survey, stakeholder focus groups and provider consultation were conducted in 2023 to understand use and experience of sexual health services. The consultation was primarily carried out to inform the re-commissioning of integrated sexual health services across Wandsworth, Richmond and Merton. The key findings from each of the consultations are presented below, information gleaned from other consultations conducted as part of the needs assessment has been weaved into the relevant sections:

## Residents Survey

54 respondents with a connection to Richmond completed the survey. 79% of the respondents were Richmond residents, the remainder were connected through work or education. Respondents were predominantly female (78%) and aged 45-54 (30%); 26% were aged 25-44. 48% were in a married or civil partnership. 76% of respondents described themselves as heterosexual, 11% as homosexual and 11% as bisexual. 85% identified as White ethnicity, 2% were Black and 5% were Asian or Asian mixed.

Of the 56 Richmond respondents, 36% said they had accessed sexual health support or advice more than one year ago, 27% within the last six months, 21% within the last year and 16% had never accessed a service. The majority of respondents (76%) confirmed that they were aware that they could access STI testing, treatment, contraception or advice from specialist sexual health services, 89% were aware of services from General Practice, 50% from pharmacies and 47% from online services. When asked which sexual health services respondents have used in the last year the most frequently used provision was for menopause care from a GP (34%). 24% obtained STI testing (excluding HIV) using online services and 21% had sought advice and information about family planning.

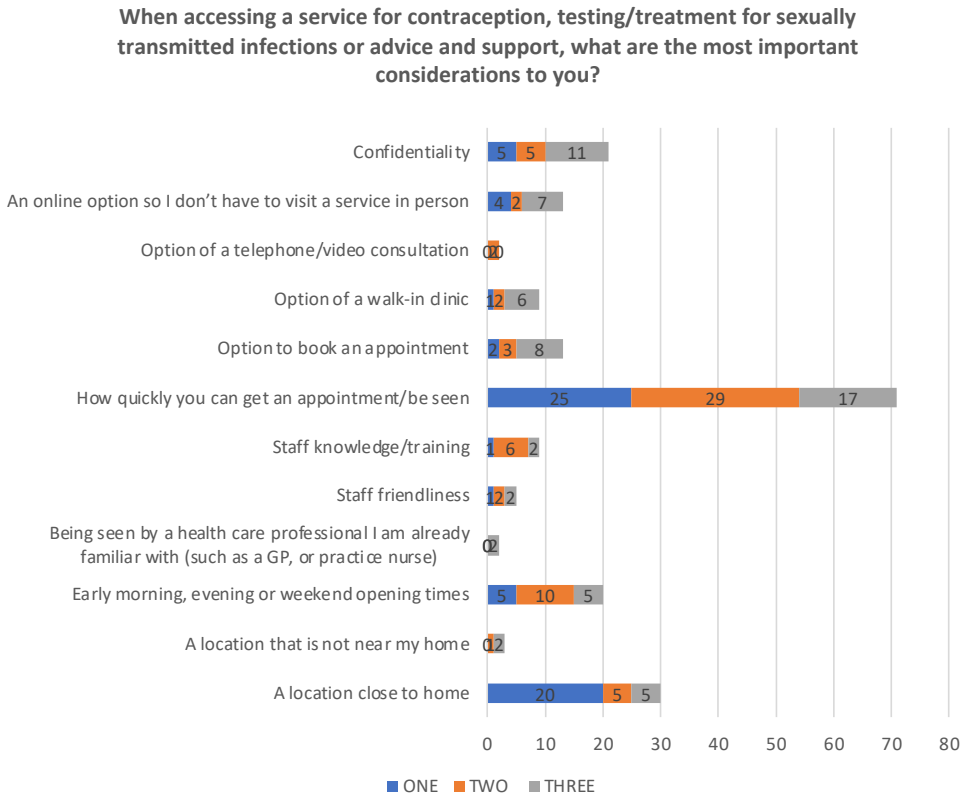
## Figure 83: Services accessed by Richmond residents




Source: Richmond residents survey (2023)

When asked what the most important consideration was for people to access contraception, STI testing / treatment or advice / support, Richmond respondents rated the most important consideration as the speed of getting an appointment followed closely by a service that is closer to home. Confidential services were rated as the third most important issue over all.

## Figure 84: Most important consideration when accessing services




Source: Richmond residents survey (2023)

Frustration with the lack of borough based sexual health provision was evident among Richmond respondents, with the loss of sexual health services at Acorn medical practice in Twickenham being most keenly felt. One respondent summarised this quite clearly:

> "I used to visit Acorn clinic in Twickenham which was much more convenient. Travelling to Wimbledon or Clapham isn't ideal when you live in Richmond".

