



London Borough of Croydon

Sexual and Reproductive Health Needs Assessment

2026



31^{TEN}

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ABBREVIATIONS

AI – Artificial Intelligence

ART – Antiretroviral Therapy

BASHH – British Association for Sexual Health and HIV

BHIVA – British HIV Association

CASCAID – Complex Assessment and Support for Children and Adolescents in Distress

CAG – Clinical Advisory Group

CHS – Croydon Health Services

CIPFA – Chartered Institute of Public Finance and Accountancy

CVA – Croydon Voluntary Action

CYP – Children and Young People

CTAD – Chlamydia Testing Activity Dataset

EHC – Emergency Hormonal Contraception

ESHP – Enhanced Sexual Health Pharmacy

GBMSM – Gay, Bisexual and other Men who have Sex with Men

GP – General Practitioner

GUMCAD – Genitourinary Medicine Clinic Activity Dataset

HARS – HIV and AIDS Reporting System

HIV – Human Immunodeficiency Virus

ICB – Integrated Care Board

IMD – Index of Multiple Deprivation

ISH – Integrated Sexual Health Service(s)

JSNA – Joint Strategic Needs Assessment

LARC – Long-Acting Reversible Contraception

LBC – London Borough of Croydon

LHPP – London HIV Prevention Programme

LSHP – London Sexual Health Programme

MSI – Marie Stopes International

NCSP – National Chlamydia Screening Programme

NHSE – NHS England

OHID – Office for Health Improvement and Disparities

ONS – Office for National Statistics

PEP – Post-Exposure Prophylaxis

PLWH – People Living With HIV

PrEP – Pre-Exposure Prophylaxis

PSHE – Personal, Social, Health and Economic Education

RSE – Relationships and Sex Education

SEND – Special Educational Needs and Disabilities

SHL.UK – Sexual Health London online service

SRH – Sexual and Reproductive Health

SRHAD – Sexual and Reproductive Health Activity Dataset

STI – Sexually Transmitted Infection

TOP – Termination of Pregnancy

UKHSA – United Kingdom Health Security Agency

EXECUTIVE SUMMARY

Sexual and reproductive health (SRH) is a key priority for public health and an essential factor when it comes to the overall health and wellbeing of the London Borough of Croydon's residents. Local authorities have a statutory responsibility to commission comprehensive, open-access SRH services, including contraception, testing and treatment for sexually transmitted infections (STIs), and sexual health promotion. Croydon has a range of SRH services in place through its integrated service and tailored offer for key groups, displaying quality provision. This needs assessment considers the range of SRH needs across the life course, with a focus on reducing inequalities, vulnerable groups and improving health outcomes for Croydon residents.

This needs assessment has adopted a rigorous mixed-methods approach combining primary collected data and insights with secondary data from national datasets and local sources. It has embedded principles of co-production to understand current and future SRH needs within the London Borough of Croydon and to inform commissioning, service planning, and strategic decision-making.

A variety of bespoke resident engagement and qualitative co-production activities were undertaken to support the identification of key barriers, understand what works for communities and priorities for service improvement and gaps in needs.

Over 350 residents, service users and potential service users, service partners and people with a connection to Croydon were engaged with through the format of 1:1 qualitative interviews, community-based 'vox pop' outreach in key settings or services and tailored survey methods. Targeted outreach ensured inclusion of key vulnerable populations, including ethnic minority communities, people with disabilities, young people, GBMSM, people living with HIV, sex workers, those experiencing mental health challenges, homelessness, substance use, and migrants, refugees and asylum seekers.

Key findings in relation to STI indicate a high burden of STIs and HIV, with chlamydia, gonorrhoea, trichomoniasis, genital herpes and genital warts the most commonly diagnosed infections. While gonorrhoea and syphilis rates are declining, rapidly increasing shigella and trichomoniasis present emerging concerns, alongside high reinfection rates and chlamydia detection below national targets. STI burden remains disproportionately higher among deprived communities, Black residents and GBMSM. Alongside this, Croydon continues to be considered an area of extremely high HIV prevalence, with A&E blood-borne virus testing driving progress and new diagnoses, but testing has not returned to pre-pandemic levels. Late HIV diagnosis—particularly among heterosexual people—alongside ongoing stigma remain significant challenges.



Contraception and STI screening are areas of high demand within services in Croydon, though overall levels of contacts with services for reasons of contraception have declined in recent years. Use of long-acting reversible contraception (LARC) remains below national averages, with engagement highlighting ongoing barriers related to access, awareness and personal choice factors.



Croydon continues to experience high abortion rates across age groups, alongside the highest under-18 conception rates in London, although access to abortion services for teenage pregnancy is generally good based on proxy indicators. Abortions are disproportionately higher among some ethnic minority groups, while repeat terminations are showing signs of decline based on provider data. Improving post-abortion contraception uptake and engagement in SRH care remains a key service challenge.

Engagement with priority groups highlighted declining participation in youth targeted services such as the C-Card scheme and ongoing challenges in sustaining engagement with sexual health care in the long term. While awareness of services is generally good, high stigma, complex social pressures (including homelessness, substance use and mental ill-health), and practical barriers such as clinic location, awareness of what's available, concerns about safety when moving around the borough and on transport, opening times and confidentiality can hinder access and uptake.

Groups engaged expressed a strong preference for flexible, local, anonymous and digitally enabled services that are easy to get to from their community. CHS Outreach team and its mobile service was consistently recognised as a trusted and effective model of delivery which meets community needs.

This needs assessment establishes sexual and reproductive health as a significant public health priority in Croydon. Cross cutting recommendations include:

- further engagement with communities and service users to understand gaps and opportunities to align service models with the needs of residents.
- identify best approaches to information sharing between partners in the system.
- recognition of the roles and responsibilities of different partners operating in service delivery.
- developing ownership of an action plan to take findings and recommendations forward.

Addressing current and future SRH needs will require a coordinated, prevention and community-focused approach involving commissioners, providers, and local partners. The findings of this needs assessment provide an evidence base to support strategic planning and to improve SRH outcomes for all Croydon residents.

1. Introduction

This section provides an overview of the purpose of the Needs Assessment.



It exists to update Croydon's sexual and reproductive health picture since 2018 and inform future commissioning activities to meet the needs in the borough.



This highlights the impact of COVID-19, growing and diverse demographic context and changing population needs.



It also outlines the key national, regional and local policy drivers which shape services and their priorities.

AIMS AND OBJECTIVES

The primary purpose of this needs assessment is to provide a robust, evidence-based understanding of the current and future sexual and reproductive health needs of Croydon's population, to inform and guide commissioning strategies. As the previous assessment was conducted in 2018, it is vital to now re-evaluate the current landscape considering progress made, changing demand, and evolving needs to identify areas requiring focus and improvement particularly given the post Covid landscape that we now operate in. This assessment will support the development of future health strategies, commissioning decisions, and policy directions regarding sexual health to ensure they effectively meet the needs of Croydon residents.

To gain a comprehensive understanding of sexual and reproductive health needs, this assessment will:

- Provide an overview of the population, with a focus on vulnerable groups disproportionately affected by poor sexual health.
- Identify and evaluate the effectiveness of existing services in Croydon, assessing whether they meet local needs and highlighting any gaps in provision.
- Highlight inequalities, unmet needs, and barriers to access, considering intersectionality and the interactions between different forms of inequality.

- Embed principles of co-production and collaboration through active stakeholder engagement, particularly with the steering group.

BACKGROUND

What is sexual and reproductive health?

Sexual and reproductive health refers to a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of sexually transmitted infections (STIs), protection from sexual and gender-based violence, and education on safe and healthy relationships.

The World Health Organisation's (WHO) current working definition of sexual health is:

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

The WHO current working definition for reproductive health is:

".....a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

Why is it important to look at sexual health?

Measuring sexual health in a population is crucial as sexual ill health affects all age groups and sections of society, whilst it disproportionately affects vulnerable groups more, such as young people under 25, ethnic minority groups, and those who face poverty and social exclusion¹, thus generating inequalities.

¹ Department of Health (2001) The national strategy for sexual health and HIV.

² BMA Women's Reproductive Health Report (2018).

³ Investing in the public health grant, The Health Foundation (2025).

Although certain groups bear the brunt of reproductive ill health because of biological, wider social, economic and political factors, poor reproductive health casts a burden on the entirety of society, creating a case for public health, human rights and economic reasons to invest in reproductive health².

Sexual health services are under intense pressure financially, as the Public Health Grant to Local Authorities (LAs) meant to fund sexual health services was reduced between 2015/16 and 2020/2021. The Health Foundation estimates that there has been a 26% real-terms per person decrease in the value of the Public Health Grant between the initial allocations for 2015/16 and 2025/26, whilst sexual health services have been an area significantly impacted, seeing a 32% reduction in spending³. These budget reductions have caused significant challenges for local councils to address sexual health challenges and needs. Despite this, it is understood that reducing investment in sexual health services can result in higher future costs due to severe long-term health consequences.

NATIONAL POLICY CONTEXT AND IMPORTANCE

A Framework for Sexual Health Improvement in England (2013)

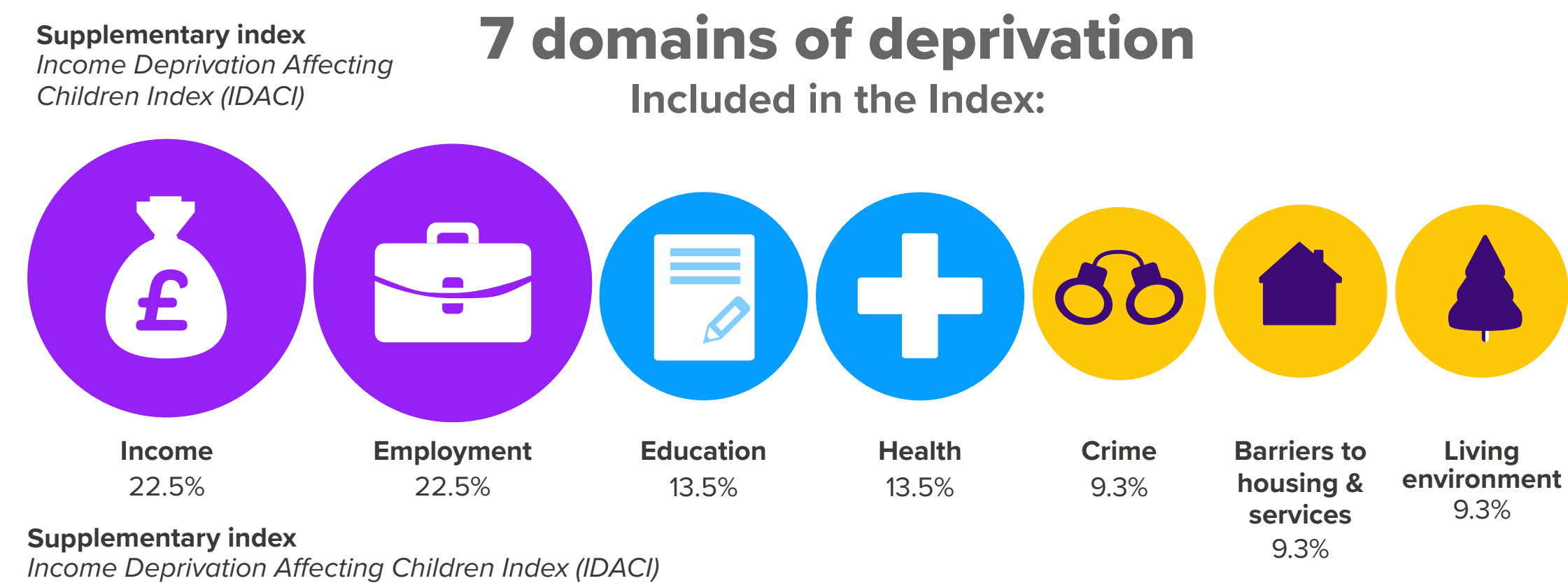
In April 2013, the government set out its ambitious approach for improving sexual health within "A Framework for Sexual Health Improvement in England," a model that promotes integrated, confidential and non-judgemental sexual health services for everyone. This programme tied Local Authorities to the requirement of commissioning open-access sexual health (STI and contraception) services that meet the needs of local populations.



In 2019, the All-Parliamentary Health and Social Care Select Committee on Sexual Health reported that some progress has been made from the 2013 legislation, though, not enough due to cuts to spending for sexual health services. Responding to the criticism in this report, central government agreed to develop an updated strategy that is yet to be delivered.

Core20PLUS5

Core20PLUS5 is a nationwide NHS England approach to inform action and reduce healthcare inequalities at both national and system level including in Sexual and Reproductive Health. This programme promotes accelerated action for the most deprived 20% of the national population identified through the national Index of Multiple Deprivation (IMD). The seven domains of deprivation are set out in the diagram below:



Graphic 1: 7 Domains of deprivation – adapted from Department for Communities and Local Government (now Ministry of Housing Communities and Local Government) [Infographic](#).

In addition to the 20% identified by the IMD, PLUS population groups should be identified at a local level. Populations typically identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010 and groups experiencing social exclusion⁴.

Women’s Health Strategy for England

The National Women’s Health Strategy was established in 2022⁵, under the acknowledgement that females in this country spend a greater proportion of their lives in ill health and disability compared to males, but that the health system has historically been geared towards males.

This led to the creation of a 10-year strategy to improve the health and wellbeing of women and girls across England. It entails:

- A boosted health outcome for all women and girls.
- To radically improve the way in which the health and care system engages and listens to all women and girls.

⁴ NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.
⁵ This HNA notes that a new Women’s Health Strategy is to be updated and published in April 2026. At the time of writing this HNA, the strategy has not been published yet.
⁶ [Teenage Pregnancy Prevention Framework](#).
⁷ *ibid.*

The government plans to achieve this by:

- Taking a life course approach.
- Focusing on women’s health policy and services throughout their lives.
- Embedding hybrid and wrap-around services as best practice.
- Boosting the representation of women’s voices and experiences in policy-making, and at all levels of health and care systems.

Teenage Pregnancy Prevention Framework

The National Teenage Pregnancy Prevention Framework was developed in 2018 to help local areas assess their local programmes to see what is working well, identify gaps, and maximise the assets of services to strengthen pregnancy prevention for young people⁶.

Adoption of this programme by Local Authorities is crucial as England experiences higher teenage birthrates than their peers in Western European countries. Rates of unplanned youth pregnancy are unequal between Local Authorities and often contribute to inter-generational inequality.

This framework is promoted, as evidence shows that developing knowledge, skills and aspirations for young people will delay sex until they are prepared for healthy, consensual relationships and understand the importance of contraception. Sustaining a downward trend and making further progress is one of the key objectives of the Department of Health’s Framework for Sexual Health Improvements in England⁷.



Towards Zero: the HIV Action Plan for England – 2022 to 2025

At the start of 2019, the government committed to a new ambitious strategy to achieve zero new HIV infections, and AIDS and HIV-related deaths in England by 2030. This will require persistent effort, and the adoption of new strategies to reach everyone at risk, even hidden populations⁸. A key strategy within this framework is maintaining a focus on the combination of prevention and testing, including opt-out testing in certain areas.

Relationships and Sex Education (RSE) and Health Education

In England, RSE or RSHE aims to help prepare pupils for the opportunities and responsibilities involved in their adult life related to healthy relationships and health. This can promote their moral, social, mental and physical development, helping support young people to cultivate positive characteristics and prevent harms or negative consequences by helping them understand healthy behaviours and identifying when things are not right⁹.

In 2019, the Relationships and Sex Education and Health Education (England) regulations made these subjects compulsory for all pupils receiving either primary or secondary education throughout the country¹⁰. This was established on the understanding that this knowledge is crucial to enable children and young people (CYP) to make informed decisions about their wellbeing, health and relationships. To comply, schools must have up-to-date written policy for relationships education, or where they teach sex education. The statutory requirements do not apply to sixth form colleges, 16 to 19 academies or Further Education (FE) colleges although guidance promotes offering these subjects regardless.

In 2025, guidance was updated (to come into effect in September 2026) recognising changes in society, technology and safeguarding challenges facing young people today. The guidance puts a stronger emphasis on digital risks and online harms, the importance of age-appropriate sequencing and clearer messages about starting RSE lessons early in primary education. It also emphasises teaching skills alongside knowledge, transparency with parents and guidance on how gender identity should be discussed including teaching about biological sex.

REGIONAL SEXUAL HEALTH STRATEGIES

London Sexual Health Programme & London Sexual Health Transformation

During 2017, most London Councils formed an alliance to establish a transformation programme for sexual and reproductive health services across London and introduce a collaborative commissioning model. The programme ended in 2017, and activities transitioned to the London Sexual Health Programme (LSHP), hosted by the City of London on behalf of all authorities.

The London Borough of Croydon (LBC) is a member of the London Sexual Health Programme (LSHP), a partnership of 31 London Local Authorities collaborating with the NHS to enhance access to sexual health services amid reductions in public health funding for local councils. Therefore, the Integrated Sexual Health (ISH) provider (CHS NHS Trust) is required to cooperate with LSHP on developments for London, including engagement in the pan London Clinical Advisory Group (CAG).

⁸ Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025 - GOV.UK.

⁹ Statutory guidance on relationships education, relationships and sex education (RSE) and health education. Department of Education, 2025.

¹⁰ Relationships Education, Relationships and Sex Education and Health Education guidance. Department of Education, 2019.

There are three main aims:

- Transforming the way sexual health services are delivered through procurement.
- The use of an integrated sexual health tariff payment mechanism.
- A London-wide e-Service providing free Home STI Testing Kits.

LBC is a partner of the integrated sexual health tariff payment mechanism and works collaboratively with sector partners to ensure tariff currencies are shared across a geographical area which supports patient flows for cross-charging.

Sexual Health London ([SHL.UK](https://shl.uk)) is an online service commissioned by 30 London Local Authorities. The service providers take home STI kits. The London Borough of Croydon did not join the London-wide e-Service programme but is listed as a named authority on the OJEU notice. The option to join the service remains open to authorities who are not currently part of the programme.

Fast track cities Programme London (HIV)

The Fast Track Cities Programme London aims to end new transmissions of HIV, stop preventable HIV deaths and eliminate the discrimination and stigma associated with HIV.

The Fast-Track Cities initiative is a partnership of organisations, including the Mayor of London, NHS England, UK Health Security Agency, Integrated Care Systems, London Councils the voluntary sector and people living with HIV committed to reaching the following goals by 2030¹¹:

The goals of the programme include:

- End new HIV infections in the capital.
- Put a stop to HIV-related stigma and discrimination.
- Stop preventable deaths from HIV-related causes.
- Work to improve the health, quality of life and well-being of people living with HIV across the capital.

The outcomes and work of the programme to date has involved:

- Facilitating the roll out of Opt-out HIV & Blood borne virus testing in A&Es around London, which Croydon was involved in as part of the pilot. This has now been rolled out in all emergency departments in the capital.
- Peer-support programmes for HIV clinics.

London HIV Prevention Programme (LHPP)

The London HIV Prevention Programme is a London wide initiative dedicated to ending new HIV infections. It has been funded and supported by all London Local Authorities since 2013¹². The Programme is based on four proven ways to prevent HIV:

- Test regularly.
- Use condoms.
- Take PrEP.
- Know that undetectable equals untransmittable.

Additionally, LHPP commissions outreach organisations to work within communities with high rates of HIV to provide accessible testing, free condoms, lube, and information and guidance. LHPP aligns with the nationwide goal to end new HIV infections by 2030.

LOCAL STRATEGIES – LONDON BOROUGH OF CROYDON

Croydon Partnership 11 to 25 Exploitation Strategy (2023)

The purpose of this strategy is to give strategic direction and provide scrutiny and oversight at a senior level from partner agency representatives. This seeks to ensure that collective resources are working as effectively as possible to prevent, disrupt and protect children and young people at risk of exploitation and extra familial harm. A strategic board was also established alongside this to deliver and monitor the progress of the Croydon Partnership 11 to 25 Exploitation Strategy and related Action Plan.

London Borough of Croydon – Sexual and Reproductive Health JSNA 2018

The most recent JSNA on Sexual and Reproductive health was published by the London Borough of Croydon in 2018. It provided an overview of the needs and demographic of the population and established recommendations to deal with the challenges identified. The report stated that a new needs assessment will give the opportunity to reassess how services can be most effectively delivered for Croydon residents.



¹¹ Fast Track Cities London, website <https://fasttrackcities.london/>.

¹² [About - Do It London](#).

Croydon Sexual Health Strategy 2011-2016

The 2011-2016 Croydon Sexual Health Strategy was developed to improve the sexual health of people living in Croydon¹³. The strategy proposed several approaches, such as health promotion, education and development of specific services.

The overarching aims of the strategy were to:

- Improve the sexual health of the population.
- To reduce inequalities in sexual health.
- Set targets in line with national priorities and monitor progress as appropriate to local populations.
- Ensure prevention is integral to service delivery.

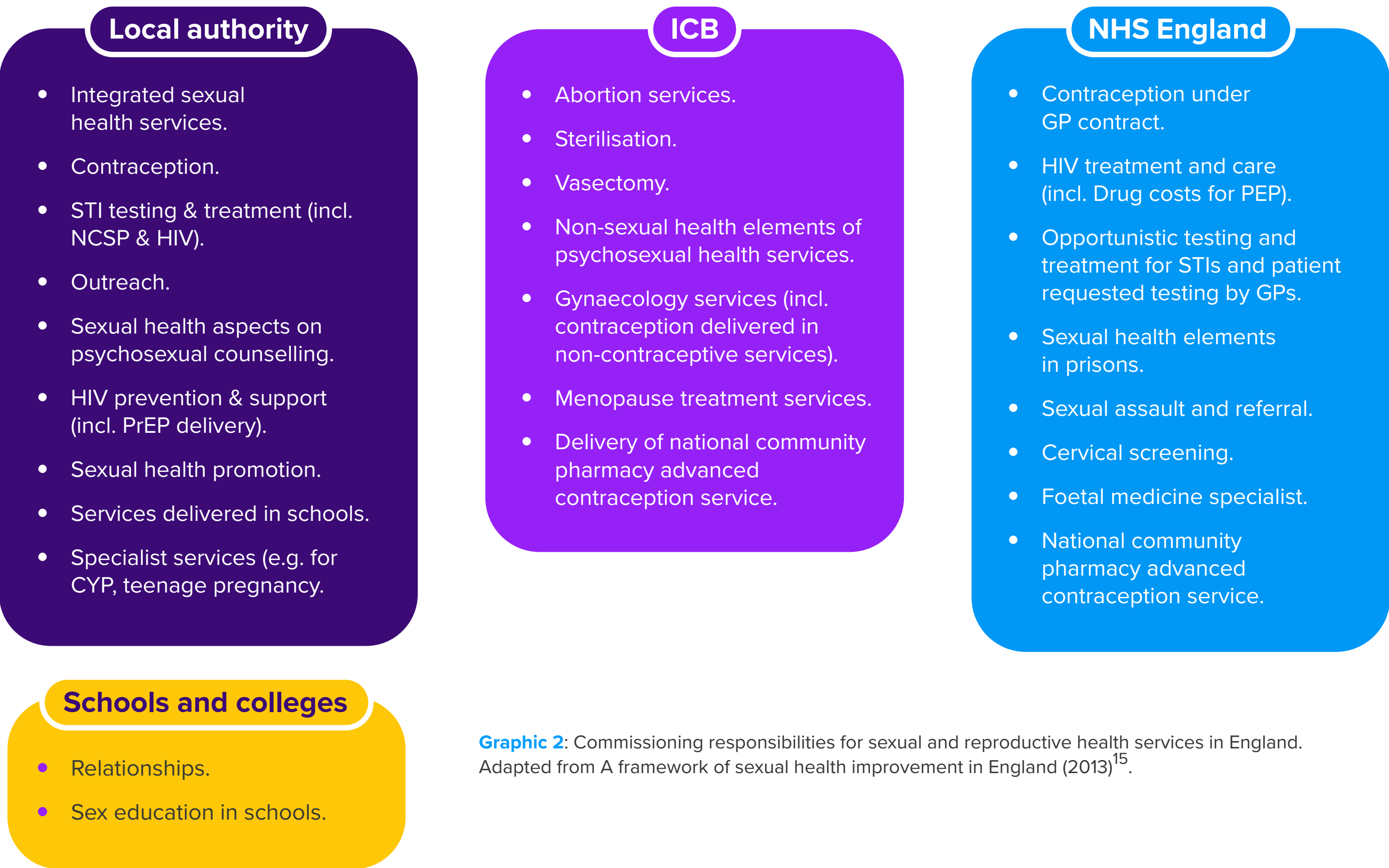
This approach was developed based on the findings from the 2010/11 Croydon JSNA on sexual health, and with reference to national and regional strategies and guidance.

CHANGING COMMISSIONING CONTEXT

Following the Health and Social Care bill in 2013¹⁴; Local Authorities have the commissioning responsibility for sexual health and reproductive health services. Current responsibilities for commissioning different areas of sexual and reproductive health services are divided between three separate groups:

- Local Authorities;
- Integrated Care Boards (ICB); and
- NHS England.

The diagram below sets out the commissioning arrangements and responsibilities for LAs, the Integrated Care Board (ICB) and NHS England (NHSE) for provision of sexual and reproductive health services.



Graphic 2: Commissioning responsibilities for sexual and reproductive health services in England. Adapted from A framework of sexual health improvement in England (2013)¹⁵.

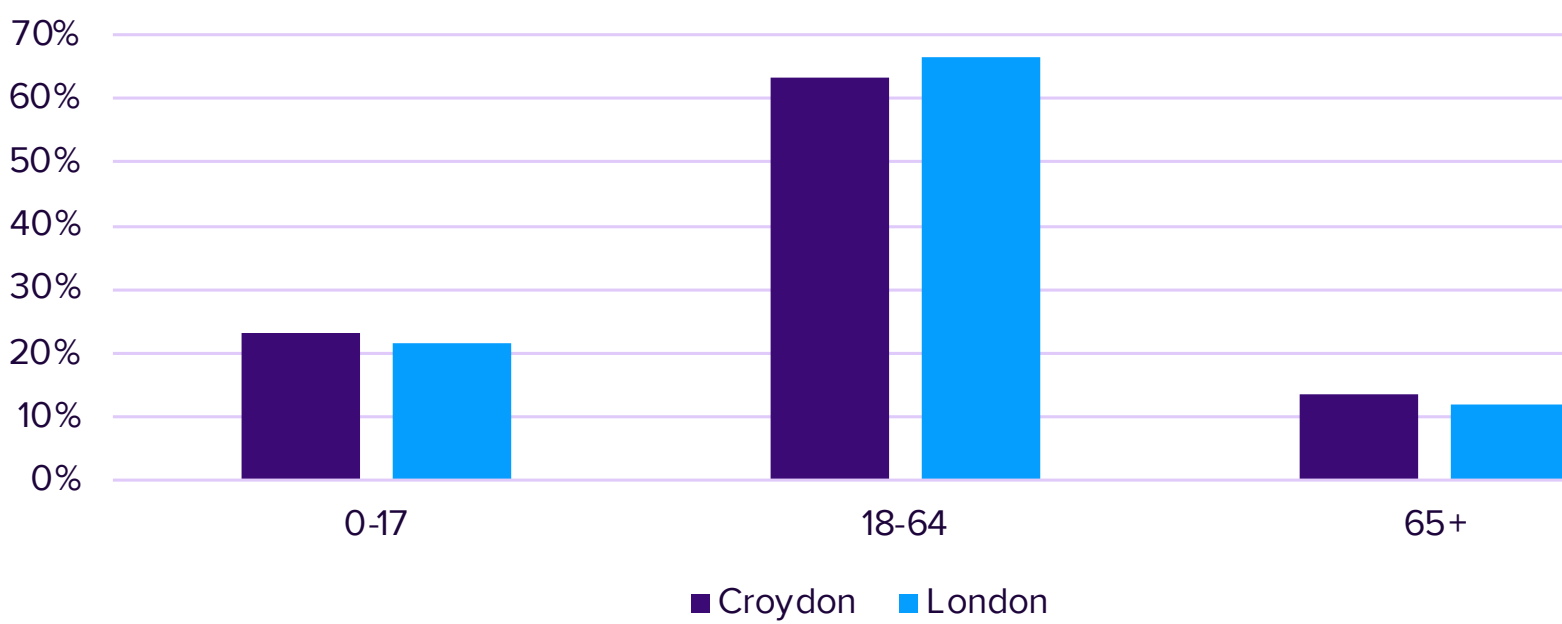
LAs are now responsible for commissioning specialist integrated sexual health services (ISHSs), which includes testing and treatment for sexually transmitted infections (STIs), the provision of HIV PrEP and a full range of contraception¹⁶. The specificity of this commissioning outline is not meant to limit the range of services delivered by a local provider but rather articulate specific services the Local Authority is responsible for. The LA, NHSE and ICB commissioners are expected to work together to map service user pathways and plan their commissioning strategy based on population need. This strategy must be met with locally conducted Needs Assessments for proper implementation.

¹³ Microsoft Word - Croydon Sexual Health Strategy 2011- 2016.doc.
¹⁴ Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.
¹⁵ Department of Health & Social care (2013) A Framework for Sexual Health Improvement in England.
¹⁶ Integrated sexual health service specification.

CROYDON DEMOGRAPHIC CONTEXT AND PROFILE

Population

The London Borough of Croydon (LBC) has the largest population of all London boroughs with approximately 390,800 residents (ONS Census 2021). Croydon has a larger population of CYP and 65+ residents than the London average (Graph 1). The borough continues to grow, and the Greater London Authority (GLA) projections predict the number of Croydon residents will rise to approximately 500,000 by 2050¹⁷.



