# Camden Sexual Wellbeing and Reproductive Health System Review and Work Programme 2025-2030

October 2025

NHS Central and North West London NHS Foundation Trust

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NHS North Central London Integrated Care Board

healthwatch Camden

Camden

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# Executive summary

Camden is a young, diverse borough. We have more residents aged 15-40 than the national average, we are more ethnically diverse, and we have a higher proportion of LGBTQ+ residents compared with England overall.

We are committed to addressing health inequalities wherever they arise. Camden's Sexual Wellbeing and Reproductive Health (SWRH) System Review and Work Programme 2025–2030 sets out our approach to improving sexual and reproductive health outcomes for all residents. The programme aims to ensure that everyone—regardless of age, gender, sex, sexuality, ethnicity, disability, or background—can access high-quality, culturally competent, and trauma-informed care.

The review is informed by our **2024 Sexual Health Needs Assessment**; interviews, focus groups and surveys with over 190 residents most likely to experience worse sexual and reproductive outcomes or greatest barriers to access; frontline staff feedback; local and national research and reports.

## Navigating this report

The review and work programme set out findings and recommendations in relation to four key domains, or 'pillars'. These are interrelated but can also be read individually. Click each heading below to go straight to that section.

## Pillar 1: Healthy, fulfilling and safe relationships

Young people want trusted adults – be they parents, teachers or youth workers – to help navigate the world of information in which they live. We need to grow the network of adults who feel equipped and confident to support children and young people around sex and relationships.

They value relevant, inclusive, and practical RSE (Relationships and Sex Education) that reflects their lived experiences. Only 40% of year 8/10s responding to the 24/25 Health Related Behaviour Questionnaire (HRBQ), a survey carried out with around 1100 primary and 1800 secondary school pupils in Camden schools every few years to explore young people's thoughts and behaviours in relation to their health and wellbeing said RSE taught them about how to resist pressure in relationships. Only 30% felt it helped them really understand contraception or sexual health and only 23% said RSE taught them well about issues related to pornography. There is more work to do to ensure RSE meets the needs of LGBTQ+ young people, neurodivergent children, those with SEND and reflects considerations of faith and cultural norms and taboos.

Online harms, pornography, and harmful sexual behaviours are growing concerns, with a need for nuanced, age-appropriate education. **England's Children's Commissioner** found that the average age at which children had seen pornography was 13, and similarly in Camden young people told us of early exposure to pornography. Young adults navigate complex relationship dynamics with national research showing differing understanding of consent and more exposure to potentially health harming practices when compared with older generations.

Disabled adults and autistic adults often lack support for their intimate lives and can face stigma or infantilisation.

### Recommendations include:

1. Develop our PSHE content, delivery and resources to:
    - Better reflect Camden's diverse communities and LGBTQ+ young people
    - Support more focus on helping CYP navigate relationships and problem solve when they go wrong
    - Strengthen the focus on addressing harmful sexual behaviours, and the harmful impact of pornography and sexualised online content on real life relationships
2. Ensure young people and professionals who work with them know how to get help around sexual health, HPV vaccination, contraception, menstrual health and harmful relationship behaviours – through youth-led campaigns and publicising services
3. Enable foster carers and parents to feel more confident talking to their children about puberty, sex, relationships, consent and managing potential harms, by improving our training offer
4. Develop a network of trained 'trusted adults' across the community, skilled and experienced in talking to young people about puberty and physical health, safe relationships and sexual health
5. Increase access to high quality RSHE education in and outside of school for young people by reviewing how and where our health education offer is delivered
6. Ensure young adults can find support to navigate healthy

and safe relationships, experience good sexual health and understand how to get help if they need it, by reviewing the offer in 16+ education settings

7. Strengthen coproduction approaches to ensure a representative group of young people is trained to help us continually develop our sexual health education and clinical offer
8. More strongly recognise the interdependence of sexual health, relationships and mental health in strategic planning and education, advice and guidance and support services for young people, including reviewing access to 1:1 confidential advice for young people experiencing harm in their relationships

## Pillar 2: High quality sexually transmitted infection (STI) testing and treatment

Camden has some of the highest STI rates in London. Camden ranked 9th out of 33 London boroughs for rates of new STI diagnosis in 22/23 (**Camden needs assessment, 2024**). The rate of Gonorrhoea, often a marker of unsafe sexual activity, has more than doubled between 2012 and now. This may partially reflect increased testing, but likely also indicates an increased burden of disease.

Disparities exist by age, ethnicity, sexual orientation, and disability. Gay and Bisexual Men who have Sex with Men (GBMSM) continue to bear the greatest burden of sexual infections, but rates are rising faster amongst heterosexual populations. STIs are highest among men aged between 20 and 34 years, but very low rates of detection in older adults over 65 may suggest a cohort at risk who are less likely to access screening.

Young people report very low knowledge of how to access free condoms (only 23% of year 8/10 respondents to our Health-Related Behavioural Questionnaire said they know where to access them). Asian residents are under-represented in STI diagnosis rates considering our population make-up. We have limited data about needs, access to sexual health services and outcomes for disabled and/or neurodiverse residents and the same is true for our trans and non-binary populations. These are clear gaps to address in our understanding.

Residents – including young people, people who were homeless, people who use drugs/alcohol, sex working women, disabled people and LGBTQ+ people in particular – generally had positive experiences of sexual health services once they accessed them. Where barriers exist, they include knowledge of services and STIs (for many, available online information was hard to navigate or unclear); stigma and discomfort visiting sexual health clinics; an unwelcoming or non-inclusive physical environment or staff manner; and/or language barriers. Many residents said outreach approaches helped them make prior connections, which helped them feel confident and safe accessing care.

### Recommendations include:

1. Increase access to condoms, by reviewing our C-Card free condom scheme and promoting free condoms to adults at greatest risk including those who sex work
2. Reduce the spread of STIs by continuing to implement new clinical guidelines as they emerge (examples include Men B vaccines and doxyPeP medication)
3. Improve access to information, advice, guidance and interventions for residents at greater risk of being underserved.

4. Improve collection and of equity data to inform how sexual health services and systems understand and address the needs of our diverse communities.
5. Develop staff skills and confidence in sexual health settings to improve the experience of residents more likely to face barriers accessing care
6. Increase the visibility of local sexual health sites eg Archway and in particular Mortimer Market through a promotional campaign
7. Address environmental barriers in Sexual Health services to improve the experience of residents more likely to face barriers accessing care, reviewing how accessible spaces, communications and care models are to different populations.
8. Develop staff skills and confidence in non-healthcare settings, starting in our emerging neighbourhood models
9. Improve access to sexual health, cancer screening and HPV vaccination information, advice, testing and interventions for undergraduate and/or postgraduate university students
10. Ensure carers of adults with a learning disability and/or autistic adults feel confident supporting those they care for around their sexual health and to maintain safe healthy relationships

## Pillar 3: Towards zero transmission and living well with HIV

Camden has decreasing, but still high HIV prevalence compared with London and England. We have proactive testing resulting in lower late diagnosis than London or England. However late diagnosis remains a concern, especially among heterosexual men and women who are more likely to be diagnosed late. We see ethnic disparities, with Black, mixed and 'other' ethnic groups more prevalent in new diagnosis rates.

Key issues residents living with HIV told us about included a desire for more information about available services; variability in interactions with healthcare professionals that ranged from exceptional to unacceptable; changing needs, lack of information/advocacy and worries about ageing (over 60% of our residents living with HIV are over 50); and the perpetuation of stigma and discrimination and its negative impact on our residents' daily lives.

### Recommendations include:

1. Ensure that adults (including older adults) living with HIV and accessing social care support feel confident to share their diagnosis and are treated with respect and without discrimination, through annual awareness raising campaigns for staff
2. Address social isolation experienced by LGBTQ+ residents and/or people living with HIV, particular amongst older community members, including through our Camden Together campaign
3. Develop the availability of PrEP – increase reach to heterosexual men and women and Under 21s by exploring digital access and promotional campaigns
4. Help address stigma and discrimination around HIV by increasing understanding in the general population through annual HIV awareness campaigns led by residents living with HIV

## Pillar 4: Good reproductive health across the life course

Camden's women experience some worse reproductive health outcomes than London or England and reported predominantly negative experiences of reproductive care.

Our cervical and breast cancer screening and HPV vaccination uptake rates fall well below the North Central London and England averages. Only around half of Camden's women aged 25-49 had undertaken cervical screening in 23/24. Coverage is lower amongst Asian and White Other groups (NCL Cancer Alliance, 2024).

Abortion rates are low compared with our neighbours and take up of long-acting reversible contraception (LARC) is in line with London. Many younger women voiced worries about hormonal options, showing how important it is to have good advice on contraceptive choices

Waits for gynaecology can be long; 44% of women in NCL were waiting more than 18 weeks at March 2025 (**NHS England RTT Waiting Times Data, 2024-25**). Women said reproductive and sexual healthcare felt fragmented and hard to navigate.

Menopause information and advice is a particular gap. Many women told us that with so much online content available, it can be difficult to know what's accurate and trustworthy.

Many women talked of not feeling listened to when describing symptoms and/or pain. Cultural stigma, racism, and trauma affect access and experience of care – several Somali and Bangladeshi women in our insights programme said they avoided sexual health clinics, for example, due to stigma, cultural assumptions, fear of being seen by members of their own community and discomfort in mixed-gender or highly sexualised environments.

Other groups where more carefully tailored care would help overcome barriers include trans and non-binary people, disabled people and survivors of trauma. For some women such as those who were homeless or with other needs such as drug or alcohol use, outreach approaches were highly valued.

### Recommendations include:

1. Improve access to reproductive health information, advice and guidance, particularly for residents facing greater inequity of access e.g. Black and South Asian communities, older women.
2. Improve women's experience of accessing healthcare for menstrual challenges, menopause or other reproductive health needs by increasing knowledge and skills in the Primary Care and Sexual Health workforce
3. Increase cervical and breast cancer screening uptake by work with primary care, targeted promotional work in communities with lower uptake and rolling out HPV self-sampling
4. Increase HPV vaccination rates through targeted campaigns, catch up promotions and staff training
5. Explore opportunities to increase access to contraception through outreach and better offer of postnatal contraception
6. Address the variability of experience that women told us about regarding menopause and menstrual health in Primary Care and other healthcare settings
7. Improve how we understand and address inequalities in access and outcomes to reproductive healthcare through better collation and use of equity data

8. Join up services catering to different aspects of reproductive health so women and other people with reproductive health needs get holistic advice, guidance and care about their health, including exploring feasibility of a women's health hub in Camden.

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## Conclusion

There are many common themes across our four areas for action. These include:

- Equity and inclusion: Prioritising underserved groups including women, LGBTQ+ residents, our minoritised ethnic communities, disabled people, neurodivergent people and those facing multiple disadvantage.
- Trauma-empathetic practice: Embedding compassionate, person-centred care across all services.
- Resident voice and co-production: Involving residents in shaping education, campaigns and services.
- Data and insight: Using local and national evidence to drive continuous improvement.

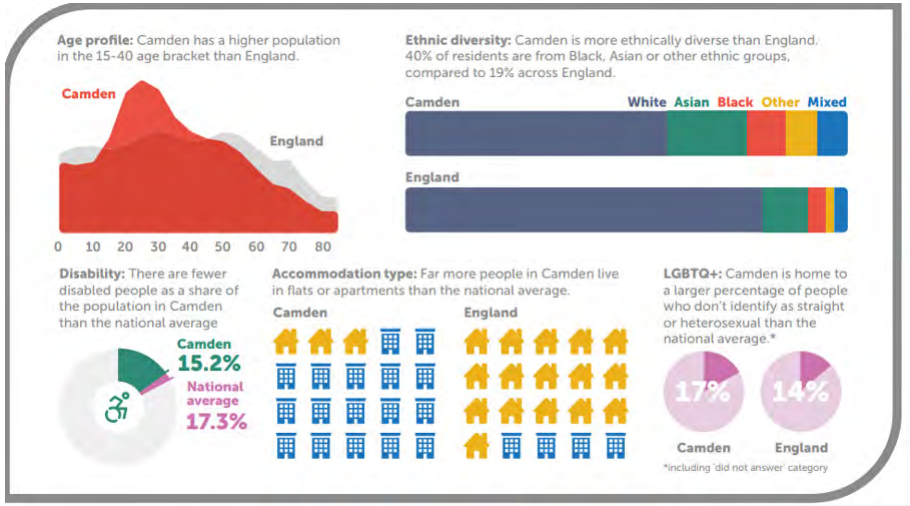
The work programme is intended as a roadmap for all partners – across health, education, social care, and the voluntary sector – to work together to create a borough where everyone can thrive in their sexual and reproductive health. It seeks to create more inclusive, equitable, and effective service delivery that reflects the real lives and needs of Camden's residents.

# Introduction

# Introduction

"*In Camden we want to make our borough the very best place to grow up, live a healthy life and age well with dignity and independence. Everyone should be able to contribute to their community and lead a full and active life, regardless of their age, ability, and social background*" (We Make Camden, March 2022).

Camden is a young, diverse borough. We have more residents aged 15-40 than the national average, we are more ethnically diverse and we have a higher proportion of LGBTQ+ residents compared with England overall. We are proud of our diversity, and committed to addressing inequalities wherever our population encounters them.




(**State of the borough report, 2024**)

**Our Health and Wellbeing Strategy 2022-2030** sets out Camden's long term ambitions:

- Start Well: All children have the fair chance to succeed and no-one gets left behind
- Live Well: People live in connected, prosperous and sustainable communities
- Age Well: People live healthier and more independent lives, for longer.

Sexual wellbeing and healthy relationships, sexual health and reproductive health are all key factors supporting our residents to achieve these objectives.

This work programme is intended to provide a guiding framework for the commissioning, planning and delivery of services for our residents, including but not limited to our statutory sexual health services or NHS-commissioned health services. In particular, the programme is intended to improve access to care for those most underserved – including but not limited to women, LGBTQ+, Black, Asian and other minoritised ethnic residents, disabled and neurodivergent residents and those experiencing multiple disadvantage including homelessness, drug and alcohol use, mental health concerns and/or domestic abuse.

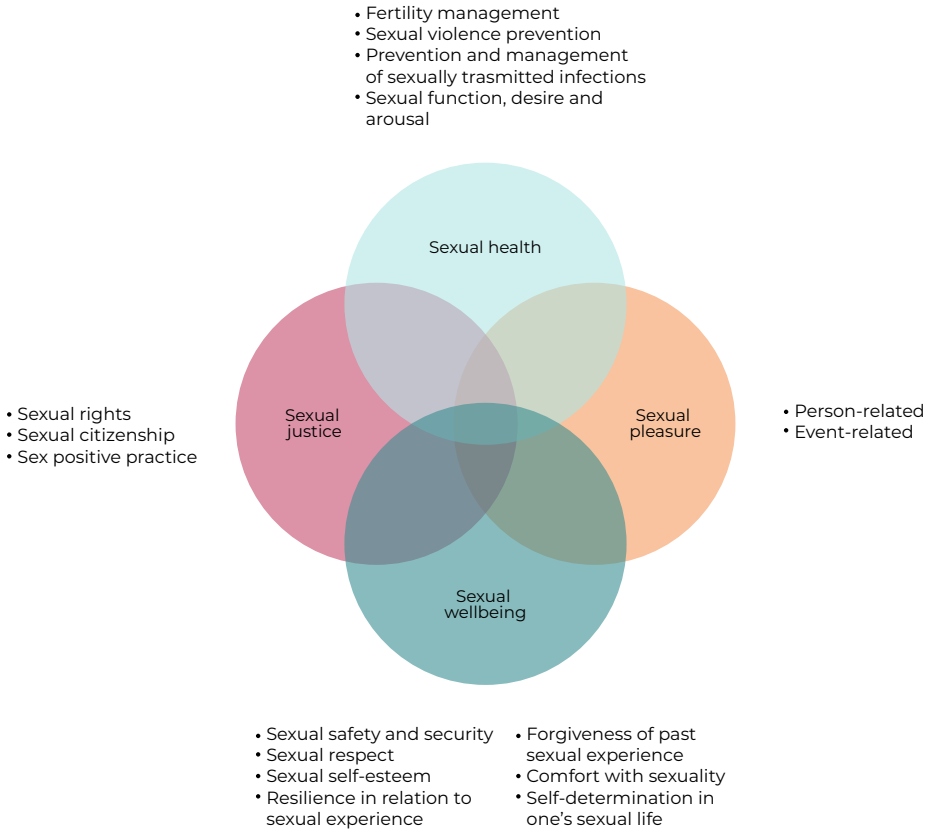
# Our definitions and our work areas

## Sexual health

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

## Sexual wellbeing

> *"Sexual wellbeing brings conceptual clarity to our shared understanding of sexual health, identifies areas of conceptual difference, and clarifies a much broader public health perspective on sexuality beyond sexual health alone."*




(**Mitchell et al, 2021**)

## Reproductive health

> *"Reproductive health affects both men and women but women bear the brunt of reproductive ill health, not only as a result of their biological status but also because of a wider social, economic and political disadvantage"* (British Medical Association (BMA), 2018).

Reproductive health is often correlated with pregnancy planning and contraception. However, the greater proportion of women's lives is spent outside of pregnancy and childbirth. Thus, Camden's work programme will take a broader focus to improve support for women and girls around menstrual difficulties, period poverty, menopause, gynaecology access, Female Genital Mutilation (FGM) and prevention of cervical cancers.

Diagram 1 below sets out the scope of what we mean by the term 'reproductive health'.

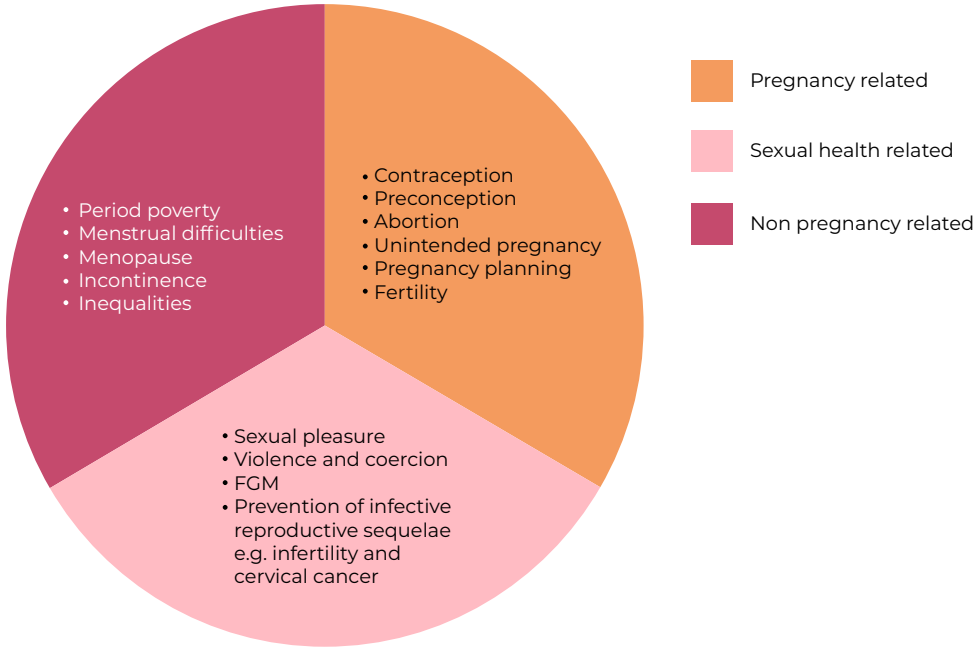



**Diagram 1: Mann and Stephenson, BMA, 2018**

We have not included fertility treatment in this work, because North Central London Integrated Care Board **undertook a detailed review of provision** in 2021, **resulting in a revised fertility policy** in 2022.

