SSA EQUALITY IMPACT AND NEEDS ANALYSIS

Directorate	DASS & Public Health
Service Area	Public Health
Service/policy/function being assessed	Sexual and Reproductive Health Strategy
Which borough (s) does the service/policy apply to	Richmond
Staff involved in developing this EINA	Kate Jennings (Senior Public Health Lead) Patricia Mighiu (GP Registrar) Isabel Monger (Public Health Support Officer) Lea Siba (Assistant Director of Public Health and Wellbeing) Sara Parfett (Sexual Health Commissioning Officer)
Date approved by Directorate Equality Group (if applicable)	
Date approved by Policy and Review Manager All EINAs must be signed off by the Policy and Review Manager	*This is a draft document, the EINA will be finalised following consultation with the public and relevant stakeholders.*
Date submitted to Directors' Board	

1. Summary

Please summarise the key findings of the EINA.

Background and Context

Sexual and reproductive health is an important public health issue with health, social and economic impacts that can affect the population across the life course. Poor sexual and reproductive health can lead to a range of outcomes including STIs, HIV, unintended pregnancies, abortions, and adverse psychological impacts related to sexual coercion and abuse. The Sexual and Reproductive Health Strategy (SRHS) 2025-2030 is a strategic plan that will outline the actions to be taken by the local authority, NHS, and other partners to improve the sexual and reproductive health of Richmond residents, over the next 5 years to the end of 2030. The sexual and reproductive healthcare needs of Richmond residents were assessed in the latest revision of the Richmond Sexual and Reproductive Health Needs Assessment (SRHNA), published in 2024.

The SRHNA identified six high level strategic priorities outlined below:

1. Promote relationships and sex education (RSE) and sexual and reproductive health education through the life course, targeting disproportionately affected and underserved groups.
2. Improved prevention of and rapid, targeted diagnosis and access to treatment for STIs and HIV.
3. Improve HIV prevention including the increased uptake of pre-exposure prophylaxis (PrEP) amongst underserved groups.
4. Increased reproductive choice and prevention of reproductive related ill-health.
5. Increased role of wider community in promoting positive sexual and reproductive health recognising links to emotional health and well-being.
6. Increase sexual health service provision and access for Richmond adults.

Proposed Changes. The proposed changes that will arise following implementation of the strategy are based on the following key recommendations[1] from the SRHNA. Each recommendation has been mapped to the eight World Health

[1]

Organisation intervention areas that promote positive sexual and reproductive health, suggested high level priority areas for the strategy (P1-6) and the life-course approach (Start Well (SW), Live Well (LW) and Age Well (AW)). Specific attention is also given to those in underserved groups:

1. Provide appropriate advice, information and training to parents & carers to enable early conversation that build a strong foundation for RSE and protective behaviours through the life-course **(SW, P1)**

2. Strengthen support to schools, local teacher training programmes and youth and community services to build skills in the delivery of relationships and sex education, including how to access to services and expand information on reproductive health (in-line with national guidance). **(SW, P1)**

3. Increase training for the wider workforce to build confidence and skills to engage residents in healthy discussions on sexual and reproductive health through the life course, including the identification of sexual harm or abuse. **(LW/AW, P1)**

4. Prioritise the expansion of access to contraceptive choices, particularly long acting reversable contraception (LARC) through expanding online contraceptive services, integrating the new national pharmacy contraceptive service and expanding routine 'open' LARC availability in General Practice. **(LW, P4)**

5. Work towards standardisation of the pharmacy EHC offer across South West London ensuring EHC can be clearly accessed and promoted to high-risk groups. **(LW, P4)**

6. Ensure that the forthcoming sexual and reproductive health strategy complements and strengthens existing crime prevention, violence against women and girls (VAWG) and safeguarding strategies, recognising the links between sexual and domestic violence and poor sexual and reproductive health outcomes. (**SW, LW, P5)**

7. Increase the representation of ethnic minority and lower socio-economic groups in reproductive health services, specifically fertility, cervical screening and reproductive cancer prevention and treatment programmes. **(SW, LW, P4)**

8. Explore ways to improve access to menopause support including provision of HRT for ethnic minority groups. **(SW, LW, P4)**

9. Employ targeted sexually transmitted infections (STI) prevention programmes that encourage consistent and correct condom use, STI related screening / testing programmes and take-up of STI related vaccinations. **(SW, LW, P2)**

10. Prioritise the provision of online and open access, adequately funded sexual health services for rapid STI diagnosis and treatment with robust contact tracing. **(SW, LW, P2, P3)**

11. Strive to achieve zero HIV transmission through targeted early diagnosis and identifying and enabling underserved groups to increase access to PrEP. **(LW, AW, P3)**

12. Explore and prioritise commissioning options that will increase access to open sexual health services for Richmond Adults. **(LW, AW, P6)**

13. Improve referral and access to both pre-conception and post-abortion contraceptive options via termination, perinatal, midwifery and 0-19 health services. **(SW, LW, P4, P5)**

14. Increase awareness of the link between sexual dysfunction, cardiovascular health, dementia and early death. **(LW, AW, P5)**

15. Increase the understanding and representation of underserved groups within our partnership approach to tackling inequalities in relation to sexual and reproductive health outcomes **(SW, LW, AW, P1-5).**

In order to effectively deliver on the recommendations of the SHRNA, a new contract for the provision of an open access Integrated Sexual Health (ISH) service will be procured, to commence in October 2026. The new service will continue to offer comprehensive open access sexual health services, whilst aiming to improve the emphasis on reaching those at greatest risk of poor sexual health outcomes. This will additionally ensure that the ISH service is consistent with local plans (i.e. the SRHNA and the 2025-2030 SRHS) and will be delivered in an integrated and innovative way that ensures sustainable service provision in line with the 5-year strategy. As a sexual health service, best practice dictates that the ISH service will be delivered in recognition of gender identity, sexual orientation, pregnancy, maternity and marital/civil partnership status, whilst simultaneously considering the importance of promoting accessibility to service users. The existing ISH service contract comes to an end in September 2024; to ensure there is no gap in local service provision, an interim service contract will be in place with the incumbent provider during 2024-2026.

Key stakeholder workshop:

In July 2024 a stakeholder workshop was held with almost 40 key partners to shape the priorities and actions proposed for the next strategy. Partners from across the sexual and reproductive health landscape, social care, schools, children's services and community and voluntary sector services worked together to develop and agree priority actions to target disproportionately affected and underserved groups.

The stakeholders workshop increased our collective knowledge of our existing offer that supports sexual and reproductive health. The new strategy will build on this offer. Stakeholders identified the strengths and gaps of our current provision and partnerships in relation to the eight intervention areas noting:

Strengths	Gaps
• The Healthy Child Programme • Early help offers through children's centres • STI & HIV prevention, testing and treatment services • Mandated RSHE • Free and confidential sexual health services • C-card schemes • Borough wide access to LARC & EHC. • Strong voluntary and community sector and partnership working. • VAWG strategy • Self-referral to termination services. • Dementia strategy	• Focus on underserved groups such as fathers, adults with learning disabilities, unpaid carers, care experienced CYP, refugee and asylum seekers. • Community engagement and culturally competent services such as maternity services and engagement with faith groups. • Operational and resource gaps such as in nursing provision, lack of joined up working, lack of capacity for staff to be trained, need to keep websites updated, lack of a coordinated list of training/resources. • Lack of accessibility to services were also identified.

Stakeholders developed a range of possible actions to close these gaps and prioritised some 'must do' actions the strategy should take forward relating to each of the intervention areas:

- Development of a directory of sexual and reproductive health services including access to support resources, particularly for parents and adults with learning disabilities.

- Stronger emphasis on supporting vulnerable children and young people to access information, education and services in the environments they most frequent.
- Supporting the borough to 'switch on' the pan London online contraceptive service.
- Healthy relationships education and awareness for all, but specifically gender based violence education with boys and young men.
- Joint action with developing women's health hubs and family hubs to formalise the interconnectedness of sexual and reproductive health.
- Targeting late diagnosis of HIV and increasing PrEP access for underserved groups through exploring the extension of HIV testing through General Practice.
- Explore opportunities to expand post abortion support and counselling.
- Increase training for health and other professionals to support older people in relation to sexual and reproductive health.