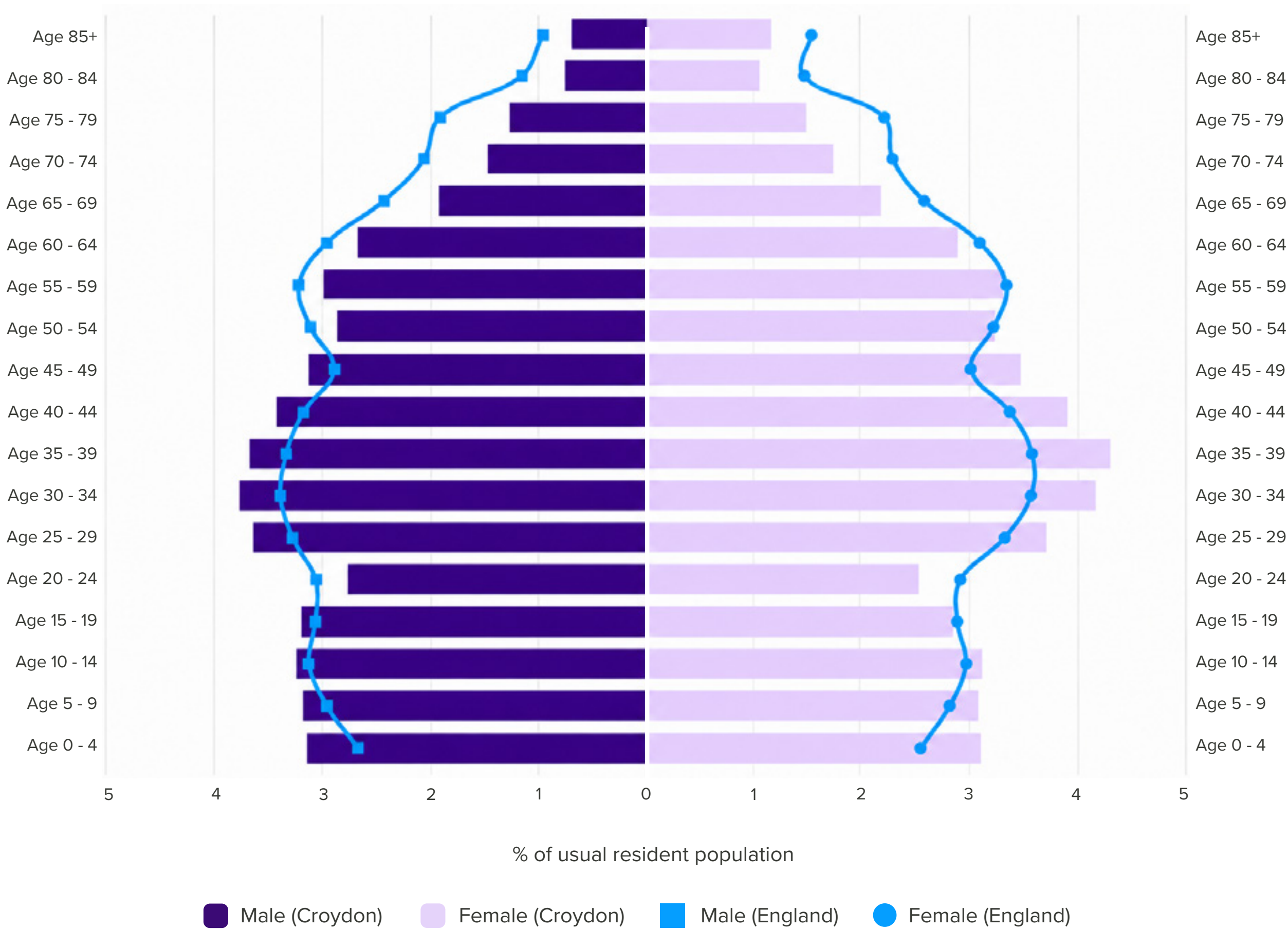
Graph 1: Croydon Population Breakdown 2024. Source: ONS, Population estimates.



¹⁷ Microsoft Word - BOROUGH PROFILE_June2025_WORD.docx.

Gender

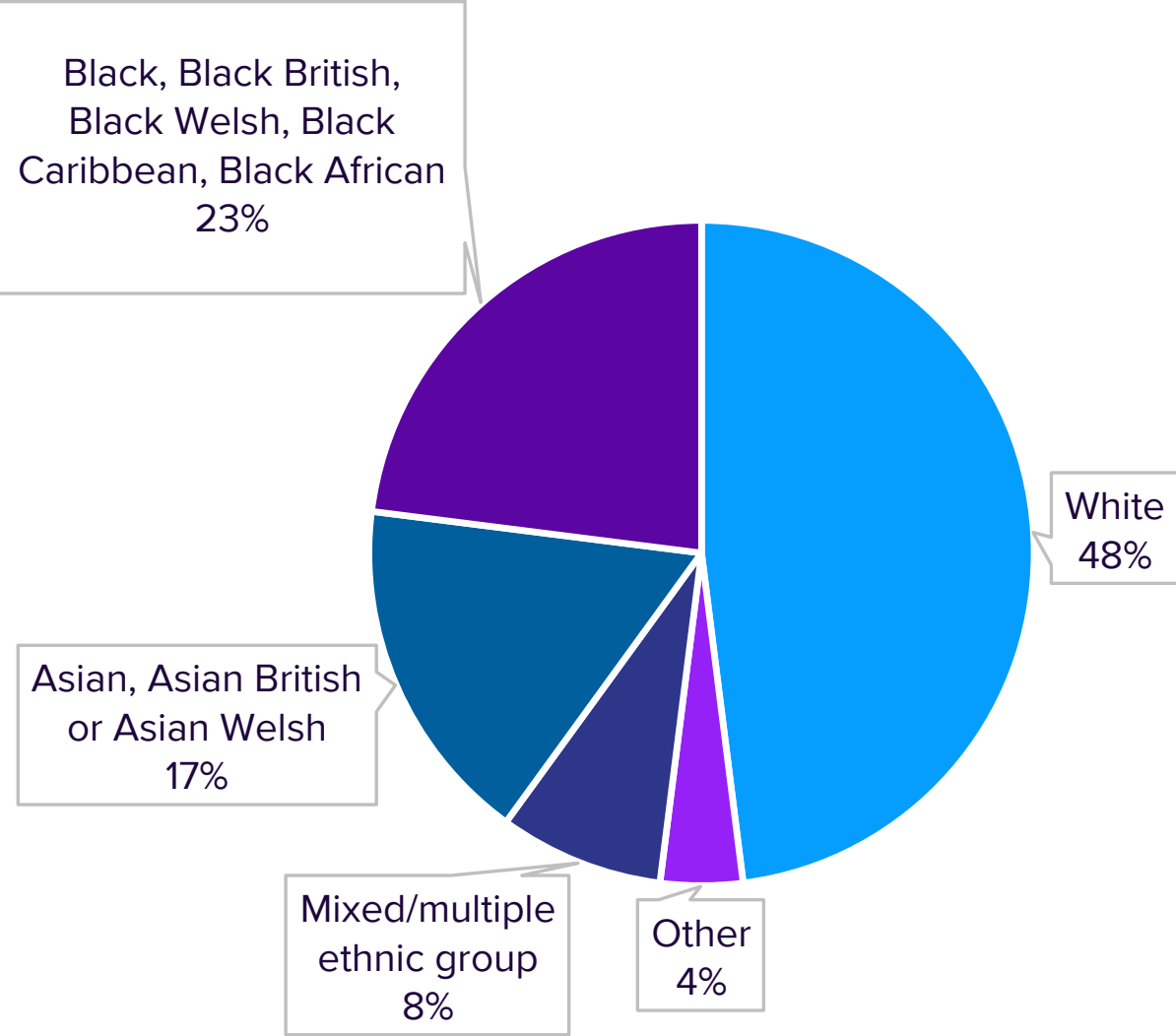
In LBC, females make up a smaller proportion of residents under age 25, but from age 26 onwards, females outnumber males. The graph below shows a notable gap in the 35 to 39 age group, and this difference grows even more pronounced among those aged 85 and older, where there are nearly twice as many females as males. The Croydon Observatory reported the population comprising of 52% females, and 48% males in 2024.



Graph 2: Percentage of population by 5-year age groups (2024). Source: Croydon Observatory.

Ethnicity

Croydon’s ethnic breakdown comprises of 48.4% of residents who identify as White, 22.6% as Black (Black British, Black Welsh, Caribbean or African), 17.5% of residents as Asian (Asian British or Asian Welsh), 7.6% as Mixed or Multiple Ethnic Groups, and the remaining 3.9% as Other. Like other London boroughs, Croydon has a higher proportion of residents from the Non-White communities compared to the national average¹⁸. This number continued to increase between 2011 and 2021 and there has been a 6.7% reduction in the number of residents from the White communities residing in Croydon.



Graph 3: Broad Ethnic Groups in Croydon. Source: ONS, Census 2021.

Sexual orientation

The 2021 Census survey included questions on sexual orientation, applicable for residents aged 16 years and over. Based on these results, 9,530 residents, (3%) identified as being part of the LGBTQ+ community in Croydon, which is slightly lower than London overall average (4.1%) and roughly the same as the England average (3.1%).

18 [Microsoft Word - BOROUGH PROFILE_June2025_WORD.docx](#).



The table below shows the breakdown of identified sexual orientation and a comparison to London and National records.

Sexual orientation	Croydon	London	England
Straight or Heterosexual	87.8%	86.2%	89.4%
Gay or Lesbian	1.5%	2.2%	1.5%
Bisexual	1.2%	1.5%	1.3%
Pansexual	0.3%	0.4%	0.2%
Asexual	0.0%	0.0%	0.1%
Queer	0.0%	0.1%	0.0%
All other sexual orientations	0.0%	0.0%	0.0%
Not answered	9.1%	9.5%	7.5%

Table 1: Sexual orientation in Croydon, London and England. Source: ONS, Census 2021.

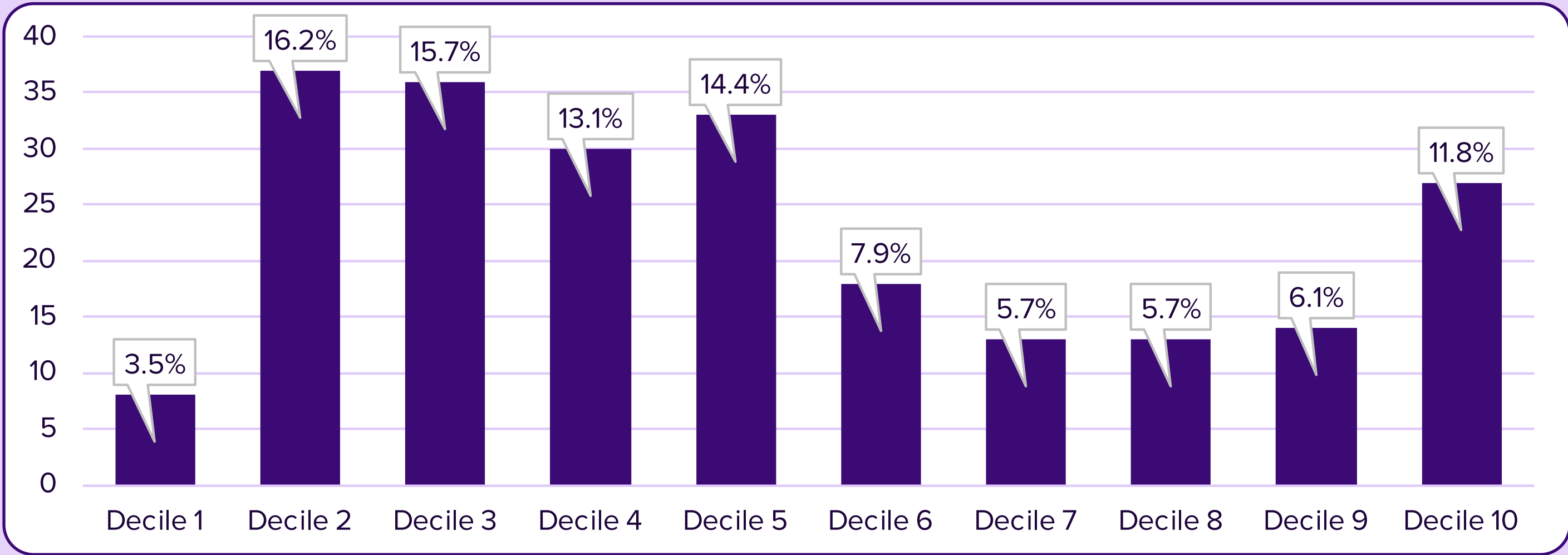
Deprivation

Croydon has an average score of 0.136 for the income domain, which places it as the 97th most deprived Local Authority out of the 317 lower tier authority districts in England, or 73rd out of the 151 upper tier authorities. LBC has been ranked 18th most deprived out of the 33 London boroughs.

One IMD measurement is health deprivation and disability, based on the risk of premature death and the impairment of quality of life due to poor mental or physical health. Croydon’s average score for this domain was -0.174, making it the 165th most deprived lower tier authority out of the 317.



The graph below breaks down the domain by the percentage of Croydon’s population that falls within each decile. Decile 1 represents the 10% most deprived areas and Decile 10 represents the 10% least deprived areas within the country.



Graph 4: Indices of Multiple Deprivation and Disability Domain – Lower Super Output Areas by Decile in Croydon (1 being most deprived and 10 being least deprived). 2025. Source: MHCLG.

2. Methodology

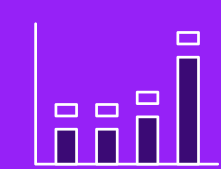
This section provides an overview of the methodology taken to undertake the needs assessment.



The approach taken combines qualitative community engagement with robust quantitative publicly available and service data.



Extensive co-production took place involving over 350 residents, service users, professionals and community organisations. This included targeted engagement with vulnerable and at risk groups (e.g. young people, migrants, people experiencing homelessness, GBMSM, people living with HIV).



National surveillance datasets were also used to identify trends, inequalities and service gaps.

ENGAGEMENT WITH STRATEGIC AND COMMUNITY PARTNERS

Qualitative engagement and co-production designed for this needs assessment, undertaken with a variety of key service partners, communities, voluntary associations and organisations aimed to understand service suitability, access, what's working well and improvements that are needed, specifically those in our vulnerable and underserved communities to understand any unmet needs.

The community engagement undertaken incorporated the views of over 350 individuals across Croydon. This was in the form of qualitative discussions held with key groups and individuals such as:

- Service users and non-service users across the life course.
- Service leads and professionals.
- Community and voluntary sector from a range of areas including refugee organisations, drug and alcohol providers, mental health providers, young people organisations and ethnic minority community advocate groups.

And on the ground qualitative engagement with residents including vulnerable groups.

- The vulnerable groups engaged with included but was not limited to, people of the following groups or communities:
 - » Global south ethnic background /Ethnic Minority background.
 - » With learning/physical disabilities.
 - » Who are young people¹⁹.
 - » Who are gay, bisexual and other men who have sex with men (GBMSM).
 - » Who are living with HIV (PLWH).

¹⁹ For the purposes of the research and engagement undertaken as part of this report, young people falling within the age range of 16 to 25 were focussed on.



- » Who are sex workers.
- » With mental health issues.
- » Who are undocumented migrants, refugees and asylum seekers.
- » Who are homeless/rough sleeping residents.
- » Who have experienced problems using substances.

A survey was also undertaken to understand awareness of services, preferred methods of access and gain insight into people's experiences. This was administered online through MS Forms and face-to-face with residents. Communications to promote it were circulated through GP forums in the borough, key venues such as umbrella voluntary associations (e.g. Croydon Voluntary Action), online newsletters, young people's services and grassroots organisations working with ethnic minority communities.

Key opportunistic venues such as GP and sexual health clinic waiting areas were also used to promote the survey.

Vox pop style engagement was also undertaken within communities alongside the CHS outreach team, through public locations where we could reach Croydon's residents such as the town centre, as well as venues targeted to reach specific underserved groups such as schools, colleges, drug and alcohol centres, initial accommodation centres, supported housing accommodation for young people and pop-up buses used to support rough sleepers.

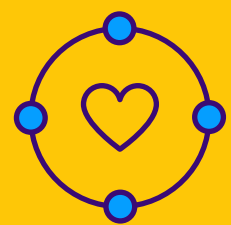
QUANTITATIVE METHODS AND DATA ANALYSIS

The following recognised datasets were analysed and conclusions were drawn to support the identification of needs and qualitative findings.

- Office for National Statistics (ONS) Census data 2021.
- Department of Health & Social Care Fingertips Sexual and Reproductive Health Profiles.
- UKHSA Spotlight on sexually transmitted infections in London.
- UKHSA Annual epidemiological spotlight on HIV in London.
- GUMCAD STI Surveillance System.
- CTAD Chlamydia Surveillance System.
- UKHSA HIV & STI Data Exchange.

3. The local picture, overview of services and commissioning arrangements

This section describes Croydon's integrated sexual health service model and commissioning responsibilities of the local authority.



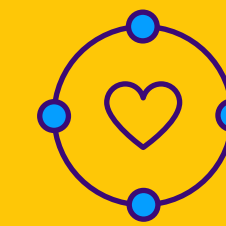
It outlines the range of clinical, outreach, primary care and pharmacy-based provision available to residents while also reviewing the service landscape, ways of access and activity trends.



The majority of contacts at SRH services are from local residents.



There is an increasing shift towards online and non-face-to-face services and outreach services play a critical role in reaching high-need and marginalised groups.



There are opportunities to strengthen services through making them more flexible and make access easier.

COMMISSIONING ARRANGEMENTS

Under the 2013 framework for sexual health improvement in England²⁰, Local Authorities are required to provide or make arrangements to secure provision of an open access integrated sexual health services in their area. Additionally, in December 2021, the government published an action plan towards ending HIV transmission, AIDS and HIV-related deaths in England 2022 to 2025²¹.

Since 2020, commissioning HIV PrEP routinely also falls under local authority responsibility as part of a combined approach to HIV prevention. This meant sexual health services became responsible for delivering PrEP to certain groups at higher risk of HIV, whilst NHS England continue to fund the costs of HIV PrEP drugs as per the arrangements following the PrEP Impact Trial²². There are differences in PrEP need by population group and local contexts, however key groups for which PrEP is promoted amongst include MSM, those with HIV-positive partners, sex workers, Black

and minority ethnic groups (particularly Black African communities), trans and gender diverse people.

Within Croydon, the integrated service as well as sexual health service within primary care settings is commissioned by the Council's Public Health Function. The integrated service is delivered by Croydon Health Services (CHS) NHS Trust who currently provide a level 3, combining the Contraception and Sexual Health Service, and the Genitourinary Medicine Service.

²⁰ 2013 framework for sexual health improvement in England.

²¹ Towards Zero: the HIV Action Plan for England 2022 - 2025.

²² Routine commissioning of HIV pre-exposure prophylaxis (PrEP) in England: Monitoring and evaluation framework. UKHSA, 2022.

SERVICE AIMS AND OBJECTIVES

The service seeks to provide open and easy access, cost-effective, high-quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections, according to evidence-based protocols.

As well as delivering clinical services, the integrated service is expected to support the Mayor of Croydon’s Business Plan and the outcomes for services delivered, these are:

- The Council balances its books, listens to residents and delivers good sustainable services.
- Children and young people in Croydon have the chance to thrive, learn and fulfil their potential.
- Croydon is a cleaner, safer and healthier place, a borough we’re proud to call home.
- People can lead healthier and independent lives for longer.

The aim and vision of Croydon’s Sexual and reproductive health services is to improve the sexual health and well-being of the people of Croydon. The service aims to do this by commissioning an innovative prevention orientated sexual health service, which responds to a changing environment of sexual health and relationship needs across the life-course.

The service aims to play a key role in delivering preventative interventions that will enable people to make informed decisions about relationships; planning a pregnancy; contraception; sex and sexual health; building personal resilience and promoting healthy choices.

The Integrated sexual health service model aims to improve sexual health by providing:

- non-judgmental and confidential services through open access.
- meeting the majority of sexual health and contraceptive needs at once, often by one health professional.
- services with a mix of provision types (e.g. booked clinic, walk-in, sit and wait, outreach) and extended opening hours (evenings after 6pm and possibly weekends).
- a variety of locations which are accessible by public transport.
- supported by remote and online provision.
- services that are appropriately tailored to and are accessible by LGBTQ+ communities.

The integrated service outlined various development areas to ensure high quality service is provided to all Croydon residents that need sexual health services including:

- **C-Card** – develop and manage a local C-Card condom distribution scheme giving people quick and easy access to free condoms and working with Primary Care and Local Authority partners to ensure effective delivery.
- **Holistic offer for vulnerable cohorts** – ensure there is a holistic outreach offer that includes vulnerable cohorts (where appropriate including young people) and those who do not traditionally engage in services.
- **STI & HIV testing** – work to increase access and take up of the e-service STI testing offer, including:

- » promotion of take away kits from service sites;
- » awareness amongst Croydon residents of the service;
- » refining the quality and timeliness of the service; and
- » improving of the e-service offer through increasing return rate of tests and e-service pathway improvement.

OVERVIEW OF SERVICES CURRENTLY COMMISSIONED

The below table provides a summary of the variety of services commissioned by LBC as part of the Integrated Sexual Health (ISH) offer and Primary care offer.

Service	ISH	Primary care (GPs & Pharmacies)
Long Acting Reversible Contraception (LARC)	X	X
Contraception	X	
Emergency Hormonal Contraception (EHC)	X	X
C-Card	X	X
Chlamydia screening and treatment	X	X
HIV rapid testing	X	X
HIV prevention (incl. PrEP)	X	
STI management and treatment	X	
HIV Partner notification	X	
Outreach services	X	

Table 2: Services commissioned by LBC as part of the ISH offer, through Primary Care and in Pharmacies – Croydon Council.

Primary Care

The Primary Care offer for sexual health commissioned by LBC includes general practice, enhanced sexual health pharmacies (ESHPs), non-enhanced sexual health pharmacies, and other commissioned services such as Marie Stopes International (MSI) and the chlamydia screening programme. General Practitioners are commissioned to provide EHC, LARC, Chlamydia screening and HIV testing.

There were 5 enhanced sexual health pharmacies actively operating in Croydon as of September 2025. They can provide emergency contraception, oral contraception, pregnancy testing, chlamydia screening and treatment. Since October 2025, the Pharmacy Contraceptive Service was expanded to enable all pharmacies the ability to:

- provide free access to oral EHC;
- pharmacy technicians are now approved to provide the service; and
- drospirenone was added to the progestogen only pill list that can be prescribed in pharmacies.

The intention is to expand access to EHC and allow all community pharmacies the ability to provide equitable access to EHC for patients. This also provides an opportunity to initiate a patient on oral contraceptives as part of an EHC consultation^{23 24}. EHC is now moving into the national pharmacy contract from October 2025 and will no longer be commissioned through Public Health funding.

The table on the right displays an overview of number GPs and Pharmacies providing LARC/contraception and EHC/Enhanced Sexual health functions.

	Chlamydia screening	LARC	Enhanced sexual health
Pharmacies	4		5
General practices	9	24	

Table 3: Active primary care providers delivering key sexual health functions – Croydon Council Commissioning (September 2025).

Outreach and key vulnerable groups

Outreach services commissioned by Croydon’s Public Health Function include:

- **Spectra** (partnered with Metro and Kunsaka) – Provides support for people across SWL at high risk of poor sexual health outcomes to improve and maintain their sexual health and relationship wellbeing. In Croydon this includes outreach sessions for young people, MSM, Black communities, testing, condom distribution, family support, group sessions and advocacy. Note this is part of the joint commissioning model commissioned by Wandsworth on behalf of all South-West London (SWL) boroughs to provide a SWL Sexual Health and HIV prevention service for high-risk groups.
- **Croydon Health Services (CHS)** – Holistic outreach mobile service which delivers contraception, advice, rapid testing and health promotion/prevention at various sites across the borough. The locations visited by the team are determined by their service specification and activities are also guided by Public Health data. Currently, the Outreach team’s main locations and sites of activity include:

- » Supported accommodation buildings for vulnerable people and young people (e.g. Evolve housing).

- » Temporary accommodation for people seeking asylum in the borough (e.g. Initial accommodation centres).
- » Drug and alcohol centres (CGL Lantern hall).
- » Schools and colleges.
- » Public venues e.g. Town centre/high street/town hall.
- » Rough sleepers project.
- » Services for young people in contact with the Youth Justice Service, looked after children and those leaving care (The Turnaround Centre).

- **C-Card scheme** – distributes condoms to young people 13 to 24 years old offering access to free condoms in a wide range of places. Currently 8 organisations or institutions working with young people (e.g. pharmacies, outreach teams, schools) are registered as distribution points and/or new registration sites (these providers include pharmacies, the sexual health clinic and some schools/college centres).
- **GetttingItOn.com** – a website initiated by what was formerly Croydon Primary Care Trust and has since been developed in partnership with young people, Local Authorities and health services across SWL.

In addition to the services set out above, there are also wider services for young people such as health visiting, school nursing, the Young People’s Sexual Health Service within The Point Clinic, Homeless Health Team, as well as other third sector organisations to support young people’s health needs more broadly (including Off the Record, Kooth, CVA). The CHS Outreach service offer additional Sexual Health Promotion lessons with schools, colleges, and alternative provisions. These sessions enhance the delivery already offered in education settings. For education settings that include sixth form provision the team offers a drop-in for C-Card sign up, STI testing and general advice/support.

23 <https://www.england.nhs.uk/publication/nhs-pharmacy-contraception-service/>.
24 <https://www.gov.uk/government/publications/community-pharmacy-contractual-framework-2024-to-2025-and-2025-to-2026/community-pharmacy-contractual-framework-2024-to-2025-and-2025-to-2026>.

The services currently not commissioned by LBC Public health but available within the wider sexual health landscape in the borough are included in the below table.

Service	Delivery setting/provider			
	ISH	Secondary care	Primary care (GPs/pharmacies)	Other provider
Termination of pregnancy				X
Menopause care		X	X	
EHC		X	X	X
Contraception for non contraceptive purposes or delivered in non-SHS		X	X	X
Sterilisations/vasectomies				
HIV treatment and care (incl. drug costs)	X			
Opportunistic testing & treatment for STIs (incl. requested in GPs)		X	X	
Sexual assault referral				X
Cervical screens		X	X	
National community pharmacy contraception service	X	X	X	
Non-sexual health aspects of psychosexual services				

Table 4: Services not currently commissioned and delivered by LBC.



Service quality

Assessing current provision of the commissioned service indicates that the integrated sexual health service is delivering many of its stated aspirations and meeting a range of local needs, whilst there are several areas presenting opportunities for further strengthening of provision. Reviewing and assessing against the key aspirations outlined in its specification, the integrated service provider offers.

- A sexual health clinic based in one location for residents to access within Croydon University Hospital.
- Services through a mix of provision types including:
 - » online bookings with slots being released at the start of the day, with appointments for the following working day;
 - » online oral contraception and STI screening for Croydon residents;
 - » a young person’s clinic, The Point, which runs on Tuesday afternoons. This is available for those under 18 to walk in;
 - » under 16s are able to walk in to the clinic at anytime and be seen as a priority;
 - » extended opening hours are currently run once weekly until 6.30pm; and
 - » the clinic does not currently operate a weekend service.
- Outreach mobile service provision is run by a small team within CHS sexual health Outreach team (outlined above in this section), who visit a range of locations to meet needs of vulnerable groups. The range of settings and uptake of outreach service assessed qualitatively and through consultations with partners indicate that the outreach offer is broadly effective in addressing local need and reducing unmet need among populations less likely to access clinic-based services.

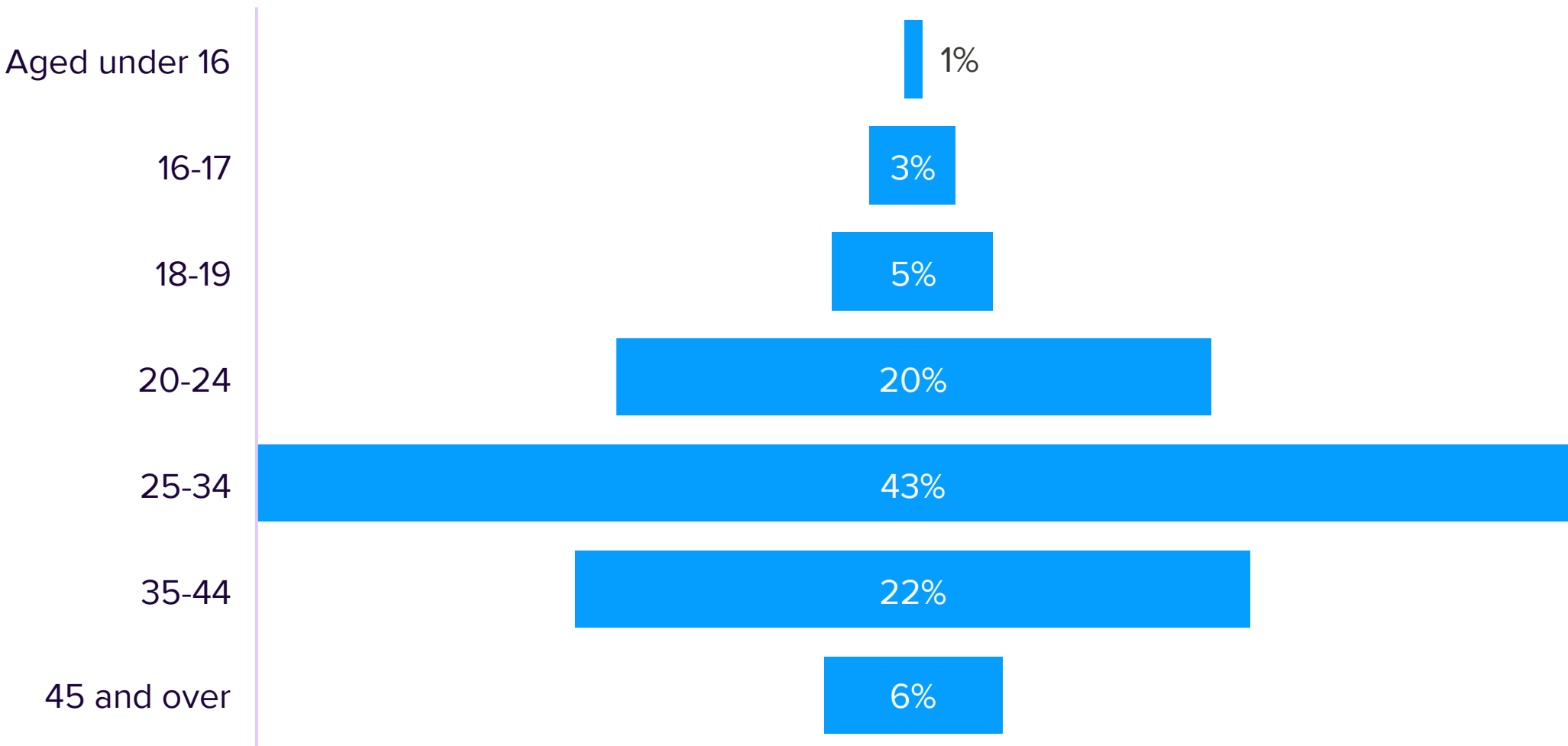
The service is regarded as having a significant impact on the community and opportunities of maximising their reach is assessed further in the needs assessment.

