Love Sex Life
Our Sexual Health Matters

Transforming sexual and reproductive health for BAME communities in Lambeth, Southwark and Lewisham

Main Report

A report by the Love Sex Life LSL Partnership

Contents

Thanks

We would like to thank all of the 150 online survey participants, 11 NAZ service users (who were remunerated for their time) and community and SRH stakeholders who provided input during the consultation period, including:

Victoria Alvarez, Save Latin Village

Sophia Benedict, Pecan Women's Service

Dougie Boyd, Brook

Ron Bourne, Stephen Lawrence Charitable Trust

Leandra Box, Race Equality Foundation

Gemma Dickson, Lambeth College

Aicha Kallo, NAZ

Nathan Lewis, Southwark LGBT Forum

Jennifer Dobbie, Guy's and St Thomas' Sexual Health Clinic

Jide Macaulay, House of Rainbow

Sophia Mindus, Fulfilling Lives LSL

Monty Moncrieff OBE, London Friend

Stephe Meloy, Lewisham LGBT Forum

Rianna Raymond-Williams, Shine ALOUD

Solomon Smith, Brixton Soup Kitchen

Claudette Stewart, Mursell Estate

Ineala Theophilus, Brook

Marc Thompson, PrEPster

Introduction

Introduction

The COVID-19 pandemic made it clearer than ever that there is an urgent need to address inequalities that are at odds with good sexual health for many BAME people in Lambeth, Southwark and Lewisham. The Love, Sex, Life LSL Partnership (Love, Sex, Life) was commissioned in the Spring of 2020 by the councils of Lambeth, Southwark and Lewisham (LSL) to work on addressing these inequalities to ensure all can access high quality, culturally sensitive sexual health services and education across the three boroughs.

BAME (Black, Asian and Minority Ethnic) communities make up 44% of Lewisham's population, 44% of Lambeth's and 47% of Southwark's. The LSL Sexual and Reproductive Health Strategy 2019-24 highlights that LSL has some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and termination of pregnancy.

This report explores three core themes that arose from our research: the need for safe spaces; the need to counter stigma and improve sexual and reproductive health awareness; creating culturally sensitive and reproductive health systems and services; and the additional barriers that BAME and LGBTQI+ women face. The report makes a series of recommendations to improve the sexual and reproductive health outcomes of the various BAME communities within the London boroughs of LSL.

The findings of the report will be used to produce a cohesive communications strategy in LSL. The communications strategy will drive the overarching objectives of Love, Sex, Life commissioned by the councils of Lambeth, Southwark and Lewisham in partnership with Brook, NAZ, Shape History and the Stephen Lawrence Charitable Trust (henceforth known as 'the Partnership').

i | About this paper

The paper is the write up of Shape History's discovery phase from April to June 2020. The discovery phase aimed to gather an understanding of the community and their current attitudes to their sexual health and related services. This feeds into, supports and explores facets of the LSL Sexual and Reproductive Health Strategy 2019-24 which outlines why LSL has some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortion.

This paper will be used to produce a cohesive communications strategy and influence service provision of Love, Sex, Life in LSL, including stakeholder and persona mapping, a cross channel campaign plan, micro influencer engagement and outreach, key messaging and narrative, and timelines.

Love, Sex, Life builds upon the work of The Rise Partnership (April 2016 to March 2020). Our service will confront inequality in BAME sexual health, aiming to drive and build capacity with individuals and communities. The partnership will collaborate with a variety of groups to build a community led communications strategy, enabling social and attitudinal change towards sexual and reproductive health (SRH). Crucially, the project's impact will be measured and evaluated..

ii | Who is the research audience?

This report, Transforming sexual and reproductive health for BAME communities in LSL, is a report for all members of Love, Sex, Life and Sexual Health Commissioners and is intended to shape our communications strategy and our wider services. The report will be published to be shared with our wider BAME sexual health community, including organisations supporting service users, individuals interviewed and those engaged with the partnership for the duration of the service.

iii | Contextual considerations

We considered a number of contextual considerations when developing both the research methodology and analysing the findings. These were:

iii.i | Environmental

Specific environmental factors were analysed before the research was conducted and taken into account when building our methodology and analysis. Perhaps most notably, the COVID-19 pandemic has exacerbated health inequalities. Long-standing disparities in health outcomes between people from BAME backgrounds and the white British population are coming to light, highlighting the impact of structural inequalities and institutional racism on individual wellbeing and health.

The Public Health England report, Beyond the data: Understanding the impact of COVID-19 on BAME groups published in June 2020 went on to corroborate early accounts of inequalities in the impact of COVID-19[1]. The impact of COVID-19 on BAME communities in LSL was a theme that formed the focus of an initial community consultation, which opened up to more detailed discussion on signposting of services, mental health and wellbeing, reticence to accessing services and housing. From the first community consultation, themes around stigma and safe spaces emerged. These initial themes then formed the basis of the stakeholder interview questions, service user questions, the survey and further community consultations.

HIV Inequalities

London has been at the forefront of delivering innovative provisions for Human Immunodeficiency Virus (henceforth described as HIV), becoming the first city in the world to diagnose, treat and virally suppress 97% of people living with HIV[2]. Much of this prevention work was focused on the homosexual and African communities, respectively. These efforts have led to a significant decrease in HIV transmissions, especially for men who have sex with men (MSM). However, this hasn't been reflected in BAME heterosexuals and women.

On a local level, LSL has the highest rate of diagnosed HIV in England, with over 8,700 of the boroughs' residents receiving a diagnosis[3]. In LSL generally, there has been a significant reduction in new HIV diagnoses, however for BAME communities and more specifically Black communities within the boroughs, the risks for contracting HIV remain high. A high proportion of women diagnosed with HIV in the boroughs are Black African, with this group also having a higher proportion of late diagnosis.[4]

Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) for those diagnosed. Nationally, rates of HIV are higher amongst gay/ bisexual men, though notably higher in London than the rest of England.[5] Risk groups have also been identified across England: these include men who have sex with men, and heterosexual people with Black African ethnicity, amongst others. These findings broadly reflect the HIV rates in LSL, though notably HIV rates are generally higher in these boroughs than the national average.

The National AIDS Trust (NAT) HIV In African Communities Report, a policy report published in 2014, provided a clear sense for the possible reasons underlying the

1 Public Health England Beyond the data: Understanding the impact of COVID-19 on BAME communities. 2020
2 Public health England Annual epidemiological spotlight on HIV in London
3 Joint Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy. 2019-2024
4 Joint Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy. 2019-2024
5 Public Health England Progress towards ending the HIV epidemic in the United Kingdom 2018

disparities in HIV outcomes and suggested why prevention campaigns too focused on only African men and women are not only alienating to other black communities, but are also not responsive to new trends in acquired infections. Bearing in mind the large Black African community in the three boroughs, as well as the shifting demographics of acquisition in boroughs like Lewisham, this suggests that current approaches need adapting. The report argues that future prevention work should not exclusively focus on African men and women.

The key findings of the NAT report we considered were:

- Examine housing, immigration and poverty as both risk factors to contracting HIV and influences on Black African's experience of living with HIV;
- Rethink the current approach to faith groups for outreach programmes which should be a priority of government and local level bodies;
- Investigate the prevalence of gender-based violence amongst women living with HIV, including Black African women;
- Move away from an ethnicity-based approach and start to integrate HIV prevention work on a wider level within the heterosexual population to prevent alienation and stigmatisation;
- Black African women living with HIV face multiple risk factors to their health and wellbeing.

Sexually Transmitted Infections (STIs) inequalities

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20–24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at ages 15–19. It is unclear what is driving this pattern, with the LSL Sexual Health Strategy speculating that this could be down to pressure from male partners in heterosexual couples. The trend could be due to increased testing of females and/or presence of symptoms. The following trends are drawn from the LSL Sexual Health Strategy[6].

As of 2018, Lambeth and Southwark respectively have some of the highest rates of STIs in the country, with diagnoses per 100,000 at 3,392 in Lambeth and 2,809 in Southwark, compared to the national rate of 784.4. Lewisham has recorded the highest rates of STI re-infection in LSL. A limitation was that we weren't able to source existing data about BAME STI inequalities in LSL.

Reproductive health inequalities

Austerity measures in the UK have resulted in significant cuts to public spending and sexual health provision services. Studies show that funding cuts can disproportionately

6 Joint Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy. 2019-2024

affect people from ethnic minority backgrounds and especially be evident in poor sexual health outcomes[7].

The LSL Sexual and Reproductive Health Strategy (2019-24) highlights that black African and Caribbean women have higher rates of abortion. When looking at the higher abortion rates for Black African and Caribbean women in LSL[8] it's essential we understand the decision to undertake an abortion is shaped by historical, individual, societal and economic factors.[9]

The rate of abortion is higher in LSL amongst women describing themselves as of Black Caribbean and Black African heritage.[10] If the need for abortion is used as a proxy measure for not having reproductive needs met (abortion being the last intervention to prevent an unwanted pregnancy), Black women in LSL have the highest level of unmet reproductive health need. Black women experiencing poorer reproductive health in LSL reflects the wider inequalities Black women experience around their reproductive and maternal health. A 2018 report by Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) found that the chance of death in childbirth is 1 in 2,500 for black women while for white women the rate is five times lower[11]. Through our analysis of interviews with local community stakeholders and service users, poorer reproductive health was linked with temporary housing, poverty and with pressure/stigma from partners using contraception, as well as late diagnosis of HIV in Black women over the age of 50, particularly those in monogamous relationships. This is an area that needs further investigation.

iii.ii | Social/Cultural

We approached the research understanding that various societal and cultural factors also impact sexual and reproductive health outcomes in LSL.

