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

Summary of the evidence

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What is this document?

This document summarises the evidence and good practice underpinning the LSL Sexual and Reproductive Health Strategy 2019-24. The four chapters of our strategy draw on these evidence reviews and the accompanying intelligence pack to set out our plans for the coming years. References for all evidence and statements within our strategy are provided within this document, and not within chapters themselves.

Contents

Healthy and fulfilling sexual relationships 3
Good reproductive health across the life course 7
High quality and innovative STI testing and treatment 11
Living well with HIV 15
References 18

HEALTHY AND FULFILLING SEXUAL RELATIONSHIPS

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.[1] Exposure to domestic abuse and unhealthy relationships, as a victim or witness, is associated with poorer emotional wellbeing and physical health.[2] The mental and physical consequences of abuse may increase a victim's risk of further exploitation and may be associated with related risk factors for poor health, such as substance misuse and risky sexual behaviour.[3, 4] In some cases, domestic abuse is cyclical and those who were themselves victims may go on to perpetrate abuse or continue to enter into unhealthy interactions.[5] 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 interpersonal relationships.[6]

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 prevent exploitation or abuse. Despite this, schools have had no statutory responsibility to provide comprehensive RSE and the most recent government guidance is now 17 years old.[7] In Lambeth, Southwark and Lewisham (LSL), RSE is largely taught through science and through personal, social, health and economic (PSHE) education programmes at school. PSHE sits alongside the national curriculum and covers three broad themes: health and wellbeing, relationships, and living in the wider world. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions, sexually transmitted infections (STIs) and in increasing reporting of sexual exploitation and abuse.[7-9] Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up,[10-12] highlighting the importance of appropriate RSE. However, important issues such as coercion, navigating the practicalities of consent, social media, online safety and same-sex relationships are topics poorly covered by current curricula.[7] The majority of young men and women surveyed in the recent Natsal-3 report felt they should have known more when they first felt ready to have some sexual experience;[12] 62% of these cited lessons at school as their primary source of sex education. Among the additional topics they wanted to learn more about were sexual feelings, emotions and relationships. Alongside a focus on risk and unhealthy relationships, high quality RSE should emphasise the positive aspects of healthy sexual relationships, including negotiating the sex that you want. A recent national survey revealed that 60% of students hadn't learned about sexual pleasure.[13] Young people should not be dissuaded from sexual relationships for fear of coercion or abuse. Instead, they should be properly equipped with the necessary information to negotiate safe and pleasurable sex when and how they want it. In order to deliver frank discussions around sex, however, teachers must be open and comfortable discussing the topic. Unfortunately, qualitative studies from the UK and abroad have highlighted that many teachers feel uncomfortable or embarrassed having these conversations.[11]

As of September 2020, RSE will become statutory across the UK, a delay on the anticipated 2019 start-date.[14] 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. 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 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 (2019-2024) has been set out by NHS England[15] 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, and those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource in navigating sexual experiences and can help people of all ages to develop an awareness of unhealthy behaviour and the confidence to address it. Facilitating healthy and fulfilling relationships is therefore important in preventing future unhealthy relationships and poor reproductive health, and reducing the risk of acquiring STIs and HIV. It is an integral part of a holistic sexual and reproductive health strategy.

Knowledge of healthy relationships is an important tool for all children and young people. However, some are more likely to suffer from unhealthy sexual experiences and relationships and thus may have additional need for information about risk factors and warning signs. Women are disproportionally affected by domestic violence across the life course and are nearly twice as likely to have experienced domestic abuse than men.[16] The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime.[17, 18] Coercive or controlling behaviour was introduced as a new offence in December 2015[19] and research has suggested that these behaviours are highly gendered, with women being the predominant victims.[20] The Crime Survey for England and Wales was updated in 2017 to include related questions to better capture the nuanced aspects of unhealthy relationships and abuse.[16]

From the age of 16, 49% of gay and/or bisexual men report experiencing at least one episode of domestic abuse. This is compared to only 17% of men overall.[5] The prevalence of abuse among transgender people is even higher: 80% reported experiencing emotional, physical or sexual abuse from a partner or ex-partner in 2010.[21] Despite the prevalence 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.[22] The lack of information available in traditional settings such as schools may drive some young people to seek advice and support from adult-oriented groups, for example online forums where they may be vulnerable to exploitation.[23] Rates of intimate partner violence are higher among those with a physical or mental disability; they are between two to three-fold higher odds of being a victim.[24] In addition, any child living in a household in which there is intimate partner violence or a regime of intimidation or control is at increased risk of experiencing, and also perpetrating, violence as an adult.[5] While many of these children may be reached by school-based interventions, special attention should be paid when they come into contact with health or social services. RSE lessons must therefore be inclusive of all levels of disability, sexual orientation, and life circumstances to ensure equal access to information.

