

The State of the Nation



Sexually Transmitted Infections in England

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Foreword

We are at a pivotal moment in the response to sexually transmitted infections (STIs) in England.

The choice is clear: either we all step up and take firm action or we sit back and continue to see STIs spiral out of control and the threat of drug resistance increase. Everyone from national government to local community organisations has a part to play in this.

For too long there has been insufficient focus and action centred on STIs and broader sexual health.

With this report we are trying to make a start in rectifying this. This state of the nation report seeks to shine a spotlight on STIs. We do not set out all of the answers – in fact we raise many more questions than we find answers to. But we're aiming to start a conversation and highlight important issues – from inequalities and the communities who are disproportionately affected by STIs, to the need for sufficient funding for sexual health services and the important steps that are now needed to train and support sexual health champions.

This report is timely. The government has committed to drafting a national sexual health and reproductive health strategy. A much needed – and urgently needed – step if we are to tackle the rise in many STIs. With a new government in place we have the opportunity to put STIs and sexual health firmly on the agenda.

We want to see action – we have set out recommendations that we believe are essential if we are to tackle STIs. And we must all be part of the solution, to take action and push for change.

Equally, Terrence Higgins Trust has committed to addressing persistently high rates of STIs in its new organisational strategy for 2020-23. As both Terrence Higgins Trust and BASHH, we are firmly recommitting to working together to tackle STIs.

As we begin a new decade we must ensure that this is the defining moment in turning the tide on STIs. We believe with real commitment from every part of the system we can make real progress on the journey to end STIs in England. Now let's get started.



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Executive Summary

There were 447,694 new diagnoses of sexually transmitted infections (STIs) in England in 2018, against a backdrop of deep funding cuts and demand outstripping availability for sexual health services. Though there have been successes in reducing diagnoses of HIV and genital warts, there have been increases across common STIs including chlamydia and herpes, whilst rates of syphilis and gonorrhoea are soaring. On top of this, new challenges are emerging with rarer STIs, including mycoplasma genitalium (Mgen), shigella and trichomoniasis, as well as the continued threat of antimicrobial resistance (AMR). The clear lack of vision in England for tackling these STIs and the threat they pose, as well as the unwillingness to prioritise this, does little to combat the rising concern.

This report aims to bring together the current knowledge on STIs in England - looking at the trends in STIs, and who they are affecting. Why we are seeing these trends, and why some groups are more affected than others is key to addressing them. In doing this, the report will focus on behaviours that may be associated with transmission, as well as structural issues such as inequalities, barriers to access, visibility and awareness. This will be considered within the political context of changes to commissioning structures and continuing brutal cuts to public health funding. In summarising what is known, the report will also identify the gaps in knowledge. This report aims to make recommendations for improving the state of the nation's sexual health in relation to STIs.

The sector-wide calls for a national sexual health strategy have finally been answered, with the government in 2019 committing to deliver this. It is now essential that the strategy addresses the issues that are set out in this report and uses it as a starting point to address the poor state of the nation's sexual health.

Inequalities

The burden of STIs is not evenly distributed with some communities disproportionately affected. Inequalities are two-fold: structural and data-based. Structural inequalities include the impact of poverty - with individuals living in poverty experiencing higher rates of STIs. However, there is also much we don't know about the impact of structural inequalities on sexual health. There is little research looking at the impact of discrimination, including racism, homophobia and transphobia, on the trends seen in STIs.

The research on inequalities is largely lacking. This is evident within the data gaps identified. This report found little evidence or data looking at men who have sex with men (MSM) who don't identify as gay or bisexual, as well as trans and non-binary, including gender diverse, people, and sex workers. There is also a lack of evidence on specific ethnic minority communities - with too much data using the unhelpful 'BAME' and "other" groupings. An intersectional approach was missing from the evidence, which focuses often on one specific group, thus failing to look at the experience of multiple marginalised identities. Ultimately, the lack of data in these different areas erases the experience of anyone in these groups, and the voices of people affected by poor sexual health will not be heard without a better understanding in these areas. The limited information on inequalities does little to inform a holistic approach to STIs and needs resolving if we are to tackle STIs.

National Vision and Priority

In order to overcome the increasing rates we are seeing in many STIs, and seek a solution to the under-funded and over-burdened sexual health services, the commitment to a national sexual health strategy is vital. However, there has been a complete lack of recent national vision on sexual health and STIs have not been seen as a priority. In autumn 2019, the UK Government finally committed to a sexual health and reproductive health strategy.

The current indicators in the Public Health Outcomes Framework (PHOF) that exist to monitor progress in STIs are not good enough, and despite the introduction of a new overall indicator, there is a risk that it will mask trends in specific STIs. We also urgently need strengthened evidence on the return on investment of STI prevention interventions to support the case for such interventions.

Behaviours

Behaviours associated with STI risk include condomless sex, increased number of sexual partners, and concurrent sexual partners. In addition, chemsex and the use of dating apps are changing behaviours and associated risk. However, surprisingly, there is limited up-to-date research on behaviours – even in MSM who have seen the biggest volume of research to date. There is also a stark lack of research on what is driving behaviours.

Advances in HIV have come a long way to improve the lives of people living with HIV and increase HIV prevention options. PrEP has undoubtedly contributed to the reduction in transmissions of HIV, and provides an opportunity to engage individuals at higher risk of STIs into sexual health services. The message of U=U has emphasised that people living with HIV with an undetectable viral load can't pass it on. However, HIV and STIs are still viewed in silo. This must change to ensure that the sexual health of people living with HIV does not fall through the gaps.

A Lack of Prevention Options

Though we are seeing these changes in behaviours, the current STI prevention tools available are simply not keeping up. For prevention of STIs, we are overly reliant on the well flogged combination of condoms and regular testing. Access to condoms has been impacted by cuts to prevention services and a lack of public engagement in condom use has been compounded by their perception. For instance, with some people thinking of condoms as a way to prevent pregnancy as opposed to STIs as well. Testing is key in preventing onward transmissions of STIs and for the initiation of treatment to prevent any complications. Partner notification has been impacted by reductions in the sexual health workforce and changing behaviours, such as anonymous sex, making partner notification more challenging.

Clear success stories seen in the impact of the HPV vaccine and PrEP for HIV are examples of additional and acceptable prevention methods. Learning from these successes could enable new ground to be covered in the world of STIs.

The Need for Sustainable Sexual Health Services

What is clear from the research is that the political context has had a major impact on sexual health in England. Both the Health and Social Care Act (2013) and public health funding resulted in seismic shifts in the delivery of sexual health services. The changes in commissioning structures have left systems fragmented, complex procurement processes in place and barriers to long term planning. Within the current response there is a move towards co-commissioning in an attempt to rectify this. What this will look like is currently unclear.

Public health funding cuts have been brutal, resulting in sexual health budgets being cut by a quarter. A recent Government promise of a 1% budget increase in public health is nowhere near the radical uplift needed to support strained sexual health services. These cuts gamble with the sexual health of the nation, risking widening inequalities as well as failing to provide accessible and holistic services. Cuts have also impacted the workforce, for example by preventing staff training and development.

While demand rises on sexual health services, they have been left strained and unsupported by these budget cuts. There is a need for improved investment and the proposed co-commissioning needs to urgently improve integrated working across services.

Access

The changing commissioning structures and funding cuts have been highlighted as contextual issues impacting the sexual health of the nation. Where this is strikingly apparent is in access to sexual health services. Public health funding cuts have compromised service user access by facilitating service closures and staff cuts, both of which have contributed to longer waiting times and difficulty accessing appointments, as well as impacting on key preventative services such as outreach with communities.

Online access to self-sampling test kits enable people who are able to use this platform to carry out STI tests in the comfort of their own home, however these do not work for everyone. Local pharmacies have become another player in some parts of the country, through the provision of tier 1 and tier 2 sexual health services. Although innovative and, potentially, outstanding service provision has been supported by these outlets as well as online services, it is critical to recognise that both of these are not substitutes to sexual health clinics, and access to face-to-face services needs to be supported.

The benefit of community organisations can be seen in the response to HIV. For STIs and HIV, such organisations have been able to reach groups that may not usually engage with services, providing testing and advice, carrying out research, and enabling the co-production of services.

Awareness and Information

Compulsory relationships and sex education (RSE) is a welcome step to ensuring young people's awareness of STIs and safer sex practices, and schools must be fully funded to ensure that it is delivered at a high quality across the country.

However, key groups such as older people and migrants may have already missed out on this education. Myths and misconceptions among older people can contribute to STI transmissions. Considering that older people are also often absent from health promotion messaging these risks are exacerbated. Health promotion messaging should also be inclusive of people who have low levels of either health literacy or English literacy.

Visibility and Stigma

The response to HIV has been successful in helping to improve the lives of people living with HIV. The voices of people living with HIV have been clear, pushing for change, and are seen in the research, co-production of services, and in combating HIV stigma. In contrast, sexual health champions are few and far between. The invisible voices of people affected by poor sexual health leaves the fight against STIs without clear community advocates.

Safer sex practices, including the use of condoms, dental dams, and lube, are often missing in mass media and porn, with missed opportunities to encourage these behaviours on a wider scale. Mass media could be a way to help to encourage norms that are related to safer sex behaviours and tackle misinformation. Increasing visibility, therefore, has a key role to play in tackling the trends seen in STIs. The lack of voices, champions and visibility of sexual health in mass media runs the risk of perpetuating stigmatising attitudes.

The Bigger Picture

STIs occur within a wider context. Even one STI may be related to further co-infections with other STIs. Beyond this, HIV, STIs and sexual health should no longer be considered in silo. As shown by the complications untreated STIs can cause, reproductive and sexual health are also clearly intertwined. This can also relate more broadly to wider health, for example mental health, and this relationship should not be overlooked. The wider social determinants impacting sexual health, and in particular relating to STIs, are clear. Inequalities, and the economic and political context all have an effect on STIs.

Clearly, a holistic approach is vital for ensuring future planning and strategies regarding STIs and sexual health.

Conclusion

This report is vital if we're to ever tackle unacceptably high rates of STIs as it provides a stocktake of the current situation of STIs in England, as well as highlighting the stark gaps in the current evidence available. It is evident that although progress is being made in some areas, such as HPV and genital warts, there is still a long way to go if the current increasing trends in STIs are to be, at the very least, managed, and, ultimately, reversed.

Access, awareness, choice, and visibility of sexual health are all key components to keeping up with the changes in STIs, however, there are clear barriers and glaring gaps among each of these. A large part of being successful in this progress is producing richer data and evidence in order to understand the full picture. Without this, only surface level solutions will be proposed, when it is evident that real change must target the roots of the problem. The government has a critical role to play in supporting this change through recognising the damaging impact of funding cuts and silo working. The upcoming national sexual health and reproductive health strategy will be key and has the potential to address many of the recommendations in this report.

Despite the clear challenges we face, we now have the opportunity to come together and realise the potential improvements that can be made and finally address the trends seen in STIs. We will be working to implement the recommendations of this report as part of both Terrence Higgins Trust and BASHH's work on sexual health. We hope you will join us.

Purpose of this Report

When it comes to sexual health, in some cases England has been leading the way – we have made huge strides in reducing new HIV transmissions and the implementation of the girls HPV vaccination programme has greatly reduced cases of genital warts. But, on the flip side, this country is seeing rates of gonorrhoea skyrocket, syphilis diagnoses are the highest since World War II, and drug resistant strains of STIs are a very real threat to the nation's sexual health. The long term implications and disparate experience of STIs highlight the need for urgent action.

Despite this, there is a demonstrable gap in national ambition and vision on eradicating STIs, as well as an incomplete evidence base to underpin decisions on how to respond. In order to overcome the current trends seen in STIs, there needs to be an understanding of what is happening, where it is happening, who it is happening to and why.

This report will review the current data and evidence around STIs, examine the prevention interventions and barriers that exist to tackle them in the current political and clinical context, and will also highlight the current gaps in knowledge and understanding. We do not seek to set out all of the answers. Rather, we hope that this report will shine a spotlight on a neglected health issue, that it will ignite conversations - and importantly action - to address this. The report sets out recommendations that we believe are needed to tackle STIs and address any gaps in evidence.

The scope of this report is focused on England only. This does not deflect from the need for action in other nations in the UK – each of which has its own unique sexual health and STI challenges, and different health structures and decision making processes.

We focus down on STIs rather than broader sexual health. However, throughout the report we are clear that STIs, HIV and broader determinants of sexual health are inextricably entwined.

In this report we focus mainly on STIs other than HIV. Terrence Higgins Trust and NAT (National AIDS Trust) have established the national HIV Commission, an independent process to find ambitious and achievable ways to end new HIV transmissions and HIV-attributed deaths in England by 2030. The HIV Commission will publish its recommendations in spring 2020. As the Commission will set out the future actions needed to tackle new HIV transmissions, we do not seek to duplicate its work in this report. However, we are clear that there are many lessons that can be learnt from the response to HIV that may benefit how we respond to other STIs.

The British Association for Sexual Health and HIV (BASHH) is the leading medical charity promoting the study and practise of preventing, treating and managing sexually transmitted infections, HIV and other sexual health problems, ensuring high standards of governance in provision of Sexual Health and HIV care. Terrence Higgins Trust is the leading HIV and sexual health charity in the UK and aims to address sexual health inequalities, end new HIV transmissions, and support people living with HIV to live well. Both BASHH and Terrence Higgins Trust are committed to working together to push for action to tackle STIs and poor sexual health in the UK.

An Introduction to Sexually Transmitted Infections

STIs can be transmitted through sex, sharing sex toys or genital contact¹. They can therefore affect multiple body sites including genitals, rectum, anus, mouth and throat. An additional barrier to tackling STIs is that many can be asymptomatic with individuals having no idea that they have an infection until they are tested positive.

Whilst we often talk about “STIs” as a collective, it is important to understand the similarities and differences between the range of individual pathogens that can cause an STI.

Some STIs including Human Immunodeficiency Virus (HIV), Human Papillomavirus (HPV) (the cause of genital warts), and herpes are caused by viruses. Others are bacterial including syphilis, gonorrhoea, chlamydia, shigella, and *Mycoplasma genitalium* (Mgen). An STI may even be caused by a protozoa as is the case with trichomoniasis.

The epidemiology of STIs is never static. As well as the more common STIs in England, there are also newly emerging and rarer STIs. Mgen is not a new STI but it is only recently that we have had a test to diagnose it. In addition, shigella is a gastrointestinal infection which can also be sexually transmitted and this route of transmission is becoming more common.

Prevention of STIs

Understanding routes of transmission is important when it comes to preventing STIs. Whilst condoms and dental dams are still the most effective methods for preventing the transmission of most STIs through sex, they may not prevent the transmission of some STIs via skin to skin genital contact. In the case of HIV, we now have a combination of effective prevention interventions which include condoms, pre-exposure prophylaxis (PrEP), and testing, as well as treatment as prevention – when someone living with HIV is on effective medication they cannot pass HIV on.

Vaccines also have a key role to play in preventing STIs. HPV is a group of viruses – some strains of which can cause genital warts or potentially fatal cancers. The HPV vaccine was introduced into the schools immunisation programme in England in 2008, initially targeting school-aged girls, though now the programme has been extended to also include boys aged 12 to 13 years old. It has been associated with a decrease in cases of genital warts – particularly in young women². Vaccines are also in development for chlamydia³, a strain of herpes⁴ and vaccines focused on meningitis have also been found to have a preventative impact on gonorrhoea⁵. However, there is a long way to go before these vaccines are fully effective and commercially available.

Our response to dealing with STIs is ever evolving. For instance, concerns around the transmission of pharyngeal gonorrhoea through kissing⁶ have prompted new methods

1 FPA (2019) STIs Overview, available online: <https://www.sexwise.fpa.org.uk/stis/stis-overview>, (date accessed: 19/11/2019).

2 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019).

3 NHS (2019) Promising Initial Results Raises Hopes for Chlamydia Vaccine, available online: <https://www.nhs.uk/news/medication/promising-initial-results-raise-hopes-chlamydia-vaccine/>, (date accessed: 19/11/2019).

4 Awasthi, S. et al. (2019) Immunization with nucleoside-modified mRNA encoding herpes glycoproteins C, D, and E protects against genital herpes, *Science Immunology*, 4(39).

5 Edwards, J.L. et al. (2018) *Neisseria Gonorrhoeae* Vaccine Development: Hope on the Horizon?, *Current Opinion in Infectious Diseases*, 31(3), pp. 246-250.

6 Chow, E.P.F. et al. (2019) Kissing May be an Important and Neglected Risk Factor for Oropharyngeal Gonorrhoea: a Cross-sectional Study in Men who have Sex with Men, *Sexually Transmitted Infections*, 95(7), pp.516-521.

of prevention to be explored, including the use of mouthwash. This may help inhibit pharyngeal gonorrhoea⁷, however this is still in the early stages of research.

Testing for STIs is a key intervention. Not only does it ensure that an individual can get prompt diagnosis and treatment, but it also helps to prevent onward transmission of undiagnosed STIs. Some STIs can be diagnosed visually (e.g. genital warts) whilst others are tested via genital swabs or samples of blood, urine or saliva.

Treatment for bacterial STIs often involves a course of antibiotics which should clear the infection. Whilst most STIs are cleared by treatment, exceptions include HIV which remains a life-long condition (but with effective treatment people living with HIV have a normal life expectancy) and herpes which remains in the body for life (but is often dormant and asymptomatic).