There is a growing body of evidence which demonstrates that the development of Sexual and Reproductive medicine has relied on unethical medical research often on colonised populations[12]. With Western SRH deeply rooted in practices of experimentation and of mass sterilisation for colonised women as a means for population control, this has created an inherited mistrust for many people from former colonised territories[13]. These factors have been linked to poor sexual health

7 Cuts to sexual health services are putting patients at risk, says King's Fund (2017)
8 Sexual and Reproductive Health Strategy 2019–24 Lambeth, Southwark and Lewisham Public Health Departments
9 London School of Hygiene and tropical medicine: Understanding differences in conception rates among under 20s in Britain and France (2016)
10 Sexual and Reproductive Health Strategy 2019–24 Lambeth, Southwark and Lewisham Public Health Departments
11 MBRRACE Maternal, New-born and infant clinical outcome review program. Saving lives, improving mothers care. 2014-2016 (2018)
12 CFFP Decolonising sexual and Reproductive health (2020)
13 Geographies of Power, Legacies of Mistrust: Colonial Medicine in the Global Present, Richard C. Keller (2006)

outcomes for people from BAME backgrounds and lower levels of trust in health services[14].

The colonial past of public health has a direct impact on current modes of thinking in many diaspora communities living in the United Kingdom, manifesting in well documented suspicion[15] and avoidance around vaccinations and other medical practices, including around HIV vaccine trials[16].

iv | Overview of research design

iv.i | Research objectives

The objectives were twofold:

• To identify current barriers or gaps in provision that Black African, Black Caribbean and other minority ethnic residents experience with regards to their sexual and reproductive health.

• To identify solutions and opportunities for improving sexual health outcomes, education and engagement across LSL through highlighting best practice and inviting residents to offer their input and preferences.

iv.ii | Research methodology

To gather findings, Shape History took a mixed methodology approach to research with an online survey, a series of qualitative interviews with NAZ's service users and a further 21 qualitative interviews with a range of providers and specialists. As far as possible quotation is used to allow community members to articulate their own experiences.

Initially, the original research methodology involved in-person consultations, focus groups, and interactive and visual surveys. However, due to the rapidly changing landscape as a result of COVID-19, Love, Sex, Life had to immediately adapt and the research methodology was affected as a result. In the end, we focused on a digital survey for the general public, interviewing local and relevant SRH stakeholders, and interviewing service users. We decided on this route of discovery as it was the most practical way to reach people during lockdown.

iv.iii | Survey

We collected data using an online survey on online platform Typeform which was promoted via social media, and via email to local SRH and related service stakeholders. It was also promoted during the qualitative interview process with

14 Disparities in Black Reproductive Well-Being, Power to decide, Cat McKay, Jacqueline Pelella (2020)

15 This is why some black parents don't vaccinate their children, Gal-dem (2019)

16 Why blacks do not take part in HIV vaccine trials, Demetrius L Moutsiakis 1, P Nancy Chin (2007)

SRH and community stakeholders, with links sent following interviews. The survey attracted 150 participants, most of which were based in Lambeth, Southwark or Lewisham. Since the survey was solely available to complete online, our assumption is that the data collected are limited to people with more digital connectivity.

A social media toolkit was created with example posts for Twitter, Facebook and Instagram, as well as graphics. The toolkit was shared with the partnership as well as wider stakeholders within Lambeth, Southwark and Lewisham. The survey was promoted from 11 May 2020 until 12 June 2020. Every week, the survey responses were analysed to assess which audiences we were reaching and what audiences we were missing. There were a low number of male responses In the penultimate week the survey was live, we created graphics specifically for men to try and improve the number of male respondents. We also reached out to Black Men's Health, PrEPSTER, and other relevant organisations to try to increase the number of male respondents. There were over 300 link clicks through to the survey, but only around 20-30 responses on the actual survey from the ads.

The survey participants had the following demographics:

Gender identity

137 out of 150 participants answered the question regarding gender identity. 72% (99 participants) identified as female, 26% (36 participants) identified as male and 2% (two participants) identified as gender fluid. None of the participants self-identified as intersex. The imbalance owes to the digital recruitment of survey participants where participants were able to self-select to take the survey rather than being recruited, so ensuring more equal balance of gender will be prioritised in forthcoming Love, Sex, Life research.

Ethnic origin

144 out of 150 participants answered the question regarding ethnic origin. Out of these 144, the ethnic origin of survey participants was:

Black African
18%

Black British
15%

White British
13%

Indian
10%

Mixed Ethnicity
8%

Black Caribbean
7%

Latino
5%

Mixed Ethnicity Caribbean
4%

Any other Asian background
4%

Chinese
3%

Mixed Ethnicity African
3%

Pakistani
3%

Prefer not to say
1%

Other
4%

Sexuality

60% of participants self-identified as heterosexual or straight, 15% as homosexual or gay, 13% as bisexual, 4% as pansexual, and 7% preferred not to say, or identified as other/ unsure.

Borough

129 out of 150 participants answered the question regarding which borough they were a resident in. The most participants were Lambeth residents (27%), then Southwark (19%) and Lewisham (17%). The remaining 36% mainly lived in other London boroughs, including neighbouring South London boroughs Greenwich, Croydon, Sutton, Merton and Wandsworth. We included respondents from other boroughs in our analysis as although we promoted the survey heavily within LSL we acknowledge that some respondents may live out of borough, but work in LSL or access sexual health services there. We felt that these contributions were important to capture. We also felt that the lived experiences of those from the BAME community is relevant and valuable even if they may not live within the boroughs as they may be facing similar barriers. Whilst a high number of people answered the survey from outside of the borough or didn't declare where they lived, we have identified this as an important lesson to take forward for future surveys. Moving forward, questions identifying where the respondent may be from will be compulsory or the survey will end if they do not live in the boroughs.

iv.iv | Use of sexual health services in survey participants

When was the last time you used an in person sexual health service?

- **21%** Between six months and one year ago
- **18%** More than one year ago
- **17%** Never
- **15%** Less than six months ago
- **12%** More than two years ago

Our survey found that approximately a third of people are not regularly (two years ago and above) testing for STIs, with 17% of participants (25/145) never having used an in person sexual health service. The survey also looked to understand the barriers to why people may not access services. While stigma and shame, (explored in the next section) were cited as barriers, equally family and privacy, financial hardship and immigration were also cited.

Have any of the below issues ever been a barrier to you accessing services?

26%	**Fear of judgement**
20%	**Family and privacy**
9%	**Mental health issues**
6%	**Financial hardship** (i.e. no money for travel)
3%	**Housing**
3%	**Immigration status**
1%	**Domestic violence** (i.e. my partner is controlling or violent)
52%	**None of the above**

iv.v | Qualitative interviews with residents

We were able to collect further information and insight through our qualitative phone interviews with Naz's service users who are living with HIV. Considering the unheard needs of the growing Latin American community, NAZ's Latin American service manager was able to facilitate the collection of additional data with a shortened version of the survey with some questions tailored to the experiences of those living with HIV. In total, we interviewed 11 service users living with HIV.

iv.vi | Interviews with providers and sexual health specialists

We conducted 21 qualitative interviews with a mixture of local service providers, including sexual health specialists but also including: probation services; an organisation focused on vulnerable women residents in LSL; and community-based activist organisations. All have experience delivering frontline services to LSL communities, as well as a few London-wide providers. Our approach to analysing the collected data followed the Framework Method, appropriate for multi-disciplinary research teams that can include a mixture of social scientists, health professionals and lay-people.

The Framework Method has some limitations, being resource-intensive, however the limited sample size means we integrated the thematic analysis with the more analysis of the quantitative data from the public survey and we can compare and contrast data, including against existing data like in the LSL Sexual Health Strategy, which forms the initial context for this work[17].

iv.vii | Community forums

Early in the project we were able to engage with groups from Southwark and Lewisham but less so with delegates from Lambeth. Ultimately some delegates of Lambeth SRH stakeholder organisations engaged via 1:1 telephone calls.

Previously scheduled in-person engagements were abandoned quite early with the emergence of COVID-19. After our first event in March 2020 in Sydenham, Lewisham, all stakeholder engagement activity quickly migrated online. This purely virtual approach was initially more challenging in terms of motivating stakeholders to engage with peers they had never met prior to this project.

During a stakeholder engagement session in September, the consensus among attending members, mostly from Lambeth, was that there would be great value in the formation of a SRH stakeholder network in which peers could share knowledge and experience and combine resources, as well as work more collaboratively. Some of these networks certainly exist, particularly between BAME communities within the boroughs, but the need for a more sector specific network was raised. It is the aim of Love, Sex, Life to build this network through existing and new partnerships across the boroughs. Most felt that

17 Joint Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy. 2019-2024

the most obvious solutions for the challenges many of them faced could be overcome through cooperation.

In total, four consultation events were held with 19 stakeholders from the Lewisham BME Network attending. These sessions were led by the Stephen Lawrence Charitable Trust. Seven stakeholders were from Lambeth, seven stakeholders from Lewisham, and five from Southwark.

v | Our approach and use of language

We are guided by the belief that in order to tackle current inequalities, we must address the colonial history of healthcare by grounding our work in social justice and calling out systemic injustice and racism. We approached the research understanding that various societal and cultural factors also impact sexual and reproductive health outcomes in LSL. Cultural factors that currently impact Black African and Caribbean, Latin American and South Asian communities are varied but include stigma and insensitivity relating to; HIV, sexually transmitted infections (STIs), sex and relationships.

Glossary

RSE: Relationships and sex education became compulsory in the England from September 2020.[18]

SRH: Sexual and reproductive health is used in this report to denote the state of physical, mental and social wellbeing in all matters relating to human reproduction and the reproductive system. The use of the term denotes that people are able to have a satisfying and safe sex life, and have the right, the capability and the freedom to decide if, when and how often to reproduce. It requires a positive and respectful approach to sexuality and sexual relationships.

BAME: BAME is used to denote Black, Asian and Minority Ethnic communities in this report. To quote Charity So White, "the language we have to hand is not perfect". We use BAME in reference to all racialised groups who are impacted by the structural inequalities described throughout the report.

