TOGETHER WE CAN

Terrence Higgins Trust

Delivering Equitable Outcomes

What we want to see from the new Sexual and Reproductive Health Strategy

The new national Sexual and Reproductive Health Strategy (SRH Strategy) for England provides a key opportunity for the UK Government to set out an ambitious approach to improving sexual health and reproductive health outcomes across all communities. We believe the strategy must include a number of key areas in its overarching vision and operational detail if it is to be a success.

The strategy must:	
1	Take a sex positive and human rights-based approach with gender equality and cultural sensitivity, equity, and social participation at its core.
2	Be ambitious, setting out commitment and actions to make progress towards the WHO 2030 goal to end STIs as a public health concern and initially the 2025 targets of lowering STI incidence by 20%.
3	Prioritise action towards significantly reducing health inequalities and assuring equity of access to services.
4	Tackle all forms of unmet need as a central ambition, setting out how unmet need will be monitored and what steps will be taken to meet need across all communities.
5	Adopt a cross-system approach with joint ownership by key system organisations with a role in sexual health, as well as clarify the role of integrated care systems.
6	Involve the community sector in the national and local implementation of the strategy.
7	Be fully funded including an uplift in funding for sexual health services.

In order to achieve this, there must be:	
1	Clearly defined targets, a monitoring and evaluation framework and annual reporting on progress.
2	Funding and support for research and innovation across all forms of sexual and reproductive health, including continuation of the national HIV, sexual health and reproductive health innovation fund.
3	Maximisation of the opportunity for collaborative commissioning of HIV, reproductive and sexual health services.
4	Commitment to commissioning mixed models of care to ensure face-to-face appointments remain available for all that need them, and digital access is expanded where appropriate.
5	Full utilisation of prevention tools that are currently available, such as the national HPV vaccination programme, properly resourcing partner notification and increasing access to all STI testing.
6	Commitment to mandate sexual health promotion and community outreach as part of primary prevention services.
7	Support for schools to fully deliver relationships and sex education.
8	A reversal of the changes to the National Chlamydia Screening Programme and recommencing of testing of young people of all genders, in order to protect people of all genders and prevent the framing of sexual health as a 'women's only' issue.
9	Support for all organisations involved in sexual health to adhere to antimicrobial resistance treatment and surveillance policies and facilitate the adding of emerging strains into these protocols.

Vision: Towards a positive approach to sexual health

The World Health Organisation (WHO) define sexual health as:

> ***'...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.'***
>
> (WHO, 2006a)

The new SRH strategy must consider all aspects of this definition if it is to have a real impact on the sexual health of the nation – this includes adopting a positive approach to sexual health. The strategy should support services and interventions to work holistically so they can drive forwards positive sexual wellbeing.

It must tackle threats to a person's physical sexual health, for example by reducing the incidence of sexually transmitted infections (STIs), as well as meeting people's mental and emotional needs by tackling sexual health stigma, discrimination and structural barriers to information and services. The strategy must support services and community interventions to work in partnership to prevent sexual ill health and narrow health inequalities.

The world is changing fast, the COVID-19 pandemic has rapidly increased the use of telemedicine and online access to information and testing. However, these changes, whilst promoting access for some, can create new barriers for others. The new SRH strategy cannot adopt a one-size fits all approach if it is to meet the needs of all. It must ensure face-to-face appointments continue for all those that need them, as well as facilitating the adoption of new technologies and modes of access.

Ambition: Ending STIs as a public health threat

The new SRH strategy should set out the government's commitment to achieving the WHO goal of "ending STI epidemics as a major public health concern by 2030". This would see the UK levelling up with France who has already committed to the 2030 goal in their 2017-2030 Sexual Health Strategy[1].

Vision and goals laid out in the WHO Global Health Strategy: Sexually Transmitted Infections 2016-2021 and draft WHO European region Action Plan 2022-2030.

SD1: To create a unified vision of the HIV, VH, and STIs epidemics within UHC and a health systems approach			
	SD2: HIV	**SD3: Viral hepatitis**	**SD4: STIs**
Vision	Zero new HIV infections, zero HIV related deaths and zero HIV related discrimination in a world where people living with HIV are able to live long and healthy lives.	A world where viral hepatitis transmission is halted and everyone living with viral hepatitis has access to safe, affordable and effective prevention, care and treatment services.	Zero new infections, zero STI-related complications and deaths, and zero discrimination in a world where everyone has free and easy access to prevention and treatment services for STIs, thereby allowing people to live long and happy lives.
Goal	End the AIDS epidemic as a public health threat.	Eliminate viral hepatitis as a major public health threat.	End sexually transmitted infection epidemics as a major public health concerns.