- Services tailored for LGBTQ+ communities are primarily run through SPECTRA.

SERVICE ACTIVITY

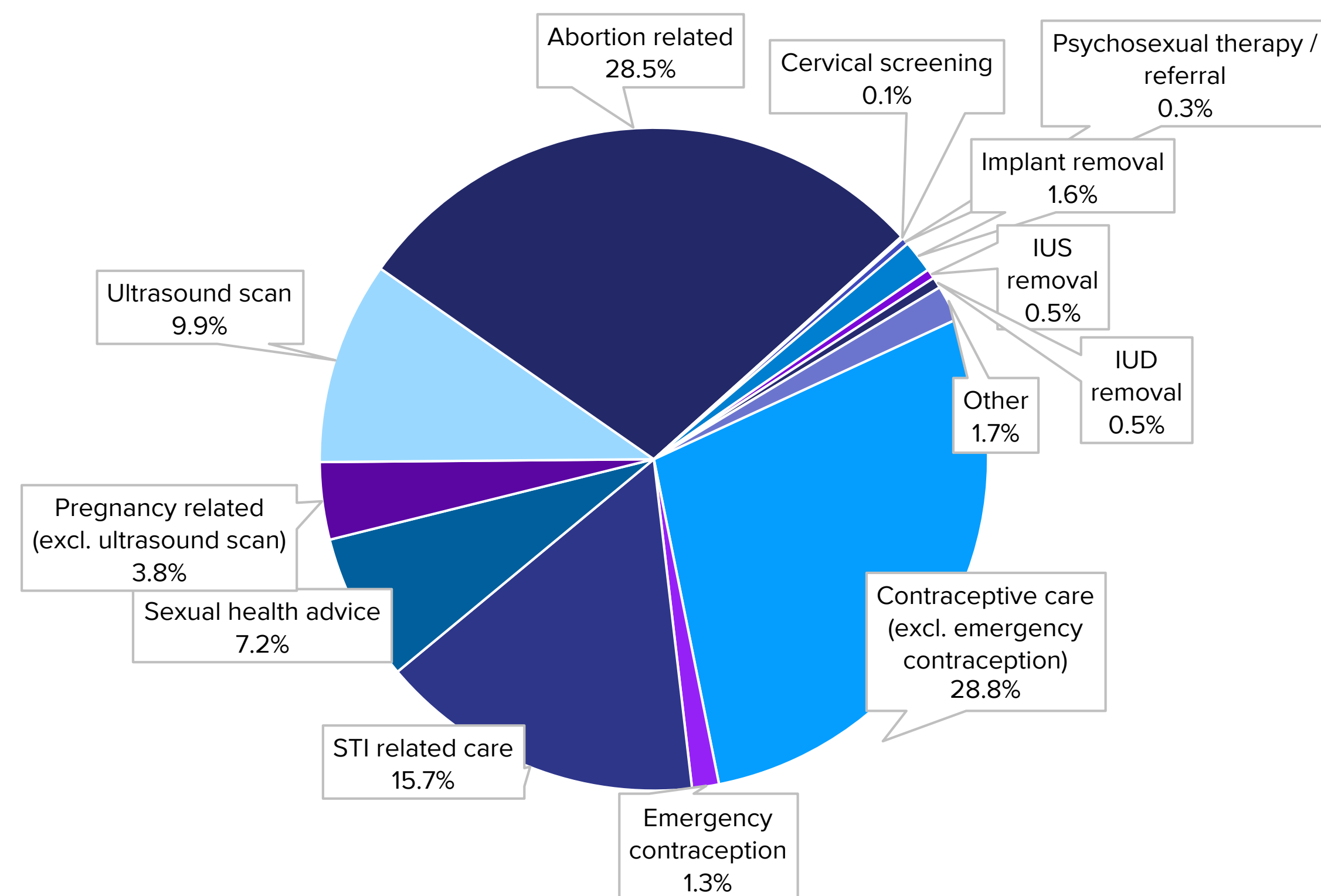
In 2024, there were 5,700 contacts with sexual and reproductive health services at Croydon Health Services clinic. 6,735 Croydon residents accessed Sexual and reproductive services and 63.5% of these service users were between 20 to 34 years old.

Over half of all consultations were for either contraception (28.8%) or abortion related concerns (28.5%), 15.7% of consultations were related to STI care. As such, contraception, termination and STI related care continue to be the priorities for sexual health services in the borough (Graph 6 - next page).



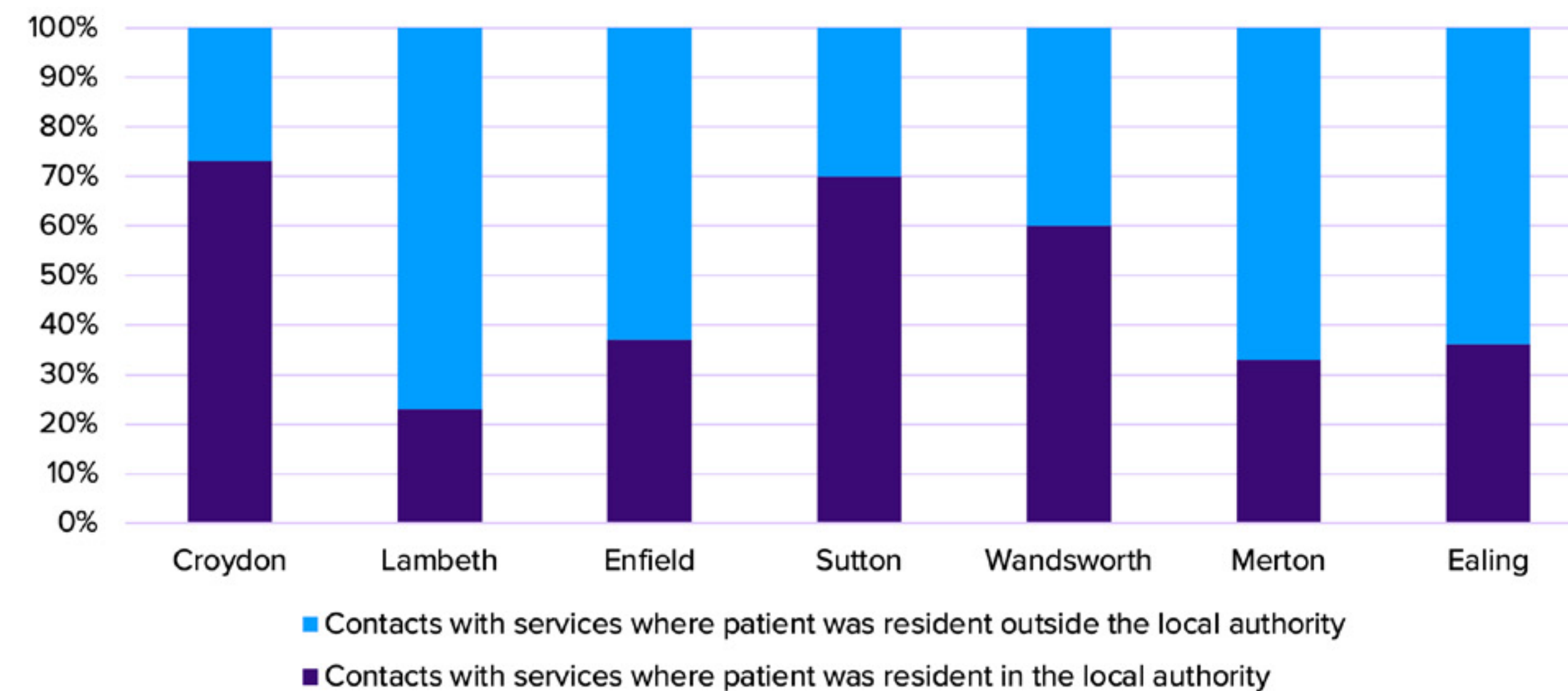
Graph 5: Croydon Female residents using Sexual and Reproductive Health Services by Age Group, 2024. Source: Sexual and Reproductive Health Activity Dataset (SRHAD) NHS Digital.





Graph 6: All Activity at Sexual and Reproductive Health Services among Croydon residents in 2024. Source: Sexual and Reproductive Health Activity Dataset (SRHAD) NHS Digital.

In 2024-25, of all contacts with Croydon SRH services, 73% were with patients resident in Croydon. The remaining 27% of contacts at Croydon SRH services were made up of patients resident outside of Croydon. The percentage of contacts with SRH services with Croydon residents was 86% the previous financial year.

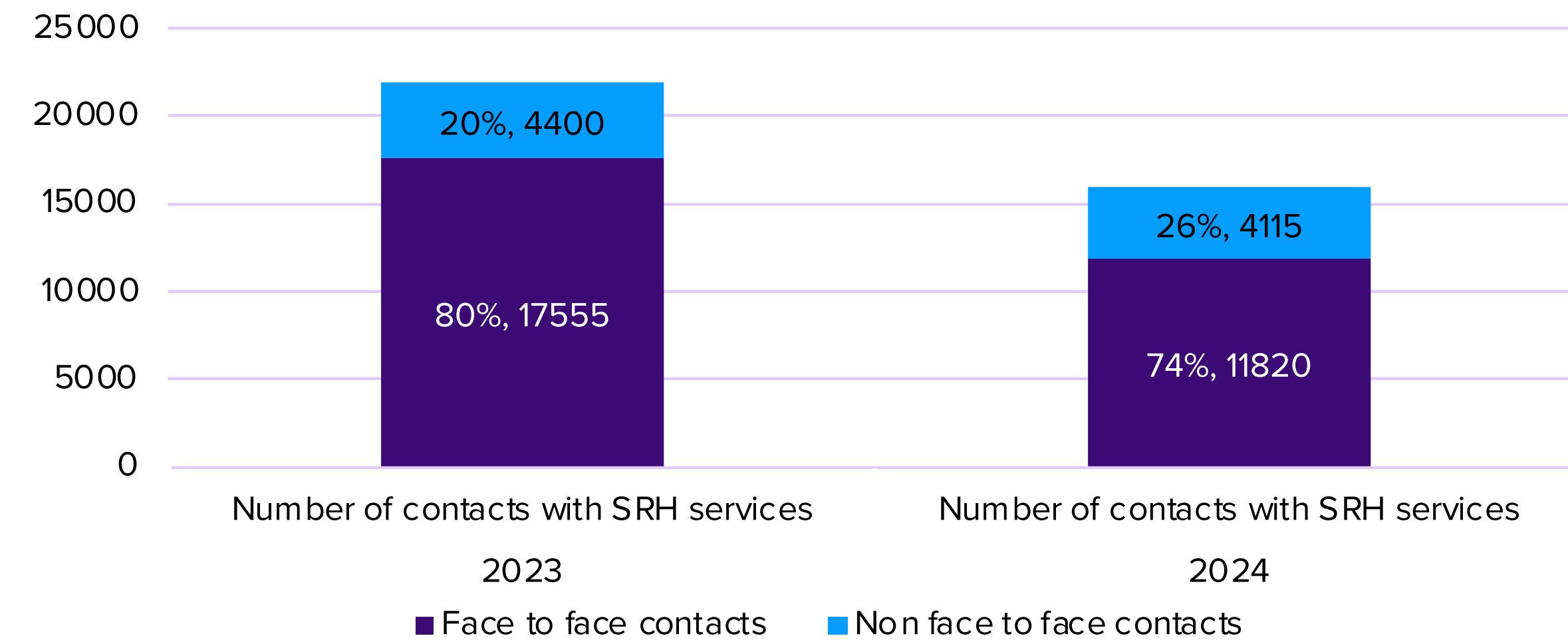


Graph 7: Contacts with SRH services - cross boundary use of services 2024-25. Source: SRHAD data NHS Digital.

The trend shows that the percentage of Croydon residents accessing SRH services outside of the borough has increased over time, from 2023-24 to 2024-25 this has been an increase of 93%, (from 14% to 27%).

From 2023 to 2024, the number of total contacts with SRH services dropped by 27.5% by around 5,700 contacts.

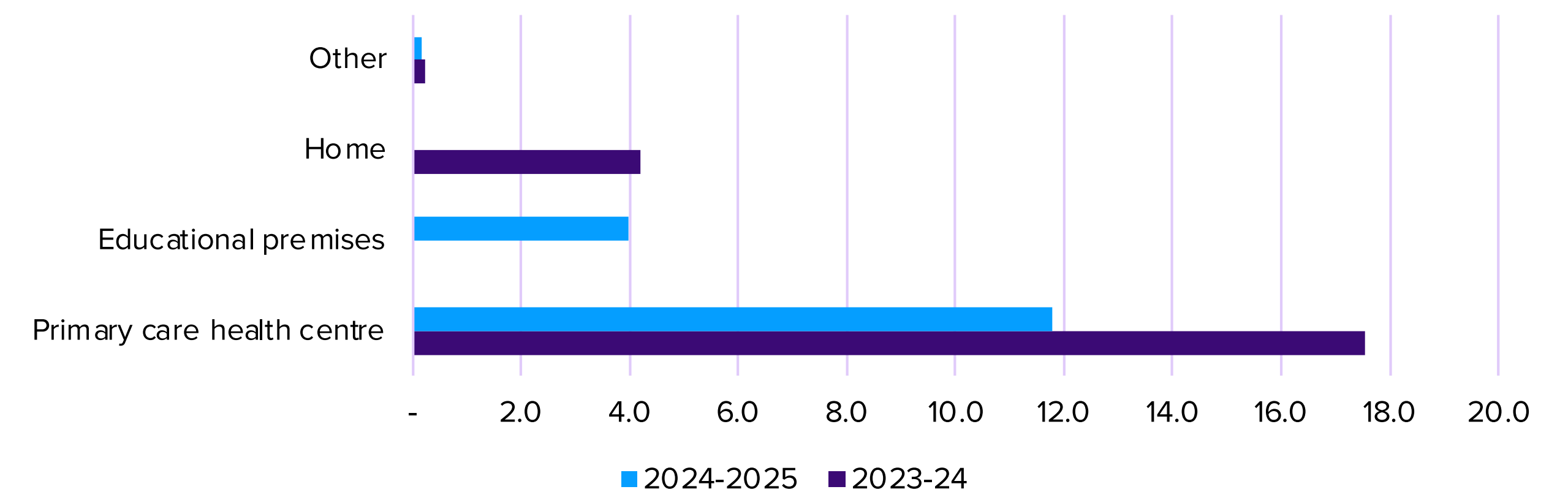
In 2024, the most popular method of consultations remains face to face methods, although we see an increasing shift towards more patients opting for non face to face methods of contact compared to previous years. Contacts via non face to face methods rose from representing 20% of all contacts with SHSs in 2023 to representing 26% of all contacts in 2024 (Graph 8 - next page).



Graph 8: Croydon residents contacts with Sexual and Reproductive Health Services by method of contact 2023 and 2024.
Source: SRHAD data NHS Digital.

This shift towards non face-to-face method of contact may be driven by a broad range of interlinked factors, such as wider changes in service delivery, capacity challenges within clinics, evolving patient preferences for anonymity or convenient online services as well as expansion of local alternative online pathways for testing and contraception.

The most common location of contact with services was within a health centre, with 11,800 contacts in 2024. This was a reduction from 17,500 in 2023. In this data, “health centre” refers to specialist sexual and reproductive health service activity delivered in a primary care or community health centre setting. Routine sexual health care provided by general practice is generally not captured in these figures.



Graph 9: Croydon residents contacts with Sexual and Reproductive Health Services by location of contact (thousands).
Source: SRHAD NHS Digital.

CROYDON E-SERVICE STI SCREENING OFFER

Nationally, it is expected that integrated sexual health services provide service users with the option of accessing services without the need for seeing a practitioner or attending a clinic in person, to allow service user choice. This is to allow individuals to be able to access services at their convenience, ease and privacy as well as reflect wider changes in demand for online health services. E-services are therefore also an opportunity to provide people with information about sexual health, facilitate online triage and signpost to the most appropriate services for their needs by giving them the option of ordering self-sampling STI kits.

An e-service can enable improved population coverage and increased detection of infections in the community. It can also help to manage demand and improve access to clinic-based services for those requiring a face-to-face appointment.

In Croydon, these expectations and requirements are addressed through provision of two dual online e-services for STI testing. This consists of a universal offer (for 16+) operated directly by the CHS clinic for a range of STIs and an additional service operated by Preventx to support with volume and demand that is targeted towards 16 to 24 year olds, covering chlamydia and gonorrhoea. These both offer postal self-sampling kits.

The aims of Croydon’s STI e-services are as follows:

- Prevent and control chlamydia through early detection and treatment of asymptomatic infection.
- Reduce onward transmission to sexual partners.
- Prevent the consequences of untreated infections such as pelvic inflammatory disease and infertility.

The main objectives of the e-services are to:

- Encourage chlamydia screening in line with NCSP standards among 15 to 24 year olds in Croydon.
- Contribute towards delivery of the chlamydia diagnostic rate of 3,250 per 100,000 15 to 24 year olds in Croydon.
- Deliver sexual health screens through postal kits ordered online to residents of the borough.
- Provide live reporting and statistical analysis tools for all screening kits and partner notification.

The below table summarises the differences between what the two e-services offer.

Service	CHS e-service	Preventx Freetest.me
Young people (16 to 24 year olds)		X
All ages (16+)	X	
Chlamydia	X*	X
Gonorrhoea	X*	X
HIV	X	
Syphilis	X	
Trichomoniasis	X**	
Hep B	X***	

Table 5: Comparison of Croydon E-service offers.

* Throat and rectal swabs are accommodated if required.
** All vaginal swabs are tested for trichomoniasis.
*** Hep B is offered to GBMSM only at this time.

Pathway for how the e-services operate:

- **Accessing the service and requesting a kit:** Residents are able to request a free test kit online and have this posted to their address (for the CHS service there is also the option to pick this up from the clinic).
- **Eligibility:** Eligibility is established through information gathered during registration online (this includes triaging questions such as demographic information, reported sexual history and other related risky behaviours). These services are aimed towards asymptomatic patients. If the resident reports symptoms they will be prompted to visit the sexual health clinic or other health professional (e.g. GP) and advised to have a full STI screen during an appointment.
- **Signposting and onwards referral:** The e-services also provide an opportunity to act as a tool for signposting and onwards referral. This is done through web links to publicly accessible appointment booking systems or information for other relevant services commissioned by the borough for users with needs requiring an intervention at a clinical healthcare service outside the scope of the e-service. Onwards referral could include to alternative STI testing, contraception, confirmatory testing, treatment and vaccination. The provider will also immediately signpost service users reporting acute symptoms to their nearest sexual health specialist clinic.
- **Management and notification of results:** Once completed, test kits are returned back to the provider and are then processed by pathology labs, results are recorded on the system and patients are then notified of their result. Consent is obtained for any onward referral where appropriate.
 - » For the CHS run e-service, an automated message will be sent to the patient for negative results. However, for positive results, the service will call the patient to arrange an appointment for treatment (which can be offered on the day).

» Management of all positives happens in line with NCSP standards, which includes arrangement of treatment and follow up treatments, patient led and anonymous partner notification, arrangement of treatment for partners without waiting for test results, health promotion and safe sex advice, follow-up contact within two weeks of agreed treatment collection/post treatment and an offer of re-test at around three months.

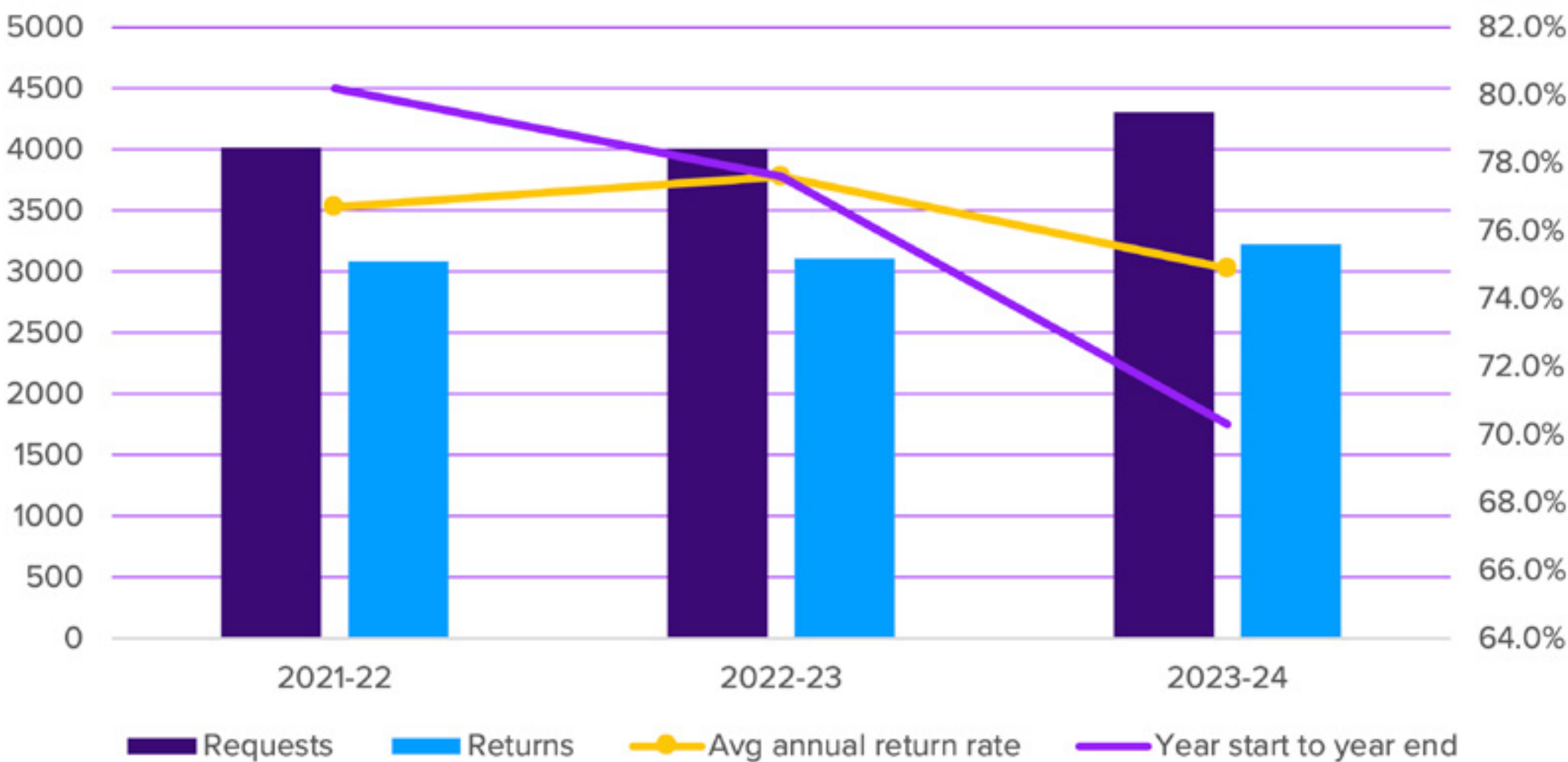
- **Safeguarding concerns:** Questions are embedded within the request platform which will trigger if there are any high risk/safeguarding concerns. Service users between 15 and 17 will be asked safeguarding questions which are mandatory through both platforms. Where there is a safety or safeguarding concern raised, a clinically trained service staff member or Health Advisor is advised to contact the individual for safeguarding purposes, to assess their safety further and refer onwards to relevant services to appropriately support the individual. If CHS cannot reach the individual, the trained service staff member follows a process to contact the individual by preferred means of contact in order to recommend self-referral to safeguarding, share relevant support services or use their clinical/ professional judgement as to whether to automatically refer the individual to safeguarding.
- **Frequent users:** The provider must contact an individual flagged by the system as a frequent user (defined as those where a kit has been ordered more than three times in a twelve month period). Where this is the case, the service is required to intervene not in order to prevent them using the service, but to initiate motivational interviewing or support with those at elevated risk of pregnancy, STIs and HIV and refer them onto other appropriate services where needed.

PREVENTX FREETEST.ME STI SCREENING E-SERVICE FOR 16 to 24 YEAR OLDS

The first offer is provided through Preventx, this aims to support volume of demand on the CHS e-service and is targeted towards 16 to 24 year olds in the borough.

Patients are able to request a free kit from the website freetest.me which is posted to their address. The service pathway is summarised above.

Orders, returns and positivity – Preventx Freetest.me e-service offer



Graph 10: Orders and returns in Croydon from 2021-2024 – Source: Preventx data.

Data from the Preventx e-service provider from 2023/24, show that there were 3,222 kits returned of the 4,304 kits requested (Graph 10).

Year on year, from the 2021/2022 financial year to date, the number of returns and requests have remained fairly stable. These have only slightly increased by 4.5% and 7.2% respectively between 2021/22 and 2023/24.

The average yearly return rate (the rate of service users requesting kits from the freetest.me service who returned their kit) was 74.9%. Looking at this period, the most popular month to order kits was July with 440 requests, whilst March was the least popular with 306 requests.

25 Pan London Sexual and Reproductive health Needs Assessment 2024.

From April 2021 to March 2024, the rate of service users requesting kits from the freetest.me service who returned their kit (return rate) decreased by -12.34%, from 80.2% in April 2021 to 70.3% in March 2024. Based on yearly average return rates this constitutes a -2.35% percentage change.

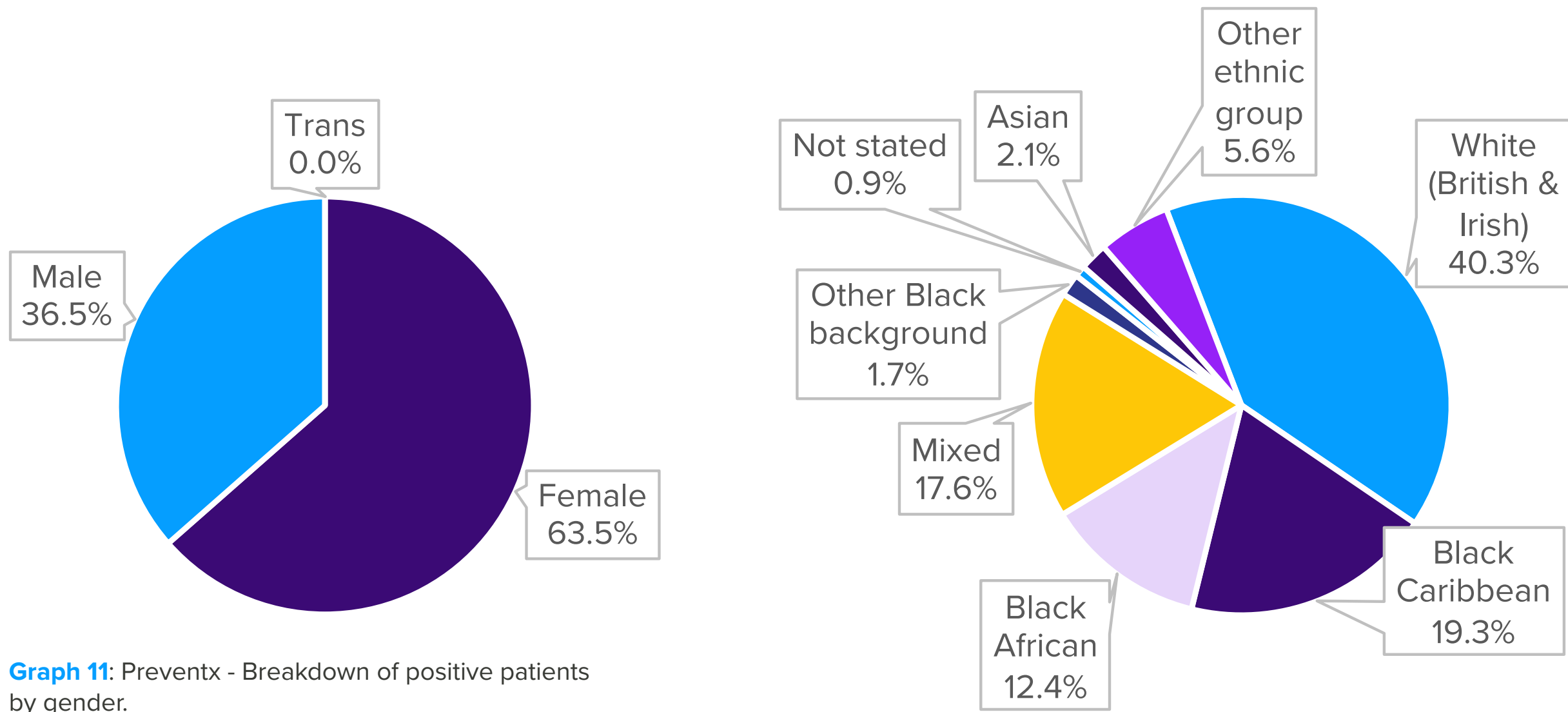
When compared against the SHL.UK e-service return rate performance measures, which is the London regional e-service offer for STI screening and contraception available to residents in participating boroughs, Croydon’s Preventx e-service performs similarly. In 2022-23 SHL.UK had a return rate of 80%²⁵, which is comparable to Croydon’s average yearly return rate of 77.6% that year.