### Gender and sex

In this report, we refer to women and girls for conciseness. However, we recognise that people who do not identify as women – such as trans, non-binary and/or intersex people – may also experience menstrual difficulties, pregnancy, menopause and other reproductive health needs, and benefit from improved care from services. Recommendations in this work programme apply to all those needing support with their reproductive health.

## Our ambitions – four key areas of focus

### Healthy, fulfilling and safe relationships

- Young people feel informed about how to avoid harmful relationships, maintain good sexual health and where to get help when they need it
- Disabled residents and/or neurodivergent young people and adults (whose intimate lives are sometimes overlooked) get the right advice and support
- Earlier intervention and prevention to reduce the risk of sexualised violence and harmful relationships.

### High quality STI prevention, testing and treatment

- Improve health education and better access to testing, treatment and support to reduce the spread and impact of STIs
- Address inequalities in sexual health outcomes and access to testing and treatment between different populations.

### Towards zero HIV transmission and living and ageing well with HIV

- Improve health education and better access to testing, treatment and support to reduce HIV transmission
- Reduce late diagnosis and inequalities in those more likely to be diagnosed late
- Tackle the stigma and discrimination faced by residents living with HIV
- Improve support for residents living with HIV as they get older.

### Good reproductive health across the life course

- Women, girls and others with reproductive health needs know how to get reliable, culturally appropriate information about reproductive health and help when they need it
- More professionals feel confident supporting and signposting women around women's health
- Address inequalities in take up of breast and cervical cancer screening, HPV vaccinations and access to contraception
- Reduce fragmentation of care
- Women's healthcare is more trauma-informed, especially for survivors of abuse.

## About Camden's services

Sexual and reproductive health commissioning is highly complex, and requires close collaboration across NHS, Council and VCS partners.

Camden Council commissions sexual health services for adults (Central and North West London Foundation Trust (CNWL)) and children and young people (Brook), HIV support services (CandiNetwork), an online sexual health and contraception offer (SHL) and Long-Acting Reversible Contraception (LARC) via pharmacies and primary care.

NHS North Central London Integrated Care Board (NCL ICB) commissions other services including our abortion providers and gynaecology (currently via Royal Free and University College London hospitals primarily).

NHS England commissions cervical screening (our NCL Cancer Alliance), a range of specialist provision and some elements of contraception/STI work in Primary Care. Appendix A sets out more detail of Camden's service offer and commissioning responsibilities.

## What informs our findings

- Our 2024 **Sexual Health Needs Assessment**, which provides data and benchmarking across a range of sexual health, HIV and contraception indicators.
- Insight run by the Council, Healthwatch and CNWL via interviews, focus groups or surveys, from over 190 residents where we know either health outcomes or access to services are sometimes worse than for the majority:
- Children and young people – year 6, teenagers and young adults
- Women over 40 experiencing perimenopause/menopause
- Somali and Bangladeshi women
- Residents who are homeless
- Those accessing drug/alcohol support
- Those living with HIV
- LGBTQ+
- Residents with physical and/or learning disabilities
- Drew from feedback from neurodivergent residents via our Autism Strategy work
- Two recent Healthwatch reports: **Young People's Sexual Health** (April 2024) and **Living with Endometriosis** (November 2024)
- Findings from the Health-Related Behavioural Questionnaire (HRBQ) carried out in Camden's primary schools with years 5 and 6 and secondary schools in year 8 and 10 every 2-3 years.
- Interviews and conversations with multiple stakeholders (including local and national voluntary sector leads, teachers, NHS teams including primary care, sexual health and gynaecology professionals, academic experts and service leaders from across the Council
- A stakeholder summit held with over 40 professionals from different backgrounds
- A small frontline staff survey (27 respondents from education, sexual health services, children and adult social care, VCS, other NHS providers)
- National and regional strategies, research and reports (see appendix).

## Forthcoming violence against women and girls strategy

In Spring 2026, Camden will publish a new strategy addressing the risk and impact of violence against women and girls. This report is intended to contribute to our evidence base underpinning that strategy.

# Pillar 1: Healthy, fulfilling and safe relationships

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**Healthy and fulfilling sexual relationships** are those that are consensual, respectful, safe, and based on mutual trust and communication. They support each person's wellbeing, reflect their values and needs, and allow people to feel confident, respected, and in control of their choices.

We want everyone in our borough to feel empowered to have sexual relationships that meet these standards. This starts with our young people, for whom a solid understanding of sexual wellbeing, harmful behaviours and bodily rights can help inform their choices throughout their lives.

The young people we spoke to in the development of this report were very articulate about their experiences and generally positive about their relationships. The majority know and understand what a healthy, safe relationship looks like – and what it doesn't look like. They are highly literate in how they use social media and online technology to navigate information, and they are clear about its limitations.

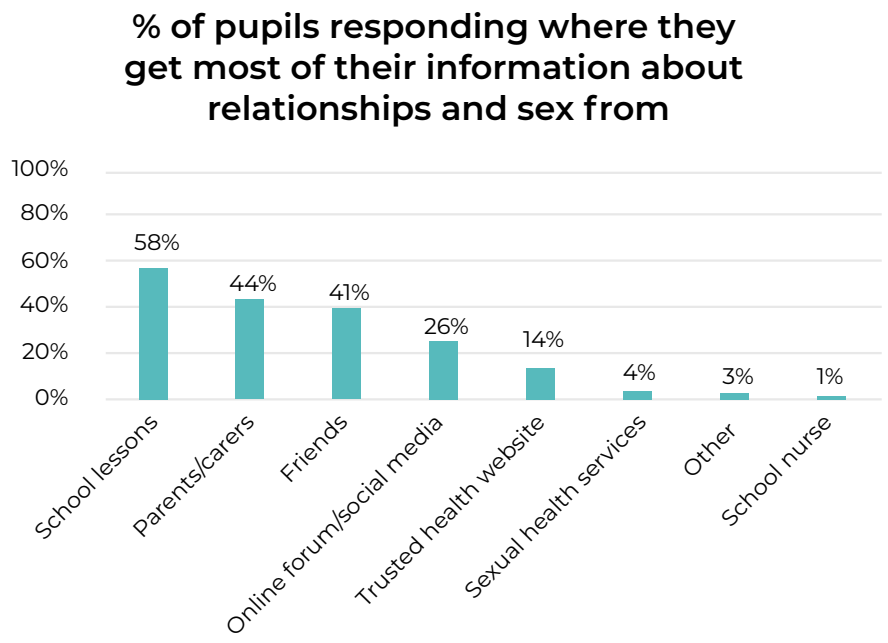
Young people live in a world full of information – some of it they look for, but a lot comes at them without asking. They form relationships both in person and online, where they also face various risks to their safety and wellbeing. This all happens in a society where misogyny, violence, homophobia, racism, and hate can feel widespread.


*(House of friendship: what does a healthy relationship and unhealthy friendship look like – Christ Church School Year 6 focus group, April 2025).*

# Finding a trusted adult

In our insights work, when asked where they got most of their information about relationships and/or sex, children and young people of all ages reported significant variation in response between parents, teachers, friends and/or older siblings.

This feedback was echoed in the 2022 Health Related Behavioural Questionnaire:




*HRBQ 2021/22*

But almost all said they needed and valued a trusted, human source of reliable and accurate information – access to adults who can help navigate the online information.

For some children and young people, the preferred trusted adult is their parent or carer. But many children and young people said either their parents did not feel comfortable talking about sex, relationships and/or puberty-related subjects, or they did not have time because of issues in their own lives, or the children preferred to talk with an adult less intimately involved in their lives. Many young people said they feel discomfort when discussing relationships, body changes such as menstruation, or sex at home.

> *"Give our parents the tools to talk with us. Some want to help, but don't know how" (Camden YP focus group, 2025)*

For others, their preferred adult is a teacher. Some felt a school nurse would be preferable. Older young people valued sessions they'd experienced in youth clubs, run by Brook, for example or said they might trust their youth worker. In our Primary focus groups, children liked the idea of an anonymous way to ask a reliable adult for answers to personal or sensitive questions, such as a worrybox or similar.

Thus we need to ensure parents/carers, older family members and professionals in lots of different settings are all equipped to be able to provide guidance, advice and information about real life and online relationships – so children can find someone of their choice in their network who they trust to talk to.

## Professional confidence talking about relationships and sexual health to children and young people

Children of all ages, even Primary, can tell when an adult feels uncomfortable or lack knowledge talking about sensitive and stigmatised subjects. They told us this limits their ability to engage with them. Ensuring professionals in schools, social care and youth settings have the support they need (training, resources, supervision, learning/sharing networks etc) is key to creating safe spaces for children to discuss sensitive and personal subjects. But many professionals said they would welcome more support to increase their knowledge and confidence.

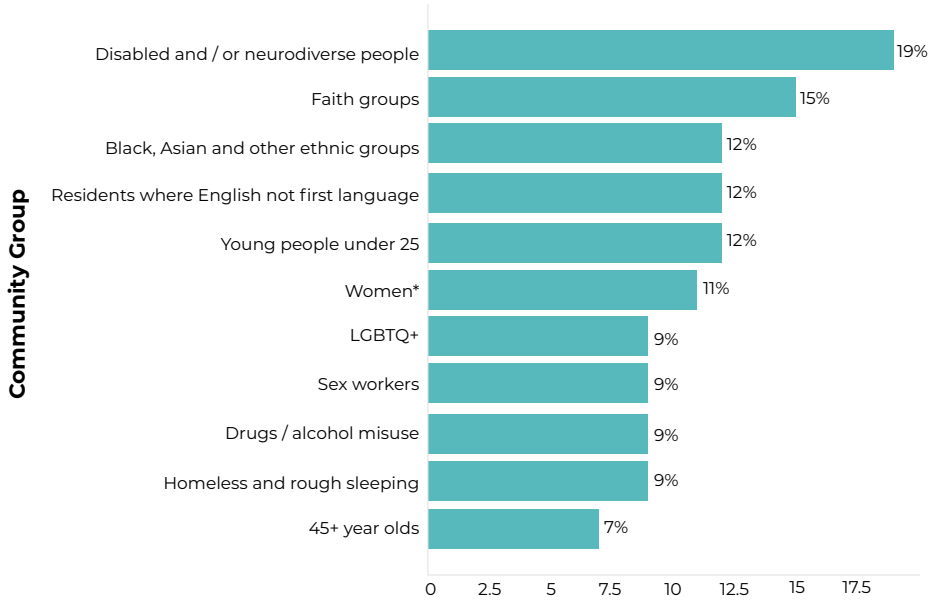
Nationally only 1/3 of teachers said they'd had their RSE training needs assessed in the last 12 months. Given rapid societal changes for children, regular assessment of teachers' training needs tailored to the settings they work in is important. In Camden, some school PSHE leads requested more accessible professional development, particularly on healthy vs. abusive behaviours, terminology, and responding to disclosures. Some school PSHE leads said it could be challenging to engage their peers in PSHE training. Given all the training requirements and related pressures teachers face, attending regular PSHE training can feel difficult to fit in.

Respondents to our all age staff survey (the majority but not all of respondents worked with children and young people) also called for more training around certain communities, particularly disabled and/or neurodivergent residents and people of faith.

*Camden Insights staff survey, 2025*

This suggests that we need to enhance our learning and development offer and ongoing support for professional practice around relationships, sexual wellbeing and reproductive health.

**Priority Communities for Staff Learning and Skills Development (N=27)**




*Women includes gynaecological, reproductive, perimenopause and menopause health

## Case study: staff training and curriculum planning

During Haverstock's curriculum planning process, they identified several challenging topic areas within the RSHE curriculum. The Head of Personal Development and her team developed a targeted training programme aimed at increasing staff confidence and improving quality.

Each year group team receives a 30-minute training session after school during directed time, one week before they deliver a particularly sensitive or complex topic. In addition to this just-in-time support, staff also receive dedicated RSHE training once per term, focusing on a selected tricky or sensitive area. These termly sessions allow for deeper exploration and collaborative planning - helping teachers build long-term confidence and expertise. The full training programme is shared with all teaching staff before the start of the academic year.

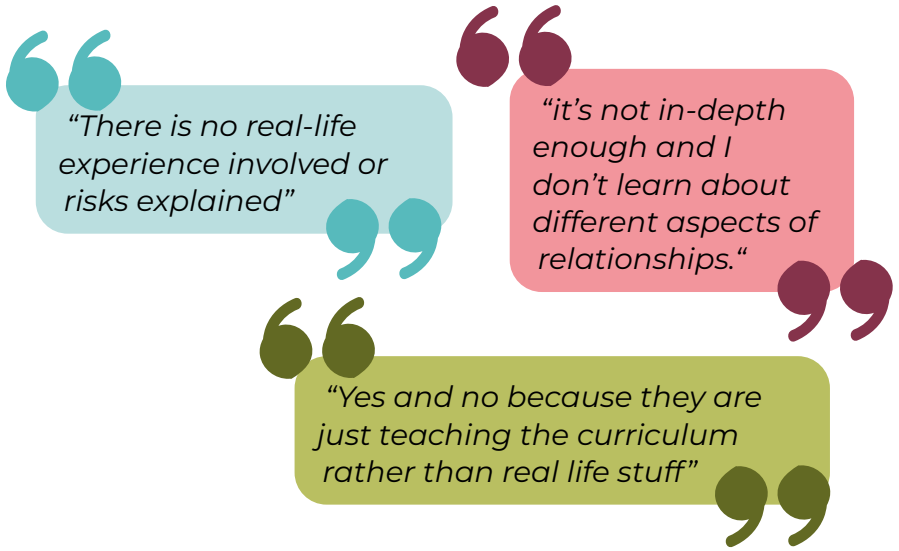
One example is the topic of Female Genital Mutilation (FGM). As nationally, many staff initially lacked confidence in delivering this content. All relevant staff complete the National Safeguarding Training and take part in a bespoke training session, further enriched by insights gathered through learning walks.

Feedback from staff has been overwhelmingly positive. Teachers report feeling significantly more prepared and confident. This improved readiness ensures students receive accurate, sensitive, and age-appropriate information in a respectful and safe learning environment.

## Schools and Personal, Social, Health and Economic (PHSE) education

Nationally and locally, children value their PSHE lessons, and relationships and sex education (RSE) in particular, very highly. Year 6 children in our focus groups at Christ Church School were able to recall and reflect on content they'd covered in past years.

However, some young people we spoke to felt that sex education began too early (in primary school) or too late (only a one-off in secondary), and that it lacked practical relevance. A consistent theme across our Insights work and national evidence was that sometimes lessons were not rooted in young people's current, lived experience, driving young people to look elsewhere for information:

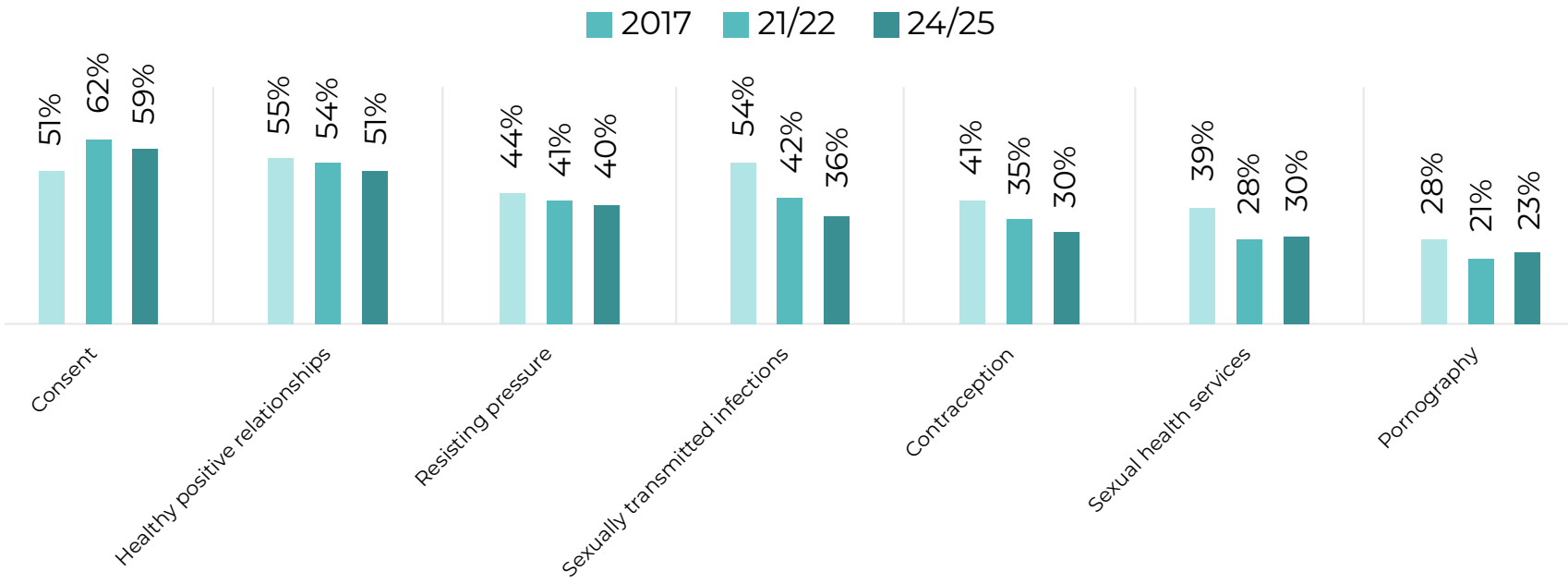



*(**Healthwatch, 2024**).*

All age groups reported they want to revisit relationships topics ('once is not enough') or go into greater depth. A lack of sustained or age-appropriate follow-up sessions contributed to misinformation, confusion, and discomfort. This reiterates the importance of spiral/cyclical approaches to RSE content that grows as young people do.

The chart on the next page shows that fewer than half of Year 8 and Year 10 students responding to the Health Related Behavioural Questionnaire (HRBQ) in the 24/25 school year found their lessons helped them understand key topics relating to sexual wellbeing and sexual health.

## % RSE lessons helped understand 'quite a lot of' a 'a lot' (Year 8/10)




*HRBQ findings 2017-2025*

In the national **Sex Education Forum's 2024 RSE poll** of 1002 young people, nearly 80% of young people said they learnt all they need about how babies are conceived and born, but **only** around half said they learnt enough about power imbalances in relationships, sexual pleasure/consent, pornography or how to access sexual health services – mirroring our local findings.

Some young women in Camden said their education was too scientific or male-oriented, leaving critical topics like vaginal health, cervical screening, and period management underexplored.