If the 2030 goal is to be met this new strategy must include targets on lowering the incidence of STIs. We recommend that the new strategy adopts the interim 2025 targets set out in the new 2022-2030 Action Plan for ending HIV, viral hepatitis and STIs in the WHO European Region[2].

STI targets set out in the WHO Global Health Strategy: Sexually Transmitted Infections 2016-2021 and draft WHO European region Action Plan 2022-2030.

[1] https://solidarites-sante.gouv.fr/IMG/pdf/strategie_sante_sexuelle_def_ang.pdf
[2] HIV-Hepatitis-STIs-actions-plans-consult-eng.pdf (who.int)

Indicator		Baseline 2020	Interim 2025 Targets	2030 Targets
Impact	Number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis in adults (age 15-49) per year	23 million (2020)	18.4 million -20%	9.9 million -90% for GC and syphilis -50 for chlamydia and trichomoniasis
	Number of new cases of syphilis in adults (age 15-49) per year	240,000 (2020)	-20%	-90%
	Number of new cases of gonorrhoea in adults (age 15-49) per year	3.8 million (2020)	-20%	-90%

In the last surveillance reports published by the European Centre for Disease Control, the UK had the highest diagnosis rates of chlamydia[3] and gonorrhoea[4] and third highest diagnosis rate for syphilis[5] of all reporting countries. This is in part due to our successful screening programmes and high quality surveillance reporting, but is also indicative of a high level of ongoing transmission.

This new SRH strategy is an opportunity for the UK Government to position itself as a global leader in sexual health. There has already been a push to be the first country to achieve the 'zero HIV' goal through the HIV Action Plan[6]. The next step must now be to also commit to working towards ending STIs.

[3] https://www.ecdc.europa.eu/sites/default/files/documents/AER-for-2018-STI-chlamydia.pdf
[4] https://www.ecdc.europa.eu/sites/default/files/documents/gonorrhoea-annual-epidemiological-report-2018.pdf
[5] https://www.ecdc.europa.eu/sites/default/files/documents/syphilis-aer-2018.pdf
[6] https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025

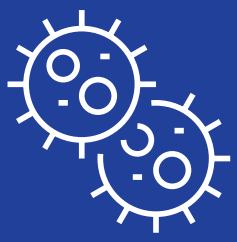
Equal progress: Significantly reducing sexual health inequalities

Trends within sexual health, as with many other aspects of health, are influenced by inequalities within our society. It is no coincidence that some of those at greatest risk of poor sexual health are also those most marginalised in society.

For example:

50%

of all STI diagnoses occur in people aged 15 – 24 years.



*Gay and bisexual men account for **75%** and **48%** of all syphilis and gonorrhoea diagnoses in 2020 respectively.*[7]

4x

*It has been found that women of Black ethnicity are four times more likely to **die during pregnancy** and birth than white women.*[8]

4x

***Rates of gonorrhoea** are four times higher in people of Black ethnicity compared to people of white ethnicity.*

Knowledge and access to PrEP drops significantly when looking at any eligible group beyond gay and bisexual men. We also know many of the most marginalised groups such as people from the trans community, migrant and asylum seekers, and sex workers face huge barriers to receiving care relevant to their needs.

[7] UKHSA surveillance data
[8] https://www.npeu.ox.ac.uk/mbrrace-uk/reports

The inequalities observed in sexual and reproductive health are stark and unacceptable.

In order to address these inequalities the new strategy must have equity at its core – it must address why inequalities exist in sexual health outcomes and be clear what action will be taken to overcome them. For example, many of the specific needs of young people could be addressed through access to sexual and reproductive health, HIV- and gender-based violence prevention services, as well as better access to high quality gender sensitive life skills-based sexual and reproductive health education as part of a holistic multisector approach to young people's development.

The strategy should specifically monitor progress against its aims within each community group affected by poor sexual and reproductive health outcomes, and take further action where unequal progress is being made. In addition, the Public Health Outcome Framework data should be published with breakdowns by demographic group available. The strategy should prioritise action to tackle inequalities, including through the design and delivery of tailored services and interventions ensuring that they are designed and implemented with those they seek to serve.