Positive impacts of the strategy:

The strategy sets out evidence-based priorities that we will focus on to improve the sexual and reproductive health of the local population. The SRHNA identified that certain communities are disproportionately affected by poor sexual and reproductive health, and the interventions and actions are targeted towards priority and underserved groups including:

- Young people aged 24 and under, by focussing access to contraception and STI prevention toward these groups through targeted 'at risk' service provision.
- Gay, Bisexual and Men who have sex with Men through targeted prevention and access to STI and HIV treatment.
- Black minority and ethnic groups by targeting STI and HIV prevention activities toward these groups
- Ethnic minority and lower socio-economic groups, by focusing on improving access to fertility, cervical screening and reproductive cancer prevention and treatment programmes, as well as menopause support and access to hormone replacement therapy (HRT).
- Increased activity with people and carers of those with disabilities.
- Older adults, by focusing on increasing awareness of the link between sexual dysfunction, cardiovascular health, dementia and early death.
- Increased access to prevention and treatment with underserved groups including substance users, those with mental health issues, refugee and asylum seekers, homeless, women who have sex with women, sex workers and transgender people. This will largely be achieved through additional training for people working with these groups.
- Increased support, education and training professionals working with and adults with learning disabilities and parents of children with learning disabilities.

Negative impacts of the strategy:

One of the main aims of the strategy, in line with Richmond council's Prevention Framework 2021-2025, is to improve health and wellbeing and reduce inequalities. However, there are gaps in data regarding certain protected characteristics which impairs our ability to comprehensively evaluate the potential impact of the strategy on these individuals. Further, we acknowledge that certain segments of the population may encounter obstacles in accessing services. To address these challenges, we have actively collaborated with relevant stakeholders to explore optimal engagement strategies for vulnerable groups. For example, we held consultation exercises with:

- Young people, including those in marginalised groups such as the children in Care council and pupil referral units.
- Young people and adults with SEND
- LGBTQ+ groups of young people and adults
- Adults from Black, Asian and Ethnic Minority Communities
- Older People

- Stakeholders and providers of Mental Health, Substance Misuse and Safeguarding related services
- Stakeholders and providers of disability services
- Voluntary and Community Sector Stakeholders
- Providers of sexual and reproductive health services
- Providers of services for adults involved in sex work
- Stakeholders of providers working with mental health and substance use services.

2. Evidence gathering and engagement

a. What evidence has been used for this assessment? For example, national data, local data via DataRich or DataWand

Evidence	Source
Local data on equalities, population, deprivation	DataRich
Evidence of need, services available, and effective interventions	Richmond Sexual and Reproductive Health Needs Assessment

b. Who have you engaged and consulted with as part of your assessment?

Individuals/Groups	Consultation/Engagement Results	Date	What changed as a result of the consultation
VAWG Partnership Group People at risk of or experiencing violence including domestic abuse	Strengthen links and understanding of sexual reproductive health and gender-based violence	23rd Jan 24	Strategy now contains a section on gender-based violence with specific actions
Central London Community Healthcare (CLCH) 0-19 service forum Professionals working with families	Noted Sexual Health need of Young People consistent with findings.	13th March 24	Actions strengthened in relation to pregnancy and parenthood
Kingston and Richmond Safeguarding Children's Partnership (KRSCP) Quality Assurance group Children at risk of or experiencing harm	Noted concern regarding low levels of sexual abuse identification	18th Jan 24	Improving identification of child sexual abuse now a high-level priority
Garrat Park SEND YP Group & Share Support adults with SEND group Young adults and adults with SEND	Greater understanding of the needs for this group	6th & 26th Feb 24	Several actions identified targeting this group.
Local Pharmaceutical Committee Providers of community pharmacy services	Note further integration of pharmacy provision needed across SW sector	7th Feb 24	Strategy recognises importance of standardising systems to improve accessibility for underserved groups

Community Drug Partnership Providers working with people with substance misuse concerns	Note link between SM and SH in future strategy	14th March 24	Specific action highlighted for people using substances
Disabilities partnership Providers of disabilities services	Psychosexual support needed for families caring for those with disabilities	28th Feb 24	Several actions identified targeting this group.
No straight Answer Youth group & Provider groups LGBTQ+ young people and adults	Free and non-judgmental access to supplies and services.	15th September 2023	Ensure services are targeted to these groups.
CLICK – Children in Care Council Young people looked after	Note need to support foster carers / social workers with sexual health	16th Jan 24	Several actions identified targeting this group – e.g. training.
Wandsworth Youth Council Young people aged 19 and under (issues extrapolated for Richmond)	Note strengthen training for teachers on RSH	16th Jan 24	Actions in the strategy focussing on young people who are disproportionately affected.
Multicultural Richmond and Health Champions Group Black, Minority and Ethnic Communities	Tailor prevention and Tailor prevention and support to needs of Asian community, empower and foster intergenerational protective relationships. Increase service reach in Richmond.	18th Sept 23 23rd Feb 24	Cultural competence to be a focus for some actions – especially around training and service access
Richmond Consultation forum Older people	Integrate services with General Practice, training for health champions, increase support for the elderly.	23rd Nov 23	There will be a specific piece of work in relation to older people.
Richmond VCS Forum Providers of community and voluntary services	Results of needs assessment shared, Clarify difference between learning disabilities and neurodisabilities.	28th Feb 24	VCS services to provide comment through the public consultation.
Safeguarding adults forum (SAF) Adults at risk of or experiencing harm	Needs assessment approved. Conduct further consultation with traveller groups, improve sexual and reproductive education through the life-course.	20th March 24	SAF members to provide comment through the public consultation.
Mental Health stakeholders forum Providers working with people with mental health concerns	Increase training for mental health workers around sexual and reproductive health including signposting to services	29th May 24	Actions around mental health and sexual health noted within the strategy – including outreach in mental health services and training

50 professionals from across the partnership including from schools, CVS, SRH services Strategy development stakeholder workshop	Almost Participants suggested key actions for the strategy and prioritised them.	11th July 24	Priority actions for the strategy identified in respect of underserved groups including protected characteristics.

3. Analysis of need

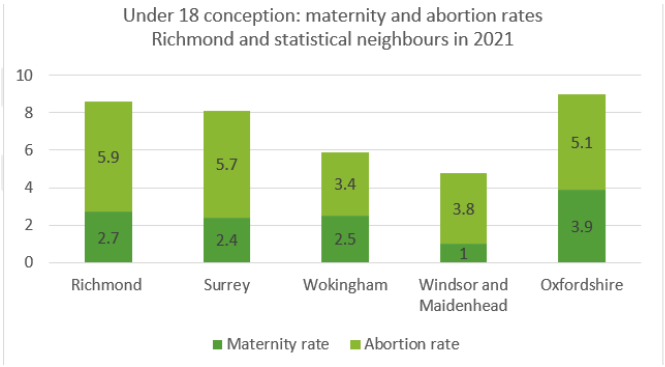
Potential impact on this group of residents and actions taken to mitigate impact and advance equality, diversity and inclusion

Protected group	Findings
Age	The age demography of Richmond is changing. Since the 2011 census there has been an increase of 24.9% of people aged 65 and over, with the highest increase among those aged 70-74 years old. Young people in the age brackets 20 to 39 have decreased while those age 15 and under have increased by 6.1% in total[2]. Greater London Authority population projections show that by 2030, the number of 25–44-year-olds, those with the greatest demand on sexual and reproductive health services, will fall by 9%, while the greatest increase in Richmond will be seen in the 80+ population which will increase 38% (an additional 3500 residents). Young people aged 15-24 years are at high-risk of STIs. In particular, young women may be more likely to diagnosed with an STI[3]. This finding is true for Richmond, as shown by the latest (2020) UKHSA summary profiles of local authority sexual health (SPLASH) reports. These reports found that 41.4% of diagnoses of new STIs made in SRH services and non-specialist SRH services in Richmond residents were for young people aged 15 to 24 years old. Furthermore, 24% of people accessing the local integrated Sexual Health Service (ISH) in 2022/2034 were aged between 18 and 24. Teenage parents and their children experience poorer health, educational and economic outcomes, and inequalities. Compared with older mothers, there is a 30% higher rate of stillbirth, 60% higher rate of infant mortality and 30% higher rate of low birthweight amongst babies born to mothers under the age of 20[4]. The under-18 conception rate has dropped 62.8% from 1998 to 2021. The 2021 conception rate in Richmond is now 9.6 per 1000 young women under the age of 18. However, Richmond had the second highest under-18 conception and abortion rate compared to its statistical neighbours, indicating that it would benefit from increasing preventive measures to reduce abortions. Hampton North and Heathfield have significantly higher rates of under-18 conception than the rest of Richmond. **Figure 1: Under 18 maternity and abortion rates, Richmond and Statistical neighbours**