With regard to positivity rates, within the year of 2023-24 there was a 6.1% Chlamydia positivity rate and a 1.2% positivity rate for gonorrhoea. Across all infections, the yearly positivity was 7.2% (3222 tests).

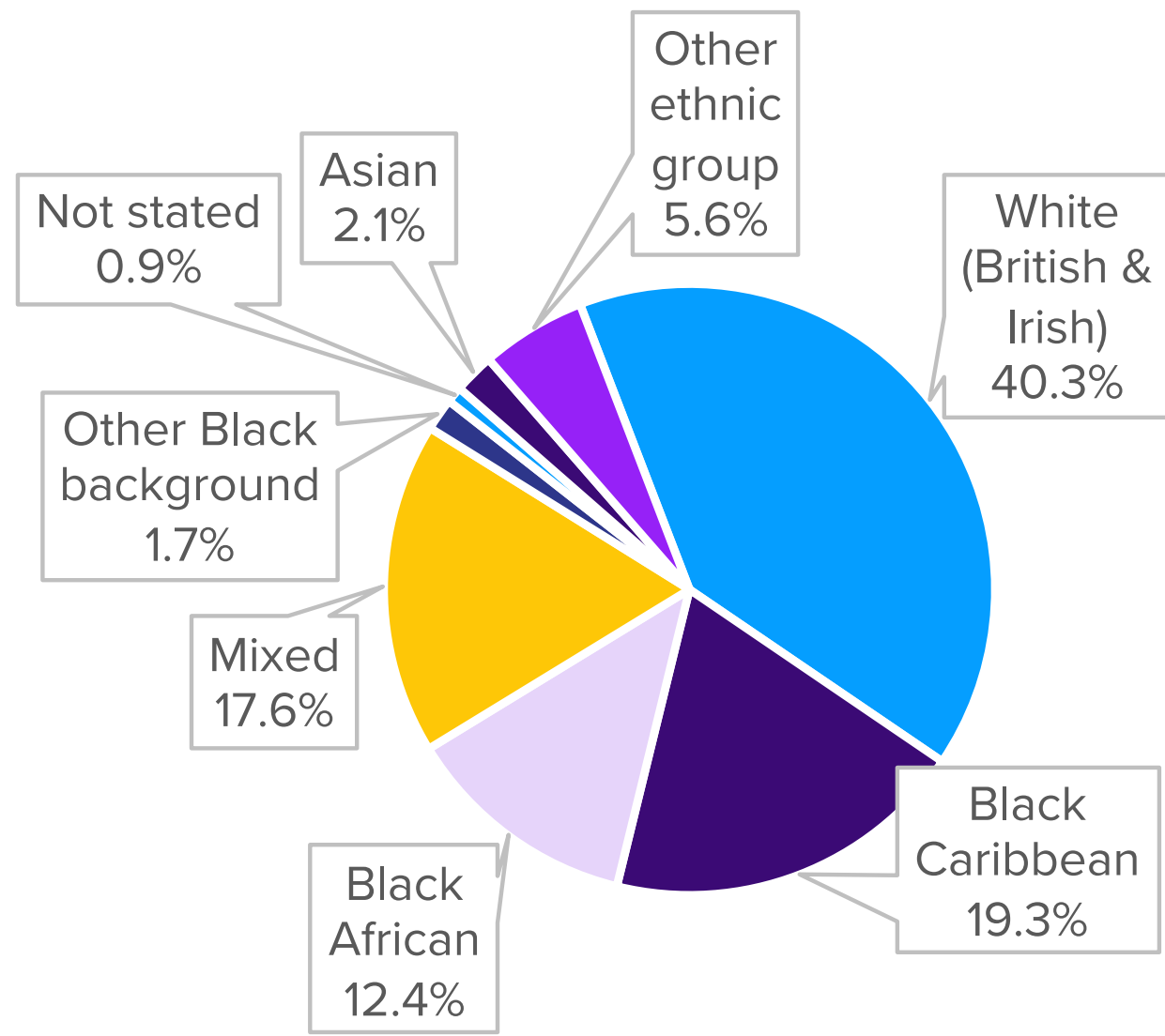
Over time, positive results across chlamydia and gonorrhoea returned kits remained largely stable year on year. For chlamydia, positivity remained similar year on year, increasing marginally from 6.6% in 2021/22 to 7.5% in 2022/23. This dropped again slightly in 2023/24 6.1%. For gonorrhoea, positivity did not change across 2021/22 to 2023/2024, at 1.2%.



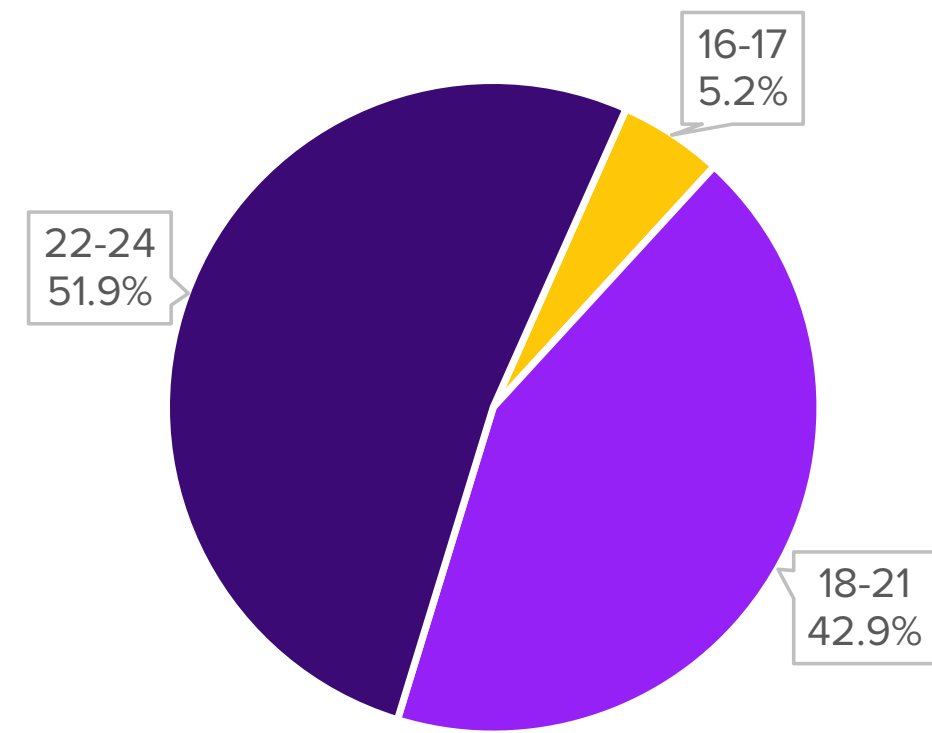
The below graphs show a breakdown of positive results for 2023/24, across demographic indicators. Overall, data shows that within the Preventx service females made up significantly more of the total positive results than male patients, representing 63.5% of positive results. Trans patients were accessing the service although no positive results were recorded within this group. Those living in the top 3 most deprived areas (by decile) made up more positive results than those in less deprived areas, constituting 50.3% of positive results. The distribution of positivity was diverse across ethnicities with the highest proportion of positive results in White British/Irish and Black Caribbean groups (40.3% and 19.3% respectively). 22 to 24 year olds represented the largest share of positive results, with 51.9% of total positive results. 18 to 21 year olds also represented a significant share of positive results, at 42.9%.



Graph 11: Preventx - Breakdown of positive patients by gender.



Graph 12: Preventx - Breakdown of positive patients by ethnicity.



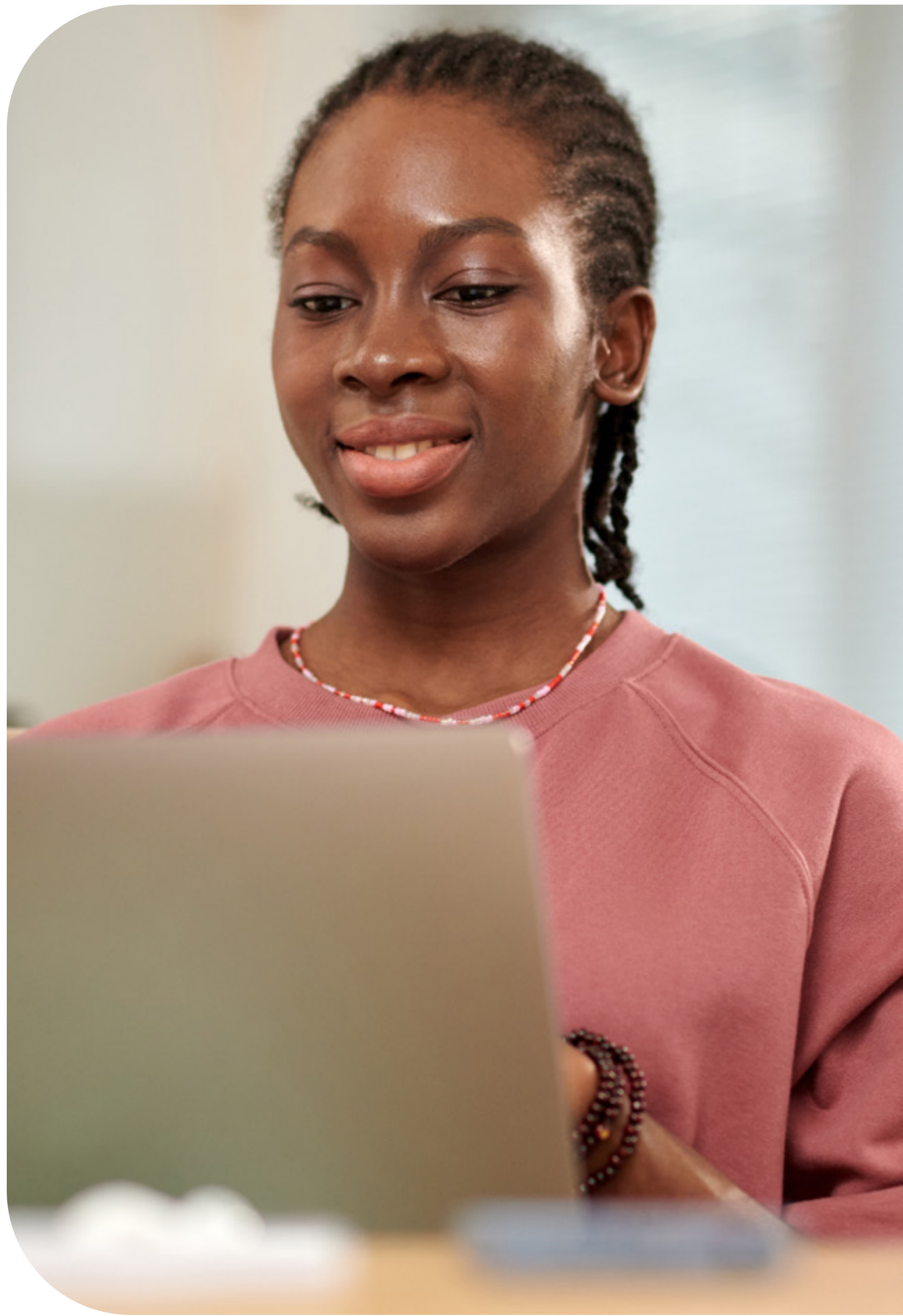
Graph 13: Preventx - Breakdown of positive patients by age.

E-service user profile - Preventx Freetest.me e-service offer

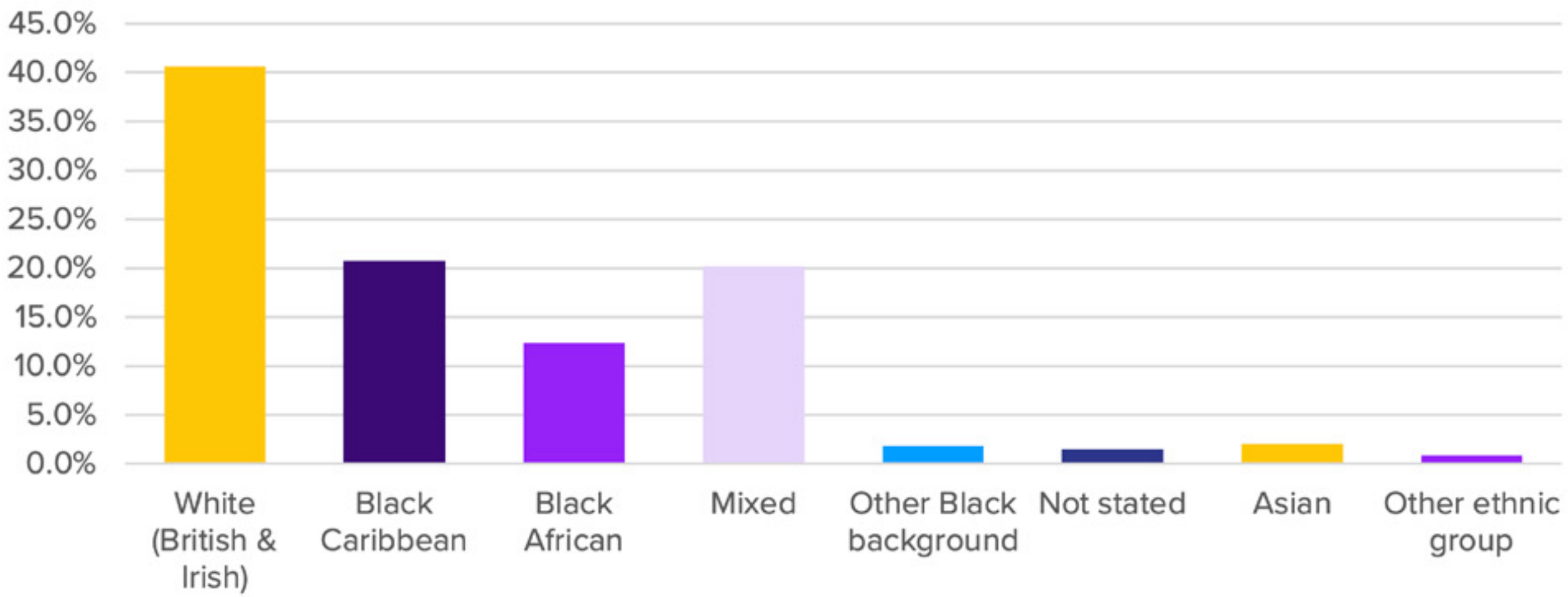
In 2023-24, of the 4,304 kits ordered by users, 3,222 STI screening kits testing for Chlamydia and Gonorrhoea were returned.

The following demographic profile of users accessing the service is based on 2023-2024 figures:

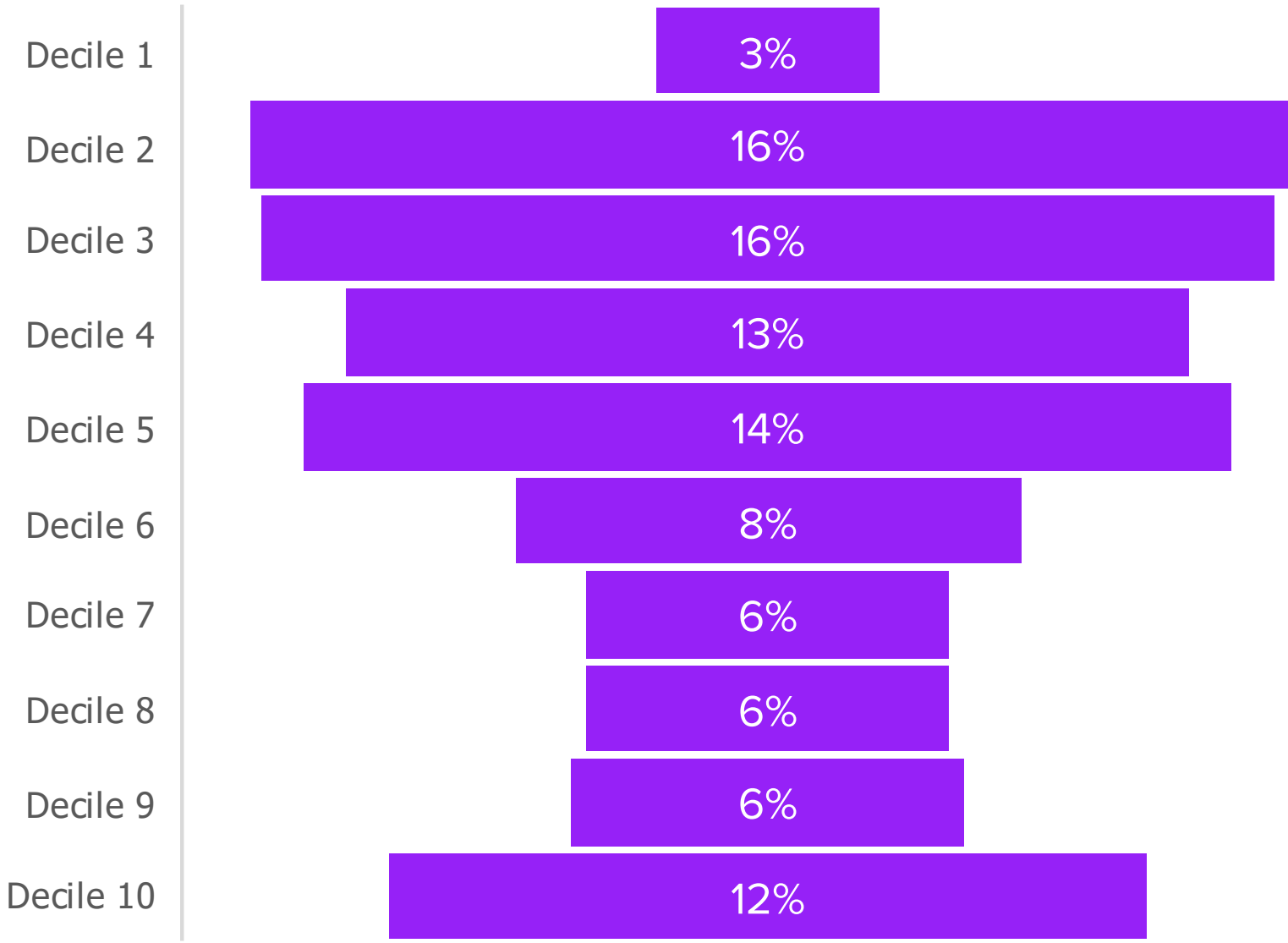
- **Gender:** Females made up 65.4% of order requests, with 34.3% males and 0.2% trans.
- **Sexuality:** Heterosexual people make up 90.9% of kits ordered, whilst gay or lesbian made up 3.3% of kits ordered. 3.7% of kits ordered were those of bisexual sexuality and 2.1% were unknown.
- **Age:** 63.7% of kit orders were within the 22 to 24 age group, whilst 31.9% were in the 18 to 21 age group, leaving 4.4% ordered by 16 to 17 year olds.



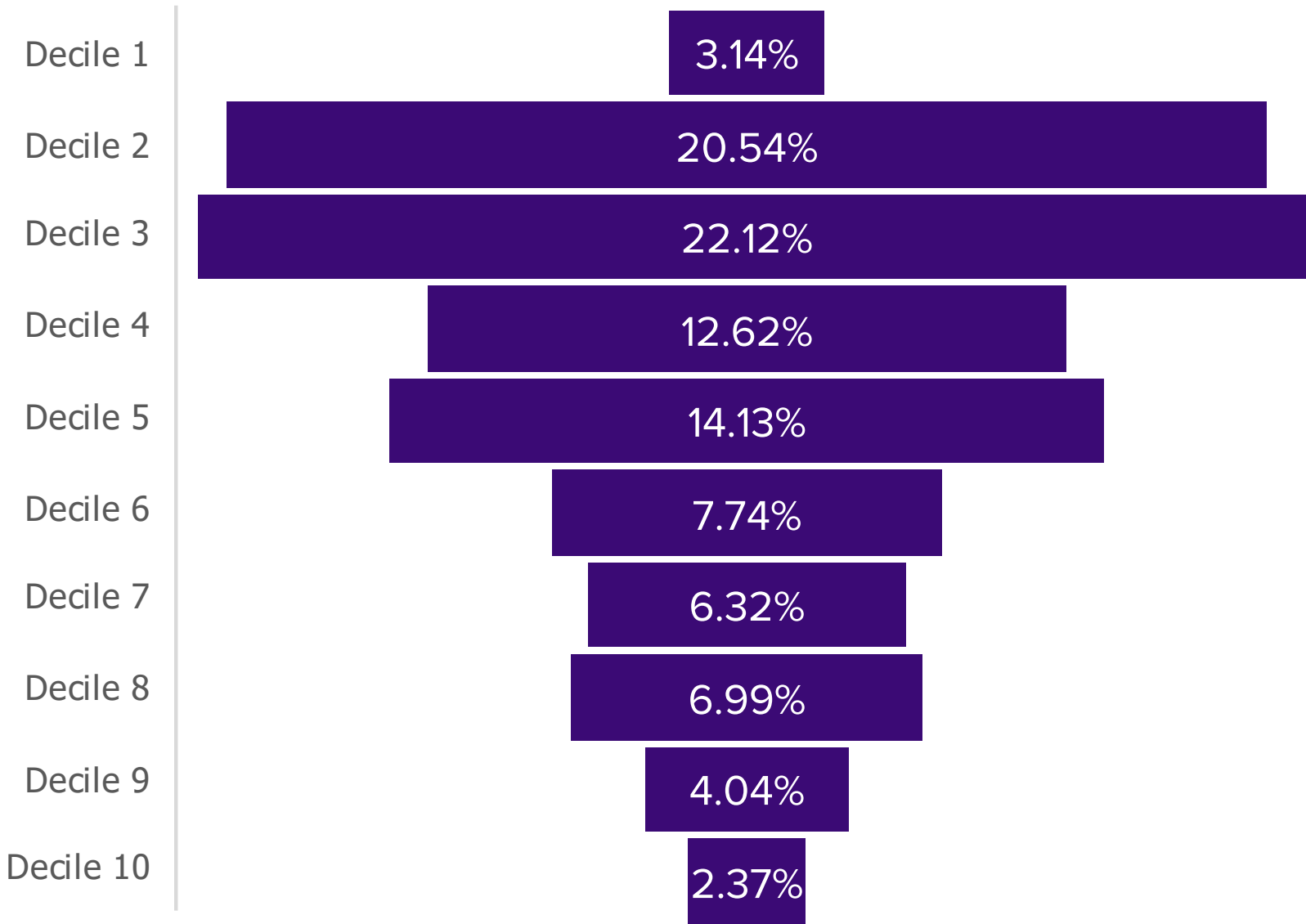
- **Ethnic group:** 41% of all service users are of White ethnicity, 20% were of Mixed ethnicity, 21% were of Black Caribbean and 12% were Black African. 2% of service users were of Asian ethnicity (with the majority of this being Indian ethnicity).
- **Deprivation:** Over 45% of orders were from people living in the more deprived areas of Croydon (Decile 1, 2 and 3) (Graph 16).



Graph 14: Orders by ethnicity 2023-24. Source: Preventx data.



Graph 15: LSOAs by decile in Croydon, 2025. Source: Croydon observatory, ONS data.



Graph 16: Orders by deprivation decile (proportion of postcode) 2023-24. Source: Preventx data.



CHS CLINIC STI SCREENING E-SERVICE

The second offer is provided through the CHS Sexual Health clinic and covers routine screening for Chlamydia and Gonorrhoea for asymptomatic patients. Users can also opt in to add on a HIV and Syphilis kit and a Hep B test is offered to those who identify as GBMSM. All vaginal swabs tested for chlamydia and gonorrhoea will also be tested for trichomoniasis within this offer.

The STI test kit e-service allows residents to request a STI kit which can be either collected from the clinic or posted to an address of their choice. Further details of the pathway service users access the service by is summarised above.

The below data and analysis, looking at 2023/24 user requests and demographic profile, originates from the historic platform the e-service operated on prior to 2025/26. The e-service has recently migrated to a new platform which aims to provide a more user-friendly experience for patients requesting kits and may enable improved data capture going forward.

Orders, returns and positivity – CHS Clinic e-service

The e-service for STI testing offered by the CHS Sexual health clinic offers chlamydia, gonorrhoea, HIV, syphilis and Hepatitis B screening.

In 2023/24, 8894 kits in total were returned. Of the 8,894 kit returns, 5418 also were tested for HIV and Syphilis, 694 were tested for HIV, Syphilis and Hepatitis B.

Over time, the number of returns has remained fairly stable, within this service returns have only slightly increased by 6% from 2021/2022 (8,389 returns) to 2023/24 (8,894 returns).

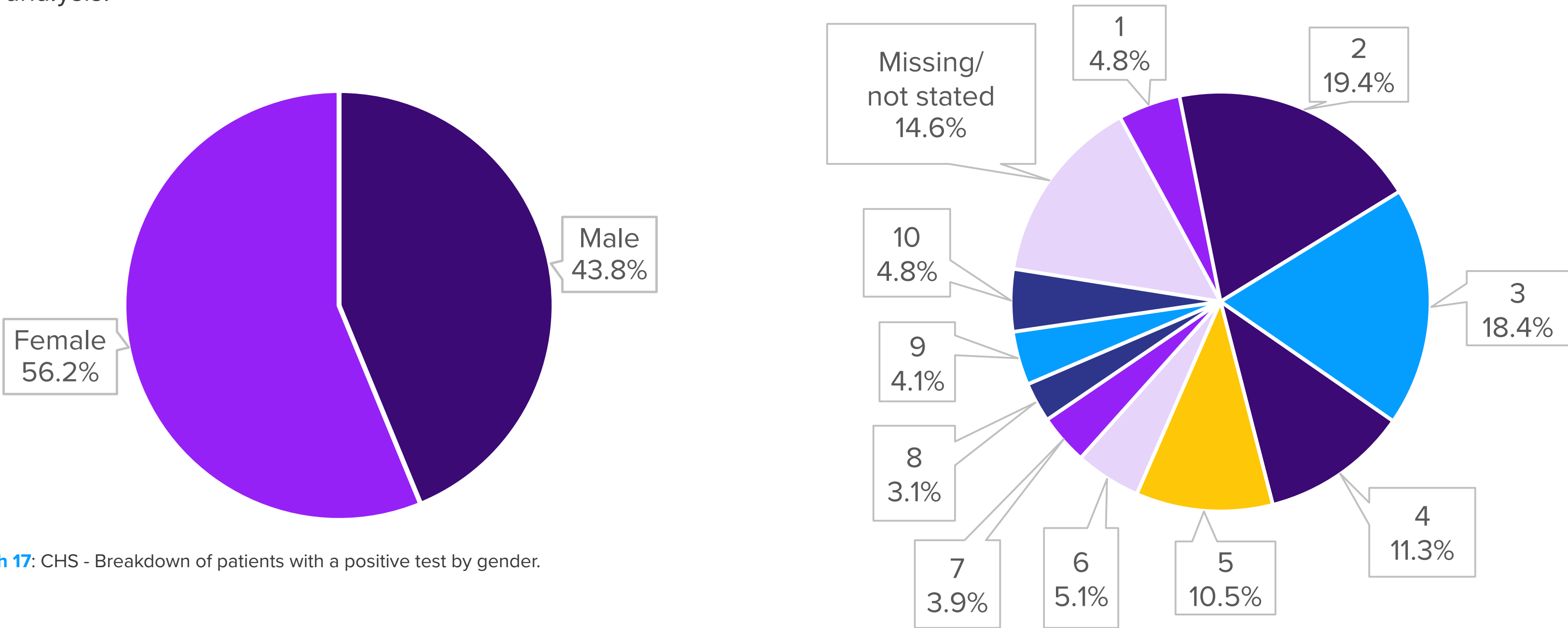
For this service, the total number of kit requests is not available due to limitations in the previous e-service platform. Historically, the system allowed users to submit an unlimited number of kit requests, which were then manually assessed by the service. Requests made within an appropriate timeframe were fulfilled, while those deemed inappropriate were rejected. As a result, accurate request numbers and return rates cannot be calculated, as they would not provide a reliable representation of service uptake and overall rate of returns.

With regard to positivity rates of returned kits, across the year of 2023-24 there was an 8.4% positivity rate across all infections (8894 tests). Year on year, since 2021/22 there has not been significant changes in positivity (6% between 2021/22 and 2023/24). Positivity rates have remained relatively stable over time and therefore does not indicate substantial changes in the ability of the service to reach or detect populations with high prevalence year-on-year.