Our community: Love, Sex, Life is a partnership commissioned to serve the communities most impacted by sexual health inequalities. In the three boroughs, these are the Black African, Black Caribbean, South Asian, Latin American and any other minority ethnic groups. It is important to note the large amount of mixed-race

18 UK Government Department of Education guidance: Relationship and Sex education and health education (2020)

and multiple-ethnicity individuals born and living in the three boroughs, and that many individuals do not fall into the categorisations captured in public health data. It is therefore important to acknowledge the limitations of speaking by and for such diverse communities, who may share similar structural barriers to health, but who have diverse individual experiences.

Marginalised: When we discuss marginalised or at-risk groups in the report, we do this in the context of breaking down the implicit barrier between residents and sexual health services. This is particularly relevant in the three boroughs where communities, notably the Caribbean Windrush immigrants still face the impact of hostile immigration policy (historical and current).

PEP: PEP is a course of anti-HIV medication where people must get the treatment as soon as possible after a possible exposure to HIV, ideally within a few hours.

PrEP: PrEP is a drug taken by HIV-negative people before and after sex that reduces the risk of getting HIV. In England it was available as part of a trial before being routinely commissioned from October 2020. It is also available in Scotland and Wales.

MSM: Men who have sex with men. The term is often used to describe this group without considering issues of self-identification of sexuality.

HIV Positivity: People testing positive for HIV.

GBV: Gender-based violence and violence against women are terms that are often used interchangeably as it has been widely acknowledged that most gender-based violence is inflicted on women and girls by men. Throughout the report we use the term GBV to denote all forms of gender-based violence, including domestic violence, reflecting the disproportionate number of these particular crimes against women.

NRPF: No recourse to public funds. Section 115 of the Immigration and Asylum Act 1999 states that a person will have 'no recourse to public funds' if they are 'subject to immigration control'. This means they have no entitlement to the majority of welfare benefits, including income support, housing benefit and a range of allowances and tax credits[19].

Reproductive rights: The 1967 Abortion Act legalised abortion in Great Britain under the condition that two registered medical practitioners agreed that the continuation of pregnancy would affect a woman's mental or physical health. We look at reproductive rights through the lens of the continual power of Western Imperialism.

19 London Council No Recourse to public fund (NRPF)

vi | How these research findings & recommendations can be used

These research findings and recommendations are intended to be used to shape and guide Love, Sex, Life's approach to sexual health promotion and establish a functional and trusted feedback loop between residents and commissioners to promote, evolve and improve access to services.

Initially, this research was solely intended to inform the communications strategy and plan of Love, Sex, Life. It was and remains the intention of Shape History to develop and execute communications that are co-designed and act upon key insights gathered from service users. However, following the conclusion of the research and an evaluation of the findings, it has become clear that they have the potential to provide valuable insight that may influence activity beyond the communications and promotion of Love, Sex, Life.

Therefore, whilst the original audience for this report was the Love, Sex, Life internal team, it is now apparent that certain findings recommendations may be relevant to the wider SRH sector, as well as the residents it has consulted and commissioners.

Addressing local stakeholder apathy with commissioned SRH services

It is also important to note that external publication and communication of these recommendations and findings, both through owned channels and earned media, is essential to addressing the fatigue and apathy towards public health research expressed by BAME residents from LSL (see Community Forum, p7). Proactive communication of the report, and the way in which this may influence and shape service provision within Love, Sex, Life and wider SRH sector, is crucial to building trust with BAME residents that their voices and opinions are valid, heard, and actioned. As referenced above, establishing these feedback loops, both public and private, will help the promotion and adoption of services.

Key Findings and Recommendations

Each section contains a number of key findings followed by a set of recommendations.

1

Creating safe & accessible spaces for BAME communities to improve SRH outcomes

1 | There is a need to create safe & accessible spaces (both formal and informal) for BAME communities to improve SRH outcomes

Overview of Key Findings

I. Structural barriers impact BAME community members from seeking testing and treatment
II. The COVID-19 pandemic exacerbated existing SRH inequalities
III. Preferences for accessing Sexual Health Services in formal and informal settings, including at the GP (52%), or in specialist SH services and community settings are mixed
IV. IV.Service users are often aware of contraceptive options in comparison to other SRH concepts
V. BAME Voluntary sector organisations provide additional practical support to service users but are overstretched

Our stakeholder engagement work revealed a combination of social and economic factors which result in there being additional barriers BAME communities face in accessing high quality sexual health services and education compared to their white counterparts: a situation which has been exacerbated by the local impact of the COVID-19 pandemic. A combination of limited informal settings to seek advice and support on SRH issues and reluctance to seek out and engage with formal SRH services were cited by stakeholders as some of the reasons that contribute to the poor SRH outcomes that BAME communities experience in LSL.

1.1 | Structural barriers prevent BAME community members from seeking testing and treatment

The importance of creating safe spaces both within communities and in SRH service provision where LSL residents can safely engage with their sexual health is of particular importance when considering the additional structural inequalities that BAME communities face. Undeniably, these disadvantages impact how readily residents can engage and prioritise their sexual health. For example, the saturated social housing market was highlighted by an interviewee during stakeholder engagement interviews as a barrier that has deprioritised sexual health for residents. We heard that a consequence of being forced (by unaffordability of renting elsewhere) to live with family members encouraged secrecy with regards to sexual health as service users may not have the privacy to take phone calls from health professionals or advice lines. Indeed, our survey found that of the 143 respondents who answered the question about barriers to accessing services, 41/143 respondents said that aspects of their home life /housing created a barrier – more than a quarter of respondents. Not having a comfortable and appropriate space at home was also linked with unsafe or risky sexual behaviour, which is an area of concern for many young people living with family members.

There is existing evidence that socio-cultural beliefs and taboos that contribute to poor SHR outcomes for BAME women; for example, women in long-term monogamous relationships feeling powerless when asking their husbands or partners to access STI testing, or being at risk of STIs and painful periods due to a lack of education around SRH[20].

For many Black African, Black Caribbean, Latin American, Middle Eastern and South Asian immigrants of the first and second generation, we were told through our interviews with local community stakeholders that either currently living in accommodation with family members with stigmatising views and beliefs relating to SRH, or exposure to them within the local community, means that individuals in these communities face obstacles to accessing healthcare for social or emotional reasons and experience a lack of agency..

To understand the specific barriers that the BAME community may face in accessing treatment it's important to look beyond sexual health. Our services need to recognise the different health needs and barriers to accessing support that face the BAME communities, and how this manifests across the three boroughs.

20 In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women (2017)

1.1.1 | Multiple disadvantage

One local organisation described the ongoing cycle of street-based sex work and drug and alcohol addiction linking with poorer health outcomes in Lambeth. We were told that there is a varying demographic of sex workers working in Lambeth, who are typically born in Brixton and raised there, and an overrpresentation of BAME women. In Lewisham, the Fulfilling Lives LSL service has identified that many are young care leavers. A common theme expressed by sex workers is the lack of faith in the support system and a sense of being passed around multiple services, which will be discussed later in this section. Ensuring that sexual health promotion efforts are reaching these women is essential but clearly a challenge considering the fragmentation of services available.

As was described in a report by Fulfilling Lives, a local service supporting people experiencing multiple disadvantages, "it is acknowledged that generally the treatment structure offered to women does not enable them to consistently engage. It is likely that there may be more women with bloodborne viruses or STIs going untreated"[21]. It was also described that this group of women have higher rates of pregnancy over their lifetime and experience the trauma of removal of children.

1.1.2 | Immigration

Through our stakeholder analysis as well as wider context research, we observed that current immigration rules restrict migrants from accessing many public services, (known as the UK Home Office's hostile environment policy)[22]. This was highlighted as an additional barrier that migrant residents who are currently without access to public funds face. It should be noted that sexual health services are not restricted in this respect, but rather that there is a lack of awareness that they are open access services. Considering our young, mobile and diverse[23] population, ensuring that migrants and others whose needs are currently not being met are aware of how to safely access testing needs a more dedicated strategy. Currently, outreach, word of mouth or referral from other agencies or community groups are relied upon to meet the needs of recent migrants or those with additional barriers to access, including language barriers and those experiencing domestic violence. We have learned that many marginalised women and men will not necessarily present to clinics so a community asset-based approach may be an effective way of reaching them with sexual health information, advice and guidance. Therefore, collaborating with local organisations who are part of the NRPF Network and other organisations working with vulnerable groups should seek to strengthen good SRH self care and drive clients into services.

21 Fulfilling Lives LSI, Shared Learning Forum: Women's Access to Drugs and Alcohol

22 Hostile environment explained, The joint council for the welfare of immigrants (webpage)

23 Sexual and Reproductive Health Strategy 2019–24 Lambeth, Southwark and Lewisham Public Health Departments

1.2 | The COVID-19 pandemic exacerbated existing SRH inequalities

95% of people surveyed hadn't been informed by their GP or local service about how to access Sexual and Reproductive Health Services during lockdown*

From Love, Sex Life 2020 Survey

**Love, Sex, Life's website has been updated with open Sexual and Reproductive Health and other related services. This page will be regularly reviewed to ensure all information and contact details are up to date.*

The COVID-19 pandemic introduced a number of risks to the sexual health and emotional wellbeing of BAME people in LSL. The perception that in-person clinics were closed alongside the lack of signposting or referral by GPs as a result of the restrictions implemented due to the COVID-19 pandemic presented an immediate risk to sexual health. In our public survey, 50% of respondents cited having concern around reduced services during lockdown but comments were raised around testing for STIs with responses including: "Not sure where to get tested" and not "understanding when safe to have sex with new people".

1.2.1 | Signposting

20% of survey participants have been impacted by sexual health clinics reducing their in-person appointments*

From Love, Sex Life 2020 Survey

**Love, Sex, Life's website has been updated with open Sexual and Reproductive Health and other related services. This page will be regularly reviewed to ensure all information and contact details are up to date.*

A lack of clear signposting to open and available SRH services during the lockdown period was described by most survey participants, with 95% of respondents (138 participants) not being informed by their GP about how to access SRH during lockdown. Furthermore, 20% of respondents (29 participants) said they were affected by clinics reducing their in person appointments. When asked if they were worried about any aspect of their sexual

health during lockdown, 50% of respondents said they were not. Of the 69 respondents who said they were worried, many of these worries were around access to contraception (14 respondents) and testing (17 respondents), suggesting a possible disconnect between available services, and in the public perception of which services were indeed available.