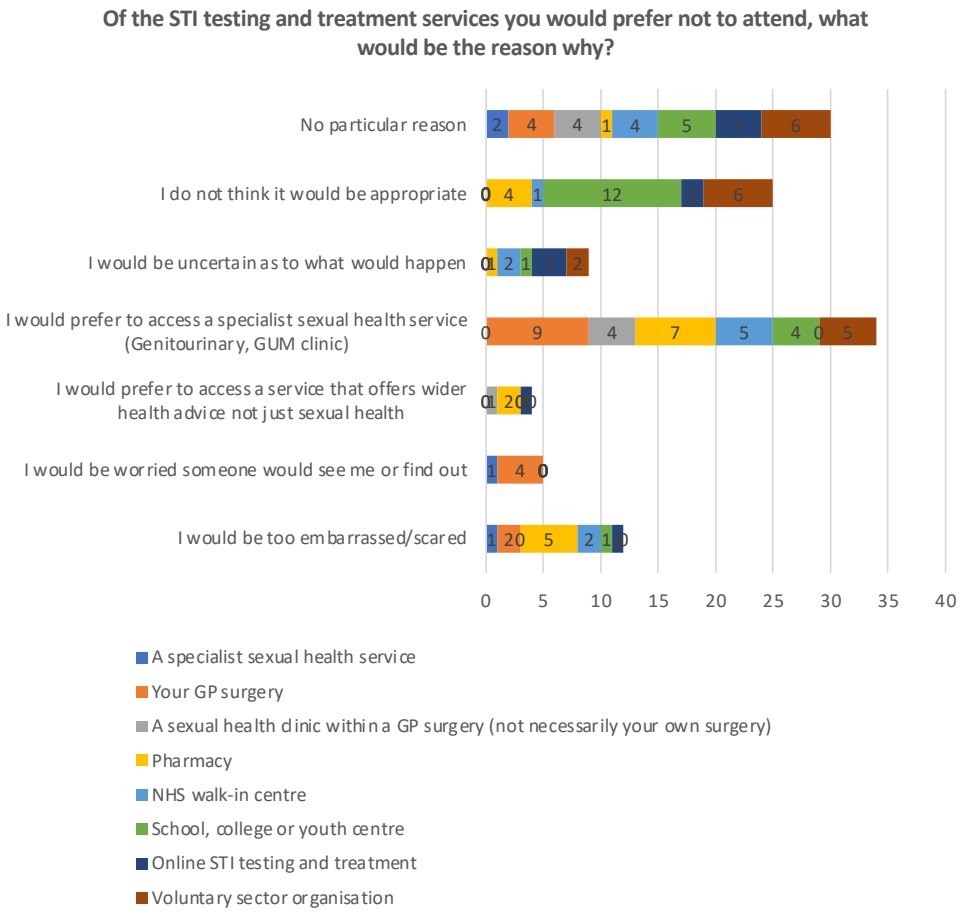
Information and communication about local service provision was also cited as being an issue and a frustration for respondents. Given that menopause care was the reason respondents most frequently cited use of sexual health services in Richmond one respondent also commented:

> "At age 55 the option for a coil removal / replacement is limited. Replacement is not covered under Sexual Health and as it's deemed for 'menopause', options are limited".

In terms of accessing services for testing and treatment for STIs (including HIV) respondents said they would most prefer to attend a specialist sexual health service, closely followed by a specialist sexual health clinic within their GP service. A general preference for specialist sexual health services was given as the main reason for not preferring other services. Additional reasons cited for not attending services were about lack of information regarding where services are located and a preference for specialist services to be integrated with other primary care services.

The limited walk-in provision and phone triage system offered by Falcon Road was reported as being a barrier for high-risk groups such as GBMSM, young people, sex workers and trans and non-binary people and they have limited financial ability to travel to services out of borough.

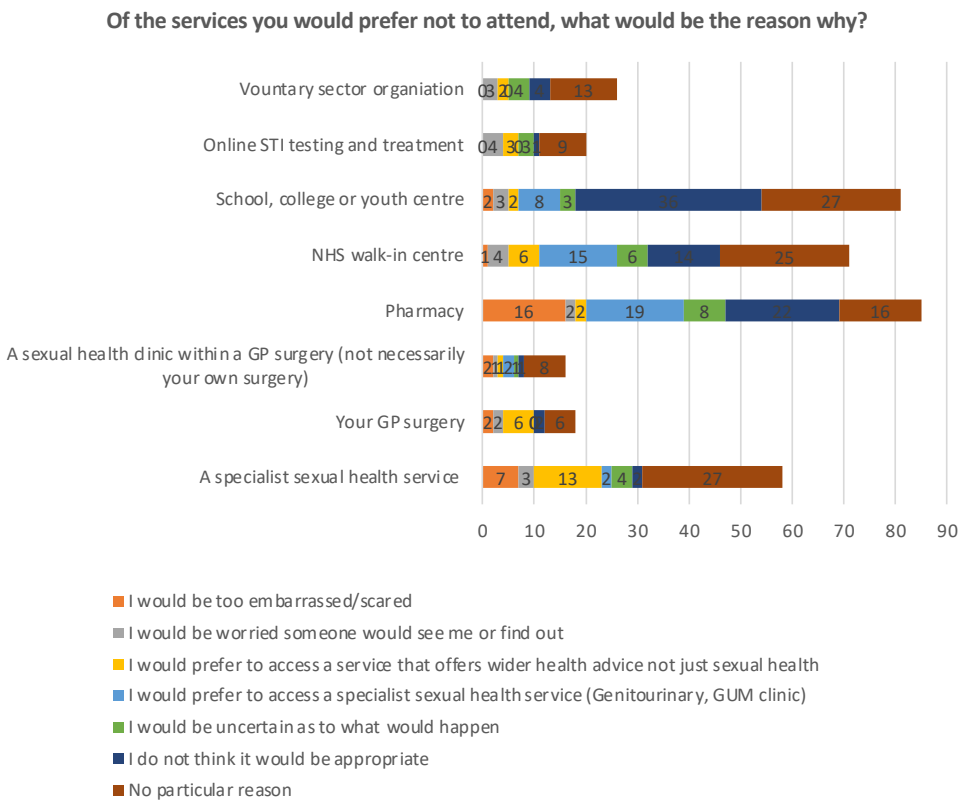
**Figure 85: Reasons for not attending STI services**




Source: Richmond residents survey (2023)

In terms of accessing contraceptive services respondents said they would prefer to go to their GP (55%) followed by a specialist sexual health service (24%). The most frequently cited reason for not accessing a specialist sexual health clinic was that they would prefer to be able to access wider health advice, not just sexual health. Respondents cited pharmacy as the service they would least prefer to attend for contraception, the most frequent reason was that it was felt to be inappropriate.