The prevention, diagnosis and treatment of STIs is imperative in order to stem rising diagnoses, ensure that onward transmission is halted, and prevent the development of any complications related to untreated STIs

Whether bacterial or viral, if left untreated, many STIs can have complications or long term consequences including infertility or pelvic inflammatory disorder (PID). If left untreated, syphilis can eventually cause damage to the heart, brain, bones or nervous system. Though pregnant women are offered tests for syphilis, cases of congenital syphilis have also been recently reported^{8,9} in England.

The prevention, diagnosis and treatment of STIs is imperative in order to stem rising diagnoses, ensure that onward transmission is halted, and prevent the development of any complications related to untreated STIs.

7 Chow, E.P.F. et al. (2017) Antiseptic Mouthwash Against Pharyngeal Neisseria Gonorrhoeae: a Randomised Control Trial and an In Vitro Study, *Sexually Transmitted Infections*, 93(2), pp. 88-93.

8 Williams, O. (2019) Written Evidence from the British Association for Sexual Health and HIV (BASHH), available online: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/96748.html>, (date accessed: 19/11/2019).

9 Furegato, M. et al. (2017) Factors associated with Four Atypical Cases of Congenital Syphilis in England, 2016 to 2017: an Ecological Analysis, *Euro Surveillance*, 22(49), <https://doi.org/10.2807/1560-7917.ES.2017.22.49.17-00750>.

The Current Trends in STIs¹⁰

In 2018, there was just under half a million (447,694) diagnoses of STIs in England with a 5% increase in diagnoses seen from 2017. These statistics are stark enough, but they also mask significant increases in some STIs, and the progress made in others.



INCREASING

CHLAMYDIA

SYPHILIS

HERPES

GONORRHOEA

SHIGELLA



STABLE

GENITAL HERPES



DECREASING

HIV

GENITAL WARTS

The most commonly seen STI in England is chlamydia with nearly 220,000¹¹ diagnoses in 2018 – nearly half of all STIs diagnosed that year. Chlamydia has increased 6% between 2017 and 2018 and 15% since 2009.

As well as chlamydia, a number of other STIs are on the rise. Diagnoses of gonorrhoea have increased by 26% between 2017 and 2018 (56,259 diagnoses in 2018) and have rocketed by 249% in the past ten years. A similar trend is seen with syphilis with 7541 cases in 2018 – a 5% rise from 2017 but an increase of 165% over the past decade. Syphilis, an infection that many still think is a “disease of history” is currently at its highest levels since World War II.

Genital herpes has increased by 23% in the past ten years. After a steady increase between 2009-2013, the trend has largely plateaued for the last five years, with a 3% rise seen between 2017 and 2018. Trichomoniasis and shigella are less common STIs in England, however since 2017 there have been 8% and 91% increases in new diagnoses respectively¹². Since surveillance on Mgen began in 2015 diagnoses have increased 2171% with 1,794 cases in 2018. This staggering rise is likely to be due to an increase in testing since a test to specifically diagnose Mgen has only recently been available¹³.

5% increase in diagnoses seen from 2017

In England, we are seeing some success. Genital warts are on the decrease with a 3% fall since 2017 and a 27% reduction since 2009¹⁴. New HIV diagnoses are also on the decline. Public Health England data for 2018 show a continued fall in new HIV diagnoses, although the steep decline we have seen over the past few years is now starting to plateau. In 2018, there were just over 4,000 new HIV diagnoses (4,044) in England – a 6% drop from 2017.

A further development saw three cases of extensively drug resistant gonorrhoea (XDR-DG) identified in the UK in 2018

¹⁰ The data in this section has been taken from the Public Health England (2019) STI report and annual data tables, all available here: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>

¹¹ 218,095 cases

¹² Public Health England (2019) Table 4: All STI Diagnoses and Services by Gender and Sexual Risk, 2014-2018, available online: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019).

¹³ Public Health England (2019) Table 4: All STI Diagnoses and Services by Gender and Sexual Risk, 2014-2018, available online: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019).

¹⁴ Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019).

Emerging STIs and the Threat of Drug Resistance

The range of STIs we see in England continues to change and existing STIs evolve. Whilst we have seen the re-emergence of older infections including syphilis, we are also seeing emerging STIs, as well as infections that are finding a new lease of life through sexual transmission routes.

Of major national, and international concern, is the emergence of anti-microbial resistance which was described by Dame Professor Sally Davies, the former Chief Medical Officer for England as "a very real threat"¹⁵. Worryingly, evidence shows drug-resistance is now threatening the effective treatment of a number of STIs. AMR in STIs is not just an issue of national priority but has global implications for sexual health.

The first line of the most recent Public Health England report on drug-resistant gonorrhoea is stark: "the effectiveness of first-line treatment for gonorrhoea continues to be threatened by antimicrobial resistance"¹⁶. The report shows that resistance to individual front-line treatments for gonorrhoea is increasing. A further development saw three cases of extensively drug resistant gonorrhoea (XDR-DG) identified in the UK in 2018. These cases were resistant to three frontline antibiotics used to treat gonorrhoea. In response to this, Public Health England introduced enhanced surveillance of drug resistant gonorrhoea at sexual health services. However, BASHH remain concerned that the lack of access to antimicrobial sensitivity testing of gonorrhoea may result in some sexual health clinics unable to treat gonorrhoea cases by their drug sensitivity profile¹⁷.

Mycoplasma genitalium (Mgen) is a sexually transmitted bacterium that was first isolated in 1981¹⁸ with a test only recently being introduced in England and Mgen only included in Public Health England STI data

since 2015. Testing for Mgen is not currently consistently available in sexual health clinics in England and so data is likely to hugely underestimate the prevalence of this STI. In 2018, a BASHH survey of public health commissioners found that only 10% were planning to provide funding for Mgen testing¹⁹. Prior to the introduction of a test, Mgen has traditionally been mis-diagnosed and treated as chlamydia – fuelling concerns of the emergence and spread of anti-microbial resistance. 72% of BASHH experts said that if current practices do not change, Mgen will become a superbug, resistant to 1st and 2nd line antibiotics, within a decade²⁰. The Public Health England Health Matters: Preventing STIs resource estimates that "AMR *M. genitalium* is thought to affect 1% to 2% of the general population, and anywhere between 4% and 38% of people who attend STI clinics"²¹. BASHH released new guidelines in 2018 which set out best practice in testing and treatment of Mgen²². The parliamentary Health and Social Care Committee recommended in 2019 that all sexual health clinics should be funded to provide a full range of STI testing, including for Mgen²³.

15 Davies, S.C. et al. (2011) 'Annual Report of the Chief Medical Officer Volume 2: Infections and the Rise of Antimicrobial Resistance, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138331/CMO_Annual_Report_Volume_2_2011.pdf, (date accessed: 19/11/2019).

16 Public Health England (2018) Surveillance of Antimicrobial Resistance in *Neisseria Gonorrhoeae* in England and Wales, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746261/GRASP_2017_report.pdf?_ga=2.89470683.1558347328.1566820089-1377398478.1488979946, (date accessed: 19/11/2019).

17 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019)

18 Soni, S. et al. (2018) 2018 BASHH National Guideline for the Management of Infection with *Mycoplasma Genitalium*, available online: https://www.bashhguidelines.org/media/1182/bashh-mgen-guideline-2018_draft-for-consultation.pdf, (date accessed: 19/11/2019).

19 BASHH and BHIVA (2019) Written Evidence from the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA), available online: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/90616.html>, (date accessed: 19/11/2019).

20 BASHH and BHIVA (2019) Written Evidence from the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA), available online: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/90616.html>, (date accessed: 19/11/2019).

21 Public Health England (2019) Health Matters: Preventing STIs, available online: <https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis>, (date accessed: 19/11/2019)

22 Soni, S. et al. (2018) 2018 BASHH National Guideline for the Management of Infection with *Mycoplasma Genitalium*, available online: https://www.bashhguidelines.org/media/1182/bashh-mgen-guideline-2018_draft-for-consultation.pdf, (date accessed: 19/11/2019).

23 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019)

Another emerging STI is shigella, a gastrointestinal infection that has traditionally been associated with travel. However, more recently, two strains of shigella (*S. sonnei* and *S. flexneri*) have been associated with sexual transmission. Although numbers are currently low – there were 63 diagnoses in England in 2018 - this is a 91% increase from 2017 and is up 163% since 2015. MSM are disproportionately affected by sexually transmitted shigella (68% of diagnoses in 2018)²⁴. In 2019, Public Health England shared data on a concerning cluster of cases of multi-drug resistant shigella that was likely to be associated with MSM²⁵.

RECOMMENDATION: Local authority sexual health commissioners must ensure funding is available to enable all sexual health services to provide the most accurate diagnostic tests for all sexually transmitted infections including trichomoniasis and Mgen, in line with national guidelines.

RECOMMENDATION: Treatment, guidelines and surveillance measures already in place for AMR should continue for STIs across all agencies that deliver care, and be extended for STIs that may pose a newer threat to AMR, for example Mgen.

Geographical Variations in STI Trends²⁶



Diagnoses of STIs are not proportionately distributed across England with differences seen between geographic areas. London consistently has the highest diagnosis rate compared to all other regions for all

of the most common STIs and sees a higher proportion of STIs in MSM. The second highest rate is seen in the North West whilst the East of England sees the lowest overall rate of STIs.

London consistently has the highest diagnosis rate compared to all other regions for all of the most common STIs

Some areas are seeing above average rises in particular STIs. For instance, in South East England, herpes and syphilis are showing above average increases, and in the East Midlands, North West, East of England and Yorkshire and the Humber this is the case for gonorrhoea diagnoses.

The same is true for decreases in some STIs. South East England is seeing a slower rate of decline in genital warts than the rest of England. London has seen lower increases in gonorrhoea diagnoses than the rest of England – and the number of diagnoses of syphilis in MSM in London is plateauing. Overall, the North East has seen greater decreases in STIs in young people than the rest of England.

The proportion of STIs diagnosed in different populations differs geographically. In some areas including the South East, East of England, South West and Midlands, a lower proportion of new STI diagnoses are seen in MSM than the national average.

²⁴ Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018. Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019).

²⁵ Public Health England (2019) Multi-drug Resistant Shigella *Sonnei* Cluster (CTX-M-27) probably Associated with MSM: Information for Health Care Professionals, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769163/SHGLL-SONN_2018275.pdf?_ga=2.81665367.1558347328.1566820089-1377398478.1488979946, (date accessed: 19/11/2019)

²⁶ All of the data in this section is from PHE data tables available here: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, and the Public Health England spotlight reports for each region.

Key Populations Affected by STIs



Although STIs can affect anyone, there are certain groups that experience disproportionate rates of STIs. These groups include young people, people living with HIV, MSM and specific ethnic minority communities.

Men who have sex with men are disproportionately affected by both syphilis and gonorrhoea. 75% of all new diagnoses of syphilis and nearly half (47%) of gonorrhoea diagnoses in 2018 were in MSM²⁷. Further to this, 43% of new HIV diagnoses in 2018 were in this group²⁸.

75% of all new diagnoses of syphilis and nearly half (47%) of gonorrhoea diagnoses in 2018 were in MSM



Individuals from ethnic minority communities²⁹ account for 1 in every 5 (20%) of all STI diagnoses³⁰. A common theme in this report is that we must delve deeper into the data and not make general assumptions if we are to have any hope of supporting the sexual health of individuals and communities. For instance, there are obviously differences in STI rates by ethnicity with Black Caribbean individuals and Black non-Caribbean/non-African individuals generally seeing the highest rates of new diagnoses among many STIs, particularly gonorrhoea³¹. Asian and Asian British individuals have the lowest diagnoses rate at half that of the general population³².

Understanding intersectionality in the data is important. But as we discuss later there is often gaps in the data and research.

People living with HIV accounted for 3% of all STI diagnoses in 2017³³ but are

disproportionately affected with population rates much higher than in people who are not living with HIV. Gonorrhoea and syphilis are the most common STIs among people living with HIV. MSM living with HIV accounted for 88% of STI diagnoses in people living with HIV³⁴. Of MSM, men from Latin American and Caribbean ethnicities are most likely to have co-infection of HIV and one of the five main STIs³⁵.

Individuals from ethnic minority communities²⁹ account for 1 in every 5 (20%) of all STI diagnoses

Although rates of STIs among older people remain low, increases are being recorded in this population, particularly of gonorrhoea. In 2018, there was an 18% increase in new STI diagnoses among older men (45-64) and a 4% increase among older women since 2014³⁶.

27 Public Health England (2019) Table 2: New STI Diagnoses and Rates by Gender, Sexual Risk, Age Group, and Ethnic Group, 2014 to 2018, available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019)

28 Public Health England (2019) Trends in New HIV Diagnoses and in People Receiving HIV-related Care in the United Kingdom: Data to the end of 2018, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/835084/hpr3119_hiv18-v2.pdf, (date accessed: 28/11/2019)

29 The problematic nature of this term will be discussed in the next section, however has been used here as this is what the data provided.

30 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019)

31 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019)

32 Public Health England (2019) Table 2: New STI Diagnoses and Rates by Gender, Sexual Risk, Age Group, and Ethnic Group, 2014 to 2018, available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019)

33 PHE Data Request: GUMCAD and HARS data

34 PHE Data Request: GUMCAD and HARS data

35 Public Health England (2019) The Sexual Health of GBMSM and BAME Populations in England, available online at: https://www.hivpreventionengland.org.uk/wp-content/uploads/2019/04/STI-trends-in-key-populations_HM.pdf, (date accessed: 03/12/2019)

36 Public Health England (2019) Table 2: New STI Diagnoses and Rates by Gender, Sexual Risk, Age Group, and Ethnic Group, 2014 to 2018, available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019)

37 Public Health England (2019) Table 2: New STI Diagnoses and Rates by Gender, Sexual Risk, Age Group, and Ethnic Group, 2014 to 2018, available at: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019)

38 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019)

For older people over the age of 65, both men and women experienced a 23% increase in new STI diagnoses over this time period³⁷. Young people (15-24 year olds) represented nearly half (48%) of all new STI diagnoses in 2018³⁸. This group is disproportionately affected by chlamydia - seeing 61% of all chlamydia diagnoses and nearly half (43%) of genital warts diagnoses. Young people also saw roughly a third of all gonorrhoea diagnoses (36%), and herpes diagnoses (39%), as well as 14% of all syphilis diagnoses³⁹.

Young people (15-24 year olds) represented nearly half (48%) of all new STI diagnoses in 2018³⁸

Public Health England's 2018 report on STIs found that "young women are more likely to be diagnosed with an STI than their male counterparts"⁴⁰. Of all young people diagnosed with an STI in 2018, 64% of the men and more than 99% of the women identified as heterosexual⁴¹.

As we will explore later in the report, there are some communities that we don't know enough about in regards to STIs. For instance, globally transgender people are thought to be at an increased risk of HIV⁴², however there is limited data on the rates of other STIs among this community in England.

39 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019).

40 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf, (date accessed: 19/11/2019).

41 Public Health England (2019) Table 2: New STI Diagnoses and Rates by Gender, Sexual Risk, Age Group, and Ethnic Group, 2014 to 2018, available online: <https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables>, (date accessed: 19/11/2019)

42 <https://www.who.int/hiv/topics/transgender/en/>

Inequalities, Inequities and Erasure

Bearing the Weight

As seen in the previous section, the burden of STIs is not evenly distributed. MSM, individuals from some ethnic minority communities and people living with HIV are among those disproportionately impacted by higher rates of STIs. We will see later on how behaviours and barriers to accessing sexual health services can be associated with increased risk of STIs. However, it is important to understand the structural context in which these issues take place and how they might impact higher STI rates, drive behaviours, and restrict access.

Although these disproportionate STI trends are evident, there is little research establishing the effect that the wider structural context can have on STIs. We can see clearly that people from marginalised groups, who often experience discrimination, are bearing a disproportionate burden of STIs. However, an insufficient focus has been given to connect the dots and fully understand the drivers of the inequality seen in the STI burden in England.

What is the impact, for example, of racism? Of homophobia? Of transphobia? There is only piecemeal and sporadic work in this area. Why is it that individuals of some ethnic minority communities remain at a disproportionate risk of STIs? And why are there no systematic strategies and programmes to understand and overcome this?

The high rates of syphilis and gonorrhoea among MSM are taking place within the context of a society which assumes heteronormativity. And yet, when looking for explanations of these trends, the focus of evidence is on behaviours, with little research on the impact of, for instance, homophobia. It is imperative to learn from past mistakes seen

in the persecutory attitudes of the reaction to AIDS in the 1980s.

The experience of multiple marginalised identities also increases the burden of inequalities in STIs. Gay and bisexual men living with HIV, especially those from Black Caribbean, African and 'other' communities, experience a disproportionate rate of STIs⁴³. However, there is minimal research taking into account the intersectional experience of structural inequalities in regards to STIs.

What is the impact, for example, of racism? Of homophobia? Of transphobia?

Globally, transgender people face higher rates of HIV with risk of transmission up to 12 times greater than the general population⁴⁴. We do not know about STI rates in trans and non-binary, including gender diverse, people in England as this data is not available. As discussed below, more data is needed on this. However, it is also imperative to understand how the sexual health of trans and non-binary, including gender diverse, people is impacted by the context of cisnormativity and transphobia apparent within England. The sexual health sector should be working with trans organisations and communities to co-produce research and data on the sexual health of trans and non-binary, including gender-diverse, people to better understand their experience.

Although we have some data on the inequalities experienced by communities at higher risk of STIs, there is little understanding of the context these trends occur in and the relationships and overlap between these inequalities. There is a dire need for an intersectional approach in the research in order to inform the approach to tackling STIs.