1.2.2 | Availability of in-person triaging

We were told that open-door/walk-in clinics are working well to support people without access to a stable internet connection, or without privacy in the home to safely browse the web, to order a home test. We found that 45% (66 participants) had accessed at-home testing, a further 50% (73 participants) had not and 4% (6 participants) were not aware of them being available, indicating that signposting about the availability of home-testing may increase overall testing levels in LSL.

"A lot of people haven't been tested in the past but they are now coming forward, they're trying to quickly engage people in care and get them started on relevant treatments. We have heard that people with partners for a long time without testing are coming forward. Sex is still happening but people are feeling stigmatised and are fearful of judgement."

Local service provider comment during stakeholder consultation

COVID-19 increasing HIV testing

As described by the above service provider, the COVID-19 Pandemic has increased anxieties about underlying health conditions and a need for sexual health screening. For example, during one consultation with LSL stakeholders, we heard that while there had been a reduction in testing, there has been anecdotal increase in people testing positive for HIV (HIV Positivity).[24]

24 See appendix for questions asked to stakeholders during the consultation.

1.2.4. | Shame as an inhibitor to help seeking behaviour

> *"Boredom is a big factor in people's actions. As organisations, as individuals, we need to find a way to make ourselves approachable. For people who do have an addiction, or for people who just want to have sex - there is still that aspect of shame. How do we remove that element? There needs to be a balance of firm information, and making ourselves seem accessible."*
>
> **Nathan Lewis, Chair of Southwark LGBT Forum**

Messaging[25] and government guidance around avoiding having sex with new sexual partners to avoid the spread of COVID-19 was mentioned in interviews with service providers, with people feeling stigmatised and fearful of judgement if they seek support or SRH services. Brook saw the same or higher need for condom distribution during the first lockdown period of three months in comparison to previous year on year data. One stakeholder suggested that this may also have had a negative impact on residents with higher risks to their SRH, who may be more reticent to access SRH services. The stakeholder suggested that "people are feeling quite stigmatised, fearful of judgment, particularly sex workers".

1.2.5 | Impact on BAME LGBTQI+ residents

> *"COVID-19 has disrupted the lives of many of our service users. We've actually had an increase of somewhere between 120 to 132% to our work. A number of people spending lockdown with family and friends have had to go back into the closet. LGBT folks [in this situation] have to hide their [HIV] medication if they're in lockdown with their family. For those who are asylum seekers and refugees they feel isolated because they do not have access to money. Then we've had a number of cases of domestic violence, you know, within family circles and also within a same sex relationship[s]. We had to support one lesbian woman to find alternative accommodation."*
>
> **Jide Macauley, House of Rainbow**

25 Don't hook up during the COVID-19 lockdown, Terrence Higgins Trust (2020)

The consultation found that many members of the LGBTQI+ community experienced difficulties in their sexual health and emotional wellbeing during the pandemic. As reported during interviews both with service users and with providers, having to spend increased amounts of time with family members who may not be aware of their sexuality, many younger LGBTQI+ people found themselves forced to conceal aspects of their identity, including those with existing health conditions such as HIV and some were forced to hide their medication. In LSL, this presents long term risks to the wellbeing of this particular community and efforts must be made to signpost individuals to safe spaces in which they can access support and advice. Ensuring safeguarding is core to any efforts will be essential for those living in fraught home environments where there is a risk of violence or of stigmatisation. For LGBTQI+ migrants with unsettled status, this is an additional factor that services like the House of Rainbow are supporting their beneficiaries with – but mainstream services and policymakers need to be equipped to deal with these additional needs.

1.2.6 | Growing preference for no contact testing

COVID-19 has demonstrated the potential of at-home testing and screening with NHS trusts moving a significant number of appointments and screenings online. Our survey attempted to determine how popular home testing was in the local BAME community and found that while 46% of respondents (66/145) had accessed at home testing, a further 50% (73/145) hadn't. Promotional work can also be undertaken to promote home testing and establishing this as a core part of self care in the community.

Some interviewed also reported a squeeze in postal testing capacity which will need addressing to meet increased demand , despite LSL making more testing kits available as part of pandemic response[26]. Some testing laboratories had capacity diverted to COVID-19 testing meaning there was downward pressure on STI testing ability. Adapting to the challenges and opportunities that COVID-19 has created for SRH services will require the availability and signposting of home-testing kits to be prioritised going forward..

> *"To have open and honest conversations you have to have a high level of trust within the room. A group of people who don't know each other, don't understand confidentiality, [and] will not necessarily open up. One on one stuff is very expensive, but there are interesting ways to do it. For example [in] pharmacists, chemists, people go in to pick up prescriptions; it's a good opportunity to drip key sexual health messages."*
>
> **Community stakeholder, Lewisham**

26 LSL COVID 19 Impact Assessment (2020)

1.3 | Preference for accessing Sexual Health Services in formal and informal settings are mixed

Of the 145 respondents who answered the question 'If you could choose, where would you like to access Sexual Health Services, including testing for HIV and Sexually Transmitted Infections, Support and Treatment?', the vast majority of participants (66% or 96/145) preferred to access sexual health services in clinical settings and 52% (76/145) at the GP. A significant number suggested informal and discrete settings, such as specialised support services (14% or 29/145) and community groups (6% or 9/145). During interviews with service users from NAZ as well as the wider community stakeholders, outreach in local settings, particularly within local affiliated support services such as probation and domestic violence support, was highlighted as successful for engaging more vulnerable community members.

Outreach in local places like shopping centres and barber shops, and interventions hosted in community settings like churches, community centres and specialist support services were highlighted by both SRH workers, a community leader, and BAME voluntary sector leaders throughout the consultation phase as best practice to engage many BAME residents, building long term trust within the community and increasing engagement with local services. As was said during one interview, people depend on [outreach]; "people don't always have the £1.50 to get on the bus [to meet you]. They are waiting for you to come and literally provide them with condoms"

If you could choose, where would you like to access Sexual Health Services, including testing for HIV and Sexually Transmitted Infections, Support and Treatment? (Multiple selection)
145/150 respondents

At a Specialist Sexual Health Clinic	**66%**
At the GP	**52%**
Walk in Centre	**46%**
Pharmacy	**31%**
Specialist Support Service (for example housing association or women's advice centre)	**15%**
Community Group	**6%**
Don't know	**2%**
At my place of worship	**1%**

.

1.3.1 | Positive impacts of faith-based interventions

Case Study: Reverend Fred Aninn[27]

Reverend Fred Annin founded Actionplus Foundation (UK) in 1997 to campaign against HIV stigma and prejudice, which operates both in the church and in the community. His quest has been to support the growing number of people living with HIV from the African Community.

He personally led the campaign by targeting the Black African churches to interact with their pastors and educate them about HIV, and the benefits of early testing. In 2007 Reverend Fred opened the branch of Actionplus Foundation in Ghana and successfully led his charity to reduce the rate of HIV infection in the country from 4% in 2007 to 1% in 2013. Actionplus became the first HIV organisation in the UK to open a HIV testing centre in a church, and additionally opened 4 testing centres across London. This is a major breakthrough towards HIV intervention in the UK and Africa. For the past 18 years, Fred's extraordinary achievements have been accomplished without resources to funding, relying on donations and his personal sacrifice to the cause.

The efficacy of outreach programmes with religious leaders for some BAME communities was raised during interviews with LSL based stakeholders and community leaders. In London, BAME-led organisations as well as increasingly councils and local authorities[28] have engaged in partnerships with faith groups to help improve health and social outcomes. One example is the Islington VAWG agency the Kurdish and Middle Eastern Women's Organisation (KMEWO) partnering with the Finsbury Park Mosque as a method of community engagement and recruitment of Muslim women from Middle Eastern and North African backgrounds to their services, including English for Speakers of Other Languages (ESOL) classes.[29]

Through recruiting women at the local Mosque, KMEWO saw a sharp increase in referrals to domestic violence services and welfare benefits. This highlights the importance of investing in the "by and for" BAME voluntary sector[30] who are uniquely positioned to understand the needs of communities and act as the first point of contact with those who are marginalised. The language of communities being "difficult to reach", has frequently been used to describe migrant communities, must be understood under the lens of wider barriers that have kept BAME communities alienated from social services and public health services; the Windrush scandal being a notable example, with it being ubiquitous to many LSL migrants.

27 Reverend Fred Annin, Excellence in Diversity Awards
28 Local government association. Working with faith groups to promote health and wellbeing (2017)
29 Kurdish and Middle eastern women organisations: Lost in translation no more; Evaluation Report (2015)
30 29 Voice for change England magazine issue 1 (2020)

With regards to sexual health work, faith-based interventions have been used by Naz as a method for facilitating dialogue particularly when there is a lot of religious stigma around sexual health, sexuality and reproductive rights. During consultations, we heard of specific examples of collaborations with faith-based communities that have been effective in creating links and shifting stigma. However, as can be seen from the below quote from a community stakeholder, the enormity of the undertaking is clear.

> *"My personal view - I don't see [stigma] changing in the next decade as such. Particularly across South London, because of the massive faith communities, e.g. in Southwark. There is a general lack of information that's been given to communities. In terms of going to a faith group, in Southwark there's Reverend Fred Anin, who has done amazing work in HIV testing in faith groups - to get other faith groups to get to this point, takes time."*
>
> **Nathan Lewis, Chair of Southwark LGBT Forum**

The above statement also highlights the balancing act that faith groups often play. At one end, they can perpetuate existing stigma, and on the other, they can be powerful agents of change and empowerment. This makes engaging faith settings even more important. One learning from the KMEWO Lost in Translation project is that both recruitment and service work can be carried out in a faith setting, but there is also added value in creating neutral spaces in primary schools and other community settings.

