Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24

Final draft

Lambeth, Southwark, and Lewisham
Public Health Departments

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Lambeth

Lewisham

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Contents

Glossary

The following list provides a glossary of common terms used throughout this strategy.

ART	Anti-retroviral therapy
BAME / BME	Black and minority ethnicities
BASHH	British Association for Sexual Health and HIV
CCG	Clinical Commissioning Group
Chemsex	Sex that occurs under the influence of drugs
CSE	Child sexual exploitation
EHC / EC	Emergency hormonal contraception
EJAF	Elton John AIDS Foundation
EMA	Early medical abortion
FTC	HIV Fast-Track Cities initiative
GHB/GBL	Gammahydroxybutrate / gammabutyrolactone
GP	General practice
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSV	Herpes simplex virus
LARC	Long-acting reversible contraception
LGA	Local Government Association
LGV	Lymphogranuloma venereum
LGBTQI+ others	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, and
LSL	Lambeth, Southwark, and Lewisham
MC	Molluscum contagiosum
MSM	Men who have sex with men
NHS	National Health Service
OC	Oral contraception
PEP(SE)	Post-exposure prophylaxis (for HIV) (after sexual exposure)
PHE	Public Health England
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis (for HIV)
PSHE	Personal, social, health and economic education
Sexual health	Sexual health is used interchangeably with sexual and reproductive health
RSE	Relationships and sex education
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TasP	Treatment as prevention (for HIV)
TOP	Termination of pregnancy; abortion
UDM	User-dependent method (of contraception)
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV and AIDS
U = U	Undetectable = untransmittable
Women	In this strategy, the term ‘women’ (in the context of the reproductive health of those that have sex with men) encompasses both cis women and other women with uteri (e.g. trans men) that have sex with men.

1. Executive summary

Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England. We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and Black and minority ethnic (BME) communities suffering the greatest burden. Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

Since the publication of LSL's most recent strategy (2014-17), there have been some significant changes in the sexual health landscape. The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to end in the near future. New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts. Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them. Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics. Finally, the use of pre-exposure propylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publically-funded HIV prevention agenda nationally.

There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with a HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

New HIV diagnosis rates are falling across in LSL, but too many people still receive a late diagnosis, and there are an estimated 1,000 residents living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50-64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest rates of late diagnosis. Furthermore, a dispropoprtionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20-24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15-19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a

general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning to due antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms, or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders, and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available available on indicators for safe and healthy sexual relationships.

To build on the progress we have made and meet the most salient challenges facing our boroughs over the next five years, we will work together on four key priority areas:

Priority	Vision and key outcomes
Healthy and fulfilling relationships	People are empowered to make their sexual relationships healthy and fulfilling: ▪ People make informed choices about their sexual and reproductive health ▪ People in unhealthyor risky sexual relationships are supported appropriately
Good reproductive health across the life course	People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives: ▪ Reproductive health inequalities are reduced ▪ Unwanted pregnancies are reduced ▪ Knowledge and understanding of reproductive health and fertility are increased
High quality and innovative STI testing and treatment	The local burden of STIs is reduced, in particular among those who are disproportionately affected: ▪ There is equitable, accessible, high-quality testing and treatment that is appropriate to need ▪ Transmission of STIs and repeat infections are reduced
Living well with HIV	We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths: ▪ People living with HIV know their status and are undetectable (=untransmittable) ▪ People living with HIV are enabled to live and age well

This strategy sets out the actions we will take in each of the above priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. We know that this is an ambitious strategy, and we cannot deliver it in isolation. We recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, each borough will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Board in addition to each borough's Health and Wellbeing Board.

2. Context

2.1. What is this document?

This report sets out Lambeth, Southwark and Lewisham's (LSL) shared ambitions for sexual and reproductive health (SRH) in our boroughs for the next five years. Our strategy assesses the most up to date intelligence and information we have on SRH, sets out a number of priority areas for action between 2019 and 2024, and what actions we will take to address these priorities.

Appended to this document are two additional resources for readers: a **statistical appendix** which summarises the latest sexual and reproductive health data and intelligence in LSL, and a pack of **evidence summaries** which provides a short summary of the most up to date evidence and guidance in relation to each of our priority areas. The evidence summary pack also includes a full list of references (references are not included in the strategy itself for presentation purposes).

This document is presented in its current format for consultation purposes; a more attractive final version including forewords will be produced in late autumn for final authorisation by each local authority and publication.

2.2. Why do we need a joint strategy?

Separately, LSL face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions. We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately (in relation to the Public Health Grant) and in real terms, we spend a significant sum on sexual and reproductive health services to meet both the needs and demands of our populations.

As the challenges we face are similar, LSL are in a stronger position to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

To underpin our collaboration, we need a clear strategic direction for action. This strategy provides that direction.

When our last strategy was published in 2014, we set out to *improve sexual health in LSL by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities*. This focus on service delivery was appropriate for the time, a year after commissioning responsibility transferred to local government. In the period of the last strategy, we:

- Integrated sexual and reproductive health services across our local system, maintaining a high quality of delivery;
- Invested in and developed a new model of online STI testing and provided proof of concept for this type of service (leading to it being adopted across London);
- Commissioned community-focused HIV prevention programmes and rolled out condom distribution schemes; and
- Commissioned innovative and collaborative young people's services with a greater focus on overall wellbeing.

Four years on from our last strategy, some challenges remain, and there have been substantial changes in sexual health and in the system as a whole. There have been

improvements in many outcomes, but not experienced by all; a focus on reducing inequalities is more salient than ever. Despite the creation of new ways of accessing sexual health services, demand continues to rise, and access to other settings such as general practice is increasingly difficult. The availability of pre-exposure prophylaxis (PrEP) has transformed HIV prevention, especially for men that have sex with men (MSM), but condomless sex is now an increasing challenge, and some STIs are on the rise. The financial climate is ever more challenging, but despite this, we remain committed to investing in prevention and exploring new ways of delivering services.

We're proud of the innovative way we approach sexual and reproductive health service provision in LSL, and we strive to continue to be system leaders over the next five years (and beyond).

However, we can't make improvements in isolation. We recognise that good sexual and reproductive health is intertwined with many other areas of health and wellbeing, as well as our wider communities. This joint strategy has therefore been developed to complement and tessellate with a range of other local strategies in each borough, and other strategies at a regional level (e.g. Mayor's Health Inequalities Strategy).

2.3. Inequalities in sexual and reproductive health

The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population. Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, Black communities, and MSM.

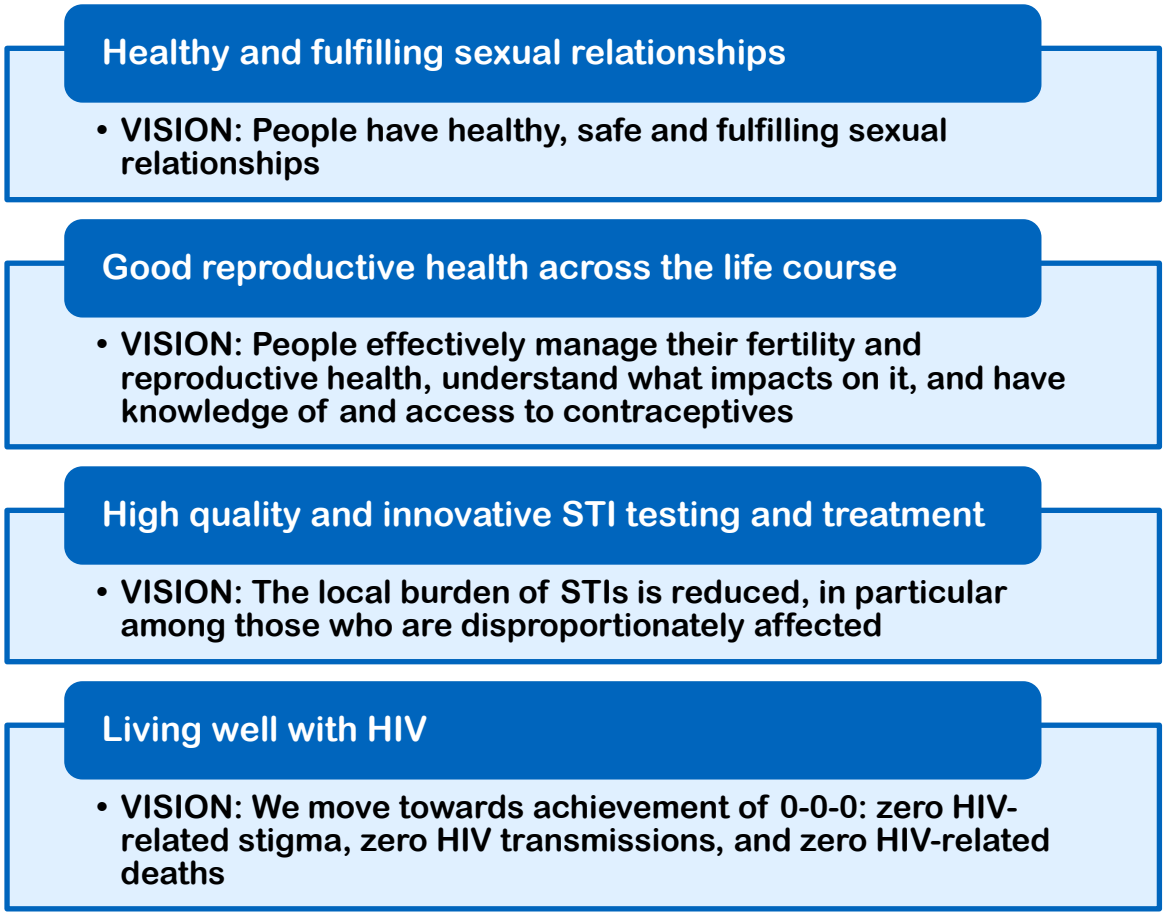
The following characteristics are Protected under the Act:

- Age
- Race
- Gender
- Disability
- Marital status
- Pregnancy and maternity
- Religion or belief
- Sexual orientation
- Gender reassignment

While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to also target resources to those most at risk in order to reduce the burden of poor sexual health in our communities. This theme is threaded throughout this strategy.

3. Our vision for sexual and reproductive health

Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:



4. Principles underpinning our strategy

LSL will work collaboratively to deliver our vision, guided by a common set of principles:

We will work in partnership, at a local, London and national level	We will commission high quality, effective and financially sustainable services, and capitalise on technological innovations	We will listen to service users' views and experiences and use these to improve what we do	We will focus on reducing inequalities in sexual and reproductive health	We will support the development of a resilient sexual health system

Prevention focused
Evidence based

5. Commissioning responsibilities and local services

We recognise that the commissioning landscape for sexual and reproductive health can be complex. Various bodies have commissioning responsibilities in this area, which could make delivery of a strategy challenging. This is why the first principle of our strategy is to 'work in partnership' to deliver our shared vision.

While local authorities are responsible for most sexual and reproductive health care, this is not exclusively the case. Since April 2013, local authorities, Clinical Commissioning Groups (CCGs), and NHS England have had commissioning responsibility for the following services:

Local authorities	▪ Contraception, including any enhanced services commissioned in general practice or pharmacy settings including all prescribing costs – but excluding contraception provided as an additional service under the GP contract ▪ STI testing and treatment, including chlamydia testing and HIV testing ▪ Sexual health aspects of psychosexual counselling ▪ Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies
CCGs	▪ Abortion services ▪ Vasectomy ▪ Non sexual-health elements of psychosexual health services ▪ Gynaecology, including the use of any contraception for non-contraceptive purposes.
NHS England	▪ Contraception provided as an additional service under the GP contract* ▪ HIV treatment and care, including post-exposure prophylaxis after sexual exposure (PEPSE) ▪ Promotion of opportunistic testing and treatment for STIs, and patient requested testing by GPs* ▪ Sexual health elements of prison health services ▪ Sexual Assault Referral Centres ▪ Cervical screening

*Delegated responsibility to CCGs locally

Public Health England (PHE) supports effective local commissioning by providing data and intelligence, guidance and also commissioning central prevention programmes (e.g. HIV Prevention England).

The commissioning responsibilities outlined above translate into the services and programmes on the following page, mapped against the key priorities of this strategy.