43 Bailey M.M. (no date) The Impact of Intersectional Stigma on the Sexual Health of Black Gay Men, available online: http://sites.nationalacademies.org/cs/groups/dbassite/documents/webpage/DBASSE_191475.PDF (Accessed 07/10/19)

44 UNAIDS (2019) Communities at the Centre: Global AIDS Update, available at: https://www.unaids.org/sites/default/files/media_asset/2019-global-AIDS-update_en.pdf, (date accessed: 19/11/2019)

RECOMMENDATION: For too long, the inequalities that exist in regards to the burden of STIs have been ignored. Charities, community groups, sexual health services, commissioners and policy makers must now acknowledge these inequalities and no longer ignore their existence.

RECOMMENDATION: In the face of such stark inequalities, the lack of research into the structural drivers of STIs in communities who face disproportionate burdens of STIs is unacceptable. Increased focus and funding must be made available to researchers, working alongside affected communities, to fill this evidence gap.

RECOMMENDATION: Now is the time for action. The Department for Health and Social Care, working with Public Health England, local authority commissioners and affected communities, must take affirmative action to tackle these inequalities, including through the design and delivery of tailored services and interventions.

Hidden Costs

There is an evident link between deprivation and poor sexual health, with the most deprived areas of England experiencing the highest rates of STIs⁴⁵.

There is a lack of information on the exact impact living in poverty has on restricting access to sexual health services. We can currently only make assumptions that poverty may act across multiple levels to encourage poor sexual health outcomes; through restricting access to services or primary prevention methods and by diminishing the power, autonomy and efficacy an individual has to negotiate safer and consensual sex.

Although sexual health services are publicly funded, there are still costs associated with the ability of individuals to access them. These costs can be incurred generally through time taken off work, and the loss of productivity⁴⁶. There is no research looking at the impact of

this on people living in deprivation, though we can assume this may potentially have an impact through the loss of critical working hours or for sick days taken to attend a sexual health clinic.

One piece of research using the Natsal-3 survey highlighted the potential impact of poverty. It found higher prevalence of chlamydia among women living in deprived areas despite testing rates not being any higher⁴⁷.

Issues of poverty may also affect some more than others, for example 1 in 3 people living with HIV are living⁴⁸ in poverty. People living with HIV already experience barriers to health services⁴⁹ and there is a complex, but little understood, relationship between HIV and poverty.

It is clear that intersectionality is always important. One study found nearly half (47%) of Black British people lived in the most deprived areas of England, with only 4% living in the least deprived areas⁵⁰. Both socioeconomic circumstance and ethnicity were found to be an important factor in the increased rates of STIs among people of Black Caribbean and non-Caribbean/non-African Black ethnicities in England, although more research is needed to understand more fully the interplay^{51,52,53}.

45 Davies, S.C. (2015) Annual Report of the Chief Medical Officer 2015, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/654806/CMO_baby_boomers_annual_report_2015.pdf, (date accessed: 19/11/2019).

46 FPA (2015) Unprotected Nation 2015, available online: <https://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf>, (date accessed: 19/11/2019).

47 Woodhall, S.C. et al. (2015) Is Chlamydia Screening and Testing in Britain Reaching Young Adults at risk of Infection? Findings from the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *Sexually Transmitted Infections*, 0, pp.1-10.

48 Positive Voices (2018) Talking About HIV and Our Needs, available online: https://img1.wsimg.com/blobby/go/db9f6878-0f44-42a6-b528-581039772168/downloads/1csbtcptn_723688.pdf, (date accessed: 19/11/2019).

49 Positive Voices (2018) Talking About HIV and Our Needs, available online: https://img1.wsimg.com/blobby/go/db9f6878-0f44-42a6-b528-581039772168/downloads/1csbtcptn_723688.pdf, (date accessed: 19/11/2019).

50 Furegato M, et al (2016), Examining the Role of Socioeconomic Deprivation in Ethnic Differences in Sexually Transmitted Infection Diagnosis Rates in England: Evidence from Surveillance Data. *Epidemiology and Infection*, 144(15), pp.3253-3262.

Caribbean Sexual Health Clinic Attendees in England: Evidence from Cross-Sectional Bio-Behavioural Surveys, *BMC Health Services Research*, 19(668).

SexualHealthPolicyNW_ACCESSIBLE.pdf, (date accessed: 19/11/2019).

51 Wyal, S. et al. (2018) Understanding the Burden of Bacterial Sexually Transmitted Infections and Trichomonas Vaginalis among Black Caribbean's in the United Kingdom: Findings from a Systematic Review, *PLoS One*, 13(12), doi: 10.1371/journal.pone.0208315.

52 Aicken, C.R.H. (2019) Pathways to, and Use of, Sexual Healthcare among Black Caribbean Sexual Health Clinic Attendees in England: Evidence from Cross-Sectional Bio-Behavioural Surveys, *BMC Health Services Research*, 19(668).

53 Furegato M, et al (2016), Examining the Role of Socioeconomic Deprivation in Ethnic Differences in Sexually Transmitted Infection Diagnosis Rates in England: Evidence from Surveillance Data. *Epidemiology and Infection*, 144(15), pp.3253-3262.

People who are homeless can experience higher rates of STIs⁵⁴. However, there is a lack of understanding of how homelessness can increase difficulties in accessing sexual health services, and the links with increased sexual risk behaviours. Considering homelessness is rising in England, increasing by 3% in 2018 from 2017⁵⁵, and the multitude of forms it can take from rough sleeping to statutory homelessness⁵⁶, the group of people this can affect is only getting bigger and more varied. It is also not clear whether the current research on STIs refers to all forms of homelessness or one form in particular. Action needs to be taken to ensure adequate provision of sexual health services and prevention efforts for this group.

RECOMMENDATION: The response to STIs to date has insufficiently examined the link between STI risk and wider determinants of sexual ill-health. The Government's new sexual health and reproductive health strategy must have addressing inequality at its centre, and should include actions to understand and tackle the wider socioeconomic determinants that may play a role in driving STI rates in England.

The Dangers of a Data Gap

Understanding the trends and inequalities related to STIs is key to improving the sexual health of those affected. However, as we have set out, there is a stark lack of evidence on the inequalities that place people at an increased risk of STIs or that hinders access to sexual health services. There are also gaps in epidemiological and demographic data which erase people from the statistics; if these people aren't counted in the data then their experience won't count towards informing policy and services. These gaps highlight the erasure of identities.

Despite the collection of detailed ethnicity breakdowns at sexual health clinics, this is aggregated up to an often meaningless level in the Public Health England national

data. The term 'BAME communities' is frequently used in reports and categorises a broad range of ethnicities together, with a lack of meaningful breakdown of ethnicity. This can skew understandings and does not allow for an in-depth perspective of who is actually experiencing higher rates of STIs and why. For example, the category of 'other' does not allow scrutiny of how STIs are impacting communities, such as Latino American communities. The lack of detail masks the true picture and this aggregation facilitates the erasure of communities. In some aspects this is slowly being addressed and we welcome Public Health England's upcoming report looking at ethnic minority communities and STIs, with the hope that this will provide much needed perspective and more understanding of STI data by ethnicity.

These gaps highlight the erasure of identities

MSM are a key group experiencing higher rates of STIs, this group includes both gay and bisexual men, as well as MSM who don't identify as gay or bisexual, including those who are part of prison populations. However, there is little information on this group, despite the fact that MSM who don't identify as gay or bisexual may be an important group in the transmission networks of multiple genders. There is also the issue that gay and bisexual men are often categorised together, failing to address the diversity of sexuality between the two. There is therefore little evidence that bisexual men's sexual health needs are being met.

There is limited national data based on research in England on the rates of STIs among trans and non-binary, including gender-diverse, people. Though national

54 Department of Health (2013) A Framework for Sexual Health Improvement in England, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf, (date accessed: 19/11/2019).

55 Shelter (2018) Total People Recorded as Homeless as at Q1 2018, https://england.shelter.org.uk/_data/assets/image/0020/1621352/image003.jpg, (date accessed: 19/11/2019).

56 Crisis (no date) About Homelessness, available online: <https://www.crisis.org.uk/ending-homelessness/about-homelessness/>, (date accessed: 19/11/2019).

HIV epidemiological data now includes trans and non-binary, including gender-diverse, people, STI surveillance data often fails to recognise trans and non-binary identities, meaning that there is little understanding of the sexual health of this group. It is a scandal that there hasn't been access to this data but a welcome step is Public Health England's commitment to begin to collect data as part of national STI surveillance. It is important that this data collection is accurate and inclusive following the same format as the HIV data collection that CliniQ⁵⁷ helped to write. The timely introduction of this PHE data collection is therefore imperative to both ensure the inclusion and to meet the health needs of trans and non-binary, including gender-diverse, people.

The lack of detail masks the true picture and this aggregation facilitates the erasure of communities

In England, certain elements of sex work are criminalised including the purchase of sex and soliciting for sex in a public place⁵⁸. This can place sex workers at risk of harms, such as violence, by limiting their capacity to ensure their clients will not harm them^{59,60}. Further to this a large scale review of 33 countries (including the UK) found that in places where there was "repressive policing" of sex work, sex workers were "twice as likely to have HIV and/or another STI"⁶¹ and 1.5 times more likely to engage in condomless sex with clients^{62,63}. Although sex workers are found to have high engagement with sexual health services, and test regularly⁶⁴, there are evident associations between the criminalisation of sex work and STIs. However, there is limited research based in England. Further to this, transactional sex, for example in exchange for food or shelter, is evident among some homeless people⁶⁵, as well as some people who are receiving universal credit under conditions of austerity⁶⁶, and the impact of this on sexual health or STIs is not clear. Whilst sex workers may be engaged with services,

advice and sex work networks that promote safety, others, including those in poverty, may fall through the gaps due to barriers of criminalisation, and better understanding is needed around transactional sex, sex work, and criminalisation.

RECOMMENDATION: The erasure of identities in STI data must be reversed. Public Health England STI epidemiological data needs to better recognise the diversity of identities, providing data on transgender and non-binary people, specific ethnic minority communities and MSM who do not identify as gay or bisexual.

RECOMMENDATION: More research is needed, co-produced with individuals who engage in sex work or transactional sex to understand how their needs can be better met to ensure their sexual health, including STI prevention, and safety is ensured.

57 <https://cliniq.org.uk/>

58 CPS (2019) Prostitution and Exploitation of Prostitution, available online: <https://www.cps.gov.uk/legal-guidance/prostitution-and-exploitation-prostitution>, (date accessed: 19/11/19).

59 Platt, L. et al (2018) Associations between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-analysis of Quantitative and Qualitative Studies, *PLOS Medicine*, 15(12).

60 LSHTM (2018) Criminalisation and Repressive Policing of Sex Work Linked to Increased Risk of Violence, HIV and Sexually Transmitted Infections, available at: <https://www.lshtm.ac.uk/newsevents/news/2018/criminalisation-and-repressive-policing-sex-work-linked-increased-risk>, (date accessed: 19/11/2019)

61 LSHTM (2018) Criminalisation and Repressive Policing of Sex Work Linked to Increased Risk of Violence, HIV and Sexually Transmitted Infections, available at: <https://www.lshtm.ac.uk/newsevents/news/2018/criminalisation-and-repressive-policing-sex-work-linked-increased-risk>, (date accessed: 19/11/2019)

62 Platt, L. et al (2018) Associations between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-analysis of Quantitative and Qualitative Studies, *PLOS Medicine*, 15(12).

63 LSHTM (2018) Criminalisation and Repressive Policing of Sex Work Linked to Increased Risk of Violence, HIV and Sexually Transmitted Infections, available at: <https://www.lshtm.ac.uk/newsevents/news/2018/criminalisation-and-repressive-policing-sex-work-linked-increased-risk>, (date accessed: 19/11/2019)

64 McGrath-Lone et al., (2014) The Sexual Health of Female Sex Workers Compared with Other Women in England: analysis of Cross-sectional Data from Genitourinary Medicine Clinics, *Epidemiology*, 90(4).

65 Department of Health (2013) A Framework for Sexual Health Improvement in England, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf, (date accessed: 19/11/2019).

66 Work and Pensions Committee (2019) Universal Credit and "Survival Sex", available online: <https://www.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/inquiries/parliament-2017/universal-credit-survival-sex-inquiry-17-19/publications/>, (date accessed: 29/11/2019)

“Normative” Narratives

How information is provided is critical in helping impart knowledge and understanding. However, many STI patient information leaflets follow a heteronormative and cisnormative narrative, making assumptions about their audience and thus failing to include those who identify as LGBT. Information often uses terms such as “in men” and “in women” but the statements are referring to cis gender experiences, and whilst what they actually mean is “penis” and “vagina”. Not only does this continue the erasure of identities, but it may also prevent individuals who do not identify as cis gendered from being given the necessary information to make considered and informed choices around their sexual health.

Heteronormativity can be seen in the lack of focus on women who have sex with women (WSW). WSW are often considered at low risk of STIs, however transmission is still possible. Despite this, primary prevention methods predominantly focus on condoms, with little mention of dental dams. The LGBT Foundation provides information for WSW, pointing to the importance of dental dams as well as lube to have safer, pleasurable sex⁶⁷. Further to this, the LGBT Foundation is currently carrying out a National Sexual Wellbeing Survey for WSW to explore topics that include “wellbeing, confidence, communication, pleasure, behaviour, exploration and access to services”⁶⁸. Hopefully, the results of this study will help to fill the evident gaps in focus on this community.

RECOMMENDATION: STI Patient information leaflets, and health promotion materials need to move beyond heteronormative and cisnormative narratives, ensuring the inclusion of other sexualities and gender identities.

As we have seen, STIs are not distributed evenly, with some groups facing an increased burden and many factors interplaying result in inequalities. However, data is desperately needed to better understand these differentials and there remain huge gaps in the research around ethnicity, deprivation, gender identity and STIs. An intersectional approach is lacking in evidence, though clear relationships between poverty, STIs and other marginalised or stigmatised communities, highlight the need for this approach to sexual health to be prioritised.

67 LGBT Foundation (2014) Beating about the Bush, available online: <https://s3-eu-west-1.amazonaws.com/lgbt-media/Files/65326acc-9733-4bc2-a214-946023508894/FINAL%2520VERSION%2520BATB%25202014.pdf>, (date accessed: 19/11/2019).

68 <https://lgbt.foundation/news/national-sexual-wellbeing-survey-2018-women-who-have-sex-with-women/213>

National Vision and Priority

National Ambition on Sexual Health

Syphilis and gonorrhoea are on the increase, health inequalities around sexual health are stark, and drug resistant STIs are a continued threat. Yet England lacks a current long-term strategy on how it will address the rising rates of STIs and improve sexual health.

In 2013, to coincide with the implementation of the changes occurring as part of the Health and Social Care Act, the Department for Health released "A Framework for Sexual Health Improvement in England"⁶⁹. The stated aims of the framework were to "set out our ambitions for good sexual health" and "provide a comprehensive package of evidence, interventions and actions to improve sexual health outcomes". The ethos of the framework was welcome – a focus on sex positivity as well as safeguarding, and a commitment to tackle HIV and other STIs.

Yet England lacks a current long-term strategy on how it will address the rising rates of STIs and improve sexual health

The Department sought to "improve the sexual health and wellbeing of the whole population", acknowledged that sexual health was relevant to all age groups, and rightly recognised that inequalities needed to be addressed to achieve this. The key objectives of the framework included:

- Building knowledge and resilience among young people
- Rapid access to high quality services
- People to remain healthy as they age
- Prioritising prevention
- Reducing rates of STIs among people of all ages

- Reducing onward transmission of HIV and avoidable deaths from it

The framework did not go far enough in providing a clear direction on how its objectives would be achieved, nor how the key principles for effective commissioning would work in practice.

Much of the basics of the framework is still relevant today – the need for evidence-based information and advice, timely access to sexual health services, choice around prevention interventions, and the need for "joined-up provision that enables seamless patient journeys across a range of sexual health and other services". However, a significant amount has changed since its release – with emerging STIs, changes in HIV trends, the introduction of PrEP and recognition of treatment as prevention, and the impact of cuts to sexual health services, all shaping the future of sexual health.

In the last seven years, there has been no new comprehensive, overarching sexual health strategy

In the last seven years, there has been no new comprehensive, overarching sexual health strategy. Instead, only piecemeal, narrow strategy documents have been released – on isolated topics or from one organisational perspective only. In 2015, Public Health England released a strategic action plan focused on health promotion⁷⁰. It set out the actions that Public Health England would take around sexual health, HIV and reproductive health promotion and improvement. And in 2019, a syphilis action plan⁷¹ was released from Public Health England. The 2019 Public

69 Department of Health (2013) A Framework for Sexual Health Improvement in England, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf, (date accessed: 19/11/2019).

70 Public Health England (2015) Health Promotion for Sexual and Reproductive Health and HIV, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf, (date accessed: 19/11/2019).

71 Public Health England (2019) Addressing the Increase in Syphilis in England: PHE Action Plan, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806076/Addressing_the_increase_in_syphilis_in_England_Action_Plan_June_2019.pdf, (date accessed: 02/12/2019).

Health England Infectious Diseases Strategy⁷² aims to “halt the rise” in STIs.

When it comes to HIV, our collective ambition is clear. The government has committed to ending new HIV transmissions by 2030 – a target some individual cities had already fixed their sight on via the HIV Fast Track Cities programme. Organisations who have a direct responsibility in delivering this target share its ambition and are working to make sure it is achieved. The government has agreed to form an expert HIV advisory group to draft an HIV action plan, and to take into consideration the outcomes of the national HIV Commission – supported by Terrence Higgins Trust and NAT (National AIDS Trust). A clear commitment, a clear case for action, and a clear process for understanding what additional effort is needed to achieve success.