The value of co-production has long been acknowledged throughout academia and practice, however it is not always realised at all levels from strategy development through to service design and implementation. This strategy should provide a framework, funding and support for ensuring all interventions are co-produced – including with the most marginalised groups affected by sexual and reproductive health.

The strategy must also go beyond services to the root causes and drivers of these observed inequalities, tackling racism, homophobia, transphobia and socioeconomic inequality.

There is much that needs to be understood around how an individual's intersecting identities can conspire to make them more vulnerable to poor sexual health outcomes. There are various factors such as socioeconomic status, geographical location, mental health issues or substance misuse which can interplay with a person's identity such as their ethnicity or gender, that can affect a person's risk, ability to access relevant health information or receive appropriate care[9] [10]. This strategy will only lead to equitable progress for all by tackling these wider social drivers, such as by investment; joining up commissioning models to include wider determinants of health inequality e.g., mental health and substance misuse services with sexual health services; and removing economic barriers to accessing sexual health.

[9] https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30182-2/fulltext

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984393/SRH_variation_in_outcomes_toolkit_May_2021.pdf

Access: Addressing unmet need

The extent of unmet sexual health need across the UK population is not at all understood. There are many different elements to unmet need; for example, young people leaving the school system without being taught about sexual consent, people who do not regularly test for STIs despite being vulnerable, and those who try but cannot get a sexual health appointment or who during an appointment do not receive complete or appropriate care. These differing forms of unmet need have not been quantified and there is little understanding of how inequalities play a role in the distribution of unmet need.

The new strategy should have tackling all forms of unmet need as a central ambition. It should set out how unmet need will be monitored and what steps will be taken to meet need across all communities and in all settings, such as prisons and secure units.

The strategy should reflect the British Association for Sexual Health and HIV (BASHH) guidelines and include mandatory targets to ensure that all patients receive a sexual health appointment within 48 hours of contacting a clinic, alongside the waiting time at walk-in clinics being less than two hours[11]. Additional targets should also be included that reflect timely access to online sexual health services.

The strategy must reinforce that sexual health services will remain truly open access and set out what action will be taken against local authorities who are not providing open access services.

The COVID-19 pandemic has had a direct impact on the provision of sexual health services. Illness and redeployment of staff led to severe workforce constraints, reducing people's ability to access services. The strategy must be seen in the context of COVID-19 and include a clear plan on how sexual health services will be supported to get back up to capacity as well as implement lessons learnt, for instance around online access and telemedicine, and putting tacking inequalities at the heart of recovery of sexual health services post-pandemic.

[11] British Association of Sexual Health and HIV Standards for the management of sexually transmitted infections (STIs) (https://www.bashh.org/about-bashh/publications/standards-for-the-management-of-stis/)

Accountability:
A shared commitment

The strategy must adopt a cross-system approach. It should clearly set out ultimate accountability for its delivery, who is responsible for each action within the strategy, and how organisations will be held to account on progress against its delivery.

In order for progress against the strategy to be measured, it must include clear and defined targets. A monitoring and evaluation framework should be released that provides regular publically available progress updates. This should include progress against the WHO goal and BASHH access targets – including progress within communities most affected by poor sexual and reproductive health.

In addition to these targets we also support the recommendation from the Health Select Committee's report[12] for the strategy to set clear national quality standards for commissioners to adhere to.

To ensure that progress is being made not only against all targets and standards, but also for all population groups, a national implementation oversight group should be established, as is the case for the national HIV Action Plan. This oversight group should be inclusive of all stakeholders who have a role in delivering the strategy, including the community sector, and have a clear focus on monitoring whether the strategy is implemented in an equitable manner and progress is seen for all.

The government should release an annual update on progress against the strategy including an oral statement to Parliament on progress made.

The government must also commit to refresh the strategy two years after release if little progress has been made or progress is unequal across community groups.

[12] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/full-report.html

Involvement: The importance of community organisations

The value of patient involvement, community engagement and co-production have long been recognised across the health sector. When the Health Select Committee first recommended the need for a new SRH strategy in 2019, its report[13] clearly stated the need for involvement of all stakeholders across the sexual and reproductive health sector in the development of the strategy. As part of this involvement it was recommended that a National Working Group be established with representatives from public health, NHS England, commissioners, local government, patient representatives and service providers. This has not happened.