Priority	Safe, Healthy and Fulllfilling Relationships	Good Reproductive Health Across the Life Course	High Quality STI Testing and Treatment Services	Living Well with HIV
What does good look like?	▪ Knowledge, confidence and skills for safe, healthy and fulfilling relationships	▪ In control of their body and fertility ▪ Understand what factors impact on fertility ▪ Choice and access to a range of contraceptive methods	▪ Self-sampling of STIs ▪ Access to appropriate testing ▪ High quality clinical services	▪ Increased HIV testing ▪ Earlier diagnosis ▪ Retention in care ▪ Holistic health management
Commissioner: Council	High quality RSE in schools Targeted work to young people Tackling homophobia, transphobia, misogyny in communities Community outreach / targeted health promotion work Targeted CHEMSEX work	High quality RSE in schools Young people friendly services Knowledge of and access to full range of contraceptive offers Come Correct condom scheme for under-25s Integrated reproductive and sexual health services	High quality RSE in schools Young people friendly services Come Correct condom scheme for under-25s Online STI self-sampling or testing Integrated reproductive and sexual health services Specialist clinical services	Reducing stigma and promoting good sexual health Community outreach / targeted health promotion work Online STI self-sampling or testing Integrated reproductive and sexual health services
Council & CCG	Psycho-sexual health services	Online offer of oral contraception Pharmacy and primary care FGM prevention	Pharmacy and primary care testing	Pharmacy and primary care testing
CCG		High quality abortion services Vasectomy and sterilisation services		Care and Support
NHSE		HPV vaccination Cervical screening	PrEP	HIV treatment services

Table 1: Local sexual and reproductive health services mapped against strategy priorities

6. Our priorities

6.1. Healthy and fulfilling sexual relationships

What do we mean by 'healthy and fulfilling sexual relationships'?

Our ambition is for all people in our boroughs to be empowered to make their sexual relationships healthy and fulfilling.

We know that a large part of improving sexual and reproductive health outcomes is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Much of the work relevant to this topic falls within the remit of safeguarding teams and complementary strategies are available to support this work, addressing domestic abuse, violence against women and girls, and child sexual exploitation, among others.

However, Public Health has a role supporting relationships and sex education (RSE) in schools. Through effective collaborations, Public Health can promote and encourage partners, agencies, and providers to champion healthy relationships, with the aim of supporting people of all ages to understand and identify risky sexual behaviour and prevent abuse.

This chapter therefore serves as the preventative strand of our strategy.

Introduction

Background and policy context

Social relationships are an important determinant of health and wellbeing across the life course. A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships. Negative, harmful relationships have consequences to physical and emotional health and, in some cases, may drive a cycle of unhealthy behaviour. For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence, and control to engage in healthy sexual relationships.

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to raise awareness of exploitation or abuse. Despite this, schools currently (as of 2018) have had no statutory responsibility to provide comprehensive RSE. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions and STIs, and in increasing reporting of sexual exploitation and abuse. Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up, further highlighting the importance of appropriate RSE. However, recent national surveys, qualitative studies, and local surveys across LSL on RSE have revealed significant inadequacies in the breadth of topics covered and the quality of teaching.

Amendments to the Children and Social Work Act by the Department for Education have legislated statutory RSE across the UK as of September 2020, a delay on the anticipated 2019 start-date. This affords schools (maintained, academy, and independent) the opportunity to develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of our vulnerable women, young LGBTQI+ people, and others. Effective collaboration between partners and providers is critical to achieving this. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in secondary schools.

Schools will have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years has been set out by NHS England (April 2018) and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse, and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences and can help people of all ages to identify unhealthy relationship behaviours and give them the confidence to address it. Healthy and fulfilling sexual relationships are important for good reproductive health, and for reducing the risk of acquiring STIs and HIV. Empowering people to make their sexual relationships healthy and fulfilling is an integral part of a holistic sexual and reproductive health strategy.

Current picture

Epidemiology / local needs

We know that sexual health is more than the absence of disease, however, few data are available on the broader aspects, including safe and healthy sexual relationships. Proxy measures can instead be used to indicate general trends and suggest areas of improvement or good practice.

Comprehensive, contemporary RSE can empower people to engage in healthy sexual relationships and may act as a protective factor against future risky behaviour. Local research with young people in Lewisham and Southwark during 2016 and 2017 revealed views that 'relationships and sex' was the issue most concerning to young people and their peers. However, these studies also exposed sparse and inconsistent education about healthy relationships across different schools. Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex, and a general inclusion of healthy relationships. A key part of this is reducing stigma around sex and sexual relationships, and developing professionals' confidence and skills in having these conversations. Additional gaps in knowledge were identified in the legal consequences of sexting that, despite its prevalence in this age group, remained largely undiscussed in RSE.

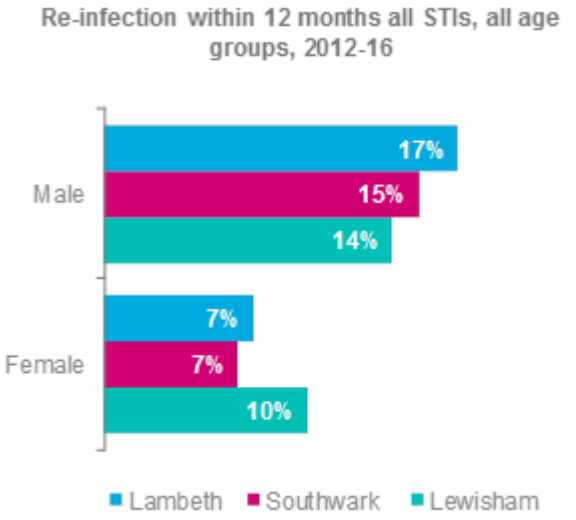
Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services has been a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme Come Correct, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful nationally. This is reflected in the high number of repeat users (compared to new registrations) locally.

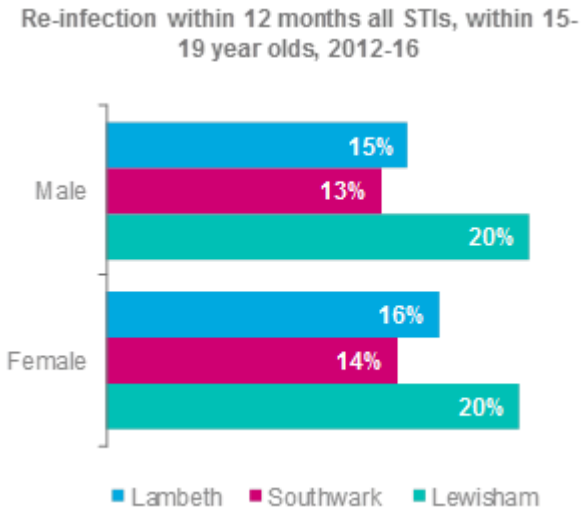
Abusive and coercive relationships affect people of all ages, genders, and sexualities but some groups are at higher risk of unhealthy sexual relationships than others. People identifying as LGBTQI+ may be at greater risk of experiencing abuse in a relationship. The prevalence of domestic abuse in MSM is high: from the age of 16, 49% report experiencing at least one episode of abuse. Given our significant local population of MSM, these figures are cause for concern. The prevalence of abuse in transgender people is even higher; an estimated 80% report experiencing emotional, physical or sexual abuse from a partner or ex-partner. Despite the risk for of domestic abuse in these populations, over half (53%) of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships

issues at school and therefore may not be sufficiently equipped with the knowledge and skills to engage in the sexual relationships that they want.

In 2016/17 across London, the rate of domestic abuse-related incidents and crimes recorded by the police was 23 per 1,000; women are nearly twice as likely to have experienced domestic abuse as men. The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime. While we lack quantitative data locally, qualitative research has highlighted the prevalence of emotionally abusive behaviour among LSL's population of young people. The 2017 Lewisham Healthwatch report 'Let's Talk About Sex' revealed young people were rarely identifying controlling behaviour or emotional abuse as evidence of an unhealthy relationship. The 2016 SHEU survey of secondary students in LSL found that 12-17% of students surveyed reported a jealous partner when seeking to spend time with friends and 10-14% said their partner looked through their phone.

Engaging in risky sexual behaviour, e.g. condomless sex, may be one of many indicators of an unhealthy sexual relationship. The rate of new STI diagnoses in LSL has been consistently higher than the London and England average since 2012. Re-infection with an STI indicates ongoing risky behaviour and across LSL men are more likely than women to become re-infected within 12 months of diagnosis. Young people are considered to be at increased risk of re-infection because they tend to lack the skills and confidence to negotiate safer sex. In 2016, twice the proportion of 15-19 year old women were re-infected compared to women of all ages. Lewisham had the highest rate of STI re-infection among LSL from 2012-16, particularly in young people.





'Chemsex' – sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL, and mephedrone – has become prominent in some parts of the MSM community. Through local surveys, we know that our population of MSM are more likely to use drugs associated with chemsex than MSM elsewhere in London or England. These substances pose significant health risks and risk of overdose. Qualitative research in Southwark indicated an increased mental health risk (including low self-esteem) for those who partake in chemsex. Research participants also identified vulnerability and risky sexual activity as common concerns since maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we need to ensure that people who are more likely to engage in risky sexual relationships are also appropriately supported and empowered to make safe, healthy decisions.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The focus on healthy sexual relationships in this strategy is a new development, in line with local needs and a changing policy context.

The introduction of statutory RSE from September 2020 is a significant achievement for public health and RSE advocates across the UK, and has created opportunities for the development of meaningful, relevant discussions of healthy sexual relationships.

In 2017, Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people. The services focus (to varying degrees) on the provision of services and information on sexual health, substance misuse, and mental and emotional wellbeing. Underpinning these services is an acknowledgement that young people take risks, and a shared ambition to support young people with risk-taking behaviours to build resilience, coping strategies, and decision-making skills. These services have been in place for a short time, but early outputs and service user engagement is encouraging.

Ongoing challenges

Data

Insufficient data are available to describe and quantify potential inequalities in achieving healthy relationships. We are working with our partners to explore methods of capturing early years risk factors (adverse childhood experiences), which impact on a child's risk seeking and taking behaviour later in life. Despite its growing impact in LSL, local data on the underlying causes of youth violence and the risk posed to young people involved are sparse.

We also don't fully understand the needs of sex workers in our boroughs, and their access to and use of services to support their sexual health.

Detailed needs assessments are on-going and planned to better understand local needs where routinely collected data are not available.

RSE provision

Until RSE is made statutory in 2020, provision will remain inconsistent across schools. As such, there are likely inequalities in children's experiences and understanding of relationships and sex. Individual programmes and workshops have been developed for schools, e.g. the Esteem programme in Southwark that delivers lessons on critical thinking around peer pressure and understanding healthy relationships. However, programmes such as this must be purchased by schools and there is therefore significant variation in provision across the boroughs.

Emerging issues

Youth violence

Serious youth violence (SYV) is a growing issue across London and LSL. Young people involved in gangs are at risk for a significant physical and mental health impacts; however, young women in particular are increasingly recognised as the invisible victims. UK research has exposed widespread sexual abuse of women and girls involved in gangs and in county line drug trade, who are frequently exploited as part of initiations or to pay off debts. Challenging the impact of gang violence and protecting young women and men is a regional and local priority. Among our local efforts is a Southwark school-based, peer-led workshop by The Participation People on understanding healthy relationships. In Lambeth, St Giles run a workshop 'Expect Respect' for women and girls at risk of exploitation. Helping young people