The term ‘chemsex’ has become prominent in some parts of the MSM community and describes sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone. Locally, we know that our population of MSM are more likely to take drugs associated with chemsex than MSM elsewhere in London or England.[25] These substances pose a significant health risk and risk of overdose. Anecdotal evidence from qualitative research in Southwark revealed an increasing mental health risk (including low self-esteem) for those who partake in chemsex.[26] Vulnerability and risky sexual activity were also a common concern as 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 in risky sexual relationships are also appropriately supported to make safe and healthy decisions.

Child sexual exploitation (CSE) is a significant concern in LSL as it is elsewhere, and we know through internal analyses that exploitation is linked with gang-related activity and with drug running across county lines. The responsibility of safeguarding children and identifying exploitation should be embedded within all professional practices. Children and young people at risk for, or currently being sexually exploited may present with physical injury, addiction, poor mental health and repeat use of emergency hormonal contraception, among others, and may interact with a range of professionals.[27] Training on identifying and referring cases of CSE should therefore be available across all services. Sexual health professionals are uniquely placed to discuss sexual activity and relationships with a young person and should be mindful of deteriorating health, disclosure of multiple partners or repeat visits for STI treatment.[27] Schools reach the majority of children and therefore have an important role to play in both preventative education and identifying CSE and abuse.[28] They tend to see the same group of children over time and can identify changes in behaviour or health. Evidence suggests that education programmes may increase the likelihood of a child disclosing abuse[29] and that a whole-school approach of zero tolerance for abuse, alongside longer-term lessons through RSE that teach young people about healthy relationships may be effective in preventing CSE.[28, 30, 31]

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. Sexting may be construed as modern-day flirting, however, sending explicit photographs among under 18-year-olds is a criminal offence.[32] Similarly, new forms of online abuse such as revenge porn (the non-consensual sharing of sexual content) are becoming increasingly recognised offences.[33] It is therefore critical that young people be informed of how to operate safely online. Notre Dame RC School in Plymouth was recently highlighted by Ofsted for their modernised PSHE programme.[34] At the suggestion of sixth form and year 10 students, they implemented peer-led workshops focusing on social media, coercion, and how to end a relationship safely. Students particularly liked being taught by older students and reported feeling more comfortable engaging with them on these topics.[34] Highlighting the grey areas before abuse begins may empower students to identify and prevent an abusive relationship from developing.

Findings from the 2016 Healthwatch Southwark report, 'Young Voices on Sexual Health,' revealed that education about healthy relationships was sparse and inconsistent across different schools.[35] 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. Healthwatch Lewisham ran a series of workshops with young people aged 11-19 years in 2017 and found that 'relationships and sex' was the issue most concerning to young people and their peers.[17] 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.[17] Qualitative research identifying best practice in RSE has suggested that young people prefer to be taught by someone other than a teacher or tutor, as it might be uncomfortable or blur boundaries between them.[36] Peer educators were well respected, however, their credibility was in some cases undermined by youth. External sexual health professionals were preferred as they were perceived as providing greater confidentiality.[36]

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 remains 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 in engaging young people. This is reflected in the high number of repeat users (compared to new registrations) locally.

For LSL's young and diverse population, knowledge and guidance about healthy relationships is an important resource in navigating their own sexual experiences; this is largely provided by school-led RSE. These lessons could benefit from integrating input from young people, such as employing external educators and widening the breadth of discussion to increase engagement in both the messages being delivered, and in local services. While information should be made available universally, vulnerable groups such as children exposed to domestic abuse, LGBTQI+, and children and young people with disabilities may benefit from targeted support.

GOOD REPRODUCTIVE HEALTH ACROSS THE LIFE COURSE

Reproductive health is important across the life course and can impact overall health at any stage. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status.

In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year.[37] Some unintended pregnancies do not lead to live-births; 52% and 12% of unplanned pregnancies are estimated to end in abortion and miscarriage respectively.[38] Having a child can put enormous financial and emotional pressure on couples and children born to mothers under the age of 20 have a 63% higher risk of living in poverty.[39] Moreover, teenage mothers themselves are 22% more likely to be living in poverty by age 30, compared to first time mothers over 24 years.[39] One in five 16-18 year-olds not in education, employment or training is a teenage mother.[39] Both physical and emotional health may also be affected. Sexually transmitted infections (STIs) such as chlamydia and gonorrhoea can cause pelvic inflammatory disease, which may increase a woman's risk of ectopic pregnancy or infertility.[40] Human papilloma virus (HPV) can cause genital cancers in men and women that, in some cases, may lead to infertility.[41, 42] Difficulties conceiving may strain relationships and cause stress to both mother and father. Furthermore, postpartum mental health in the three years following birth is likely to be poorer in mothers under 20 years.[39]

Reproductive ill-health incurs financial costs to the individual and to the state. For example, unplanned pregnancies leading to maternity may have long-term costs to local authority housing, education, and social care.[43] Teenage pregnancies may, in some cases, be costly to both mother and child with regards to earning potential and future employment.[43] Terminating a pregnancy has direct costs to the NHS: in 2010, approximately £143m was spent on abortions.[44]