Children even at primary school age said they want to talk about complex and emerging topics – including online friendships, social media and body image, gender identity and online misinformation. This shows the importance of the Council and schools regularly engaging with and checking in with children and their parents to coproduce the PSHE curriculum overall and RSE topics specifically – to reflect how they interact with the world in real terms, and to consider how sensitive topics can be discussed in age-appropriate and culturally appropriate ways. **New RSE guidance has been published in July** and stresses the importance of coproduction and consultation with children and parents/carers. It highlights the importance of whole school approaches to relationships, harm, online influences including AI and pornography, and tackling misogyny.

## Content imbalance and under-representation in RSE

Older young people in Camden said they did not feel their relationships and sex education was always reflective of them in terms of racial or faith identity, sexual orientation if they were LGBTQ+, and/or the way they live their lives. Some said it felt distant or irrelevant. This is echoed in the national **Sex Education Forum's 2024 RSE poll** in which only 43% of respondents said they saw themselves represented in materials. This suggests a need for further work to ensure teaching materials and content continues to be carefully balanced to be relevant to our young people's faith, culture and ethnic identities whilst also relevant to the world they grow up in.

## Faith, culture and sex and relationships education

Young people, parents and professionals all talked about the impact culture or faith can have on engagement with some RSE or PSHE subjects.

> *"Some faith communities feel that sex is a taboo subject and will opt out of this topic."*

(Camden Insights staff survey, 2025)

Delivering balanced, inclusive but culturally appropriate relationships and sex education is complex. Teachers, youth workers and social workers said that they would welcome more training on understanding how cultural and religious considerations may affect engagement with sensitive topics like sexual health, consent, and relationships.

> *"Training around supporting people from various faith groups with sexual wellbeing"*

> *"Working effectively with faith groups so a clear, safe and healthy message is given" (Staff survey, 2025)*

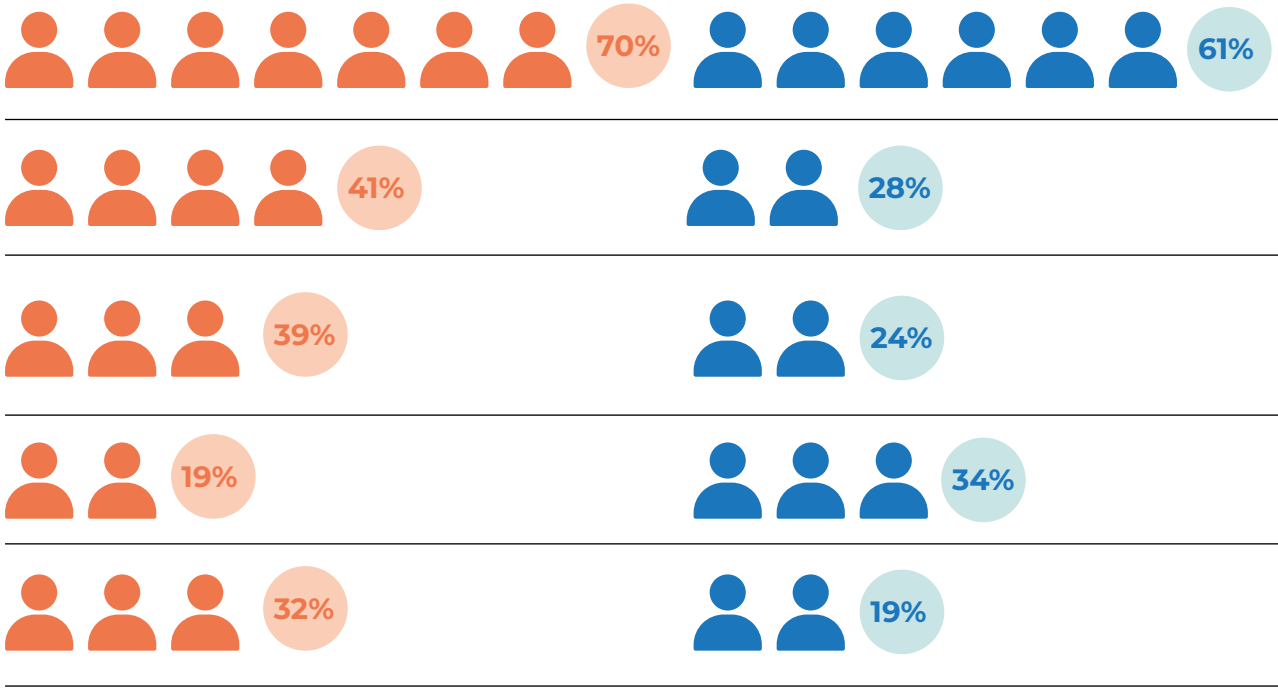
## LGBTQ+ young people's experiences

More work is needed to understand any differentiation between how Camden's LGBTQ+ young people, including trans and non-binary, compared with cis-gendered and/or heterosexual young people navigate healthy, safe relationships and benefit from sex education.

However, our 21/22 Health-Related Behavioural Questionnaire suggests differences between feedback from young people defining as LGBTQ+ (n.b. the much smaller sample sizes for LGBTQ+ cohort means a note of caution about comparability is needed, but nonetheless findings warrant further exploration). LGBTQ+ young people reported greater understanding of consent principles and STI prevention, but potentially more need for information, advice and support around aspects of relationship building.

## Health Related Behavioural Questionnaire – LGBTQ+ responses

LGBTQ pupils' results in **orange*,** non LGBTQ pupils results in **blue****




(HRBQ, Camden Council, 2022)

That more LGBTQ+ children compared with heterosexual young people said they'd like other young people to teach about relationships and education could suggest a greater disconnect with teacher-led content. In the **Sex Education Forum's 2024 RSE poll**, whereas 50% of all respondents rated the quality of their RSE lessons at school as 'good', only 38% of LGBTQ+ young people did.

> *"Tell people that LGBTQ+ people exist and teach kids properly so they feel the school system is working with them instead of against them, please"* (SEF, 2024)

Thus we need to ensure the LGBTQ+ community can see themselves in the curriculum, through inclusion in teaching materials and get access to tailored support when they need it.

### Young people who may need additional or specialised RSE support

Studies suggest that autistic people are less like to identify as heterosexual than their non-autistic peers (**University of Cambridge, 2021**). Autistic adolescents and young adults may be more likely to enter online relationships and so at heightened risk of online harms. Work about the nuances of relationships, consent and understanding risk and coercion can be very challenging for some neurodivergent young people.

Individual sessions or small group provision in addition to mainstream classes recognising the specific experiences of autistic young people can be beneficial to support with nuanced topics around relationships and consent.

Children with SEND are more likely to be bullied and can be at greater risk of abuse and/or exploitation. They may find it more challenging to access developmentally appropriate RSE. An individualised, tailored approach alongside class/group-based education (for example, specific RSE objectives included with personal education plans, EHCPs and/or social care plans) may help ensure young people's needs are not neglected. We could strengthen our offer of support for parents/carers about how to hold age and developmentally appropriate conversations with their children.

## Harm in relationships

### Safe online relationships – greater nuance

Online relationships form a significant part of how children and young people interact with one another outside the school environment. Children and young people feel confident about online safety overall – but an area all age groups, including Year 6 children, said they wanted to know more about was how to navigate relationships online as well as in real life. For example, how to handle hurtful or harmful gaming chats, or social media interactions. All age groups felt that RSE lessons about online safety should cover more realistic real-life scenarios. Research carried out on child, parent and teacher attitudes to online safety in Camden and Islington in 2024 found similarly that whilst adults focussed more on extreme harms, children worried more about everyday interactions (Camden and Islington Public Health, March 2024). **The new RSHE guidance (Dfe, July 25)** has updated guidance on addressing online harms, including addressing the risks of AI as an information source and the rise of AI-related risks such as deepfake image-sharing.

Online safety education needs to include more focus on these emerging risks, alongside the day-to-day pressures young people really worry about which contribute to poor emotional wellbeing.

## Young people, pornography and harm

Social media and pornography were repeatedly cited by older young people as promoting unrealistic standards around appearance, behaviour, and consent, especially impacting perceptions of women. Young people understand these standards are unrealistic – but the proliferation of glossed and/or sexualised online content means it is hard not to be influenced. We observed a gendered impact to this:

- Boys often internalise ideals around dominance, gym culture, and toxic masculinity
- Girls experience pressure around body image, beauty standards, and sexualised behaviour.

There is a growing body of national research and evidence into the intersection between some types of pornography and harmful real-life behaviours. The national Children's commissioner surveyed 1000 16–21-year-olds and found that:

- The average age young people first viewed pornography was 13
- 27% had viewed it by age 11
- 79% had encountered violent pornography before the age of 18
- 47% of all respondents aged 18-21 reported experience of a violent sex act. (Children's Commissioner, 2023).

In Camden, multiple young people reported having seen pornography, typically by accident, before the age of 10. Yet in the 24/25 Health Related Behavioural Questionnaire, only 23% of young people said lessons had helped them understand pornography. This re-emphasises the need for adult-led education to be guided by and grounded in young people's real-life experiences.

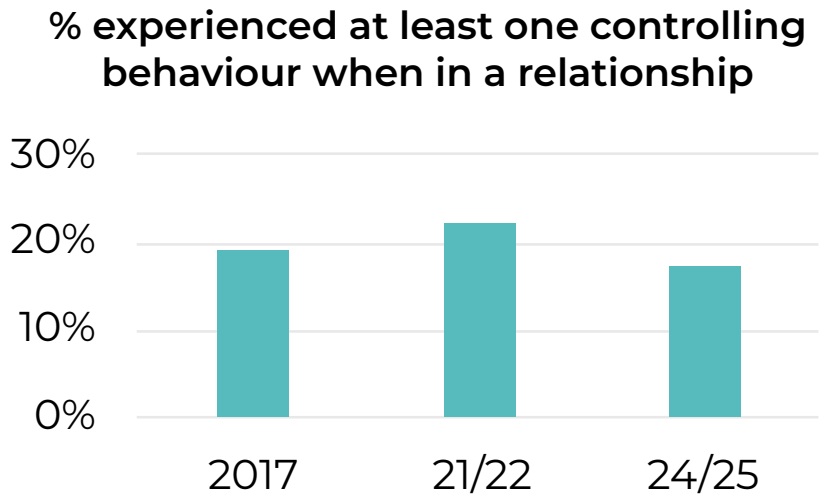
## Harmful sexual behaviours

Harmful sexual behaviours can be defined as sexual behaviours amongst under 18s that is "developmentally inappropriate, may be harmful towards self or others and/or be abusive towards another child, young person or adult" (Centre of Expertise on Child Sexual Abuse, 2023). They can occur online or in real life. Examples might include online image sharing, inappropriate sexualised language, inappropriate touching, sexual harassment or violence and rape. Not all will be illegal (though some will be and young people need guidance to understand the law better), but most incidents will leave a legacy of trauma on the recipient.

At the lower end of the continuum, the variability in what young people experience as normal vs harmful makes ensuring they have a clear understanding of what consent means to them in different contexts is critical. In the 24/25 HRBQ, 59% of young people said their RSE lessons at school were useful in explaining consent – but only 40% said they helped them understand 'resisting pressure'. There is scope to improve how we support young people in the grey areas.

## Harmful relationship behaviours and peer-to-peer abuse

Between the 21/22 and 24/25 HRBQ surveys, we have seen a small decrease in the proportion of young people in years 8 and 10 saying they had experienced at least one controlling behaviour in a relationship.




*HRBQ, Camden Council, 2017-25*

Other common forms of teenage relationship abuse include emotional abuse, online abuse, financial control, snooping (emails, phone use etc), sexual and physical abuse (**Children's Society**).

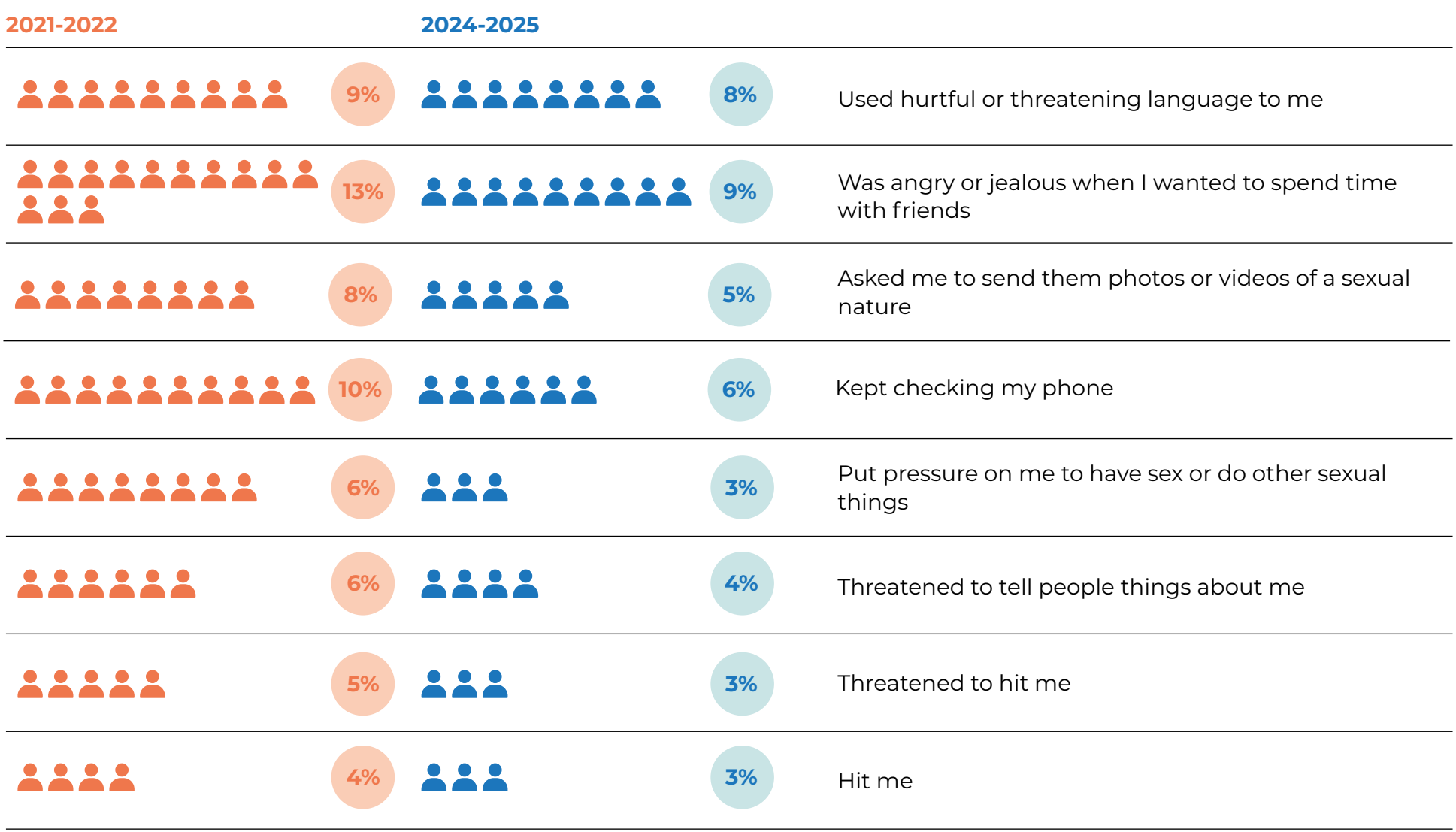
## Child sexual exploitation

A young person in Camden Children's Safeguarding Children's Partnership's '**Vulnerable Adolescents: Tackling Risk and Exploitation Strategy 2023-25**' describes sexual exploitation as:

> *"Someone taking advantage of you sexually, for their own benefit. Through threats, by bribes, violence, or humiliation, or by telling you that they love you, they will have the power to get you to do sexual things for their own or other people's benefit or enjoyment (including: touching or kissing private parts, sex, taking sexual photos)".* (**Camden, 2023**)

The strategy sets out a range of actions undertaken or in train in Camden. Camden has robust multi-agency partnerships and pathways to identify and address peer to peer abuse and sexual exploitation. However, we can still do more at the preventative end, helping young people navigate relationships, develop resilience and being able to talk to a trusted adult as early as possible before harms escalate.

**Percentage of pupils responding that the following things have happened to them in a relationship with a boyfriend/girlfriend**




*(HRBQ 21/22-24/25)*

# Healthy relationships into adulthood

## Information and guidance for disabled and/or autistic adults

Autistic people told us through our Autism Strategy engagement work, as nationally, that they felt education around their intimate lives was neglected or was not unhelpful.

> *"Frequently, autistic people are infantilised by their neurotypical peers as well as the medical community... this isn't an accurate depiction of autistic people"* (**Ambitious About Autism, 2024**)

They fed back that professionals working with autistic adults sometime made inaccurate assumptions about their appetite for entering into relationships, or focussed disproportionally on risks.

Adults responding to our survey both with physical and learning disabilities said similarly, that professionals did not talk to them about sex or relationships, so they felt underinformed.

Professionals in our staff survey told us disabled people they work with face inaccurate assumptions about asexuality or infantilisation and have often experienced a lack of SEND inclusive education at school.

> *"People with learning disabilities are seen as 'eternal children' and often excluded from sexual health education."* (Camden staff survey respondent).

Thus we could do more across education, health and children's and adult social care to give disabled and/or autistic people's intimate lives both space and recognition. We need more balanced representations of their intimate lives which recognise but are not solely driven by considerations of risk.

# High-risk and harmful sexual practices: a gendered aspect

## Non-volitional

Over 2 million women are estimated to have experienced sexual harassment (**National Police Chief's Council, 2024**) nationally. In the (now somewhat outdated) Natsal survey of 15,000 UK residents, 1 in 10 people said they had experienced non-volitional sex and this often occurred at a young age.


Natsal 3: **Infographics – NATSAL (survey 2010-2012)**

A Crown Prosecution Service survey of 3,000 adults found that though progress has been made in public perception of and stereotypes about rape – young adults aged 18-24 held some serious misconceptions:

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

## Volitional but high-risk

A **2020 Government Equalities Office government literature review** found evidence of an association between pornography use and harmful sexual attitudes and behaviours towards women and this was especially true for the use of violent pornography. Key themes it found included an influence shaping unrealistic expectations of 'real-world' sexual encounters and greater acceptance of sexual aggression towards women. **Baroness Bertin's review, 2025** similarly heard evidence suggesting association between pornography

use and shifts in what is perceived as 'normal' sexual practices but with a potentially harmful and often gendered aspect. This is an area for professional vigilance and further research, and we need to make sure professionals feel equipped to talk about health risks of some sexual practices, so that people can make fully informed consensual choices.

Some clinicians locally reported seeing an increasing number of residents in sexual health services presenting following engagement in sexualised drug use (referring to the use of drugs to enhance sexual experiences). Whilst we do not have local data, national evidence suggests sexualised drug use (which includes chemsex as a subset) between 3–29% of men who have sex with men (**British Psychological Society, 2023**). Some reports suggest increased use amongst heterosexual partners too. Sexualised drug use participation can have a range of adverse physical, mental health and social outcomes related to both the impact of drugs used and the increased risk of unsafe sexual practices.