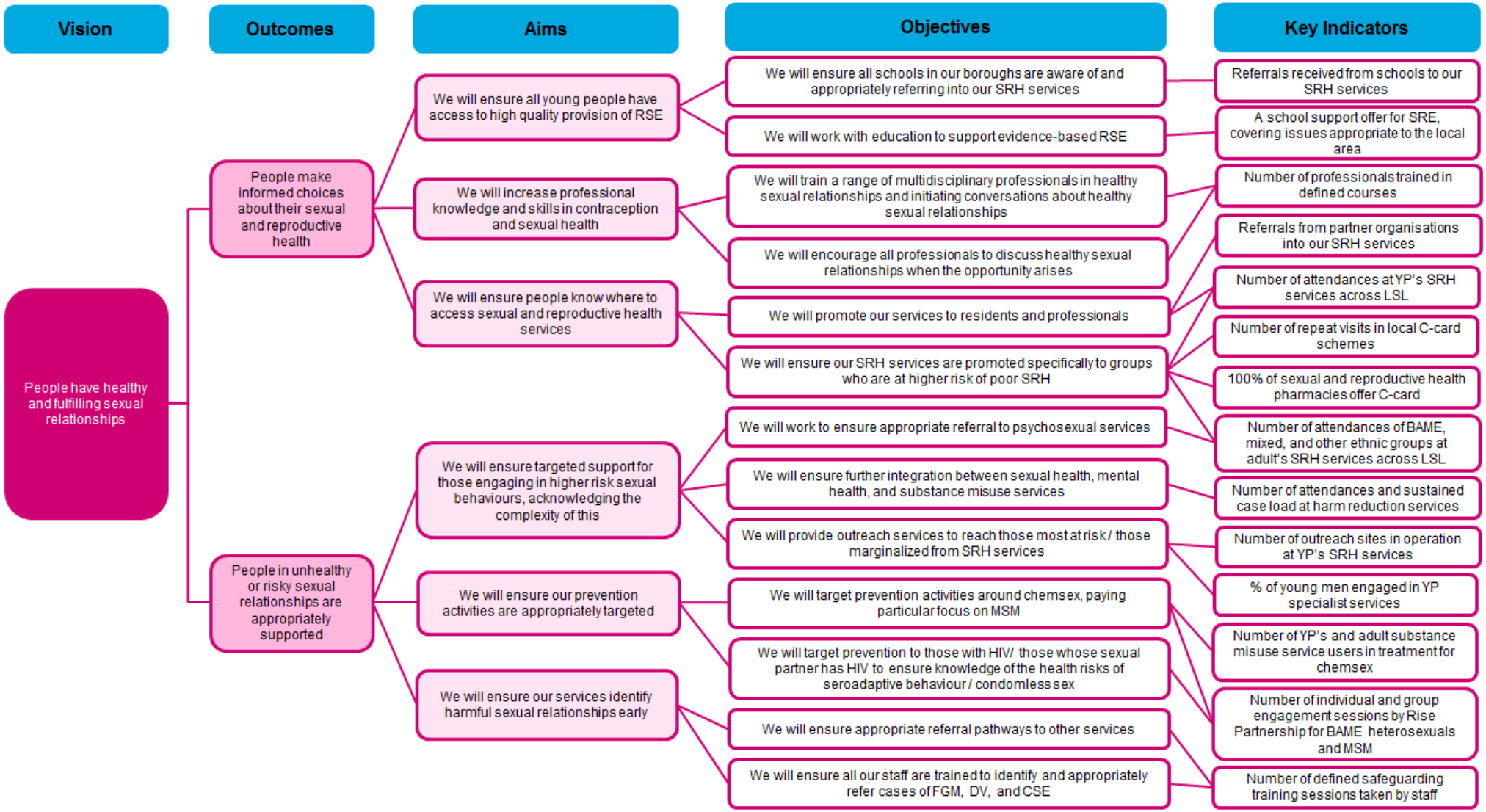
to recognise and avert risky sexual behaviour and relationships is a critical outcome for this strategy.

Online relationships and safety

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element, exposing children to new risks such as revenge porn and increasing opportunities for online grooming and exploitation. It is therefore critical that young people have the knowledge and the skills to operate safely online.

Healthy and fulfilling sexual relationships: what we want to achieve by 2024

The figure below sets out our vision for healthy sexual relationships in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



6.2. Good reproductive health across the life course

What do we mean by 'good reproductive health across the life course'?

Our ambition is for all people – but especially women and people with uteri – in our boroughs to have the skills, knowledge, and access to services that allow them to effectively manage their fertility and reproductive health.

The reproductive life course – starting at menarche and continuing through to menopause and beyond – is important for all, although the relative importance of reproductive issues varies between individuals and at different stages of life. Reproductive experiences and choices are embedded in and influenced by societal constructs, with societal and cultural expectations of what is 'normal' affecting how people, and especially women, make their reproductive decisions. There is a need for conversations about reproductive health to be normalised, allowing frank and open discussion, and enabling those who need additional support to reach it.

We recognise the importance of reproductive health on overall wellbeing, and that for many people, this includes the capability to have children and the freedom to decide if and when to do so. The birth rate is declining, as people delay their first pregnancy. This strategy does not focus on conception support, but on the wider factors affecting reproductive health. These include: knowledge and understanding of fertility, reproductive health, and contraceptive options; access to high quality contraception and termination services that meet the needs of all; and the uptake of screening, vaccination and testing programmes, which affect reproductive health in the long term, including if, when and how women choose to become pregnant. Professionals' knowledge, beliefs and attitudes are as important as those of individuals in improving reproductive health.

This chapter has clear links with our other ambitions in our strategy. Being in a healthy and fulfilling relationship and having access to high quality STI testing and treatment impacts on reproductive wellbeing. Thus, our ambitions in these other chapters will also contribute to delivering good reproductive health across the life course.

Introduction

Background and policy context

Nationally, the integration of sexual and reproductive health services under the umbrella of 'sexual health services' has been a positive development in terms of improving access to a wider range of services and reducing stigma. However, it has meant that the big issue of STIs has often dominated the national conversation around sexual health, as well as local and regional strategies. We want to redress this balance and focus on improving reproductive wellbeing in LSL.

Reproductive health is an important component of overall health across the life course, and can impact wellbeing at any stage, and can impact the wellbeing of children. Consequences of poor reproductive health exacerbate inequalities in health, education, and socio-economic status (and conversely, these factors also impact on reproductive health). In the UK, more than three-quarters of women of reproductive age want to either avoid or achieve pregnancy at any given time. Overall, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore require effective contraceptive methods. In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year. Unplanned pregnancies are also a missed opportunity to optimise pre-pregnancy health for both woman and child.

Unplanned pregnancies leading to maternity may have long-term costs not only in health terms, but also to local authority housing, education, and social care, and may have additional unintended consequences for the family itself. For example, teenage pregnancies may, in some cases, be costly to both mother and child in regard to earning potential and future employment. In the whole population, risk factors for unplanned pregnancy include lower

educational attainment, younger age, substance misuse, and smoking. Some BME groups have higher rates of abortion (an indicator for unwanted pregnancy), and this is the case for Black African and Caribbean women in LSL.

Some unplanned pregnancies, regardless of the age of the mother, will become wanted. However, a proportion will result in termination. Access to safe, legal abortion, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy.

Terminating a pregnancy has direct costs to the health economy: in 2010, approximately £143m was spent on abortions in England (the number and rate of abortion has stayed approximately stable since). In contrast, publically-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years. Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only is essential contributor to good overall health and wellbeing, but also yields savings for public services.

In 2013, the Government published a national 'Framework for Sexual Health Improvement in England', which recognised the need to ensure that people have access to the full range of contraception, that women with unwanted pregnancies are supported to make timely, informed decisions, and that local areas develop innovative, value for money interventions and services to respond to needs. The 2018 PHE guidance 'Sexual and reproductive health and HIV: Applying All Our Health' also emphasised the importance of facilitating easy access to the full range of contraceptive methods in a range of accessible settings. These ambitions remain central to local areas' reproductive health improvement strategies.

The LGA / PHE Teenage Pregnancy Prevention Framework (2018) was published to help local areas address and reduce teenage pregnancy, and suggested key factors for a successful, whole-systems strategy. This approach was first outlined in the 2016 report 'Good progress but more to do: teenage pregnancy and young parents,' by the same authors. This report highlighted the health inequalities experienced by young parents and their children and included best practice case studies. It remains a valuable resource to date.

In June 2018, PHE published the beginnings of a new 5-year framework for reproductive health improvement. This included a survey of women's views on reproductive health (the key findings of which are captured in sections below) and a professional consensus statement on six key pillars of reproductive health, as follows:

1. Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
2. Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
3. Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.
4. Proportionate universalism: The ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need.
5. User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives.

6. Wider determinants: The opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

Good reproductive health in LSL is thus reflective of a comprehensive, prevention-centred, whole-system approach to reproductive wellbeing that offers support from adolescence through to older age, targeting those most at risk in order to reduce inequalities. At any reproductive stage, individuals should have the ability and freedom to make choices about the aspects of their reproductive lives, and be able to access a range of contraceptive methods and other reproductive support services. Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services to ensure people continue to enjoy safe and healthy sexual lives.

Despite the availability of guidance, improvement frameworks, and quality local services, challenges remain in preventing unwanted pregnancy and in ensuring knowledge, uptake and access to contraceptive options across LSL.

Current picture

A declining birth rate and older age of first maternity

There were a total of 13,433 births to women living in LSL in 2016. The general fertility rate (measured as the birth rate) in LSL has been declining since at least 2012. The birth rate is lower in Lambeth and Southwark than it is in Lewisham: in 2016 the birth rate in Lambeth was 47.4 births per 1,000 women aged 15 to 44 years, compared to a rate of 54.3 per 1,000 in Southwark. Lewisham (63.7 per 1,000) had a similar rate to London (63.6) and England (62.5). This is linked to women choosing to delay their first pregnancy.

The mean age of mothers having their first live child has increased over time nationally. In 2016, the mean age of first time mothers in England was 28.8 years and has been increasing by 0.2 years annually for the previous ten years. A similar pattern can be seen in LSL; hospital admission records show that in 2016/17, the proportion of deliveries to women aged 35 years or above was 33%, 31% and 32% respectively. Between 2014/15 and 2016/17, there has been an increase in the proportion of deliveries to women aged 35 years or above by 2.2% in Lambeth, 1.9% in Southwark and 2.3% in Lewisham suggesting that more women are having children at a later age.

Prevention of HPV

The national human papillomavirus (HPV) immunisation programme was introduced to protect women against the main causes of cervical cancer, which in turn impacts on reproductive health. The national target in England is for 95% of all Year 8 girls to have received at least on dose of the vaccine. LSL did not meet this target in 2016/17, with 90% coverage in Lambeth, 86% in Southwark and 82% in Lewisham. The London coverage rate was 83.8%. There has been a slight improvement in LSL in recent years, although Lewisham remains consistently behind Lambeth and Southwark.

As of July 2018, the Joint Committee on Vaccination and Immunisation recommended HPV vaccination be extended to boys aged 12-13. However, the specifics of this programme remain unknown. Trans men and women, and MSM are eligible for the HPV vaccine up to and including age 45 through sexual health clinics.

Knowledge and attitudes toward contraception

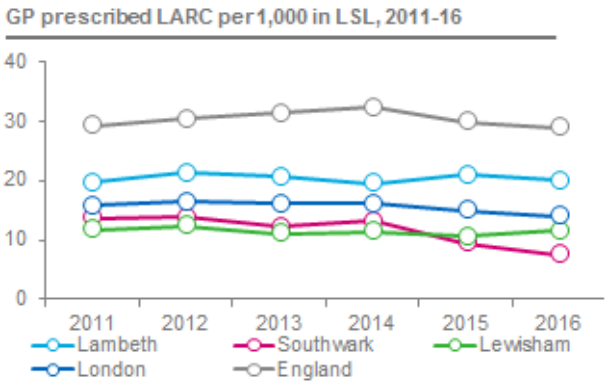
Contraception is important for all women of reproductive age who have sex with men as it enables them to effectively control if and when they choose to become pregnant. If women do want to become pregnant at some stage, contraception also provides a longer opportunity to address health issues in advance of the pregnancy, leading to better health outcomes for both mother and child. Contraception is not purely a woman's responsibility, but women need to be empowered to make conscious decisions about their reproductive life, and have the knowledge, skills and access to services to allow them to do so.

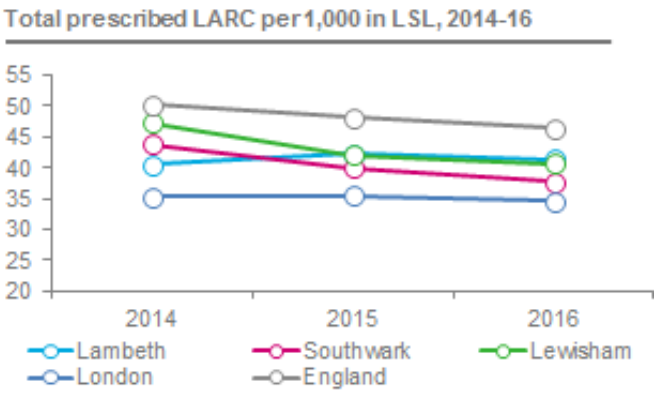
Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people about safer sex, types of contraception and local support services, in order to prevent unintended pregnancy and the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms, and this is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Poor knowledge of contraceptive options continues through to adulthood, and is perhaps reflected in high rates of user-dependent methods (UDM) such as the contraceptive pill and condoms. Recent focus groups with women across LSL demonstrated poor knowledge of LARC methods in older women of reproductive age (range: 25-45 years), and while younger women (18-24 years) knew about a wider range of contraceptive methods including LARC, there were misconceptions about their use and safety. We acknowledge that our population is fluid; young people that go to school in our area may not stay in our area as adults, and vice versa. However, there is a clear need for improved education as part of RSE in schools, in addition to public awareness campaigns. RSE was anticipated to be made statutory as of September 2019 but this has been delayed until September 2020.

Access to and choice of contraception

LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM. Of women attending SRH services, LSL women are more likely than the national average to choose UDM such as the contraceptive pill or condoms, and this is highest in Lewisham.