In contrast, publicly-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.[38] 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 the UK, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore requiring contraceptives.[40, 45] The median age of first heterosexual intercourse is considered to be 16 for both men and women,[46] though national estimates suggest almost one-third of young people have had sex before this age.[47] Most information pertaining to reproductive health for young people is provided by relationships and sex education (RSE) lessons, parents, and health professionals,[10] however, there are notable issues in awareness of free and available reproductive health services among young people. A 2016 survey of school-aged children in Lambeth, Southwark, and Lewisham (LSL) revealed only 20% of young people reported knowing where to get free condoms[48-50] and STI rates in young people are higher in LSL than the regional and national average, and than in other age groups. This suggests a missed opportunity to embed discussions of contraception

when treating young people with STIs and to promote good overall sexual and reproductive health (SRH).

Unfortunately, challenges remain in ensuring equality in knowledge of contraceptive options and access to preferred methods. The rate of under-18 conception is consistently higher across LSL compared to London and England,[51] which represents 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. Long acting reversible contraceptives (LARC), in contrast to user-dependent methods ((UDM) e.g. condoms, oral contraceptives (OC)), do not depend on daily concordance and have been proven more clinically effective than OC at only one year of use.[52] Despite these benefits, uptake remains low in the UK at about 12% of women aged 16-49, compared to 25% for OC and 25% for male condoms.[53] In Lambeth and Lewisham, the rates of GP-prescribed LARC have remained relatively stable since 2011.[51] In Southwark, the rate has decreased to 7.5 per 1000 women, the fifth-lowest rate among London boroughs.[51] 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.

RSE in schools provides an opportunity to reach young people at risk for becoming pregnant and deliver messages around contraception and reproductive health. These should be accurate and aligned with information from healthcare professionals. Advice relating to contraception should be culturally appropriate, non-judgemental, and given according to the needs of each individual.[47] An example of best practice is highlighted in Shropshire County Council, who invested in their RSE curriculum to tackle high levels of teenage pregnancy. Collaboration was achieved between school nurses, parents, and school staff in order to train teachers to deliver targeted, evidence-based messages on reproductive choices and challenges.[39]

Pharmacies play a vital role in offering accessible SRH services, in particular to young people who may feel uncomfortable visiting their GP or a sexual health clinic. Pharmacies tend to have consistent and long opening hours, allow for relative anonymity, do not require appointments, and are usually more conveniently located than GP surgeries or sexual health clinics.[47, 54, 55] However, the current model of sexual health provision in pharmacies across LSL is disjointed and is not contributing to improved reproductive health outcomes. LSL has high rates of abortion and repeat abortion, and highly accessed emergency hormonal contraception (EHC) services at pharmacies. In Lambeth and Southwark, 80% of women accessing EHC declared previous use and, in Southwark, 50% of these had used EHC in the past 6 months. Under the current model of provision, most pharmacies are unable to provide on-going contraception alongside EHC and must refer to GP or sexual health clinics. This fragments the patient pathway and increases the risk of unmet contraceptive need and unintended pregnancy. In response, sexual health provision in pharmacies across the three boroughs is being reshaped to most effectively support women seeking contraceptives and reproductive and advice.

Online offers of contraception may also be a way of improving access. The Southwark- and Lambeth-based online service SH:24 has been delivering online OC since March 2017 as part of a pilot scheme, providing free OC to local women. The service has also begun an offer of paid OC for women not living in Lambeth and Southwark, which has proven extremely popular. While private supply of contraceptives is not suitable for everyone, the observed demand has demonstrated it is an acceptable way of improving access for a subset of the population.

Finally, school- or community-based drop-in clinics can be an effective method of reaching young people and improving their access to SRH services. Bristol City Council successfully established a network of drop-in clinics at secondary schools, run by a sexual health nurse and youth worker. They were able to reach nearly two-thirds of the population of young people; 5,000 pupils attended a drop-in service in one year to discuss healthy relationships, contraception, and sexual health.[39]

Contraceptives such as condoms should also be made available in non-traditional settings, for example at leisure centres and libraries, to improve access for young people. 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 recently evaluated nationally and found to be successful in engaging young people.[56] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable.[56] In LSL, there has been an increase in c-card registrations and in repeat users, compared to 2016.[57] These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.[10]