[2] ONS, Census 2011 and Census 2021

[3] Sexual mixing in opposite-sex partnerships in Britain and its implications for STI risk: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) - PMC (nih.gov)

[4] Public Health England (2019) A framework for supporting teenage mother & young fathers



Source: ONS contraception rates, 2021

The above data highlight the importance of prevention programmes with continued focus on younger age groups to ensure under 18s, particularly in higher rate wards have clear pathways to services should they be identified.

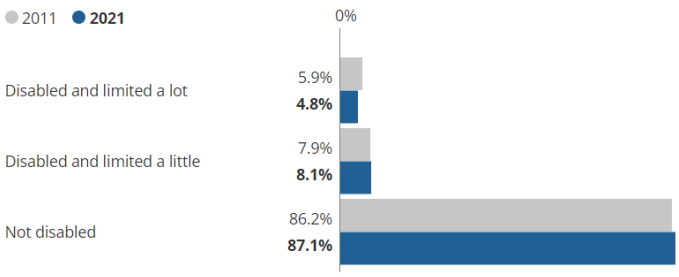
The sexual health needs of older people have historically been overlooked. However, this is an important group to consider as research from The University of Manchester showed that 54% of men and 31% of women over the age of 70 are still sexually active[5]. Between 2020 and 2022 there has been an increase in rates for both men and women aged 65 and over in London and in England for Chlamydia, Gonorrhoea, Herpes, and Warts with an increase in Syphilis also seen for men. This shows there is a need for increased STI testing and sexual health education for older people. Consultation carried out as part of the ISH service review revealed a lack of sexual health services for older adults (retired plus) and their difficulty accessing reproductive and sexual health services due to poor mobility and transport links.

Resultantly, whilst the needs of young people remain a key area to address, the strategy will also increase support for older people to recognise the changing demographics and needs of the borough.

Disability

In 2021, 4.8% of Richmond upon Thames residents were identified as being disabled and their daily activities limited a lot [6].

Figure 2: Richmond age-standardised proportion of usual residents by long-term health condition or illness



Source: Office for National Statistics – 2011 Census and Census 2021

[5] Love and intimacy in later life: study reveals active sex lives of over-70s

[6] ONS, Census 2011 and Census 2021

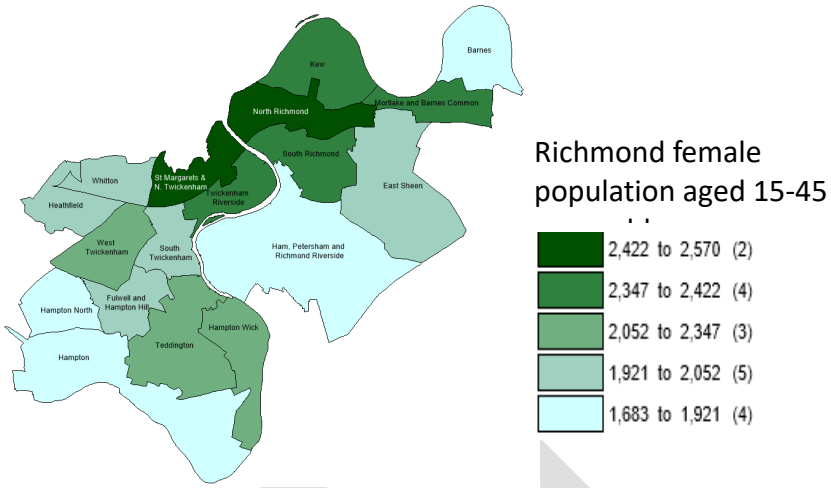
	People with physical disabilities have significant sexual and reproductive health disparities and higher rates of sexual distress when compared with the general population. Furthermore, people with learning disabilities do not have as good or equal access to sex and relationship education or information as those without. They are at higher risk of negative sexual experiences, contracting STIs, and unwanted pregnancies[7]. National data tells us that patients with learning disabilities have lower rates of cervical screening uptake than patients without learning disabilities[8]. Consultation with Richmond adults with learning disabilities, as well as with professionals working with people with learning disabilities, revealed that accessible sexual health services and RSE are important barriers to sexual and reproductive health in this population. Severe mental illness (SMI), such as schizophrenia and bipolar disorder, persist over time and can result in extensive disability leading to impairments in social and occupational functioning. While some individuals have long periods during which they are well and are able to manage their illness, many individuals with SMI have difficulties in establishing stable social and sexual relationships. Despite variability in sexual activity among people with SMI (for example, people with schizophrenia-spectrum disorder are less likely than those with other major psychiatric disorders to be sexually active)[9], high-risk sexual behaviour (e.g. unprotected intercourse, multiple partners, sex trade and illicit drug use) is common and rates of blood borne viruses, such as HIV and Hepatitis C, have been found to be higher among people with SMI (including those who are homeless and/or have a substance misuse problem) than the general population[10]. One action to be considered for the strategy is to establish a sexual health clinic linked to mental health services. In conclusion, those living with physical disabilities, learning disabilities and severe mental illness face a higher burden of poor sexual and reproductive health outcomes, and must be considered an area of priority for the sexual and reproductive health strategy. Access to appropriate and informative sex education will be considered for those with special educational needs.
Sex	More women than men access ISH services primarily due to contraception needs. The figure below shows the distribution of females aged 15-45 (considered to be at childbearing age) in Richmond. The map indicates that the demand for contraceptive services is likely to be greater in the northern wards of the borough.

[7] Baines, S., Emerson, E., Robertson, J., & Hatton, C. (2018). Sexual activity and sexual health among young adults with and without mild/moderate intellectual disability. BMC public health, 18(1), 667

[8] Cancer Screening. Breast, cervical or colorectal cancer screening test, 2019-20

[9] Sexual health risk reduction interventions for people with severe mental illness: a systematic review Pandor et al 2015

[10] Ibid

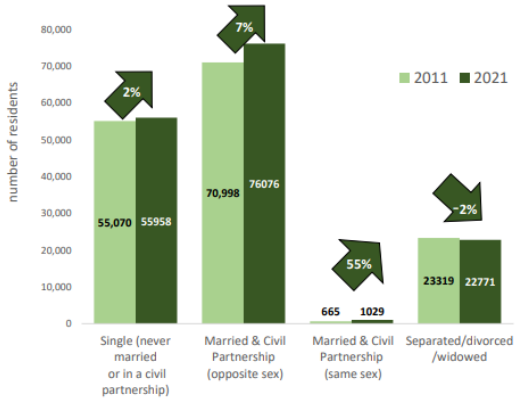
	Figure 3: Distribution of female population aged 15-45, 2020[11]  Source: London population projections explorer Despite higher service use amongst women, men continue to have higher rates of new STIs than women (1,901 and 863 per 100,000 London residents, respectively)[12]. Men have higher rates of gonorrhoea reinfection in Richmond: an estimated 3.1% of women and 8.2% of men diagnosed with gonorrhoea at a sexual and reproductive health service between 2016 and 2020 became reinfected within 12 months. Given the higher service access amongst women for contraceptive needs, women's health hubs must be continued as a part of the new strategy. Additionally, the recognition of higher STI rates amongst men will be addressed through an enhanced condom scheme in the borough.
Gender reassignment	Latest 2021 census data has identified that 0.1% (n=226) of Richmond residents specify that their gender is different from that registered at birth, but do not specify a particular gender. 0.1% (n=137) identify as Trans women and 0.1% (n=113) identify as Trans men. A further 0.1% (134) identify as other gender identity[13]. However, the sexual health outcomes for those who have undergone gender reassignment locally are not known and there is no relevant routine national monitoring data for gender reassignment status. Furthermore, national data on STI rates amongst transgender people is lacking. Despite this evident gap in the data, there is evidence to suggest that transgender people are more likely to be diagnosed with HIV or other sexually transmitted infections and that many experience discrimination within the healthcare system[14]. A sex worker needs assessment carried out in Richmond in 2022 found that, of 543 online sex worker adverts, 150 trans and/or MSM workers were identified of sex workers identified as transgender (as analysed through sex worker adverts), indicating a potential overrepresentation of transgender individuals amongst this group. These findings, in conjunction with consultation with LGBTQ+ people have informed the actions for this strategy.
Marriage and civil partnership	The legal partnership status of Richmond residents is shown in the table below[11]. **Figure 4: Marital Status of individuals in Richmond**