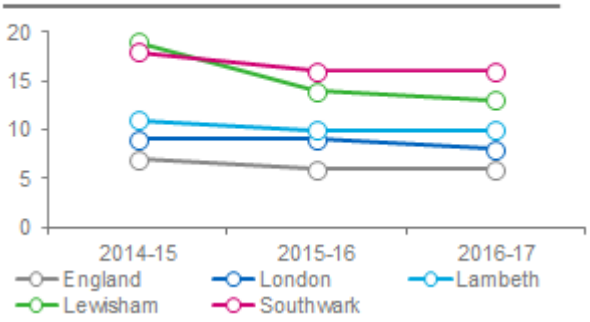
Rates of LARC prescription in general practice across LSL are lower compared to prescriptions at sexual and reproductive (SRH) services, with the exception of Lambeth. This is the opposite trend to England and likely reflects the accessibility of SRH services in our boroughs (and in London in general). Lambeth has better-developed sexual health provision in general practice, and this is reflected in these rates. However, LARC prescribing rates in

SRH across LSL are now lower than London. Compared to Lambeth and Lewisham, Southwark rates of GP-prescribed LARC have declined substantially, compared to stable rates of prescription from SRH.

Common issues in general practice preventing the provision of a LARC service include training and difficulty maintaining competency, general practice capacity (longer appointment time, availability of trained staff and chaperones, suitable rooms), and financial incentives (the opportunity cost of providing a different service in the same time).

Rates of emergency contraception usage are higher in LSL than England and London, and only in Lewisham have rates of EHC fallen in the past three years. Repeat use of EHC is a significant issue in LSL. 80% of women using EHC in Lambeth and Southwark pharmacies in 2016/17 self-declared previous use; half of these had used EHC in the last six months (Southwark). This is a strong indicator of unmet reproductive health needs and a major missed opportunity for intervention.

Women provided emergency contraceptives by SRH services per 1,000 population aged 16-54, 2014-15 to 2016-17



Listening to local women

Focus groups on contraception and reproductive health undertaken with a diverse sample of women across LSL in 2018 supplemented what data have told us about the needs of local women, with the following key findings.

Views on contraception

- Women are anxious about unwanted pregnancies and want to be confident in their contraception choices, so that they can fully enjoy sex. They also want to know that the contraceptive they use will not have a detrimental impact on their physical and emotional wellbeing, now and in the future.
- While they know that contraception is there for them, they have difficulty accessing services when they need it.
- Fairly low level of knowledge and low confidence, combined with false beliefs are reducing their perceived choices
- Many women feel they aren't always getting the full picture from professionals, and feel the way professional advice is delivered to them can be 'cold' and/or judgemental, failing to take in to account feelings and past experiences.
- Social taboos, stigma and fear of shame and embarrassment are major barriers to accessing contraception services.

The services women want

- Women who don't currently have their contraceptive needs met can be broadly characterised into two main groups:
  - Transactional: Women who know what contraception they want, but are having trouble accessing this;
  - Unsure: Women who don't know which contraception they want or aren't actively seeking contraception, who may need help to decide.

Services need to be more tailored to meet the needs of all of these women.

- Women described a need for 'whole woman' focused services that consider their wider needs around sex and reproductive health, that helps women feel positive and empowered though a discrete, non-judgemental and comfortable service.
- Women were in agreement about needing more choice in accessing contraception, e.g. whether she has to attend in person, or can access the service remotely through online/phone access and home or local pharmacy deliveries of contraception.

Women who are not using existing contraceptive services should receive opportunistic contraceptive advice when they are in contact with health services for other issues or conditions, for example, after taking emergency contraception, after having an abortion, or after having a baby.

Teenage conception

The rate of under-18 conception is consistently higher across LSL compared to London and England, which suggests an unmet need in contraception care as well as a failure to comprehensively tackle the wider determinants of teenage pregnancy. Moreover, this suggests a lack of awareness of, or confidence in accessing other more effective methods of contraception. LARC methods do not depend on daily concordance and have been proven more effective than oral contraception at only one year of use. Despite these benefits, uptake remains low in the UK and in LSL. This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

Since 1998, LSL has achieved dramatic decreases in teenage conception, however, the rates remain higher than in London and England. Teenage pregnancy is more likely to end in abortion than other age groups, and approximately two-thirds of under-18 conceptions in LSL are terminated.

Abortion

Across the life course, the rate of abortion can be viewed as an indicator of a lack of access to contraception services and advice, as well as problems with individual use of contraceptive method. Analysis suggests there are inequalities in the abortion rates in women aged 15-44 in LSL, with the highest rates among women identifying as Black African or Caribbean.

Across LSL, over 40% of abortions in 2017 were among women who had previously had an abortion that year ('subsequent abortions'). This is higher than the London and England average, and highest in Lewisham (44%). Subsequent abortions are also not distributed equally in the population, with Black African and Caribbean women again bearing the greatest burden. This indicates a lack of access to and/or use of appropriate contraception. New data on subsequent abortions in women aged under 19 years show that the rate of subsequent abortion in this age group declined slightly between 2016 and 2017 (in LSL, London and England), but rates are still too high given their younger age and missed opportunities for intervention. In 2017, 8.2% of Lewisham women, 11% of Lambeth women, and 13.1% of Southwark women aged under 19 who had an abortion had also had a previous abortion in that year. Rates of subsequent abortion in over-25s are not available.

The time immediately following abortion is an important period for contraceptive intervention, particularly LARC methods. However, LARC uptake in abortion services in LSL has remained below 45% since 2014/15, and has now declined to around 20%. This may be due to the increase in women choosing early medical abortions (EMAs, under 10 weeks), as opposed to surgical abortion or a later medical abortion. EMAs do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion. In 2017-18, local clinic data for LSL women indicate that 61% of abortions at BPAS and 64% of abortions at MSI were EMAs, slightly higher than the national rate (60%), and trends indicate that EMA uptake rates are expected to increase. Exploring other methods of on-going contraception (e.g. OC) while undergoing termination may serve as a bridging method until LARC is appropriate.

Admissions related to poor reproductive health

Pelvic inflammatory disease (PID) refers to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. About one-quarter of cases are caused by untreated STIs. Admissions for PID have been consistently higher in Lewisham than the other LSL boroughs and remains above the national average, but have declined since 2012/13 – by contrast, rates in Southwark and Lambeth have increased (but remain below the national average).

Ectopic pregnancy is a serious condition that usually results in hospital admission. Rates of admission have fluctuated over time. In 2015/16, Southwark had third-highest rate (140 per 100,000) of ectopic pregnancy in England. All three boroughs' admission rate for ectopic pregnancy is above the national average, and Lewisham is also above the London rate.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The following have been the most notable achievements in reproductive health in LSL since the publication of our last sexual health strategy:

- A reduction in the number of teenage mothers and teenage pregnancies leading to birth. This has been underpinned by:
  - An ongoing and sustained reduction in teenage pregnancy, both in young women aged under 18 and under 16
  - Of teenage conceptions that have occurred, an increasing majority have not led to maternity
  - Improved access to emergency contraception and termination services
  - The roll-out of the C-Card scheme across the boroughs (though we cannot say that this has had a linear impact on teenage conception rates)
- A slight decline in the rate of abortion in women of all ages
- A slight increase in the proportion of women choosing LARC at sexual health centres
- An increase in the coverage rates for the HPV vaccine for teenage girls, protecting them from future HPV infection.
- The HPV vaccine has now been extended to MSM opportunistically (during 2018), to prevent infection leading to HPV-associated cancers, including anal, throat and penile cancer. However, heterosexual males remain unable to access HPV vaccination on the NHS.

However, despite these achievements, significant challenges remain. There are still a number of poorer outcomes in reproductive health in LSL, which are driven by ongoing and emerging issues described in section 0.

Ongoing challenges

General access to contraception

Since our 2014-17 strategy, services have regularly been at capacity. wider system pressures on general practice have meant that it has been increasingly difficult for many people to access their practice, which has had an impact on GPs being able to meet residents' urgent or ongoing reproductive health needs (e.g. repeat prescriptions, LARC, or emergency contraception). More recently, there have been similar pressures on sexual health services, with demand outstripping the number of appointments and walk-in spaces available.

Within LSL, rates of EHC usage are highest in Southwark and local surveys have shown that there is already considerable demand for sexual health services, with patients being turned away from busy clinics, and online services also regularly at capacity. As may be expected, demand for emergency contraception is high and the rate of abortion in LSL (despite a declining trend) remains high and is above the national average. Furthermore, the rate of women taking up LARC following their attendance at an abortion clinic has declined in the last 5 years in LSL, which may lead to ongoing unmet reproductive health needs.

We are operating within the constraints of extraordinarily lean budgets, but we continue to innovate to meet increasing demand. To improve access to reproductive health services, we have moved to provide support in new and innovative ways. New models of practice include leveraging the accessibility, ease, and anonymity of pharmacies, and increasingly incorporating an online aspect to our services (for low risk individuals). The condom distribution scheme Come Correct has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute contraception to young people. Our ambitions and ongoing innovations are outlined in more detail in section 4 and in the accompanying action plans.

Inequalities

Like overall health and sexual health, good reproductive health is not equally distributed in the population. If the need for abortion is used as a proxy measure for not having reproductive needs met (abortion being the last intervention to prevent an unwanted maternity), black women in LSL suffer the poorest reproductive health. The rate of abortion is higher in LSL amongst women describing themselves as of black Caribbean and black African ethnicities. Nationally, women that have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.

Not all services work for all people, so a range of responsive universal and targeted services are needed. In developing new and improving reproductive health services, and following on from recent focus groups with local women, we will be working alongside young, black women in LSL in particular to understand their specific needs and co-design services and programmes.

We also know that there is a growing Latin population in our boroughs, and we will be working to better understand their sexual and reproductive health needs and tailor our services appropriately.

<u>Emerging issues and trends</u>

E-services for contraception

The use of e-services in sexual health is growing in popularity. E-services to this point have primarily been for STI testing and treatment, and complement traditional sexual health clinics by enabling appropriate low risk (asymptomatic and non-vulnerable) individuals to self-sample through the usage of kits ordered online and posted to home. In LSL, just under half of the patients attending sexual health clinics that were offered and took up the offer of online instead of clinic testing were women. While it is clinically appropriate for low risk women to use e-services, this has removed opportunistic contraception consultations in these patients. Service-level data from sexual health clinics indicate a reduction in contraception provision since the channel shift to the e-service was implemented, and we intend to explore this further. It is essential that women using online STI services receive appropriate messaging around contraception, and that there are a range of services in place to meet contraceptive needs of

women in LSL. Furthermore, we will endeavour to ensure that vulnerable people will always be seen face-to-face, as appropriate to their needs.

A pilot of online oral contraception in Lambeth and Southwark proved popular, and there are online contraception options in the commercial market. These developments will feed into how we will meet the vision of this strategy, allowing us to better respond to local needs in a cost effective and modern way.

Fertility awareness apps

A number of app-based methods supporting 'natural family planning' (fertility awareness) have emerged in recent years. These support women in monitoring and recording different fertility signals during her menstrual cycle to estimate when she's likely to get pregnant, and take appropriate action to avoid this if relevant (e.g. abstaining from sex, or using contraception such as condoms). These apps' reliability and effectiveness in avoiding pregnancy is unknown.