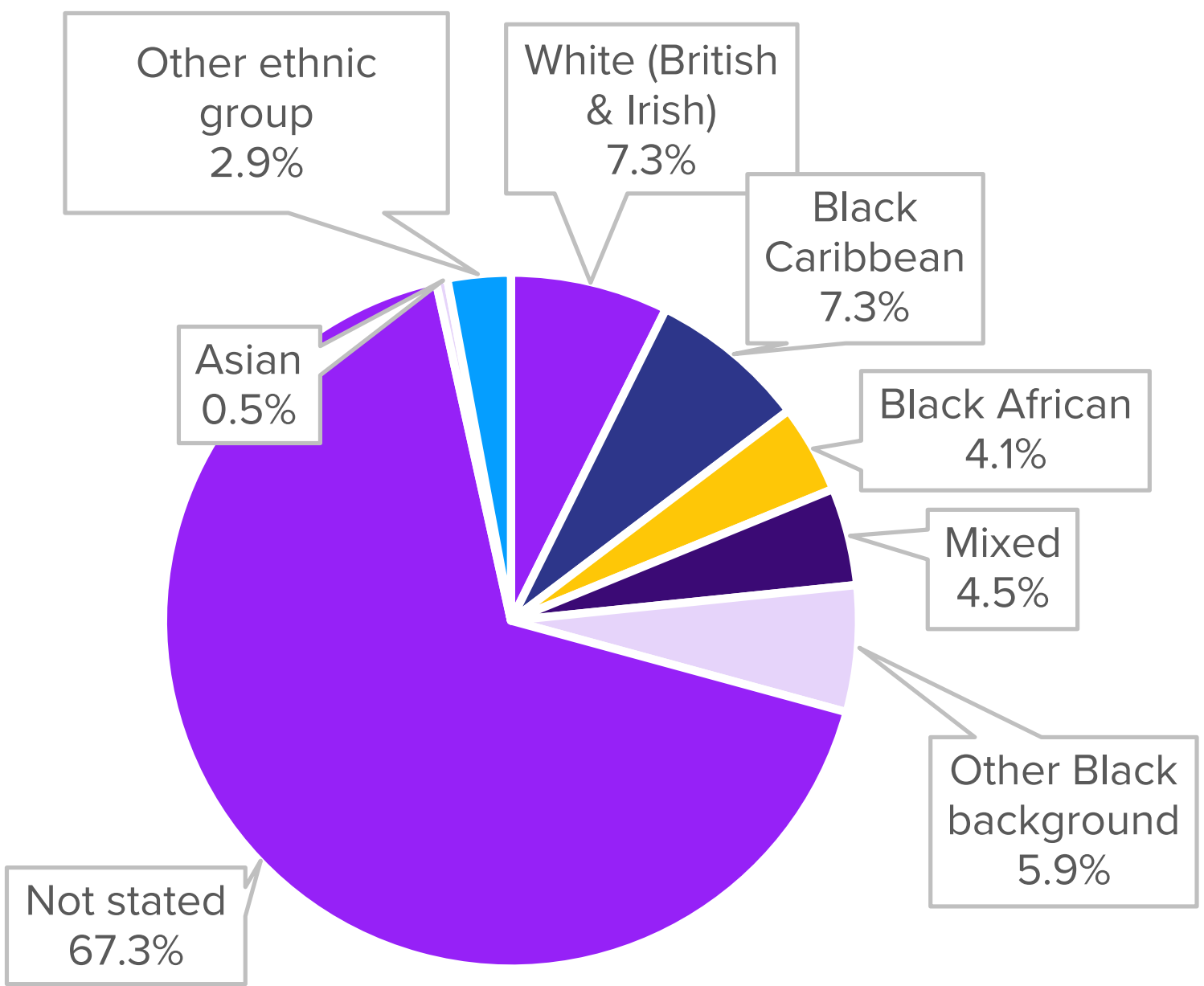
The following graphs show a breakdown of positive results for 2023/24 within the CHS e-service, across demographic indicators. Overall data shows that females made up only slightly more of the total positive results than males. Those living in the top 3 most deprived areas (by decile) made up more positive results than those in less deprived areas, constituting 42% of positive results together. Excluding the high proportion of those whose ethnicity was not known (67%), the share of positivity was diverse across ethnicities, with the highest proportion of positive results in White British/Irish and Black Caribbean groups. 18 to 21 year olds represented the largest share of positive results at 32.6%.

A positivity breakdown by infection was not readily available for the CHS service, and therefore has not been included in this analysis.

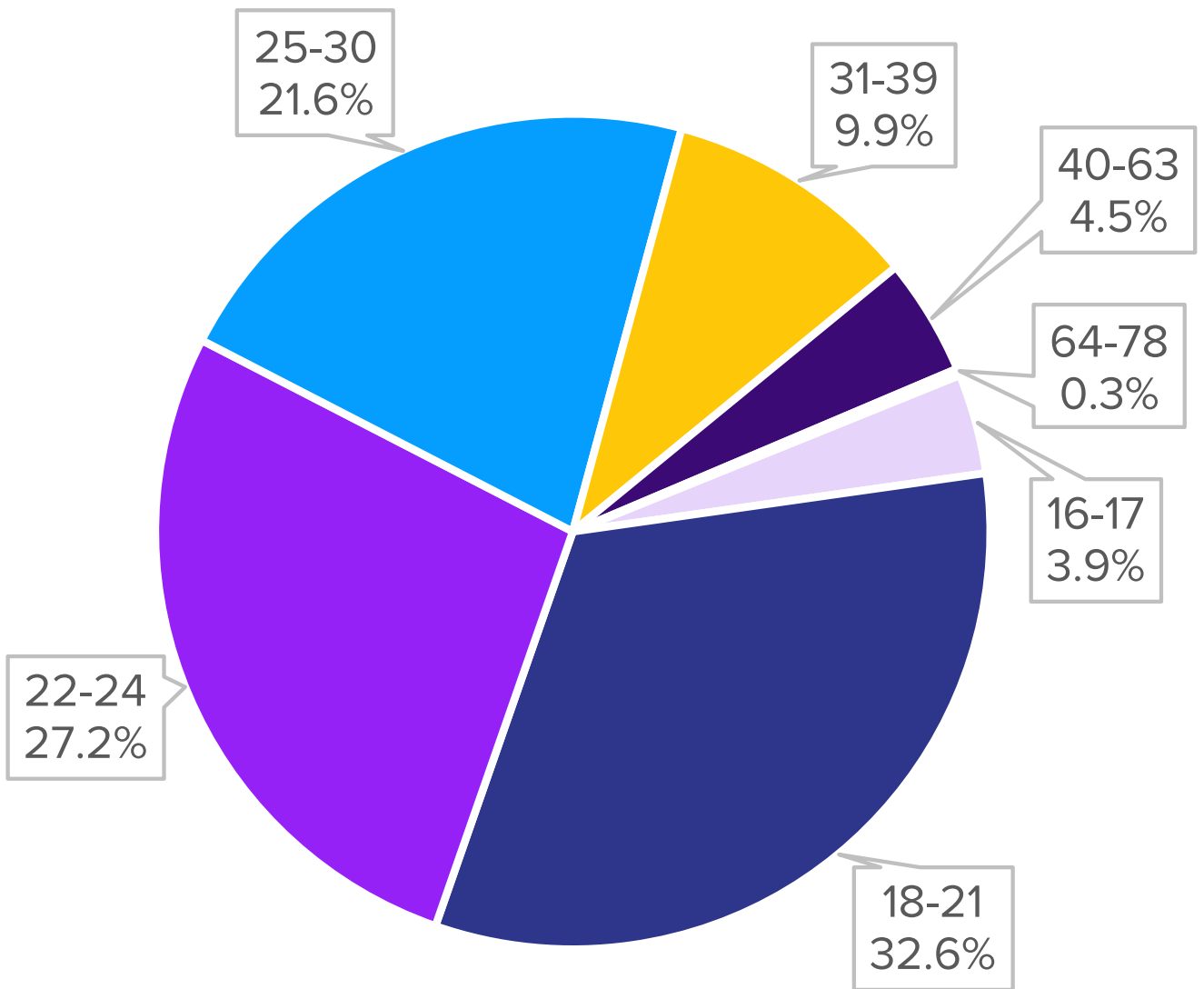


Graph 17: CHS - Breakdown of patients with a positive test by gender.

Graph 18: CHS - Breakdown of patients with a positive test by deprivation decile.



Graph 19: CHS - Breakdown of patients with a positive test by ethnicity.



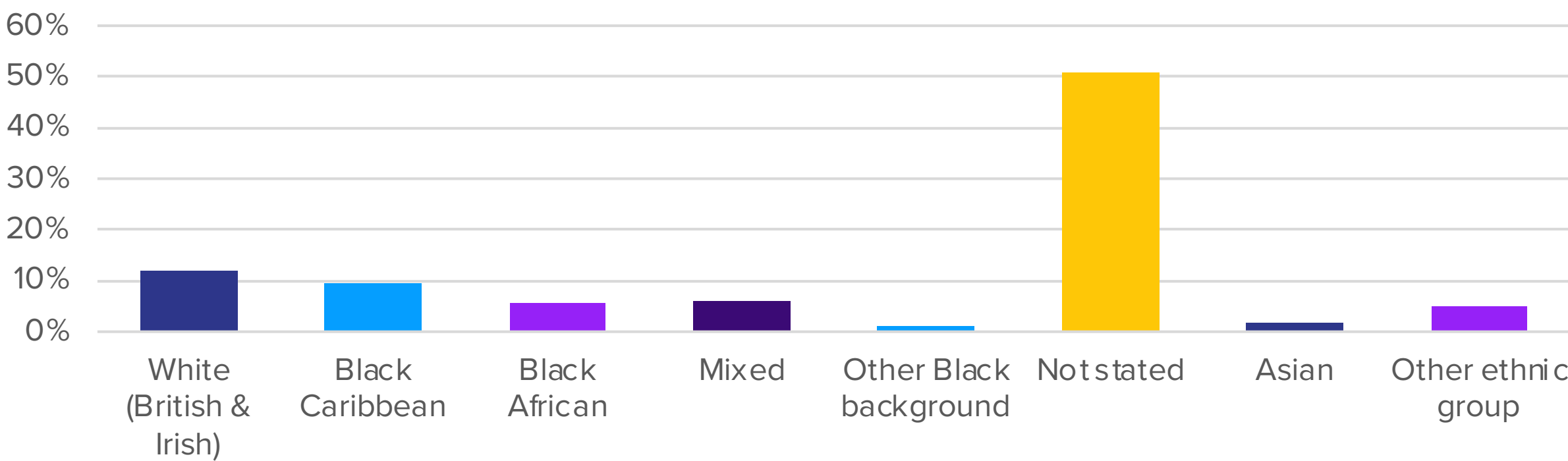
Graph 20: CHS - Breakdown of patients with a positive test by age.



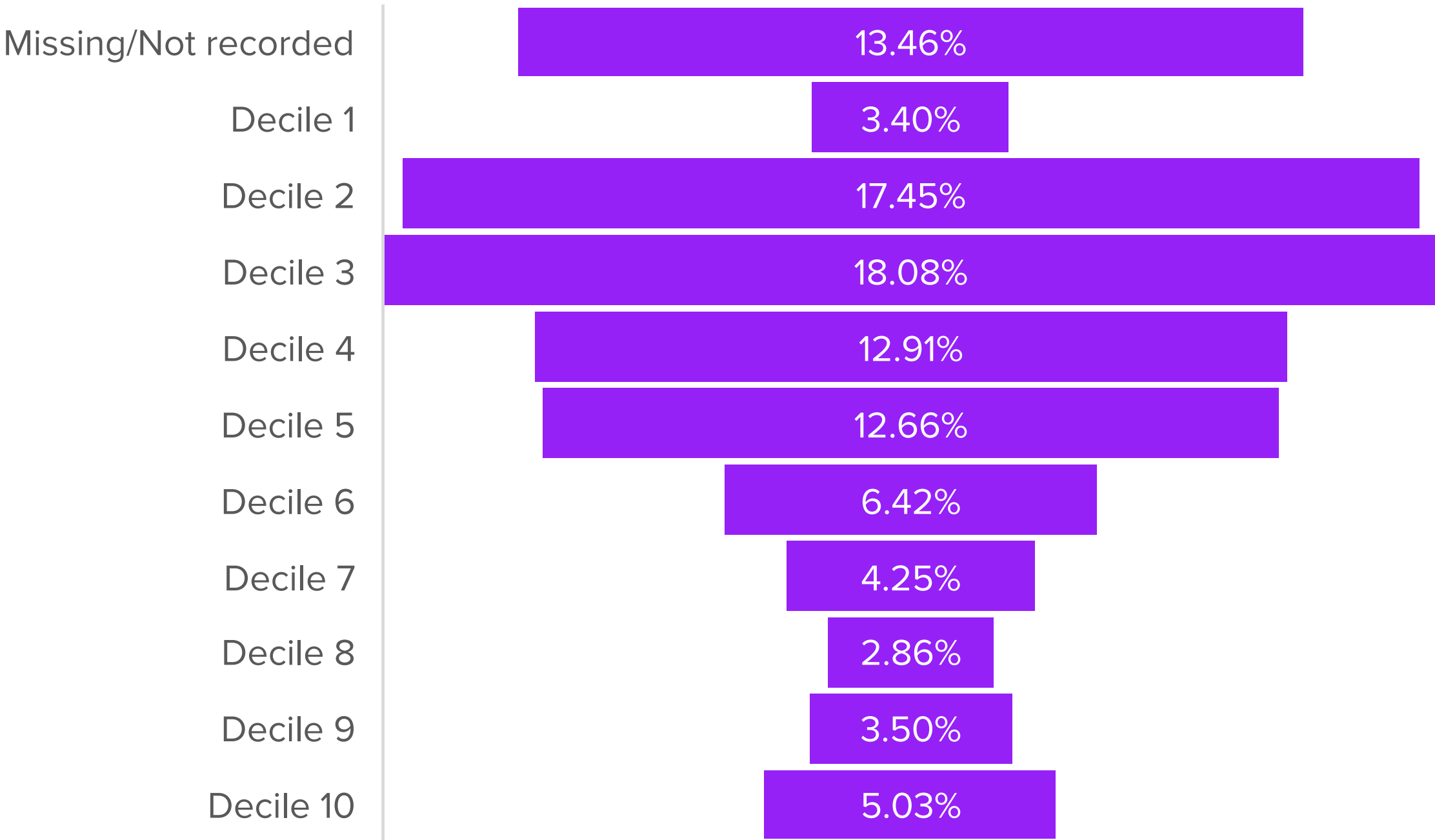
E-service user profile – CHS Clinic e-service

The following demographic profile of service users is based on the 2023-2024 profile:

- **Gender:** Females made up 65% of order returns whilst males made up 35%.
- **Sexuality:** when asked what their sexuality was, heterosexual was selected in 39% of kit orders, whilst gay or lesbian made up 4% of kits ordered. 2% of kits ordered were those of bisexual sexuality. However, it is important to note 55% of overall returns were of unknown, other or not stated sexual orientation.
- **Age:** 1% of kit returns were recorded for patients under 18, 25% of returns were 18 to 24 years old, 54% of returns were within the 25 to 36 age group, 4% of returns were within those aged 49 to 78.
- **Ethnic group:** More than 12% of all service users were of White ethnicity, 10% were of Black Caribbean and 6% were Black African ethnicity. 6% of returns were within those of Mixed ethnicity and 2% of returns were within those of Asian ethnicity (with the majority of this being Indian ethnicity). However, it is important to note that 51% did not state their ethnicity.
- **Deprivation:** 39% of orders were from people living in the top 3 most deprived areas of Croydon (Decile 1, 2 and 3).



Graph 21: Orders by ethnicity 2023-24. Source: CHS E-service data.



Graph 22: Orders by deprivation decile (proportion of postcode) 2023-24. Source: CHS E-service data.

When interpreting this data, it is important to note that this data contains high levels of non-response and incomplete demographic information due to users opting to not complete optional demographic information as part of their kit request, which may limit the accuracy and representativeness of the findings on the user profile. The e-service offered has recently migrated to a new platform which aims to provide a more user-friendly experience for patients requesting kits including users creating an account and requesting kits. These changes aim to encourage users to fill in demographic information by making it easier to do so, through this it is anticipated that completeness of this data might be improved. Alongside this, for those that are required to attend for treatment follow ups, the clinic also encourages the completion of demographic information to support the collection of this data.

SUMMARY, CONCLUSIONS & RECOMMENDATIONS

In summary, the STI screening e-service offers available to Croydon residents aim to cater to target groups of the community more at risk of STI incidence (i.e. young people between 16 to 24) but also offer a comprehensive universal e-service accessible to the wider community via the clinic. These e-services seek to meet the needs of at risk sexually active groups and increase the convenience by which residents can obtain STI screening regularly - in those who are asymptomatic. The above data gives an understanding of the type of user, demographic trends and may point to ease of access in using the e-services through high requests-returns rates.



Explore the implications for Croydon relating to positivity and standardisation of reporting and data, shifting trends of services moving from face to face to online.



Further in-depth engagement could explore and facilitate better understanding of satisfaction levels amongst service users, their experience with the current e-services scope and any key priorities for service improvement or delivery.



Work with providers/services to understand why certain individuals aren't using the services and identify barriers are to them using the service.



4. Sexual Health

This section provides an overview of the key trends and areas of need across sexually transmitted infections (including HIV) in the borough, making comparison to national and regional areas.



In Croydon, the most commonly diagnosed STIs are chlamydia, gonorrhoea, trichomoniasis, genital herpes and genital warts. Shigella and trichomoniasis are increasing rapidly and represent emerging areas of concern.



There are inequalities in STI burden and reinfection rates among people living in deprived areas and those of Black ethnicity and GBMSM.



Croydon remains an area of extremely high HIV prevalence and despite testing rates slowly increasing the borough there has not been recovery to pre-pandemic levels.



Late diagnosis and initiation of treatment remain a challenge particularly in heterosexual people. High levels of stigma around HIV are also a prevalent issue.

SEXUALLY TRANSMITTED INFECTIONS (STI)

Sexually transmitted infections (STIs) are transmitted through sexual contact and exposure, for example through vaginal, oral or anal sex with an infected sexual partner.

These can cause symptoms but also be asymptomatic. Due to this, frequent STI screening of groups with higher needs or poorer outcomes is needed, conducted in line with national guidance. If treatment and detection happen at an early stage, long term consequences such as infertility, ectopic pregnancy or pelvic inflammatory disease can be prevented. STIs are an important area of public health concern because of the long and short-term consequences they can have on a person's health, fertility, psychological health and social effects.

STIs are prevented by use of condoms, vaccination (in the case of Hep B and HPV) or pre- and post-exposure HIV prophylaxis (PrEP and PEP).

Chlamydia, gonorrhoea, syphilis, trichomoniasis, herpes simplex virus (HSV), human papillomavirus (HPV), HIV and some types of viral hepatitis are common STIs. More recently, outbreak associated viral infections, such as Mpox, mainly transmitted through vectors or physical contact, have been identified as also sexually transmissible.

In London, STIs are an area of particular public health concern due to various drivers. London has higher proportions of young adults, this age group has a tendency towards more new sexual partners, more associated risky

behaviours and sometimes higher partner turnover which are thought to increase STI transmission risks. London also has a high population density, diverse populations including large LGBTQ+ communities and varied relationship behaviours and attitudes towards sexual health.

Nationally, numbers of new STI diagnoses have increased year on year since 2021, with syphilis and gonorrhoea diagnoses now both exceeding levels seen in 2019. STIs disproportionately affect gay, bisexual and other men who have sex with men (GBMSM), young people (aged 15 to 24) and some minority ethnicity communities across the country.

In 2020, the COVID pandemic caused national disruption to sexual health services widely, resulting in decreased STI testing and diagnoses. Testing rates largely recovered by 2021 and diagnoses levels across some infections returned and exceeded pre-pandemic rates by 2022. Genital herpes rates however, have remained lower than pre-pandemic levels and have increased slower. Genital warts diagnoses have decreased widely, due to the impact of the HPV vaccination and its protective nature, especially within under 25s who were early cohorts to be offered the vaccine²⁶.

DIAGNOSIS

The rate of new STIs diagnosed per year is a key indicator of ongoing STI transmission in the population or community. It can also indicate sexual health behaviour trends and effectiveness of prevention or screening efforts.

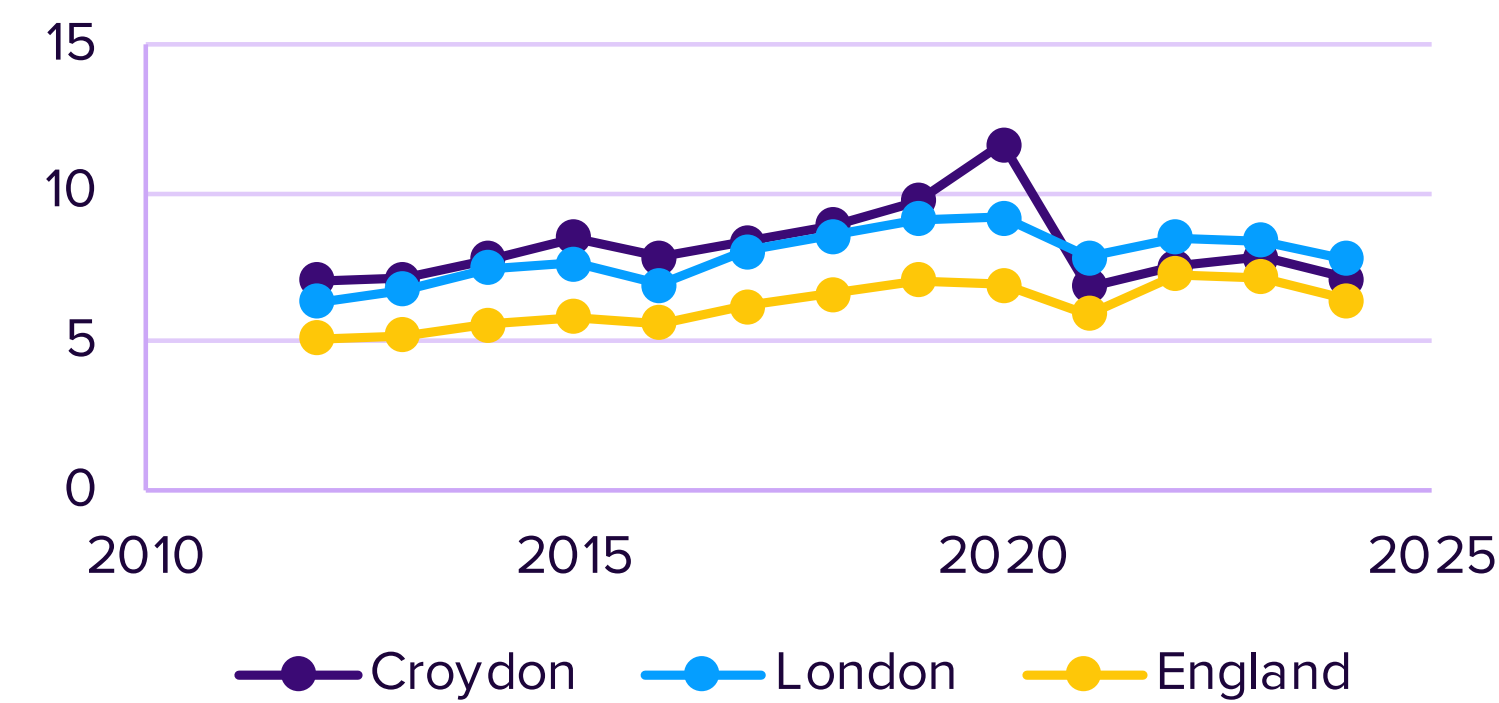
The most recent data shows that in total, 4,167 new STIs were diagnosed in residents of Croydon in 2024²⁷. For the combined indicator of all new STI diagnoses (excl. Chlamydia in under 25s), Croydon’s rate of 845 per 100,000 is well above the England rate (482 per 100,000), however significantly below the London average rate (1,182 per 100,000).

The Croydon rate of all new STI diagnoses follows a similar trend to the London region average rates with a peak during the COVID pandemic period that remained lower than London’s average peak level during this period. This trend has shown a slight upward increase direction since 2021, overall.

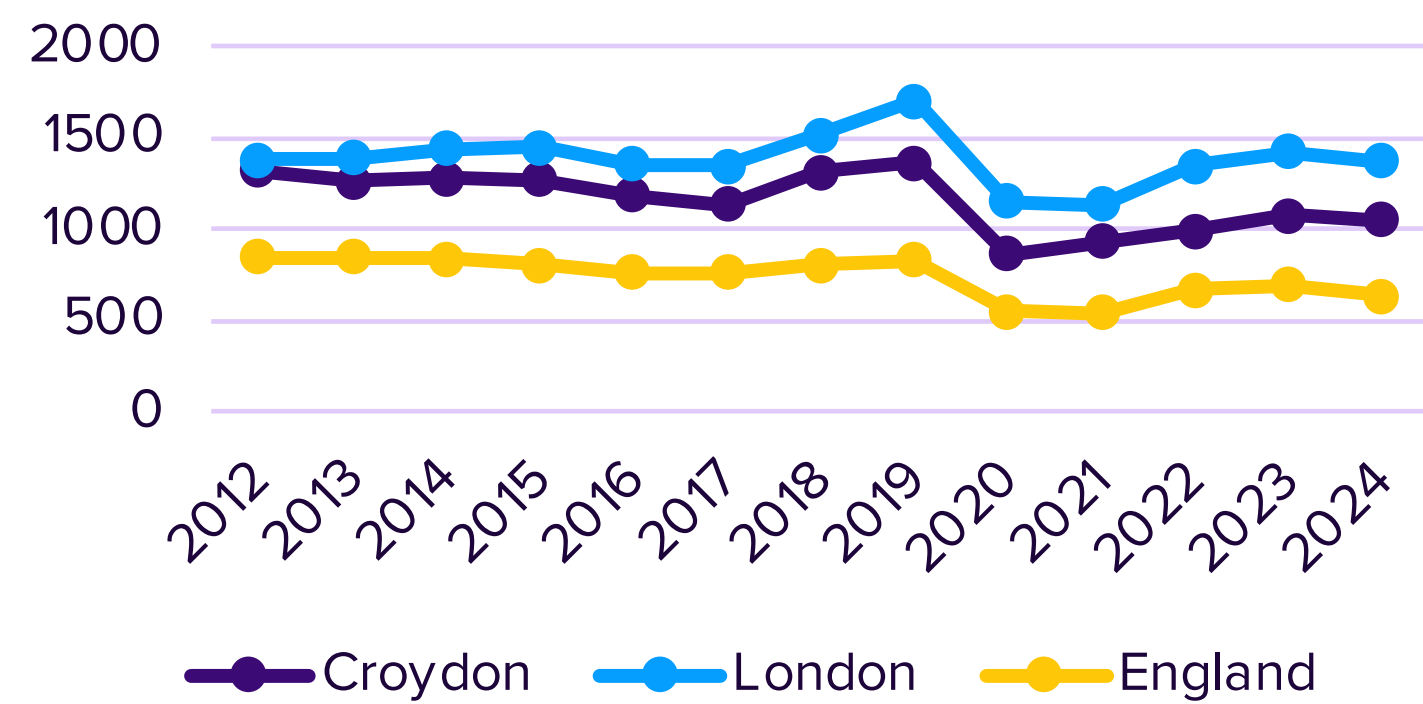
STI diagnoses and positivity rates are closely linked, STI positivity as an indicator shows the proportion of tests that were positive, of those testing and accessing SRH services. Croydon’s STI testing positivity (excl. chlamydia under 25s) at 7.1% in 2024 was very similar to the London average at 7.8% and the England average of 6.4%.

A positivity rate close to the regional and national averages suggests Croydon’s sexual health interventions and risk profile are broadly typical for London, rather than being an outlier.

The impact of the COVID pandemic is evident in data on the STI positivity rate. Graph 23 shows how Croydon’s rates peaked well above London average rates during the pandemic period. However, since 2021, Croydon’s rate has been consistently very similar to London’s. Maintaining this rate at or below London’s average should remain a strategic focus.



Graph 23: STI testing positivity % (excl. chlamydia age 24 and under). Source: UK Health Security Agency



Graph 24: New STI diagnoses (excl. chlamydia aged 24 and under) per 100,000. Source: UK Health Security Agency.



²⁶ SPLASH Report, Croydon 2025.
²⁷ OHID, Public Health Profiles, 2025.

The most commonly diagnosed STIs in Croydon in 2024 were as follows (in descending order):

STI	COUNT	RATE	RECENT TREND
CHLAMYDIA	1,575	396	→
GONORRHOEA	797	200	↓
TRICHOMONIASIS	479	120.4	↓
GENITAL HERPES	272	68.4	→
GENITAL WARTS	239	60.1	↑

Table 6: The most commonly diagnosed STIs in Croydon in 2024. Source: OHID, Public Health profiles 2025.



The table below shows how Croydon compares to the national and regional (London) picture across key indicators for STI, and changes in key STIs from 2023 to 2024.

Diagnoses	Croydon 2023	Croydon 2024	% change 2023 to 2024	Rank among 16 CIPFA neighbours	Rank within England: 2023	Value for England: 2024	Value for London region
NEW STIs	1,110.60	1,048.00	-5.64%	8	23	632	1,369
New STIs (excl. chlamydia aged <25)	839	845.00	0.72%	8	21	512	1,182
Chlamydia	443.1	396.00	-10.63%	8	26	293	525
Gonorrhoea	229	200.00	-12.66%	9	23	124	367
Syphilis	27.5	21.90	-20.36%	13	27	16.5	46
Genital warts	53	60.10	13.40%	11	38	43.4	77.3
Genital herpes	64.5	68.40	6.05%	7	26	48.3	84.6
Mycoplasma genitalium	47.2	55.80	18.22%	3	12	15.7	42.7
Trichomoniasis	120.6	120.40	-0.17%	1	2	17.4	42.2
Sexually transmitted Shigella spp.	14	23	64.29%	11	33	10	36

Table 7: Rates per 100,000 population of new STIs in Croydon and England: 2023 to 2024. Source: Office for Health Improvement and Disparities. Public health profiles. 2025 <https://fingertips.phe.org.uk/#>.