The reproductive health of both men and women may be affected by some STIs. HPV is of particular concern for its ability to cause cancer of the cervix, vulva, vagina, penis and anus. While not all types of HPV cause cancer, an estimated 90% of cases of anal cancer relate to HPV infection.[42] and, of the approximate 3,100 cases of cervical cancer reported each year in the UK, nearly all are related to viral infection.[41] In 2011-2013, Lambeth had the highest rate of cervical cancer registrations of all London boroughs.[51] Sexually active individuals should be reminded of the importance of condoms in reducing the risk of contracting HPV (and other STIs) through intercourse.[41] Since 2008, a vaccine against the two most common cancer-related types of HPV has been available free of charge to girls aged 12-18 through the NHS.[58] At present, the NHS does not offer the vaccine to young men, despite the relationship between HPV and male cancers.[58] However, in April 2018, Public Health England introduced a nationwide HPV vaccination programme for men who have sex with men aged 45 or younger, as this group is likely to receive little indirect protection from female vaccination.[59] All women aged 25 or over, irrespective of vaccination status, are invited for cervical screening through the NHS Cervical Screening Programme.[60] The programme aims to identify abnormal cervical cells early to prevent the development of cancer. Most treatment for cervical cancer will result in infertility.[60]

Some unintended pregnancies, regardless of the age of the mother, will become wanted; however, a proportion will result in termination. Access to safe and legal abortion care, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Since our previous strategy, access to high quality abortion services has improved; however, inequalities persist across LSL in terminations of pregnancy (TOP). The TOP rate per 1,000 population is consistently higher among Black African and Black Caribbean populations in the three boroughs, reaching over 50 per 1,000 population in some areas.[61] LSL should seek to address the underlying drivers of these inequalities, for example cultural preferences for barrier methods of contraception.[62]

After delivery or between pregnancies is an often unrecognised period during which women require effective contraception.[63, 64] Short inter-pregnancy periods increase a woman's risk of complications in the subsequent pregnancy, including preterm birth, low birthweight and stillbirth,[65, 66] and thus present a critical time to intervene. Furthermore, during pregnancy, women are frequently in contact with healthcare professionals and are therefore accessible to information about, and supply of contraception. This is especially important for vulnerable

women who are at high risk for future unintended pregnancy (i.e. young women, women who have had previous children removed).[67] National guidelines recommend that professionals providing care to pregnant women be able to offer their chosen method of contraception following pregnancy or termination, or facilitate access to these services.[67] Female and male sterilisation should be included among the range of available methods of contraception discussed within the context of a patient's individual circumstances.[68] Support for effective, appropriate contraception should continue for as long as a patient is sexually active, extending through menopause and into old-age.

Good reproductive health is thus reflective of a comprehensive, whole-system approach to reproductive wellbeing that offers support from adolescence through to old-age. At any reproductive stage, individuals should understand the range of contraceptive methods available to them and be aware of how best to access them.[69] Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services. As people move through life, their personal circumstances should continue to be at the centre of the discussion of preferred contraceptives, ensuring they continue to enjoy safe and healthy sexual relations.

HIGH QUALITY AND INNOVATIVE STI TESTING AND TREATMENT

Sexually transmitted infections (STIs) facilitate the transmission of HIV, cause a number of cancers and contribute to poor sexual and reproductive health and overall wellbeing.[70, 71] The sequelae of untreated STIs include infertility, ectopic pregnancy, and harmful impacts on mental health and sexual relationships.[52, 72, 73] Furthermore, STIs are a significant contributor to health inequalities, which in turn increase a person's risk of poor sexual health and limit their access to prevention, testing and treatment; STIs remain one of the most common acute conditions. A total of 422,147 new diagnoses of STIs were reported for England in 2017, of which 48% were chlamydia, 14% genital warts, and 11% gonorrhoea.[70, 71] The overall number of new STI diagnoses in 2017 was similar to that of the previous year, however, there have been notable differences in the trends of particular infections.[70, 71] Syphilis and gonorrhoea diagnosis rates increased by about 20% relative to 2016, there was a 7% relative decrease in genital warts, while chlamydia incidence remained stable.[71]

Lambeth, Southwark and Lewisham (LSL) have historically had some of the highest national rates for STIs. In 2017, Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark in third, with Lewisham 11th.[51, 74] This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

To reduce inequalities, we need to improve the sexual and reproductive health (SRH) of key groups including young people, men who have sex with men (MSM), and Black and minority ethnic groups (BAME).[40] Lambeth, Southwark, and Lewisham residents are predominantly young, with a larger proportion of the population aged 25-34 years.[51, 75] We are also more ethnically diverse than England: approximately one quarter of LSL residents are from a Black ethnic background. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.[74] We therefore have a large population at higher risk of poor sexual health.

Tackling the burden of STI requires both disease-specific interventions as well as wider intervention at several levels as detailed in national guidance.[40] At the population level, it is integral to build an honest and open culture and reduce sexual health stigma, while at the community level it involves ensuring adequate access to contraception such as through condom distribution schemes as well as access to testing and treatment of STIs in a variety of settings, especially for high risk groups.[40] Screening for common STIs like chlamydia should be offered routinely and opportunistically to young people. Protecting people against reinfection through having timely and effective treatment, and appropriate and effective partner notification pathways in place is crucial. Incorporation of education and access to correct and timely information is important plan and can be achieved through use of evidence-based online services and websites such as "Sexwise",[40] but importantly, starting early through effective delivery of RSE in schools.