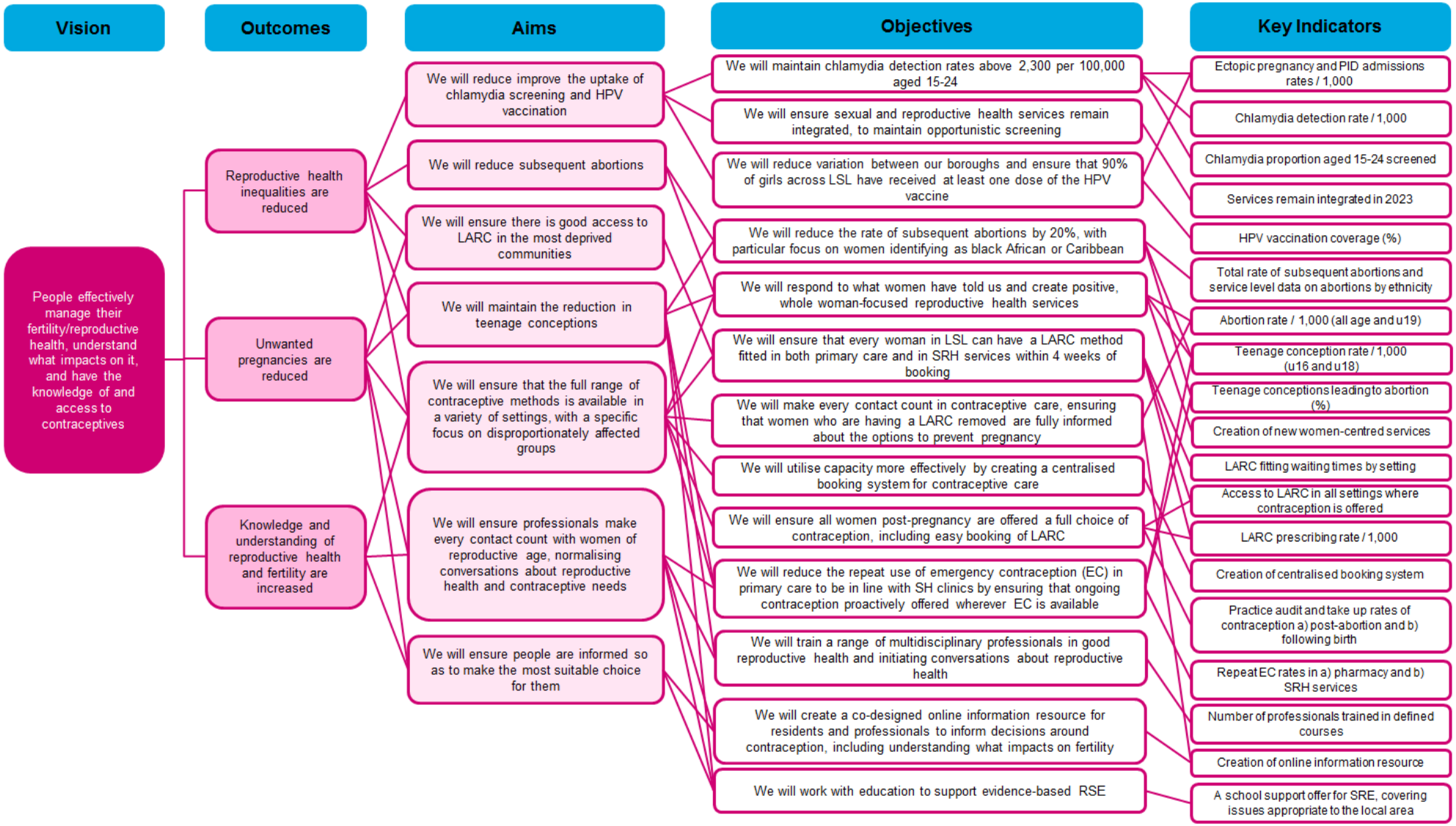
Some of these apps have been promoted as being as effective as the oral contraceptive pill with perfect use (but remain untested in independent clinical trials), and like many user dependent methods, perfect use is uncommon – 7 in 100 women had an unintended pregnancy in a year of typical use of one of the most popular fertility awareness apps. Fertility awareness methods are also affected by factors such as illness, stress, alcohol, and travel. Non-user dependent methods remain the most effective form of contraception, and condoms protect against STIs.

Anti-choice protests at abortion clinics

People have a right to access safe and legal abortion, free from harassment. This has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Anti-choice protests at abortion clinics in our boroughs and across London are unwelcome and actively harmful to local people. A Home Office decision on creating safe zones around abortion clinics is awaited. Regardless of this decision, LSL will uphold the rights of local people to access abortion-related care free from harassment as a key tenet of promoting reproductive health.

Good reproductive health across the life course: what we want to achieve by 2024

The figure below sets out our vision for reproductive health in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



6.3. High quality and innovative STI testing and treatment

What do we mean by 'high quality and innovative STI testing and treatment'?

Early access to comprehensive high quality STI testing and treatment services help to reduce transmission, trace and treat sexual partners, prevent repeat infections, and reduce inequalities in sexual and reproductive health.

We are fortunate in LSL to have a number of world-class clinical sexual health centres. Building upon this, we will focus on ensuring quality across the totality of our system, from prevention to testing, treatment and partner management. We believe that this will ensure the best use of capacity within the local sexual health system and support the reduction of the burden of STIs, particularly in young people, MSM, and Black and other minority ethnic communities unequally affected. We see an opportunity to strengthen the links between sexual health services and education, prevention, and promotion activities.

Our sexual health services have a history of innovation: from the integration of sexual and reproductive health provision, to the development of online services. We want to continue to support and foster further cross-sector innovation to meet our dual challenge of ensuring a financially sustainable system and changing the trajectory of STIs in our population.

Introduction

Background and policy context

Historically and currently, LSL has some of the highest rates of STIs in England. In 2017, Lambeth had the highest rate of new STI diagnoses nationally, followed by Southwark in third, with Lewisham 11th. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

STIs are a significant contributor to and result of health inequalities. We cannot reduce these inequalities without improving the overall sexual and reproductive health (SRH) of key groups, including young people, MSM, and Black and minority ethnic groups. LSL residents are predominantly young, with a larger proportion of the population aged 25-34 years. We are also more ethnically diverse than England, with approximately one quarter of LSL residents identifying as Black. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.

In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing have increased against a backdrop of significant and ongoing financial challenges. This has driven a need for innovation to ensure our services remain fiscally sustainable.

LSL have historically been leaders in innovative SRH services in London. We pioneered online STI testing for asymptomatic patients, and provided proof of concept for e-services as a core part of a cost-effective sexual health system. This approach has since been adopted across London ('Sexual Health London'). Although e-services primarily aim to create capacity at SRH clinics by targeting asymptomatic patients, they may be attractive to people who feel uncomfortable accessing SRH services, thereby improving testing accessibility.

Condom use remains a primary method of preventing STI acquisition and transmission. The pan-London condom distribution scheme, Come Correct, is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were evaluated nationally and found to be successful in engaging young people. Increasing numbers of repeat users compared to new registrations suggest the scheme is popular and acceptable. These schemes are particularly

important in reaching young men, who are less likely to visit their GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.

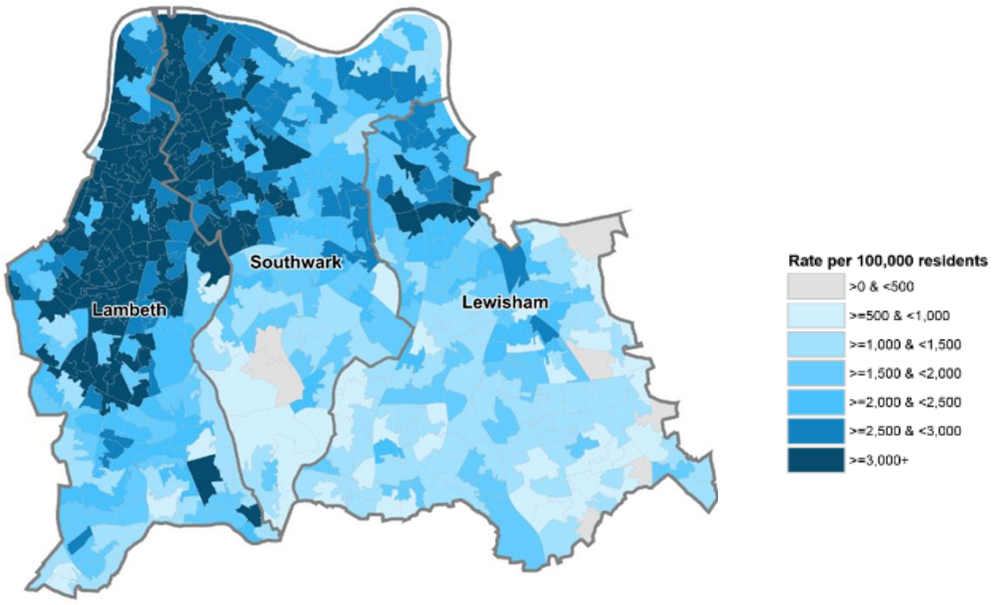
Free condoms are also a core component of the London HIV Prevention Programme, Do It London, of which LSL are major contributors. This element of the programme provides condoms to MSM, primarily in gay venues. Condom outreach to MSM will remain central to a health promotion strategy alongside PrEP in the coming years.

The open access nature of services means we have to collaborate across London and enable innovation to meet the diverse needs of our local populations, building on the work of the London Sexual Health Transformation Programme.

Current picture

In 2017, just over 22,000 new STIs were diagnosed across LSL. STIs are unequally distributed within the population and disproportionately affect young people, MSM, and some Black and minority ethnic populations. Across LSL, there is a strong correlation between areas of deprivation and rates of STIs, highlighting transmission within geographically connected sexual networks and how this contributes to overall health inequalities.

Incidence of new sexually transmitted infections across LSL, 2017



Trends in STI diagnoses are multifactorial and reflect a combination of sexual behaviours, service accessibility and use, diagnostic techniques, and surveillance systems. Lambeth, Southwark and Lewisham have historically had some of the highest rates of STIs and HIV nationally. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse and mobile populations.

Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local services, in order to prevent the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms. This is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Many STIs such as trichomoniasis, shigella, and hepatitis remain a burden and the cause of considerable activity in sexual health clinics. However, this strategy will largely focus on the five most commonly diagnoses STIs in LSL: chlamydia, gonorrhoea, syphilis, genital wards, and herpes.

Chlamydia

Prevalence of chlamydia in the general population is between 2-3% and it is likely that many infections are undiagnosed and untreated. About 10% of untreated infections will result in reproductive health complications. Of all chlamydia diagnoses made across LSL in 2016, 61% of these cases were in men and, while chlamydia is more prevalent among men across the life course, the rate among young women (aged 15-19 years) is approximately double that for men. While the chlamydia detection rate across all three boroughs exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15-24 years, it has fallen since 2014 and continues on a downward trend. Increasing the screening rate overall and in young men is a priority.

Gonorrhoea and syphilis

Gonorrhoea is the second most commonly diagnosed bacterial STI, however, its prevalence within the general population is low. Moreover, due to its relatively short period of infectiousness, gonorrhoea is concentrated within groups with higher rates of partner change and partner concurrency. Gonorrhoea infection is a global concern as it has developed resistance to an increasing range of antibiotics and it is estimated that a third of all infections are now resistant to one antibiotic. Gonorrhoea primarily affects men: nine in ten cases in LSL are diagnosed among men, with over three-quarters of those being MSM.

The rate of syphilis diagnosis in Lambeth and Southwark has increased by 103% and 116% respectively since 2008; these are now the highest rates of syphilis nationally. While rates fell from 2015 to 2016, they increased again in 2017 with approximately 850 cases diagnosed. The rate of syphilis diagnosis in Lewisham is similar to London (41 per 100,000) and, while Lewisham has experienced a larger proportional increase since 2008, rates remain at half that of Lambeth and Southwark. Syphilis tends to be associated with high-risk sexual networks.

In Lambeth and Southwark, 90% of syphilis cases in 2017 were in people who identified as gay. This was lower in Lewisham: 78%. Rates by age reveal the greatest burden of syphilis is in the 34-44 years age group. This is significantly older compared to other STIs but reflects the London age distribution. Small outbreaks of syphilis have occurred in male heterosexual groups. In heterosexual women, cases are disproportionately concentrated among Black and minority ethnic women. In London, rates of congenital syphilis remain extremely low due to a comprehensive antenatal screening programme.

Across LSL, a third of all diagnoses occur in the primary stage of infection, a third in the secondary phase, and a third early latent. This is particularly worrying as we know that if left untreated, syphilis can spread to the brain or other parts of the body and cause serious, long-term health problems. Genital sores caused by syphilis also make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV. This is concerning as co-infection with HIV increases the risk of central nervous system complications.

Our proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups. There is evidence that people with multiple syphilis infections play an important role in transmission and may be at higher risk of subsequent infections. SRH services should therefore focus on reaching this high risk population. Increasing testing in high risk MSM groups is another priority as is reducing late syphilis diagnosis and improving partner testing and treatment.

Genital warts

Genital warts are caused by infection with specific subtypes of human papilloma virus (HPV), commonly passed on through condomless sex. Genital warts are the third most commonly diagnosed STI in LSL, with just under 2,000 cases diagnosed in 2017. The majority of these are in heterosexuals. Rates of diagnosis were highest among those aged 20-24 across all three boroughs. There are inequalities in the rate of genital wart acquisition, in particular among mixed ethnic groups in Lewisham and other ethnic groups in Lambeth.

Genital herpes

Rates of genital herpes have been broadly stable since 2012. Among these five most common STIs, genital herpes is the only one in which more women are diagnosed than men. As with genital warts, rates of diagnoses are considerably higher in those aged 20-24 years. In young people aged 15-19 years, the difference in diagnoses rates between the sexes is particularly pronounced.

The majority of genital herpes (83%) cases are diagnosed in people who identify as heterosexual, and most in heterosexual women. Rates of diagnosis across the three boroughs vary by ethnicity, with the highest rates in Lambeth 'other' and Lewisham mixed ethnic groups. Asian ethnic groups have the lowest rates of genital herpes across LSL.

Other STIs

While this strategy focuses on chlamydia, gonorrhoea, syphilis, genital warts and genital herpes, the collective burden of other STIs on individual wellbeing and service capacity is important and we must remain agile to emerging diseases. Of particular importance are high risk STIs such as shigella and viral hepatitis, which are not diagnosed and treated in sexual health services but for which our services play a vital role in prevention. Shigellosis clusters predominantly associated with sexual transmission in MSM have increased significantly since 2014.