Now contrast this to other STIs. What is the ambition around gonorrhoea or chlamydia in England? What is the future direction of the National Chlamydia Screening Programme following the external peer review? Are we aiming to end all new STI transmissions? Is this even possible with the current prevention technology available? Who is held accountable when increases in ongoing transmission of STIs are seen?

Terrence Higgins Trust and BASHH, alongside colleagues from local government institutions, have been calling for the development of an ambitious, national sexual health strategy. There is an urgent need for a clear, cohesive and comprehensive strategy that reinforces responsibilities, helps to address current challenges in the system, and sets out a clear ambition to tackle STIs.

Our call was reinforced by the parliamentary Health and Social Care Committee. In their 2019 report on sexual health⁷³, which Terrence Higgins Trust and BASHH inputted into closely, the Committee called on the Government to develop a new sexual health strategy to provide clear national leadership in

this area.

The government listened and in their official response to the Committee in October 2019 they committed to developing a national sexual and reproductive health strategy⁷⁴. The strategy will be cross-system: “...the development of an updated sexual and reproductive health strategy will be led by the Department for Health and Social Care (DHSC) working in partnership with Public Health England (PHE), NHS England and Improvement (NHS E&I), local government and other partners.” The Government’s commitment focused on addressing the urgent challenges sexual health services face. This is very welcome. In addition, the strategy must address the underlying drivers of the rise in STIs and commit to action to address this.

There is an urgent need for a clear, cohesive and comprehensive strategy that reinforces responsibilities, helps to address current challenges in the system, and sets out a clear ambition to tackle STIs

RECOMMENDATION: The Government must ensure the national sexual health and reproductive health strategy is delivered as a matter of urgency. The strategy must set out ambitious targets to tackle STIs in England, providing detail on how these targets will be achieved, and setting out clearly the responsibilities of each statutory (and non statutory) organisation in working towards the ambition of the strategy.

72 Public Health England (2019) Infectious Diseases Strategy, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831439/PHE_Infectious_Diseases_Strategy_2020-2025.pdf, (date accessed 19/11/2019)

73 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

74 Department of Health and Social Care (2019) Government Response to the Health and Social Care Committee Report on Sexual Health, available online: <https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2019-20/Government-response-to-the-committee-fourteenth-report-of-Session-2017-e2%80%9319-on-sexual-health.pdf>, (date accessed: 29/11/2019).

For the strategy to be a success, all stakeholders need to step up their focus and action on STIs.

RECOMMENDATION: Few charities exist focused specifically on sexual health. The charities within this sector need to increase their leadership and fully engage in the national strategy to ensure that it benefits communities at risk of STIs.

RECOMMENDATION: Local government has a key leadership role to play- locally, regionally and nationally. It must actively shape the new national strategy, and work in partnership locally to implement the strategy to the benefit of local communities affected by STIs.

RECOMMENDATION: Public Health England and the Department of Health and Social Care must prioritise sexual health including STIs. The national strategy is an opportunity for both organisations to show leadership and commitment to tackling STIs in England.

Monitoring Progress on STIs

Progress on sexual health including STIs is monitored through the Public Health Outcomes Framework (PHOF)⁷⁵. Historically, there have been two high level indicators on HIV and STIs as part of the health protection data set:

- Chlamydia detection rate in individuals aged 15-24
- Late HIV diagnosis rate

An HPV vaccination coverage indicator is included – looking at take up in girls only. An indicator on the coverage of HIV testing during pregnancy is also included as part of the health improvement data set. Using a chlamydia indicator as a proxy for broader sexual health in young people may be justified. However, it does not go any way

towards monitoring progress of other STIs that predominately affect other age groups or other populations (e.g. MSM) and specific ethnic minority communities.

In 2019, the outcome of Public Health England's review into the PHOF accepted the inclusion of one new STI indicator - a new indicator will now measure new STI diagnoses (excluding chlamydia in the u-25s). This is a welcome step. However, it is essential that disaggregated data is available under this new indicator. Looking at new STI diagnoses collectively hides important trends – for instance the increases seen in syphilis and gonorrhoea, and the progress made in regards to genital warts.

RECOMMENDATION: Public Health England should ensure the use of the new STI indicator within the PHOF is fit for purpose and provides an insight into progress on reducing specific STIs.

RECOMMENDATION: Public Health England should consider how the expansion of the HPV schools-based vaccination programme to some boys will be reflected in the HPV indicator within the PHOF.

Making the Case for Investment in Sexual Health

In 2018, Public Health England released a return on investment report⁷⁶ that clearly showed that for every £1 spent on contraception now will result in £9 in savings over 10 years. An incredibly powerful statistic that has reinforced the benefits of investment in contraception services.

Even if we disagree, policy decisions are based on the cost and benefits to the public

⁷⁵ <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

⁷⁶ Public Health England (2018) Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for Publicly Funded Contraception in England. available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730292/contraception_return_on_investment_report.pdf. (date accessed: 19/11/2019).

purse. Public Health England has produced guidance for local authorities to understand the relationship between local spend and sexual health outcomes⁷⁷ and has set out economic evidence around HIV and contraception where it exists⁷⁸.

But there is still a gap in the need for high level return on investment modelling for STI prevention, testing and treatment interventions. We need clear data to reinforce the case on why it is so important to invest in STI prevention and treatment services.

RECOMMENDATION: Public Health England, working with local government and BASHH, should carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.

The lack of national ambition on sexual health is alarming in the face of increasing rates of STIs and drug resistance. A long term strategy to tackle these issues is desperately needed. We need additional data on the return on investment of STI prevention and treatment and the new national indicator on STIs must be fit for purpose if we are to track progress.

⁷⁷ Public Health England (2017) Practical Guidance to SPOT for Improving Sexual and Reproductive Health, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/675836/SPOT_Guidelines.pdf, (date accessed: 19/11/2019).

⁷⁸ Public Health England (2019) Health Economics Evidence Resource, available online: <https://www.gov.uk/government/publications/health-economics-evidence-resource>, (date accessed: 19/11/2019)

Keeping up with the Times: Changing Behaviours

Historically, shifts in STI trends have been associated with social change. High rates of syphilis and gonorrhoea in the 1940s have been associated with armed forces returning from war, followed by a rapid decrease when penicillin was introduced as treatment. There was a resurgence of STIs in the 1960s and 70s when more liberal attitudes towards sex were prominent and contraception options broadened with the advent of the contraceptive pill. The higher rates of syphilis diagnoses among men suggested transmission among MSM, whilst gonorrhoea, genital herpes and genital warts increased among both men and women⁷⁹. There were dramatic reductions in STIs in the 1980s and early 90s due to the panic associated with HIV and AIDS and resultant increases in condom use, especially among key populations such as MSM⁸⁰. However, there was a re-emergence of increases in STIs in 1995⁸¹, and finally the trends we see today.

When we talk about why we are seeing increasing trends in some STIs, the stock answer is often largely based on changes in behaviour and the type of sex or sexual act. It is undisputable that behaviour has a large impact on STIs. Whether its sexual behaviour or health seeking behaviour – all are likely to have an influence on an individual's risk of acquiring STIs.

But what does recent data show, and are there any areas where a more up-to-date evidence base is needed?

Who, What and Why?

Evidence shows that the holy trinity of sexual behaviours associated with increased risk of STIs are condomless sex, increased number of sexual partners, and concurrent sexual partners.

However, when it comes to behaviours, there is limited up-to-date UK-based research. The little research there is focuses on a few specific groups, and doesn't always delve into why certain behaviours that are associated with sex are changing over time. Behaviour should not be seen in isolation and there are likely to be a number of reasons driving behaviours; of course, personal preference and pleasure need to be considered among these. If the types of sexual behaviours people are engaging in are associated with STIs it is critical that this is fully understood and that prevention efforts are able to be tailored to these behaviours.

However, when it comes to behaviours, there is limited up-to-date UK-based research

The largest volume of evidence on specific behaviours is related to MSM. The rises in syphilis, lymphogranuloma venereum (LGV) and shigella among MSM have been associated with reports of condomless or "unprotected" anal intercourse and attending sex parties (group sex)^{82, 83, 84}. For syphilis, these behaviours may also be facilitated by chemsex or geospatial social networking applications⁸². LGV is associated with having HIV or another STI, anal enema use, fisting and the use of sex toys⁸³. High levels of HIV positivity are also associated with shigella, as is chemsex⁸⁵.

79 Lowndes, C.M. and Hughes, G. (2010) Epidemiology of STIs: UK, *Epidemiology and Sexual Behaviour*, 38(5), pp.211-215.

80 Hunt, A.J. et al. (1993) Changes in Condom Use by Gay Men, *AIDS Care*, 5(4), pp.439-448.

81 Lowndes, C.M. and Hughes, G. (2010) Epidemiology of STIs: UK, *Epidemiology and Sexual Behaviour*, 38(5), pp.211-215.

82 Public Health England (2019) Addressing the Increase in Syphilis in England: PHE Action Plan, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806076/Addressing_the_increase_in_syphilis_in_England_Action_Plan_June_2019.pdf, (date accessed: 19/11/2019).

83 Macdonald, N. et al. (2014) Risk factors for rectal lymphogranuloma venereum in gay men: results of a multicentre case-control study in the UK, *Sexually Transmitted Infections*, 90(4), pp.262-268.

84 Public Health England (2016) Inequalities in sexual health: Update on HIV and STIs in men who have sex with men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503706/2016-02-22STIHIVinMSMinLondonFINALv1.0.pdf, (date accessed: 19/11/2019).

85 Public Health England (2016) Inequalities in sexual health: Update on HIV and STIs in men who have sex with men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503706/2016-02-22STIHIVinMSMinLondonFINALv1.0.pdf, (date accessed: 19/11/2019).

Increased attention in recent years has been focused on chemsex among MSM, which involves sex whilst under influence of drugs – “chems” – typically Crystal Meth, M-Cat and G. Evidence has shown chemsex has been increasing^{86, 87}. There is insufficient evidence to prove a direct causal link between chemsex and STIs, but evidence is clear that there is an association between chemsex drugs and STI “risk behaviours”⁸⁸. Some research⁸⁹ has also importantly looked at why MSM engage in chemsex. Reported reasons included enabling individuals to have the sex they wanted – by increasing libido and stamina or by increasing sexual feeling and intimacy. Evidence suggests that in some instances there is insufficient linkages between sexual health, drug and alcohol services to support people engaged in chemsex, and in some cases insufficient drug and alcohol screening at sexual health clinics⁹⁰. There is also evidence that chemsex is higher in MSM living with HIV than MSM in the general population⁹¹.

If the types of sexual behaviours people are engaging in are associated with STIs it is critical that this is fully understood and that prevention efforts are able to be tailored to these behaviours

There is also some evidence of risk associated behaviours among swingers engaging in group sex, including heterosexual men and women. One observational study of a swingers event for under 35s in Southern England found occurrences of condomless dipping and “unprotected” oral sex. Attendees often reported forgoing safer sex practises due to “getting caught up in the moment”. Swinging was therefore found to enhance sexual encounters for attendees, whilst encouraging some behaviours associated with STI risk. However, this study was based on a very small sample size⁹² and more research is needed to fully understand the impact of swinging on STIs.

The changing methods of finding sexual partners in England, including through online apps and groups has regularly been identified as associated with increased risk of STIs. The large scale Natsal 3 research, undertaken between 2010-2012⁹³, showed that finding sexual partners online was associated with markers of sexual risk (including concurrent partners, a high number of partners, and condomless sex). But again, there is a lack of more recent evidence to fully understand if behaviour has continued to change in the intervening years.

There is also some evidence available on young people’s sexual practises. Looking at the transition to university, one study, albeit with a small sample size⁹⁴, examined the relationship between the university social lifestyle and “risky sex”. “High levels of alcohol consumption, increased sexual opportunities, liberation from moral surveillance and the expectations of the stereotypical highly sexually active student” were seen as factors in increasing sex that could increase risk of STIs and pregnancy. But again, there is minimal evidence and this research focuses on a small subset of young people. There are still questions to be asked- how have these behaviours changed over time and is there more change to come? Are there any changes in the way that young people meet

86 Sewell J, et al. (2018) Changes in recreational drug use, drug use associated with chemsex, and HIV-related behaviours, among HIV-negative men who have sex with men in London and Brighton, 2013–2016, *Sexually Transmitted Infections*, 94(7), pp.494-501.

87 Bourne, A. (2014) The Chemsex Study: Drug use in Sexual Settings among Gay and Bisexual Men in Lambeth, Southwark and Lewisham, available online: <http://sigmaresearch.org.uk/files/report2014a.pdf>, (date accessed: 19/11/2019).

88 Bourne, A. et al. (2015) ‘Illicit drug use in sexual settings (‘chemsex’) and HIV/STI transmission risk behaviour among gay men in South London: findings from a qualitative study’, *Sexually Transmitted Infections*, 91, pp.564-568.

89 Weatherburn, P. et al. (2017). Motivations and values associated with combining sex and illicit drugs (‘chemsex’) among gay men in South London: findings from a qualitative study, *Sexually Transmitted Infections*, 93, pp.203-206.

90 Stevens, O et al. (2019) Chemsex-related drug use and its association with health outcomes in men who have sex with men: a cross-sectional analysis of Antidote clinic service data, *Sexually Transmitted Infections*, doi: 10.1136/sextrans-2019-054040.

91 Public Health England (2018) Syphilis Epidemiology in London: 2017 Data Update, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/766674/Syphilis_epidemiology_london_2017.pdf, (date accessed: 19/11/2019).

92 Honey, D. (2018) Swinging: What we Should be Asking?, P128, available online: <https://www.bhiva.org/file/jhWlaZopMPYnm/AbstractBook2018.pdf>, (date accessed: 19/11/2019).

93 Cabecinha, M. et al. (2016) Finding sexual partners online: prevalence and associations with sexual behaviour, STI diagnoses and other sexual health outcomes in the British population, *Sexually Transmitted Infections*, 93, 572-582.

94 Chanakira, E. (2014) Factors Perceived to Influence Risky Sexual Behaviours among University Students in the United Kingdom: A Qualitative Telephone Interview Study, *BMC Public Health*, 14(t).

sexual partners, including through online technology? As society becomes more accepting of different sexualities and genders, will sexual identity of this younger generation have any impact on sexual behaviour?

There is very little empirical evidence on changes in sexual behaviours in older people that may be associated with the increased incidence of STIs that are seen in this group. Current rises in STIs among older populations have been associated with higher divorce rates, new sexual partners and misconceptions around the need to use condoms^{95,96}. For some older populations, condoms are seen as a way to avoid pregnancy, and as many of those engaging in sex have either had a vasectomy or gone through menopause, condoms may not be seen as needed. In addition, it is unclear whether changes in STI testing is playing a role in the increased diagnoses in this group⁹⁷.

Advances in HIV

In recent years, Public Health England data has indicated that people living with HIV are disproportionately impacted by some STIs. According to Public Health England,^{98,99} HIV sero-adaptive behaviour could be contributing to this rise. This involves the selection of sexual partners based on known or perceived HIV status. The evidence base on serosorting is again fairly old – with the main data in the Public Health England references dating from 2008. It might be the case that this evidence is not out of date. But it is clearly evident that much has changed since 2008.

The widespread recognition of treatment as prevention and the knowledge that an individual living with HIV who is on effective treatment cannot pass it on (Undetectable = Untransmittable) has changed everything. For the first time since the HIV epidemic began, people living with HIV can have sex in the knowledge they aren't passing on HIV to their partners. The positive impact that this has on people living with HIV goes without saying.

We must all continue to share the message of Can't Pass It On/"U=U" and work to end the misinformation around HIV that is still widespread. But we also must make sure that we are supporting people living with HIV and their partners to think about HIV and STIs together and the risks that STIs continue to pose. As we mention throughout this report, for too long HIV and STIs have been seen in isolation, to the detriment of the sexual health of people living with HIV.

Public Health England evidence¹⁰⁰ has indicated that HIV positive MSM are more likely than HIV negative MSM to engage in behaviour that increases risk of STIs – including condomless anal sex. The mental health of MSM living with HIV may also play a role in STI risk with one study¹⁰¹ showing that there was an association between depression/anxiety and condomless sex.

HIV pre-exposure prophylaxis (PrEP) – a highly effective drug that prevents transmission of HIV – is an incredible advance in HIV prevention. Its increased use in England – particularly in MSM – is undoubtedly a factor in the reduction in new HIV transmissions. The eligibility criteria for joining the current PrEP Impact Trial in England includes reported instances of condomless sex in the past three months¹⁰². PrEP results in individuals at

95 NHS Staffordshire and Stoke on Trent Partnership (2016): Over 50s urged to take care of their sexual health after rise in STIs. Available at: www.staffordshireandstokeontrent.nhs.uk/BoardMeetings/Over-50s-urged-to-take-care-of-their-sexual-health-after-rise-in-STIs.html, (date accessed: 19/11/2019).

96 THT (2018) Still Got It: Sexual Health of the Over 50's, available online: <https://www.tht.org.uk/sites/default/files/2018-04/StillGot%20Got%20It%20-%20Over%2050s%20Insight%20Briefing.pdf>, (date accessed: 19/11/2019)

97 Davies, S.C. (2015) Annual Report of the Chief Medical Officer 2015, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/654806/CMO_baby_boomers_annual_report_2015.pdf, (date accessed: 19/11/2019).