Correct and consistent condom use remains the principal intervention for preventing STIs and reducing 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 recently evaluated nationally and found to be successful in engaging young people.[56, 77, 78] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable. In LSL, there has been an increase in C-card registrations and in repeat users, compared to 2016. These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for

contraceptives and may otherwise miss out on SRH advice. Further work needs to be done, however, to engage BAME in these distribution schemes given contraceptive usage in general is lower in this population.[62]

Part of the success in managing to maintain such services through a financially challenging period has been through introduction of innovative methods of access. This is most apparent in web-based access to STI testing and treatment. A randomised trial conducted in Lambeth and Southwark in 2014-15 found that e-STI testing delivered through SH:24 increased uptake of STI testing across all groups including those at highest risk.[79] An added advantage of this method is that traditional structural and social barriers to STI testing may be overcome through online service delivery and home-testing.[80] Service innovations to improve STI treatment rates once diagnosis is confirmed vie e-STI testing continue to be active areas of research.[79] Self-testing online services have since been extended across London (now 'Sexual Health London') with the aim of freeing capacity at SRH clinics by targeting asymptomatic patients, ensuring those most in need of a face-to-face intervention receive one.

A diverse range of pathogens can be sexually transmitted and, while complications vary widely, all contribute to the burden of poor health.[40] Five STIs from the bulk of diagnoses seen both across England and in LSL: chlamydia, gonorrhoea, syphilis, genital warts, and genital herpes.[74] Several others such as shigella, hepatitis, lymphogranuloma venereum (LGV), trichomoniasis and molluscum contagiosum (MC) form a much smaller percentage of overall STI burden.[71, 79]

Chlamydia remains the most common STI diagnosed across England and LSL. In 2017, 9,000 cases were diagnosed in LSL with reported rates in Lambeth and Southwark over double that of London and triple that of England.[51, 74] Untreated chlamydia can lead to several gynaecological and urological complications such as pelvic inflammatory disease and epididymitis.[81] The chlamydia detection rate in 15-24 year olds is an important indicator of good sexual health.[72] All three boroughs in LSL have met and exceed the recommended rate of 2,300 per 100,000 people. Young people remain at greatest risk of chlamydia and annual opportunistic screening of sexually active people aged 15-24 years is recommended.[82] Chlamydia testing should be offered in a range of settings to increase opportunistic testing, including primary care, online, outreach and termination of pregnancy services, however, a decrease of around 8% in testing was observed between 2016-17 nationally.[71] This represents a continued decline that has only been somewhat compensated for by increases in the provision of online SRH services.[51, 83]

Rates of gonorrhoea diagnosis have risen sharply from 2016 to 2017 nationally and locally. This is particularly concerning alongside the increasing prevalence of azithromycin- and recently, ceftriaxone-resistant gonorrhoea.[84, 85] Gonorrhoea was the second most prevalent STI in LSL in 2017, with diagnosis rates 4-8 times greater in Lambeth (654 per 100,000), Southwark (565), and Lewisham (302) compared to England (79). Men in general have higher rates of diagnosis across all ages. In LSL, gonorrhoea remains concentrated in certain groups, particularly MSM and BAME.[51, 74] Similarly to chlamydia, frequent gonorrhoea testing allows for timely diagnosis, treatment, prevention of serious complications, and onward transmission through case and partner management.[85]

A syphilis outbreak was declared in 2017. Nationally, a total 7,137 cases of syphilis were reported in 2017, of which just under 1,000 were diagnosed in LSL residents.[71, 74] the disease can remain latent and asymptomatic for many years before manifesting with dermatological, neurological and cardiovascular symptoms.[86] Rates of syphilis diagnosis in Lambeth and Southwark were higher than in London in 2017, while rates in Lewisham were

similar to England. Nearly all (98%) of cases in LSL were in men with those aged 35-44 most affected.[51] Syphilis is also most common among individuals who are at higher risk of other STIs, such as HIV.[87] The highest number of cases of syphilis in over half a century were recorded in 2017 and, in response, PHE is developing an action plan to help address these rising rates especially among vulnerable groups.[40] This may require greater national coordination of efforts as well as innovative approaches such as targeted social media messaging to raise awareness of outbreaks when they occur.[88] Screening HIV-positive men and MSM for syphilis every three months has also been demonstrated to improve detection.[87]

Cases of genital warts continue to decline with a 90% decrease reported since 2009 nationally.[51] This decline has been mirrored in LSL though rates are still higher than the national average. The rate of diagnosis in Lambeth and Southwark (219 and 209 per 100,000 respectively) in 2017 was double that reported for England.[74] The introduction of a school-based HPV vaccine for girls is believed to have been the key driver in this reduction.[73] This success has instigated a roll out of the vaccine in MSM population to tackle increasing rates in this group.[71]