**Figure 86: Reasons for not attending contraceptive services**

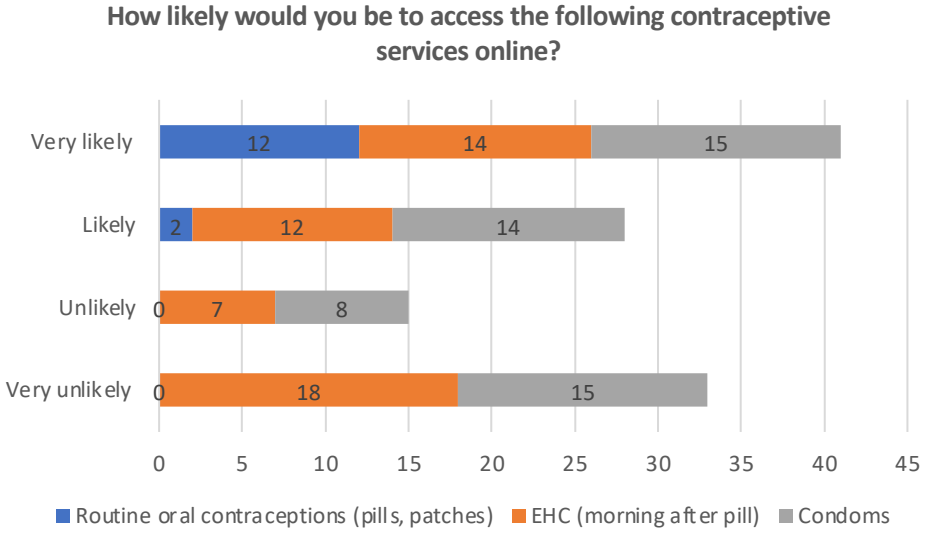



Source: Richmond residents survey (March 2023)

As part of the transformation of London SH services access to sexual and reproductive services online has been increased. This has included increasing access to both contraception access and STI testing and treatment. This in part was to enable face to face services increase capacity for complex cases.

Respondents were asked to reflect on their appetite for more online provision. Richmond residents suggested they generally have an appetite for this, but they would most likely use online services to request condoms and less likely for routine oral contraception, although this is offered in some London boroughs and is being explored locally.

**Figure 87: Likelihood of accessing online contraceptive services**




Source: Richmond residents survey (March 2023)

The most likely reason given for not wishing to access online contraceptive services was that they were not aware that this could be an option.

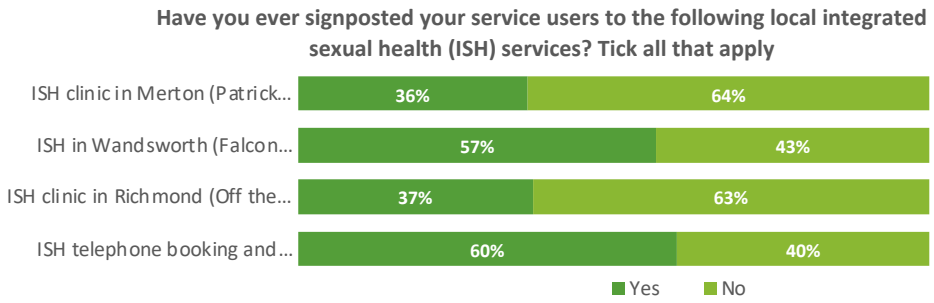
Finally, respondents were asked if they had any other comments regarding sexual health provision in Richmond. Most comments were about the lack of availability of in-borough services, particularly access to walk-in provision and improved publicity / signposting for existing services.

## Staff Surveys and Focus Groups

Staff consultation on sexual health service provision was conducted through surveys and focus groups with staff both within and external to sexual health service provision. Staff most affiliated with Richmond came from adult social care, pharmacies, general practice, community and voluntary sector services and education settings, Kingston and St George's Hospitals. Their professions included GP / medical consultant, pharmacist, social worker, care worker, nurse, early help practitioner, administrator and teacher, demonstrating a wide variety of responses.

60% of the 36 respondents said they had signposted their service users to the ISH telephone booking line and 57% to the ISH service at Falcon Road:

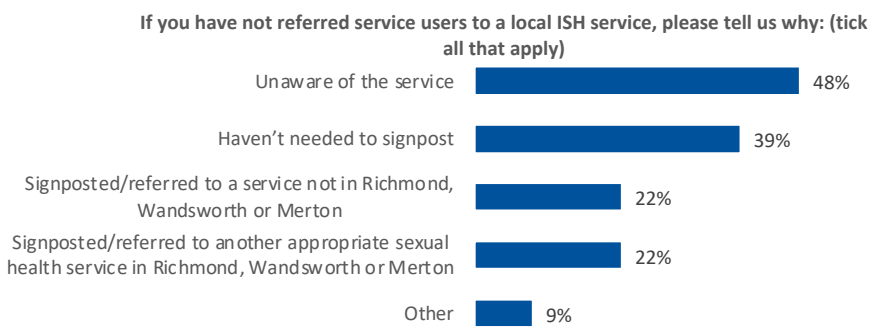
### Figure 88: Signposting to sexual health services




Source: Richmond staff survey (2023)

More interestingly, 48% of respondents cited being unaware of the service as a reason they had not referred service users.

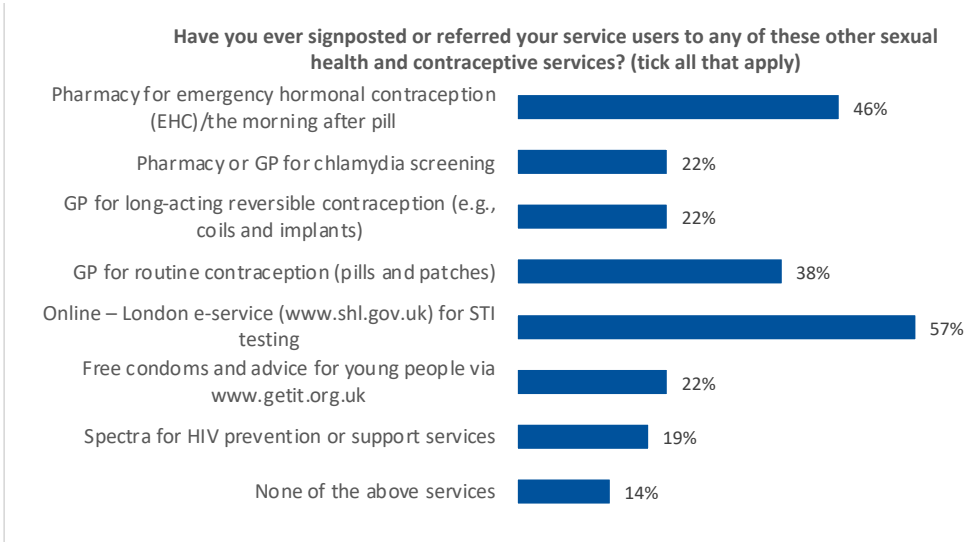
### Figure 89: Staff awareness of ISH services