SEXUALLY TRANSMITTED INFECTIONS BY CATEGORIES

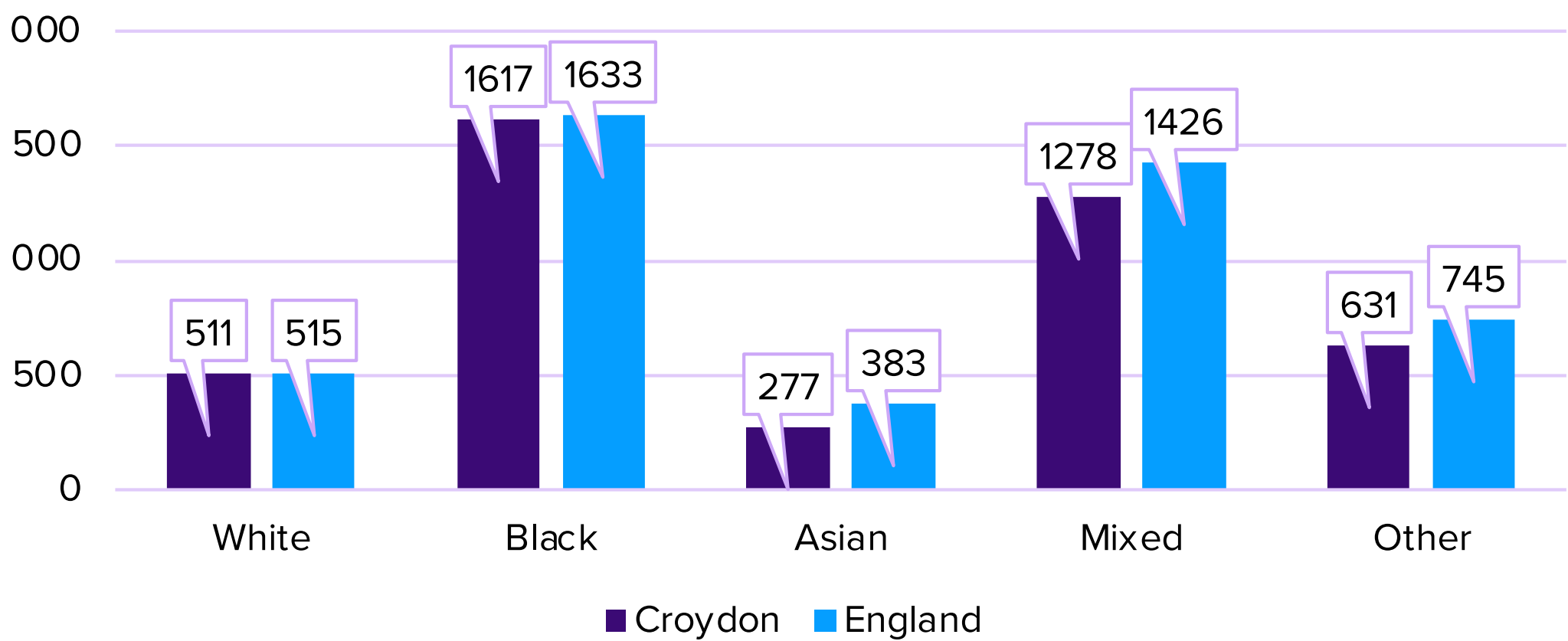
A link can be observed between STIs, age, deprivation and ethnicity.

Age

In Croydon in 2023, young people aged 15 to 24 years old comprised 37.6% of diagnoses of new STIs made in SHSs. Compared to England national averages of 41.6%, this is slightly lower.

Ethnicity

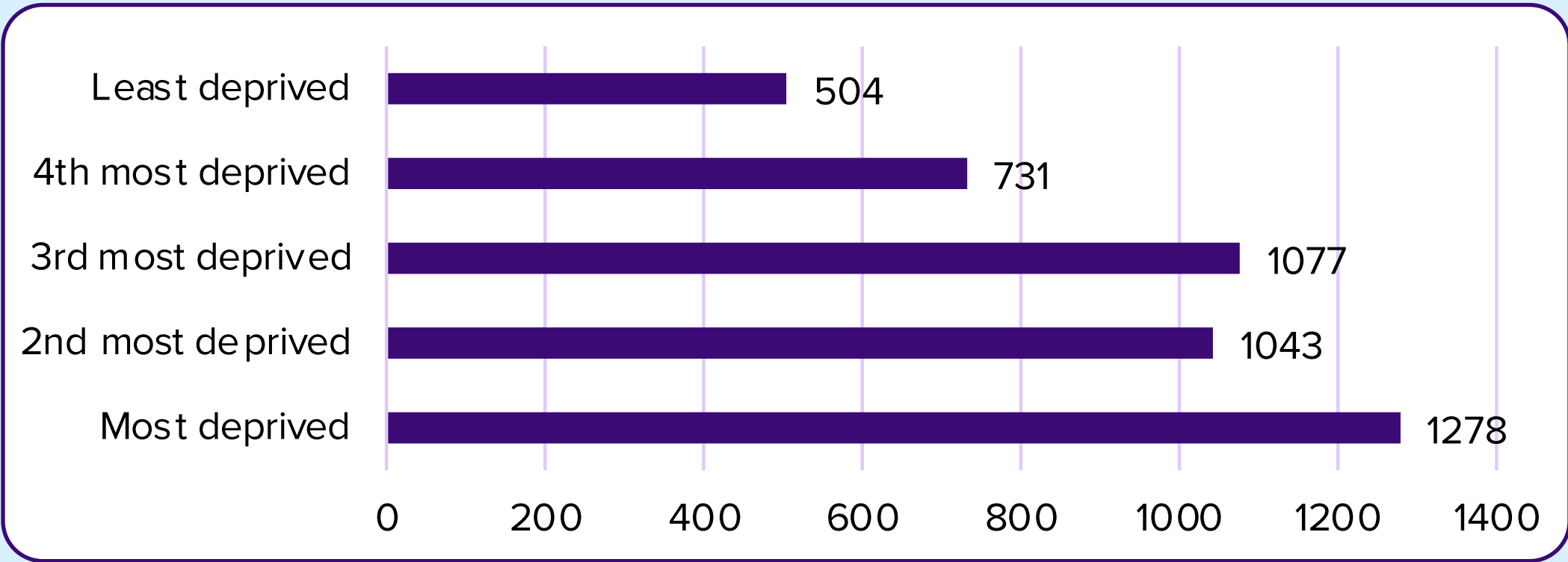
Croydon in 2023, 35.5% of all new STI diagnoses in sexual health services were within people of Black ethnic origin.



Graph 25: Rates of new STIs per 100,000 population aggregated by ethnic group in Croydon and England (SHS diagnoses only), 2023. Source: Data from routine returns to the GUMCAD STI Surveillance System. Excludes CTAD Chlamydia Surveillance system data. Rates are based on 2022 ONS population estimates sourced from 2021 Census.

Deprivation

In Croydon in 2023, 50.3% of STI diagnoses were from residents living in the top 1 and 2 most deprived areas. Slightly higher rates can be observed in the 3rd most deprived areas. The below map shows that high levels of deprivation, HIV prevalence, STI and Chlamydia diagnosis are more concentrated towards the north and east of the borough.

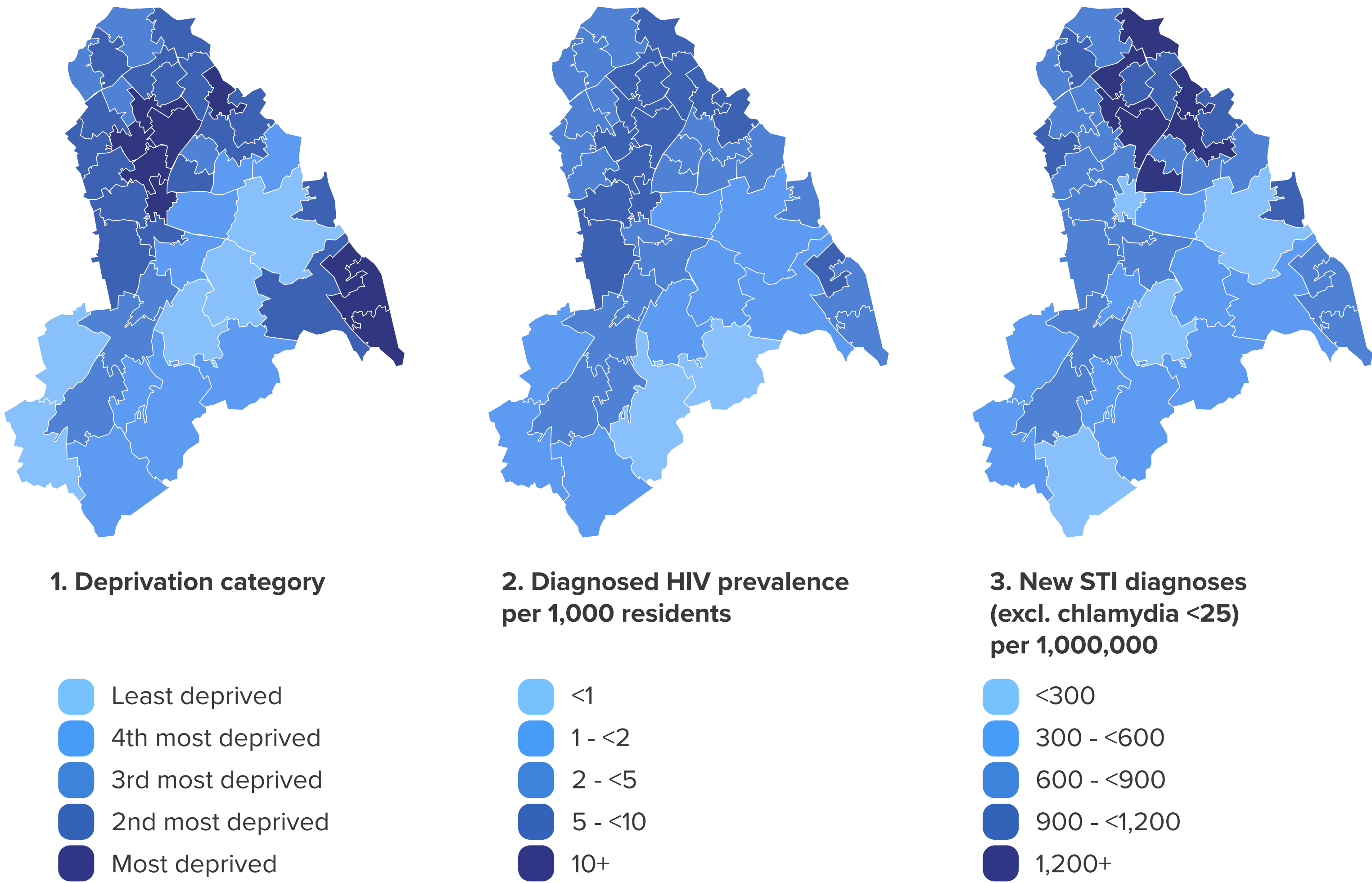


Graph 26: Rates per 100,000 population of new STIs by deprivation category in Croydon (SHS diagnoses only): 2023. Source: GUMCAD data.



Gender

Of those diagnosed with new STIs in 2023 that were Croydon residents, 57% were males and 42.9% were females²⁸. For individuals where sexual orientation was recorded and known, 24.2% of new STIs were among GBMSM compared to 27.5% in England. Within this group, notably syphilis was more common than across other sexual orientations.



Graphic 3: Maps of variation in Deprivation, Diagnosed HIV prevalence, New STI diagnoses and Chlamydia detection rate by Middle Super Output area in Croydon, 2023. Source: ONS Data and OHID Public Health Profiles data.

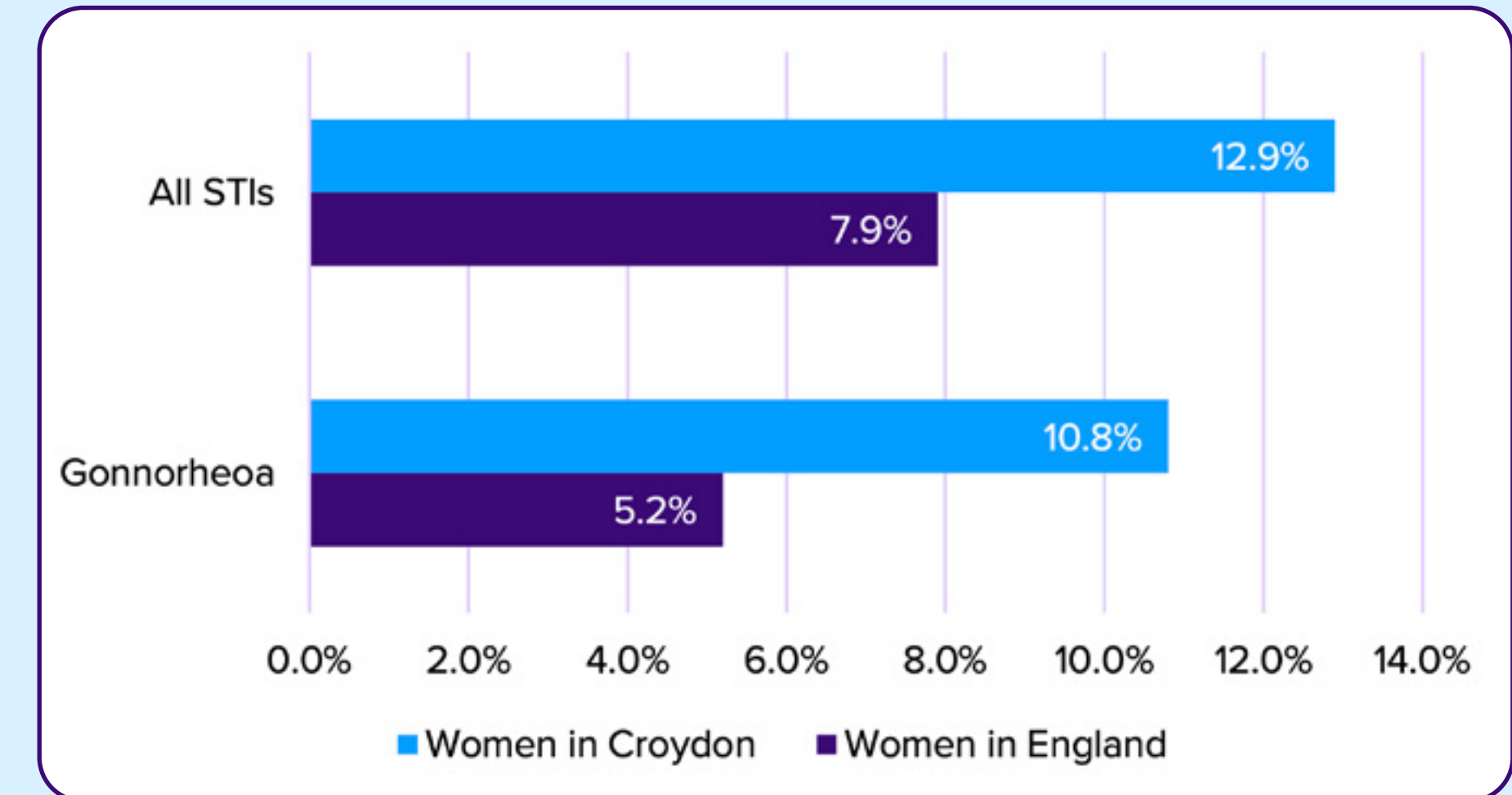


²⁸ This includes diagnoses in Sexual health services and non-specialist sexual health services.

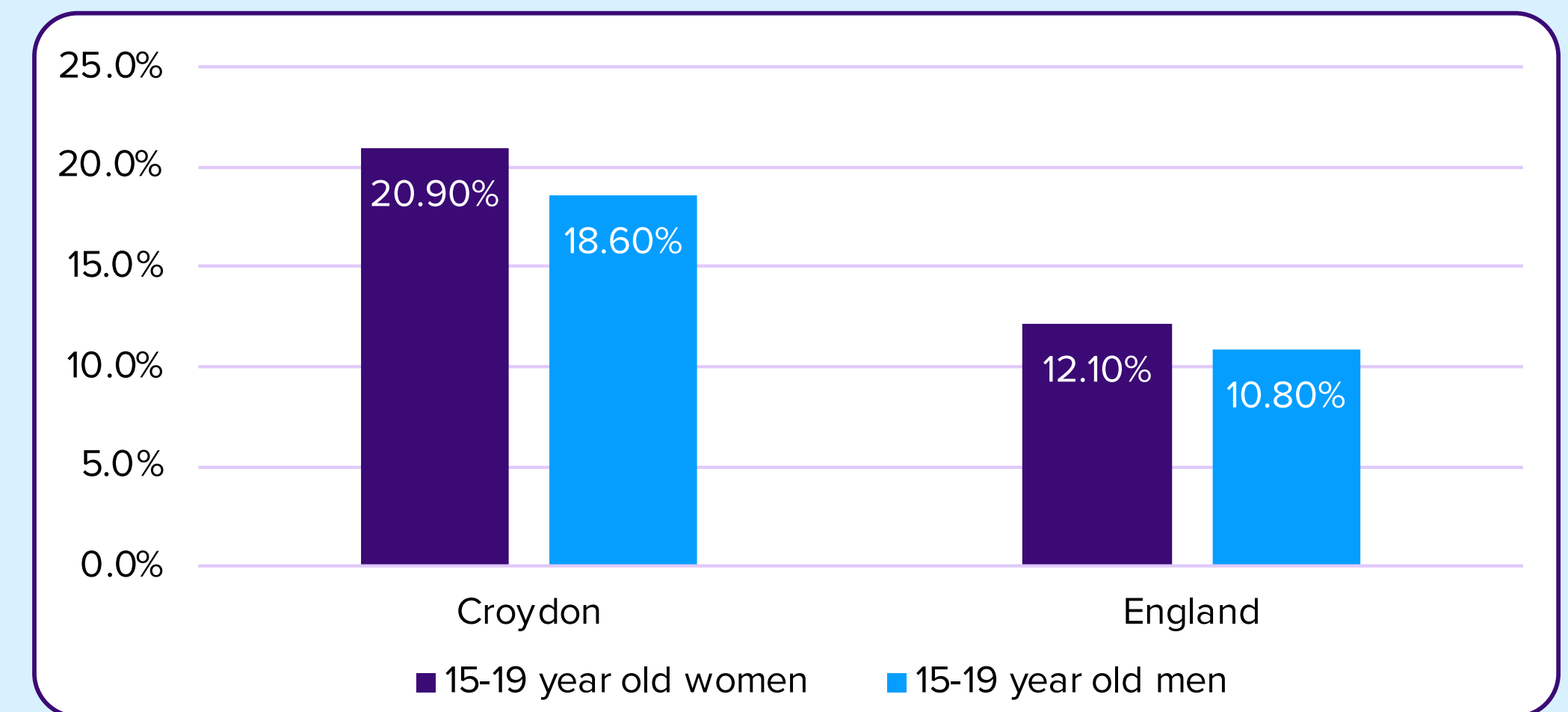
REINFECTION

STI reinfection indicates that ongoing transmission is actively occurring within a population. It can be a marker of frequent high-risk behaviour, however identifying new infections can also be a consequence of regular testing which is a positive behaviour.

- From 2019 to 2023, in Croydon residents, an estimated 12.9% of females and 15.8% of males presenting with a new STI at a SHS became re-infected with a new STI within 12 months. This is higher overall than the England averages, which show that, 7.9% of females and 12.8% of males became re-infected with a new STI within 12 months.
- In Croydon 10.8% of females and 16.1% of males diagnosed with gonorrhoea at a SHS between 2019 and 2023 became reinfected with gonorrhoea within 12 months. Nationally, an estimated 5.2% of females and 15.5% of men became reinfected with gonorrhoea within 12 months.
- Young people are more likely to become reinfected with STIs which can worsen infection persistence and health service workload. In Croydon, within 15 to 19 year olds presenting with a new STI at SHS during the 5-year period between 2019-2023, an estimated 20.9% of young females and 18.6% young males became re-infected with a new STI within 12 months.
- In England, 12.1% of 15 to 19 year old females and 10.8% of 15 to 19 year old males became reinfected with a new STI within 12 months.
- In Croydon the gender gap in reinfection is especially pronounced for females. Females in Croydon are more than twice as likely to be infected with Gonorrhoea and 1.6 times more likely to be infected with any STI overall compared to females nationally.
- Amongst young people in Croydon, reinfection rates are substantially higher than national rates. Young females in Croydon are disproportionately affected by STI reinfection as compared to young males and all-age males. Young females in Croydon are 73% more likely to be re-infected with an STI than young females nationally.



Graph 27: STI reinfection among women in Croydon vs Women in England.
Source: UKHSA.



Graph 28: STI reinfection rates in young people (15 to 19) Croydon versus England, 2019-2023. Source: UKHSA.

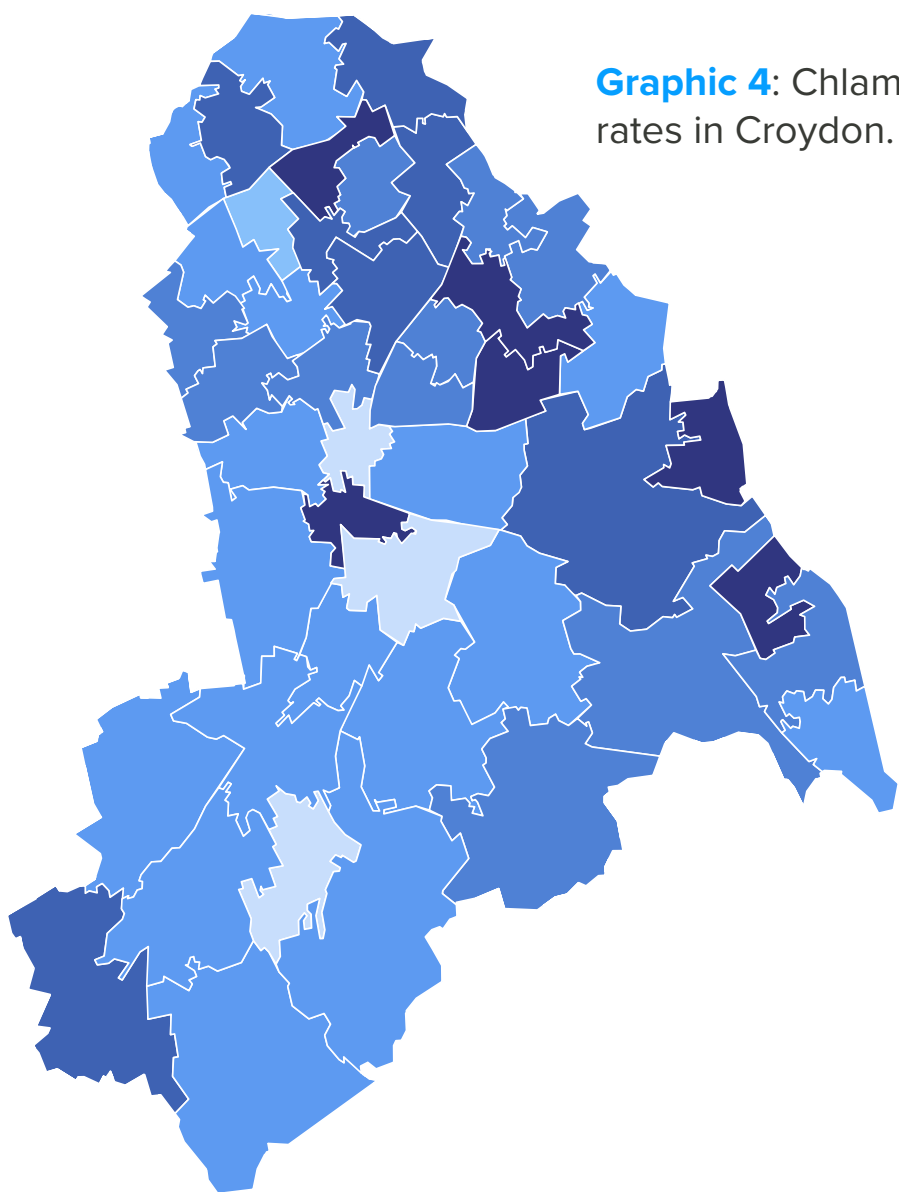
CHLAMYDIA

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. It can occur in males and females and is caused by the bacteria Chlamydia trachomatis, easily treated using antibiotics.

The National Chlamydia Screening Programme (NCSP) in England is focused on reducing the harms from untreated chlamydia infection and offers free, opportunistic screening, treatment and partner management and prevention to sexually active young males and females under the age of 25. Reducing the prevalence of chlamydia among young people aged 15 to 24 is currently prioritised as Public Health Outcomes Framework (PHOF) Indicators.

The Chlamydia detection rate per 100,000 in under 25s is a measure of Chlamydia control. The UKHSA recommends authorities work towards achieving a detection rate of at least 3,250 per 100,000 female population 15 to 24 as a best practice target. Increasing diagnosis rates for chlamydia among people aged 15 to 24 years are largely driven by changes in testing activity through the NCSP although ongoing high levels of condomless sex have also contributed²⁹. Due to its often asymptomatic nature, a high detection rate reflects successful identification of infections that if untreated would lead to serious reproductive health consequences.

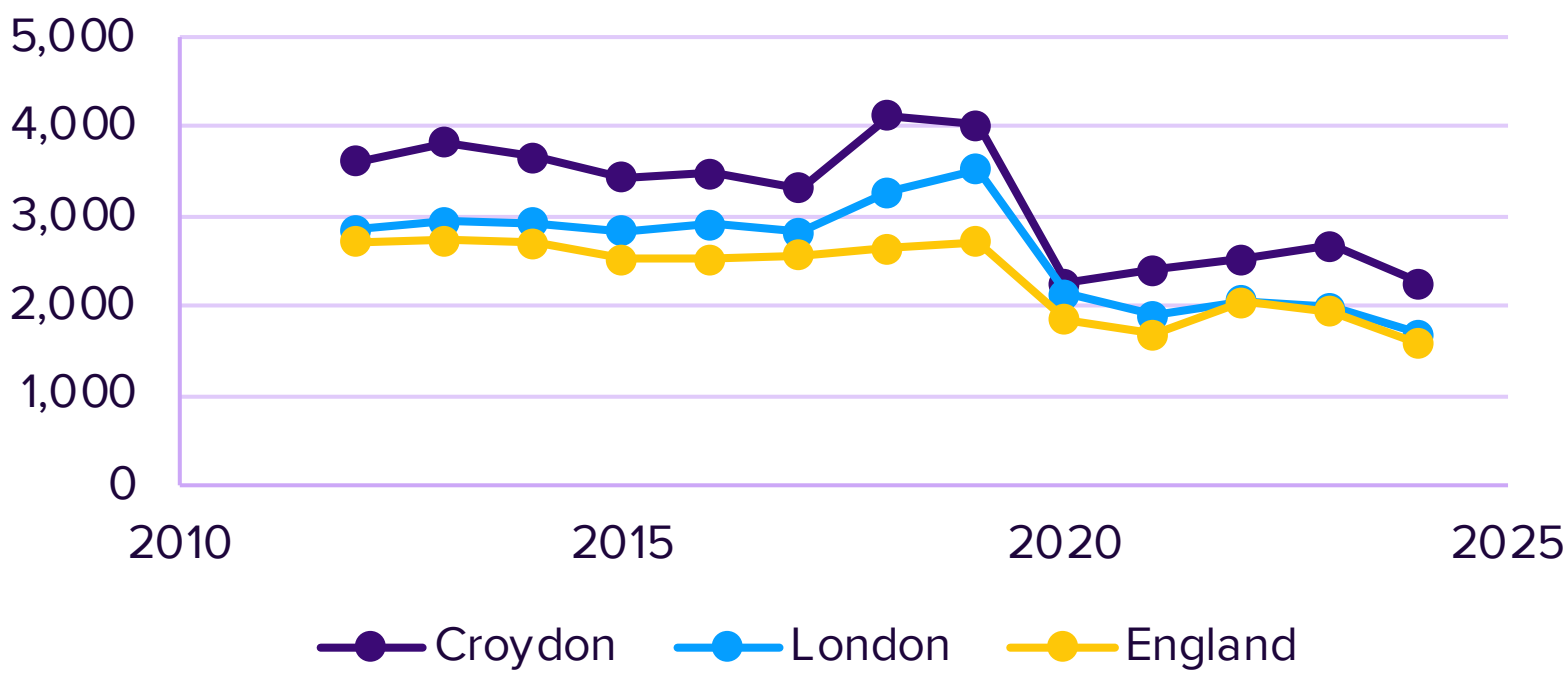
The data shown in the map below indicates lower detection rates in areas within the south and east of the borough which could be reflective of ease of access to testing closer to the north and areas in the centre of the borough. As such, areas with a detection rate of <2,400 per 100,000 could be targeted for increased screening e.g. pharmacies.



Graphic 4: Chlamydia detection rates in Croydon. Source: UKHSA.