While the effectiveness of partnering with religious leaders has been widely noted and accepted, they must not be used as a blanket solution for engaging with BAME communities. We heard that there is little evidence on the evaluation of faith-based interventions and their efficacy. This has led to an undervaluation of their impact and so little is still known of the long term impact and potential that these interventions can provide.

1.3.2 | Digital platforms present an opportunity for improving RSE

The COVID-19 pandemic has put pressure on local capacity for in-person sexual health services. Digitalising support services as far as possible requires initial investment in developing engaging communications strategies and content that reaches target audiences, but is certainly necessary to fill the gap in promotion and support services

during the pandemic. Our survey suggests that this is an opportunity for people living in the three boroughs, with 28% (41/143) of survey respondents accessing RSE online on forums like Reddit or Mumsnet. To reach younger people, collaboration with university societies was recommended as well as working with "micro-influencers", defined as individuals with influence within a specific community with under 10,000 followers on social media platforms.[31]

The survey revealed the desire to be able to easily access SRH information on credible sources online. Currently, as one community stakeholder pointed out, younger adults either speak with "friends and peers [or] use the internet to access informal sources of information, for example, someone's website". On the other hand, the NHS website was described by one participant as "very formal, where adults go."

With this in mind, signposting young people to clear, accurate and accessible RSE and SRH information online at least in the short term can be used as a method of countering the trend that arose during the stakeholder interviews of young people avoiding in-person services, particularly post-COVID-19. Without trust or confidence in where to access services, the consequences are that young people may not be getting tested for STIs or having unprotected sex that leads to increased spread of STIs and HIV. An over reliance on forums and non-expert advice online also raises safeguarding concerns and is another aspect to consider when digitising services.

1.4 | Service users are often aware of contraceptive options in comparison to other SRH concepts

Our research found that female participants were more likely to be aware of contraceptive options in comparison to other SRH concepts, such as STI knowledge and testing or consent. 77 out of 144 respondents rated their experience with the contraception services available to them in their borough above 5. 138 participants answered the question 'Where do you go for advice about contraception?' and the survey found that most participants found information about where to access contraception information via their GP (45% - 62/138) or NHS website (45% - 62/138) rather than through speaking with friends (29% - 40/138) and family (7% - 9/138). 49% (71/144) were not using any contraception at all, while the most commonly used form of contraception was the external (male) condom (25% - 36/144), followed by the contraceptive pill (6% - 21/144), and the coil (5% - 9/144). The survey did not determine whether or not respondents were in long-term relationships or not having sexual intercourse at all, which may have an impact on these results.

One common concern participants had during lockdown was where to find information about contraception, particularly around regular prescriptions, with one participant describing their "concern about receiving contraception from GP when they're only open for emergency issues". Access to contraception was recognised by health providers as an essential service during lockdown; however, it is interesting that respondents did not regard it as such.

31 Buffer Blog post. Why micro influencers may be the most effective influencer marketing strategy (2019)

1.5 | BAME Voluntary sector organisations provide additional practical support to service users but are overstretched

> *"I go to NAZ, Riverhouse, my GP and sexual health clinics. I get meals, therapy (massages, physio), advice services, like for money."*
>
> **NAZ service user living with HIV, Lambeth**

For many BAME residents, BAME-led voluntary sector organisations are often the first point of contact for support, including SRH services. In interviews with service users it was repeatedly pointed out that the support had had a transformative impact on their wellbeing. For those living with HIV, having the opportunity to connect with other service users from the same or similar cultural background and relatable lived experience is an additional benefit the sector provides to its service users.

One SRH provider created a WhatsApp group and broadcast list to provide mutual support to HIV positive individuals during the first lockdown in the United Kingdom in 2020, a group which now exceeds 2,000 people. The organisation was able to use these networks to share information about COVID-19 and HIV with significant numbers of people, demonstrating the potential of informal networks in reaching African migrant communities. This could be an effective template for working with other migrant communities. However, the sustainability of the sector needs to be considered in long term plans. Many BAME Voluntary Sector Organisations were described as being best placed to support the needs of BAME people by building trust with their service users. However, BAME Voluntary Sector Organisations are going beyond their typical service delivery of SRH support and advice, psychosocial support to providing practical support (ranging from immigration advice/signposting, housing advice/support, employment advice/support, educational advice/support, supporting service users on how to register at a GP) to service users, as well as the opportunity to connect with other service users from their community or similar cultural background through formal support groups or more informal networks including via Whatsapp.

1.5.1 | Service users go to multiple providers to access different specific services

A recurrent theme that arose during an interview with a local service provider, was the myriad of services that many BAME community members with multiple service needs find themselves directed to, as well as a possible issue with signposting. Interviews with NAZ service users living with HIV and with SRH workers revealed a trend where service users experience inconsistent availability of services, meaning some individuals go to one

provider for multiple issues, while some will go to multiple services to access all of these. From a user perspective, the fact that services aren't joined up makes seeking support and advice more complex. For those most at risk in LSL, this was linked during interviews with a possible discouragement from accessing the support.

We were told of a possible competitiveness that exists between organisations who may "intercept" service-users to encourage them to use their services. This is also an opportunity for designing more joined up sexual health services in LSL. For example, London Friend provides services supporting the mental wellbeing and general health of LGBTQI+ people, and often locates their services within sexual health clinics and drug and alcohol addiction services as a way to speed up people's pathways to accessing the services they need[32].

1.5.2 | Intersecting needs of BAME domestic violence and SRH services

In our survey, of those who responded (69 out of a possible 150) to the question 'If you have experienced any form of sexual violence did you access support?', the majority of the 69 respondents answered that they did not access support (75% or 52/69). More research is needed to understand the exact causes of this, however interviews with specialist women's centres described that there are a number of barriers for survivors of GBV accessing services, including lack of awareness of places to go to for support. Local service providers also highlighted the fact that many women may not feel as though their experience could be described as of concern or abusive, raising the need to find ways to open up discussions about safe and healthy sexual relationships. The Pecan Women's Centre, a specialist support service for women who have been through the criminal justice system, places an emphasis on recognising the "warning signs of what domestic abuse actually looks like in subtle ways".

The research suggested a need for better signposting between sexual and reproductive health services and domestic violence support for women. While there are a number of "by and for" domestic violence agencies serving LSL women across London, the intersection of organisations supporting women with sexual violence and women's sexual and reproductive health were described as working in silos, meaning that women presenting to sexual health clinics or to domestic violence agencies are missing out on an opportunity to access multiple services.

Women accessing other support services, such as drugs and alcohol support or in temporary accommodation may also be missing out on straightforward ways to also receive SRH support. For more vulnerable women, community-based providers such as the Pecan Women's Centre and Fulfilling Lives LSL, offer support within women's only

32 https://www.fulfillinglivesevaluation.org/about/the-partnerships/lambeth-southwark-and-lewisham/

spaces. A more joined up approach towards sexual health and wellbeing was described as having the most impact with this service user cohort. By providing a "one stop shop" environment, women attending support services are able to have their needs catered to in a holistic way. These environments were described to enable women to feel more comfortable to disclosing sexual violence, and slowly build resilience and knowledge about their rights.

Recommendations

- **Ensure communities have clear signposting to sexual health services (accommodating for life in COVID-19).** Our research found the need for better signposting about the availability of in-person and digital services, including remote STI and HIV testing, and where to access contraception support. This could be achieved through digital health promotion campaigns and by direct communication between GPs and their patients. For residents experiencing multiple disadvantages (like living in temporary housing) as discovered during our consultation period, they are less likely to engage with SRH services. Outreach support such as modelled by the Fulfilling Lives programme may be more appropriate. .
- **Ensure no-contact health services are available where possible.**
    1. Give options to people about locations of mobile testing or pick-up access to home-testing kits located in local access points including churches, mosques, shopping centres, nightclubs and support services.
    2. Work in collaboration with community members to understand their ideal place to access services, for example, creating safe spaces in unconventional spaces to reach those who need it most.
- **Position sexual health testing and support in discrete locations or embed within adjacent services.** We have learned that many people who are more reticent about their sexual health and will not necessarily present to clinics, were receptive to outreach in other support services they were using. In practice, this might look like a migrant woman who was already accessing immigration, employment or mental health support in a BAME Voluntary Sector organisation learning about aspects of her reproductive health during a wellbeing class.
- **Advocacy and funding.** Local SRH stakeholders that we engaged with cited a range of challenges facing their organisations and their beneficiary communities. The broad consensus was that they were uncertain what the future of funding would hold for their organisations with most traditional funders operating under the banner of the London Community Response Fund which focused solely on COVID-19 relief efforts at the expense of themes such as SRH. Stakeholder groups were also concerned about how in the medium to long term they would be able to adapt to a socially distanced model of service delivery. Therefore to continue to work meaningfully with these groups, there is a need for capacity building and more support to BAME organisations so they can continue to act as safe spaces for marginalised community members. We

overarchingly saw the need to support grassroots organisations with the expertise to reach our BAME community.

- **Create culturally specific interventions to tackle GBV:** Prioritisation of interventions that aim to prevent cycles of violence and abuse is essential to better-supporting survivors of GBV and addressing the normalising of sexual violence that the research uncovered. Collaborating with existing organisations and practitioners who already have direct links with their communities as well as lived experience will be essential to succeed. Working with groups of women facing multiple risks to their wellbeing in trusted settings, is how projects like the Pecan Women's Centre and Fulfilling Lives LSL have intervened in cycles of normalised sexual violence. An example we were told is the weekly women's drop-in in Blenheim Church in Peckham run by the Southwark Women's Hub.