Source: Richmond staff survey (2023)

The most common reason for referral to a sexual health service was for online STI testing, closely followed by a need for EHC in pharmacies:

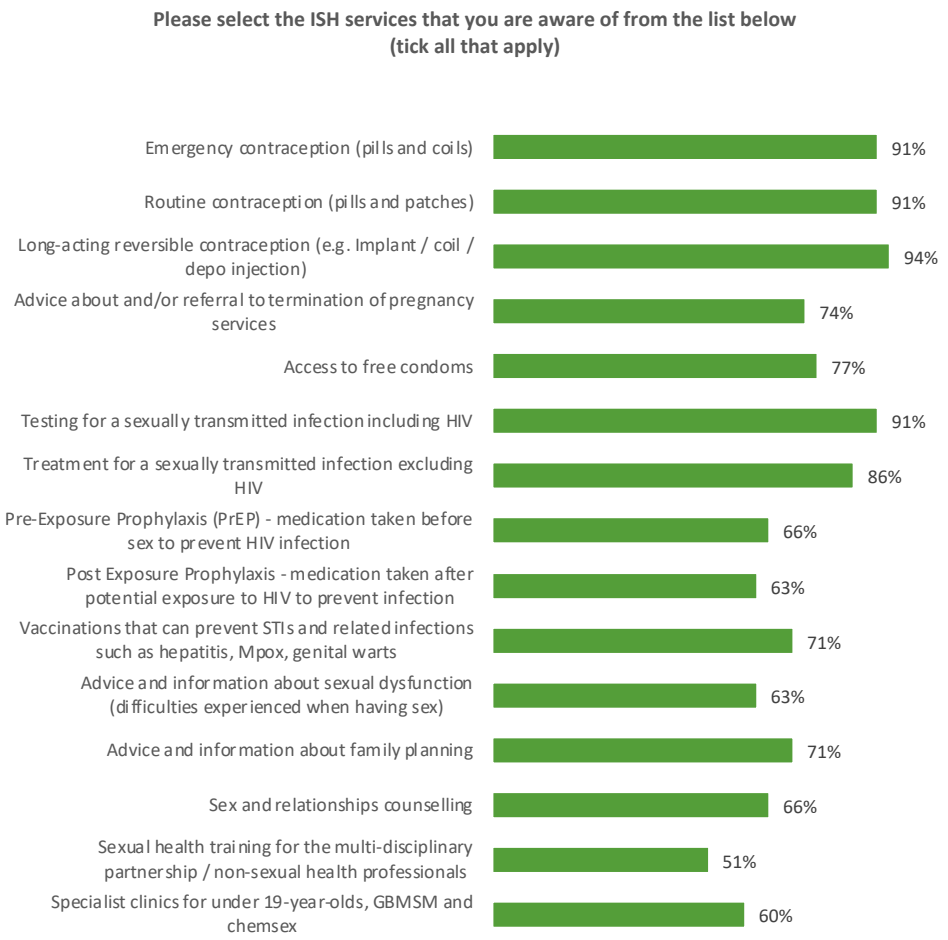
### Figure 90: Staff awareness of wider sexual health services




Source: Richmond staff survey (2023)

Awareness of the variety of sexual health services among staff was varied, with most knowing about LARC, STI testing and treatment and routine contraception / EHC. Less well-known services included sexual health training for non-sexual health specialists, specialist clinics for under 19s, GBMSM and chemsex, sexual dysfunction and HIV preventive medication.

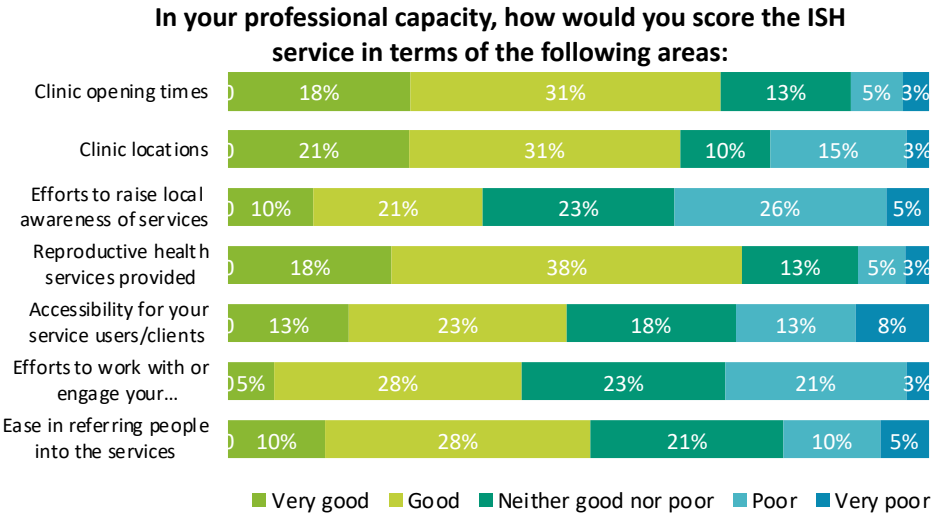
## Figure 91: Staff awareness of ISH service interventions




Source: Richmond staff survey (2023)

Respondents were asked to rate various elements of the ISH service. The reproductive service offer (contraceptive services) and clinic opening times were seen to be the most positive aspects, but the least effective elements were the efforts to raise local awareness of services and engage with partners. This chimed with comments from the residents.