Prior to the recent public health restructure, the Public Health England Expert Advisory Group on HIV, sexual and reproductive health provided a forum for community organisations to input into and advise key policy and decision making. However, in 2021 this group was disbanded and there has been minimal opportunity for stakeholder engagement in the shaping of the SRH strategy and its implementation.

In order for the new strategy to meet the needs of all and be efficiently executed at the service level, it is vital that community organisations are involved throughout the process from drafting the strategy content through to its implementation.

It is encouraging that there is an expectation that the voluntary sector will be involved in the new local Integrated Care Partnerships and have influence over implementation at the local level. This must, however, include community organisations directly involved in sexual health. The same must also occur for national implementation and oversight.

Representation of communities most vulnerable to poor sexual health outcomes will ensure that the strategy has fully considered the needs of these populations as well as the barriers they face. Involvement of the community sector will ensure that the strategy is workable, adaptable at the local level and will function within the structural context.

The new national SRH strategy must also formally recognise and support the benefits community organisations can bring to engaging and supporting communities at greatest risk of STIs.

Community organisations have detailed knowledge of the key populations vulnerable to poor sexual health outcomes. This knowledge is needed for the strategy to not only shape appropriate services and interventions for those that need them most, but also to tackle the drivers of poor sexual health outcomes.

[13] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/full-report.html

National and local government should support community organisations to share intelligence and data (where appropriate) to better understand service impact and uptake, and recognise emerging trends and patterns at an early stage.

Community organisations are also best positioned to access communities and individuals who are less likely to come into contact with mainstream services. It is only through community outreach and community testing that no one is left behind and individuals are not permitted to fall through the gaps of an already highly fragmented health care system.

Without this knowledge and access supplied through community organisations the new SRH strategy will struggle to achieve a lasting impact on the sexual health of the nation.

Resources: Fully fund the strategy

For equitable and ambitious progress to be made, the government must commit to fully funding the strategy.

Sexual and reproductive health services have systematically had their funding cut to unsustainable levels. Health Foundation data indicates that sexual health service budgets have been cut by 14% between 2015/16 and 2020/21, at a time when STIs have skyrocketed and demand for sexual health services rose year on year[14]. The National Spending Review published in autumn 2021 only committed to a 'real terms' maintenance of the local authority public health grant and did nothing to reverse the years of cuts. The public health grant allocations published early 2022 were a tiny increase in budget but not making up for both rising inflation and service pressures. Within this funding situation sexual health services are being stretched beyond capacity and will be unable to meet the needs of all.

The new strategy must set out a funding plan that will both include a COVID-19 recovery plan and reinvestment in much needed services.

An increase in funding for the local authority public health grant will not only enable increased access but stable funding will also encourage local authorities to commission services longer term. This will allow for better long term strategic planning and relieve some of the administrative pressures on both commissioners and service providers of short-term commissioning.

[14] https://www.health.org.uk/news-and-comment/charts-and-infographics/why-greater-investment-in-the-public-health-grant-should-be-a-priority

Research and Innovation

As mentioned, there is much to be understood about the drivers around sexual health and unmet need. There is also a need to develop more tools to support the nation's sexual health and wellbeing. Within HIV, innovations such as PrEP and U=U (those on effective treatment can't pass on HIV) have been game changers. The same is needed if we are to truly tackle other aspects of sexual ill health.

The strategy must go beyond the much needed investment in services and invest in research so that new innovative prevention methods may be developed. If current trends are to be reversed and progress made for all population groups more tools and prevention options are needed.

The strategy must provide funding, frameworks and opportunity for much needed research to fully understand the sexual health of the nation. This research must generate the evidence base for policy decisions such as cost-benefit analyses of new and existing interventions, as well as development of innovative ideas – everything from new tests, new ways to access services, to novel health promotion strategies.

There must be a commitment to continue the national HIV, sexual and reproductive health innovation fund, but with additional funding for a renewed focus on inclusivity, tackling of inequalities, gender equality, and culturally sensitive approaches through innovation.

In addition, we recommend that new funding is provided for an annual national conference for the sexual and reproductive health sector. This conference should be inclusive of all related stakeholders and facilitate shared learning, sector development, and ensure that sexual health interventions reflect the changing situation in the UK.

Commissioning:
The opportunity of joined up care

Over the past decade the healthcare sector as a whole has become increasingly fragmented. This new strategy is an opportunity to set out how HIV, reproductive and sexual health services can be better commissioned and funded, such as through collaborative commissioning.