The incidence of genital herpes (HSV) has remained relatively stable nationally and in LSL. New diagnosis rates in London were 54 per 100,000 compared to Lambeth, Southwark and Lewisham respectively (148, 124 and 105 per 100,000). It remains the only STI which is more prevalent in women in LSL.[74] Many genital herpes infections are asymptomatic, however, they can cause severe systemic disease in neonates and facilitate HIV transmission.[89] Routine testing for genital HSV is not recommended unless symptomatic or in targeted groups where partners are affected or multiple partners are involved.[90, 91]

Several other less prevalent, high-risk STIs are also treated through SRH services across LSL hence preventative strategies here are also important.[40] Viral hepatitis remains high on the public health agenda with the commitment from PHE to the WHO Strategy on elimination of hepatitis C as a major public health threat by 2030.[92] Rates of hepatitis B reported in LSL are also higher than the London average with an incidence of 2.54 per 100,000 compared with 1.7 per 100,000 in London.[51] Males and MSM in particular have been disproportionately affected. In addition, hepatitis A immunisation recommendations have been updated following the ongoing outbreak primarily affecting MSM in England: to opportunistically vaccinate all MSM attending SRH clinics without previous evidence of vaccination for hepatitis A and B, and to educate around preventative activities and condom distribution.[93, 94]

Lymphogranuloma venereum cases peaked in 2014 but have been declining since. Of LGV diagnoses made in England in 2016, 91.7% were among MSM, 73.4% lived in London and 67.5% were HIV-positive. Clinicians are advised to always consider LGV testing and to maintain high suspicion in these high-risk groups.[95]

Shigella has been traditionally associated with travel to lower income countries where sanitation is poor. However, since 2009, case numbers in England (particularly in MSM) have increased dramatically. Work undertaken by PHE in London highlighted that education and understanding of shigella remain low despite attempts for engagement through social media campaigns, posters and through sexual health clinics. Although cases among men have fallen in recent years, SRH clinics and health protection teams must continue to provide advice to SRH professionals on how to prevent spread and protect themselves.[96]

Molluscum contagiosum and trichomoniasis together encompassed over 100 new diagnoses in LSL in 2017 although they are less clinically severe infections (with the exception of infections in those with late-stage HIV).[97] BASHH recommends that all individuals presenting

with molluscum contagiosum should be given a full STI screen.[97] Trichomoniasis is associated with reproductive morbidity and increased rates of HIV transmission hence prompt treatment and contact tracing are recommended on diagnosis.[98]

Several vulnerable groups are disproportionately affected by STIs – young people, MSM, and Black communities. Young people aged 15-24 years still experience the highest diagnosis rates of most STIs.[40] Historically, young women have had higher rates of genital warts however this has seen a significant decline with the introduction of a UK school-based HPV vaccine.[73] 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 support services, in order to prevent the transmission of STIs. However recent work has revealed that nearly a third of schools lack good RSE and updates in government guidance are now needed (in anticipation of statutory RSE being introduced in September 2020), with consultation work underway.[11] A Cochrane review in 2016 revealed that too much RSE provision placed emphasis on abstinence or delayed sexual initiation rather than provision of information about contraceptives, for example.[99] School-based surveys in LSL have reinforced these results, demonstrating 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) and safer sex when educating children and young people as part of RSE to promote good overall sexual and reproductive health.[56]

MSM bear the burden of many types of STIs, with the main challenges among MSM being the large relative increases in gonorrhoea (21%), chlamydia (17%) and syphilis (17%) observed nationally in 2017 compared to 2016, and mirrored in LSL.[51] Several behaviours likely explain these trends including increased condomless intercourse, multi-partner sex facilitated by geosocial networking applications, and a rise in 'chemsex'. This may also be partly explained by an increasing availability of HIV pre-exposure prophylaxis (PrEP). While PrEP has dramatically changed the landscape of HIV prevention, recent literature on coincident outcomes have suggested PrEP use may be associated with a reduction in the use of condoms and an increase in STI acquisition.[100] Research in England via the Impact trial continues. The national extension of targeted MSM HPV vaccination is expected to help reduce the incidence of genital warts and HPV-related cancers, though a lag is expected before full benefit is observed.[71]

With regards to ethnicity, the highest rates of STI diagnoses are among Black Caribbean and Black 'other' groups. Rates of STIs across England are highest in urban areas – especially in London – reflecting areas of higher deprivation. We know that Black communities are more likely to live in the more deprived areas of our boroughs.[101] Interventions and services should be informed by the opinions and experiences of BAME groups to ensure services are attractive and sensitive to the needs of specific communities.[75, 102] Engagement with faith communities and leaders in creative ways has also been shown to yield better participation in SRH services.[75]

Trends in STI diagnoses therefore highlight several areas for concern both nationally and in LSL, especially with regards to drug-resistant gonorrhoea, rising rates of syphilis, and an apparent increase in condomless sex. For LSL, strategies are needed that increase STI testing, aid targeted condom distribution services and use of condoms, and provide effective access to treatment. This is most crucial in those groups who are at greatest risk of STI acquisition. Engaging 'hard to reach' groups, especially in an environment of austerity, will require continued innovative approaches and testing methods informed by those communities to ensure appropriate reach of services.