## Figure 92: Quality of ISH service provision




Source: Richmond staff survey (2023)

Respondents felt that communication with stakeholders could be best improved through direct email correspondence and staff attending key meetings. Where services were rated as poor or very poor stakeholders reported that the lack of provision of sexual health services in Richmond other than for young people and difficult transport access to Clapham Junction for complex provision. Staff also commented that contraceptive services were limited with patients being bounced back to GPs for routine contraception. Access for more vulnerable clients, especially those with disabilities, was perceived as challenging due to complex online and telephone booking systems as well as difficult entry to the building.

Focus groups conducted with a range of partners in key services including public health, GP, pharmacy services, disability services, voluntary services, social care and 0-19 health services found common themes that resonated with survey findings. A common theme was the lack of information about the sexual health service offer in the borough and pathways into and through the service. The lack of services in Richmond was a strong theme as was the pressure on GPs and pharmacists, who would be generally willing to provide additional services, especially LARC services, but not without funding or training and with support from the ISH service. Feedback from patients using GP and pharmacy services also indicated a dissatisfaction with waiting times for LARC at ISH and Falcon Road Hub was thought to be not ideal for patients situated on borough boundaries[239].

Capacity to increase sexual and reproductive services within both General Practice and Pharmacy was felt to be limited. The transient nature of the pharmacy workforce further limits provision. Strengths regarding existing provision included the close transport links of the Falcon Road specialist clinic, the excellent response of the service to Mpox, EHC provision in pharmacies, home-testing and young people focussed specialist services. Some solutions however, to further improve were put forward:

- Development of a sexual health service map to avoid inappropriate referrals.
- Guided tours of the service to encourage use by vulnerable groups
- Fast-track system for vulnerable groups
- Increase sexual health training for non-sexual health care professionals
- Direct line to sexual health services for professionals referring vulnerable clients
- General improvements to the ISH phone system to reduce phone waiting times.
-

## Sexual Health Service Staff Consultation

Further consultation with staff within integrated sexual health services confirms that those presenting at specialist services need more complex care although general demand fluctuates with unpredictable media coverage.

**Changing demands on services:** Demand for walk-in sessions has increased and options to book appointments online too far in advance often increases non-attendance. Services are seeing an increased demand for LARC and routine coil fitting to help manage menopause, driven largely through GP referral, but this often leaves women disappointed as this is not offered by the service (as LARC fitting for gynaecological indications is not commissioned by local authorities). There is a need, however, to ensure there is an element of routine contraception work, including LARC fitting to ensure skill development to enable management of complex cases.

Incorrect referral for long-term management of PrEP, which can only be provided through hospital-led HIV clinics (due to specialist monitoring for possible kidney issues) also undermines confidence in the service. The view of the service is that the only specialist clinic still required would be a young people's clinic as there is a reduced demand for specialist GBMSM clinics. The central nature of the specialist ISH service based at Clapham Junction is necessitated due not only for ease access from transport links, but also for access to professionals to undertake sexual and reproductive health training for the development of specialist skills in contraception, STI and HIV treatment and management, particularly for complex case management.

**Workforce pressures:** As with many health services, there is a risk to the workforce regarding workload pressures, high sickness levels, lack of availability of consultants in sexual health and budget constraints. Fragmented commissioning, particularly with HIV treatment services provided elsewhere, also leads to a lack of dual trained HIV/ genitourinary medicine consultants and low retention rates.

**Changing epidemiology:** Sexual health service staff report that changing sexual behaviours are leading to increased rates of infections such as syphilis in groups previously considered low risk, such as heterosexual groups causing an increase in cases of congenital syphilis and complex presentations such as neurosyphilis both of which require co-ordinated care across multiple specialties. Increased presentation and identification of child sexual exploitation, poor mental health and substance-misuse issues are all increasing demand on the service.

The recent Mpox outbreak highlighted the potential pressure from new and unfamiliar infections, particularly in a globalised world. Sexual health services were required to pivot and establish new service pathways alongside establishing vaccination programmes for both patients and staff. Current established referral routes within the NHS necessitate the need to refer to the GP for routine medical care including urology, circumcision, colposcopy, ultrasound and dermatology, these further delays treatment and patient care.

**Key Findings:**

Richmond residents have a range of preferences for how and when they engage with services. It is therefore paramount to offer a range of provision to meet differing needs, including both online and face to face provision in a range of settings. The residing factor is that services have accessible opening hours to meet all need. Some recommendations have been taken forward within the new sexual health service specification and sexual health provision is being expanded as far as funding allows. Service pathways, however, can be complex and would benefit from simplification. Demand on sexual health services is high prevention programmes will likely reduce this demand somewhat and should be the focus for the new strategy.

239 Sexual and Reproductive Health Services Procurement -primary care engagement update, Richmond and Wandsworth Public Health Presentation Dec 2023

## Key Findings and Recommendations

1 The population of over-45s is expected to increase in Richmond over the next ten years while those in the 25 to 40 age bracket will decrease and reduce demand on contraceptive and reproductive services, but there is likely to be an increase in the 15 to 24 aged population thereby altering the demand on sexual and reproductive services.

- Increased capacity may be needed for chlamydia, STI testing and contraceptive services over the lifetime of the next strategy.
- Additional training and skill development for those working with increasing older populations will be necessary.
- Access to contraceptive services for women should be focussed for those living in the north of the borough.

2 The COVID-19 pandemic, which was then followed by Mpox clearly reduced the capacity to deliver testing and diagnosis opportunities and some behaviour change in sexual behaviours were seen. The pandemic, however, created an opportunity to increase online service provision which has continued post-pandemic.