[11] https://apps.london.gov.uk/population-projections/: Accessed 7th September 2023

[12] Spotlight on sexually transmitted infections in London: 2022 data

[13] ONS, Census 2011 and Census 2021

[14] Hayon R. Gender and Sexual Health: Care of Transgender Patients. FP Essent. 2016 Oct; 449:27-36. PMID: 27731969



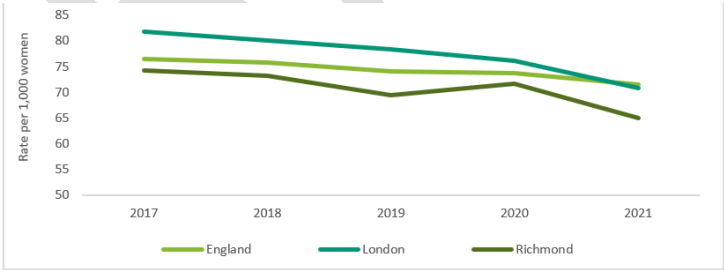
Source: Census Data Atlas (2021)

Sexual health outcome data related to this protected characteristic was limited, but evidence from the Richmond Young People's survey did find that Year 8 pupils in single parent families are more likely to have seen pornography (37% vs. 26%)[15]. RSHE programmes delivered in schools and comprehensive training to teachers and governors is offered by the borough. Some schools and youth settings offer training and interventions with parents that may cover this.

Pregnancy and maternity

The number of conceptions in Richmond is decreasing, and this rate is declining substantially faster than both England and London trends.

Figure 5: Rate of all conceptions in Richmond compared to England and London between 2017 and 2021



Source: ONS conception data, 2021

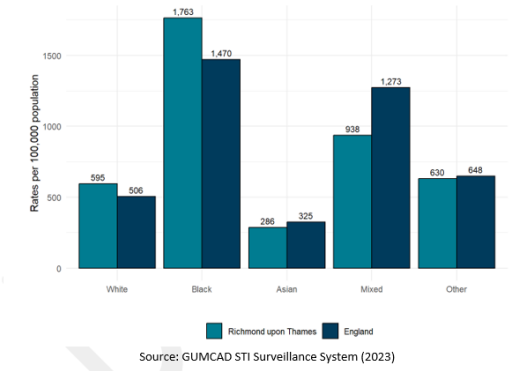
In Richmond there are currently 475 residents diagnosed with pelvic organ prolapse. Pelvic organ prolapse is more common in white females, however, when compared with the percentage of females in the population there is an under-representation of those in mixed ethnicity, Asian and Other groups

The Sexual Health and Reproductive Strategy stakeholder workshop identified gaps around culturally competent pregnancy services and noted the need for services and advocacy needed for adults with learning disabilities experiencing pregnancy. The full sexual and reproductive health needs assessment considers intersectionality for underserved groups, which includes those with protected characteristics. For example,

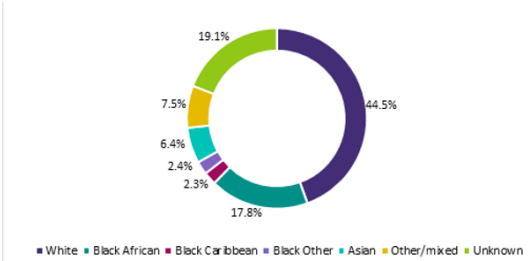
[15] Richmond Young People's Survey

	the needs assessment considers disparities in access to reproductive health services such as access to pelvic health and infertility treatment services where there is under representation of those from certain ethnicity groups. One action to be considered may be to target service provision toward these groups. The proposed women's health hub is likely to increase access to gynaecological services and from their infertility services.
Race/ethnicity	Sexual and reproductive health outcomes can be closely linked with ethnicity, with people from some ethnic backgrounds having disproportionately poorer outcomes than those from other backgrounds. Richmond is the least ethnically diverse population of all the London boroughs with only 19.5% of the population describing themselves as non-white[16]. **Table 1: Richmond population by Ethnicity** Source: Richmond Analytics team As illustrated in figure 6, local and national data shows that STI diagnosis rates per 100,000 people were highest among those of Black ethnicity. STI diagnosis is significantly overrepresented amongst those of Black ethnicities compared to the local population in Richmond. In the 2021 census, 1.9% of people described themselves as Black, Black British, Black Welsh, Caribbean or African whereas 4.6% of STI diagnosis were in Black ethnic groups[17]. Rates of new HIV diagnoses in 2020 also vary by ethnicity, with the highest rates seen among those of White (44.5%) or Black African (17.8%) background. **Figure 6: New STIs by ethnic group per 100,000 population in Richmond and England, 2022** Source: GUMCAD STI Surveillance System (2023)

Ethnicity	Richmond 2011	Richmond 2021	% Change	Ethnicity	Richmond 2011	Richmond 2021	% Change
White	**86.0%**	**80.5%**	**-5.5%**	**Black**	**1.5%**	**1.9%**	**0.4%**
English, Welsh, Scottish, Northern Irish or British	71.4%	63.0%	-8.4%	African	0.9%	1.2%	0.3%
Irish	2.5%	2.5%	-0.1%	Caribbean	0.4%	0.5%	0.0%
Gypsy or Irish Traveller	0.1%	0.0%	0.0%	Other Black	0.2%	0.3%	0.1%
Roma	N/A	0.2%	N/A	**Mixed**	**3.6%**	**5.5%**	**1.8%**
Other White	11.9%	14.7%	2.8%	White and Asian	0.7%	2.2%	1.5%
Asian	**7.3%**	**8.9%**	**1.7%**	White and Black African	0.4%	0.6%	0.2%
Bangladeshi	0.5%	0.5%	0.0%	White and Black Caribbean	1.5%	0.8%	-0.7%
Chinese	0.9%	1.4%	0.5%	Other Mixed or Multiple ethnic groups	1.0%	1.8%	0.8%
Indian	2.8%	3.7%	0.9%	**Other ethnic group**	**1.6%**	**3.3%**	**1.6%**
Pakistani	0.6%	0.9%	0.3%	Arab	0.6%	0.9%	0.3%
Other Asian	2.5%	2.5%	0.0%	Any other ethnic group	1.0%	2.4%	1.4%



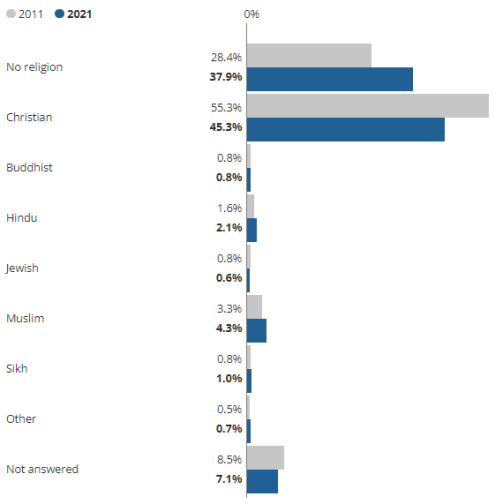
[16] www.trustforlondon.org.uk/news/census-2021-deep-dive-ethnicity-and-deprivation-in-london
[17] How life has changed in Richmond upon Thames: Census 2021