98 Public Health England (2014) HIV and STIs in Men who have Sex with Men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771143/2014_09_17_STIs_HIV_in_MSM_in_London_v1_0.pdf, (date accessed: 19/11/2019).

99 Public Health England (2016) Inequalities in sexual health: Update on HIV and STIs in men who have sex with men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503706/2016-02-22STIHIVinMSMinLondonFINALv1.0.pdf, (date accessed: 19/11/2019).

100 Public Health England (2016) Inequalities in sexual health: Update on HIV and STIs in men who have sex with men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503706/2016-02-22STIHIVinMSMinLondonFINALv1.0.pdf, (date accessed: 19/11/2019).

101 Lampe F, Speakman A, Sherr L, Phillips A et al. (2013) Psychological and physical symptoms and sexual behaviour among HIV-diagnosed men who have sex with men (MSM) in the UK, British HIV Association, HIV Medicine, 14 (Suppl. 2), pp.1–10.

102 PrEPster (no date) 5 Things You Need to Know to Join the Impact Trial, available online: <https://prepster.info/impact/5things/>, (date accessed: 19/11/2019).

higher risk of HIV and STIs regularly attending sexual health services and testing for STIs. Research is not currently available in England on the links between PrEP use and broader sexual health, including STI prevention and incidence. However, data produced as part of the PrEP Impact Trial in England will help to fill this research gap. PrEP should be seen as part of a comprehensive sexual health promotion package. HIV and STI prevention messages and efforts must be realigned and siloed working end to ensure that all individuals are given the holistic sexual health information and support required.

Who is Missing?

Public Health England's Syphilis Action Plan identifies a potentially diverse group that needs greater focus: MSM who do not identify as gay or bisexual¹⁰³. There has been some suggestion¹⁰⁴ that this group may be a population that links HIV transmission between MSM and heterosexual women but evidence on this is poor and cannot be extrapolated for STIs.

Further to this, there is next to nothing that focuses on behaviours among women in the general population- a huge gap that we have continued to see within the wider focus on STIs.

There is also insufficient research exploring behaviour and the link with STIs in ethnic minority communities. An analysis¹⁰⁵ of the Natsal-3 data from 2010-2012 looked at sexual behaviour by ethnicity. It found that Black Caribbean men reported comparatively higher numbers of partners in the past five years and Black Caribbean and Black African men reported greater proportions of concurrent sexual partners. This evidence was supported by a systematic review, which also found multiple partners and concurrent partners among people of Black Caribbean ethnicity¹⁰⁶. However, the NATSAL data is now up to ten years old and there is a need for new research to look at whether any behaviour

has changed, and better understand the relationships between behaviour, safer sex, and STIs in these communities.

RECOMMENDATION: There is an urgent need to update the evidence base around behaviours linked to STIs. Public Health England and the Department for Health and Social Care, working with academics, clinicians and community organisations, must invest in research to provide a more up-to-date evidence base on the changing behaviours that are associated with increased risk of STIs; and work with commissioners and providers to ensure that this evidence is translated into effective targeted prevention interventions and enhanced partner notification.

RECOMMENDATION: HIV charities, services and commissioners must consider the sexual health needs of people living with HIV and work with communities to co-design targeted services and interventions that meet the diverse needs of all people living with HIV. The promotion and availability of PrEP must be better aligned with broader sexual health messaging to ensure that PrEP is seen as part of a comprehensive sexual health prevention strategy.

Some changes in behaviours are associated with the increased transmission of STIs. With a reliance on out of date evidence – particularly focused on MSM, there is a concerning lack of recent data on behaviours and the drivers behind them.

103 Public Health England (2019) Addressing the Increase in Syphilis in England: PHE Action Plan, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806076/Addressing_the_increase_in_syphilis_in_England_Action_Plan_June_2019.pdf, (date accessed: 19/11/2019).

104 Ragonnet-Cronin, M. et al. (2018) Non-disclosed Men who have Sex with Men in UK HIV Transmission Networks: Phylogenetic Analysis of Surveillance Data. *Lancet HIV*, 5(6), pp. 309-316.

105 Wayal, S. et al. (2017) Ethnic Variations in Sexual Behaviours and Sexual Health Markers: Findings from the Third British National Survey of Sexual Attitudes and Lifestyles (NATSAL-3). *The Lancet*, 2(10), pp.458-472.

106 Wayal, S. et al. (2018) Understanding the Burden of Bacterial Sexually Transmitted Infections and *Trichomonas Vaginalis* among Black Caribbean's in the United Kingdom: Findings from a Systematic Review, *PLoS One*, 13(12), doi: 10.1371/journal.pone.0208315.

Lack of Choice and Options Around Preventing STIs

Primary prevention is a key way to prevent the transmission of STIs; however, the options for this are limited. Currently primary prevention consists of condoms, information and advice, behavioural change interventions, the HPV vaccine for genital warts, and PrEP and treatment as prevention for HIV. Testing and treatment for STIs and partner notification are important secondary prevention interventions. A restrictive choice of options may prevent people from engaging with these methods, especially considering the issues surrounding access to prevention methods.

Condoms are Key

As highlighted, condomless sex is a key risk factor for STI acquisition and changes in condom use have been widely reported. In 2016, Public Health England indicated an increase in the proportion of MSM in London who were engaging in unprotected anal intercourse between 1998 and 2008 - with a third (36.6%) of all men reporting unprotected anal intercourse within the previous three months in 2008 compared to a quarter (24.3%) in 1998¹⁰⁷. But again, there is a lack of more recent data to understand what has changed in the past 12 years in MSM's use of condoms.

With regards to young people, a Public Health England Yougov survey¹⁰⁸ in 2017 found that almost half (47%) of sexually active young people reported having sex with someone for the first time and not using a condom. 1 in 10 of the surveyed young people said that they had never used a condom.

Condom use was still associated with contraception with twice as many young people reporting that the main reason they used condoms was to avoid pregnancy (58%), as opposed to avoiding getting an STI (29%)¹⁰⁹. It is unclear whether this behavior has

increased in recent years or has always been at this level.

1 in 10 of the surveyed young people said that they had never used a condom

The perception of whether condoms are considered necessary also varies depending on the sexual act being carried out as 52% of people have been found to believe it is not possible to get an STI through oral sex¹¹⁰ and 90% of people have never used a condom during oral sex¹¹¹.

The lack of engagement with condoms suggests a need to re-engage people in their use and to break down any myths.

The reliance on condoms in sexual health promotion combined with evidence of increasing condomless sex highlight the need for wider options that may prevent STIs.

90% of people have never used a condom during oral sex

RECOMMENDATION: When it comes to condoms, something needs to change. Our knowledge on their use is out of date, and the marketing and promotion of condoms is dated. Funding should be provided to charities and community groups who are well placed to engage communities on why condom use is reducing and what actions could be taken to increase use and increase access.

107 Public Health England (2016) Inequalities in sexual health: Update on HIV and STIs in men who have sex with men in London, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/503706/2016-02-22STIHIVinMSMinLondonFINALV1.0.pdf, (date accessed: 19/11/2019).

108 Public Health England (2017) Campaign to Protect Young People from STIs by Using Condoms, available online: <https://www.gov.uk/government/news/campaign-to-protect-young-people-from-stis-by-using-condoms>, (date accessed: 19/11/2019).

109 Public Health England (2017) Campaign to Protect Young People from STIs by Using Condoms, available online: <https://www.gov.uk/government/news/campaign-to-protect-young-people-from-stis-by-using-condoms>, (date accessed: 19/11/2019).

110 British Condoms (2019) Sex Survey Results 2019, available online: <https://britishcondoms.uk/blogs/sex-survey-results-2019/>, (date accessed: 19/11/2019).

111 British Condoms (2018) The Official 2018 Sex Survey from British Condoms, available online: <https://britishcondoms.uk/blogs/sex-survey-2018/>, (date accessed: 19/11/2019).

STI Testing

Testing is also a key prevention method as testing and treatment prevents the onward transmission of STIs. Currently the types of tests include self-testing or self-sampling kits available online or in clinics. These may require urine samples, self-swabs and finger prick tests¹¹², which can either give an immediate result for self-testing or be sent to a laboratory for testing self-sampling kits. Alternatively, the collection of samples and physical examinations can be carried out at a sexual health clinic^{113,114}. Facilitating testing through a wide range of methods is key, considering one survey from 2018 found that 64% of people had never been tested for an STI¹¹⁵.

Screening itself has been found to have a positive effect on the practise of safer sex and engagement with STI testing. A survey of the National Chlamydia Screening Programme in England found that young people were more likely to re-test, and more likely to practise ways to prevent chlamydia transmission during sex, for example through using condoms, after screening¹¹⁶.

As testing can have a positive impact on sexual health by preventing onward STI transmission, aiding the treatment of STIs and engaging people in safer sex practices, it is evidently a key prevention method. The positive impact of testing highlights the need for testing methods to keep up with public preference. A pilot ran by SH:24 found that there was a preference for STI self-testing as opposed to self-sampling^{117,118}.

RECOMMENDATION: Lessons should be learnt from HIV testing approaches, and actions taken by national and local commissioners to increase choice of STI tests - to make it as easy as possible to access testing.

Partner Notification

Partner notification supports individual's diagnosed with STIs to notify any previous sexual partners who may have been put at risk, to let them know to get tested and treated¹¹⁹. The aim of partner notification is to identify any additional cases in order to prevent further transmission¹²⁰. BASHH minimum standards for partner notification varies depending on the STI¹²¹.

More evidence is needed on the consistency and quality of partner notification as well as the impact of anonymous sexual partners. Behaviours such as anonymous sex where individuals may not have the contact details of their sexual partners have the potential to complicate partner notification. Further to this, funding cuts have led to reductions in health advisor posts in sexual health clinics¹²². These posts are vital for partner notification and advising and supporting service users newly diagnosed with an STI¹²³.

More effective partner notification delivery is currently being explored, for example the LUSTRUM trials are focusing on accelerated

112 | Wanna Know (2019) Get Tested, available online: <http://www.iwannaknow.org/teens/sti/testing.html>, (date accessed: 19/11/2019).

113 | Wanna Know (2019) Get Tested, available online: <http://www.iwannaknow.org/teens/sti/testing.html>, (date accessed: 19/11/2019).

114 | NHS (2018) Visiting an STI Clinic, available online: <https://www.nhs.uk/live-well/sexual-health/visiting-an-sti-clinic/>, (date accessed: 19/11/2019).

115 | British Condoms (2018) The Official 2018 Sex Survey from British Condoms, available online: <https://britishcondoms.uk/blogs/sex-survey-2018/>, (date accessed: 19/11/2019).

116 | Public Health England (2014) Components of Chlamydia Screening and the Impact of Screening on Behaviour, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/475159/2014_NCSP_web_survey_report.pdf, (date accessed: 19/11/2019)

117 | Pebody, R. (2019) Two-thirds Prefer Self-testing over Self-sampling, available online: <http://www.aidsmap.com/news/oct-2019/two-thirds-prefer-self-testing-over-self-sampling>, (date accessed: 19/11/2019).

118 | Baraitser P, et al. (2019), User preference for HIV self-testing or self-sampling within a free online sexual health service: a service evaluation, *International Journal of STD and AIDS*, 30(12), pp.1239-1242.

119 | NICE (2019) Sexual Health: Quality Statement 6- Partner Notification, available online: <https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-6-Partner-notification>, (date accessed: 19/11/2019).

120 | Department of Health (2013) A Framework for Sexual Health Improvement in England, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf, (date accessed: 19/11/2019).

121 | BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

122 | Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

123 | Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

partner notification to increase the speed at which sexual networks receive treatment for STIs. This study takes into account partners met through dating apps and provides self sampling kits for partners as part of the notification process¹²⁴. Although the results of this trial are not yet available, there are evidently innovations in this area to consider which would need to be supported by funding.

RECOMMENDATION: Additional models of effective partner notification that take into account changing behaviours are being researched and recommendations from this should be considered by sexual health commissioners and providers.

RECOMMENDATION: It is evident that without adequate funding, there will be further reductions in the sexual health workforce, and any effective model of partner notification will be jeopardised. Funding, including for health advisor posts, must therefore ensure that sufficient workforce is in place to carry out effective partner notification.

Building on Successes

Successes in some STIs provide an insight into how the range of prevention options can be widened.

Genital warts are caused by a virus called human papillomavirus (HPV). Strains of HPV can also cause potentially fatal cancers including cervical, anal, penile and throat cancers. As HPV is passed through skin to skin contact, condoms have a limited effect. Since 2008, a school based HPV immunisations programme has been implemented in England. The vaccine provides a high level of protection against the HPV strains that cause genital warts, leading to a 63% decrease in genital warts diagnoses in girls aged 15-19 since 2014.

Terrence Higgins Trust alongside partners including HPV Action, have long called for an expansion of the HPV immunisation programme to both boys and MSM - who are not covered by herd immunity from the girls programme. In 2016, a pilot programme was initiated in sexual health services in England for MSM – rolling out as a full HPV vaccination programme from 2018. The Department for Health and Social Care also (eventually) committed to extending the school-based vaccination programme to boys aged 12-13 years old. This roll-out commenced in September 2019. There continues to be a disparity between progress made in reducing genital wart incidence in boys and girls. The extended schools programme will start to address this disparity, however a catch up programme for boys also needs to be implemented to ensure that no one will be missed.

The vaccine provides a high level of protection against the HPV strains that cause genital warts, leading to a 63% decrease in genital warts diagnoses in girls aged 15-19 since 2014

RECOMMENDATION: A catch-up programme should be introduced for the HPV vaccine for the boys who will have missed out on this.

RECOMMENDATION: Additional options to prevent STIs are needed, with support for research into innovations urgently required from Government and research funding bodies. These options should build on current successes, learning from them, and reflect changing sexual behaviours.

124 LUSTRUM (no date) Information for Patients and Public, available online: <https://www.lustrum.org.uk/information-for-patients-and-public/>. (date accessed: 19/11/2019).

For the prevention of STIs, there is an over reliance on the well flogged combination of condoms and regular testing. Restrictive choice of primary prevention methods and their inability to keep up with behaviours are likely to impact the trends seen in STIs. A better understanding of partner notification in the context of anonymous partners and online dating is needed. Choice is clearly instrumental in providing safer and more pleasurable sexual experiences.

The Need for Sustainable Sexual Health Services

	Local Authorities	Clinical Commissioning Groups	NHS England
Services Provided	<p>Contraception and advice to avoid unintended pregnancies</p> <p>STI testing and treatment</p> <p>Psychosexual counselling</p> <p>Sexual health specialist services and outreach</p> <p>Social care services</p> <p>Includes GPs, community pharmacies, National Chlamydia Screening Programme (NCSP), and specialist services</p>	<p>Abortion services including STI and HIV testing and contraceptive services</p> <p>Female sterilisation</p> <p>Vasectomy</p> <p>Non-sexual health elements of psychosexual health services</p> <p>Contraception for non contraceptive purposes</p> <p>HIV testing</p>	<p>HIV treatment and care</p> <p>Testing and treatment for STIs</p> <p>HIV testing</p> <p>Sexual health in secure and detained settings</p> <p>Sexual assault referral centres</p> <p>Cervical screening</p> <p>HPV vaccine</p> <p>Specialist foetal medicine services</p> <p>Infectious diseases in pregnancy screening programme</p> <p>Includes GP Provision</p>

Table 1: Service Provision by Commissioner¹²⁵

A Changing Sexual Health System

The Health and Social Care Act 2012 resulted in a wholesale restructure of the health and social care system – including for sexual health services.

Since 2013, open access specialist sexual health services that include STI testing, treatment and partner notification are the responsibility of local authorities. NHS England also commissions GPs to test and treat STIs in some circumstances.

In 2014, Public Health England launched guidance¹²⁵, the aim of which was to provide additional clarity on the new responsibilities for sexual health commissioning. The guide focused on whole-system commissioning – across HIV, sexual health and reproductive

health, and encourages commissioning to be centred on the most effective pathways for patients.

A wealth of evidence has highlighted barriers that resulted from the 2013 changes to the commissioning landscape. The All-Party Parliamentary Group on Sexual and Reproductive Health¹²⁶ highlighted the structural divisions that resulted across the HIV, sexual health and reproductive health pathways and issues around procurement of services. The Kings Fund in its report on NHS pressures¹²⁷, found that “pressure on genito-urinary medicine (GUM) services has

¹²⁵ Public Health England (2015) Making it Work, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf, (date accessed: 19/11/2019)

¹²⁶ All Party Parliamentary Group on Sexual and Reproductive Health in the UK (2015) Breaking Down the Barriers, available online: <http://theagc.org.uk/wp-content/uploads/2015/07/APPG-SRH-UK-Breaking-down-the-barriers.pdf>, (date accessed: 19/11/2019).

¹²⁷ Robertson, R. et al. (2017) Understanding NHS Financial Pressures, available online: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf, (date accessed: 19/11/2019).

increased and patient care in some parts of the country has suffered as a result".

In 2017, Public Health England and the Association of Directors of Public Health therefore undertook a comprehensive review¹²⁸ of the commissioning of sexual health services. The review was focused on the perspectives of commissioners (although there was a low level of engagement from CCGs) but did not survey providers of sexual health services. The extensive findings looked at all aspects of commissioning from service specifications, to tendering, to outcomes. It reinforced issues around fragmentation in commissioning, workforce issues, the impact of increased demand of services and of budget cuts. It also raised issues around insufficient expertise of some commissioners and concerns with access to services for individuals at greatest risk of poor sexual health.