Chlamydia detection rate per 100,000 aged 15 to 24 (Female)

- 1 - <1,200
- 1,200 - <2,400
- 2,400 - <3,250
- 3,250 - <4,400
- 4,400+
- Suppressed

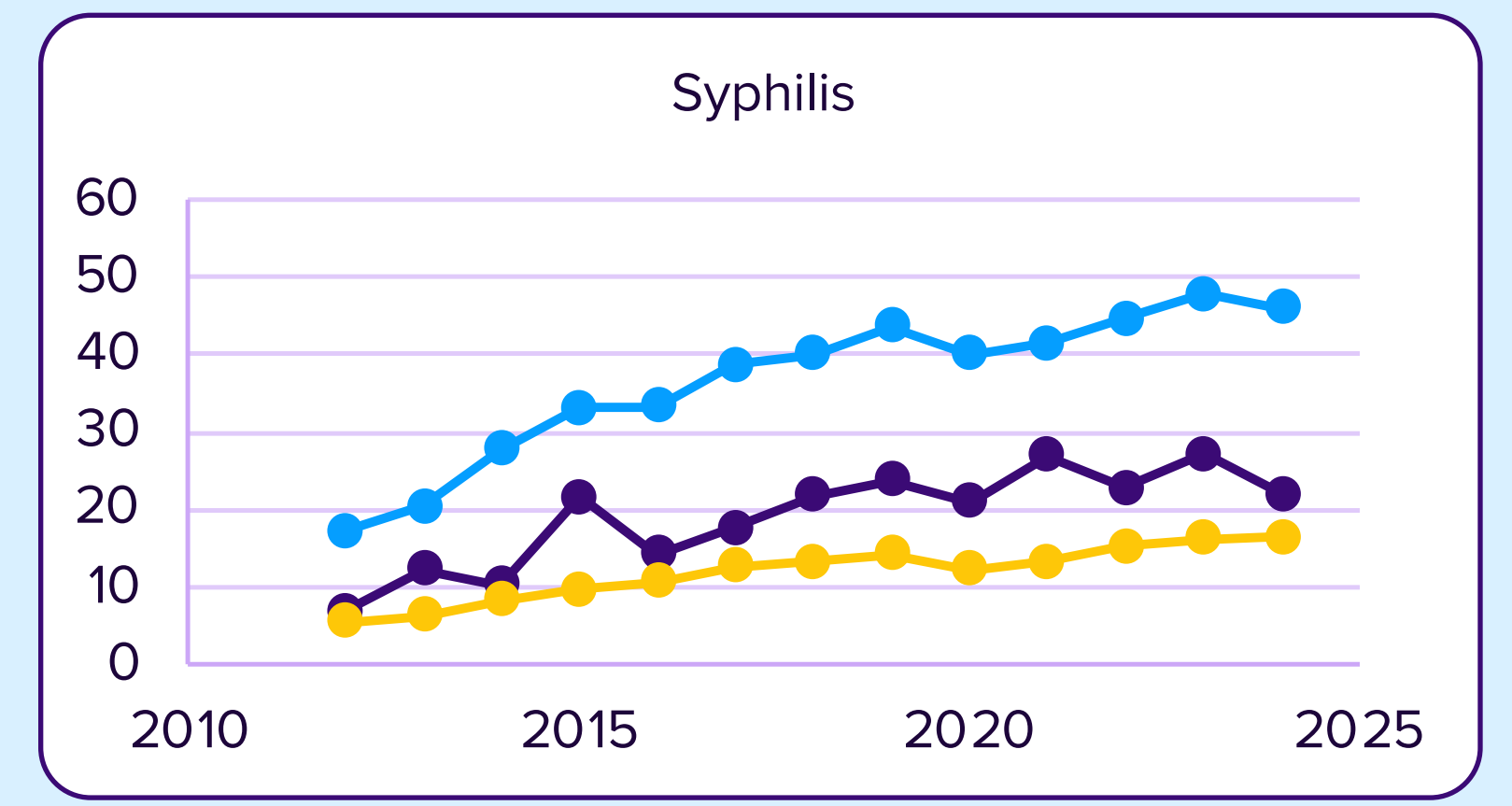
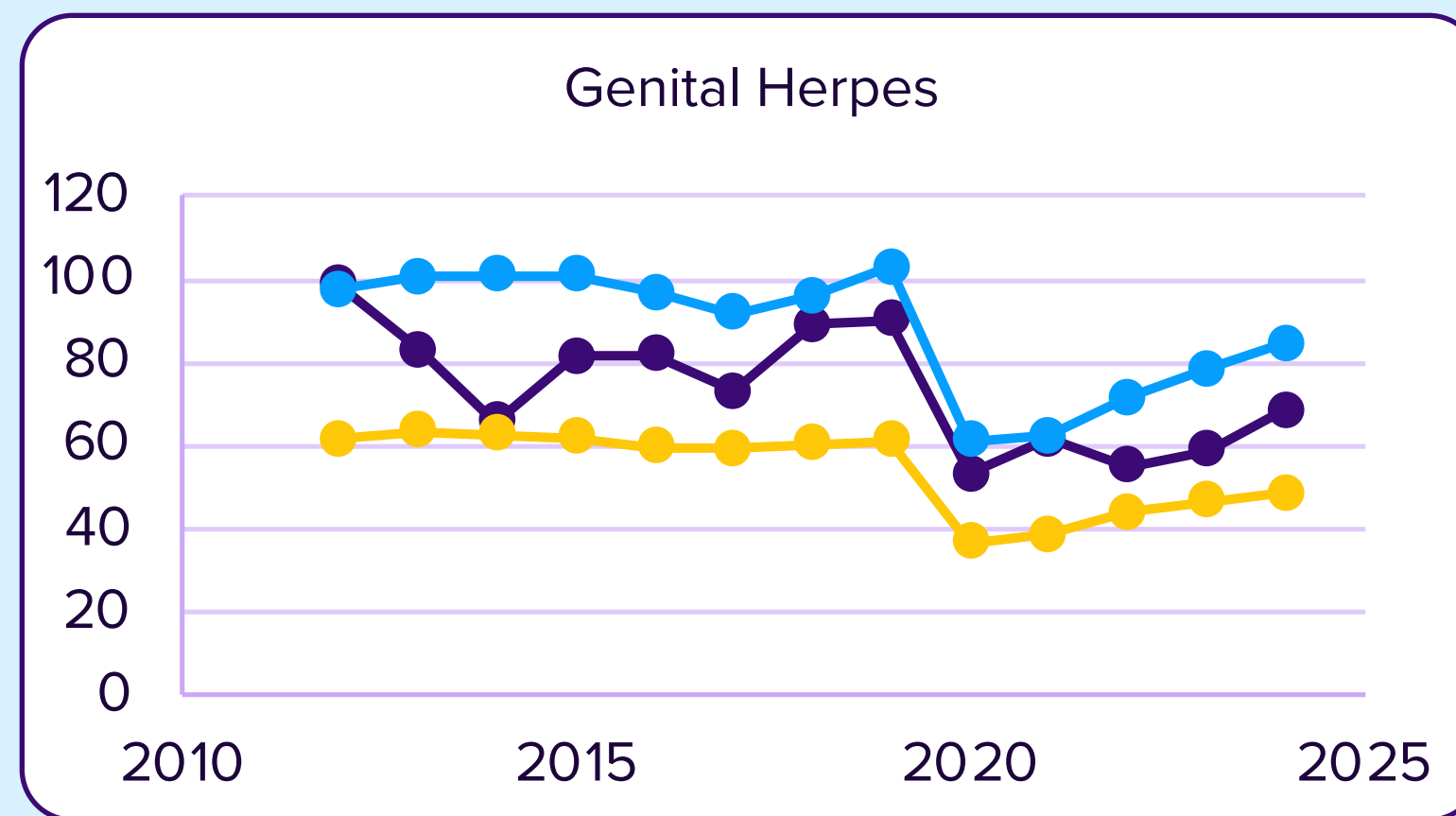
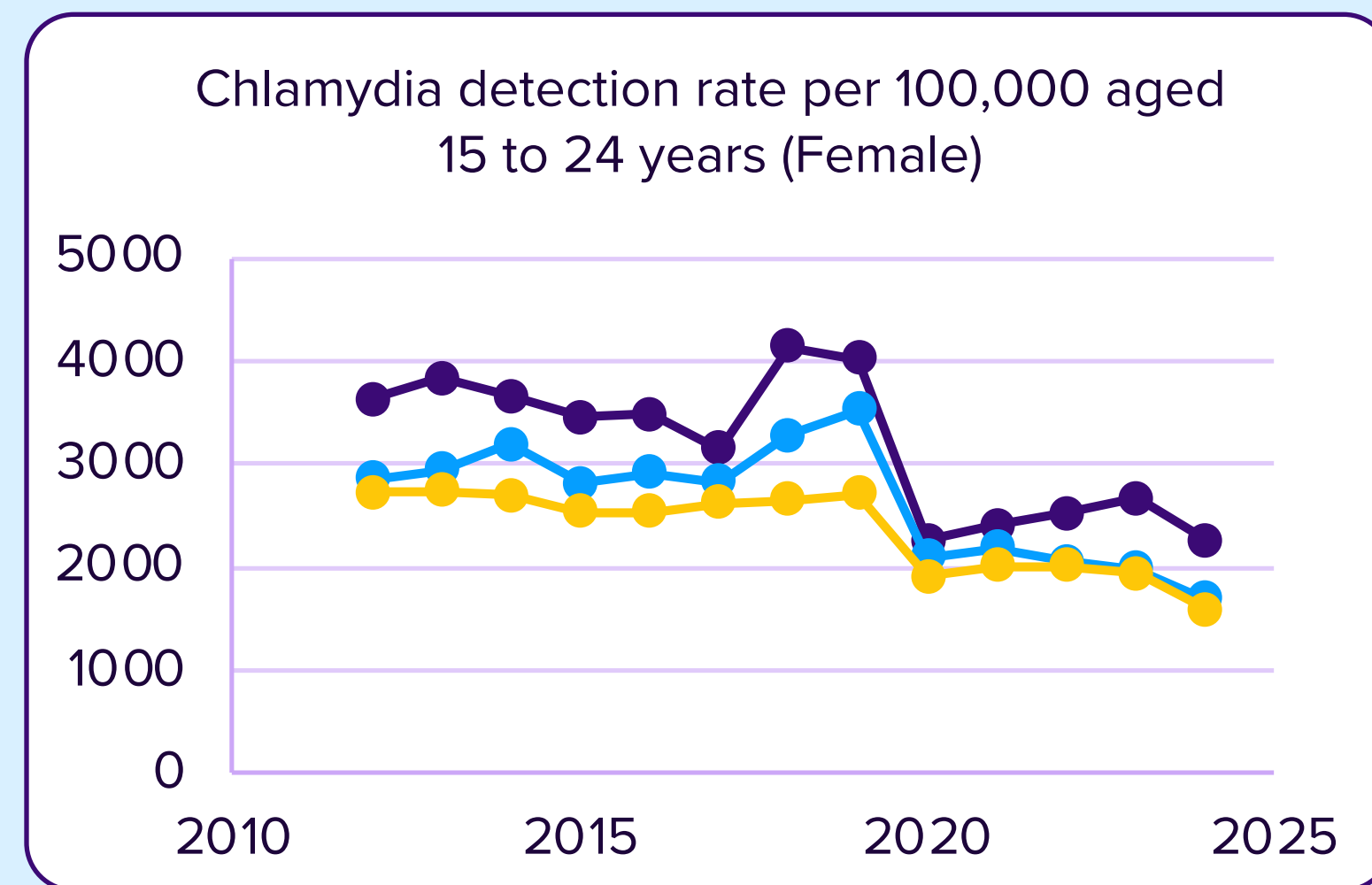
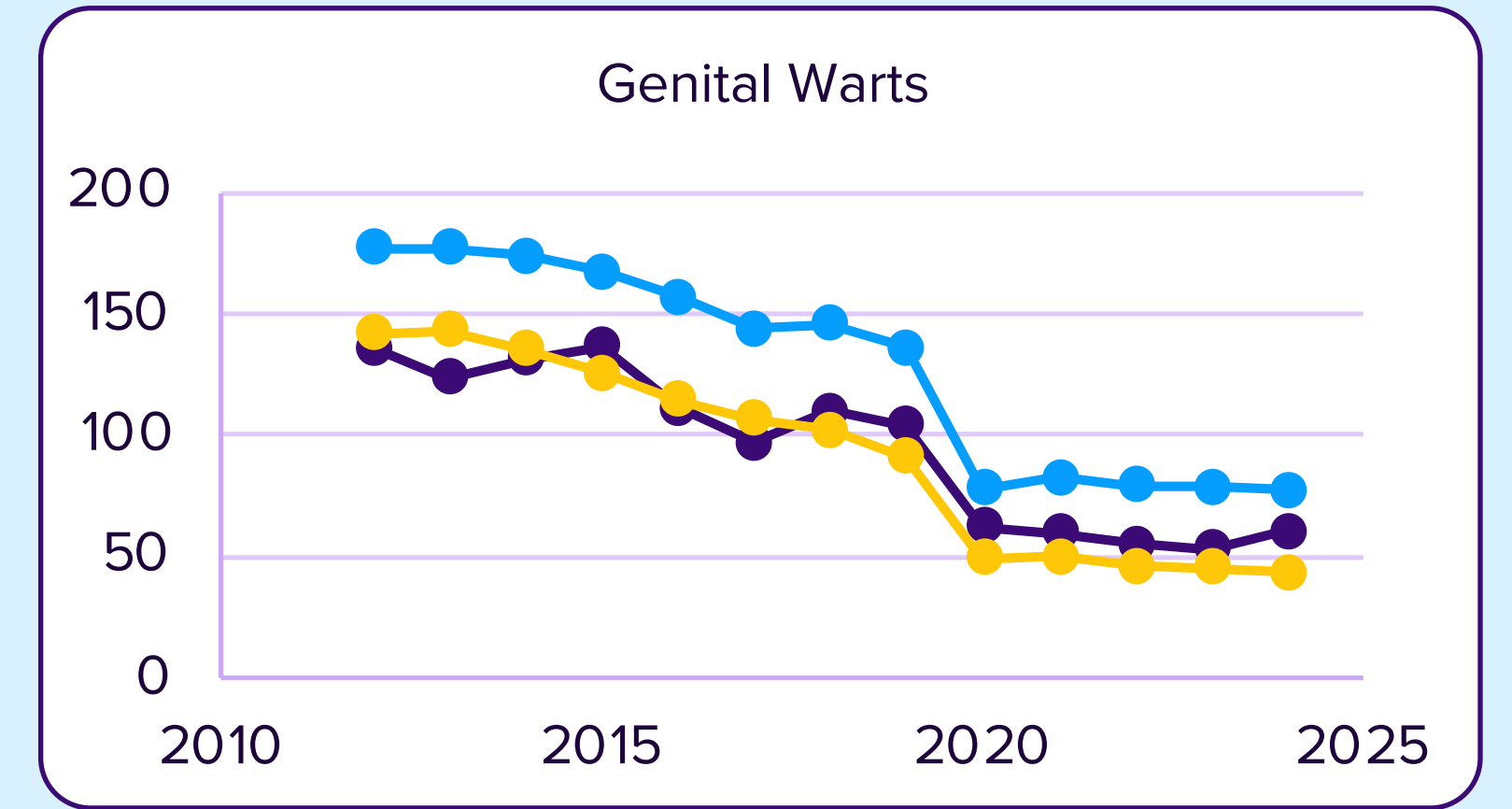
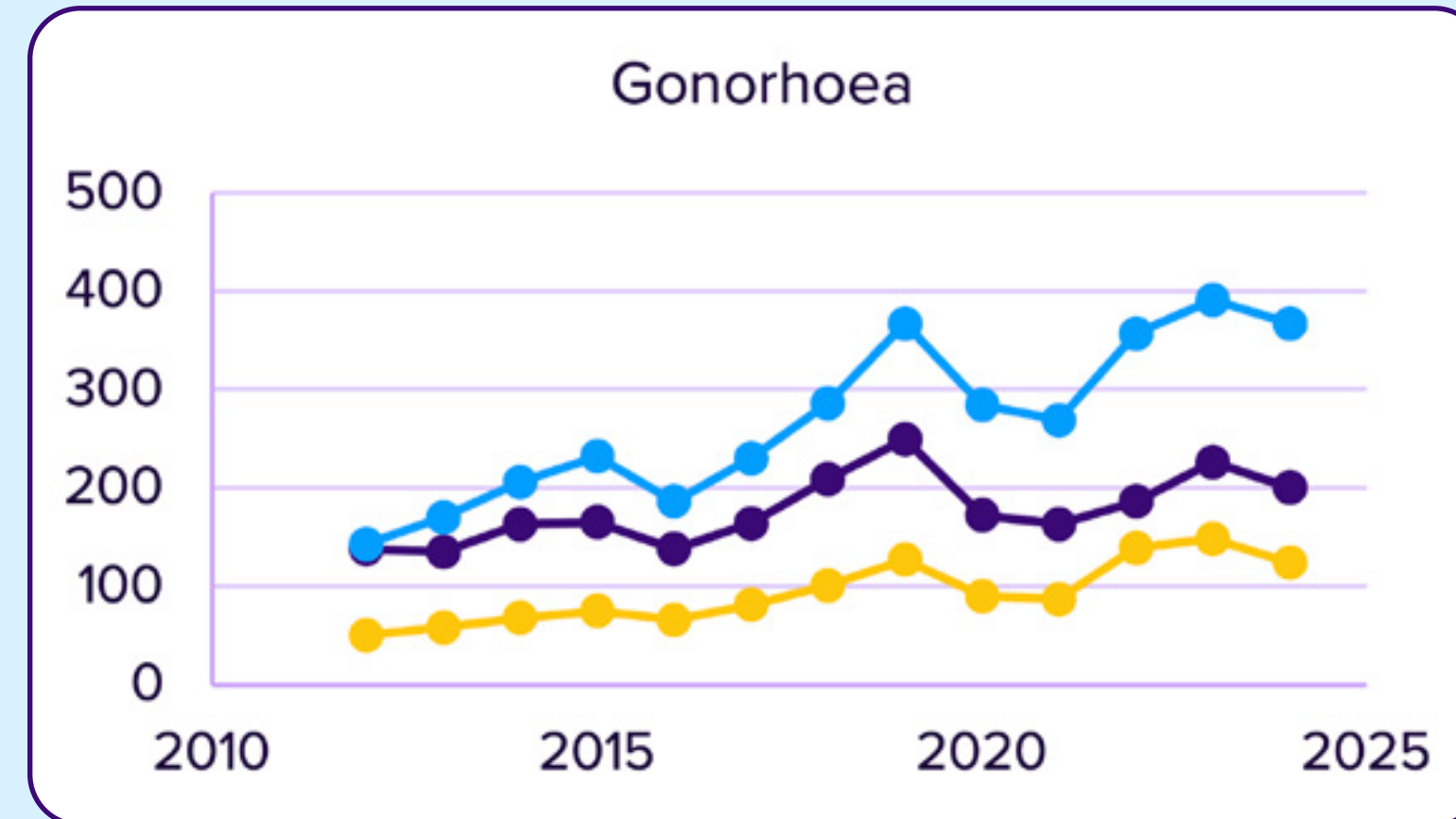
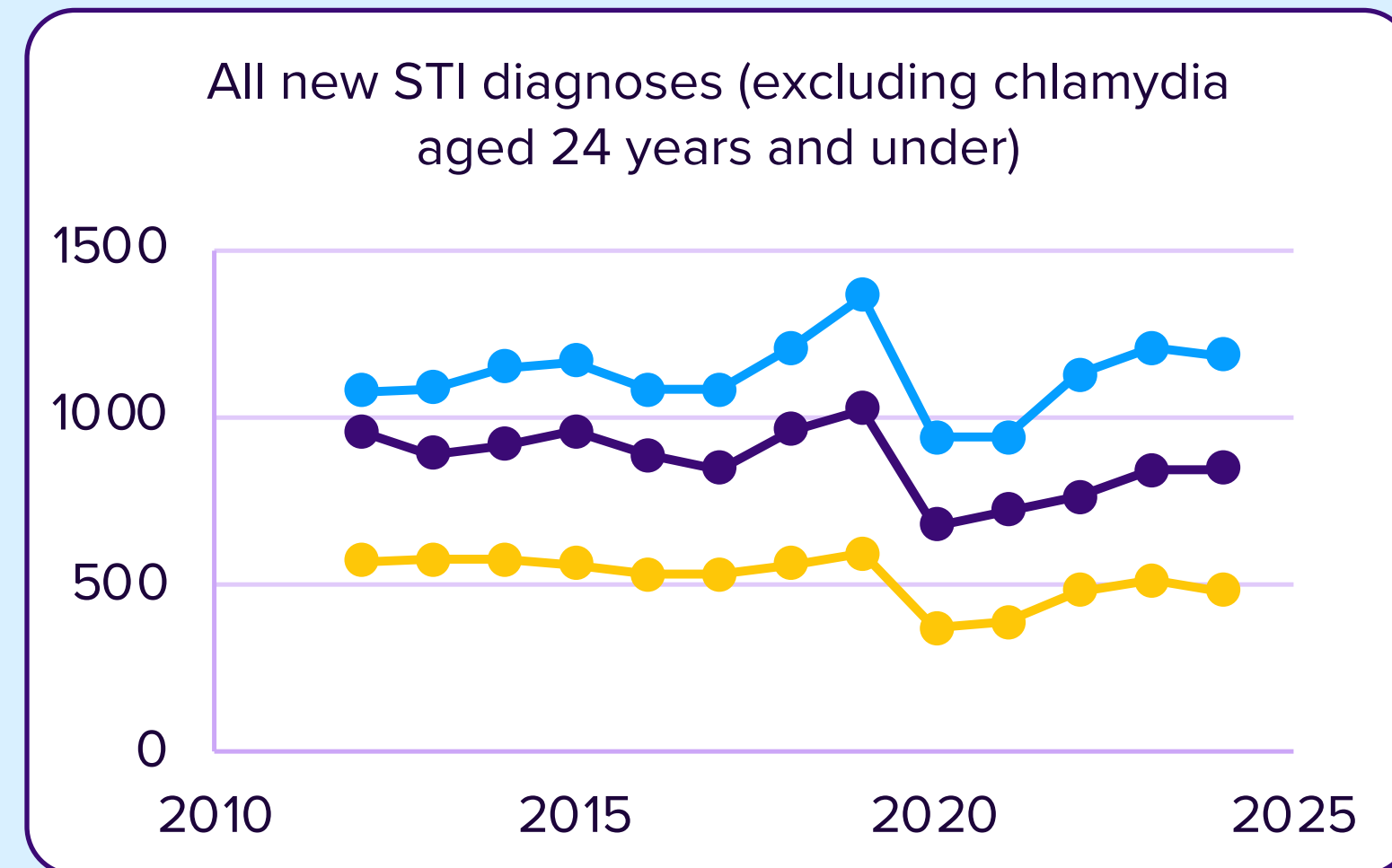


Graph 29: Chlamydia detection rate per 100,000 females aged 15 to 24. Source: OHID Public Health profiles, 2025.

In Croydon, the Chlamydia detection rate for 2024 per 100,000 females aged 15 to 24 was 2,262. When benchmarked against targets this ranks in the “red” zone falling under 2,400/100,000 females aged 15 to 24. These rates have been worsening since 2019 and have not recovered to pre-pandemic levels of around 4,016 in 2019 for example. This does fall above the national rates (1,589) and London regional rates (1,688). This rate places Croydon at the 3rd highest detection rate in London for 2024.



29 SPLASH Report Croydon 2025, UKHSA.



—●— Croydon —●— London —●— England

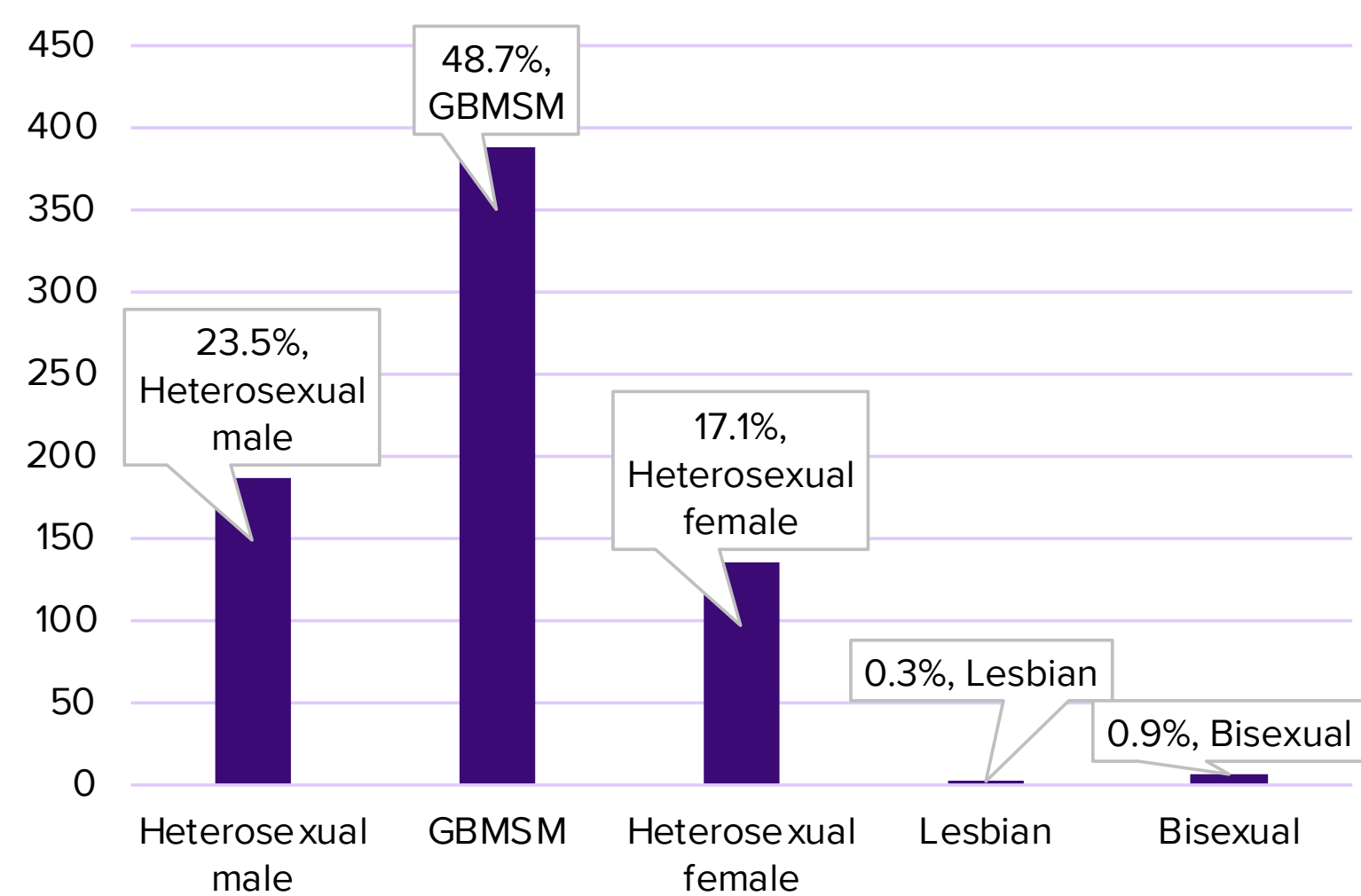
Graph 30: Rates per 100,000 population by diagnosis in Croydon compared to England, from 2012 to 2023. Source: UKHSA.

GONORRHOEA AND SYPHILIS

There has been a long-term trend of increasing gonorrhoea diagnostic rates across the local, regional and national context.

In Croydon in 2024, the Gonorrhoea diagnostic rate was 200 per 100,000 people, with 797 diagnoses overall. Since 2021 these rates have climbed significantly, but from 2023 show signs of slight decline (Graph 30 - previous page).

Gonorrhoea is more prevalent in men than females and specifically within GBMSM. In Croydon, 49% of all patients with Gonorrhoea were GBMSM in 2024.



Graph 31: Patients with Gonorrhoea, by sexual orientation Croydon 2024. Source UKHSA, GUMCAD Reports.

There has been a resurgence of Syphilis across the UK, notably rates in England increased by 15% in 2022 from the previous year. In 2024 in Croydon, the rate for diagnosis of syphilis was 21.9 per 100,000 people. This is above the England rate of 16.5 but significantly lower than the London region of 46. This represents a drop in diagnosis rates by -20.36% in Croydon from 2023, efforts to maintain these decreased levels should be continued.

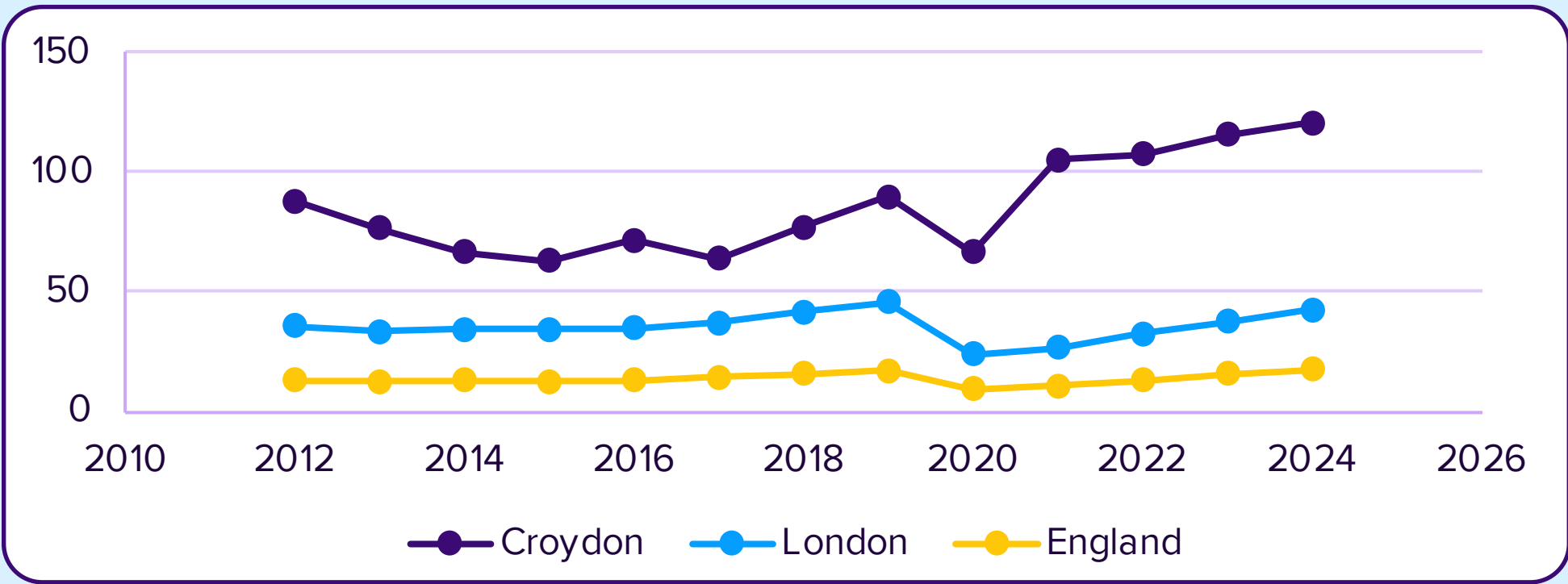
30 Global health sector strategies 2022 to 2030.