	Figure 7: Proportion of new HIV diagnoses first diagnosed among people living in England by ethnicity, 2020  Source: UKHSA, HIV Annual Data Table, 2021 Local data shows that gynaecological cancers are more likely to be diagnosed among the White population and under diagnosed in Black, Asian, and other ethnic groups. Among men, rates of cancer vary according to ethnicity. Black males in Richmond are at greatest risk of prostate cancer. By comparison, incidence rates of testicular cancer are lower in the Asian ethnic group compared with the White ethnic group. Ethnic differences also exist in the rates of diagnosis of menopause and HRT prescribing. For example, white women are more likely to be diagnosed with menopause than Black or Asian women and are more likely to receive treatment than all other ethnic groups. National Data suggests that UK communities most at risk of Female genital mutilation are Kenyan, Somali, Sierra Leonean, Egyptian, Nigerian and Eritrean, Yemeni, Afghani, Kurdish, Indonesian and Pakistani[18]. Information published by the Roma Support Group through NHS England in 2016 recognised sexual health taboos amongst Roma communities where sexual and reproductive health topic may be considered unclean and only appropriate to discuss amongst females[19]. Furthermore, whilst there is little quantitative data available on the extent of violence against Gypsy, Roma and Traveller women and girls, charities and agencies working with these communities report prevalent and normalised domestic abuse[20]. Disparities in sexual health outcomes amongst communities of different races and ethnicities will be addressed in the sexual health strategy with specific outreach work targeted towards underserved groups, as well as engagement with communities to understand and address barriers to sexual health care. Furthermore, all commissioned services will be required to have access to interpreters for those whose first language is not English.
Religion and belief, including non-belief	In 2021, 37.9% of Richmond upon Thames residents reported having 'no religion', an increase from 28.4% in 2011. 45.3% of people in Richmond upon Thames described themselves as Christian and the Muslim faith was the second most popular religion at 4.3%. 37.9% of residents stated having no religion. **Figure 8: Percentage of usual residents by religion, Richmond**

[18] https://assets.publishing.service.gov.uk/media/5c7e9d1440f0b6333380e4ee/FGM_The_Facts_A6_v4_web.pdf

[19] https://www.england.nhs.uk/wp-content/uploads/2016/07/roma-info-leaflet.pdf

[20] https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/360.pdf



Source: ONS, 2021

Whilst data on sexual health outcomes and religious beliefs are limited, the Sexual Health and Reproductive Health Strategy stakeholder workshop identified a need to involve faith groups in community engagement to tackle gender-based violence prevention, support and care. The strategy will brings focus to delivering culturally competent training to health professionals and aim to increase understanding of the role religion and culture can have on people's engagement with sexual health services.

Sexual orientation

Data from the 2021 census estimates that 3.4% of the population (5,238) aged 16+ are LGBTQ+[21]. The graph below compares the percentage of LGBTQ+ people in each of the different age cohorts with the population of the borough in the age group. For example, 10.2% of the borough are aged 16 to 24 (light green) and within this age bracket 21% of the 3.4% are aged 16 to 24 (dark green).

Figure 9: Selected sexual orientation by age, Richmond

Source: DataRich (2021)

Whilst more people identifying as heterosexual accessed sexual health services in 2022, residents identifying as homosexual were overrepresented in-service use. In people where sexual orientation was known, 28.5% of new STIs in Richmond residents in 2020 were among gay, bisexual and men who have sex with men (GBMSM). This compares to 27.1% in England. The proportions of new STIs that were diagnosed in men who have sex with men (MSM) in Richmond for 2018-2022 show that the prevalence of syphilis and gonorrhoea were particularly high for MSM in comparison to other STIs.

[21] ONS, Census 2011 and Census 2021

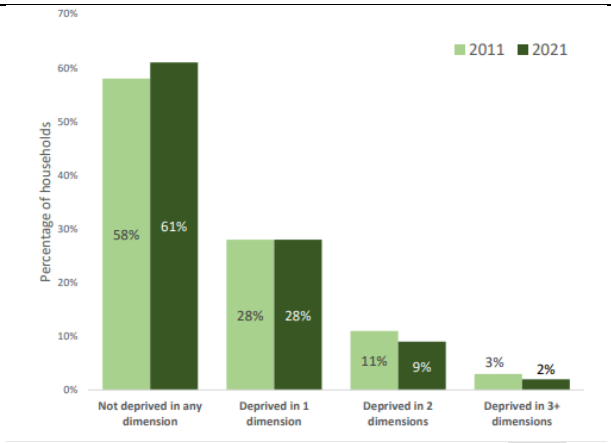
	GBMSM are also disproportionately affected by HIV. It is therefore essential to prioritise access to testing and diagnosis for this group. Latest data from Office of Health Improvement Disparities (OHID) found that coverage of HIV testing among eligible GBMSM patients was lower in Richmond (73%) compared to both London (73.3%) and England (74.1%) rates[22]. Notably, the HIV late diagnosis rate for GBMSM in 2022 was 33.3% which is higher than London at 29.4% and similar to England's 34.2%. Locally, data from the 2022 Health Related Behavioural Questionnaire (HRBQ) of Richmond pupils found that year 10 LGBTQ+ pupils are more likely to have had sex (17% vs. 12% non-LGBTQ+) and are more likely to have experienced controlling partner behaviour (30% vs. 22%)[23]. Newly released data from the UK Health Security Agency shows that rates of chlamydia diagnoses amongst women who have sex with women (WSM) have increased 144% from 90.6 per 100,000 in 2018 to 221.8 per 100,000 in 2022. Over the same period, similar patterns are seen for gonorrhoea and herpes, rising from 51.2 to 174.6 per 100,000 and 45.7 to 124.1 per 100,000 respectively[24]. Furthermore, despite evidence that bisexual women are twice as likely to develop cervical cancer, women who have sex with women (WSW) have typically not been the focus of cervical screening initiatives[25]. This highlights a need to recognise and address need amongst WSW, a historically underserved group, as such the strategy will raise awareness of the needs of this group through sexual health MECC training delivered to sexual health professionals.
Across groups i.e. older LGBT service users or Black, Asian & Minority Ethnic young men.	Consultation carried out as part of the integrated sexual health (ISH) service review of sexual health services for older adults (retired plus) revealed challenges related to older people identifying as LGBTQ+ and those with HIV entering care homes, as well as their families and other carers/staff. A priority area for action will be to understand the impact of sexual and reproductive health for the older population, including those where intersectionality plays a factor such as older GBMSM with HIV in care homes or those with HIV and dementia for example.
Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups: • **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	**Deprivation (measured by the 2019 English Indices of Deprivation)** Richmond remains the least deprived borough in London (ranking 238th) and is within the 50% least deprived boroughs across all indices of deprivation. Almost 90% of Lower Layer Super Output Areas (LSOA) in Richmond fall within the 50% least deprived nationally. The LSOA ranking the highest amongst the 10% most deprived in London was in Hampton North. **Figure 10: Household deprivation, Richmond**

[22] OHID Sexual and Reproductive Health Profiles (2023)

[23] Richmond Young People's Survey

[24] Sexually transmitted infections (STIs): annual data tables - GOV.UK (www.gov.uk)

[25] HSC0057 - Evidence on Health and social care and LGBT communities (parliament.uk)



Source: Census data Atlas, 2021

There is a clear link between prevalence of STIs and deprivation. Just under 60% of all new STI diagnoses were among people living in the least deprived areas in the borough as can be seen in Table 2.