The new strategy must make clear the role of Integrated Care Systems in supporting both the joined up commissioning and the delivery of HIV, reproductive and sexual health services.

The new strategy is also an opportunity to look at how the commissioning of joined up services could tackle some of the drivers of sexual ill health and the observed inequalities. For example, through the joint commissioning of blood borne viruses, drug and alcohol, gender based violence, mental health, financial advice and sexual health interventions and services. This could help ensure there are no missed opportunities for providing advice and interventions across all areas. These forms of services would also help prevent some of the barriers created for individuals who are not registered with a GP or who do not wish to access particular services through their family GP.

The strategy must ensure that there is a commitment to commissioning mixed models of care. The move to telemedicine and online access was vital during the pandemic and many sexual health services should be heralded for how efficiently they transitioned to these new ways of working. Online services work well for some individuals and where demand for these services is increasing they should be expanded. However, these virtual forms of contact cannot fully replace face-to-face services with COVID-19 starkly highlighting the impact of digital poverty. Online forms of access are not appropriate for all individuals and risk creating barriers to those without access to technologies, those who have concerns around confidentiality, have certain disabilities or have more complex or safeguarding needs. Whilst the new strategy should support expansion in routes and access to testing and care, this should not be at the cost of face-to-face appointments where needed. Choice is key and all services must be supported to offer a range of access routes and forms of care.

The new strategy is also an opportunity to better support the commissioning of tailored services for marginalised populations. Staff training should be implemented to ensure all services deliver appropriate and sensitive care for all patient groups.

All organisations commissioning and delivering sexual health services at a local level should undertake regular Equality and Diversity Impact Assessments to help ensure that their services consider and respond to their impact on different groups and communities.

As mentioned, people from the trans community face major barriers to appropriate care, especially when living in areas that do not have trans specific or inclusive sexual health services. This must be addressed. Similarly, the strategy must work for sex workers. For people who work in the sex industry the ability to access non-judgemental sexual health advice and services can be a hurdle in maintaining sexual health and wellbeing.

Prevention: Maximising successful interventions

Considering prior to the pandemic rates of STIs were on the increase, in order for this 2030 goal to be achieved the new strategy must double efforts to fully maximise the prevention tools that we currently have.

Information and advice

The strategy should commit to mandating primary sexual health prevention services, such as health promotion, condom distribution, and sexual health training for professionals and community outreach. This is required to ensure that these specialised services, which are so vital if equitable access is to be achieved, are protected from service cuts.

Currently, they are not a mandated part of sexual health services and it is up to the discretion of local authorities as to whether they are commissioned. All aspects of primary prevention are, however, a vital component of sexual health work as it supports people to remain well, reducing the burden on sexual health services. In addition, community outreach, for example, facilitates access to some of the most marginalised groups in society who may otherwise not come in to contact with sexual health messages and support. The strategy should recognise that primary prevention is an integral part of sexual health services by fully mandating their provision.

Condoms

The ability to access and willingness to use condoms must be seen as a crucial pillar of primary prevention for both sexual and reproductive health. 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 access and use.

Relationships and Sex Education

Relationships and Sex Education (RSE) is now mandatory in all schools in England. Its implementation has been delayed and recent evidence from the Sex Education Forum shows that one third of young people were still finishing school without being taught how to access a sexual health service. In addition 46% were not taught about sexual pleasure and 28% did not learn how to recognise healthy relationships[15]. All young people should leave school with the sexual health knowledge they need. The strategy should reinforce the need for an adequate focus on sexual health content within RSE

[15] https://www.sexeducationforum.org.uk/sites/default/files/field/attachment/Young%20Peoples%20RSE%20Poll%202021%20-%20SEF%201%20Feb%202022.pdf

lessons and ensure schools deliver consistent up to date information. This should include providing support, resources and training for schools and teachers.

HPV Vaccination

The past few years have seen some meaningful progress in access to the HPV vaccine. This includes the move to include boys into the school immunisation programme and the recent change to a two dose regimen for gay and bisexual men through sexual health services.

However, there are still many who are struggling to access the vaccine. A key group are young men who only just missed out on being included in the school programme. Many parents are struggling to understand why their sons are not being offered this protection, with expensive private healthcare as their only option for accessing the vaccine. The strategy must set out how the needs of this population of boys can be met and reconsider running a catch up programme for 15-18 year olds who missed out at the introduction of the school programme.