During 2017, there was a Europe-wide outbreak of sexually transmitted hepatitis A virus, with 942 cases in England and Wales alone, primarily affecting MSM in the 25-34 age group. Of these, 414 were from London. Control of the outbreak was confounded by a global hepatitis A virus vaccine shortage and the fragmentation of commissioning responsibilities between NHS England, Public Health England and Local Authorities. As of January 2018, the incident had been de-escalated from enhanced to standard response however London has been the worst affected region and there will likely be a significant lag-time before diagnoses return to pre-outbreak levels. It remains critical to raise awareness amongst MSM and ensure opportunistic vaccination continues.

Lymphogranuloma venereum (LGV) is a type of chlamydia that infects the lymph node for which surveillance was established in 2004. Diagnoses in LSL peaked in 2014 and have been declining steadily since then, in parallel with chlamydia as a whole. There were 109 diagnoses in LSL in 2017, all of which were in men of predominantly 24-34 years. Despite the decline, it is still vital to maintain a high index of suspicion for LGV and offer asymptomatic testing for HIV-positive MSM as this group is most affected (67.5% of new diagnoses).

Shigella clusters in MSM have increased significantly since 2014, with 1,056 excess male cases reported in London between 2012 and 2016. This population is disproportionately affected by the *S. flexneri* species which causes severe disease. People living with HIV are particularly vulnerable to a severe, invasive form of shigellosis. Despite the risk, PHE has reported extremely low awareness of shigella among MSM.

There was also a significant London-wide excess of male cases of hepatitis B in 2016, explained at least partly by sexual transmission amongst MSM. LSL has consistently had a

significantly higher incidence of hepatitis B than the London average: a mean incidence of 2.54 per 100,000 compared to 1.7 per 100,000 in London.

For shigella and hepatitis A and B, SRH services play a crucial role in raising awareness amongst the most exposed populations as well as key preventative activities such as condom distribution and opportunistic vaccination.

With regards to hepatitis C, admissions and mortality in LSL remain higher than regional and national levels, with local data suggesting that MSM may again be disproportionately affected. This indicates a need for SRH services to work closely with substance misuse services to protect the most vulnerable populations.

Although not clinically severe infections, trichomoniasis and molluscum contagiosum together accounted for over 1,000 new diagnoses in LSL in 2016, affecting mainly heterosexual women. Trichomoniasis has been linked to poor outcomes in pregnancy and to increased HIV transmission therefore warranting prompt treatment in all patients. Molluscum contagiosum is closely linked with the incidence of other STIs and therefore affected patients should undergo full STI testing.

Risk groups

Sexually transmitted infections contribute to health inequalities and some groups are disproportionately affected by STIs.

Young people

Young people have higher rates of STIs reflecting their higher rates of sexual activity and partner change, and relatively poorer skills in negotiating safer sex. In LSL in 2016 double the proportion of 15-19 year old women were re-infected with an STI compared to women in all age groups.

Men who have sex with men

MSM report higher rates of partner change and partner concurrency and are more likely to belong to sexual networks which facilitate rapid STI transmission. In LSL, 77% of cases of gonorrhoea and approximately 86% of cases of syphilis were in MSM. Seroadaptive behaviours increase exposure to STIs and may account for this group being disproportionately affected. Moreover, recent literature on HIV PrEP has suggested that use is associated with reduced use of condoms. This may further contribute to the increased risk this cohort faces of STI acquisition. The national HPV vaccination programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses, though there may be a lag before benefits are observed in full.

Black and minority ethnic groups

White and Black heterosexual women and Black and mixed heterosexual men experience a large burden of STI diagnoses. In Lewisham, chlamydia rates are highest in mixed and Black ethnicities. Across LSL, those of Black ethnicity made up the largest proportion of gonorrhoea cases in heterosexuals. The higher rates of STIs in some Black and minority ethnic groups are partly explained by the relationship between socio-economic deprivation and ethnicity, but not fully. There is a complex interplay between cultural and behavioural factors, and access to and use of healthcare services.

Progress to date

Achievements since the last strategy

Since our last sexual health strategy, LSL successfully launched a proof of concept model of online testing of STIs. SH:24 was an innovative method of encouraging asymptomatic individuals seeking STI testing to self-test at home, thus reducing the burden on sexual health clinics and freeing up capacity within the service to treat symptomatic patients. This pilot spurred the now pan-London initiative to provide online STI testing, which was rolled out in LSL in July 2018.

We have achieved fundamental changes to the way in which we finance sexual health services, to ensure value-for-money and effective commissioning. The integrated sexual health tariff (ISHT) matches payment to the specific costs of an appointment. We acknowledge that despite now meeting the exact costs of an appointment, these new contracts have delivered a significant drop in income for our local trusts, which has contributed to the financial pressures they face. We continue to work closely with our partners to ensure that any service changes will continue to meet the sexual health needs of the population.

Ongoing challenges

LSL have proportionately large groups at higher risk of poor sexual health. Given the prevalence of STIs in our population we need to balance accessible, open-access services with targeted and proactive testing aimed at the most at risk groups (some of whom also access traditional services the least). Recent outbreaks have highlighted that under-testing of certain infections, particularly in MSM, continues to be a challenge.

Sexual and reproductive health services in LSL are at capacity. Fiscal challenges across England have contributed to the closure of sexual health clinics and commissioners are continuing to innovate to improve the reach and accessibility of our services.

Partner notification of STIs helps to prevent the onward transmission of infections. Our local SRH services actively encourage patients receiving an STI diagnosis to disclose their result to previous partners but this is highly user-dependent. SXT is a local innovation that allows for anonymous online notification of partners. Effective partner notification needs to be built into all parts of the local system.

Emerging issues and trends

PrEP

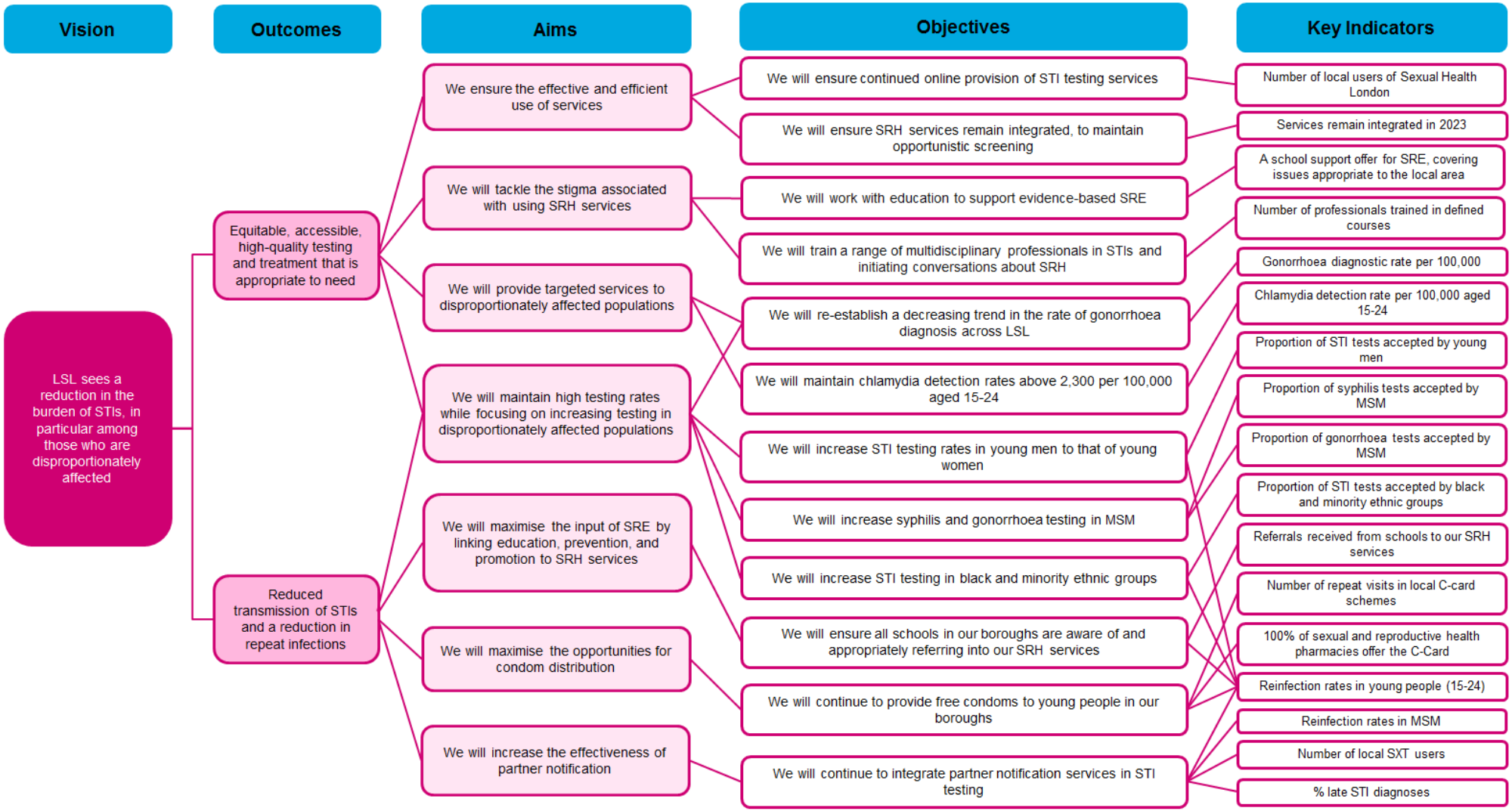
Pre-exposure prophylaxis has dramatically changed the landscape of HIV prevention. However, PrEP may be associated with a reduction in the use of condoms and an increase in STI acquisition. While these emerging results should not diminish the success of PrEP in preventing HIV transmission, sexual health commissioners and practitioners should be aware of and mitigate against this potential outcome.

Antibiotic resistance

Chlamydia, gonorrhoea and syphilis are three common STIs typically curable by antibiotics. However, over recent years, these STIs have developed a resistance to antibiotic treatment; this is particularly the case with gonorrhoea. In March 2018, the first case of multi-drug resistant gonorrhoea in the UK was identified and the World Health Organisation has warned this infection may soon become untreatable. Local authorities and SRH services must continue to work with PHE and national partners to survey and report any resistant strains, and ensure timely and effective treatment of new cases of STIs in our local population.

High quality and innovative STI testing and treatment: what we want to achieve by 2024

The figure below sets out our vision for STI testing and treatment in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year.



6.4. Living well with HIV

What do we mean by 'living well with HIV'?

Our ambition is to prevent the transmission of infection, ensure diagnosis as early as possible and ensure that PLHIV in LSL have the services and support to enable them to live a healthy and fulfilling life. This means moving towards zero new diagnoses, zero HIV-related stigma and zero deaths related to HIV, in alignment with the Fast Track Cities' aims. We will provide our populations with services and support that will enable them to live and age well with HIV, and prevent new infections and onward transmission.

Thirty years on from the beginning of the HIV / AIDS crisis in the UK, knowledge and understanding of HIV has increased dramatically, bringing real advances in HIV treatment and prevention. An HIV diagnosis today means living with a long-term condition and HIV is no longer the fatal infection that it was 20 years ago. This strategy reflects these changes, reframing HIV as a long-term condition. However, HIV infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. In addition, recruitment and retention in care is still a critical focus for some of our most at-risk groups.

Encouraging all people to be aware of their HIV status will require a commitment to ensuring accessible testing opportunities are available through a variety of channels and that people at all risk levels are encouraged to know their status. This will continue to drive the number of new diagnoses and late diagnoses down and contribute towards the goal of zero new transmissions.

With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise. To ensure that people are able to both live and age well with HIV, it is recognised that specialist HIV services and primary care will need to work together to provide a holistic care approach, managing HIV together with other chronic health conditions.

Our focus in this chapter is therefore to reinforce our commitment to ensuring access to the medical aspects of tackling HIV including strengthening combined prevention efforts and early treatment. We also commit to better understanding the social aspects of HIV, to eradicating the ongoing stigmatisation of those living with HIV and to tackling the new challenges of an aging population.

Introduction

Background and policy context

HIV remains a priority nationally, in London and especially in LSL where diagnosed HIV prevalence rates are the highest in the England. Excluding the City of London, Lambeth and Southwark respectively have the highest rates of prevalence in England.

New HIV diagnosis rates have decreased nationally and in London and 2016 saw three firsts in the 30-year history of the UK HIV epidemic: the number of new HIV diagnoses in MSM fell, the death rate among people with HIV who are diagnosed promptly and on treatment became comparable to the rest of the population, and in London the UNAIDS 90-90-90 targets were met. In 2017, London became the first city in the world to exceed 95-95-95 – that is, 95% of Londoners living with HIV infection were diagnosed, 98% of those diagnosed were receiving treatment and 97% of those on treatment were virally suppressed and unable transmit the virus.