2

Working to Counter Stigma and Improve Sexual and Reproductive Health Awareness

2 | Working to counter stigma and improve sexual and reproductive health awareness

> *"News spreads very quickly in the community and then they will stop talking to you. Some people are scared that they can catch it from you, even though it's proven that (HIV transmission) only happens through blood or sexual contact. Only my immediate family knows. Stigma in the community stops you speaking out, you have to be careful."*
>
> **Service user living with HIV, Lambeth**

Overview of Key Findings

I. Stigma and shame are preventing BAME people from testing and accessing treatment for STIs and HIV

II. HIV stigma persists: 50% or 73 responses said that people from their community are scared to get a HIV test

III. Community members experience discrimination and stigma around sex

IV. Black men require support for shame around their sexual health

V. A quarter of BAME people experienced discrimination for their sexuality

VI. Family and friends are a preferred source of sex and relationships education

Stigma and shame related to SRH has been linked in previous studies with how individuals perceive reactions to disclosure of their sexual behaviour to healthcare providers and may also be an important factor in their decision to seek SRH care[33]. In LSL, our research found that HIV and STI stigma can result in individuals being reluctant to seek out services, even if they are aware of services available, out of fear of the social isolation a diagnosis may lead to. Education, particularly addressing misconceptions and misinformation, was linked by experts to improving engagement with sexual health services, leading to the early diagnosis of HIV and other STIs as well as the reduction in transmission as a result of more awareness and use of contraception.

33 Attitudes about sexual disclosure and perceptions of stigma and shame, S D Cunningham, J Tschann, J E Gurvey, J D Fortenberry, J M Ellen (2002)

To achieve the Fast-Track Cities target of achieving zero stigma, zero no new transmissions and no AIDS related deaths (0-0-0 or 0 Stigma, 0 HIV transmissions and 0 deaths from HIV/AIDS), improving resident's knowledge about preventing HIV was found to be crucial, with community stakeholders emphasising the need to work closely with Caribbean and Black African communities[34]. Currently, persistent stigmatisation of HIV was described as a factor in the decision not to seek SRH care, but our research also found gaps in health literacy around when and where to access HIV testing. A third of respondents 34% (45/134) did not think they have ever been at risk of HIV transmission, and 25% (33/134) did not know where to access a test.

2.1 | Stigma and shame are preventing BAME people from testing and accessing treatment for STIs and HIV

Our survey findings reinforced the link between shame and embarrassment impacting sexual health outcomes, with 46% (66/145) citing embarrassment and 27% (39/145) citing shame as impacting how readily they feel discussing sexual health with a doctor. Creating spaces where individuals can speak and explore their sexuality and sexual health, as well as normalising sexual health were outlined as critical ways of beginning to lift the shame that prevents people from taking care of their sexual health.

Mainstream services must look at the way racial and HIV discrimination intersects when caring for BAME service users, so they can provide efficient care for individuals who may be coping with social isolation, stigma from the community as well as racial discrimination: something that is not necessarily relevant to the rest of the HIV positive community. Equally, while case workers and specialists we spoke to have developed appropriate methods of outreach with people who are NRPF or are living with poverty, they expressed a need for mainstream SRH services to consider adopting similar strategies to meet the needs of these service users.

2.2 | Persisting HIV stigma is linked with lower levels of HIV testing

Our research found a link between persistent HIV stigma in LSL BAME communities and fear of getting an HIV test, with 50% of respondents (73/145) saying that people from their community are scared to get a HIV test. While London has signed up to the FastTrack Cities target to end all new HIV infections in the capital by 2030 HIV stigma and transmission remains an area of improvement as identified in the LSL Sexual Health Strategy.[35]

34 FAST-TRACK CITIES: ENDING THE HIV EPIDEMIC Cities and Municipalities Achieving Zero Stigma and the 90-90-90 Targets on a Trajectory towards Getting to Zero New HIV Infections and Zero AIDS-Related Deaths (2014)

35 Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019–24

Expert interviewees identified that stigmatisation of HIV was preventing residents from accessing testing since the news of a positive HIV status can mean isolation and stigmatisation. This was reflected in our survey, which found that 30% of women (30 responses) and 21% (7 responses) of men would not seek HIV testing because of stigma. A further 19% of total respondents (25/134) were deterred by not wanting to be seen at the clinic. From the survey findings about HIV services and the fear and stigma associated, we can assume that health messages around PrEP are also not reaching local residents, which needs to be a focus of health messages moving forward. More work needs to be done to support those who feel burdened by cultural and religious HIV stigma from family, friends and community.

Discussions raised the importance of considering the possibility of racism when looking at BAME experiences of HIV, especially for black African communities, exemplified in past depictions of HIV as a "black disease". An African migrant living with HIV described the impact that stigma had had on her interpersonal relationships, including experiencing violence from a partner after she disclosed her status. She described avoiding seeking treatment because of stigma, but with support from NAZ and service users, her adherence to treatment has improved.

Without local interventions and support, residents experience continued reluctance to access services out of fear of social isolation if they are seen at a clinic, or what a positive diagnosis could mean amongst their partner, family and peers. HIV specialist case workers told us that embedding HIV interventions into other SRH and wellbeing interventions in community settings, notably in hair shops, barbers and support groups could help break down a substantial amount of stigma. They also told us that the hypervisibility of some HIV clinics can be off putting for some people to attend.

Additionally, many reported feeling stigmatised by sexual health workers themselves, particularly outside of HIV specialised services. During interviews with HIV+ service users, accounts of stigmatising experiences with health workers in the 1990s were raised. These experiences, though years ago, have had a long-lasting impact and were cited as reasons these respondents may be less engaged with mainstream clinical settings than the general public.

This sentiment is echoed in a project in East London that found that a sixth of people living with HIV had experienced discrimination for their HIV status by healthcare workers, especially by GPs, dentists and hospital staff.[36] The stigmatisation that Black African and Black Caribbean people living with HIV experience may be compounded by racism, as was described in an interview with a service user living with HIV.[37].

36 HIV-Related Discrimination Reported by People Living with HIV in London, UK' AIDS and Behavior, 12(2):255-64, Elford J et al. (2008)

37 HIV-Related Discrimination Reported by People Living with HIV in London, UK' AIDS and Behavior, 12(2):255-64, Elford J et al. (2008)

The Black African community is reluctant [to access services], because the first question is "what are your health conditions". I was expecting food as a vulnerable person as the GP said I couldn't come out, and I was sent to so many people and asked "What is your health condition, what is your health condition." Especially men, they don't want to tell anyone – that's why the spread of HIV cannot stop. They won't share with their wife that they're taking medication until the wife dies. We women, we want to live longer so we disclose."
Interview participant, Lewisham resident

2.3 | One quarter of BAME people experienced discrimination for their sexuality

Interviews with SRH experts revealed the need to engage in more open discussions about what constitutes a healthy and fulfilling sexual relationship for our BAME audience. While BAME sexual health podcasters, bloggers and journalists are becoming more influential across London and the UK, more local interventions may be required to reach specific communities, especially offline. For example, we were told that while sex educator bloggers and influencers have been vocal around a message of sexual liberation, more work is needed around consent.

Our survey found that stigma and discrimination around sexual orientation remains a large barrier in the community, with 23% (31 of total participants) facing some kind of discrimination for sexual orientation or relationships. Another growing concern is stigma impacting trans individuals from seeking sexual health advice, with one interview participant sharing a story of a Caribbean trans man who was disowned by his family. The same participant, an influential community member, said that it is hugely difficult for black men to disclose they are gay out of fear of violence "back home", compounding a disconnect from services further amplified by the Hostile Environment where LGBTQI+ migrants in particular fear being deported when they risk violence in their home countries.

Entrenched values that subdue LGBTQI+ experiences within these communities can sometimes be dictated by culture or religion, creating hostile environments for LGBTQI+ people to seek help from their own communities. The research and qualitative interviews with community stakeholders highlighted the negative mental and physical health outcomes this can have on individuals, resulting in social isolation, loneliness, negative effects on general wellbeing and barriers to finding meaningful relationships.

This suggests that health promotion campaigns that are focused on educating about sex and relationships are needed amongst adults. Some approaches to managing the effects

of stigmatisation within different cultural contexts have been education initiatives focused on positive role modelling of LGBTQI+ identities. This point was echoed in Decolonising Contraception's panel discussion on LGBTQI+ Visibility in regards to sexual health, where they discussed the editing out of "queer Africans" from their communities' histories and being told that "queerness doesn't exist in Africa", all helping to enforce feelings of disconnectedness between LGBTQI+ individuals and their cultural communities[38]

2.4 | Black men require support for shame around their sexual health

Conversations with community stakeholders brought to light feelings of discomfort amongst heterosexual Black men with regards to attending a clinic consultation. Our research found that longer-term work may be needed to encourage Black men to be tested and for attitudinal change to happen. This was also reflected in the research sample where only 26% (36/150) of participants identified as male, even when the outreach strategy focused on attracting male participants

> *"They're not at all comfortable. I only have one male friend who makes sure that he always gets tested, gets his prostate checked. And no other guy is like that. My previous partner would never do that. Unless something is burning or falling off, black men will not go to the doctor about their sexual health."*
>
> **Community Stakeholder, Lambeth**

2.5 | Family and friends are a preferred source of sex and relationship education

> *"Mostly people are actually really hungry for the knowledge and the information, because I just don't think they're getting it anywhere else or, or just not enough."*
>
> **Survey participant**

38 Decolonising Contraception - Visibility:LGBTQI black & people of colour

Many of the local professionals we spoke with revealed that there are noticeable gaps in SRE, especially within BAME communities. Of the 143 respondents who answered the question 'Where do you go to for information about sex and relationships?', 66% (95/143) did so via speaking with friends and family and 29% via online forums like Mumsnet or Reddit. Only a fifth of people surveyed (32/143) said they go to their doctor or sexual health provider for information, while more informal digital sources of information such as podcasts (22% or 32/143) and Twitter used by 18% (25/143) being popular. Opening up new spaces for discussing sex and relationships could be crucial in reducing stigma associated with sex, with 55% (80/145) of survey participants suggesting that people in their community would like somewhere to be able to talk about sex and relationships.