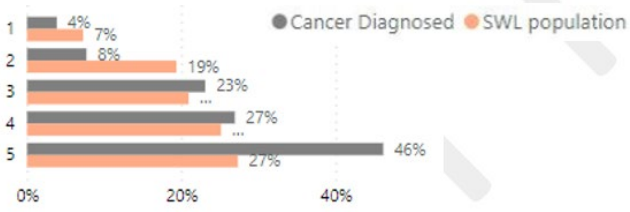
Table 2: New STIs by deprivation, Richmond 2022

Deprivation category	Number	%
Most deprived	15	1.2
2nd most deprived	65	5.1
3rd most deprived	120	9.3
4th most deprived	305	23.7
Least deprived	780	60.7

Source: Summary Profiles of Local Authority Sexual Health (SPLASH) report supplement, 2023

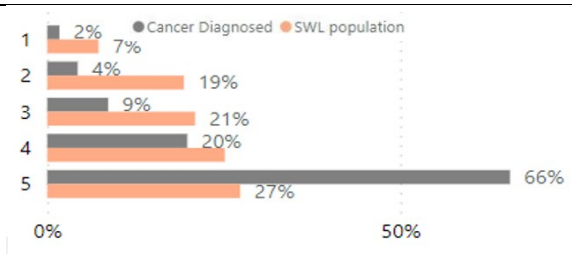
Uptake of cervical cancer screening is lower in those living in areas of higher levels of deprivation, while 50% of cervical cancer diagnoses were among women in the highest deprivation quintile. Rates of other reproductive cancer diagnoses are also higher among higher quintiles of deprivation.

Figure 11: SWL cervical cancer by deprivation



Source: SWL Health Analytics, 2023

Figure 12: SWL gynaecological cancer diagnosis by deprivation



Source: SWL Health Analytics, 2023

Access to menopause diagnosis and support varies according to deprivation indexes. Females in the most deprived cohort were least likely to access menopause help and support, and receive a diagnosis, compared with those in higher socio-economic groups. Disparities also exist when deprivation is considered for those on HRT. 0% of those on HRT are within the most deprived quintile compared to 71% in the least deprived quintile.

The majority of teenage parents and their children live in deprived areas and often experience multiple risk factors for poverty, experiencing poor health, social and economic outcomes and inter-generational patterns of deprivation[26].

Low-income groups & employment

Period poverty in the UK is increasing. A poll of 2060 UK adults, conducted by ActionAid, suggested that the number of UK women and people who menstruate who are struggling to afford period products has risen from 12% to 21% from 2021 to 2022[27]. This amounts to an estimated 2.8 million people experiencing period poverty and approximately 10,000 women aged 13 to 50 in Richmond. Furthermore, mothers under the age of 20 have a 63% higher risk of living in poverty and are 22% more likely to live in poverty by the age of 30 than older mothers.

Conversely, GBMSM reporting use of chemsex related drugs (methamphetamine, ketamine, GHB and methedrine), have been shown to have high rates of employment, suggesting a high level of functioning.

Carers

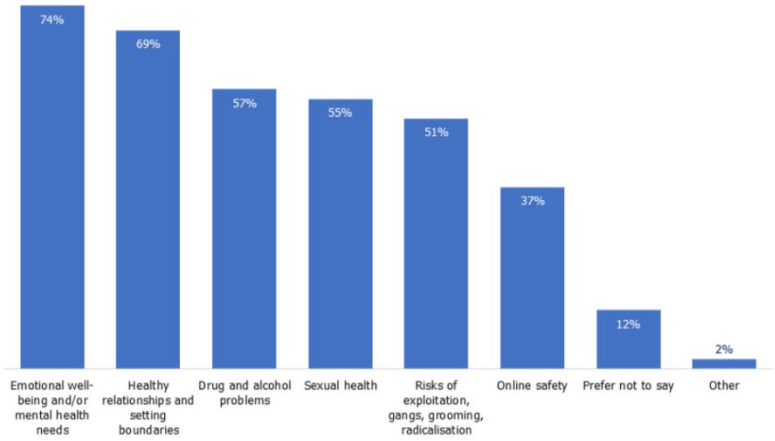
At a national level, unpaid carers show higher levels of intersecting demographic/personal characteristics that are associated with poorer sexual health outcomes. The 2021 census found that more unpaid carers in England were disabled (27.5%) compared with non-carers (17.8%) and those providing more hours of care had a higher percentage of disability. Disability rates amongst young unpaid carers (5–17-year-olds) were considerably higher than those of the same age group who did not provide care, 23.6% compared to 8.0% respectively. Unpaid carers also have slighter higher representation of LGBTQ+ sexual orientations: 3.9% compared to 3%[28]. Whilst there is limited data related to sexual health for carers specifically, these intersections with known risk factors for poorer sexual health outcomes indicate that carers may have higher rates of adverse sexual health outcomes than non-carers.

Care experienced people

[26] Department of Health: Teenage Pregnancy National Support Team: Effective Public Health Practice
[27] Cost of living: UK period poverty has risen from 12% to 21% in a year
[28] Unpaid care and protected characteristics, England and Wales: Census 2021

A 2022 government survey found that a high proportion of care experienced people aged 16-17 identify with sexual orientations other than heterosexual, with 22% identifying as LGBTQ+. 5% were of a gender that was different from their registered sex at birth. Only 55% of care leavers surveyed had had a conversation around sexual health before leaving, 69% had had discussions about healthy relationships and setting boundaries[29]. This is despite national data indicating that looked after children and care leavers have a 3 times greater rate of motherhood under the age of 18[30].

Figure 13: Topics of conversations about safety during care leaver's preparation to leave care



Source: Ofsted, 2022

Single parents

There is limited data on sexual health and single parent households, however a health-related behaviour survey conducted across Richmond primary and secondary in 2022 found that

Year 8 pupils in single parent families are more likely to have seen pornography (37% vs. 26%).

Refugee status

Refugee and asylum-seeking women are often physically, socially and psychologically vulnerable, owing to past experiences[31,32]. They have a range of social and sexual health needs, which can include suffering from the consequences of female genital mutilation (FGM), sexual violence and exploitation, or STIs due to inadequate contraceptive use[33]. Barriers to sexual health have also been identified amongst migrant, asylum seeking and refugees, including lack of knowledge around services, cultural acceptability of services and language barriers between patients and service providers[34]. Sexual and reproductive health information is made available in different languages from the Integrated Sexual Health Services and access to translation services is available on request.

[29] 'Ready or not': care leavers' views of preparing to leave care
[30] Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[31] Sudbury H. & Robinson A. (2016), Barriers to sexual and reproductive health care for refugee and asylum-seeking women; BMJ, Vol 24, Issue 4
[32] Feldman RLondon: Maternity Action and Refugee Council; 2013
[33] Wilson R, Sanders M, Dumper H. London: Family Planning Association; 2007
[34] https://pubmed.ncbi.nlm.nih.gov/37708137/

	Young fathers: The teenage pregnancy framework recognises that young fathers are more likely than older fathers and other young men to have been subjected to violent forms of punishment at home and are twice as likely to have been sexually abused. They are more likely to have pre-existing serious anxiety, depression and conduct disorders and have poorer health and nutrition. Additionally, young fathers are more likely to drink, smoke and misuse other substances, with one in six young men under the age of 25 who are accessing drug and alcohol services being young fathers[35]. Furthermore, young men's abilities to sustain a fathering role are dependent on interlinking factors including access to formal service provision. Despite recommendations for timely access to appropriate support, provision for young fathers is lacking and systematic contact with young father's should be an area of focus[36]. **Homelessness** A Richmond homeless health needs assessment conducted in 2022 found that 4% of those surveyed self-reported being at risk of or experiencing sexual abuse or exploitation. This suggests that there should be improved links between homelessness services and sexual health. The LGA also report that homeless people are more at risk of STIs and unwanted pregnancies and may be under more pressure to engage in transactional sex. **People Using Substances** The Natsal-3 survey found that men and women reporting frequent binge drinking or recent drug use were more likely to report unprotected first sex with more than one new partner; first sex with their last partner after only recently meeting; emergency contraception use within the last year; and sexually transmitted infection diagnosis/es in the past five years[37]. **Sex workers** A peer led sex worker community participation review in Richmond found that sex workers face barriers to accessing sexual health care due to limited success of services in engaging and supporting Sex workers, Sex worker concerns about privacy and data sharing leading to criminalisation, deportation, or other consequences for their personal safety and well-being and avoidance of use of services in the same area as residence. The strategy will look toward prioritising action to increase access to sexual and reproductive health for each of these groups. Provision of outreach sexual health in homelessness hubs, a new sex worker service and additional support for those using substances are provided as examples.