- There is now an increased appetite for online sexual health services. This approach should be utilised in relation to expanding the provision of contraception online.

3 The number of births continue to decline in Richmond and there is relatively good access in post-partum contraception, but maternal health deteriorated during the pandemic and will take time to recover.

- Local services should take advantage of the new funding for pelvic health announced by the government and strategic approaches aligned.

4 Continued decline in under 18 conceptions are welcomed but progress needs to be maintained, particularly as Richmond has higher percentages of pregnancies leading to abortion than its statistical neighbours and under 18s in North Hampton and Healthfields wards fair worse than the rest of the borough.

- Prevention programmes should continue to focus on younger aged groups to ensure under 18s, particularly in higher rate wards, have clear pathways to services should they be identified.
- Provide appropriate advice, information and training to parents & carers to enable early conversation that build a strong foundation for RSE and protective behaviours through the life-course.

5 While the new RSHE statutory guidance and any planned updates are welcomed young people experience variations in how it is delivered in schools. Areas to develop include:

- Encouraging schools to ensure boys feel included in conversations about puberty and growing up.
- Open conversations about pornography - what it is and isn't.
- Activities that focus on perception versus reality in relation to young people's sexual behaviour.
- Information on STI prevalence, prevention, testing and treatment including contraception options for young people.
- Information about where and how to access the full range of young people's services including that sexual health services are ***free and confidential.***
- Information on reproductive health through the life course including where / when to seek help.
- Awareness of period poverty and schemes to address these.

6 Continue to support schools and local teacher training programmes to implement the national RSHE guidance including forthcoming updates.

7 There is a clear training need around sexual and reproductive education for the wider workforce. Particularly in relation to consent and the law, information about services and the development of practical skills to enable the workforce to engage residents in healthy discussion around sexual and reproductive health, including action to reduce period poverty.

8 There has been a steady increase in provision of contraception, particularly LARC, although this was hampered by the pandemic. There is an appetite from the local population to continue to increase access to contraceptive choices. This can be achieved through:

- Supporting Richmond to switch on the online contraceptive service offered by other London boroughs.
- Ensure the new national advanced pharmacy contraception service is integrated into the local sexual and reproductive health offer.
- Standardisation and harmonisation of the EHC pharmacy offer including IT platforms across all 6 SW London boroughs to support:
  - EHC cost supply.
  - Population health management
  - Service harmonisation
- Borough EHC training and accreditation across the 6 boroughs needs to be standardised, with guides to sexual health provision across each borough, safeguarding leads contacts and local training, and more multi-disciplinary engagement with Community pharmacy.
- Continue to encourage and enable LARC accessibility through general practice as routine practice, though provision in the North of the borough needs to be increased. Enable women to access LARC from GPs other than their own practice, if not already available or known about, could be explored.
- Develop streamlined pathways for LARC between providers.
- Increase number of LARC fitters at a local level, though recognising this is hampered by workforce issues.

9 Recorded instances of sexual offences in Richmond have been steadily increasing. Freedom from violence supports safter sexual relationships, reduces risk of STIs and enables access to sexual and reproductive health care. The HRBQ for Richmond indicates a number of key concerns experienced by young people in their early relationships, with some groups experiencing controlling partner behaviour more than others. There is a need to:

- Enable schools and youth services to support children and young people to understand the differences between healthy and unhealthy relationships.

10 There is a clear link between sexual and reproductive health strategies and existing violence prevention strategies, particularly VAWG strategies and safeguarding partnerships. Some areas for further consideration in both strategies could be:

- Support and enable schools and youth services to support children and young people to understand the differences between healthy and unhealthy relationships.
- Workforce training to enable conversations about sexual health to raise confidence to enable professionals to spot the signs of and respond to sexual harm and abuse.
- Refocus attention on identification and understanding of FGM post pandemic.
- Continue to support theatre in education programmes in schools and related resources to raise awareness of CSE and sexual harm / harassment.

11 Those in lower socio-economic groups and some ethnic groups may be less likely than those in higher socio-economic or White ethnicities to seek support for fertility issues.

- Development / delivery of a fertility awareness campaign targeting groups with lower uptake.

12 There has been a steady decline in uptake of cervical cancer screening and low diagnosis of other reproductive related cancers in Black, Asian and mixed ethnicity groups and those living in areas with higher levels of deprivation.

- Increase awareness of the importance of accessing cervical screening programmes
- Ensure education with regard to reproductive diseases is factored in to RSE and sexual and reproductive health education through the life course.
- Consider the development of MECC modules in relation to reproductive health (if not already available)?

13 There are clear disparities in relation to access to menopausal support and care, including the provision of HRT as women age.

- Ensure the sexual and reproductive health strategy aligns to the developing women's health hub.
- Ensure education with regard to the menopause is embedded within sexual and reproductive health education through the life course, including access to MECC modules.

**14** This needs assessment recognises that there are concerning increases in the rise of STIs in recent years, which have been more significant across London than in other areas of the country. This increase is believed to be over and above the increase in testing capability. Some groups are more disproportionately affected than others and prevention activities, including access to treatment should be targeted accordingly.

- Continue to support and emphasise HPV vaccination programmes in schools.
- Enhance chlamydia detection programmes through broadening chlamydia screening offer where possible – including encouraging more pharmacies in the north of the borough to offer chlamydia screening.
- Target testing for gonorrhoea and syphilis on undiagnosed individuals such as through partner notifications and promoting online testing programmes.
- Ensure awareness of full range of BBVs, including trichomoniasis are captured within RSHE and sexual and reproductive health education programmes.

**15** Low diagnosis rates and low testing rate for STIs in Richmond highlights the lack of local sexual health clinics. Increasing local access to sexual health spoke services is critical to improving testing rates especially for Young People and GBMSM.

**16** There is recognition that there is reasonable access to HIV testing in the borough, but this was hampered by the pandemic. Efforts to diagnose HIV as early as possible should be increased. This includes identifying and enabling underserved groups to increase access to PrEP.