Recommendations

- **Invest in HIV education across all age groups to address HIV stigma.** HIV stigma was repeatedly linked with misinformation and myths around sexual health and HIV across many BAME communities. As was outlined in the NAT HIV in Black African Communities report, effective anti-stigma approaches should include: clear information on HIV treatment and prognosis and the availability of PrEP, as well as highlighting the improved health benefits of people living with HIV adhering to treatment. As discussed previously, engagement with faith communities is also essential considering LSL's diverse population, and "addressing wider racism, xenophobia and anti-migrant discourse"[39]
- **PrEP promotion campaigns can signpost to sexual health services and myth-bust.** Now with the availability of PrEP on the NHS, education efforts can both centre on BAME people and focus on the factual information around sexual health services in the UK. These should include that all sexual services can be accessed for free and that the new service will be available in all UK clinics, including all that are not currently providing PrEP through the IMPACT Trial. In line with the LSL Sexual Health Strategy and the findings of our consultation, PrEP and PEP promotion should focus on educating the heterosexual population, in particular BAME women who have limited pathways to accessing information.
- **Collaborate with community influencers on longer-term behavioural change.** Working with influencers and trusted individuals within different communities to promote health messaging is crucial. As was suggested by an expert, young BAME people have been driving change on social media. A critical part of educating the next generation will be to empower young people in LSL to be engaged in health and connect the dots between social injustice and health inequalities. Selecting the appropriate influencer or people to work with is an ongoing discussion that must take into account the different cultural and religious experiences and/or needs of different communities. For example, for older Black Caribbean people, engaging with pastors

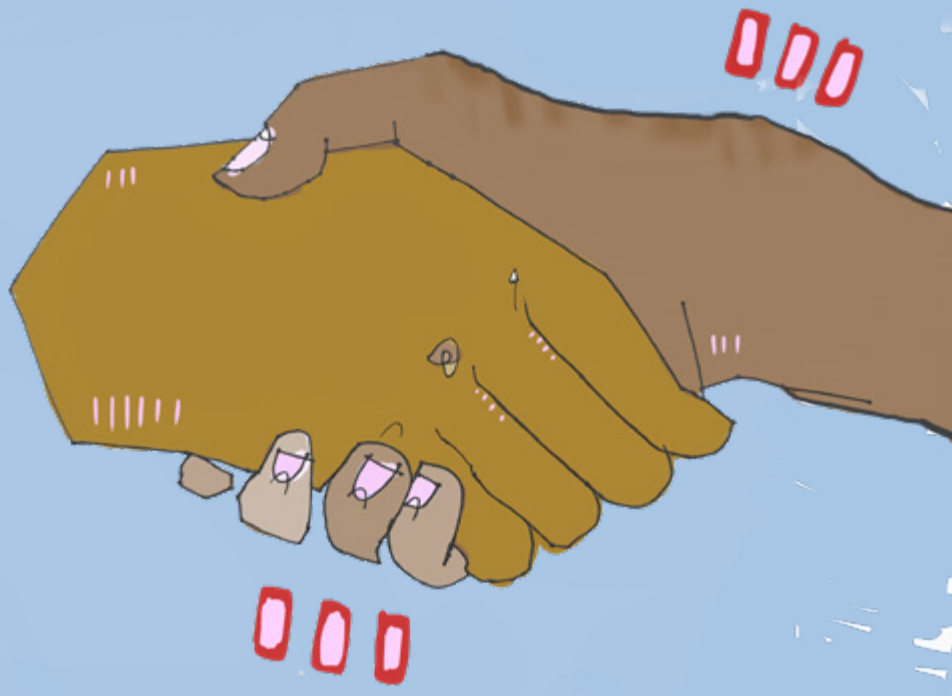
39 37 HIV and Black African communities in the UK,National Aids Trust (2014)

and other faith leaders has been effective in reducing stigma, but there cannot be a homogenous way of approaching this. For older people, continued collaboration with religious groups will support longer-term grassroots interventions to help overcome barriers to residents accessing SRH services. Embedding these local and influential channels will help to shift societal attitudes and stigmas that surround sexual health.

- **Pilot RSE group work sessions with adult and youth groups:** Learning from the success of Pecan Women's Centre, gender and LGBTQI+ specialised spaces that can act as a one-stop shop for support are effective locations for long term attitudunal change around relationships and sex. Educational interventions around consent and healthy relationships are needed to address the stigma and taboos around sex for women within BAME communities. Cultural and religious sensitivities can be acknowledged and worked through in group work, and we were told that collaboration with community leaders is often the most effective way of opening up these discussions.
- **Peer led anti-stigma workshops tailored to different audiences:** Face-to-face interventions are crucial for longer-term education and to shift attitudes. In-person community meetings are popular with older residents. Throughout interviews with organisations working with older residents, we observed the preference of specifically enjoying in-person experiences, wanting to be away from judgement and with like-minded and informed people.
- **Embedding information and education in non-clinic settings:** To reduce stigma effectively, we need to positively assert that everyone has the right to understand and enjoy their sexual health and that it should be a part of everyday selfcare. Signposting in ubiquitous locations across the local community is essential for long-term attitudinal change. This could include introducing messaging on community radio and YouTube channels, in hairdressers, barbers, restaurant and bar bathrooms.
- **Continue on-the-spot testing**: On-the-spot testing has been an effective way of preventing late diagnosis of STIs and HIV for residents who, when being seen in the clinic, carry associations of shame and discomfort.

3

Creating Culturally Sensitive Sexual and Reproductive Health Systems and Services



3 | Creating culturally sensitive sexual and reproductive health systems and services

An issue of repeated concern was a perceived lack of cultural sensitivity from sexual health providers, and sexual health related stigma embedded in services. These factors were identified as possible barriers to engaging with sexual health services. Community organisations told us that while pockets of culturally sensitive practice exist, overall the cultural sensitivity of services is inconsistent.

Overview of Key Findings

I. **Cultural sensitivity can improve BAME engagement with SRH services.**

II. **There is a need for cultural sensitivity training for mainstream health services and BAME health providers.**

3.1 | Cultural sensitivity can improve BAME engagement with SRH services

The low utilisation of sexual health services among some members of the LSL BAME community reflects complex individual and cultural relationships with their sexual and reproductive health, including but not limited to the barriers discussed in this report. A significant number of survey participants (66 responses out of 150 or 45%) felt that fear about the doctors' lack of cultural sensitivity could affect how they felt when discussing sexual health in a clinical setting. To improve engagement with services and increase health literacy, participants suggested that a more culturally sensitive clinic experience is a core aspect of the changes needed to reduce SRH inequalities in LSL. Culturally sensitive healthcare has been defined as reflecting the "the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic, or cultural heritage"[40].

While pockets of culturally sensitive services exist, survey and interview participants described experiences such as the lack of availability of translated resources meaning that migrants facing a language barrier may be over reliant on informal sources of information, or worse still miss out on up to date and accurate information about their sexual and reproductive health and how to get support.

40 Office of Minority Health . National standards for culturally and linguistically appropriate services in health care. US Department of Health and Human Services; Washington, DC: 2001.

"But if the information was there in Spanish, I think people would be more aware of the support and they will feel better psychologically."

Victoria Alvarez, Save Latin Village

A more culturally-sensitive practice in LSL was described as a service that is able to respond to the individual and shifting needs of LSL residents, including fears about immigration or a distrust in public services as well as low health literacy. While some local services were described as offering tailored support to its service users, it was suggested that many more vulnerable people fall through the cracks who are not able to phone the service or sign up online for an appointment. The continued availability of walk- in appointments and face-to-face triages is essential for this cohort of service users, as well as continued outreach programmes and collaboration with community stakeholders and faith leaders.

More generally, SRH providers expressed concerns about the availability of appropriate, culturally- specific provisions, particularly around translations and other culturally-informed preferences. Equally, BAME specialist organisations were described as often being best placed to provide insight and expertise on issues that their services users may face. Therefore, stronger links between mainstream and BAME services should be explored in order to share best practice.

Survey and interviews responses around ways in which cultural differences may manifest in clinic settings included black men not wanting to be seen by a male nurse, or incidences where male partners would like to accompany their female partners to appointments. While these are examples of socio-cultural preferences that patients may express in a clinical setting, enabling a more culturally-informed experience in clinics would need to toe the line between maintaining respect for different cultural expectations, accommodating different access needs (i.e. interpreting or request for a doctor of the same gender), and maintaining a safe space for all clients consistent with their legal rights. 49% of participants (71/145) cited the doctor's gender as a factor which could affect how they feel discussing sexual health with a doctor; this is an area that could be considered when designing professionals' training and health promotion campaigns to work on this issue and open up conversations.

3.2 | The current gap in cultural sensitivity in training for SRH professionals

"Some of it is about confidence, there are a lot of workers who are very competent and skilled and somehow when presented with someone "other" who doesn't speak the same language, looks different, they panic, forget all the experience and skills they have. We've done a lot of work on this, it happens everywhere.

There's something about feeling confident, you have these skills, you just have to ask someone - how they like to be referred to, is this something relevant for them, would they tell you about how things are in their household. It's about an open dialogue. Otherwise it puts an undue responsibility on the ethnic minority workers."