Thus we need to ensure we have nuanced conversations about consensual choices in our work with residents. NHS and VCS practitioners including primary care, drug and alcohol use, sexual health teams and VCS orgs need to be sufficiently trained to create spaces where people feel safe to disclose any support needs.

We need to work with colleagues across London to support education and awareness raising work such as sexualised drug use/chemsex awareness campaigns. We may want to explore post 16 RSHE delivery further.

# Recommendations

Further work will take place over the course of 2025/26 to cost and phase recommendations in line with resources available.

All actions will require a partnership of local authority, NHS and voluntary sector colleagues to implement, but the lead organisations for recommendations in this section are Camden Council and Camden Learning.

| Recommendation | Actions |
|---|---|
| Develop our PSHE content, delivery and resources to:<br>• Better reflect Camden's diverse communities and LGBTQ+ young people<br>• Support more focus on helping CYP navigate relationships and problem solve when they go wrong<br>• Strengthen the focus on addressing harmful sexual behaviours, and the harmful impact of pornography and sexualised online content on real life relationships. | 1. Review the Healthy Schools Programme<br>2. Map which teams and organisations are currently delivering RSHE education in school / youth settings<br>3. Update the Primary PSHE scheme of work, recognising the **new RSHE guidance**<br>4. Involve young people in updating the Healthy Schools Programme, the scheme of work and in workforce development for those delivering in schools. |
| Ensure young people and professionals who work with them know how to get help around sexual health, HPV vaccination, contraception, menstrual health and harmful relationship behaviours | 1. Run an annual youth-led awareness-raising campaign led by young people, building on our **2024/5 'Look After You' campaign**<br>2. Mapping local and national support for young people and parents and add to key directories such as NCL Waiting Room, Family Hubs, Schools website |
| Enable foster carers and parents to feel more confident talking to their children about puberty, sex, relationships, consent and managing potential harms | 3. Offer training and resources for our foster carers, tailored to reflect the diverse make up of our CLA population<br>4. Train the trainer: train our network of Parent Champions to be able to run sessions for parents/carers. |

| Recommendation | Actions |
|---|---|
| Develop a network of trained 'trusted adults' across the community, skilled and experienced in talking to young people about puberty and physical health, safe relationships and sexual health | 1. Develop and run an annual training offer for VCS youth organisations,<br>2. Establish an ongoing community of practice, with identified 'Champions' in youth organisations identified<br>3. Explore the feasibility of developing a shame-sensitive training offer for frontline practitioners in our developing Centre for Relational Practice. |
| Increase access to high quality RSHE education in and outside of school for young people | 1. Brook to review location / delivery of existing education outreach in community settings to identify any key community groups not already worked with<br>2. Review and address schools and education settings with low engagement of Brook offer<br>3. Assess how effectively RSE and PSHE reaches those young people who are not accessing education. |
| Ensure young adults can find support to navigate healthy and safe relationships, experience good sexual health and understand how to get help if they need it | Explore the feasibility of expanding our offer of RSHE in 16+ education settings. |
| Strengthen coproduction approaches to ensure a representative group of young people is trained to help us continually develop our sexual health education and clinical offer | Work with Council comms and engagement leads to help recruit and sustain ongoing youth engagement in service development. |
| More strongly recognise the interdependence of sexual health, relationships and mental health in strategic planning and education, advice and guidance and support services for young people | 1. Ensure Violence Against Women and Girls preventative work recognises peer-to-peer relationships as a key preventative factor in protecting emotional resilience for young people<br>2. Seek opportunities to increase access to 1:1 confidential advice, guidance and support to help young people experiencing potential harm in relationships. Avenues to explore include Kooth, Brook's MyLife programme, peer-to-peer support and/or our new Kailo research and design programme around preventative mental health strategies. |

## Case study – Look After YOU health campaign

Camden Youth Tell Them, a group of young people aged 16 – 22 came together to implement one of the recommendations from the **2023 Adolescent Annual Public Health Report** around increasing awareness of health services in Camden.

The group created the 'Look after YOU' campaign to encourage other local young people to get the healthcare they need, when they need it. The campaign sought to reduce health inequalities in the borough after research showed that many young people are unaware of how or where to access health services, particularly for mental health and sexual health support.

Bus stop advertisements, TikTok videos, and Instagram reels created by the group were shared to increase awareness of free health services available in Camden, including sexual health, mental health, drug/alcohol, and GP services. From October 2024 – January 2025, the campaign led to over 2,500 clicks into the **Camden Rise webpage** which consolidated health information and directed them to local services.

> **Camden Youth: Tell Them**, said: "We know that there are so many services to help under 25s in Camden – we met them to create our campaign – but that young people don't always know about them. Young people can also be put off getting healthcare because they feel embarrassed, are worried about costs or their parents finding out.
>
> "We hope that Look after YOU not only helps Camden young people to easily find the free healthcare they need, when they need it, but that they feel comfortable and confident using these services."

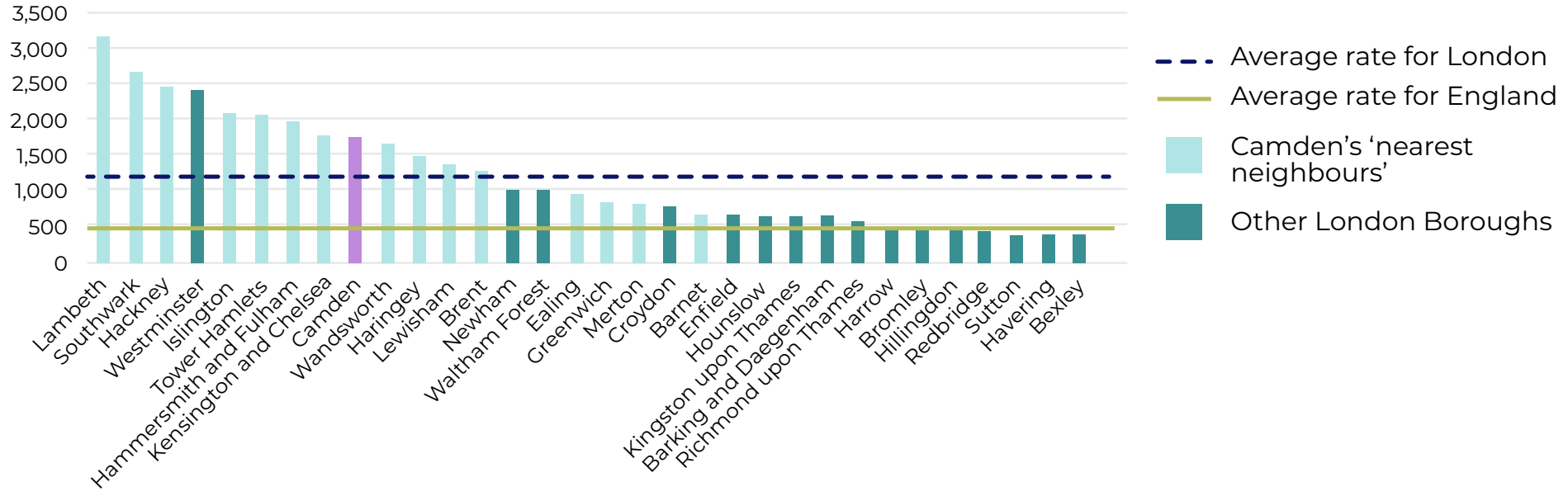

# Pillar 2: High quality STI testing and treatment

# Pillar 2: High quality STI testing and treatment

Sexually transmitted infections can in rare cases lead to significant health harms – infertility, adverse pregnancy outcomes, neonatal infections, systemic infections and permanent damage to cardiovascular and neurological systems (**UKHSA, 2024**). Preventing, identifying and treating infections early is key to minimising the risk of these health harms. STIs impact different population groups unequally so we need tailored, targeted approaches.

There is a relatively high overall burden of sexually transmitted infections in Camden; Camden ranked 9th out of 33 London boroughs for rate of new STI diagnosis in 22/23 (**Camden needs assessment, 2024**).

**New STI diagnoses (excluding chlamydia aged under 25) per 100,000 in 2022 by London Borough**



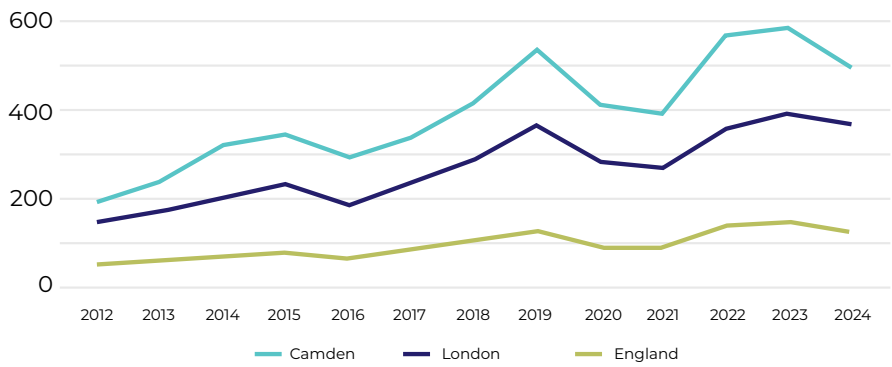

(**Camden needs assessment, 2024**).

Gonorrhoea is often used as a marker for rates of unsafe sexual activity as it is particularly common among those who change partners regularly. Camden has higher rates of Gonorrhoea than London and England. The rate of Gonorrhoea has more than doubled between 2012 and now. This may partially reflect increased testing, but likely also indicates an increased burden of disease.

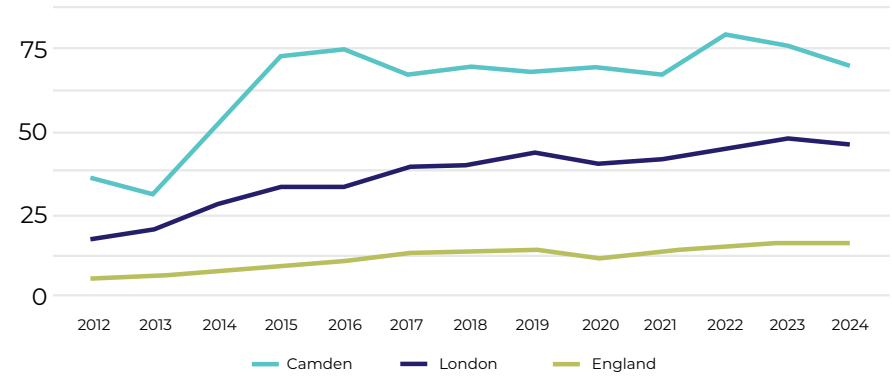
Since the emergence of antibiotic-resistant Gonorrhoea, close surveillance of resistant strains has been under way in the UK, prompt diagnosis and ensuring adherence to treatment is central to reducing the transmission of resistant strains.

After a steep rise between 2013 and 2015 the rates of syphilis in Camden have remained relatively consistent. However, Camden's diagnostic rate remains higher than London's. This could be due to lower baseline case numbers and higher testing rate but likely indicates a greater disease burden. 80% of syphilis diagnoses were among gay men.

**Gonorrhoea diagnostic rate per 100,000**




**Syphilis diagnostic rate per 100,000**



# Inequalities in STI rates

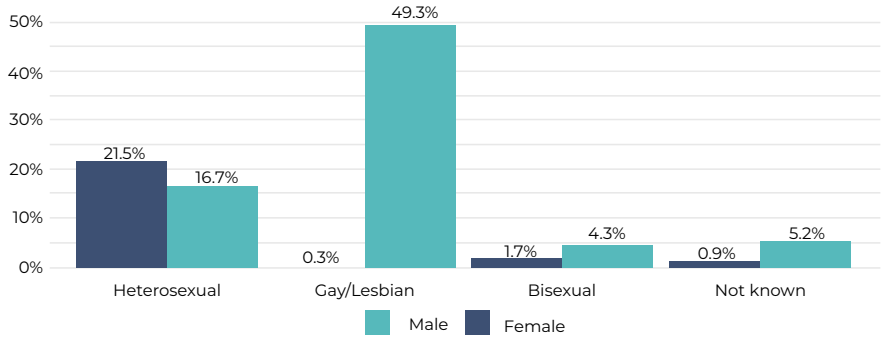
## Deprivation

Within the borough there is variation in rate of diagnoses, with rates in Bloomsbury and Holborn some of the highest in the country. STI rates are more prevalent in areas of highest deprivation.

## Sexual orientation

Gay and bisexual men who have sex with men (GBMSM) continue to bear the greatest burden of sexual infections, but rates are rising faster amongst heterosexual populations. 50% of new STI diagnoses in 2023/24 were among GBMSM followed by heterosexual women (22% – up from 18% in 22/23) and heterosexual men (17% – up from 11% in 22/23).

**Proportion of new STI diagnoses by gender and sexual orientation, Camden, 2023/24***



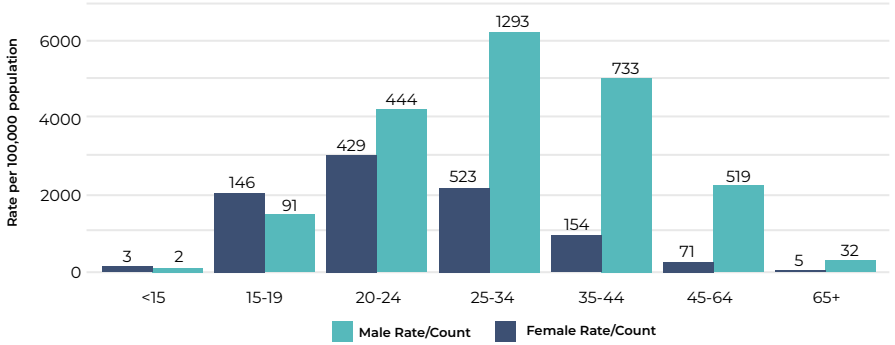

GUMCAD STI surveillance system

Nationally, heterosexual women make up 46% of those undertaking all sexual health screens, but heterosexual men only make up only 22.5%. 17.2% of screens were taken up by GBMSM despite them being a much smaller part of the overall population (**UKHSA, 2024**). Encouraging more straight men to take up testing opportunities could contribute to addressing spread of infection.

## Age

STIs are highest among men aged between 20 and 34 years. Rates of STI diagnosis are very low in residents aged over 45 and particularly in women over 65. This only partly reflects lower risk in this age group. In a study in England, 86% of men and 60% of women aged 60–69 years reported being sexually active (**Lee et al, 2016**). 12% of residents are 65 or older (**Camden JSNA Hub, 2025**) – forecast to rise to 15% by 2041. This suggests there may be a cohort of sexually active older adults at risk but who are not accessing sexual health screening.

**Number and rates of all new STI diagnoses in Camden per 100,000 population by age and gender, 2023/24***



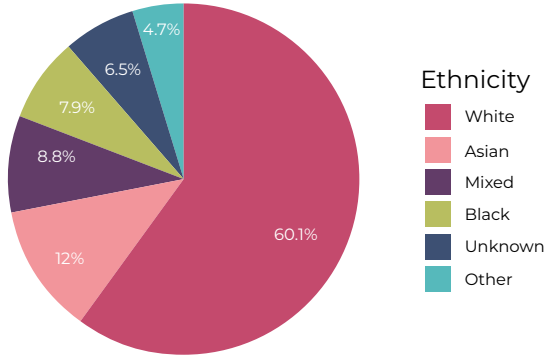

**GUMCAD STI Surveillance System**

* 2023/24: data is from 01/10/2023 to 30/09/2024

## Ethnicity

In Camden as nationally, Asian residents appear under-represented in STI diagnosis rates (12% of all STI diagnoses are amongst Asian residents, whereas Asian residents make up 20% of our population) and attendances at most local sexual health clinics. This may in part reflect different sexual norms and behaviours. But Camden's insights work found that in all communities, but particularly in some global majority communities including our South Asian and Somali communities, cultural taboos and stigma may hinder health-seeking behaviour.

**Proportion of selected STI diagnoses* by ethnicity among males and females, Camden, 2023/24***




**GUMCAD STI Surveillance System**

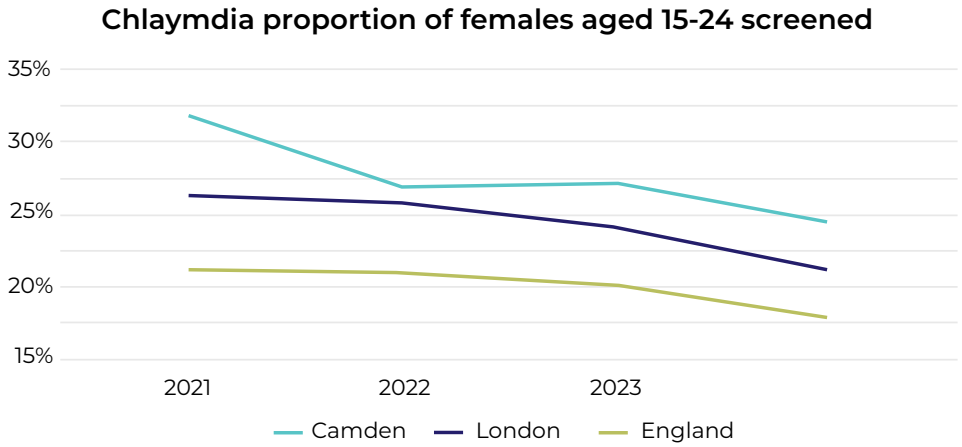
* 2023/24: data is from 01/10/2023 to 30/09/2024

We have limited data and information about the needs, access to sexual health services and outcomes for disabled and/or neurodiverse residents.

We have very limited data either locally or nationally about need, access to services or outcomes for our trans and non-binary populations. These are clear gaps to address.

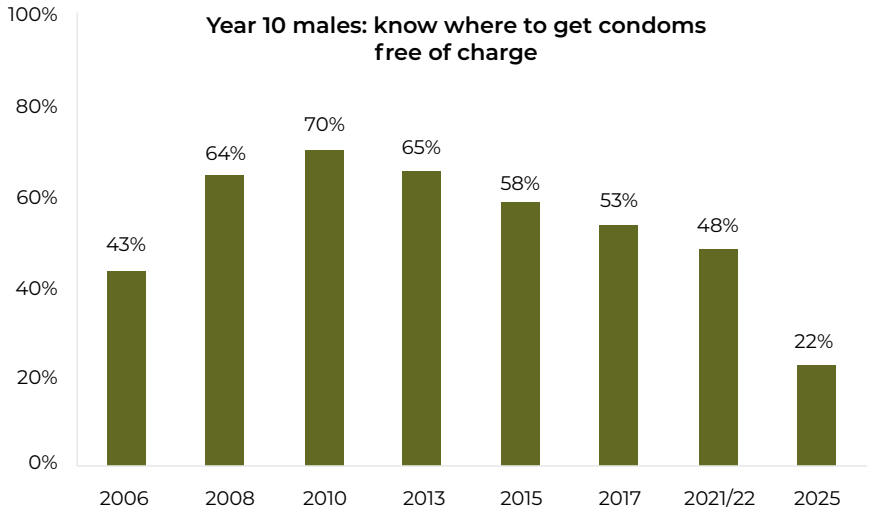
# Preventing STIs through screening, access to barrier contraception and education/communications

Camden's data suggests relatively successful approaches to screening for STIs, in part explaining some of our relatively higher diagnostic rates (though that does not minimise the burden of disease). For example, our Chlamydia screening rates remain above those of London and England.