Widespread use of combination prevention approaches has contributed towards the decline in HIV rates. Combination prevention refers to a set of behavioural, biomedical and structural approaches tailored to local levels of infrastructure and culture as well as to populations most affected by HIV. In the UK, the combination of approaches has included encouraging condom use, promoting the use of PrEP, promoting expanded HIV testing and diagnosis, advocating for self-sampling kits and ensuring prompt treatment when people are diagnosed with HIV and other STIs. Antiretroviral therapy (ART) is now so effective that those on treatment who

maintain an undetectable viral load (<200 copies) have effectively no risk of sexually transmitting the virus (undetectable = untransmissible ('U=U')). The London HIV Prevention Programme campaign, Do It London, promotes four key ways to prevent the spread of HIV: regular testing; use of condoms; PrEP; and for people living with HIV to receive treatment and have an undetectable viral load (U=U). LSL echoes this strategy locally.

With knowledge of their status and access to effective treatment, people living with HIV (PLHIV) are able to live as long as the rest of the population. As a result, HIV is transitioning away from the life-threatening illness it once was and into a long-term condition that must be managed alongside other age-related conditions and care needs.

In January 2018, London signed up as a Fast-Track City, committing partners across the capital to work together to exceed the UN's 90-90-90 targets and end new infections in the capital by 2030, reduce the negative impact of stigma and discrimination to zero, stop preventable deaths from HIV related causes and to work to improve the health, quality of life and wellbeing of people living with HIV.

Current picture

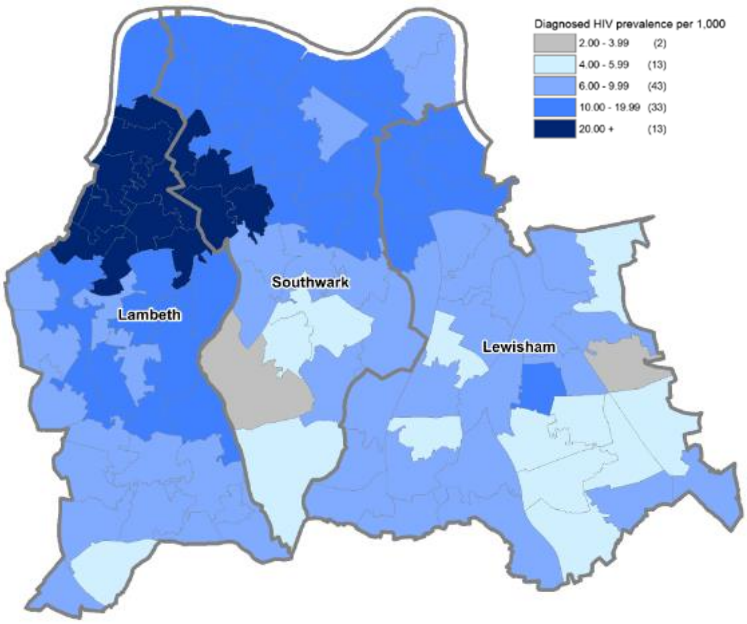
Epidemiology and local needs

Prevalence

Each borough in LSL exceeds the threshold for 'extremely high prevalence' (as defined by NICE and PHE) of HIV, and the region has the highest rates of HIV in England.

Prevalence in Southwark and Lewisham has fluctuated little in the past five years and is approximately 12.2 per 1,000 people aged 15-59 in Southwark and 8 per 1,000 in Lewisham. In Lambeth, HIV diagnosed prevalence increased up to 2015 but declined in 2017, and is currently 14.6 per 1,000 people - the highest prevalence rate in the country.

There is considerable variation in diagnosed prevalence rates across LSL as illustrated below, and a disproportionate number of new diagnoses are in the most deprived areas (particularly in Lambeth).



Diagnosed HIV prevalence per 1,000 population by MSOA (2017)

Certain population groups are more likely to be affected by HIV, namely MSM and people identifying as black African. The high prevalence of diagnosed HIV in LSL is driven by a range of factors. All three boroughs have high population turnover, including high rates of external migration. LSL also have a high population of LGBTQI+ people and very diverse populations in terms of ethnicity. Lambeth and Southwark are estimated to have the first and second highest gay and lesbian populations in the country respectively and while there are no estimates available for Lewisham, we can make an assumption of at least 2.7% which is the estimate for London. Additionally, with high rates of HIV among the black African population, our boroughs' ethnic make-up is a significant driver; across LSL, people identifying as black African account for 11% of the population aged 15 years and over.

Testing

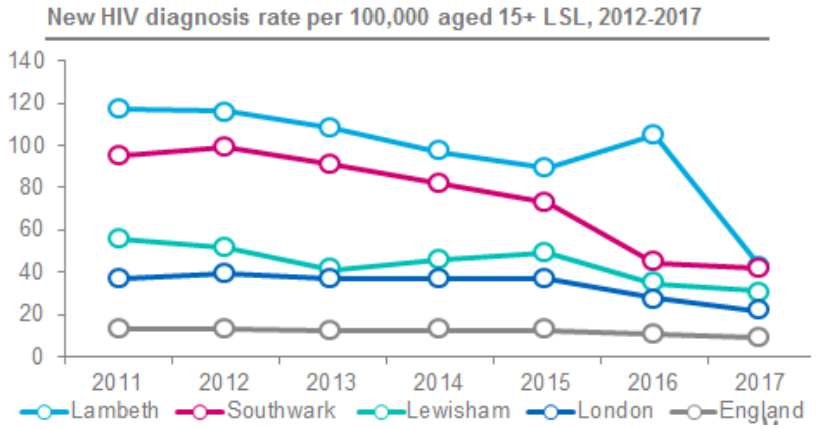
HIV testing, including frequent testing among those most at risk of HIV, continues to be one of the most important interventions to identify infection and prevent onward transmission, and is one of the four Do It London strategies to prevent HIV. Providing access to and encouraging testing in our resident population will reduce the number of undiagnosed residents, reduce the time period over which infected individuals are not receiving treatment and prevent onward transmission.

HIV testing coverage is used to monitor progress towards national recommendations on increasing testing and is defined as the proportion of 'eligible new attendees' to specialist sexual health services in whom an HIV test was accepted. Performance against this indicator is poor in LSL where coverage in all boroughs has consistently trended below the overall London rate. There is a decreasing trend in testing coverage in Lambeth and Southwark, though coverage has increased in Lewisham. Given the high prevalence of HIV in LSL, poor performance against this indicator is concerning and we will seek to better understand and address this. We will also encourage increased testing in primary care and A&E settings.

The coverage indicator measures only those tests offered and accepted within specialist sexual health services and therefore does not capture those accessing testing privately, via online channels or in alternative settings (e.g. general practice, hospital settings). Access to testing through specialist services will also show a systematic bias towards certain high-risk groups, such as MSM, who are more likely to access these services regularly.

New diagnoses

Total new diagnosis rates have continued to decline nationally year on year. Since 2015, LSL have seen a decline in key risk groups where rates have previously remained stable: MSM and the Black African population. The 2017 PHE report *Towards elimination of HIV transmission, AIDS and HIV related deaths in the UK* suggests that the decline among the Black African heterosexual population is likely due to changes in migration patterns, with fewer people arriving from high HIV prevalence countries, though this is being reviewed.

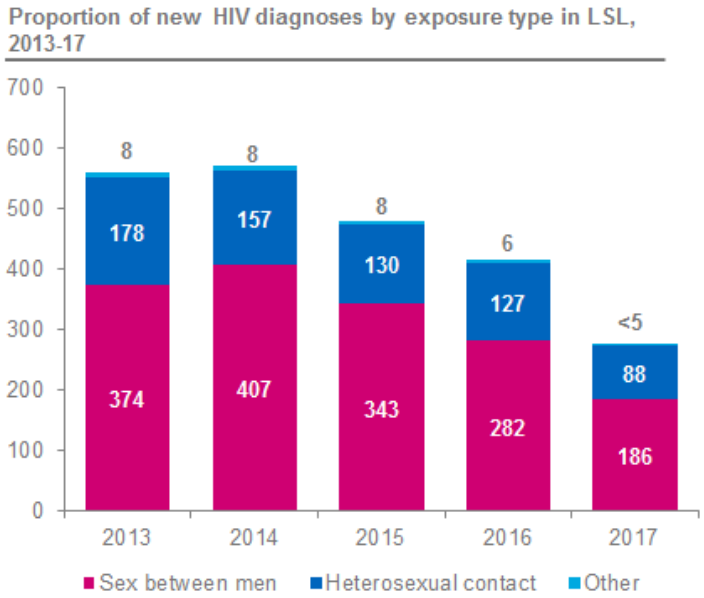


However, the decreasing trend in new diagnoses has not been seen across all populations and there has been no significant change in Lambeth and Lewisham, though rates have decreased in Southwark. New diagnoses in heterosexual women and Black African men also remain disproportionately high. Sustained effort therefore continues to be required to reduce new infections and onward transmission.

Rates of new diagnoses among residents of LSL continue to trend above both national and London rates, though there are differences between the three boroughs as seen in the figure above.

Our epidemiological review revealed that in LSL in 2017:

- Rates of HIV diagnosis are highest among those aged 35-64 years.
- The majority (76%) of HIV diagnoses are in men.
- Of all men diagnosed with HIV, 64% were white, and of all women diagnosed with HIV, 64% were Black African.
- Sex between men accounts for the majority (53%) of new HIV cases, followed by heterosexual female (14%) and heterosexual male (13%) exposure (as per figure at right).



By understanding the profile of those diagnosed, we can target ongoing efforts to tackle HIV through combination prevention approaches – for example through commissioning community-focused services targeted to black African and Caribbean communities and MSM across LSL.

Late diagnoses

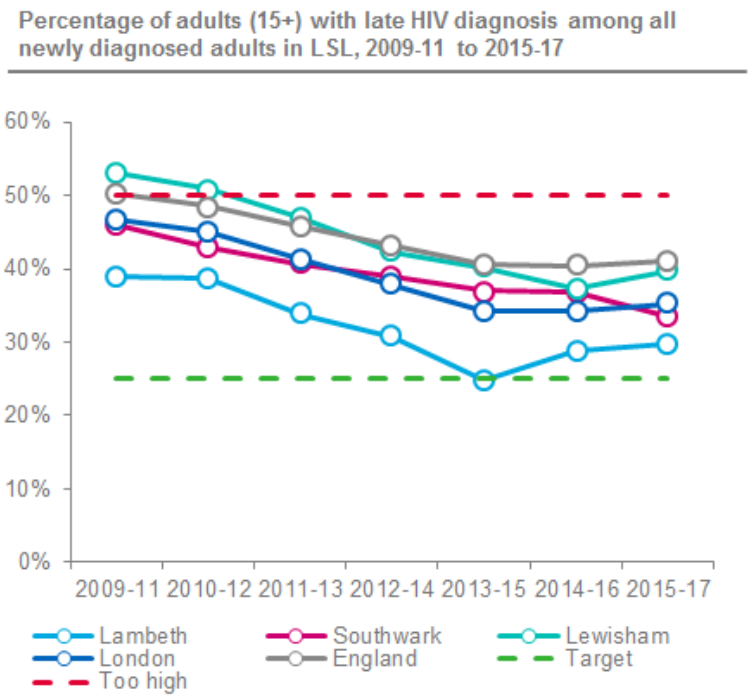
Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services, reduced response to antiretroviral treatment and increased risk of onward transmission of HIV. People diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Reducing late diagnosis is therefore a critical target in our strategy.

Over time, fewer people in LSL are receiving a late HIV diagnosis and efforts to increase testing through a variety of routes (including online and a range of community and healthcare settings) appear to have contributed to this downward trend from 2009-11 to 2015-17.

However, across LSL in 2015-17 more than 25% of people diagnosed with HIV were diagnosed at a late stage of the disease. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015-17.

In 2016, certain groups had a higher proportion of people with late diagnosis, including those aged 50-64 (53%), those identifying as black African (49%), those identifying as 'other' ethnicity (46%), those whose route of transmission was through heterosexual contact (59%), and women (55%).

These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. We know that women and BAME groups are less likely to accept HIV testing and this is reflected in higher rates of late diagnosis. Regular testing is a good way to identify HIV early and routine or opportunistic offers of HIV tests by healthcare professionals (outside of sexual health services) have been shown to be acceptable and facilitate greater uptake of testing, especially in at-risk African communities.



A multi-faceted approach is needed to tackle late diagnosis across LSL, including measures to encourage those at risk to come forward to be tested, and education and support for clinicians, particularly those working in primary care and A&E to improve their knowledge of HIV and testing, including raising the issue.