Further to this, sexual health clinicians report that the increasing complexity of both the clinical aspects and social aspects, such as safeguarding issues that patients present with, are not being taken into account when services are commissioned¹²⁹.

The current sexual health commissioning environment also requires the competitive tendering of services through local authorities. Whilst it is entirely reasonable to encourage services to be delivered in a cost-effective and efficient manner, many tenders are short-term and inhibit long-term service delivery planning, workforce training and retention. They have also meant that staff have needed to divert significant amounts of time away from clinical care to deliver tender submissions, in an environment when many clinics are already under-resourced, exacerbating an already stretched system.

Results from a recent BASHH member survey (2018) also showed that competitive tendering was linked to increasing challenges surrounding recruitment. Almost two-thirds of respondents (65%) said that it had become

more difficult to recruit appropriate staff in the past year and cited tendering as a key reason for this. Uncertainties around services can make the specialty less appealing to new recruits¹³⁰.

Local authority public health grant funding has been cut by £700 million in real terms between 2014/15 and 2019/20

Co-commissioning of sexual health services was the underlying ethos of the 2014 Public Health England "Making It Work" guidance and was a central finding in the review of sexual health commissioning. This led to a number of pilot models being tested and the Local Government Association releasing case studies of local commissioning models¹³¹. A line included in the NHS's ten year plan¹³² again put the future of commissioning in the spotlight. It committed Government and the NHS to "consider whether there is a stronger role for the NHS in commissioning sexual health services...and what best future commissioning arrangements might therefore be". The outcome of the review¹³³ recommended that sexual (and reproductive) health services remain the primary responsibility of local authorities but that they are co-commissioned locally with the NHS. However, an agreed understanding of what co-commissioning for sexual health is and

128 Public Health England (2017) Sexual Health, Reproductive Health and HIV: A Review of Commissioning, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640578/Sexual_health_reproductive_health_and_HIV_a_survey_of_commissioning.pdf, (date accessed: 19/11/2019).

129 British Association for Sexual Health and HIV, British HIV Association (2018) Written Evidence for the Health and Social Care Committee Inquiry on Sexual Health, Available online at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/90616.pdf>, (date accessed: 02/12/2019).

130 British Association for Sexual Health and HIV, British HIV Association (2018) Written Evidence for the Health and Social Care Committee Inquiry on Sexual Health, Available online at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/sexual-health/written/90616.pdf>, (date accessed: 02/12/2019).

131 1. <https://www.local.gov.uk/sites/default/files/documents/sexual-health-commissioning-748.pdf> 2. https://www.local.gov.uk/sites/default/files/documents/22%2045_Commissioning_Sexual_Health_Services_v03%20WEB.pdf

132 NHS (2019) The NHS Long Term Plan, available online: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>, (date accessed: 19/11/2019).

133 Department of Health and Social Care (2019) Government Review Confirms Local Authorities Will Continue to Commission Public Health Services, available online: <https://www.gov.uk/government/news/government-review-confirms-local-authorities-will-continue-to-commission-public-health-services>, (date accessed: 19/11/2019).

how it will be implemented across the country remains unclear. For co-commissioning to work it will be essential that the process is transparent, that a clear accountability framework is implemented, and that the involvement of clinical and community groups remains essential. Further to this, there is a need to explore the use of pooled budgets as part of the co-commissioning process to overcome silo working.

RECOMMENDATION: The Department of Health and Social Care, working with local authorities, NHS England, with input from providers and community groups, must provide clarity on the future models of co-commissioning of sexual health services, ensuring transparency and accountability are core to any changes.

Funding for Sexual Health

As mentioned, the Health and Social Care Act 2012 transferred responsibility for local public health services, including sexual health, from the NHS to local authorities.

Local authorities receive an annual ring-fenced public health grant from the Department of Health and Social Care. The core condition of this grant is that it should be used only for the purposes of the public health functions of local authorities.

The rhetoric from government has been focused on the need to step up action when it comes to prevention, with a "radical upgrade in prevention and public health" called for in the NHS Five Year Forward View¹³⁴. Yet this has not come to fruition.

Local authority public health grant funding has been cut by £700 million in real terms between 2014/15 and 2019/20. The cuts to funding has led to sexual health service budgets being cut by 25% over that time¹³⁵. In contrast, over this same period, government has invested heavily in the NHS with multi-year funding committed. Sexual health

services that are commissioned by local government have been left out of this NHS funding, despite clinical services often being delivered in NHS-branded buildings. It is clear there is a false dichotomy between 'NHS' and 'non-NHS' services which is detrimental to sexual health services.

The King's Fund highlighted that "around one in four local authorities reduced GUM spending by more 20 percent between 2013/14 and 2015/16, while around one in seven increased spending by this amount"¹³⁶, suggesting that investment may be inconsistent.

In the 2019 parliamentary Health and Social Care Committee report on sexual health¹³⁷, the Committee called the "severe" cuts to spending on sexual health "a false economy" and were concerned that they risk widening health inequalities. The Committee were concerned to hear "real and justifiable concerns that additional cuts will be applied to a sector now at breaking point". The Committee added that "looking forward to the Spending Review, the Government must ensure sexual health funding is increased to levels which do not put people's sexual health at risk." Despite this, the government's response¹³⁸ did not commit to the much needed radical uplift in public health funding required to address these concerns.

In the 2019 Government Spending Round, public health saw a temporary reprieve from cuts with a commitment of a 1% real terms increase in the grant in 2020/21. Although welcome, this is insufficient. The Health

134 NHS (2014) Five Year Forward View, available online: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>, (date accessed: 19/11/2019).

135 Finch, D. et al (2018) Taking our Health for Granted, available online: <https://www.health.org.uk/taking-our-health-for-granted>, (date accessed: 19/11/2019).

136 Robertson, R. et al (2017) Understanding NHS Financial Pressures, available online: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf, (date accessed: 19/11/2019).

137 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm2019/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

138 Department of Health and Social Care (2019) Government Response to the Health and Social Care Committee Report on Sexual Health, available online: <https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2019-20/Government-response-to-the-committee-fourteenth-report-of-Session-2017%e2%80%9319-on-sexual-health.pdf>, (date accessed: 29/11/2019).

Foundation and Kings Fund called for a £1 billion investment in public health spending in 2020/21 to reverse the impact of the cuts to public health budgets. In reality, the Spending Round investment was only a fraction of this.

Public Health England data has indicated that demand for sexual health services is rising – a 15% increase in attendance between 2014 and 2018¹³⁹. As we discuss in a later section of this report, reductions in funding are having a direct impact on access to sexual health services. Rates of some STIs are skyrocketing and progress in addressing others is at risk without additional investment. Yet there has not been a sufficient rise in resources to address this and no long term funding settlement for local authorities to plan future sexual health provision.

RECOMMENDATION: Government must commit to fully fund sexual health services, reversing the impact of past funding cuts, and provide sufficient resources to increase efforts to tackle STIs. This funding should ensure an adequately trained workforce including health advisors, nurses, doctors, and other Allied Health Care Professionals.

Future-proofing our Sexual Health Workforce

As we have set out, current commissioning arrangements have led to increased fragmentation and complicated service delivery. It has also had a negative impact on sexual health workforce planning, training and staff development. As recognised by the parliamentary Health and Social Care Committee, this situation has not only had a clear and detrimental effect on those working in the sector, but also jeopardises the 'pipeline' of future specialists in sexual health.

To help address these issues there must be a truly joined-up approach to sexual health commissioning, more effectively integrating local government and what is defined as the NHS, between which there is currently a

false distinction. There must be more clarity on where responsibility lies for creating a sustainable workforce for sexual health, as currently this falls through the gaps.

RECOMMENDATION: Workforce and training should represent a key pillar within the forthcoming sexual health and reproductive health strategy. Direction in the strategy should be given to ensuring all local contracts include provisions for how they will provide the support needs of their local workforce, including training.

Current commissioning structures and public health funding cuts are failing sexual health services, through impacting the workforce and provision of services. This has had a clear impact on the ability to tackle STIs and there is still no long-term commitment from government to address the funding shortfall. Current fragmented commissioning needs to be resolved through co-commissioning. It is evident that sexual health services run the risk of becoming unsustainable in the context of cuts, commissioning and a compromised workforce.

If England is to tackle STIs and continue progress on HIV, the Government must fully fund prevention initiatives, including sexual health clinics.

139 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr1919_stis-ncsp_ann18.pdf. (date accessed: 19/11/2019).

Access to Services

Access to sexual health services is key to reversing the current trends seen in STIs. They provide testing and treatment services and prevention information and advice. STI services can be provided within clinics but are also available through GPs, community pharmacies, online, and via community organisations. However, the clinical context and political climate have impacted access to these services.

The Strain on Sexual Health Clinics

Open access to sexual health services means that accessing STI services should be available without the need for GP referral and irrespective of place of residence¹⁴⁰. When accessing sexual health services, BASHH guidelines recommend anyone needing to be seen should be offered an appointment within 48 hours¹⁴¹. This standard is considered upheld if 98% of service users are offered an appointment within 48 hours¹⁴². This is based on a nationally mandated target introduced by the Government in 2004 although this target was then removed in 2010.

More recently, NICE published a Sexual Health Quality Standard in February 2019 which included a Quality Statement recommending that people who contact a sexual health service about an STI are offered an appointment within two working days. Further to this, those accessing services through a walk in clinic should experience "reasonable waiting times"¹⁴³. Whilst NICE encourage the use of Quality Standards to improve care and reduce variation, they are not mandatory.

Evidence has indicated that access to sexual health services is deteriorating. Public health funding cuts and the changes in commissioning have made sexual health clinics less accessible.

Evidence has indicated that access to sexual health services is deteriorating. Public health funding cuts and the changes in commissioning have made sexual health clinics less accessible

Cuts have resulted in overstretched services¹⁴⁴, compromising access for individuals whose primary choice of clinic is no longer available, which may mean further to travel to get to a clinic or attending a clinic they don't feel comfortable at. And with these individuals having to find access elsewhere, service closures are also impacting on other clinics in terms of longer waiting times and unacceptable appointment times in the face of this additional demand¹⁴⁵. Funding cuts have also resulted in sexual health staff reductions, leaving the already overstretched services struggling to cope¹⁴⁶. It is clear that these issues all feed into each other. Walk in clinics have also been compromised, with the large demand on services leading to appointment-only clinics in some areas¹⁴⁷.

A two-year study on access to GUM services found that in 2014, 95.5% of patients with symptoms suggestive of an acute STI were offered an appointment within 48 hours. In 2015 however, this figure dropped to 90.8%, well below the 98% level that was previously recommended. Analysis revealed that across

140 BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

141 BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

142 BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

143 NICE (2019) Sexual Health: Quality Statement 4- Access to Sexual Health Services, available online: <https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-4-Access-to-sexual-health-services>, (date accessed: 19/11/2019).

144 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

145 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

146 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

147 Robertson, R. et al. (2017) Understanding NHS Financial Pressures, available online: https://www.kingsfund.org.uk/sites/default/files/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf, (date accessed: 19/11/2019).

the UK, the most marked declines in access were amongst clinics in England, and that women were less likely to be offered an appointment than men¹⁴⁸.

Testing efforts are also impacted by funding. The tests for trichomoniasis and Mgen are not available at all sexual health clinics. In response to this, the Health and Social Care Committee's enquiry into sexual health¹⁴⁹ recommended that funding should support "a full range of STI testing, including Mgen, TV and gonorrhoea". However, the government's response to this sexual health enquiry¹⁵⁰ did not commit to providing funding, instead handing the responsibility over to local authorities. As trichomoniasis disproportionately impacts women from minority communities¹⁵¹, it is of the upmost importance to ask how these funding decisions impacting access disproportionately affect those who are experiencing inequalities in sexual health.

These issues of overstretched and underfunded services are problematic, especially in the face of rising demand; with a 7% increase in attendees at physical sexual health clinics or e-services from 2017 to 2018, and 22% increase in total sexual health screens since 2014¹⁵². These access issues impact all service users. Data collected by South East London sexual health clinics, indicated that in a one-month period (November 2017), 1,094 people were turned away from sexual health clinics in that area as clinics did not have enough capacity to see everyone who needed their services. Over half (54%) of those turned away reported that they had symptoms of an STI¹⁵³. This is reinforced by data from BASHH which indicates that a worryingly high proportion of sexual health doctors are having to turn away patients because they don't have capacity to see them. The recent BASHH member survey¹⁵⁴ found that there were significant reductions in 'non-core' services including STI and HIV testing. 29% of respondents reported reductions in delivery of STI testing services whilst 21% said there was a decrease in HIV testing in 2017.

It is important to note that once services are accessed the quality of care is still considered to be high. Despite this, there are concerns that services are no longer able to commit to a holistic approach, and instead can only provide a "diagnosis and treatment service"¹⁵⁵. Clearly timely and acceptable access to holistic sexual health services has been compromised by funding cuts and changes to the commissioning landscape.

Over half (54%) of those turned away reported that they had symptoms of an STI

RECOMMENDATION: The new national sexual health and reproductive health strategy should reintroduce the mandatory 48 hour access target, ensuring that the appropriate referral is given within this timeline, and that services hold up to BASHH and NICE guidelines on STIs.

RECOMMENDATION: The new national strategy must provide solutions to the current inadequate access to sexual health services – addressing the root causes of why access is deteriorating.

148 Foley, E. et al. (2017) Inequalities in Access to Genitourinary Medicine Clinics in the UK: Results from a Mystery Shopper Survey, 93(7), pp. 472-475.

149 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

150 Department of Health and Social Care (2019) Government Response to the Health and Social Care Committee Report on Sexual Health, available online: <https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2019-20/Government-response-to-the-committee-fourteenth-report-of-Session-2017%e2%80%9319-on-sexual-health.pdf>, (date accessed: 29/11/2019).

151 Public Health England (2019) Sexually Transmitted Infections and Screening for Chlamydia in England, 2018, Health Protection Report 13(19) available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806118/hpr19stis-ncsp-ann18.pdf, (date accessed: 19/11/2019).

152 Public Health England (2019) Health Matters: Preventing STIs, available online: <https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis>, (date accessed: 19/11/2019)

153 <http://www.bhiva.org/documents/Conferences/2018Edinburgh/Presentations/180418/AideenDunne.pdf>

154 BHIVA (2018) British HIV Association (BHIVA) Member Survey, September 2018 Results Summary, available online: <https://www.bhiva.org/file/5bae801b27505/BHIVA-Member-Survey-September-2018.pdf>, (date accessed: 19/11/2019)

155 Robertson, R. et al. (2017) Understanding NHS Financial Pressures, available online: https://www.kingsfund.org.uk/sites/default/files/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf, (date accessed: 19/11/2019).

Inequitable Access

For some, access to sexual health services may be exacerbated by other barriers. BASHH guidelines highlight barriers of discrimination and stigma experienced by trans and non-binary, including gender-diverse, people when accessing sexual health clinics¹⁵⁶. CliniQ¹⁵⁷ and 56T in London and Clinic T¹⁵⁸ in Brighton provide services tailored to trans and non-binary, including gender-diverse, people to ensure they feel inclusive, safe and welcoming in an attempt to overcome such barriers. BASHH provide guidelines on the provision of trans, non-binary and gender-diverse inclusive services and these guidelines highlight the need for waiting rooms and forms to be gender neutral, as well as ensuring forms and tests are inclusive of trans and non-binary, including gender diverse, identities¹⁵⁹. However, there is limited information on the availability of these services beyond those in Brighton and London and the BASHH guidelines are not a legal requirement. As a result, a major gap can be seen in the service provision for transgender and non-binary, including gender diverse, people whose identities are often not reflected in the physical environment of services¹⁶⁰.

RECOMMENDATION: Research, with peer and patient engagement, should be undertaken to fill the data gaps in the barriers experienced when accessing services and the impact structural inequalities can have on sexual health.

Primary Prevention

The Kings Fund has shown that cuts to sexual health services has disproportionately affected primary prevention¹⁶¹. Within clinics, this impact can be seen on the cuts made to outreach services and sexual health promotion as the Kings Fund reports that "they are not part of the core GUM service, so are not protected by the legal mandate"¹⁶².

Outreach services are key to engaging populations who may not attend clinics so this risks creating an additional unmet need and further driving sexual health inequality.

Investment in primary prevention is key as it promotes safer sexual behaviour preventing the transmission of an infection in the first instance¹⁶³. This is particularly important as such prevention can engage groups that may be at an increased risk through the targeted provision of outreach services¹⁶⁴.

The most recent BASHH Member Survey results also showed that there were reductions in the delivery of HIV prevention activity, outreach to vulnerable populations, cervical cytology, genital dermatology and psychosexual health services. The rapidly increasing rates of some STIs demonstrates a clear need for investment in primary prevention services that would help ease the pressure on front line services.

The impact of cuts on primary prevention can be seen in relation to condoms. As mentioned, condoms are considered the current best method to prevent STIs¹⁶⁵. They are available to purchase, however there is also provision through condom distribution schemes. These schemes may provide access to free condoms or condoms at cost price¹⁶⁶. One

156 Beere et al. (No Date) BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, available online: <https://www.bashh.org/about-bashh/publications/>, (date accessed: 19/11/2019).

157 <https://cliniq.org.uk/>

158 <http://brightonsexualhealth.com/service/clinic-t/>

159 Beere et al. (No Date) BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, available online: <https://www.bashh.org/about-bashh/publications/>, (date accessed: 19/11/2019).

160 Beere et al. (No Date) BASHH Recommendations for Integrated Sexual Health Services for Trans, including Non-binary, People, available online: <https://www.bashh.org/about-bashh/publications/>, (date accessed: 19/11/2019).