## PHE Fingertips

However, there is more we could do to promote and increase uptake of preventative measures. Chlamydia screening rates, as nationally, have fallen in Camden. Access to condoms has decreased: In the 24/25 HRBQ, only 22% of year 10 boys said they know where to get condoms – the lowest in a decade.




A 2024 Brook report (**Brook, 2024**) nationally found that one third of participants aged 16-24 reported not using condoms the last time they had penetrative sex and one fifth reported never using condoms during penetrative sex. When describing why they think young people don't use free condoms, survey participants cited feeling too embarrassed to speak to someone about getting free condoms (58%) and lack of knowledge about access points (53%). Participants expressed a preference for accessing condoms via methods that offer greater anonymity, with 77% saying they would like the option to order online or have them posted to their home or a pickup point.

> *"Condoms just suck they don't feel good at all so no one uses them I definitely need to but I can also order an STI test and get results within a week so I don't think people worry too much."* (2023 survey participant, aged 20) (**Brook, 2024)**

> *"The free condoms scheme should be more easily accessible and have postage offered as it's hard to get to the places that offer them"* (2023 survey participant, aged 19) (**Brook, 2024**)

These themes were reflected in Camden, where in our engagement, many young adults said they were unsure where to access contraception, STI testing, or get accurate information beyond Google.

The adults we spoke with also told us that information and interventions about STIs and prevention could be made more accessible. The groups at greatest risk – including sex workers, adults who are homeless, people who use drugs/alcohol - are also those most likely to have lower health literacy and/or access to online information.

> *"Main source of information about sexual health is at school. Information is not readily available outside of GPs and schools. If I suspected issues with sexual health, I would check the internet but not always a good source. You don't know what to trust"* (focus group, woman who was homeless, 30)

> *"The Easy Read and Accessible Information Standards are not being followed at all... Disability is so invisibilised, it's offensive!"* (Camden Insights 2025, LGBTQ+ Male, 56)

> *"You don't see posters or leaflets in hostels or food banks. And when you do, it's full of big words... they expect you to already know the system."* (focus group, man who was homeless, 29)

> *"Maybe have a little handbook for sex workers with all the STI's listed alongside symptoms and preventative treatment were applicable."* (Camden Insights 2025, Female, sex worker)

Most residents at high risk felt that there was limited information about STIs or the vaccines and preventative medicines available for high-risk groups. Some said there was information on individual conditions or diseases, like Hepatitis B or C, or specific preventative interventions such as PrEP, but less clear information on all the things any high-risk individual may be able to access in the round.

# Access to healthcare services and barriers

## Knowledge about sexual health services

Camden residents have convenient access to sexual health services, with clinics for adults over 18 at Mortimer Market (Euston) and Archway run by our local provider, Central and North West London NHS Foundation Trust (CNWL).

As sexual health services are open access, residents can access sexual health care at any service in England and there are a number of providers across London which are used by Camden residents.

Young people under 25 can access specialist clinics at Brook Euston and Archway or outreach in places like the Hive (Swiss Cottage). CNWL's outreach team, CLASH, does community-based outreach work focussed on engaging residents aged over 18 more likely to be underserved by traditional clinic services, with a particular focus on men who have sex with men (MSM), Black African, Black Caribbean and other Ethnic Minorities, Sex workers, people who are homeless and people who use drugs and/or alcohol.

Satisfaction with services amongst those who had accessed sexual health services was generally high:

> *"I have a great experience. At Clash and don't think they need to improve"* (Camden Insights 2025, sex worker).

> *"The clinic is close to my home. The drop-in service is very convenient. As I can fit in visits around an unpredictable schedule"* (Camden Insights 2025, sex worker)

> *"Just go in, don't have to book appointments, go in the queue and yeah, everything sorted. Do what they ask you to do for testing for everything. Urine and blood test, quite straightforward. They guide you what to do, tell you how to do things, not too long"* (interview, woman who was homeless, 47).

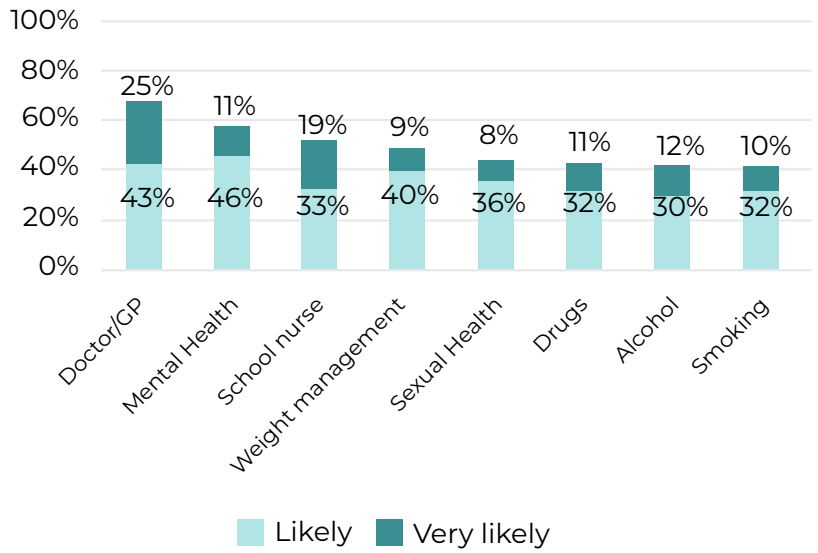
However, several residents and particularly those from our interviews with LGBTQ+ residents reported not knowing about local services and Mortimer Market in particular. This correlates with our data showing a high percentage of Camden GBMSM present at other clinics. Our LGBTQ+ residents said better advertising such as posters, leaflets, newspaper adverts would help. Most reflected they did not see themselves represented in healthcare settings such as GPs. Experience with GPs was variable.

> *"I've never heard of anything in Camden for STDs or anything like that. Everyone I know goes to Dean Street."* (Camden Insights 2025, LGBTQ+ man, 54)

> *"I don't know of any sexual health clinics in Camden. I would expect information about these sexual health clinics to be everywhere like libraries, doctors' surgeries, council buildings."* (Camden Insights 2025, Intersex person, 40)

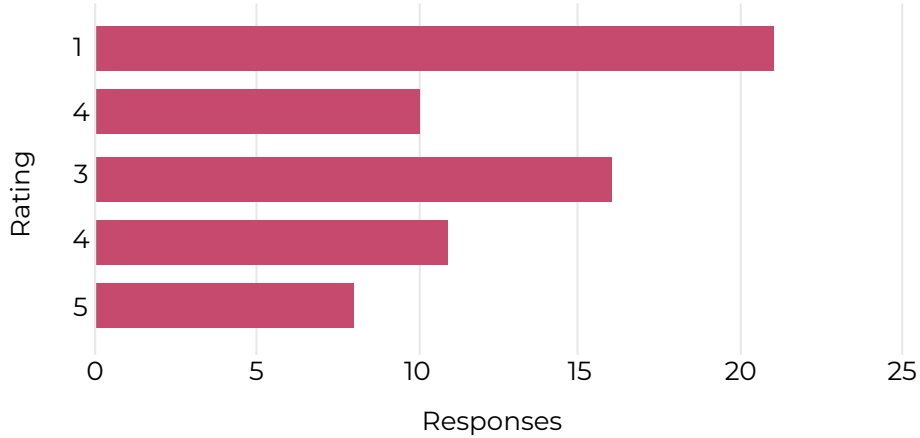
Only 44% of young people in the last HRBQ said they would be likely or very likely to access sexual health services and in a Healthwatch survey with 64 predominantly global majority residents aged 13-24, the vast majority said they did not feel comfortable accessing sexual health services.

**How likely young people would access health services**




*HRBQ 21/22 and* **Healthwatch 2024**

**How comfortable do you feel about accessing sexual health support services when you need them?**




In our surveys with 23 sex workers, 7 (30%) said they do not have an NHS GP, emphasising the importance of open access services not dependent on GP referral. However, there was good awareness of both CLASH outreach and Sexual Health drop-in clinics and multiple respondents said these services were invaluable in providing trusted help. Barriers to accessing services included:

- Language
- Systems that require pre-booked appointments
- Within day-time hours of service operations
- Lack of cultural understanding of sex work.

When asked what services could do to be more helpful, workers said:

- Free condoms and lube
- More whole-person health checks
- Support accessing GP and other e.g. mental health services
- Information about STIs and symptoms and more staff knowledge about women's health and less judgement.

Our interviews with residents who were homeless, leaving care and/or drug/alcohol using also found that outreach services are valued very highly. Most of these residents did not feel they would have accessed clinic-based or GP support without that prior connection – they said that "information is not reaching people" and people did not know about sexual health services. Some relied on google, others did not use the internet for information and wanted hard copy/posters/ leaflets – re-emphasising the need for mixed-media channels of communication.

## CLASH case study

- D is a 32-yr old Eritrean female, residing in a short-term homeless hub. English isn't her first language.
- CLASH attended an outreach session at the homeless hub as the hostel health lead discussed in need amongst the current cohort residing there.
- D attended the CLASH session and presented very distressed. She stated that her copper IUD is escalating her paranoid delusions as she feels it has evil tendencies that can't be controlled.
- D was actively smoking heroin and crack daily and sex working. She has a history of poor attendance and engagement with partner agencies including mental health and drug and alcohol services.
- CLASH spent time exploring D's concerns and empathising with how she was feeling. We discussed other LARC options with D in a way that was simple and clear to her. However, Ds started to experience opiate withdrawals and became very agitated.
- She consented to share information with her hostel worker. We arranged for D to attend CLASH the following day, the hostel staff agreed for pay for a taxi and escort her to clinic.
- On presentation, D presented less agitated and was provided with appropriate health promotion. She spoke with the CLASH nurse and opted for the implant. D would be able to feel the implant under her skin and felt it would help in managing her paranoid thoughts about LARC.
- D also had a cervical smear and full sexual health screen whilst in clinic and received medication for a herpes outbreak.

## The physical environment, staff skills and manner

Many residents spoke of the importance of trust and discretion in how sexual health services are designed and run. The type of language used, waiting room environment and confidentiality of buildings all contribute to the likelihood that residents will access a sexual health service. Fear of being recognised in or near sexual health clinics was especially pronounced among participants from ethnic minority or religious communities.

> *"Being a Somali man, none of my family and friends know that I am gay... I fear I might bump into someone I know."* (LGBTQ+ Male, 28, African British)

> *"I've been to the Mortimer market clinic. The one thing I noticed was it was mixed [gender]. I didn't research it before I went, so I think that took me by surprise. The waiting room was all mixed [gender] and that was quite overwhelming for me. I think they could have at least put it male and female. And because that clinic is just for sexual health, so everyone's already got the assumption that this person's there for sexual health, you know, it's just not very nice."* (Woman who was homeless, 25, British Indian).

Multiple residents for whom English was not their first language reported hearing complex, medicalised language that was impossible to digest, hampering their understanding of diagnosis and treatment.

> *"..having someone to explain things clearly in my own language would help a lot. When you don't understand what the doctor is saying, you feel scared and ashamed. Sometimes I pretend I understand when I don't, just so I can leave. If there was someone who could translate or even just staff who speak more slowly and use simple words, I would feel more comfortable asking questions"* (Man who was homeless, Mixed Black African and Arab, aged 23).

Of the 55 residents who were 18+ responding to a survey, 22% had a physical disability, 31% a learning disability, 20% neurodiverse, 20% had a mental health difficulty. 38% of respondents were cisgender women. Key themes reported were around lack of clarity about what services were/did, appointment information not always being clear and some experiences particularly amongst women of judgemental or discriminatory treatment by healthcare professionals.

Some people interviewed through our insights work felt health professionals were too intrusive and/or not trauma-informed in their approach. They welcomed small details like receptionists being friendly, food/drinks during long waits, being put at ease etc. Some felt health professional training in their needs was lacking.

## Sex and ageing

Several older women talked about assumptions made by some healthcare professionals that they are no longer sexually active and/or stigma about sex and ageing. Our data shows very low numbers of men and especially women over 50 accessing sexual health screening – suggesting some sexual health needs may be under-identified.

> *"Maybe it has a little bit 'cause now I kind of feel like, because I'm older, would they judge me and go ,'she's a bit old'. But we all have needs, and just 'cause you get older doesn't mean you give up on sex or you don't want it, you know?.... There's a stigma attached to ageing"* (Woman who was homeless, 60, British Indian)

# Recommendations

Further work will take place over the course of 2025/26 to cost and phase recommendations in line with resources available.

All actions will require a partnership of local authority, NHS and voluntary sector colleagues to implement, but the lead organisations for recommendations in this section are Camden Council, Brook and CNWL NHS Foundation Trust.

| Recommendation | Actions |
|---|---|
| Increase access to condoms | 1. Review the C-Card scheme and explore feasibility of more anonymous access alternative<br>2. Ensure school nurses are C-Card trained<br>3. Further promote free condoms to sex workers. |
| Reduce the spread of STIs by continuing to implement new clinical guidelines as they emerge | 1. Implement the Men B vaccine to help prevent gonorrhoea<br>2. Implement new guidelines on doxyPeP medication for those at highest risk of syphilis. |
| Improve access to information, advice, guidance and interventions for residents at greater risk of being underserved | 1. Expand clinical outreach capacity to:<br>• Vaccinate<br>• Offer contraception opportunistically<br>• Sustain PrEP promotion in newly arrived communities,<br>• Expand health inclusion health promotion approaches with South Asian communities and/or Muslim communities<br>• Expand engagement with women in Black and South Asian communities and with older women from all communities.<br>2. Coproduce an STIs handbook with service users – to bring together information in one place for high risk/lower online literacy groups such as health inclusion populations (symptoms, what the current vaccination offer is and how to get it). |

| Recommendation | Actions |
| --- | --- |
| Improve use of equity data to inform how sexual health services and systems understand and address the needs of our communities | 1. CNWL to develop a clear equity minimum dataset to be collected through the move to SystmOne. To include as minimum: physical disability, learning disability, neurodivergence, MH diagnosis, gender and sex including trans and non-binary, sexual orientation, ethnicity, language and faith and age<br>2. At least annual whole system report by borough footprint bringing together access/uptake and equity data from Brook, CNWL, Primary Care, Pharmacies SHL linked to an emerging London-wide dashboard. |
| Develop staff skills and confidence in sexual health settings to improve the experience of residents more likely to face barriers accessing care | 1. Review existing training for CNWL staff and if necessary develop a training programme:<br>• Working with neurodivergent adults<br>• Structural competence – understanding how wider social determinants and complex intersectionality impact on health behaviours<br>• Cultural competence<br>• Trauma-informed conversations<br>2. Explore the feasibility of a rotation/shadowing programme of CLASH/SHOC for Sexual Health clinic-based staff, to upskill staff in communication with inclusion health groups<br>3. CNWL to identify a professional lead for neurodivergence. Professional lead and/or other colleagues to join our emerging Neurodivergent champions scheme. |

| Recommendation | Actions |
|---|---|
| Develop staff skills and confidence in other community health settings more likely to face barriers accessing care | Ensure ongoing practice development for GPs, nurses, reception staff and pharmacists in trauma informed practice/holding trauma-information conversations. |
| Increase the visibility of local sexual health sites eg Archway and in particular Mortimer Market | Develop a promotional campaign both print and online. Targeted to key communities such as GBMSM, younger and older age adults. Materials to be developed with residents / current and future users of the services. |
| Address environmental barriers in Sexual Health services to improve the experience of residents more likely to face barriers accessing care | 1. Undertake a 'through my eyes' resident-led exercise to review how welcoming waiting rooms, online booking processes, appointment letters etc are – learning from similar exercises in drug and alcohol services. Make adaptations as appropriate.<br>2. Embed routine (annual) 'mystery shopper' patient-led exercises, including using residents who do not have English as their first language, as part of routine audit processes.<br>3. Record and monitor access to interpreters<br>4. Consider feasibility of a specialist neurodivergent- friendly sexual health clinic and/or regular service walk- throughs for neurodivergent adults<br>5. Conduct accessibility reviews of SRH services with those experiencing barriers to accessing care. |
| Develop staff skills and confidence in non-healthcare settings, starting in our emerging neighbourhood models | 1. Embed sexual health into neighbourhood structures and fora<br>2. Embed SRH questions or prompts in care assessment forms and practice guidance for social workers.<br>3. Assign an SRH Practice Development Lead for Adult Social Workers. |

| Recommendation | Actions |
| --- | --- |
| Improve access to sexual health, cancer screening and HPV vaccination information, advice, testing and interventions for undergraduate and/or postgraduate university students | Increase the number of university drop in clinics and co-deliver screening and sexual health opportunities for post-graduates over 25. |
| Ensure carers of adults with a learning disability and/or autistic adults feel confident supporting those they care for around their sexual health and to maintain safe healthy relationships | Undertake needs analysis and develop shared care carer training on talking about sex, sexual health and relationships. |

# Pillar 3: Towards zero transmission and living well with HIV

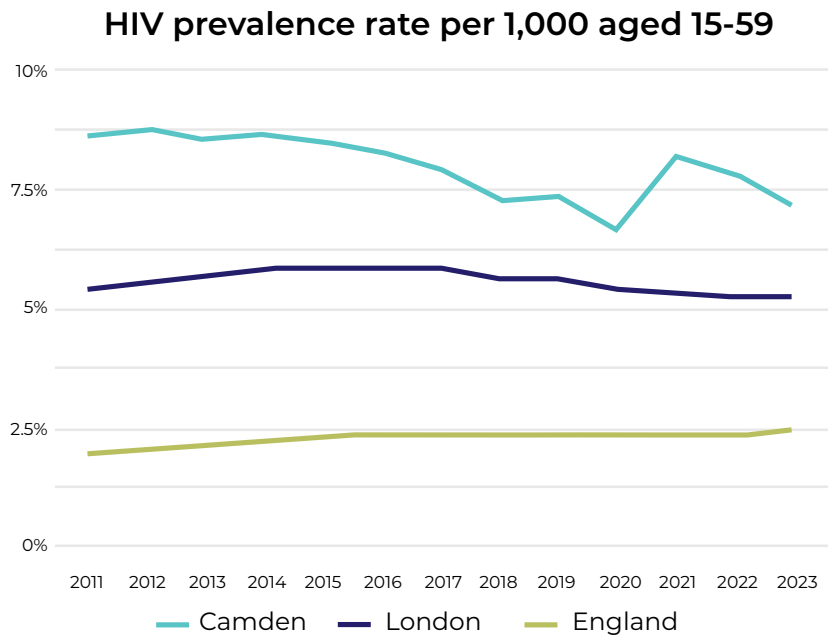
# Pillar 3: Towards zero transmission and living well with HIV

> *"A nurse in A&E asked me what PrEP was. That's bad. Staff need education and training."* (Camden Insights 2025, LGBTQ+ Interview)