- Continue to offer HIV and syphilis online screening and testing service through SH24
- Target HIV testing at high prevalence groups and those more likely to be diagnosed late
- Target PrEP uptake to relevant groups and in particular underserved groups
- Increase awareness of U=U
- Explore expanding provision of testing opportunities in general practice – with a view to rolling out an offer similar to that provided in Kingston.

**17** The total abortion rate has remained stable over the last five years, though the percentage of conceptions leading to abortion has increased possibly indicating an increase in unplanned pregnancies and a possible unmet need in contraceptive services and care.

**18** Increases in abortion rates for women aged 25 to 29 may indicate a need to target prevention to older women.

- Continue to ensure EHC / contraception is available to women over the age of 24 and is widely advertised.

**19** Increases in repeat abortions can indicate a lack of access to good quality contraceptive care.

- Increase availability of online contraception services
- Improve referral to contraceptive provision post abortion

**20** Sexual dysfunction disorders have been found to impact significantly on interpersonal functioning and overall quality of life in both men and women. Sexual dysfunction in men may indicate other risks in relation to cardiovascular disease, dementia and early death.

- Ensure sexual dysfunction in men is included within sexual and reproductive health education, heart health and dementia awareness campaigns. Including where and when to get help.

**21** Young people aged 25 and under are disproportionately affected by poor sexual health outcomes. Enabling access to sexual health services, particularly for young people at greater risk than others is key to a successful strategy. The significant distance to Falcon Road services from Richmond is a key issue for young people being able to access appropriate treatment. Top priorities identified by young people include:

- Young people focussed sexual health walk-in services.
- On-site provision of school based sexual health services.
- Assurance that sexual health services are FREE and CONFIDENTIAL
- Teachers trained in the delivery of RSE.
- Information on where, when and how to access sexual health support.
- More information on sexual and reproductive health through the life course.
- Online provision of STI testing and contraception.
- Interactive chat health websites for young people to ask questions in real-time.
- Promotion of Getting it on young people's websites.

**22** Black, minority ethnic groups are disproportionately affected by poor sexual health, with the black Caribbean community fairing particularly worse. Prevention programmes should be targeted to reach these communities. This may be strengthened through:

- Engaging and training health champions from these groups to raise awareness of sexual and reproductive health.
- Continue to offer online targeted STI and HIV testing as well as walk-in clinics.
- Sexual and reproductive health education

**23** Increases in STIs among GBMSM, in particularly gonorrhoea and syphilis is alarming and is likely not to be solely a reflection of increased and regular testing. The rise of antibiotic resistant bacteria adds to these concerns. Targeted prevention programmes are shown to be effective.

**24** The low proportion of high-risk individuals accessing PrEP is an area of concern especially given the social mixing of GBMSM beyond geographic boundaries.

**25** GBMSM using PrEP and those living with HIV need to be engaged in strategy development for GBMSM's sexual health. Continuing to promote access to PrEP for all relevant GBMSM remains a priority as does understanding how those using PrEP do so, in relation to sexual risk taking.

**26** Discrimination continues to be felt by LGBTQ+ people and this can impact on wellbeing which in-turn impacts on sexual and reproductive health, including access to sources of support. LGBTQ+ people should therefore be involved in service commissioning to ensure their particular needs are met.

**27** Trans people are a marginalised and often underserved group and are at higher risk of poor sexual and mental health outcomes.

- Funding for local bespoke Trans services, including peer-led holistic trans empowerment services, should be considered to better develop the support available to trans people from local service providers.

**28** The sexual and reproductive health needs of women who have sex with women (WSW) are poorly understood and frequently overlooked. More needs to be done to understand and adequately address the sexual and reproductive health needs of WSW:

- Improve training for health care staff
- Health prevention campaigns targeting WSW
- Ensuring health care services are LGBTQ+ inclusive, with the specific needs of WSW addressed.

**29** Using alcohol and substances is associated with poorer sexual health outcomes, however, chemsex was found to be practiced by only a minority of GBMSM, but there remains barriers to accessing services for those that do.

- Specific chemsex clinics within sexual health services may be an appropriate solution if not already provided.
- Sexual health services need to be able to discuss the different types of substances used by GBMSM and their different impacts on sexual risk taking.
- Substance misuse services (adults and young people services, including those offering needle exchange) should provide information, signposting and/or STI testing wherever possible.

**30** It is well known that people experiencing homelessness face significant health inequalities and have poorer health outcomes than the general population, including poorer sexual health outcomes and higher risk of STIs:

- People working with homeless or rough sleepers to sign-post to sexual health services.
- Exploration of an outreach service offer for this vulnerable group.

**31** The needs and experiences of sex workers are complex and often hidden. The new sex worker service is welcomed and key to ensuring the needs of this very vulnerable group are understood and responded to. There is more that can be done with mainstream services to ensure this group are included in service development and delivery:

- Training health and social care professionals to highlight key issues for this group, including need to safeguard over need to report.
- Training healthcare professionals to better identify and understand needs of sex workers.
- Ensure provision of safer sex harm reduction supplies including latex free condoms and menstrual sponges.

**32** Refugees and asylum seekers are already a very marginalised group and are less likely to be familiar with local health care and prevention services. There is a need to ensure outreach in relation to sexual and reproductive health is in place and is accessible in a variety of languages. This may include:

- Work in partnership with services supporting refugees, asylum seekers and migrants.
- Ensuring the high-risk sexual health service and HIV services are in operation within venues where refugees either reside or frequent.
- Training for workers and community groups on the sexual and reproductive health needs of refugee and asylum-seeking support services.

**33** When given sufficient and accessible sex and relationships education, many people with a learning disability are able to engage in safe, healthy and happy personal and sexual relationships and have a right to do so. Having a partner can also replace the potential need for support staff in later life.