161 Robertson, R. (2018) Sexual Health Services and the Importance of Prevention, available online: <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>, (date accessed: 19/11/2019).

162 Robertson, R. et al. (2017) Understanding NHS Financial Pressures, available online: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding%20NHS%20financial%20pressures%20-%20full%20report.pdf, (date accessed: 19/11/2019).

163 Robertson, R. (2018) Sexual Health Services and the Importance of Prevention, available online: <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>, (date accessed: 19/11/2019).

164 Robertson, R. (2018) Sexual Health Services and the Importance of Prevention, available online: <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>, (date accessed: 19/11/2019).

165 Umbrella (2019) How to Avoid Sexually Transmitted Infections, available online: <https://umbrellahealth.co.uk/sti/how-to-avoid-stis>, (date accessed: 19/11/2019).

166 NICE (2019) Sexual Health: Quality Statement 3- Condom Distribution Schemes, available online: <https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-3-Condom-distribution-schemes>, (date accessed: 19/11/2019).

example of a condom distribution scheme is the C-Card programme which provides free condoms to young people whilst providing the opportunity for young people to engage with sexual health services¹⁶⁷. The funding cuts to primary prevention have the potential to reduce access to condoms and, therefore, minimise their use¹⁶⁸, especially among those who find them expensive. If condoms are not accessible in this way, purchasing them is an alternative but there may be barriers of cost, and additionally 18% of people find it embarrassing to purchase condoms¹⁶⁹.

RECOMMENDATION: Primary prevention should be recognised as an integral part of sexual health services, with a mandatory requirement for provision to protect such services from cuts.

Access to Online Services

Online services provide access to advice and, crucially, allow people who do not have symptoms of an STI to order self-sampling kits that can be carried out without visiting a clinic. Kits are sent out after answering a series of questions that will inform the type of test provided. Kits are then returned to be tested via prepaid postage and results are received by phone, email or SMS. If a positive diagnosis is received, usually at this point the user will go to a face-to-face service to receive their treatment¹⁷⁰.

Online services provide an additional option to access services. They have been seen as a way to relieve pressure on overstretched face-to-face services¹⁷¹. Online testing has been found to increase testing volume in England, as STI testing increased by 37% following the introduction of online tests¹⁷². Therefore, online testing was found to be improving access particularly in areas with unmet need¹⁷³.

Worryingly, public health funding cuts have impacted access to these tests. A key example of this is the introduction of caps on

self-sampling kits available online with a limit being placed on the number of tests that can be sent out each day¹⁷⁴.

Although effective, online services may not be appropriate for everyone¹⁷⁵, some current guidance states that these services are only suitable for asymptomatic service users¹⁷⁶. Further to this, access may be problematic for those who do not have digital access, do not use digital means to access health services, find computers difficult such as some older people, or do not have a regular or safe address to send testing kits to. As a result, it is critical that such online services are not viewed as a substitute for face-to-face services.

Furthermore, online services may create issues surrounding safeguarding as face-to-face services offer the opportunity to pick up safeguarding issues whilst online services may not allow for this. Further exploration of this is needed.

There have also been concerns around the safety of online pharmacies and their potential to contribute to anti-microbial resistance in STIs. Previously, online pharmacies have provided access to antibiotics for diagnosed STIs without a patient's "medical histories, swab results and antibiotic sensitivities"-

167 Brook (2014) C-Card Condom Distribution Schemes, available online: https://www.brook.org.uk/attachments/C-Card_condom_distribution_schemes_-_What_why_and_how_-_July_2014.pdf, (date accessed: 19/11/2019).

168 BASHH (2018) Government Funding Cuts Leave Sexual Health and HIV Care at 'Breaking Point', available online: <https://www.bashh.org/news/news/government-funding-cuts-leave-sexual-health-and-hiv-care-at-breaking-point/>, (date accessed: 19/11/2019).

169 British Condoms (2019) Sex Survey Results 2019, available online: <https://britishcondoms.uk/blogs/sex-survey-results-2019/>, (date accessed: 19/11/2019).

170 SH:24 (no date) STIs, available online: <https://sh24.org.uk/sexual-health/stis>, (date accessed: 19/11/2019).

171 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

172 Turner, K.M.E. et al. (2019) Online Testing for Sexually Transmitted Infections: A Whole Systems Approach to Predicting Value, PLoS ONE, 14(2).

173 Turner, K.M.E. et al. (2019) Online Testing for Sexually Transmitted Infections: A Whole Systems Approach to Predicting Value, PLoS ONE, 14(2).

174 Sexual Health London (2019) Is There an Unlimited Supply of Testing Kits for Residents of All Participating Councils, available online: <https://www.shl.uk/faq/35000037141-is-there-an-unlimited-supply-of-testing-kits-for-residents-of-all-participating-councils>, (date accessed: 19/11/2019).

175 Health and Social Care Committee (2019) Sexual Health, available online: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf>, (date accessed: 19/11/2019).

176 SH:24 (no date) FAQs, available online: <https://sh24.org.uk/faqs>, (date accessed: 19/11/2019).

creating potential safety issues for patients¹⁷⁷. This failure to comply with national guidelines for the prescription of antibiotics raised fears of drug resistance¹⁷⁸.

RECOMMENDATION: Online sexual health services are a welcome addition to physical services, and should continue to receive support through funding, research and development. However, it is imperative to recognise that they are not a substitute for physical services, and should not be treated or relied on as such.

Alternative Access

The barriers to access services resulting from commissioning structures, and funding cuts, have led to alternative models of service provision plugging the gaps for face-to-face services. Community pharmacies are argued to provide an opportunity for additional delivery of some sexual health services. However, geographic variation in pharmacies being able to provide these services may be down to a lack of support from funding and commissioning structures. In 2014/15, only 28% of pharmacies were commissioned to provide chlamydia screening and only 9% commissioned to provide free condoms¹⁷⁹.

There are some areas which have utilised alternative service delivery with success. For example, Birmingham pharmacies are critical in sexual health service provision with 174 pharmacies in the area providing chlamydia screening, emergency hormonal contraception, condoms, and STI self-sampling kits, plus some may also provide the oral and injectable contraceptives, chlamydia treatment and hepatitis B vaccination. The success of this programme is supported by the training of pharmacists to provide these Tier 1 and Tier 2 services, and is reflected by the public acceptance of the programme¹⁸⁰.

Sexual health clinics in rural and smaller urban areas are often unable to find suitable premises¹⁸¹ and the provision of services

is often reliant on GPs or through these community pharmacies. Unfortunately, there is a lack of data explaining why there is variation in regional trends of STIs and the role access may play in this.

RECOMMENDATION: Access to alternative providers e.g. community pharmacies which are networked with the local sexual health service and work in partnership should be explored, recognising that the providers will be required to provide the standards of care recommended by BASHH¹⁸².

Bridging the Gap with Communities

Non-clinical interventions can also help promote and facilitate access to STI prevention and testing. Community-based organisations can help to reach those who are not engaged with clinical services and may also support specific key groups who are at higher risk of STIs. These organisations are therefore critical in bridging the access gap. There is, however, more to do to understand how these programmes can be fully utilised to tackle rising STIs.

The importance and added value of non-clinical, community-based services can clearly be seen in the success of the HIV response. Community organisations have

177 BASHH (2016) BASHH Expresses Concern at Irresponsible Online Prescribing of Antibiotics for STIs, available online: <https://www.bashh.org/news/news/bashh-expresses-concern-at-irresponsible-online-prescribing-of-antibiotics-for-stis/>, (date accessed: 19/11/2019).

178 BASHH (2016) BASHH Expresses Concern at Irresponsible Online Prescribing of Antibiotics for STIs, available online: <https://www.bashh.org/news/news/bashh-expresses-concern-at-irresponsible-online-prescribing-of-antibiotics-for-stis/>, (date accessed: 19/11/2019).

179 Public Health England (2017) Pharmacy: A Way Forward for Public Health, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643520/Pharmacy_a_way_forward_for_public_health.pdf, (date accessed: 19/11/2019).

180 Tatum, M. (2019) How Pharmacy is Helping to Contain the Resurgence of Gonorrhoea and Syphilis, available online: <https://www.pharmaceutical-journal.com/news-and-analysis/features/how-pharmacy-is-helping-to-contain-the-resurgence-of-gonorrhoea-and-syphilis/20207139.article?firstPass=false>, (Date accessed: 19/11/2019).

181 Public Health England (2017) Sexual Health, Reproductive Health and HIV: A Review of Commissioning, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640578/Sexual_health_reproductive_health_and_hiv_a_survey_of_commissioning.pdf, (date accessed: 19/11/2019).

182 BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

been able to provide HIV tests¹⁸³ as well as engagement with peer led research and the co-production of services¹⁸⁴. However, funding cuts threaten community organisations¹⁸⁵. Small charities based within communities often rely on funding from local authorities which is made more difficult when cuts are made¹⁸⁶. This is particularly worrying considering such charities are often experts on working with groups considered at a higher risk of STIs¹⁸⁷.

The strain on clinical services may also have the potential to impact these community based services. Anecdotal evidence has suggested that some HIV and sexual health organisations have experienced overspill from the overstretched sexual health clinics. As a result such organisations are also finding it challenging to cope with the increased demand.

RECOMMENDATION: The new national sexual and reproductive health strategy must formally recognise and support the benefits community organisations can bring to engaging and supporting communities at greatest risk of STIs, whilst community organisations need to further step into the sexual health space and play their part in working towards meeting the holistic sexual health needs of the communities they serve.

Sexual health services are under pressure due to rising demand and funding cuts. This provides a huge barrier in the ability to access services, particularly primary prevention efforts. Community organisations have huge potential to drive progress in the sexual health sector but are threatened by funding cuts. The shift towards online services has enhanced the number of people accessing STI testing. However, it is evident that access is compromised with some people falling through the gaps and being turned away from clinics and online services.

183 Public Health England (2019) Progress Towards Ending the HIV Epidemic in the United Kingdom 2018 Report, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/821273/Progress_towards_ending_the_HIV_epidemic_in_the_UK.pdf, (date accessed: 19/11/2019).

184 The Kings Fund (2017) The Future of HIV Services in England, available online: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Future_HIV_services_England_Kings_Fund_April_2017.pdf, (date accessed: 19/11/2019).

185 BHIVA (2018) British HIV Association (BHIVA) Member Survey, September 2018 Results Summary, available online: <https://www.bhiva.org/file/5bae801b27505/BHIVA-Member-Survey-September-2018.pdf>, (date accessed: 19/11/2019)

186 Robertson, R. (2018) Sexual Health Services and the Importance of Prevention, available online: <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>, (date accessed: 19/11/2019).

187 Robertson, R. (2018) Sexual Health Services and the Importance of Prevention, available online: <https://www.kingsfund.org.uk/blog/2018/12/sexual-health-services-and-importance-prevention>, (date accessed: 19/11/2019).

Awareness and Information

Though services are critical in reversing the trends in STIs, having the knowledge, ability and autonomy to use them is essential. Misconceptions around primary prevention and lack of awareness of where to access services and testing can exacerbate the transmission of STIs. Conversations that raise awareness of safer sex practices and STIs are critical in dispelling myths and combatting stigma, which in turn can support a reduction in the current trends seen in STIs.

Relationships and Sex Education (RSE)

There has been a major gap in the provision of relationships and sex education (RSE) in England. A 2016 Terrence Higgins Trust survey found that 61% of students only received RSE once a year or less and 89% were not taught about sex and pleasure in their RSE lesson¹⁸⁸. As of 2020, compulsory relationships education will be rolled out in primary schools, and relationships and sex education in secondary schools in England¹⁸⁹. This is meant to be a comprehensive and inclusive approach to relationships and sex education that will include information on STIs.

In order for RSE to have the desired impact, it needs to be supported by the appropriate funding, training and resources to ensure that teachers can carry out the lessons to a high quality. Face-to-face training, materials and support should be provided to teachers and it is essential that they have the appropriate information on STIs and sexual health, as well as the ability to signpost to local services.

RECOMMENDATION: The appropriate funding, training, and resources need to be provided to ensure that teachers are well equipped to provide comprehensive and inclusive RSE that includes information on STIs, and that links in with local sexual health providers and services.

Never Too Old to Stop Learning

Compulsory RSE for young people is a welcome step. However, older generations will have missed out on quality sex and relationships education and this may feed into common misconceptions among this group.

The 2015 annual report of the Chief Medical Officer stated that older generations do not benefit from the reach of health promotion messaging as it is often targeted towards younger populations¹⁹⁰. The greatest diagnoses among this group are MSM. This erasure of older people in health promotion messaging may also be apparent in other aspects of sexual health provision, however there is no evidence on whether, for instance, primary health care providers are starting conversations around STIs with their older patients.

Another community who we are potentially failing is migrants who would also benefit from targeted services and health promotion. This would be particularly key for migrants coming from countries where RSE is not commonplace, and for refugees and asylum seekers who may have had experiences of interrupted schooling and very little knowledge of sexual health. There are also issues regarding the provision of STI and broader sexual health information to those with low levels of health literacy and/or

¹⁸⁸ THT (2018) LGBT Inclusive Sex and Relationships Education in the UK, available online: <https://www.tht.org.uk/sites/default/files/2018-07/Shh%20No%20talking%20LGBT%20inclusive%20SRE%20in%20the%20UK.pdf>, (date accessed: 19/11/2019).

¹⁸⁹ THT (2019) Relationships and Sex Education, available online: <https://www.tht.org.uk/our-work/our-campaigns/relationships-and-sex-education-rse>, (date accessed: 19/11/2019).

¹⁹⁰ Davies, S.C. (2015) Annual Report of the Chief Medical Officer 2015, available online: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/654806/CMO_baby_boomers_annual_report_2015.pdf, (date accessed: 19/11/2019).

literacy in English. Without health promotion materials provided in formats that can be understood by those with low levels of health literacy or literacy in English, a large group of the population may not be reached by STI messaging and information.

Beyond this, the asymptomatic nature of many STIs may further perpetuate these issues among the general population as misconceptions around the presentation of STIs could lead many STIs to be undiagnosed, facilitating their transmission and risk of complications. However, again, there is a lack of research in this area.

RECOMMENDATION: Sexual health services and programmes must ensure interventions meet the needs of older people and sexual health promotion messaging must start to represent and target older people.

RECOMMENDATION: Health promotion messaging and information must be accessible to people with low levels of health literacy or literacy in English, as well as to migrants who may not speak English.

Though compulsory RSE is a welcome step to improving the knowledge and awareness of young people across England, many generations have missed out on this. The increases in STIs among older people reflect this gap, as well as the invisibility of this group among health promotion messaging. Health promotion messaging and services also need to be targeted to migrants.

Visibility and STI Stigma

Key factors in addressing any health issue are visibility and acceptability – from the national level to an individual level. If there is no public focus on an issue it is less likely that Government action will be taken to address it. If an issue is not visible in the public sphere, or if it is veiled in misinformation and stereotyping, it takes a lot to be a vocal advocate and change people's perceptions.

A Need for Champions

We can learn a lot from the HIV community. The response to HIV, from the 1980s to today, has been led by vocal activists. Individuals who are directly affected by HIV have been at the forefront of protest and progress – changing perceptions around HIV and pushing for action when state commitment is lacking. There are many incredible, passionate HIV activists in the UK who continue to share their personal experience – to inform and educate, to share positive messages, and to challenge individuals and organisations where needed. In addition, community organisations, such as the Terrence Higgins Trust, help to amplify the voices of people living with or affected by HIV¹⁹¹. This has also helped to ensure that research and services are co-produced and, as a result, tailored to the people that they are aiming to benefit, encouraging an inclusive and comprehensive response.

In the response to sexual ill-health including STIs, there is currently a gap when it comes to community-based, community-led actions to push for change. The voices of those directly affected by sexual ill-health and STIs are near invisible. It is unclear why this is the case. Is it because STIs are temporary – unless you experience long term complications from STIs – and you are treated and then move on? Is it because STIs are still steeped in stereotype and judgement? Could it be because charities have not invested in, and supported community sexual health activists and

communicators? Or could it be that STIs are just not seen as a priority to speak publically about?

There are some aspects of sexual health where visibility of affected communities is clear. The push for compulsory relationships and sex education in England has included very visible advocates – from young people, to parents, teachers and clinicians – all have publically shared their personal experiences to reinforce the case for good RSE in schools. Issues around sexuality, pleasure, consent, and safeguarding have also been based around passionate advocates and their personal experience.

The voices of those directly affected by sexual ill-health and STIs are near invisible

But there remains a gap when it comes to publicly talking about STIs. There is currently a lack of sexual health voices and champions. If we are to change the public's narrative around STIs – to break down judgement and to facilitate open conversations about STIs and sexual health, we must step up our support for those individuals who are willing to speak up and push for change.

RECOMMENDATION: Sexual health charities and community groups should increase focus on programmes and projects to support sexual health community champions to talk about STIs and sexual health publically, as part of a push for change in knowledge, perceptions and action.

Prevention in the Media

Not only is there a lack of voices and champions, there is also a lack of visibility of STI prevention methods, and safer sex in the public eye – including in the media. This may exacerbate the stigma associated with discussing sexual health including STIs.

191 THT (2019) What We Do, available online: <https://www.tht.org.uk/our-work/about-our-charity/what-we-do>, (date accessed: 19/11/2019)

1 in 3 young adults report never having seen a condom used in TV and film¹⁹². This lack of visibility may contribute to the low rates of condom use reported among young people, with 47% having not used a condom when having sex with someone new for the first time¹⁹³. This lack of visibility may also be apparent for dental dams, though there is a lack of research on this.