## Towards zero transmission

### High HIV diagnostic rates linked to our high intake of newly arrived communities

The proportion of people living with HIV in Camden and the rate of new diagnosis are decreasing but remain among the highest in the UK. The proportion of diagnoses first made abroad are higher in Camden than London, though looking at UK diagnoses alone, rates are similar in Camden and London (Camden SNA, 2024)

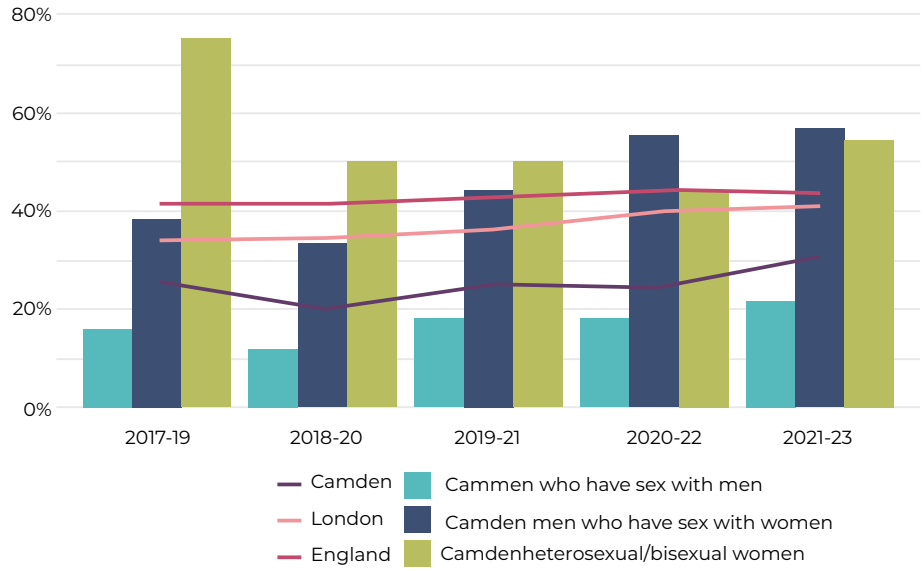



PHE Fingertips

## Good detection rates overall

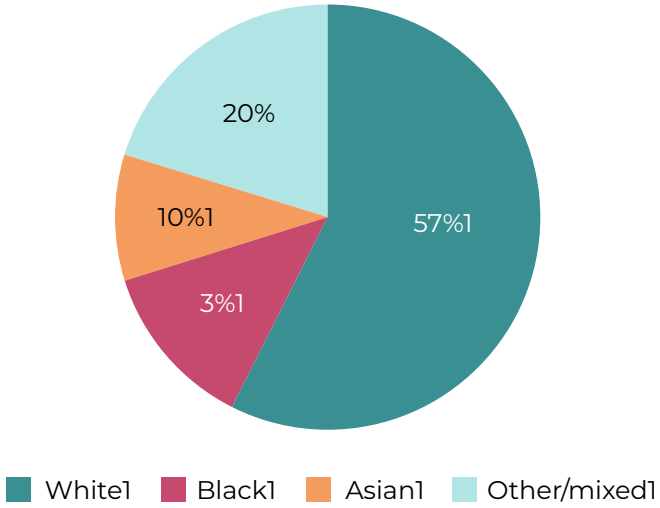
The proportion of people diagnosed late is lower in Camden than London or England. Nationally, testing among gay, bisexual, and other men who have sex with men (GBMSM) increased by 34% from 2019 to 2023 (**UKHSA 2024**), suggesting proactive testing resulting in better early identification and swift access to treatment. Late diagnosis rates are highest amongst straight men, followed by heterosexual or bisexual women (**Camden Sexual Health Strategic Needs Assessment, 2024**) – so there is work to do with these populations.

**Proportion of those diagnosed with HIV in the UK receiving a late diagnosis**




Black, mixed and 'other' ethnic groups are more prevalent in new diagnosis rates.

**New HIV diagnosis among Camden residents by ethnicity, 2018-2022**




## Pre-Exposure Prophylaxis (PrEP)

PrEP can be taken to reduce the risk of getting HIV for those at **highest risk**. PrEP coverage reflects the proportion of people with PrEP need who receive PrEP. Between 2022 and 2023, coverage fell slightly from 76% (2022) to 72% (2023), vs a London average which rose from 71% to 78% in 2023 (**PHE Fingertips**)

| Area | PrEP need 2023 | Coverage of those in need 2023 |
|---|---|---|
| Camden | 23% | 72% |
| London | 18% | 78% |
| England | 10% | 73% |

A focussed PrEP campaign is in place until July 25, including extensive engagement with Black African communities. CNWL's Q4 24/25 PrEP data suggests coverage is increasing, but sustaining and furthering this improvement must continue to be a priority.

## Living well with HIV

Twenty-two Camden residents living with HIV (via focus groups supported by Positively UK, our CNWL Bloomsbury Clinic and interview) shared their views, experiences and recommendations for improvements. The following key themes came through.

### Support and resources about managing health

In general, residents said they had good access to someone to talk to about staying healthy with HIV – and felt they could approach health professionals, local or national VCS organisations. People had positive experiences with support provided through our CANDI network.

> *"I would say for me it was a little bit flexible; to get the help of a non-profit organization, they were actually very good to listen to me. And they have been very helpful..... I have met through them, other people living with HIV. They have made it easier through the education and also training, like online courses and workshops and talks like HIV prevention, treatment care and as well as LGBTQ health as well"* (Positively UK focus group)

However, some said they'd welcome more written resources such as leaflets, useful websites – to help navigate information available in different places.

> *"We are looking forward to getting more resources. I really am really hoping to get more resources on that so I can share with my folks"*. (Positively UK focus group)

> *"I would love to also get an email with a list of resources"* (Positively UK focus group).

## Experience of healthcare professionals

Residents expressed significant variability about their interactions with healthcare professionals. This was due to individual practitioners' personal skills and/or knowledge of HIV, the impact of stigma, discrimination and bias, and communication gaps between acute, primary and community healthcare services. Experiences ranged from exceptional, life-changing care through to distressing and unacceptable.

## Examples of high quality care

*"I'm still getting used to talking front of so many people, but I would say this place has been magical to me [Mortimer Market]. I was diagnosed in 2023, and I was actually fairly new in the country. I would say at that point, I lost hope. And I don't know how to express in words, but it was through this place that gave me hope. Especially Fernando [staff]"* (focus group, Mortimer Market)

*"My GP was incredible at that time (of crisis), he literally held my hands."* (focus group, Positively UK)

## Examples of challenges people experienced

*"Once I went to some healthcare service and the doctor or the nurse, I don't know who she was, she cut herself or something, but she hadn't touched me or anything. It's not like she had been in touch with my blood or any bodily fluids. There was so much panic, and all the doctors were going, 'oh, you need to go to, this is an emergency, we need to take you somewhere'. And I was just left there on my own, left for over an hour"* (focus group, Positively UK)

*"When I actually contracted this thing, I had braces in my teeth. And when I went there to ask what's gonna happen, I told them about my HIV. And, the receptionist told me, 'Well, I don't know if we can continue treating you'. And this was a private dentist, by the way. I said, 'Are you gonna leave the braces in my mouth? These are metal braces. You're gonna leave it in my mouth?"* (Interview, Black British woman, 53)

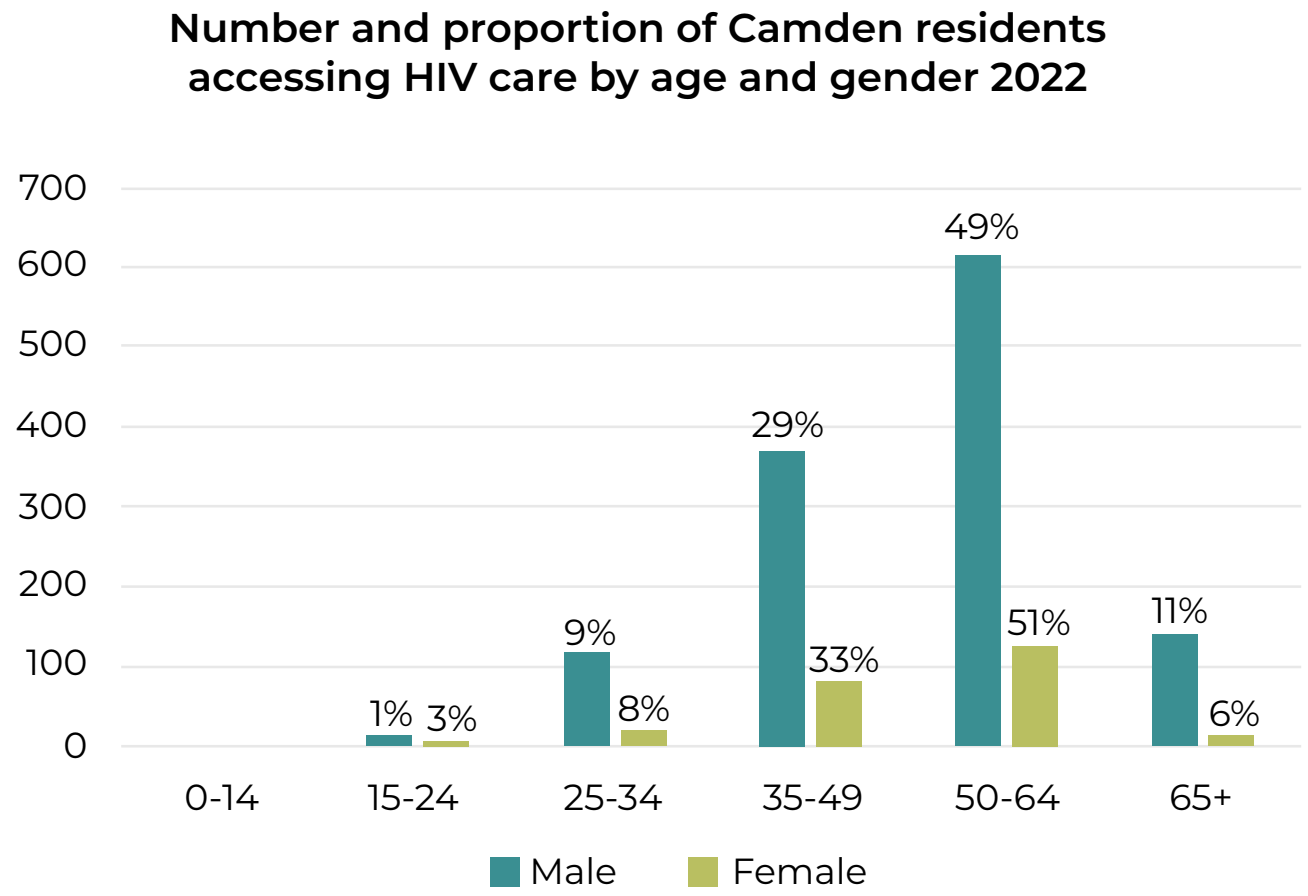
## Impact on mental health

Many people made the connection between the experience of healthcare and their mental health. Some people felt that there was a need for more training for health professionals in relation to HIV – but there was broad consensus that the biggest step change we could make is to reinforce the importance of compassionate, empathetic approaches in healthcare.

*"As a healthcare professional dealing with people with HIV, you need to be able to understand them, have empathy, have emotional skills, psychological skills, because you're dealing with very emotional people. And you need to be rooted in mental health as well"*(Positively UK)

# Ageing

Our population living with HIV is ageing. 60% of men and 57% of women are over 50 (Camden SNA, 2024). A national survey found that many over 50s experienced discrimination from social care, and a third felt socially isolated (Terence Higgins, 2017). Loneliness and risk of social isolation came up as a key theme amongst residents and professionals. Some residents reported that closures of community settings eg YMCA can have the effect that residents feel less connected to peer support.




(**Camden needs assessment, 2024**).

Three key themes emerged:

1. **Fear of and the impact of stigma on how care providers will react to residents:**

> *"This is the point I am in, now as an older person living with HIV. The fear of being judged has made it difficult for me to speak on my condition. This is the reason I find it difficult to disclose, being judged would devastate me."* (Focus group, Mortimer Market)

> *"...the government needs to strengthen anti-discriminatory framework measures, which would actually help to reduce a level of disrespect and disdain to older adults with HIV"* (Focus group, Positively UK)

2. **Limited understanding amongst some healthcare professionals in other, non-sexual health disciplines about the intersection of that speciality and HIV.**

> *"I get all my information from the HIV consultant. The GP had no idea, perimenopause, menopause for HIV patients like me. All they suggest is HRT and I didn't want that. They referred me to a gynaecologist who specialised in HRT basically, so all he was advising me on was the actual HRT. But the HIV consultant was really helpful. I didn't want any more treatments, I'm already on so many medications"* (Mortimer Market focus group).

3. **A need for more information and advocacy so residents have the tools to navigate health and social systems as they age.**

> *"I don't come here (Mortimer Market) for HIV and aging because you have got nothing on your website, Bloomsbury network. And I've seen three doctors and none of them have raised that issue. You've got a very good website, and you've got a page that has specific issues, but what's missing is HIV and ageing, because that's the biggest demographic now"* (Focus group, Mortimer market)

> *"Because what I also found out in my own little research that I've done is that my age group (50+) in particular know nothing about the questions they need to ask. And that's a real weakness in their approach to their own HIV care. You've got to know what it is that you need to talk to your doctor about"* (Focus group, Positively UK)

## Stigma, discrimination and disclosure, wider public attitudes

Almost all residents living with HIV said the impact of stigma and discrimination continues to be strong today. A number said they had not felt comfortable disclosing that they had HIV, whether to healthcare staff, wider community members or even family.

Residents felt that public awareness of HIV was no longer what it used to be. And the legacy of the highly successful late 20th century campaigns means that public perception has not caught up with the changing face of HIV in heterosexual, female and older populations.

> *"And we know the public societal perspective of HIV patients. They are viewed as people that are loose, morally not standard and all of that, painting them as the villains in their community. But we are just like every other person. We are just like every other family member, a mother, a sister, a brother, a father"* (Positively UK focus group)

> *"Whoever I talk to, you always have to think about it before. Who am I gonna see? Am I gonna tell? It's just stressful, and it's just a lot easier to not even engage with people"* (interview, Black British woman).

Respondents told us of the importance of raising the profile in HIV and called for more public education:

> *"I think basically since now HIV is not a priority, because people are not dying anymore, it's like the last thing in the agenda, if it's even in the agenda. Because there are no education campaigns or things like this, the stigma, I don't know if it's as worse as before or more. And the problem is that nobody's doing anything about it because it's not a priority now"*

# Recommendations

Further work will take place over the course of 2025/26 to cost and phase recommendations in line with resources available.

All actions will require a partnership of local authority, NHS and voluntary sector colleagues to implement, but the lead organisations for recommendations in this section are Camden Council and CNWL NHS Foundation Trust.

| Recommendation | Actions |
|---|---|
| Ensure that adults (including older adults) living with HIV and accessing social care support feel confident to share their diagnosis and are treated with respect and without discrimination | Run at least annual HIV awareness raising training for social care staff. |
| Address social isolation experienced by LGBTQ+ residents and/or people living with HIV, particular amongst older community members | 1. Ensure our 'Camden Together' campaign reflects LGBTQ+ residents and promote through the CANDI network<br>2. Deliver our Social Isolation support training package to professionals in CANDI network and CNWL<br>3. Signpost to trusted national organisations and local peer support groups. |
| Develop the availability of PrEP – increase reach to heterosexual men and women and under 21s | 1. Consider the financial viability of using the developing e-service offer and/or current CNWL Digital PrEP offer<br>2. Sustain the current PrEP awareness campaign with newly arrived residents and expand to other key at risk groups. |
| Help address stigma and discrimination around HIV by increasing understanding in the general population | Run an annual HIV awareness programme co-produced with and reflecting residents. |

# Pillar 4: Good reproductive health across the life course

# Pillar 4: Good reproductive health across the life course

Women and girls make up 53% of Camden's population (**Census, 2021**). There are gender and/or sex-related differences in some health outcomes, as set out below.

**The definition of women's health goes beyond reproductive health**

| Diagnosis, prevention, and treatment (and related products) for: | | | | | Nonexhaustive examples |
|---|---|---|---|---|---|
| **General health conditions** | **Affect women differently**<br>Cardiovascular disease[1] | | | | **Sex differences unknown or not sufficiently studied**<br>Alzheimer's disease[7] |
| | **Affect women disproportionately**<br>Autoimmune disease,[2] migraines, [3] osteoporosis[4] | | | | |
| | **Gender bias in care delivery**<br>Pain,[5] mental health[6] | | | | |
| **Largely female-specific conditions** | **Contraception**<br>Oral contraceptie, IUD[8] | **Fertility**<br>IVF,[9] egg freezing | **Maternal health**<br>Prenatal care, breastfeeding | **Menopause**<br>Peri-and post-menopausal symptoms | |
| | **Gynecology**<br>Endometriosis, pelvic floor, menstration, sexual health | | | | |
| | **Gynecological infections**<br>Bacterial vaginosis, HPV[10] | | | | |
| | **Women's oncology**<br>Breast cancer, ovarian cancer, cervical cancer | | | | |

**(McKinsey & Company, 2022)**

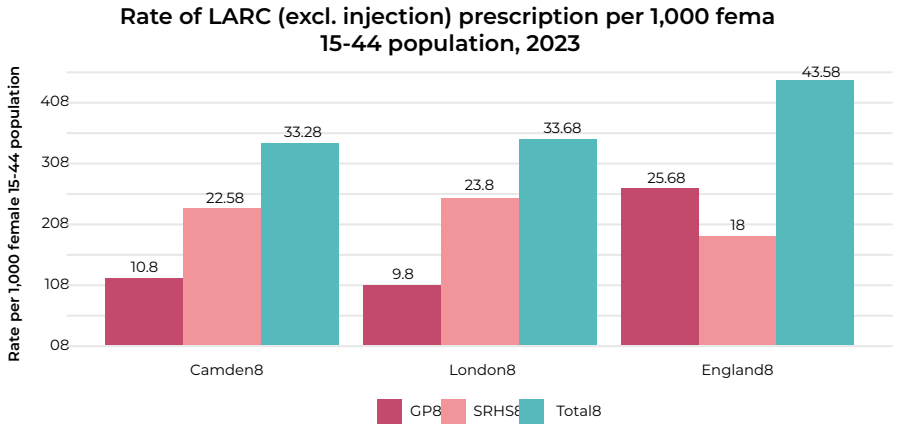
This report focusses in the main on reproductive health outcomes – but more broadly we need to think more holistically about all the ways in which gender and sex relate to differential health outcomes for women and others assigned female at birth. Sex and gender need to be better acknowledged as health determinants. Key issues in Camden include:

- Some worse reproductive health outcomes than London or England (cancer screening and HPV).
- Less well-formed relationships, leadership and sharing of expertise around women's health across clinical networks, partly because Camden does not have a community gynaecology service unlike neighbouring boroughs nor a clinical or strategic leader working system-wide in Camden. This results in fragmented care for women, with services focussed on distinct bits of healthcare – screening, sexual health/contraception etc – and not women's holistic needs.
- The impact of culture, race and racism experienced by women in access to healthcare.