Data gaps

Data gap(s)	How will this be addressed?

[35] Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[36] (PDF) The Lives of Young Fathers: A Review of Selected Evidence (researchgate.net))
[37] Khadr SN, Jones KG, Mann S, et al: Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey: BMJ Open 2016;6:e011961. doi: 10.1136/bmjopen-2016-011961

There are local data gaps in relation to both groups disproportionately affected by sexual and reproductive health and underserved groups. This is largely due to small numbers when data is stratified.	Where this is the case estimates or national data is used to understand the local picture.

4. Impact

Guidance

Positive Impact – put in here what the policy/service will do

- *to address barriers to access/under-representation*
- *to foster good relations between groups*
- *to support protected groups to benefit from the service/policy*
- *to advance equality of opportunity*
- *to eliminate discrimination, harassment or victimisation*

For example:

- *if you have identified in your analysis that a service is not currently accessed by men say how the proposed changes will address this, or*
- *if your data has shown that older residents do not access the service say how your service specification will address this, or*
- *if service user feedback shows Black, Asian and Minority Ethnic residents do not access a service what your strategy will do to address this and how this will feed into the supporting action plan, or*
- *if your strategy has identified that bringing together service users from different backgrounds will increase understanding say how you will do this*

Negative impact – if the service/policy will have a negative impact say what this will be and what action can be put in place to mitigate the impact. Even if there is only a small risk that there will be a negative impact put this into the EINA.

If you are changing a service/policy do not just put "no negative impact" you need to include how you know there will be no impact.

If the EINA covers both Richmond Council and Wandsworth Council - If the strategy/service/policy covers both Wandsworth and Richmond be clear on the impact on each boroughs' residents separately and any borough specific actions required.

Considerations and actions given below are draft and will be further refined following the public consultation on the strategy that will further define priority actions for the strategy.

Protected group	Positive	Negative
Age	• Dedicated sexual health services for young people. • Increase in access to contraception, chlamydia screening and STI testing for young people through increasing on-	Focussing on younger or older groups can reduce resources and capacity for action with those in adult aged categories, for example, an increase in women accessing repeat termination of pregnancy services.

	line provision and access to tailored interventions with harder to reach young people, including Chat Health website for CYP to communicate directly with school health teams. • Provision of condoms & chlamydia screening, EHC and pregnancy testing via school health drop-ins / school health (especially in 6th form / colleges). • Re-offer HPV vaccine to eligible young people when parents have declined and work with parents to understand the importance of the HPV vaccine. • Re-focus Condom card provision to services young people are accessing – e.g. CAMHS, YJS, Future First office for care leavers & venues with late night openings • Increase access to sex and relationships training for teachers, including local teacher training courses, youth and community services and improve close work with sexual health services. • Improvement of sexual and reproductive health information and education through the life-course – through development of a MECC module on sexual and reproductive health. • Specific focus on enhancing sexual and reproductive health conversation and interventions with older people that eliminate discrimination. • Increase awareness of the link between sexual dysfunction, cardiovascular health, dementia and early death e.g. including erectile dysfunction question or link within NHS health checks. • ISH service will be open access to people of all ages and will include provision of specialist young people's clinics across commissioning boroughs. Furthermore, all services and interventions provided shall operate across the commissioning boroughs at a variety of times and locations to meet the demands, needs and lifestyles of service users.	To mitigate against this the strategy takes a life course approach to sexual and reproductive health using the WHO framework for operationalising interventions across eight areas of equal weight. Implementing a newly commissioned ISH service may result in a transition period between the termination of the existing service and the start of the new one. During this time, there could be a temporary suspension of services, which could negatively impact people who rely on the service for support. To mitigate the risk, commissioners will ensure that existing knowledge and resources are shared between the new and incumbent provider to streamline the transition and avoid any lengthy disruptions to services. Furthermore, parties will be expected to develop robust communication plans for service users, residents and key stakeholders during any periods of change. Commissioners will also allow sufficient mobilisation time between the contract award and commencement.
Disability	• Support to enable disabled young adults to get better access to sexual	Positive action focussing on disabilities has a tendency for greater attention on people

	health services and reproductive / hygiene related products. Furthermore, providers of all commissioned sexual health services will be expected to provide a good quality and inclusive service for people with, mental health conditions, Autism, learning, physical and sensory disabilities; various levels of literacy, languages and varying levels of IT/digital literacy. • Provide clear timeframes and access to termination options and post abortion support for people with learning disabilities. • Healthy relationships training for parents / carers of young people and adults with learning disabilities. • Support people with learning disabilities to use sexual and reproductive products including period hygiene products. • Increase promotion of sexual health services, RSE and sexual and reproductive health education with appropriate and respectful support to people with and carers of those with learning disabilities. • United Response sex and relationships 'Companions' project for adults with learning disabilities	with or carers of people with learning disabilities. This can be at the expense of those with neuro and/or physical disabilities. The needs assessment has identified needs of those with neuro and/or physical disabilities, but capacity is limited to delivering specific interventions. To mitigate this the sexual health service and outreach service have set up targeted support with those with disabilities, for example a dedicated sexual health clinic for deaf people. The sex worker service has demonstrated that many sex workers also have a higher prevalence of people with disabilities thereby recognising the intersectionality of interventions. While any shift in the way services are delivered may benefit some people with disabilities, others may struggle with new ways of accessing care and therefore may temporarily not receive the care and support they require. Commissioners will ensure that clients have a choice in how they receive/access care, and that feedback is regularly sought both from service users and target groups yet to access support, in order to inform future provision.
Sex	• Joint action with developing women's health hubs and family hubs to formalise the interconnectedness of sexual and reproductive health. • Psychosexual counselling offer through women's health hubs. • Support Richmond to switch on a pan London online contraceptive service. • Normalise men's reproductive and fertility care with clear pathways to access • Explore ways to improve access to menopause support including provision of HRT for ethnic minority groups. • Increase education on termination of pregnancy for males. • Entry into services will continue to be based on needs not gender identity. All people, regardless of gender, will receive the appropriate level of sexual	Fragmented commissioning of sexual health and reproductive health services often means that services have not been developed or delivered in a joined-up fashion. Commissioners in local authority and health providers will endeavour to work together to better join up the interconnectedness between sexual and reproductive health services through joint action of women's health hubs and education targeting male related education on reproductive health and health and well-being.

	and reproductive health care and support. • Considering most STIs are more prevalent in males, an enhanced offer of condoms and the young people's condom distribution scheme will be available to males who access the future ISH service.	
Gender reassignment	• Sexual health 'high risk' outreach service targeting Gay, Bisexual and Men who have Sex with Men (GBMSM). • Free 2 B LGBTQ+ service offered in Richmond, delivering sessions in schools. • Sexual and reproductive health training highlighting needs of underserved groups. • The interim and future ISH service contracts will require upskilling of professionals around gender identity. Furthermore, the service will aim to continue to meet the needs of trans people and reduce the health inequalities they face, through provision of services which are sensitive to their needs and ensuring robust pathways for tailored support are in place.	Data and information on this group is limited at a local level. National data has therefore been used to extrapolate local understanding of issues for this group. The sex worker service has demonstrated that a number of sex workers have likely undergone gender reassignment and may be reached through the 'at risk' sexual health outreach service.
Marriage and civil partnership	• Encourage all health professionals to ask routine questions about sexual violence and domestic abuse. • Provision of open access and confidential sexual and reproductive services.	Individual decisions and choices concerning sexual and reproductive health are informed by significant life events including marriage and cultural expectations compounding this. There is an anecdotal belief among service users that confidential access to sexual health services for those who are married or in civil partnerships may be breached. To mitigate this, services operate on an open access and confidential basis.
Pregnancy and maternity	• Sign posting to post-partum contraceptive care during pregnancy and postnatally. • Free emergency hormonal contraception in pharmacies across the borough. • Advice and information on contraception post termination of pregnancy.	Prevention of teenage pregnancy has often been over focused on teenage mothers and can hide the needs of young fathers. The strategy will include specific areas of interventions for young fathers. One of the eight intervention areas for the sexual and reproductive health strategy is solely focussed toward antenatal,