There is a prevailing narrative that the lack of condom use within porn encourages viewers not to use them. However, there is no definitive, up-to-date evidence for this. There are arguments that incorporating safer sex into porn could be a powerful way to engage people in their use¹⁹⁴ and groups like Porn for PrEP have brought together adult sex industry and sexual health messages¹⁹⁵.

1 in 3 young adults report never having seen a condom used in TV and film

Not only is the lack of condoms an issue, but there is a lack of visibility of lube, especially when combined with condoms. Condoms and lube should be an integral part of the conversation on pleasurable sex, as a way to engage people with their use but also as a recognition of the transmission risks associated with sex that might not be pleasurable. Sex without the necessary lubrication can lead to abrasions and sometimes even tearing, increasing the opportunity for transmission of STIs¹⁹⁶.

Mass media has been seen as a key way to encourage "pro-testing norms", for example through the inclusion of positive attitudes towards STI testing within TV programmes that young people watch¹⁹⁷. It was found that "pro-testing norms" could increase the likelihood of young people to test for STIs and combat stigma. Past testing was found to decrease feelings of shame associated with STIs. Conversations around sex, STIs, and safer sex may have the ability to breakdown this stigma and encourage conversations with

partners and peers.

Contributing to Barriers

So why does this matter? Well, there are practical implications to this lack of visibility. Stigma has been reported as a barrier to accessing sexual health services, especially among young people¹⁹⁸ and older people¹⁹⁹. A Public Health England/Yougov study showed that sexual health is a challenging topic for young adults to discuss with 56% of men and 43% of women stating that it is difficult to talk about STIs with friends. Furthermore, 58% said that if they had an STI they would find it difficult to talk to their sexual partner about it²⁰⁰. The implications of this could include a lack of knowledge or chance to deconstruct misconceptions, and individuals may be reluctant to notify partners around STIs potentially contributing to further transmissions.

A Public Health England/Yougov study showed that sexual health is a challenging topic for young adults to discuss with 56% of men and 43% of women stating that it is difficult to talk about STIs with friends

192 Public Health England (2017) Campaign to Protect Young People from STIs by Using Condoms, available online: <https://www.gov.uk/government/news/campaign-to-protect-young-people-from-stis-by-using-condoms>, (date accessed: 19/11/2019).

193 Public Health England (2017) Campaign to Protect Young People from STIs by Using Condoms, available online: <https://www.gov.uk/government/news/campaign-to-protect-young-people-from-stis-by-using-condoms>, (date accessed: 19/11/2019).

194 Philpott, A. et al. (2017) Blurring the Boundaries of Public Health: It's Time to Make Safer Sex Porn and Erotic Sex Education, available online: <http://thepleasureproject.org/wp-content/uploads/2019/07/blurring-the-boundaries-of-public-health-2017.pdf>, (date accessed: 19/11/2019).

195 <https://porn4prep.com/>

196 Planned Parenthood (2019) How Do I Make Sex Safer?, available online: <https://www.plannedparenthood.org/learn/stds-hiv-safer-sex/safer-sex/how-do-i-make-sex-safer>, (Date accessed: 19/11/2019).

197 de Visser, Richard Oliver and O'Neill, Nancy (2013) Identifying and understanding barriers to sexually transmissible infection testing among young people. *Sexual Health*, 10, pp. 553-558.

198 de Visser, Richard Oliver and O'Neill, Nancy (2013) Identifying and understanding barriers to sexually transmissible infection testing among young people. *Sexual Health*, 10, pp. 553-558.

199 THT (2018) Still Got It: Sexual Health of the Over 50's, available online: <https://www.tht.org.uk/sites/default/files/2018-04/Still%20Got%20It%20-%20Over%2050s%20Insight%20Briefing.pdf>, (date accessed: 19/11/2019)

200 Public Health England (2017) Campaign to Protect Young People from STIs by Using Condoms, available online: <https://www.gov.uk/government/news/campaign-to-protect-young-people-from-stis-by-using-condoms>, (date accessed: 19/11/2019).

These feelings can prevent people from attending clinics due to the stigma associated with poor sexual health and, in turn, sexual health clinics^{201,202}. This was evident in the way people would prefer to access services; in a Hampshire, Southampton, and Portsmouth based survey people from Black British, Black Caribbean, Black African and Black 'other' communities showed a preference for sexual health services being available through the GP (60.5% of respondents)²⁰³. The survey concluded that the stigma associated with sexual health services made accessing services through the GP a more viable option²⁰⁴.

Although it is likely other factors may influence the preference for GPs, such as familiarity or convenience, visibility is key to breaking down stigma and encouraging access to services – both GPs and sexual health services, as well as critical conversations that can improve sexual health. It is essential that any healthcare professionals who provide sexual health service do not perpetuate stigmatising attitudes.

Visibility of positive attitudes towards STIs and sexual health are lacking, and this is a clear barrier to preventing STIs. There is an evident catch-22 in which stigma prevents the recruitment of sexual health champions and visibility of STI testing which, the evidence shows, could help to breakdown this stigma and encourage safer sex behaviours.

201 Tanton C, Geary RS, Clifton S, et al (2018) 'Sexual health clinic attendance and non-attendance in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)', *Sexually Transmitted Infections*, 94, pp.268-276.

202 Dalrymple, J. et al (2017) 'It Just Gives you the Heebie Jeebies': Late Middle-Aged Adults Engagement with Knowledge of Sexually Transmitted Infections, *Sexually Transmitted Infections*, 93(1), pp. A9

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The Bigger Picture

In this report, we sought to look in depth at the issues around STIs – an area that we felt did not have the focus and attention it needed.

But, at the end of this report, we wanted to bring STIs back into the real world.

As we have mentioned throughout the report, an STI does not happen in isolation. The way that STIs relate to each other highlights the need to consider STIs as part of a broader picture, even when taking a closer look and drilling down to individual trends. Individuals diagnosed with one STI are more likely to be diagnosed with another²⁰⁵. This co-infection is evident in gonorrhoea where one study found half of those with gonorrhoea were also diagnosed with chlamydia²⁰⁶. Not only does co-infection reflect the relationship between STIs, but reinfection is another example of the need to look further afield when considering them. PHE data shows that roughly 14% of MSM, 3% of women, and 3% of heterosexual men who had an STI would have a repeat infection of gonorrhoea within 12 months²⁰⁷.

This relationship between STIs can also be seen with HIV. Some STIs facilitate the transmission of HIV²⁰⁸ and others are more likely to affect people who are living with HIV. Therefore, it is time to stop thinking about HIV and STIs in silo, and look at the bigger picture of how they are related and affect communities.

Not only do STIs relate to each other but to broader sexual health. Stigma and shame associated with STIs have the potential to affect mental health²⁰⁹, and in turn sexual pleasure. Sexual identity, a sex-positive culture (or the polar opposite of this) impacts sexual health and therefore STIs.

We must also put STIs and sexual health into the broader context of reproductive health. Not only the long-term complications that untreated STIs can cause, for instance through issues such as infertility²¹⁰, but also the interplay between sexual health, contraception, pregnancy and ongoing good reproductive health for all women of all ages.

²⁰⁵ Nusbaum, M.R. et al. (2004) Sexually Transmitted Infections and Increased Risk of Co-infection with Human Immunodeficiency Virus, *Journal of American Osteopath Association*, 104(12), pp.527-35.

²⁰⁶ Fifer, H. and Ison, C. (2014) Nucleic acid amplification tests for the diagnosis of *Neisseria gonorrhoeae* in low-prevalence settings: a review of the evidence, *Sex Transmitted Infections*, 90(8), pp.577-9.

²⁰⁷ PHE (2018) Sexually Transmitted Infections in England, 2018, available online: <https://app.box.com/s/i6owgiotrwiwrtscybs74knyw4cvcp/file/468895636932>. (date accessed: 29/11/2019).

²⁰⁸ Nusbaum, M.R. et al. (2004) Sexually Transmitted Infections and Increased Risk of Co-infection with Human Immunodeficiency Virus, *Journal of American Osteopath Association*, 104(12), pp.527-35.

²⁰⁹ Headspace (2019) Managing your Mental Health after an STI Diagnosis, available online: <https://headspace.org.au/blog/managing-your-mental-health-after-an-sti-diagnosis/>. (date accessed: 19/11/2019).

²¹⁰ NHS (2018) Complications: Gonorrhoea, available online: <https://www.nhs.uk/conditions/gonorrhoea/complications/>. (date accessed: 19/11/2019).

Conclusion

This report is vital if we're to ever tackle unacceptably high rates of STIs as it provides a stocktake of the current situation of STIs in England, as well as highlighting the stark gaps in the current evidence available. It is evident that although progress is being made in some areas, such as HPV and genital warts, there is still a long way to go if the current increasing trends in STIs are to be, at the very least, managed, and, ultimately, reversed.

Access, awareness, choice, and visibility of sexual health, are all key components to keeping up with the changes in STIs, however, there are clear barriers and glaring gaps among each of these. A large part of being successful in this progress is producing richer data and evidence in order to understand the full picture. Without this, only surface level solutions will be proposed, when it is evident that real change must target the roots of the problem. The government has a critical role to play in supporting this change through recognising the damaging impact of funding cuts and silo working. The upcoming national sexual health and reproductive health strategy will be key and has the potential to address many of the recommendations in this report.

Despite the clear challenges we face, we now have the opportunity to come together and realise the potential improvements that can be made and finally address the trends seen in STIs. We will be working to implement the recommendations of this report as part of both Terrence Higgins Trust and BASHH's work on sexual health. We hope you will join us.

Recommendations

RECOMMENDATION: Local authority sexual health commissioners must ensure funding is available to enable all sexual health services to provide the most accurate diagnostic tests for all sexually transmitted infections including trichomoniasis and Mgen, in line with national guidelines.

RECOMMENDATION: Treatment, guidelines and surveillance measures already in place for AMR should continue for STIs across all agencies that deliver care, and be extended for STIs that may pose a newer threat to AMR, for example Mgen.

RECOMMENDATION: For too long, the inequalities that exist in regards to the burden of STIs have been ignored. Charities, community groups, sexual health services, commissioners and policy makers must now acknowledge these inequalities and no longer ignore their existence.

RECOMMENDATION: In the face of such stark inequalities, the lack of research into the structural drivers of STIs in communities who face disproportionate burdens of STIs is unacceptable. Increased focus and funding must be made available to researchers, working alongside affected communities, to fill this evidence gap.

RECOMMENDATION: Now is the time for action. The Department for Health and Social Care, working with Public Health England, local authority commissioners and affected communities, must take affirmative action to tackle these inequalities, including through the design and delivery of tailored services and interventions.

RECOMMENDATION: The response to STIs to date has insufficiently examined the link between STI risk and wider determinants of sexual ill-health. The Government's new sexual health and reproductive health strategy must have addressing inequality at its centre, and should include actions to understand and tackle the wider socioeconomic determinants that may play a role in driving STI rates in England.

RECOMMENDATION: The erasure of identities in STI data must be reversed. Public Health England STI epidemiological data needs to better recognise the diversity of identities, providing data on transgender and non-binary people, specific ethnic minority communities and MSM who do not identify as gay or bisexual.

RECOMMENDATION: More research is needed, co-produced with individuals who engage in sex work or transactional sex to understand how their needs can be better met to ensure their sexual health, including STI prevention, and safety is ensured.

RECOMMENDATION: STI Patient information leaflets, and health promotion materials need to move beyond heteronormative and cisnormative narratives, ensuring the inclusion of other sexualities and gender identities.

RECOMMENDATION: The Government must ensure the national sexual health and reproductive health strategy is delivered as a matter of urgency. The strategy must set out ambitious targets to tackle STIs in England, providing detail on how these targets will be achieved, and setting out clearly the responsibilities of each statutory (and non statutory) organisation in working towards the ambition of the strategy. For the strategy to be a success, all stakeholders need to step up their focus and action on STIs.

RECOMMENDATION: Few charities exist focused specifically on sexual health. The charities within this sector need to increase their leadership and fully engage in the national strategy to ensure that it benefits communities at risk of STIs.

RECOMMENDATION: Local government has a key leadership role to play - locally, regionally and nationally. It must actively shape the new national strategy, and work in partnership locally to implement the strategy to the benefit of local communities affected by STIs.

RECOMMENDATION: Public Health England and the Department of Health and Social Care must prioritise sexual health including STIs. The national strategy is an opportunity for both organisations to show leadership and commitment to tackling STIs in England.

RECOMMENDATION: Public Health England should ensure the use of the new STI indicator within the PHOF is fit for purpose and provides an insight into progress on reducing specific STIs.

RECOMMENDATION: Public Health England should consider how the expansion of the HPV schools-based vaccination programme to some boys will be reflected in the HPV indicator within the PHOF.

RECOMMENDATION: Public Health England, working with local government and BASHH, should carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.

RECOMMENDATION: There is an urgent need to update the evidence base around behaviours linked to STIs. Public Health England and the Department for Health and Social Care, working with academics, clinicians and community organisations, must invest in research to provide a more up-to-date evidence base on the changing behaviours that are associated with increased risk of STIs; and work with commissioners and providers to ensure that this evidence is translated into effective targeted prevention interventions and enhanced partner notification.

RECOMMENDATION: HIV charities, services and commissioners must consider the sexual health needs of people living with HIV and work with communities to co-design targeted services and interventions that meet the diverse needs of all people living with HIV. The promotion and availability of PrEP must be better aligned with broader sexual health messaging to ensure that PrEP is seen as part of a comprehensive sexual health prevention strategy.

RECOMMENDATION: When it comes to condoms, something needs to change. Our knowledge on their use is out of date, and the marketing and promotion of condoms is dated. Funding should be provided to charities and community groups who are well placed to engage communities on why condom use is reducing and what actions could be taken to increase use and increase access.

RECOMMENDATION: Lessons should be learnt from HIV testing approaches, and actions taken by national and local commissioners to increase choice of STI tests - to make it as easy as possible to access testing.

RECOMMENDATION: Additional models of effective partner notification that take into account changing behaviours are being researched and recommendations from this should be considered by sexual health commissioners and providers.

RECOMMENDATION: It is evident that without adequate funding, there will be further reductions in the sexual health workforce, and any effective model of partner notification will be jeopardised. Funding, including for health advisor posts, must therefore ensure that sufficient workforce is in place to carry out effective partner notification.

RECOMMENDATION: A catch-up programme should be introduced for the HPV vaccine for the boys who will have missed out on this.

RECOMMENDATION: Additional options to prevent STIs are needed, with support for research into innovations urgently required from Government and research funding bodies. These options should build on current successes, learning from them, and reflect changing sexual behaviours.

RECOMMENDATION: The Department of Health and Social Care, working with local authorities, NHS England, with input from providers and community groups, must provide clarity on the future models of co-commissioning of sexual health services, ensuring transparency and accountability are core to any changes.

RECOMMENDATION: Government must commit to fully fund sexual health services, reversing the impact of past funding cuts, and provide sufficient resource to increase efforts to tackle STIs. This funding should ensure an adequately trained workforce including health advisors, nurses, doctors, and other Allied Health Care Professionals.

RECOMMENDATION: Workforce and training should represent a key pillar within the forthcoming sexual health and reproductive health strategy. Direction in the strategy should be given to ensuring all local contracts include provisions for how they will provide the support needs of their local workforce, including training.

RECOMMENDATION: The new national sexual health and reproductive health strategy should reintroduce the mandatory 48 hour access target, ensuring that the appropriate referral is given within this timeline, and that services hold up to BASHH and NICE guidelines on STIs.

RECOMMENDATION: The new national strategy must provide solutions to the current inadequate access to sexual health services – addressing the root causes of why access is deteriorating.

RECOMMENDATION: Research, with peer and patient engagement, should be undertaken to fill the data gaps in the barriers experienced when accessing services and the impact structural inequalities can have on sexual health.

RECOMMENDATION: Primary prevention should be recognised as an integral part of sexual health services, with a mandatory requirement for provision to protect such services from cuts.

RECOMMENDATION: Online sexual health services are a welcome addition to physical services, and should continue to receive support through funding, research and development. However, it is imperative to recognise that they are not a substitute for physical services, and should not be treated or relied on as such.

RECOMMENDATION: Access to alternative providers e.g. community pharmacies which are networked with the local sexual health service and work in partnership should be explored, recognising that the providers will be required to provide the standards of care recommended by BASHH²¹¹.

RECOMMENDATION: The new national sexual and reproductive health strategy must formally recognise and support the benefits community organisations can bring to engaging and supporting communities at greatest risk of STIs, whilst community organisations need to further step into the sexual health space and play their part in working towards meeting the holistic sexual health needs of the communities they serve.

RECOMMENDATION: The appropriate funding, training, and resources need to be provided to ensure that teachers are well equipped to provide comprehensive and inclusive RSE that includes information on STIs, and that links in with local sexual health providers and services.

RECOMMENDATION: Sexual health services and programmes must ensure interventions meet the needs of older people and sexual health promotion messaging must start to represent and target older people.

RECOMMENDATION: Health promotion messaging and information must be accessible to people with low levels of health literacy or literacy in English, as well as to migrants who may not speak English.

RECOMMENDATION: Sexual health charities and community groups should increase focus on programmes and projects to support sexual health community champions to talk about STIs and sexual health publically, as part of a push for change in knowledge, perceptions and action.

²¹¹ BASHH (2019) Standards for the Management of Sexually Transmitted Infections (STIs), available online: <https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/>, (date accessed: 19/11/2019)

The HIV and sexual health charity for life.

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