Women's health is an agreed priority for the Local Care Partnership Board (a group of health and care leaders in Camden).

# Contraception and abortion

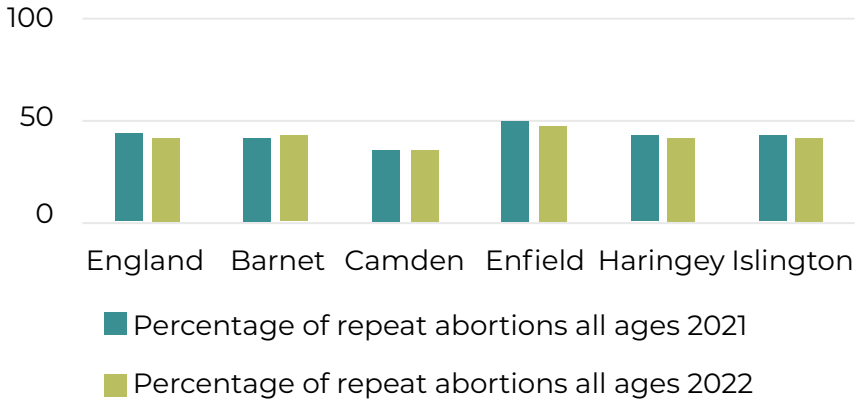
Rates of uptake of Long Acting Reversible Contraception (LARC) (types of contraception such as coils, implants or injections that are considered the most effective and reliable ways to prevent pregnancy) have stayed stable in recent years and are now in line with London averages, which fell between though remain below those of England overall.

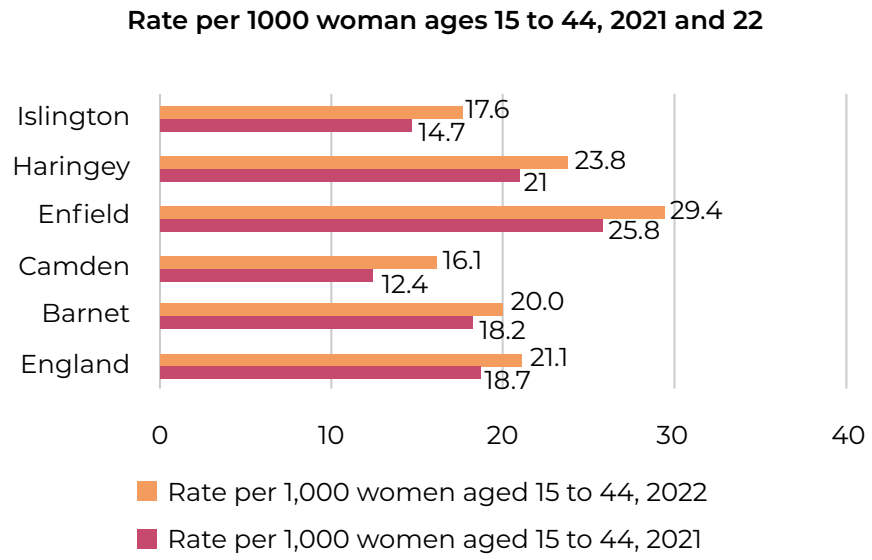



Teenage conception rates in 2021 remain around the London average at around 10 per 1,000 (Fingertips Child & Maternal Health dataset).

Overall, Camden has lower rates of abortion compared to NCL, London and England suggesting relatively better contraception coverage. Almost 90% of abortions in Camden occur within 10 weeks' gestation, suggesting good access to abortion services (OHID, 2024). We also have lower rates of repeat abortion than our neighbours; this may be linked to our LARC offer in abortion services offer as well as demographic differences. Nonetheless – abortion rates rose in all NCL boroughs between 2021 and 22 – in Camden from 12.4 to 16.1 per 1000 women aged 15-44. We will need to monitor whether this is related to the legacy of COVID-19, when access to contraception was curtailed, or a longer term trend.

**% of repeat abortions all ages, 2021 and 22**






(**OHID: Abortion-statistics-2021-data-tables-revision-September-2023.ods (live.com) and Abortion statistics for England and Wales: 2022 - GOV.UK**)

### Access, choice and control

From our insights work, a small number of young people including two care leavers said they did not want to use hormonal contraceptive options. We heard anecdotal reports of similar concerns becoming more common in sexual health services and from a VCS organisation who work with women experiencing multiple disadvantages.

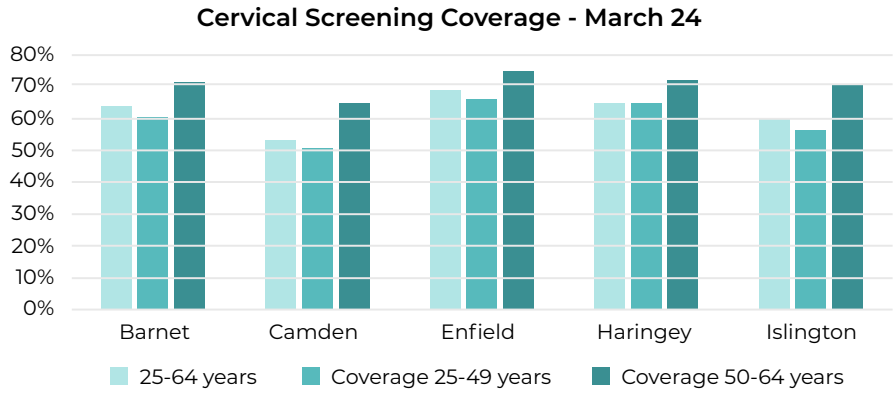
The **Advisory Group on Contraception's survey of 1,068 women** UK wide found that marginalised women such as women who were homeless or sex working were most likely to find challenges accessing a GP. Our local insights work with women sex working (7 out of 23 were not registered with a GP), our open-access resident survey and our other interviews all echoed these findings. In the national survey, only about 25% of all women said they had all contraception options discussed with them by professionals. Locally, we also heard from women that they did not always receive high quality information on side effects or alternatives that might work for them.

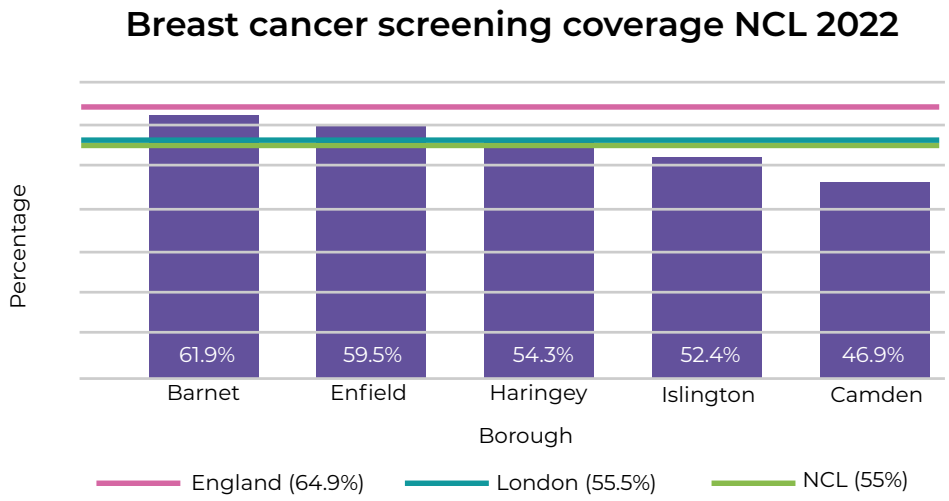
We miss key opportunities to offer women contraception, such as post-partum. NHS partners do not routinely collect or review data on unplanned pregnancies, despite the London Measure of Unplanned Pregnancy being used in UCLH.

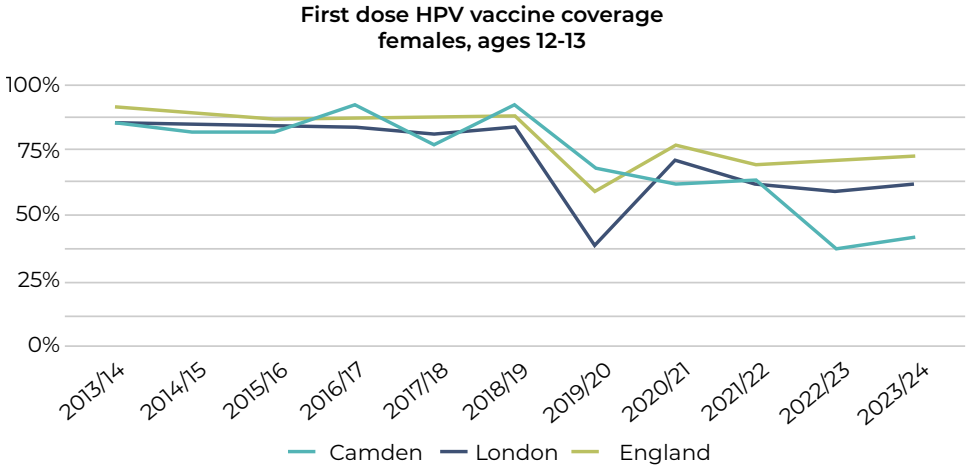
## Screening and HPV

Cervical screening rates are the lowest in NCL and below London and England. Only around half of Camden's women aged 25-49 had undertaken screening. Coverage is lower amongst Asian and White Other groups (NCL Cancer Alliance, 2024).

Breast cancer screening rates are also lowest in NCL at 47% coverage against a national average of 65% (NCL Cancer Alliance).





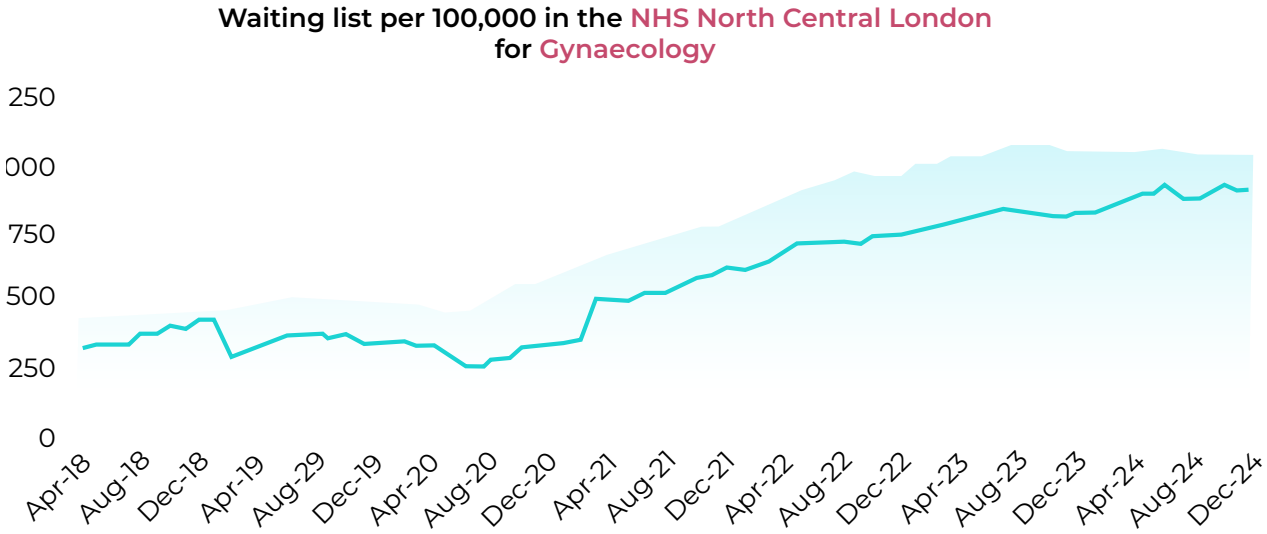

(**NCL Cancer Alliance, 2024**)

HPV vaccine coverage nationwide decreased since the pandemic but has begun to recover in London and England. Camden has yet to experience the same level of recovery.

Whilst the **July 2025 national RSHE guidance** for schools includes a greater focus on menstrual health, it does not reference cervical or breast cancers at all. In Camden we will want to find ways to ensure children, young people and adults understand these health risks and how to prevent them, including through the HPV vaccine.

# Access to support with menstrual, gynaecology, continence, menopause or other reproductive health condition

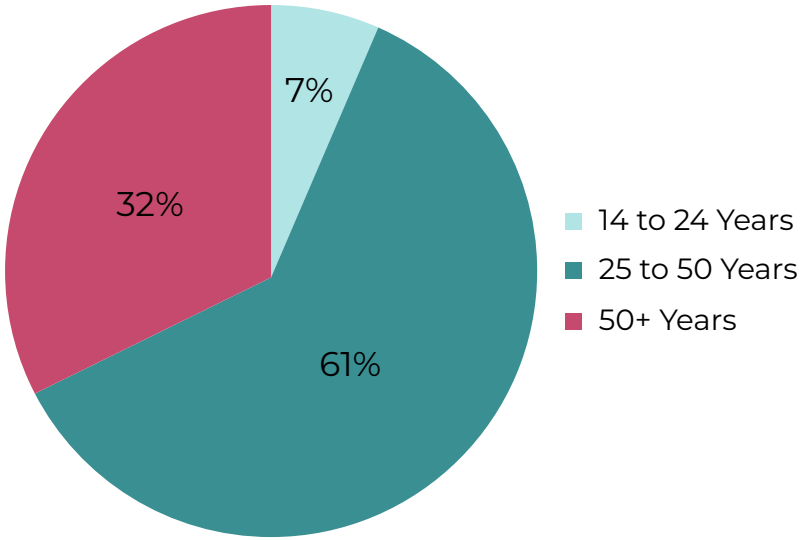
Unlike other NCL neighbours, Camden has no community gynaecology service yet. Acute gynae waiting times can be long – across NCL as a whole, 44% of women were waiting more than 18 weeks at March 2025 (**NHS England RTT Waiting Times Data, 2024-25**). The number of women waiting for secondary care gynaecology is rising.




(**LCP Waiting List Tracker**)

NCL ICB's data shows 60% of referrals to gynaecology are aged 25-50 and primary reasons include menstrual disorders and/or endometriosis or fertility-related issues. Over 50s make up 35% of referrals, for menopause support, pelvic health and chronic condition management. Clinicians in both Primary and Acute care reflect a view that up to 60% of activity currently taking place in hospitals could be undertaken in the community, maximising capacity for women needing more complex or specialist interventions and reducing waiting times.

**Camden patients by age group**




*NCL ICB Gynae Taskforce report, 2024/25*

We have limited information about the overall prevalence of menstrual and gynaecological health conditions in Camden but among the UK population it is estimated that:

- Up to one in three women live with heavy menstrual bleeding
- Around two in three women will develop at least one uterine fibroid in their lifetime
- Urinary incontinence affects as many as 40% of women
- One in ten women in the UK will suffer from endometriosis when they are of reproductive age
- Adenomyosis affects around one in 10 women in the UK.

In 2021, nearly two million girls in the UK missed a part or full day of school or college because of their period, 13% missed an entire school day at least once a month. Research published in January 2024 found that one in eight women in the UK had taken time off work in the previous 12 months due to symptoms linked to periods – more than a third of whom gave a different reason to their employer, likely because of issues of stigma and taboo (**Women and Equalities Committee report, December 2024**).

We have no local data about women's experience of menopause. In the UK, the average age is 51 but 1 in 100 women experience menopause before the age of 40 (**LGA 2025**).

According to NICE:

- Over 75% of women experience menopausal symptoms, with 25% describing these symptoms as severe
- A third of women experience long-term symptoms which may last 7 years or longer
- Perception, intensity and incidence of menopausal symptoms can vary widely from person to person and are affected by genetic, biological, hormonal, social and cultural factors
- Individual beliefs and attitudes may impact help-seeking behaviour.

(**NICE, April 25**)

# Insights – what women tell us

In addition to drawing on engagement done with women (and trans and non-binary people with ovaries) in national reports and research and Healthwatch Camden's : '**Living with Endometriosis in Camden**' report (2024), we held a focus group with Camden women over 40, interviews and focus groups with women predominantly from our Somali and Bengali populations, women who are homeless and women who use drugs/alcohol, young care leavers and heard from women who sex work via short surveys carried out in sexual health clinics and outreach. Many common themes came through.

Women's experience of healthcare was mixed. Many women, particularly from our Somali and Bengali interviews/focus groups, told us that they are more likely to trust advice and information about things like period problems, fertility, gynaecological concerns and menopause from their GP or a nurse as oppose to seeking advice online – several women said that whilst they would use online information and books, discerning what is trustworthy and accurate information can be a challenge, particularly as the women's health industry and FemTech market has expanded in recent years.

> *"The information will be accurate as it is from the GP or their nurse. We trust what the clinicians tell us."* (focus group, Kings Cross Brunswick Neighbourhood Association members).

## Being taken seriously – symptoms, pain and pain minimisation in healthcare

Of the around 100,000 women responding to the Women's Health Strategy (2022) call for evidence, over 50% said that pain related to symptoms was overlooked or disregarded (**Dept of Health and Social Care, 2022**). This was echoed very strongly by women in Camden, throughout our focus groups and interviews, in our resident survey and in Healthwatch's 2024 Endometriosis report. Multiple participants felt their GP had not appeared to take their symptoms seriously, including experiences of pain.

> *"They [health professionals] want you to struggle for a bit and then they'll take it really seriously. For me it was almost like I had to be bleeding on the floor before they took it seriously, because they didn't take it seriously until I had to go to A& E, which is quite ridiculous."* (**Healthwatch Camden Endometriosis report, 2024**).

The participants in our focus groups felt their best experiences with healthcare professionals were when the professionals listened, asked questions and didn't challenge why women were reporting what they did. Participants advocated for greater understanding and more in-depth training for first line professionals.

> *"Listen to women! Take seriously what is going for us"* (women over 40s focus group)

Camden women gave us multiple examples of healthcare professionals misdiagnosing symptoms, e.g. diagnosing anxiety or allergies instead of menopause - and women didn't always feel confident to push back when they felt misdiagnosed or not fully heard. Some examples given were concerning. In one case, the GP recommended course of action led to an ED admission as previous medical history was not considered fully. In another, a hysterectomy was recommended that was subsequently not supported by a later second opinion, sought only because of the residents' own self-advocacy – with the secondary course of action resolving symptoms without requiring such extreme intervention.

Camden women repeatedly told us they did not feel listened to about their symptoms and had to battle for help. Several participants felt that their GP had a good manner/treated them well but lacked the specialist expertise/education/training to respond to their individual needs.

## Segmentation and fragmentation and location of care

*"Bloods over there, operations cancelled and not rearranged - absolute mess and chaos"* (woman in over 40s focus group)

A consistent thread throughout our engagement was about the disjointedness of care for women. Services are commissioned by multiple organisations resulting in fragmented care.

Health initiatives and campaigns typically focus on an aspect of women's health – cervical screening, sexual health or vaccinations – and rarely holistically. The psychological impact of long-term reproductive health conditions appears rarely addressed.

> *"In five years, no one asked me, how do you feel? Do you need any support for this?"* (interview, Somali woman, 35)

Sexual health was often addressed only in the context of disease or contraception, leaving emotional and psychological needs unacknowledged, particularly for older women.