Engagement in care

Widespread use of effective ART has led to a significant reduction in morbidity and mortality among people living with HIV and is an effective means of reducing HIV transmission. The 'U=U' (undetectable = untransmittable) message is growing in recognition. However, individual and public health treatment benefits can only be achieved if PLHIV know their status, access care, and have sustained engagement with care on an ongoing basis. Poorer health outcomes are experienced among people living with HIV who engage poorly with care.

The UK has made significant progress in ART coverage in recent decades. 96% of those diagnosed are now accessing treatment and 94% are virally suppressed. In London in 2016, 97.2% of residents with diagnosed HIV were receiving ART. Of these, 96.6% were virally suppressed and were very unlikely to pass on HIV, even if having sex without condoms or use of other preventative interventions in partners such as PrEP.

More than 8,700 LSL residents accessed HIV care in 2016. This number has increased steadily in line with new diagnoses and an increased life expectancy. 98% of those accessing care in 2016 were on treatment. However, 2015 data indicates that there remain challenges in retaining a proportion of those diagnosed in care – with just 85% of those diagnosed retained within care at 1 year after diagnosis.

Substance misuse and mental health co-morbidities are risk factors for poor treatment adherence and level of engagement in HIV care is associated with multiple underlying causes and demographic, socio-economic and HIV-related factors. It's therefore key that the services provided in LSL, both in specialist and mainstream community services, cater to the differing needs of PLHIV. A range of approaches are required to improve engagement with care, and we will continue to work to maximise engagement and support adherence to treatment across the boroughs.

PLHIV also have the primary role in managing their condition. Individuals, families and communities are assets that support self-management including:

- Providing information and perspectives about HIV and treatment
- Peer support, including understanding of and assistance with self-management skills
- Reduction in HIV-related stigma

Families of people living with HIV, including children, may also have particular health or social needs, as may younger people transitioning from children and young people's specialist HIV services to adult services. The needs of these and other specific groups will be considered when planning services.

One of the greatest successes of HIV care, research and activism is that PLHIV can now lead healthy lives and have similar life expectancies to those of the general population. In 2016, more than one-third of people accessing HIV care in LSL (35%) were aged 50 years and over, compared with 24% in 2012.

There is however evidence that PLHIV are more likely to develop diseases such as diabetes, kidney disease, liver disease and other long term medical conditions associated with age. In addition, a proportion of people experience side effects when taking ART long-term.

Some older people living with HIV can feel stigmatised by both their age and HIV status, and may suffer isolation and loneliness as a result.

Both specialist HIV and mainstream services in LSL and across London will need to adapt to this changing demographic of PLHIV. Co-coordinating care more closely with other health and care services that older people need and focusing on overall quality of life as well as clinical treatment will be essential. Exploring shared care models with primary care and planning for how HIV care will be coordinated with social care, for example in care homes, is essential.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

LSL's 2014-17 sexual health strategy set ambitious targets to support PLHIV in leading healthy and fulfilling lives. These included increasing testing rates to ensure residents know their status and are on ART as quickly as possible. We implemented the following projects and system changes:

- Introduction of HIV testing in acute and primary care settings.
- Development and implementation of online STI and HIV self-sampling service, SH:24. This innovation inspired London to procure an online STI and HIV self-sampling service on behalf of 27 London boroughs, Sexual Health London (SHL), which LSL has now adopted. In addition, LSL bought into the national online HIV self-sampling service, Test.HIV.
- Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, 'Do It London', to increase testing and safer sex behaviours, and also has an outreach programme that works with MSM to encourage testing, give advice and increase knowledge around prevention methods.
- Implemented recommendations of the 2010 HIV care and support review, making changes to our local service offer towards an integrated care model in line with the HIV now being a manageable long-term condition. This work has included piloting HIV clinics in GP surgeries and improving the competence and capacity of mainstream advice, welfare and other agencies to respond to the needs of people living with HIV in line with support for those with other long term conditions.

- At King's College Hospital NHS Foundation Trust, work has been undertaken to review the needs of patients aged over 50, review IT solutions to support integration of primary and specialist care, improve communication between clinicians and potentially develop training for GPs to support integrated care.

These achievements were enabled by workforce developments that saw the introduction of more appropriate staff skill mixes to better serve the needs of patients and service users and improving training standards in sexual health.

Ongoing challenges

Tackling stigma and discrimination

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at PLHIV. Though it is 30 years from the start of the HIV crisis, stigma and misconceptions around HIV remain and are a barrier to HIV prevention, testing, treatment, care and support. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards PLHIV.

PLHIV can face stigma, prejudice and discrimination in various spheres of life from services, in the workplace and from their family and friends. They may also experience that some non-specialist services are unable to meet their needs fully because of lack of specialist knowledge or training. These social aspects of the disease are less well understood, but can significantly impact on the ongoing health and wellbeing of PLHIV and their family and friends. Stigma and discrimination can undermine HIV prevention efforts by making people fearful to seek information on HIV information, access services and adhere to treatment.

Providing the right combination of services for the health care of all people living with HIV

PLHIV in LSL are a diverse group of people whose health needs will change as they age. It is critical that HIV specialists and other services continue to evolve to meet the needs of PLHIV including the management of co-morbidities and other complex health conditions and that they reflect all members of the community that they serve.

Whilst early diagnosis and effective treatment means that people living with HIV can age well, the inevitable effects of ageing cannot be avoided and growing older with HIV can increase the chance of experiencing age-related illnesses earlier. PLHIV also have higher rates of mental health-related co-morbidities than the general population and substance use and addiction disproportionately affect people with HIV.

With increasing numbers of people living and ageing with HIV there will be increasing pressures on a range of services including specialist, primary, mental health and social care services. Complex and fragmented commissioning arrangements, and ongoing budgetary constraints across health and social care, could contribute to a lack of joined up care for PLHIV.

Given HIV is increasingly managed as a chronic disease, and along with other changes in health policy, there is a shifting in the emphasis of care towards partnership between specialist centres and primary care. LSL HIV services must learn from other existing models for co-ordinating long-term care (such as those for cancer) that have similarly evolved from providing specialised treatment to including long-term care, and adapt them as appropriate.

Work at KCH and with other partners towards understanding and designing the elements of a truly integrated care model for PLHIV in LSL has been ongoing for a number of years and actions stemming from this strategy will seek to support and further these efforts.

Undiagnosed and those not on treatment

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV. Reviewing and increasing our testing activity (particularly in primary care and A&E), ensuring we are testing the right people, and targeting those identified through profiling people who are diagnosed late will be critical to reduce the numbers of undiagnosed. This will include raising awareness among clinicians in general practice and secondary care settings of some indicator conditions that may suggest someone living with an undiagnosed HIV infection.

With the increasing incorporation of e-services in the sexual health system across London, service users must receive appropriate behaviour change messaging to ensure HIV tests are selected whenever possible.

Some residents who receive a diagnosis of HIV decline treatment or are lost to care, putting their health at risk and increasing the risk of onward transmission. Clinical and community outreach services will continue to target most at risk populations.

Data monitoring

Monitoring and the ability to assess the impact of the interventions are dependent on good quality data. HIV and AIDS reporting system (HARS) provides some of the best surveillance data internationally, but this system relies upon complete data being freely given by individuals who trust in the confidentiality of the system, and also being collected, recorded and returned in a timely and accurate manner.

Emerging issues and trends

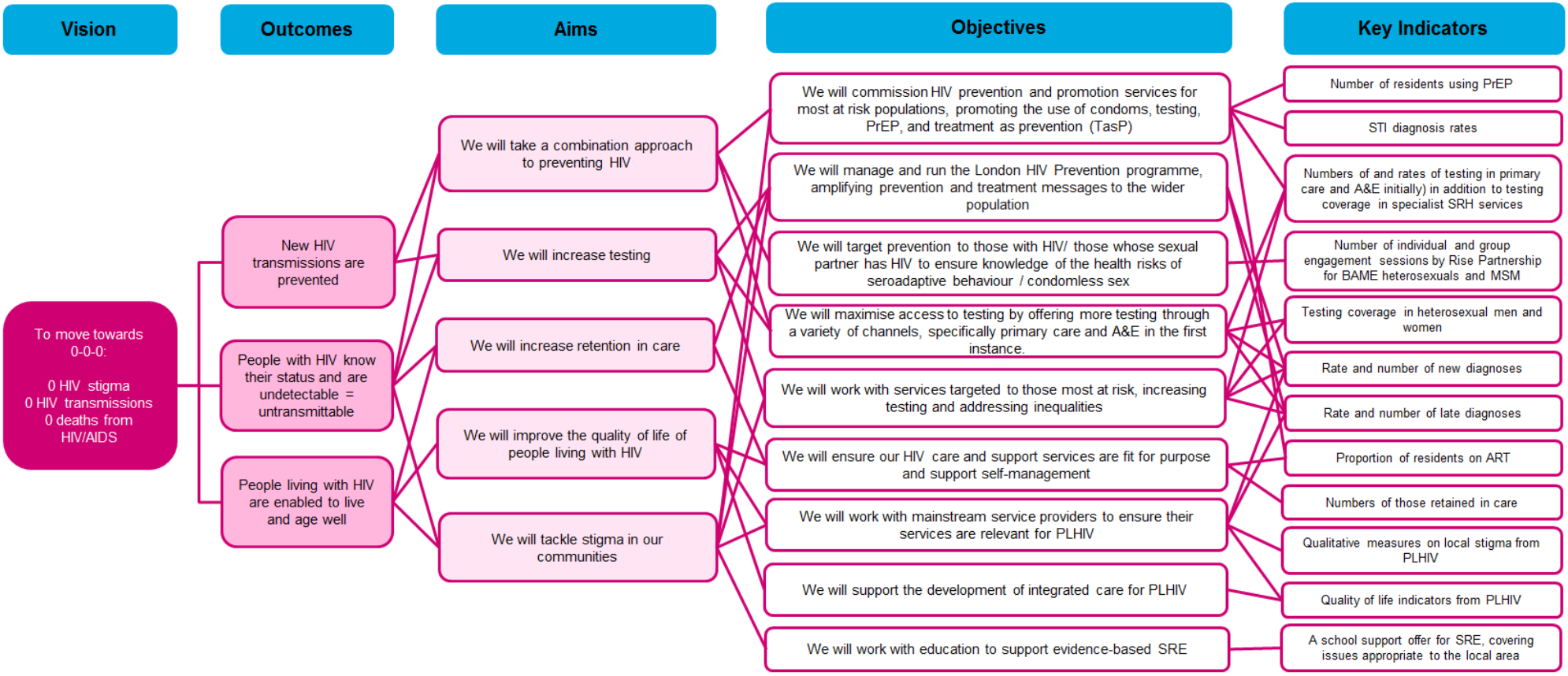
PrEP

Pre-exposure prophylaxis (PrEP) is highly effective in reducing the risk of acquiring HIV. PrEP is not currently available on the NHS (aside from the Impact trial) but the private purchase of PrEP has been increasingly popular in recent years, particularly amongst MSM, and is supported by testing at sexual health clinics. The PrEP Impact trial is currently recruiting 13,000 participants who are at a high risk of HIV, across England, to assess the need and demand for PrEP in those accessing sexual health clinics, and the likely benefit of its use in England. By late October 2018, 9,226 participants had been recruited across 140 sexual health clinics.

Although PrEP is highly effective for preventing HIV infection, research is beginning to highlight an associated decrease in consistent condom use and increase in STIs among MSM using PrEP. A reduction in condom use could also undermine PrEP's population level effectiveness if people stop using condoms and do not use PrEP consistently.

Living well with HIV: what we want to achieve by 2024

The figure below sets out our vision for improving the lives of PLHIV in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year. London has signed up to the Fast-Track Cities target of 0-0-0 (0 HIV stigma, 0 HIV transmissions, 0 deaths from HIV/AIDS). The vision for Lambeth, Southwark and Lewisham is also to move towards achieving this. Therefore, in addition to the specific indicators listed below, we will look to measure overall progress towards this vision, using any future indicators agreed at a London level.



7. How we will deliver our vision

The figures on the previous pages provide the map for how we will achieve our shared vision for sexual and reproductive health in LSL by 2024, and the indicators through which we will measure our progress.

However, we recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, each borough will have an annual action plan which will include specific steps to deliver this strategy, which will form part of the Public Health business plans. This approach to a joint strategy allows us to collaborate on many areas, but take local action as needed.

Progress against the strategy will be reviewed annually by the LSL Sexual Health Commissioning Partnership Board, which comprises commissioning, Public Health and CCG representatives from each of the three boroughs. Shared actions to deliver this strategy will also be overseen by this board.

This strategy also forms a key part of each borough's Health and Wellbeing Strategy, and so progress will be reported to each of the Health and Wellbeing Boards as locally appropriate.

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