Leandra Box, Race Equality Foundation

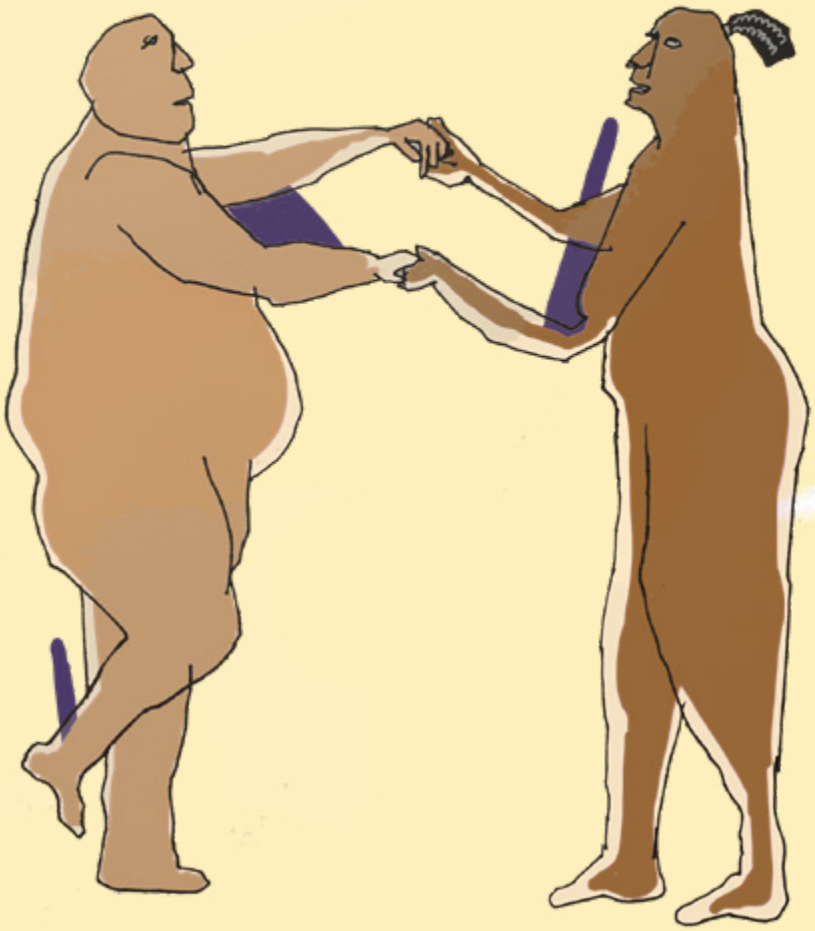
A lack of consistent cultural sensitivity training for SRH professionals could be preventing better engagement with SRH services with BAME residents of LSL. Learnings could be taken from the LGBTQI+ community, where services like London Friend, an LGBTQI+ mental health and wellbeing charity, have equipped people in sexual health services to understand the realities that LGBTQI+ people have experienced through dedicated training. Similarly, culturally informed training could enable SRH professionals to deal with a variety of needs and experiences their service users may experience and improve trust between mainstream SRH services and BAME communities.

Instances of discriminatory behaviour in SRH settings emerged as factors that can decrease trust between community members and health professionals. Accounts of historical negative experiences in clinics were described by research participants , and while this was not the norm, having a negative experience with a health professional could be a serious factor deciding whether to seek out services or not. Our research found the need for local sexual health service services to have an understanding of LGBTQI+ experiences and the impact of being LGBTQI+, especially for BAME populations, so they can provide relevant and nuanced information and care for their clients and avoid judgements and insensitive lines of questioning.

Recommendations

- **Co-creation and representation when creating programmes for and with communities**. Creating new programmes with members of local communities, while a popular practice in the public health and third sector space, needs to be appropriately compensated.
- **Cultural sensitivity training programmes by BAME sexual health experts for providers.** All sexual health providers, particularly those working in areas with diverse communities with a range of different needs, must be cognisant to the different cultural, religious, social and individual barriers in order to make appropriate interventions.
    1. Utilise videos, pamphlets, translated where applicable. As mentioned in section two, culturally specific RSE materials can support clinicians and health workers to open up discussions on difficult topics and educate.
    2. Long term training is preferable to one off cultural competency training and it offers the opportunity for meaningful adaptation to the changing needs of local communities. This should provide sexual health providers with the opportunity to practice the skills so they develop the confidence and technical skills necessary to carry this out effectively.
- **Patient advocacy.** For people who are concerned about any aspect of their local SRH service experience, a recommendation made during the Stephen Lawrence Charitable Trust's Black Third Sector Summit in October 2020 was the provision of an advocate service. In addition, people need the opportunity to advocate for their own needs at the first point of access As identified by survey participants, service users should be afforded the opportunity and space to ask for reasonable adjustments to their healthcare.
- **Ensure appropriate translation services are available within mainstream sexual health services.** Having translation services available would make SRH services more inclusive to the LSL community, which is incredibly diverse and speaks a variety of languages. For many LSL residents, English is not their first language, and this can be an initial barrier to being able to talk about their sexual health. Simply, offering more translation services and resources including flyers and video material that GPs and clinic staff can utilise to improve engagement could give more people new avenues to understand their own sexual and reproductive health.
- **Ensure all consultations and clinic services emphasise trust and confidentiality.** Health professionals need to communicate that any discussions are confidential and to be explicit that the right to confidentiality is enshrined in law.
- **Local promotion of the factual information around services is needed:** A communications campaign is needed to educate on the following points:
    1. Anyone in the UK can access sexual health services free of charge.
    2. Only a postcode is needed, not proof of address.
    3. Home testing kits are free, confidential and convenient.
    4. It is still possible to access PrEP, HIV and STI testing and treatment if you do not
    5. have a secure UK address, or if you do not have secure immigration status.

Conclusion



Conclusion

The findings of this research are aimed to form the basis for a sexual health promotion service seeking to improve sexual health outcomes for all in LSL. The report has outlined a number of troubling issues impacting sexual health, which will require long-term intervention and which the Love, Sex, Life partnership will seek to address through the delivery of culturally specific training for SRH professionals and wider LSL stakeholders. We will also deliver a cross-channel communications campaign throughout the duration of the partnership which seeks to a) create digital and offline non judgemental spaces for discussion and learning around sexual and reproductive health for BAME people in LSL and b) improve SRH literacy and reduce stigma around STIs, HIV and other key SRH concepts, and c) promote the need for more culturally-specific resources and interventions. We will collaborate with BAME content creators and SRH advocates to ensure this objective is achieved.

Resources and Further Reading

- A guide to managing your sexual health and mental well-being during coronavirus (COVID-19), Decolonising Contraception collective (2020)
- Hands up for Our Health, Doctors of the World campaign for equal access to healthcare
- HIV and Black African Communities in the UK, National Aids Trust (NAT) (2014)
- "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women, International Journal of Behavioral Medicine International Journal of Behavioral Medicine (2017)
- The role of lived experience in creating systems change, Evaluation of Fulfilling Lives: Supporting people with multiple needs (2020)
- PrEPster Resources, a range of materials to build capacity and knowledge about PrEP
- Race tick boxes and bad science mask the real reason why black people are at risk from Covid-19 - Annabel Sowemimo, gal-dem (2020)
- Racial Injustice in the Covid response, Charity So White live position paper (2020)

Appendix

Community Consultation Discussion Guide

The below discussion guide was created for community consultations, primarily done through the Lewisham BME Network.

	Purpose / Outcome of the section	Discussion guide
1	Covid-19	• I'd like to start off by talking about the current Covid-19 crisis and how it is impacting your work in the community. [open ended discussion] • Opportunities to provide mutual support during this crisis? • How to prioritise sexual health during this time?
2	Introductions	• Introducing the partnership, its aims and objectives and community focus. Partnership will deliver an empowering and engaging Sexual and Reproductive Health (SRH) Promotion Service for BAME people of Lambeth, Southwark and Lewisham (LSL), with focus on Black African and Black Caribbean communities. We believe the inequality in BME sexual health has to be scrutinised under a wider lens: factors such as housing, education, employment, representation and leadership contribute to local, as well as national health outcomes. Race is a significant factor in health inequalities and having those most impacted driving the thinking, strategy, research and leadership is key to achieving a step change in sexual health outcomes.
3	Structural inequalities and race	• I'd now like to move on to discuss some of the wider issues that impact communities' experience with their sexual health… • What are the other structural issues people were facing that could impact their experience accessing SRH services? • What are some of the ways that immigration/ the hostile environment affects your community? • What are some of the ways that housing issues affect your community? • Any other issues that you feel that impact people's sexual health.
4	Perception of issues in community (i.e. HIV, contraception, STIs)	• I'd now like to move on the conversation around the perception of sexual health and services in your community, thinking about issues such as, STIs, HIV, unwanted pregnancies and contraception. • What are the main stigmas and beliefs around these issues that you have seen in your communities? • Are there any practical ways to work to counter these? Feel free to share examples that have worked for your organisation in the past.

5	Service promotion	• How do you communicate with your service users/ beneficiaries/ network? • Where are people in your community most likely to be successfully engaged about their sexual health? (I.e. at the clinic, at their place of worship, at the community centre or women's support group) • How can sexual health services try to market themselves better to people in your community? • We have seen that working with faith leaders has been a good way to engage with communities where talking about sexual health may be taboo. Have you experienced this?
6	Barriers to accessing services	• As a whole, are sexual health services accessible in LSL? • How could they be improved?
7	Living well with HIV (from LSL Sexual Health Strategy)	• Does discussing HIV hold much stigma in your community? Is this shifting at all? • What do you think are some of the common misconceptions around HIV in your community? • Any ideas on how the conversation around HIV can be shifted?
8	Healthy and fulfilling sexual relationships (from LSL Sexual Health Strategy)	• I now want to move on to discuss healthy and fulfilling sexual relationships. This includes issues like consent in sexual relationships, sexual abuse, prejudice like homophobia, transphobia, and how to safely navigate multiple sexual partners using contraception. • Are there any blindspots or areas that need addressing on the topic of healthy and fulfilling sexual relationships.
9	Good reproductive health across the life course	• Are there any factors that influence the use of contraception in your community? • How aware is your community of where to access contraception? • Are there any blindspots or issues that need addressing on the topic of contraception?
10	Different age groups / break down of issues	• Can you think of barriers that would prevent young people [18-24] from engaging with sexual health services? • Can you think of barriers that prevent those between the ages of 25-50 from engaging with sexual health services? • Can you think of barriers that would prevent older people [50+] from engaging with sexual health services? • Can you think of any ways we could overcome those barriers to engage these groups?
11	Next steps	• As well as speaking with community leaders and representatives we are also in the process of conducting public research with residents of Lambeth, Southwark and Lewisham on their experiences and attitudes towards their sexual and reproductive health and services available. This will lead to the design of a communications strategy based on the insights from this research. There will be many opportunities to participate during this process and help shape the direction this takes. Are you interested in being involved?

This report has been jointly commissioned by the London Boroughs of Lambeth, Southwark and Lewisham.


Love Sex Life
Our Sexual Health Matters