LIVING WELL WITH HIV

HIV remains a national and regional priority, particularly in Lambeth, Southwark and Lewisham (LSL) where diagnosed HIV prevalence rates are among the highest in the country; Lambeth has the highest rate of HIV diagnosis in England. These high diagnosed HIV rates are, in many ways, an indicator of the success of policy and action, but also a reflection of our communities. With knowledge of positive HIV status and access to effective treatment, the mortality rate of people with HIV is now comparable to the rest of the population.[103] As a result, HIV has transitioned away from the life-threatening illness it once was and into a long-term condition that must be managed alongside traditional age-related illness. Health and social care practitioners must adapt their thinking to mirror the evolution of this disease and to appropriately support and manage comorbidities in people living with HIV (PLHIV) in a non-discriminatory way.

In 2014, UNAIDS set out an ambitious treatment target for HIV globally: that by 2020, 90% of all people living with HIV would know their HIV status, 90% of all people with a diagnosed HIV infection would be on treatment (antiretroviral therapy (ART)), and that 90% of all people on treatment would be virally supressed.[104] These aims are supported by current communications and campaigns around HIV: that 'undetectable = untransmittable'. In 2016, London achieved and surpassed these 90-90-90 targets: 90% of Londoners with HIV were diagnosed, 97% were on treatment, and 97% of those receiving ART were virally supressed.[105]

In January of 2018, London signed up to the Fast-Track Cities (FTC) Initiative, an international pledge to accelerate local responses to HIV and AIDS, including reaching the 90-90-90 goal.[106] As a testament to our commitment, London has set a more ambitious target to reach 0-0-0: 'zero HIV-related stigma and discrimination, zero new HIV infections, and zero preventable deaths from HIV-related causes'. London has also pledged to improve the health, quality of life and wellbeing of people living with HIV across the capital. Regionally, LSL contributes to and hosts the pan-London prevention programme 'Do It London', which provides far-reaching campaigns, free condom distribution, outreach and rapid HIV testing services. Furthermore, the Elton John AIDS Foundation (EJAF) has invested £2 million into primary care and community groups in LSL to increase HIV testing and support people diagnosed with HIV to engage in care.

HIV elimination is also a national objective. Public Health England's (PHE) strategic action plan 'Health promotion for sexual and reproductive health and HIV (2016-2019)' aims to decrease HIV incidence in populations most at risk of infection and to reduce the rate of late and undiagnosed HIV.[43] They also encourage adapting combination approaches to prevention. These involve deploying a set of behavioural, biomedical and structural approaches tailored to local such as levels of infrastructure, local culture as well as populations most affected by HIV. In the UK and particularly London, we have made considerable efforts to encourage condom use, promote expanded HIV testing and diagnosis (including self-sampling), and ensure prompt treatment and the use of pre-exposure prophylaxis (PrEP).

Both the private market and the national PrEP trial (the Impact trial) have revealed acceptability and demand for PrEP – particularly amongst men who have sex with men (MSM). The advent and accessibility of PrEP is a turning point for HIV, affording the freedom to engage in sex with an HIV positive partner safely and without fear or distress. Widespread acceptance and use of PrEP also works to combat the stigma once associated with HIV by reducing the marginalisation of those living with the virus.

These accomplishments are laudable, however, inequalities remain across LSL from HIV testing uptake to treatment and engagement in care. Anyone can contract HIV but people from some groups or parts of the world are more likely to be affected. Locally, the highest HIV diagnosis rates are seen in those aged 35-64, men of White ethnicity and women of Black African ethnicity.[74] Sex between men accounts for more than half of the new HIV cases in LSL each year. The number of new HIV diagnoses in MSM fell for the first time since the beginning of the HIV epidemic, likely driven by increased private use of PrEP and frequent testing. This decreasing trend has not been seen across all populations, however. New diagnoses in heterosexual women and Black African men remain proportionately high. In the UK and internationally, engagement of other at-risk groups including women, BAME communities, and trans people in the uptake of PrEP as a method of HIV prevention in trials has been much poorer than MSM, and more specific work to engage these groups will be required in a future commissioned PrEP service.

HIV testing, including frequent testing among those most at risk of HIV continues to be one of the most important interventions to identify current HIV infection and prevent onward transmission. Providing access to, and encouraging frequent testing has the potential to reduce the number of people unaware of HIV infection, the time with which people live with undiagnosed infection, and provides the opportunity for prompt HIV treatment. ART is now so effective that those who are treated and have an undetectable viral load (<200copies) have levels of virus that are untransmittable, even if having sex without condoms. Despite our local demographics and high prevalence of HIV, LSL testing coverage has consistently trended below the regional average.[51] This is a strong indicator to us as sexual health commissioners that more must be done to ensure those most at risk of HIV are receiving prompt testing and treatment.