As with all aspects of life the COVID-19 pandemic had a major impact on access to the HPV vaccine. School closures impacted the school HPV programme and the government has now set out its plans for catching up those children who missed out in 2020 and 2021. However, there was also a major impact on access through sexual health clinics, with 64% fewer gay and bisexual men receiving their first dose of the HPV vaccine in 2020 compared to 2019[16]. The strategy must therefore include direct consideration of a catch up programme or increased access routes to the HPV vaccine for gay and bisexual men as well as implementing the school catch-up programme.

Partner notification

Testing through partner notification systems is one of the most efficient modes of testing there is in terms of the test positivity rate. However, in order for this to be done properly the strategy must commit to proper resourcing of staff capacity and training. Recent technology developments such as mobile applications that facilitate anonymous notifications and health promotion should also be considered in the strategy.

Increasing access to STI testing

In order for there to be equitable access to testing, a range of routes should be supported by the strategy. 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.

The new strategy must ensure that good practice is shared and scaled up so access and quality of care is consistent across the country. There are numerous examples of

[16] Table 4: all STI diagnoses and services by genders and sexual risk 2016 – 2020, Public Health England annual data tables (https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables)

innovative practice across the sector including development of HIV self testing kits, and novel distribution methods such as 'click and collect' which show promising results[17]. The options and routes for postal testing should be expanded and made consistent across all local authorities. However, without a greater range of STI tests being widely available across the whole population, these innovations will fail to reach their full potential.

The pandemic has shown the appetite for telemedicine and online access to testing which should continue to be supported. This should also facilitate people being able to book appointments at sexual health services online and explore options for automated texting alerts and routes to access tests for key groups.

As mentioned, by creating a mandate for primary prevention services, community testing and outreach can be protected. Community testing is a key tool when reaching those who experience the most complex barriers to accessing services.

In addition to increased modes of access to testing, the strategy must also enhance the funding and availability of the range of tests obtainable. For example, at present testing of the recently emerging STI Mgen is only available at a proportion of sexual health services. Need and availability of tests for emerging infections, as well as antimicrobial resistant strains of STIs, must be regularly reviewed and rolled out consistently across all services.

[17] https://www.bhiva.org/file/5ca756a5a39fd/GeorgeHalfin.pdf

National Chlamydia Screening Programme: Ensuring sexual health is still a joint responsibility

The government recently implemented changes to the National Chlamydia Screening Programme (NCSP) downgrading to only testing young women and for its aim to only prevent the most extreme of health outcomes. Whilst of course tackling all negative health outcomes is welcome, this singular focus shows a worrying lack of aspiration for the sexual health of the nation. This new strategy is a chance to set that right.

These changes put an unacceptable burden of responsibility for the sexual health of young people exclusively on young women. These changes also send a message that young men don't need to be tested. This is worrying due the impact this could have on gender dynamics, relationships and the imperative for young men to care for their own sexual health. They also put people of trans and non-binary identity, as well as gay and bisexual men at an even greater risk of undetected chlamydia infection than they are already. There is a need for clarity in the message now being promoted around the NCSP and greater guidance to ensure consistency of how the programme is implemented across the country.

In addition, this NCSP acted as a good gateway to engage young people of all genders in broader STI prevention, testing and treatment. This opportunity has now been lost for half of the population.

The new strategy is a chance for the government to be bold and ambitious in its aspirations for the sexual health of the nation. But in order to achieve this the changes to the NCSP must be reconsidered.

The strategy should ensure that a focus on men is included and that the shared responsibility for sexual health remains. The strategy should not put pressure on women to be solely responsible for sexual health nor make sexual health and reproductive health a "women only" issue.

Drug Resistance

There already exists robust treatment policies and surveillance measures around antimicrobial resistance. The new strategy must help support all organisations and agencies involved in sexual health care, including private companies and commercial outlets, to adhere to these. There should also be mechanisms in place for adding emerging STIs or emerging resistant strains, such as Mgen and shigella, to the existing protocols.

The strategy must also support the work of BASHH to ensure testing and prescribing practice of all public and private service providers are in line with efforts to prevent STI antimicrobial resistance. This includes developing a policy on the emerging behavioural trends which may pose risks for driving resistance such as individuals privately sourcing doxycycline in attempts to use as pre-exposure prophylaxis against syphilis.