- Increase promotion of sexual health services, RSE and sexual and reproductive health education to people with learning disabilities and to carers and professionals working with them.
- Support people with learning disabilities to use sexual and reproductive products including period hygiene products.

**34** Sexual health for older people has been generally dismissed as older people are though not to be sexually active. Opportunities to discuss sexual health into the later years need to be considered, particularly with carers / social care professionals working where older generations are entering care homes who may have an HIV status to enable continued care and treatment.

- Training on sexual health in later life for health, social care and community and voluntary sector service professionals.
- Development of a local sexual and reproductive health charter for older residents
- Provision of information about sex for older people
- Encouragement of local policy in care home establishments that promote access to private and personal space and confidentiality for residents.
- Consideration of sexual health sessions for older people within existing clinic sessions, or within general practice.

**35** Richmond residents have a range of preferences for how and when they engage with services. It is therefore paramount to offer a range of provision to meet differing needs, including both online and face to face provision in a range of settings. The residing factor is that services have accessible opening hours to meet all need. Some recommendations have been taken forward within the new sexual health service specification and sexual health provision is being expanded as far as funding allows. Service pathways, however, can be complex and would benefit from simplification. Demand on sexual health services is high prevention programmes will likely reduce this demand somewhat and should be the focus for the new strategy.

## Proposed Strategic Priorities (high level)

The development of this needs assessment has informed the development of six key high level strategic priorities for the forthcoming sexual and reproductive health strategy. These priorities have been proposed by the sexual and reproductive health needs assessment steering group and are currently being 'tested' as the findings of the needs assessment are socialised across various strategic partnership groups.

**1** RSE and sexual and reproductive health education through the life course, targeting disproportionately affected and underserved groups.

**2** Improve prevention and rapid, targeted diagnosis and access to treatment for STIs and HIV.

**3** Improve HIV prevention including the increased uptake of PrEP amongst underserved groups.

**4** Increase reproductive choice and prevention of reproductive related ill-health.

**5** Increase role of wider community in promoting positive sexual and reproductive health recognising links to emotional health and well-being.

**6** Increase sexual health service provision and access for Richmond adults.

# Appendix One:

## Sexual and reproductive health case studies[240]

| Case study title | Overview | Link |
|---|---|---|
| **Birmingham:**<br><br>**Tailoring support to the LGBT community** | Birmingham's sexual health service works in partnership with the city's leading LGBT charity to provide tailored support to the gay, lesbian, bisexual and trans community. There has been a dedicated sexual health clinic in place since 2015 and more recently the service has partnered with the substance misuse team to launch a Chemsex support service. | Birmingham: Tailoring support to the LGBT community \| Local Government Association |
| **Derby and Derbyshire:**<br><br>**Tackling the fragmentation of the sexual health system** | In Derby and Derbyshire, local government, the NHS and voluntary sector organisations have set up a section 75 partnership to encourage innovation and new ways of working in sexual health. The approach is helping to tackle some of the problems caused by the fragmentation of the system. | Derby and Derbyshire: Tackling the fragmentation of the sexual health system \| Local Government Association |
| **Bristol:**<br><br>**Using vending machines to engage under-served groups** | Vending machines offering free sexual health tests are offering alternative way to access HIV and STI testing kits in an effort to reach groups who may traditionally face stigma accessing these services. | Bristol: Using vending machines to engage under-served groups \| Local Government Association |
| **Lambeth, Southwark and Lewisham:**<br><br>**Engaging black and Asian and multi-ethnic communities** | In 2020 the south London boroughs of Lambeth, Southwark and Lewisham sought to tackle the inequalities faced by black, Asian and Latin American people by commissioning a sexual health promotion service to work with these communities | Engaging black and Asian and multi-ethnic communities \| Local Government Association |

240 Case studies | Local Government Association

| | | |
|---|---|---|
| **Portsmouth:**<br><br>**Creating a Network of Contraception Champions** | Portsmouth's sexual health workforce has been upskilling frontline staff from other services to have healthy conversations about sexual health and in particular pregnancy planning. Staff including midwives, health visitors and social care workers have all received tailored training. | Portsmouth: Creating a Network of Contraception Champions \| Local Government Association |
| **Liverpool:**<br><br>**Improving Access to Contraceptive Services** | Women across Liverpool have easier access to a range of services, including contraception, thanks to a network of clinics, GP hubs and pharmacies. It has ensured that no woman in the city is more than a 15-minute walk from a contraception service. | Liverpool: Improving Access to Contraceptive Services \| Local Government Association |
| **East Riding:**<br><br>**Clinic on Wheels - the Importance of Outreach Work** | In East Riding a mobile sexual health clinic has been established, allowing staff to take services direct to where people are. It forms part of a multi-pronged approach to reach out to local people, especially the young. | East Riding: a Clinic on Wheels - the Importance of Outreach Work \| Local Government Association |
| **Staffordshire, Stoke and Telford and Wrekin:**<br><br>**The Benefits of Joint Tendering and Economies of Scale** | Commissioners from Staffordshire, Stoke on Trent and Telford and Wrekin councils worked together to jointly tender for sexual health and HIV services. The move has had a variety of advantages, allowing the three areas to benefit from economies of scale and better partnership working with each other and the provider for the benefit of the patients. | Staffordshire, Stoke and Telford and Wrekin: the Benefits of Joint Tendering and Economies of Scale \| Local Government Association |
| **Liverpool:**<br><br>**Setting up a network of women's health hubs** | Liverpool City Council has worked with the local NHS to set up a network of women's health hubs in GP surgeries. The hubs offer both NHS and council-commissioned services from cervical screening to long-acting reversible contraception (LARC). | Liverpool: Setting up a network of women's health hubs \| Local Government Association |
| **Leicester:**<br><br>**Running a sexual health clinic in a shopping centre** | A sexual health clinic has been set up Leicester's main shopping centre. It was chosen because it was convenient, but also through a desire to destigmatise sexual health. | Leicester: running a sexual health clinic in a shopping centre \| Local Government Association |