> *"No one asked me how I feel. Maybe this is the first time I'm telling you this."* (KCBNA focus group)

Women expressed the desire for holistic care that includes emotional wellbeing and acknowledges that sexual health is not only about infections or contraception.

## Menopause as a particular gap

In a national survey with nearly 1000 perimenopausal women, 60% of women did not feel informed at all about menopause (**Harper et al, 2022**). Camden women we spoke with said they similarly had limited knowledge, with most coming from online sources or friends/family – despite women acknowledging

issues of trust in the reliability of this information. Women called for more practical, accessible, and culturally sensitive information, particularly about menopause, (though contraception and menstrual health also came through).

> *"More information regarding the menopause is required in the form of leaflets at GP surgeries, including the symptoms of menopause."*

> *"I don't think there is enough information out there to prepare me [for menopause]. Everyone's different, but I should know."* (women over 40 focus group)

For older women experiencing menopause in particular, women reported a sense of isolation and/or anxiety in relation to what they are experiencing - and this was not really addressed in healthcare, where treatment focussed more on the physical impact of symptoms.

## Ethnicity and culture, racism and inequalities

Women from different ethnic groups may have different experiences to White women both in terms of presentation of symptoms and access to care (Fawcett Society, 2022).

Globally, only around 2% of all healthcare research funding is directed to women's health conditions other than cancer (McKinsey & Company, 2022). Clinical knowledge of ethnic differences in gynaecology is limited. There are some differences in incidence of and treatment of some conditions. For example, uterine fibroids have a higher incidence in Black and Asian women compared with White women. South Asian women and Black women have been found to be more likely to have been diagnosed with breast or ovarian cancer at a later stage, when treatment may be less effective (Royal College of Obstetricians and Gynaecologists, 2024). Inequalities in maternity outcomes are now well known.

Cultural barriers play a part in how and if women access services. Women in Camden said that cultural norms and stigma significantly shape women's experiences of reproductive health. Many participants explained that topics such as menstruation, menopause, contraception, and sexual wellbeing are not openly discussed within their communities.

> *"In my culture, talking about periods and stuff is taboo, we don't talk about it."*

> *"My mum didn't like it because I had pads on display. She was like, 'what is this nonsense?' I said, 'I've got a house full of girls, people need to know."* (KBCNA focus group)

Many women described the pressure placed on them to meet societal expectations regarding childbearing, as well as the tendency to blame women for pregnancy outcomes.

> *"If you have a boy or a girl, it's put on you. If you have a miscarriage, it's put on you."*

> *"If you can't have children, you are labelled as not feminine enough or complete enough."* (KBCNA focus group)

Cultural attitudes to and representations of menopause differ in different communities. In some cultures, discussion of the menopause remains a taboo subject not openly discussed. There may be a lack of understanding by healthcare professionals of the terms used by ethnic minority women to describe their menopause symptoms (**British Menopause Society, 2024**).

The lack of a community service in Camden makes it challenging to understand inequalities in access to gynaecology. 73% of data reported by gynaecology at UCLH and Royal Free is missing ethnicity coding (NCL ICB, 24/25 Camden data).

As we move to consolidate and improve women's healthcare in Camden, we must ensure we understand and address inequity, including by offering culturally tailored education and support to Camden's communities.

## Cultural sensitivity in sexual health services

Several Somali and Bangladeshi women in our insights programme said they avoided sexual health clinics due to stigma, cultural assumptions, fear of being seen by members of their own community and discomfort in mixed-gender or highly sexualised environments. They suggested that more female-only spaces would make them more likely to attend and seek support without fear of stigma.

> *"The first time I went, it was around Christmas, and there was a Christmas tree with condoms on it [laughs]. They decorated it with a string of condoms. And my sister said, 'I'm not going back'. There was like a frame with a whole line of penises. Even though the building was boring, sad, inside it was very loud"* (interview, woman, 46, British Bangladeshi, describing a visit to Mortimer Market Sexual Health clinic)

> *"I felt uncomfortable in the waiting room. In my hijab, I felt uncomfortable. I was the only one there."* (KBCNA focus group)

## Reproductive health for transgender, intersex, non-binary people and others assigned female at birth

We have limited data locally about health outcomes for our trans and gender-diverse populations. Census data tells us around 1400 people recorded an identity different to the sex recorded at birth, of whom 217 identified as trans men and 216 as non-binary (**Census, 2021**). All of the issues in this report are likely to have relevance for trans and non-binary people who menstruate, experience menopause, undertake fertility planning and/or access gynaecological care and we intend all of the recommendations to be inclusive. There are also issues and barriers uniquely experienced by gender-diverse people, such as greater risk of discrimination in healthcare settings designed for cisgender women, failure to discuss or promote reproductive health interventions, limited knowledge about the effects of testosterone/hormonal treatment on aspects of reproductive/physical health and the additional psychological impact experienced by some people around menstruation, menopause etc. We need to ensure sexual and reproductive and other health services understand and respond to these barriers.

## Harmful practices

Harmful practices is an umbrella term for behaviours that take place as a result of belief systems. They include early/forced marriage, honour-based abuse and female genital mutilation (FGM). These practices reflect an underlying gender discrimination and for those affected, have a significant negative impact on women's reproductive and mental health. Whilst data on how many women living in Camden are affected is limited, England's FGM dataset show that:

In 23/24, around 100 Camden women or girls were identified or being treated for FGM

55 of these women were of East African origin

The rest are from other parts of Africa, Asian or there is no record

These women were identified or treated mostly in midwifery or obstetrics, with some in gynaecology and small handful in paediatrics or primary care (**NHS Digital/NHS England, 2024**).

This is likely to be a significant underestimation of the number of women affected in Camden, given the low number identified in settings other than maternity services.

## Physical and Learning Disabilities and women's health

There is limited data available on the experience of physical- or learning disabled residents in relation to women's health. However, 38 of our survey respondents reported having a physical disability, learning disability, being neurodivergent or a diagnosed mental health need. Key issues that emerged for them were about accessibility of services. Respondents with learning disabilities raised concerns about lack of easy read information. Those with physical disabilities described feeling completely unsupported by the system.

> *"sexual and reproductive health in this borough not accessible for many... Was refused the checks I needed. Was not offered up properly appropriate advice.... Poor patient profiling and speaking to me like I was a child"* (survey respondent, with a learning disability)

> *"Being mainly bedridden and housebound for years there is zero access to sexual health and reproductive health services at all. My GP knowingly knows all this and yet the letters I get sent for overdue for cervical screening are also not accessible you'd think they would have done it by now at home for me. Even in hospital when I was there I requested this and nobody did anything at all for me whilst there"* (survey respondent with a physical disability)

## Neurodivergence and women's reproductive health

Autistic and other neurodivergent adults may experience unique challenges. Differences in sensory sensitivity and social interaction may make the physical and psychosocial changes of menstruation and menopause more challenging for autistic women and people assigned female at birth (AFAB) than their neurotypical peers (**De Visser et al, 2024**). Healthcare professionals told us they have limited training and knowledge about the specific needs of neurodivergent residents.

Inclusion health groups – feedback from women who sex work, women who are homeless and women who use drugs/alcohol Most of the women we spoke with from these groups had a largely positive experience of healthcare via Sexual Health clinics and Sexual Health outreach teams. All three groups said their most pressing women's health needs related to STI testing and treatment, contraception, and pregnancy services. But they also flagged issues related to hormonal changes, menopause, psychosexual support, and abuse as areas where greater awareness would be helpful. For these women, supporting them through their hierarchy of needs – prioritising issues of greatest risk such as housing, finance, safety, addiction support etc without forgetting about underlying reproductive health issues which can exacerbate poor physical and emotional wellbeing is key. This means delivering reproductive healthcare through outreach approaches, in settings which these women trust, is key.

## Sexual violence and trauma survivors

Across our Insights population groups, several women talked about the intersection between getting help for women's health issues and their current and historic experiences of violence. Domestic and sexual violence are not only one of the main causes of homelessness but women also experience violence or harassment at homeless services and on the street.

In 2020 Groundwell research into women's experience of homelessness, 35% of participants felt that sexual or domestic abuse was currently affecting their day-to-day life. In some circumstances, women felt that they had to have sex with men to get help or somewhere to stay, as this woman explained:

> *"People trying to help me, whatever, but in return, they want to sleep with you, and you keep telling them no. He is saying yes and that. And I was unhappy in that situation, I really was unhappy. I just wanted to have a room and be comfortable. I cry every night and say can't do this"* (**Groundswell, 2020**)

Women's healthcare services such as cervical or breast screening and other intimate examinations can feel retraumatising if not handled carefully. Multiple Camden women told us that well-meaning but overly intrusive questions from healthcare professionals in both primary care and sexual health services deterred them from seeking help again.

> *"I think first the whole point is that we want to check up on sexual health. So, I think that should be the main focus. Because if you start going on about the partner too much, it might put off the person from going. It's just a bit traumatising and it might make them to leave early."* (woman who was homeless, 25, British Indian)

Multiple women felt that being able to ask for a female healthcare professional but women did not always know they had the right to ask.

> *"After I got raped, I wasn't going to a doctor after that, cause my doctor was a man. So I didn't feel comfortable. But then I got told that I can see a female doctor instead so. I saw a key worker and they told me about it."* (woman who was homeless, 37, Scottish)

Programmes like Barts '**My Body Back**' project offer women antenatal care, screening and sexual health support specially aimed for women experiencing sexual violence – but spaces are limited. Thus it is very important all practitioners are trained in trauma-informed approaches.

## Period poverty

Groundswell's report also highlights that some women who suffered from heavy periods struggled to manage them and keep clean when they were sleeping at shelters, outside or on public transport. When they could not access tampons or pads, they used toilet paper, tissue and/or socks as pads that often caused leakages. One participant described how she tried to manage her periods when she cannot afford sanitary wear: *"When I am on the street, I get a lot of tissue and put when I have period. I did that one. Because when you buy, it costs you too much money. One day it costs about a lot. So, the street is difficult when you need to wash"* (**Groundswell, 2020**)
This emphasises the importance of accessible public toilet schemes alongside distribution of free period products wherever possible.

## Promote men's engagement in reproductive health

Women repeatedly emphasised the role of men in both reinforcing and challenging cultural stigma around reproductive health issues. They said that educating boys and men is essential for challenging these perceptions and creating supportive environments, and several mothers talked about how they were facilitating more open conversations at home.

> *"Why aren't men talking about it [menopause]?"* (over 40s focus group)

> *"I've made it a point that my boys need to know why I wear [referring to period pads]"* (KBCNA focus group)

Educating sons as well as daughters was seen as crucial to changing gendered expectations and improving future understanding.

# Recommendations

Further work will take place over the course of 2025/26 to cost and phase recommendations in line with resources available.

All actions will require a partnership of local authority, NHS and voluntary sector colleagues to implement, but the lead organisations for recommendations in this section are Camden Council, NHS NCL ICB in partnership with Camden's GP Federations, UCL Cancer Alliance, Vaccination UK and CNWL NHS Foundation Trust.

| Recommendation | Actions |
|---|---|
| Improve access to reproductive health information, advice and guidance, particularly for residents facing greater inequity of access e.g. Black and South Asian communities, older women | 1. Expand engagement approaches connecting women in communities less well served by services e.g. Black and South Asian communities, older women to health services by:<br>• Running or commissioning women's health drop in cafés in community settings (VCS, Family Hub etc) to provide information, advice and guidance around fertility planning and contraception, HPV and other vaccinations, cancer screening, menopause help and discreet relationships advice led by clinicians or other appropriately trained experts<br>• Running (or commissioning from culturally competent experts eg Somali GPs etc) menopause specific sessions tailored to specific communities<br>2. Delivering specific interventions opportunistically where possible e.g. contraception provision<br>3. Grow the number of professionals able to provide perimenopause and menopause advice by collating national and /or developing local menopause resources to signpost women to support<br>4. Ensure existing network of Community Champions and Community Bus outreach teams receive menopause training to be able to share basic information with women at community events<br>5. Run an annual women's health information campaign covering different aspects of women's health<br>6. Work with UCL to establish Camden as a research site for a trial menopause intervention education and peer support programme. |

| Recommendation | Actions |
|---|---|
| Improve women's experience of accessing healthcare for menstrual challenges, menopause or other reproductive health needs by increasing knowledge and skills in the Primary Care and Sexual Health workforce | 1. Carry out an audit of training and skills around aspects of women's health (screening, contraception, menopause, common menstrual health conditions etc) in Primary Care (through appointment of a fixed term GP Clinical lead for women's health and officer support)<br>2. Map women's health pathways and services across Primary Care, Secondary Care, Sexual Health services and the VCS to identify any gaps and to support GPs to know where to signpost women. |
| Increase cervical and breast cancer screening uptake | **Cervical**<br>1. Work with lower achieving practices to improve screening uptake<br>2. Support projects to increase HPV vaccination uptake in catch up cohorts<br>3. Provide advice to practices around changes to the screening programme<br>4. Support implementation of HPV self-sampling roll out<br>5. Develop primary care toolkit to support cervical cancer elimination ambition<br>6. Support and deliver targeted health promotion activity.<br>**Breast**<br>1. Support implementation of the call and recall administration system to improve uptake<br>2. Develop a network of champions to target population cohorts with lower screening uptake<br>3. Create a paper light breast screening pathway through regional collaboration |

| Recommendation | Actions |
|---|---|
| Increase HPV vaccination rates | 1. Vaccination UK, school nursing team and NHSE to monitor HPV progress and target schools with low uptake<br>2. Promote catch-up for our young people using co-produced materials<br>3. Increase training for staff in settings where young people attend<br>4. Develop more targeted health promotion –including parents/carers ahead of vaccines, home-educated families, those w/out English as first language. |
| Explore opportunities to increase access to contraception | 5. Delivering specific interventions opportunistically where possible e.g. via clinical outreach<br>6. Work with London-wide and local partners to promote delivery of postnatal contraception. |
| Address the variability of experience that women told us about regarding menopause and menstrual health in Primary care and other healthcare settings | 1. Explore opportunities for neighbourhood-based menopause group sessions for women with more complex menopause symptoms not requiring gynaecology referral? (Cf other group clinics eg CYP asthma)<br>2. Map existing Primary Care women's reproductive health specialists and if applicable consider a designated lead in each PCN or neighbourhood, to provide advice and guidance to colleagues, minimising the need for onward referral<br>3. Explore direct referral to gynaecology services between Brook and UCLH/Royal Free. |
| Improve how we understand and address inequalities in access and outcomes to reproductive healthcare | 1. Support acute and community gynaecology services to improve coding of and analysis of equity data, particularly ethnicity, to inform service equity<br>2. See recommendations in the 'STI' section above regarding improved data analysis in sexual health services. |

| Recommendation | Actions |
| --- | --- |
| Join up services catering to different aspects of reproductive health so women and other people with reproductive health needs get holistic advice, guidance and care about their health | Scope, design and implement a Women's Health Hub model in Camden, by undertaking:<br>1. Activity modelling to understand demand<br>2. Tariff formulation and cross-charging mechanisms between NHS and LA commissioned services<br>3. Designing a triage function<br>4. Considering co-location of different services vs virtual opportunities and identifying an appropriate location if necessary<br>5. Co-design with residents including women from minoritised ethnic communities, trans and non-binary people, disabled and neurodivergent and other underserved communities to ensure the hub is inclusive and trauma informed<br>6. Establish appropriate local governance arrangements for women's health oversight.<br>7. Ensure the model maintains strong links with domestic abuse and sexual violence support organisations, with pathways to specialist support for survivors |

# Conclusion

There are many common themes across our four areas for action. These include:

- Equity and inclusion: Prioritising underserved groups including women, LGBTQ+ residents, our minoritised ethnic communities, disabled people, neurodivergent people and those facing multiple disadvantage.
- Trauma-empathetic practice: Embedding compassionate, person-centred care across all services.
- Resident voice and co-production: Involving residents in shaping education, campaigns and services.
- Data and insight: Using local and national evidence to drive continuous improvement.

The work programme is intended as a roadmap for all partners – across health, education, social care, and the voluntary sector – to work together to create a borough where everyone can thrive in their sexual and reproductive health. It seeks to create more inclusive, equitable, and effective service delivery that reflects the real lives and needs of Camden's residents.

# Appendix - Camden's service offer

| Provider/Service | Service offer | Eligibility/How to access |
|---|---|---|
| Brook – young people's sexual health services | • STI screening<br>• Contraception including LARC<br>• Counselling<br>• Outreach services at key sites; LAC, Youth Centres<br>• RSE in schools/education settings. | • Under 25s. |
| CNWL – all age sexual health services | • Sexual health check ups<br>• Testing and treatment for sexually transmitted infections and HIV<br>• Short-term, long-term, repeat and emergency contraception (including ordering online)<br>• PrEP: Pre-exposure prophylaxis, a medication that protects people who are HIV negative from acquiring HIV<br>• Psychology service<br>• CLASH provides sexual health outreach services for sex workers, homeless people, drug users, Black Asian and Minority Ethnic people (BAME) and men who have sex with men (MSM).<br>• Independent Domestic Sexual Violence Advocates. | • Over 18<br>• Drop in sessions<br>• Appointments can be booked online or via telephone. |

| Provider/Service | Service offer | Eligibility/How to access |
|---|---|---|
| CandiNetwork – HIV Support services for people living with and affected by HIV | • Living Well CIC; providing psychological, psychosocial and behavioural changes services<br>• Positively UK; peer led support, outdoor activities, workshops and benefits support<br>• Bloomsbury Network; peer led wellbeing with a focus on reducing stigma and isolation<br>• YMCA; positive health programme to promote increase activity levels in HIV positive individuals<br>• Terrence Higgins Trust; work and skills training sessions and access to mentors<br>• Food Chain; deliver 'Eating Positively' a bespoke nutritional cooking course. | • Over 18<br>• Self referral<br>• Referral from a professional. |
| SHL London – sexual health e-service | • Online STI self-sampling kits<br>• Contraception (pills and patches)<br>• Condom. | • Open access. |
| Pharmacy and GP locally commissioned services | **Pharmacy**<br>• Emergency Hormonal Contraception (EHC); access to EHC 'the morning after pill' to under 25s<br>• C-card; access to free condoms for under 25s<br>**GP**<br>• Long Acting Reversable Contraception (LARC); IUD/IUS fittings and contraceptive implants. | • Open access to under 25s<br>• Accessed via GP. |

# Appendix

## Commissioning responsibilities for sexual health (UKHSA, 2025)

Sexual health services (SHSs) are commissioned at a local level to meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

Local authorities commission comprehensive open access SHSs (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by integrated care boards (ICBs), and at the national level by NHS England.

Local authorities commission:

- comprehensive SHSs including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- STI testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies
- delivery of HIV pre-exposure prophylaxis (PrEP).

ICBs commission:

- most abortion services
- sterilisation
- vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes
- adult specialist services for people living with HIV (from April 2025).

NHS England commissions:

- contraception provided as an additional service under the GP contract
- 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
- specialist fetal medicine services.

# Acknowledgements

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- Expert input from CNWL and Brook clinicians and service leads, Royal Free London gynaecology and primary care clinicians, St Mungos, The Hepatitis C Trust, Groundswell and Living Well CiC.