In December 2015, PHE launched a national self-testing service funded by local authorities that allows users to order free HIV test kits online. This provides an accessible, easy-to-use alternative to traditional testing and help to empower individuals to take control of their sexual health. This service has been particularly successful at engaging MSM, which has decreased the attributable HIV testing in sexual health clinics and may in turn be partially responsible for the proportional rise in new diagnoses in women and Black African men.

Our concerted efforts to increase testing, timely diagnosis, and treatment have helped to improve the life chances of those who contract HIV and over time, fewer people in LSL are receiving a late HIV diagnosis. Nonetheless, in all LSL boroughs in 2014-16 more than 25% (target) of people diagnosed with HIV received a late diagnosis.[74] Late diagnosis is highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2014-2016, closely followed by Southwark. Across LSL in 2016, certain groups had a higher proportion of people with late diagnosis: those aged 50-64 (53%), Black African ethnicity (49%) and Other ethnicity (46%), those whose exposure to HIV was through heterosexual contact (59%), and women (55%).[74] These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV and increases the risk of HIV transmission; it is therefore a critical target for reduction in our strategy.

Effective, timely treatment allows PLHIV to lead long and largely unencumbered lives. However, stigma and discrimination remain primary barriers to engagement across the course of HIV. A national survey of perceived stigma was undertaken by Stigma Index UK in 2015/16.[107] In London, while almost all (94%) participants reported someone in their social circle was aware of their HIV status, those of Black and other minority ethnicities were less

likely to have disclosed their status.[107] Among those who reported feeling stigmatised, sexual rejection was the most common cause of concern. The majority (59%) of patients who had disclosed their HIV status to their GP felt well supported, however, 13% reported having avoided seeing the GP when required. These experiences were broadly similar to that of PLHIV in the UK overall.[107]

Education and campaigns aimed at young people and the general public may help to normalise HIV and reduce the marginalisation of those affected. Stigma and discrimination have also been suggested to influence adherence to ART.[108] A large systematic review of retention in care among adult PLHIV[109] found that substance use, physical comorbidities (e.g. hepatitis C infection), and certain demographics were less likely to remain engaged in care. Key demographics identified as risk factors for becoming lost to care included being from an ethnic minority group. Sexual health professionals must recognise these added risk factors and, where possible, programmes and services should be designed to best support and engage these groups. A synthesis of qualitative evidence suggests that shifting the responsibility of holistic care and support away from clinicians onto lay workers or peer counsellors may nurture a positive outlook and increase retention in care.[108]

As PLHIV generally continue to live longer and age, it is critical that our services evolve to meet the complex needs of this population. The mental wellbeing of PLHIV is associated with adherence to treatment and overall quality of life.[110] Unfortunately, PLHIV are more likely to experience depression and anxiety, which may negatively impact treatment outcomes.[110-114] Mental health and wellbeing should be considered and supporting throughout the life course of PLHIV. As PLHIV age, they may also be affected by physical comorbidities. These may be routine age-related illnesses, however, certain conditions may be exacerbated by HIV infection and treatment, and vice-versa.[115] In terms of STIs specifically, in Lambeth and Southwark in 2017, 90% of syphilis cases were in people who identified as gay; this was slightly lower in Lewisham (78%).[74] Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV.[74] This is concerning as co-infection with HIV increases the risk of central nervous system complications. PLHIV are also most affected by lymphogranuloma venereum (LGV), a type of chlamydia that infects the lymph node. In LSL, 67.5% of LGV diagnoses in 2017 were in HIV-positive MSM. Finally, tuberculosis (TB) is one of the most common co-infections with HIV,[116] with PLHIV being at 16-27 times greater risk of developing TB than those without HIV infection.[117] Alongside these particular conditions, as PLHIV age, like the rest of the population they may develop common age-related illnesses such as cardiovascular disease and dementia.[118-120] It is therefore essential that HIV care evolves to include a wide range of professionals that effectively manage HIV as a long-term condition, acknowledge and support the social care needs and wellbeing of PLHIV, and are prepared to recognise and treat as routine communicable and non-communicable diseases.

Acquiring, living with, and ageing with HIV affects a significant proportion of LSL residents. While significant achievements have been made in reducing the incidence of HIV and improving the quality of life of those living with HIV, approaches must remain agile to address the changing landscape of HIV support. Specialist HIV services and primary care must work together to deliver holistic, person-centred care, managing HIV alongside with other chronic and acute health conditions. Strengthening our combined prevention approaches, promoting timely testing and treatment, and improving our understanding of the social aspects of HIV will support PLHIV in LSL to access the services and care they need to live a long, healthy and fulfilling life.

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