	• Targeted work with young fathers including early engagement, general support and education on being a father and how to support the family. • Explore expansion of home visiting by health visitors / health practitioners. • Take advantage of new government funding for pelvic health – such as direct referral from Health Visiting to pelvic health services • Postnatal contraception offer at hospitals include LARC at C-section, implants and contraceptive pills • The provider(s) of both the interim and future ISH service will be required to provide routine/basic and complex sexual and reproductive health services to all people including those at any stage of their pregnancy (including antenatal and postnatal), provide pregnancy testing as part of a clinical care pathway and referral services for people choosing not to continue with a pregnancy.	intrapartum and postnatal care. The strategy will highlight action in this area.
Race/ethnicity	• Targeting late diagnosis and increase access to PrEP among underserved groups • Explore extension of HIV testing opportunities through general practice to normalise HIV testing. • Train health champions to raise awareness of sexual and reproductive health – using peer to peer support/ training across the life course. • Contribution to London HIV prevention service, HIV point of care testing in London and PrEP referrals • Education and provision of PrEP during sexual health consultations • Provision of targeted clinical services for underserved communities as well as strong and inclusive marketing and promotional activities will be stipulated in the future ISH service specification. The service workforce will be reflective of (as much as possible) the commissioning boroughs' ethnic profile and communities disproportionately affected by poor sexual health outcomes.	Some black and Minority ethnic groups are disproportionately affected by poorer sexual health and HIV outcomes this will be mitigated through a strategic approach that targets these specific groups within outreach, training, campaigns and service provision. Some minority groups may find it difficult to access certain services based on cultural beliefs or negative stigma attached to sexual health. In order to facilitate equal access to sexual health services for all groups, especially Black, Asian and Other Minority Ethnic communities, we have been working with Public Health colleagues to engage with minority groups to better understand the barriers they face. This knowledge will inform the future ISH service specification and guide service delivery. All services will be required to have access to interpreters for anyone who does not have English as their first language.

Religion and belief, including non-belief	• Provide cultural competency training for health professionals to build confidence for informal conversations • Increase awareness of post abortion support that is culturally appropriate. • Explore further engagement with faith groups to reduce stigma • The provider(s) of both the interim and future ISH service will be required to be sensitive to users' religious beliefs/faiths whilst delivering interventions**.**	Economic migrants, refugees and illegal immigrants often have poorer sexual health outcomes and are underrepresented in services. Furthermore, religion, belief and ethnicity can be a barrier to accessing services Outreach with these specific groups will form a focus for the strategy through the development and provision of culturally competent training and a renewed focus on the actions of health champions. Furthermore, professionals delivering services must be aware and have a comprehensive understanding of how faith and culture can impact the choices of certain people. The ISH service provider(s) should also be able to adapt/change their interventions to meet the needs of the service user.
Sexual orientation	• Sexual health 'high risk' outreach service targeting Gay, Bisexual and Men who have Sex with Men (GBMSM). • SH-24 On-line testing and screening for STIs and HIV with rapid referral to specialist services. • Free 2 B LGBTQ+ service offered in Richmond, delivering sessions in schools. • Increase awareness of the sexual health needs of WSW.	GBMSM are disproportionately affected by poor sexual health and the strategy has historically been focussed toward this group. Women who have sex with women are a less well understood group and have often been assumed to not be affected. Evidence, however, points to an increase in STIs and poor sexual and reproductive health for this group. To mitigate this the strategy will contain action to raise awareness through MECC training of the health needs for WSW. Implementing a newly commissioned ISH service may result in a transition period between the termination of the existing service and the start of the new one. During this time, there could be a temporary suspension of services, which could negatively impact people who rely on the service for support. To mitigate the risk, commissioners will ensure that existing knowledge and resources are shared between the new and incumbent provider to streamline the transition and avoid any lengthy disruptions to services. Furthermore, parties will be expected to develop robust communication plans for service users, residents and key stakeholders during any periods of change. Commissioners will also allow sufficient

		mobilisation time between the contract award and commencement
Socio-economic status (to be treated as a protected characteristic under Section 1 of the Equality Act 2010) Include the following groups: • **Deprivation (measured by the 2019 English Indices of Deprivation)** • **Low-income groups & employment** • **Carers** • **Care experienced people** • **Single parents** • **Health inequalities** • **Refugee status**	• Expand sexual health service provision in areas of higher deprivation – the aim is to enhance the level 1-2 ISH service offer for young people in Richmond to an all-ages service offer in the future model. • The future model will be further complemented with a service offer which ensures improved accessibility for communities underserved in the current service delivery model. This will include areas with higher deprivation. Furthermore, the provider(s) of both the interim and future service will be expected to deliver services sensitive to and inclusive of the needs of carers, care experience people, single parents and refugees. • Develop a resource pack for homeless/ substance misuse / LD and asylum seekers. • Provision of sexual health outreach to the homeless e.g. SPEAR Healthlink. • Weekly 'pit stop' for sex worker service in for accessing contraception • Explore the impact of unpaid caring on sexual and reproductive health. • Looked After Children's services and school health to offer gender-based violence support. • Sex and relationships training for care experienced young people for foster carers, personal advisers, social workers and Looked After Children medical teams that include signposting to services. • Support the delivery and review of a pilot contraception clinic within a mental health service. • Establish a 'hot clinic' – once monthly clinic in substance misuse / homelessness services. • Training for health care staff on the needs of sex workers and how to support them, including maintaining confidentiality and provision of harm reduction supplies.	The sexual and reproductive health needs assessment has been comprehensive in its approach to understanding the sexual and reproductive health need of both disproportionately affected groups and those underserved. The strategy itself and actions to be taken over the next five years hold these groups centre stage thus adopting a targeted universal approach to its delivery.

	• Training for professionals on the sexual and reproductive health needs of refugees and asylum seekers.	

5. Actions to advance equality, diversity and inclusion

Guidance

Put in this table actions you have identified that will be included in your strategy/policy and supporting action plan or mitigating actions you have identified that need to be undertaken.

Include how the impact of actions will be measured for example if you resolve to make a service more accessible for older residents say what your current baseline is and what target you want to achieve.

These actions will be tracked by your Directorate Equality Group who record all actions on their EINA tracker. As well as sending the final version of this EINA to the Policy & Review Team, please send it to your Directorate Equality Group and ensure they are updated on the progress of your EINA actions.

Action	Lead Officer	Deadline
Specific priority actions to be defined following the public consultation and priority setting		
Ensure that all commissioned sexual health service specifications encourage service user choice in how they receive their care. Commissioners to include a hybrid model of care (in person, online, in-clinic, outreach).	Lea Siba	At relevant contract procurement/extension points 2025-2030
Ensure that all commissioned sexual health service specifications include targeted work with organisations and services who directly support young people, people with disabilities, people from Black, Asian and other minority Ethnic groups and local LGBTQ+ groups. This will include training and upskilling staff.	Lea Siba	At relevant contract procurement/extension points 2025-2030
Sexual Health services performance monitoring framework requirements will include enhanced equalities reporting of service users accessing contraceptive care as well as outcomes, demographic breakdown of service users by service channel or venue and where applicable nature of learning disabilities.	Lea Siba	At relevant contract procurement/extension points 2025-2030
Commissioners will ensure that if any existing services/interventions are terminated, robust pathways and communications plans will be put in place for equivalent services as required.	Lea Siba	At relevant contract procurement/extension points 2025-2030

6. Further Consultation (optional section – complete as appropriate)

Guidance

Is any further consultation planned? Set details out below.

Consultation planned	**Date of consultation**
Consultation carried out through the needs assessment and through the strategy design is considered to have been comprehensive and extensive. The public consultation will be the final stage of this work. The draft strategy will then go through council governance processes including: 1. Public Health DMT 2. DASSPH SMT 3. Public Health Board: Verbal update from Public Health Consultant 4. Directors Board 5. Richmond ASC Health and Housing Committee 6. Strategy to be published online following Committee approval 7. Strategy Launch Event	**1.** 6th November 2024 **2.** 13th November 2024 **3.** November 2024 **4.** 9th January **5.** 2025 dates TBC **6.** TBC **7.** April 2025