TRICHOMONIASIS AND SHIGELLA

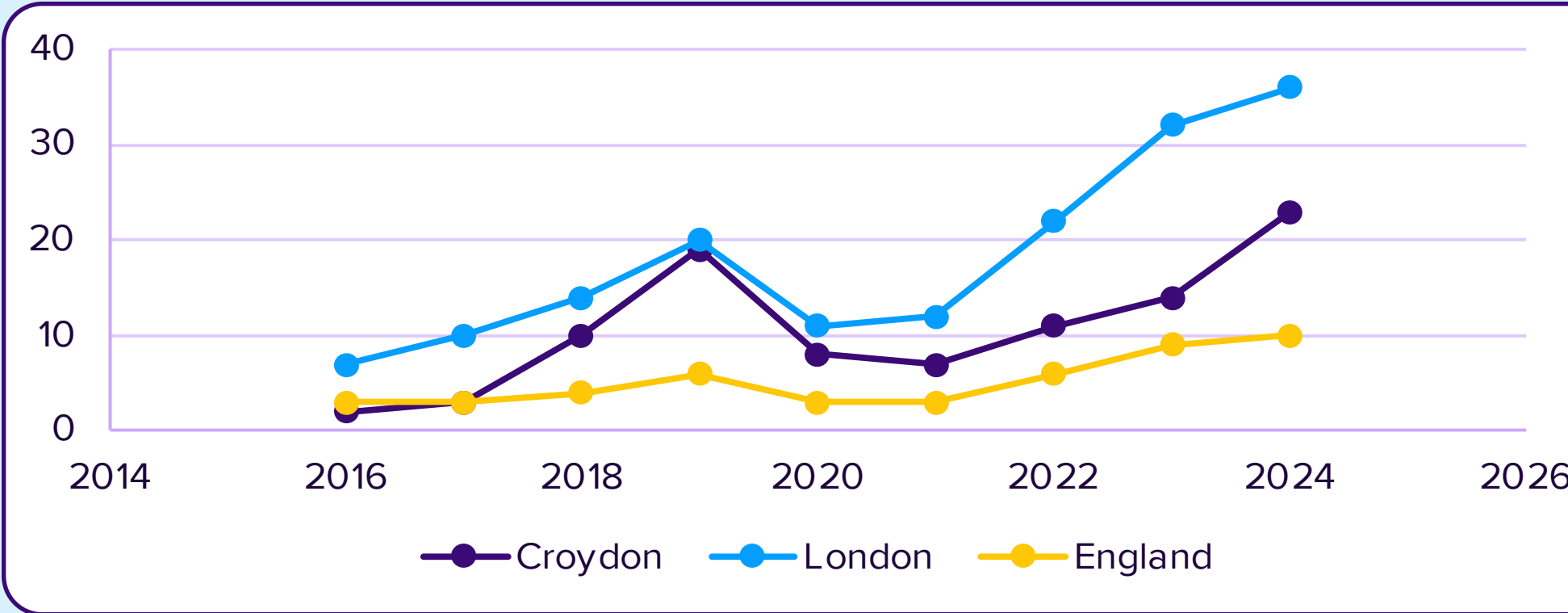
Trichomoniasis and sexually transmitted Shigella are emerging as key priorities in the sexual health landscape. Recent surveillance highlights a disproportionately high burden of trichomoniasis and shigella in Croydon, reflecting unique patterns of local diagnosis and underscoring the need for enhanced awareness, testing, and targeted intervention.

Trichomoniasis is a bacterial infection mostly affecting 15 to 49 year olds. Notably, it is often asymptomatic in males whilst presenting commonly in females with symptoms of itching, discharge and painful urination. The reduction of new cases by 50% is one of the targets set in the WHO Global health sector strategies 2022 to 2030³⁰.

Croydon ranks number one in London and number 2 in England for diagnostic rate of Trichomoniasis (120.4 per 100,000), with 479 diagnoses in 2024. Relative to national levels and other local authorities, this ranking and rate are particularly concerning, with the trend steadily increasing. As such, action should be taken as effectively as possible to ameliorate this.



Graph 32: Trichomoniasis diagnostic rate per 100,000. Source OHID Public health profiles.



Graph 33: Sexually transmitted Shigella spp. per 100,000 adult male population. Source: OHID Public health profiles.

Shigella infection is a bacterial infection that is becoming more widespread across England and other countries worldwide. As it presents enterically, most symptomatic cases present through Primary Care (e.g. GPs, Pharmacies) rather than Sexual health services. Over the last decade, the number of cases of sexually transmitted shigella among GBMSM in England has increased, with concerning increases in antimicrobial resistance. Only a minority of GBMSM are thought to be aware of Shigella and how to avoid it, however, surveillance shows transmission of these infections is commonly associated with high risk behaviours such as sexualised drug use (including 'chemsex') and multiple casual sex partners³¹.

In Croydon, Shigella infections have increased by 64.29% in the past year, and Croydon's rate of 23 new Shigella infections per 100,000 is significantly higher than England's average rate of 10 (2024). Although Croydon remains below the London average for Shigella infections (36 per 100,000), there is a rationale for monitoring this STI due to the large increase in the recent period.

HIV

England has set targets under the Towards Zero plan to end HIV transmission, AIDS and HIV related deaths by 2030. Actions to progress towards this are set out by the HIV Action plan for England 2022-25. Use of condoms, partner notification, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are methods to prevent transmission and remain HIV negative status.

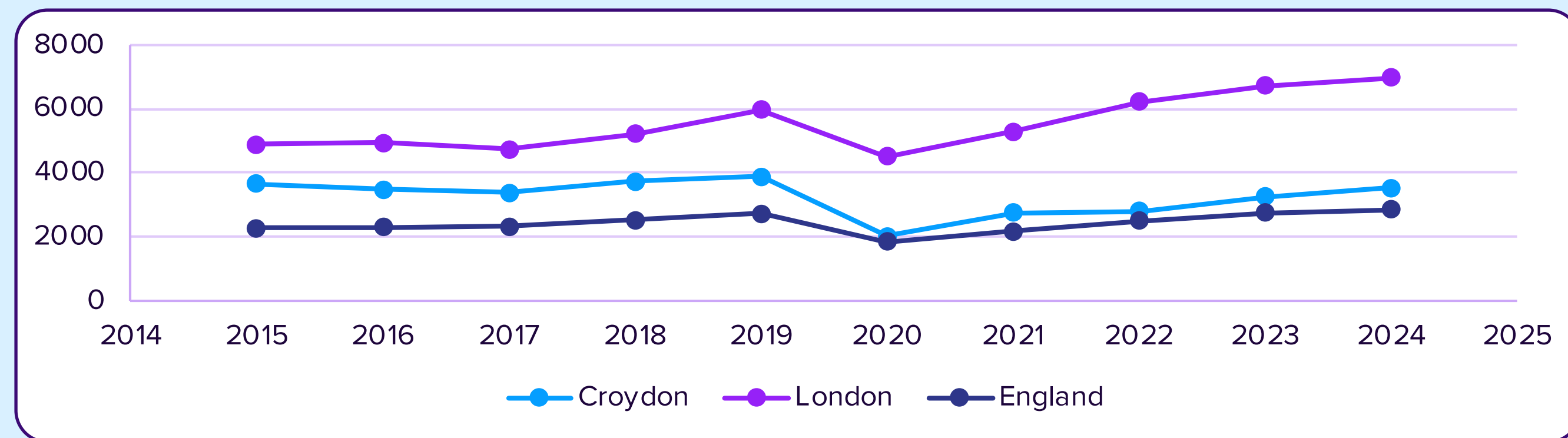
Testing

In the UK, in the period of 2023-24, the number of people being tested for HIV in sexual health services increased by 3%, from 1.278m in 2023 to 1.319m in 2024. Across the key populations facing inequities in HIV burden and access to care, ethnic minorities had the highest proportion of positivity. Despite widespread increases in testing across all ages nationally, 15 to 24 year olds showed a 7% decrease in HIV testing rate in all SHSs compared to a continued increase in the HIV testing rate in other age groups.

HIV testing is an integral component of prevention. Testing is essential to ensure that people living with an HIV infection can gain access to life-saving treatment, in turn, treatment prevents transmission onward by reducing viral load and untransmittable levels. Routine testing even for HIV-negative status individuals also provides an opportunity for awareness raising, signposting and discussions on preventing HIV and safe practices³².

In Croydon, there are several places HIV testing is available in the community, within healthcare settings and options for individuals to self-test/sample within their home. In 2024 in Croydon, 14,019 tests were conducted through sexual health services³³.

In 2024 Croydon's testing rate (3,524.7 per 100,000) remained lower than the London average (6,979.8 per 100,000) but higher than England overall (2,842.7 per 100,000). This represents an increasing trend in testing by 8% since 2023. During the pandemic, testing rates dropped significantly, and since 2021 Croydon's testing rate per 100,000 has increased by 28.5%. However, levels still haven't recovered to the pre-pandemic rates.



Graph 34: HIV testing rate per 100,000 persons resident in Croydon, 2015 to 2024. Source: Office for Health Improvement and Disparities. Public health profiles.

³¹ SPLASH Report, Croydon 2025.

³² Towards Zero - HIV action plan for England from 2022-2025.

³³ UKHSA.

2024	Croydon	Enfield (1st CIPFA neighbour)	Islington	Bromley (geographical neighbour)	London region	England
HIV new diagnoses per 100,000	11.7	12.8	11.7	4.8	10.7	4.7
HIV testing rate per 100,000	3,524.7	4,689.9	13,044.5	3,678.0	6,979.8	2,842.7
HIV diagnosed prevalence per 1,000 15 to 69 year olds	5.69	4.22	6.23	2.86	5.05	2.40
London rank (testing)	7th worst	13th worst	4th best	9th worst	-	-

Table 8: HIV diagnosis compared with CIPFA neighbours. Source: UKHSA and OHID Public Health profiles, 2025.

New HIV diagnoses

The most robust proxy indicator of HIV transmission in the UK is the rate of diagnoses (among individuals where the first positive HIV test occurred in the UK)³⁴. This indicator will be considered within this section.

HIV annual data statistics from UKHSA indicate that nationally, BBV opt out testing in emergency departments have contributed to 8% of all new diagnoses in 2024.

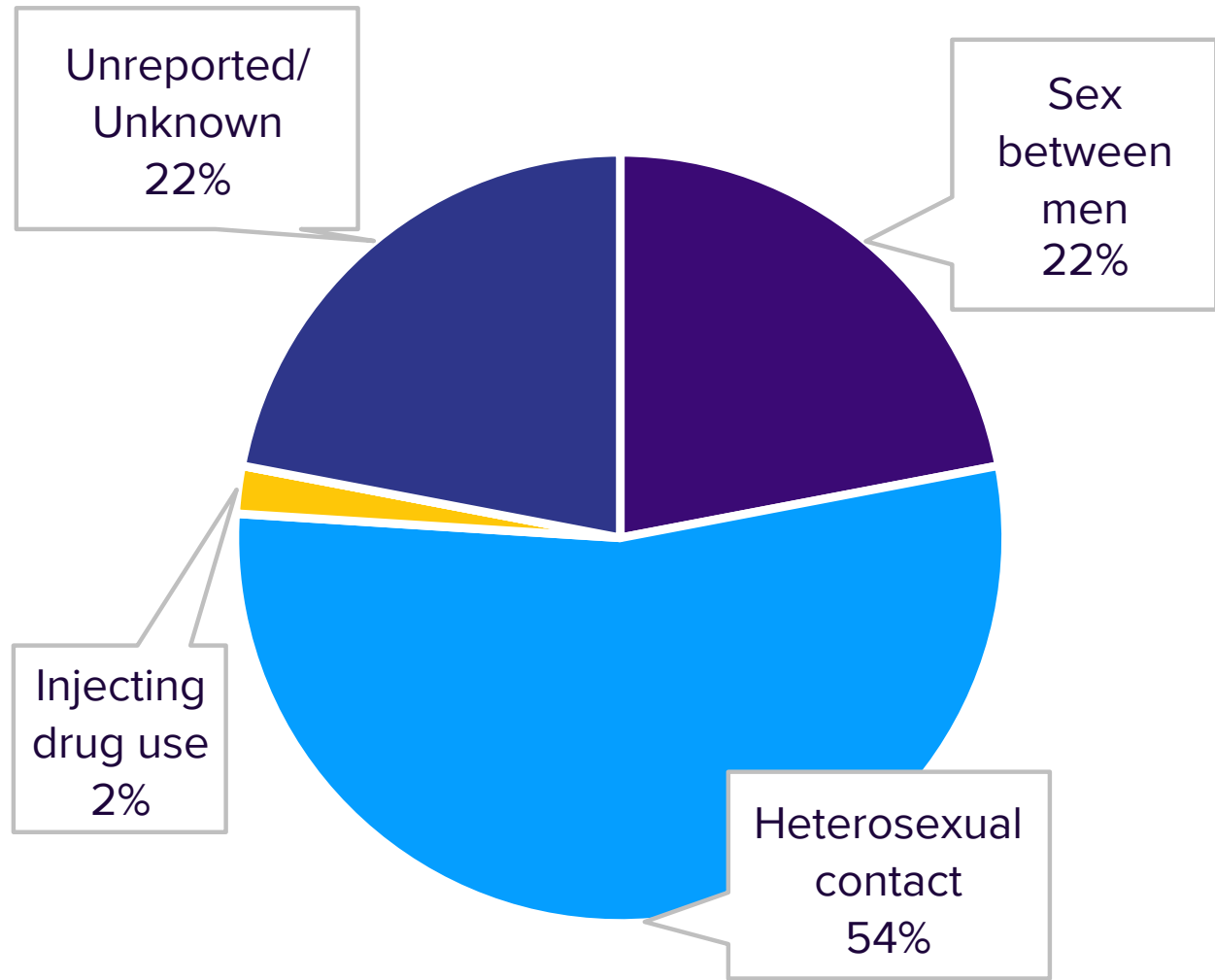
In Croydon in 2024, there was 11.7 new HIV diagnoses (of those first diagnosed in UK) per 100,000 which is similar to pre-pandemic levels. There were 6.6 per 100,000 people diagnosed abroad and continuing care in UK within Croydon in 2024, which is slightly above the London regional average of 5.6.

Across the UK, new HIV diagnoses in England have decreased among GBMSM, largely in white males. Nationally, new diagnoses in England among Black African heterosexual males increased by 15%, and decreased by 5% in Black African heterosexual females³⁵.

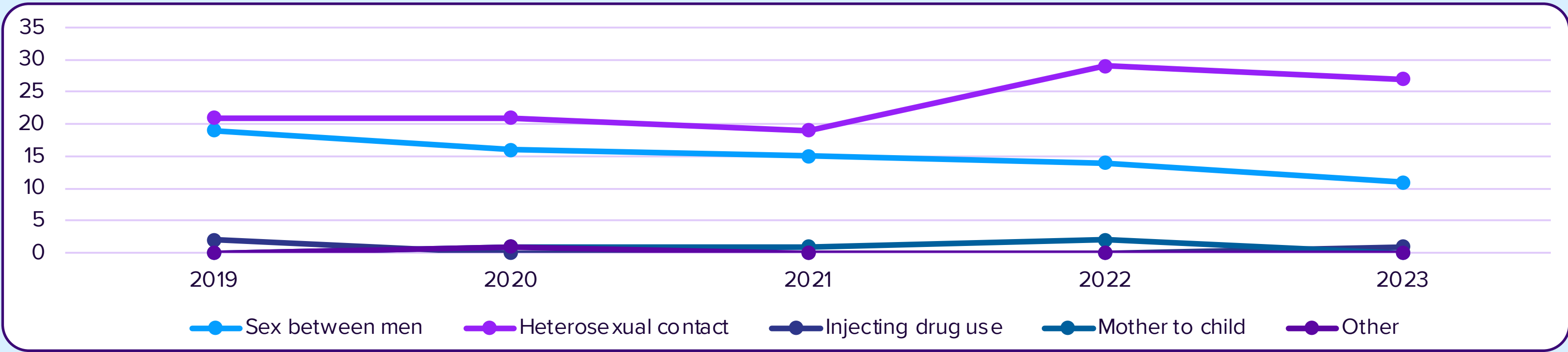
³⁴ SPLASH Report Croydon, 2025.
³⁵ <https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2025-report>.



In Croydon in 2023, the most prevalent exposure category for new diagnoses was heterosexual contact (54%), whilst 22% were within the sex between males category (Graph 23). However, it is important to note that a substantial amount was of unreported or unknown exposure category. The trend shows that exposure due to heterosexual contact has been rising since 2021, whilst exposure due to sex between males has been slowly falling since 2019.

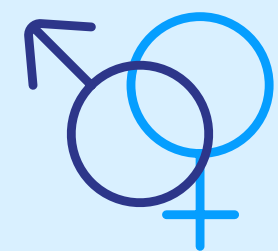


Graph 35: New diagnoses by probable exposure category (percentage) in Croydon, 2023. Source: UKHSA, HARS.

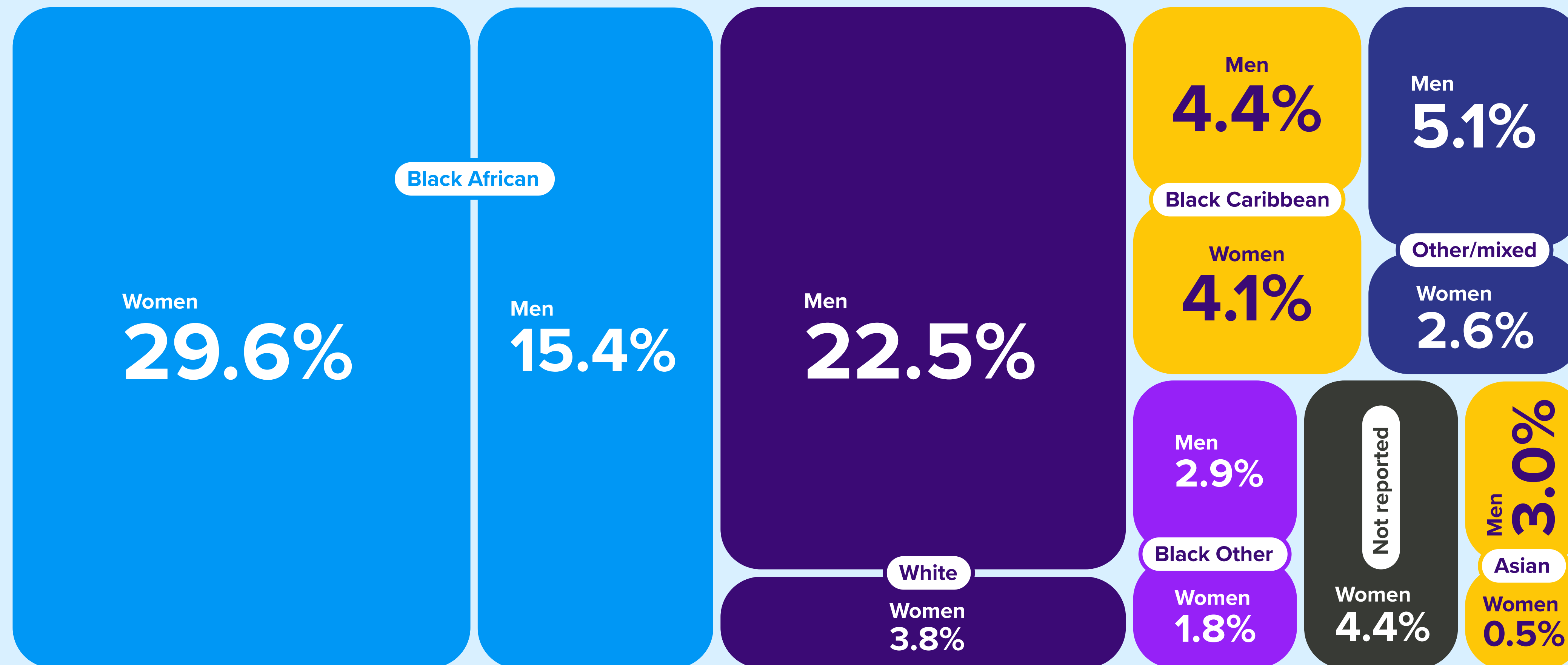


Graph 36: New HIV diagnoses in Croydon by probable exposure category in Croydon, 2019-2023. Source: UKHSA, HARS.



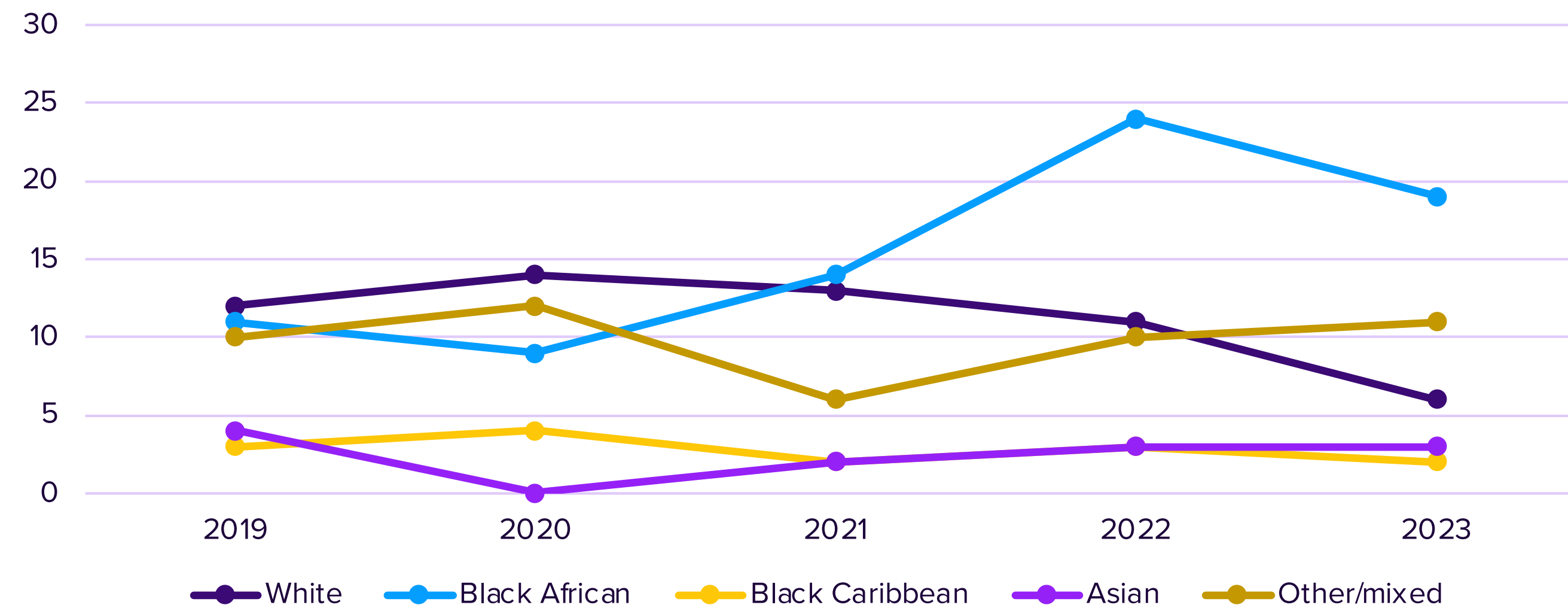


In Croydon, as of 2023 Black African ethnic group currently carry the burden of HIV prevalence across ethnic groups. Black African females are currently disproportionately experiencing the highest amount of HIV prevalence burden across all genders and ethnicities, representing 29.6% of the population seeking HIV care:



Graphic 5: Persons accessing HIV care in Croydon in 2023 by ethnicity and gender. Source: UKHSA, HIV and AIDS Reporting System (HARS).

Trend wise, new diagnoses within the Black African ethnic group have shown to decline slightly from 2022. Small increases have been seen in the number of Asian ethnic group individuals in new diagnoses across Croydon.



Graph 37: New HIV diagnoses in Croydon by Ethnicity (2019 – 2023). Source: UKHSA, HIV and AIDS Reporting System (HARS).

Prevalence and access to care

The rate of people aged 15 to 59 seen at HIV services is a commonly used indicator of HIV prevalence rate. In 2023, 1,433 Croydon residents aged 15 to 59 years accessed HIV care in HIV services, resulting in 5.69 per 1,000.

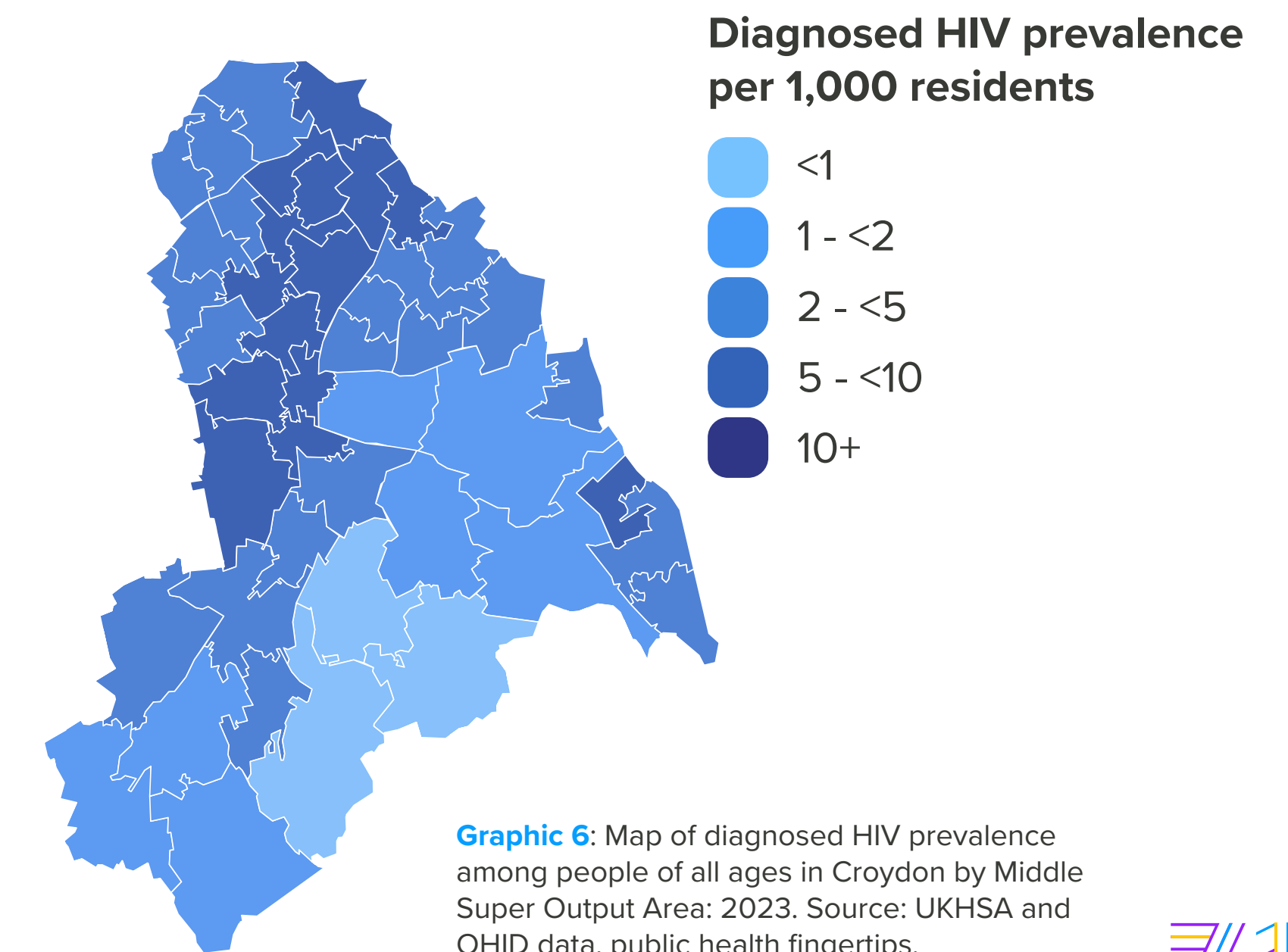
In 2017, HIV testing guidelines were updated by [NICE](#) which was co-badged with Public Health England. This guidance continues to define high HIV prevalence Local Authorities as those with a diagnosed HIV prevalence of between 2 and 5 per 1,000 and extremely high prevalence Local Authorities as those with a diagnosed HIV prevalence of 5 or more per 1,000 people aged 15 to 59 years.

Croydon is considered an area of extremely high (or red category) prevalence with a rate of 5.69. According to BHIVA/BASHH guidance, people who are accessing healthcare in high (greater than 2 to 5 per 1,000 aged 15 to 59 years old) and extremely high HIV diagnosed prevalence areas (greater than 5 per 1,000 residents aged 15 to 59 years old) should be offered an HIV test including within all general medical admissions as well as new registrants in Primary Care in order to increase uptake of testing within those who may be living undiagnosed. Croydon's prevalence levels indicate that more testing needs to take place.

When this is applied to national late HIV diagnosis data, it shows that two-thirds of late HIV diagnoses occur in high-prevalence and extremely-high-prevalence Local Authorities. This means that if this recommendation is successfully implemented in high and extremely-high-prevalence areas, it could potentially contribute to reducing two-thirds of late diagnoses nationally. (UKHSA).

The percentage of people aged 15 years and over accessing HIV care in Croydon who were prescribed ART in 2023 was 97.8%, similar to 98.5% in England.

The percentage of people in Croydon newly diagnosed with HIV in the three-year period between 2021-23 who started antiretroviral therapy (ART) promptly (within 91 days of their diagnosis) was 68.3%, this figure is worse than the England average which is 84.4%. The percentage of adults in Croydon accessing HIV care in 2023 who were virally suppressed (undetectable viral load) was 96.5%, similar to 97.7% in England.



Graphic 6: Map of diagnosed HIV prevalence among people of all ages in Croydon by Middle Super Output Area: 2023. Source: UKHSA and OHID data, public health fingertips.

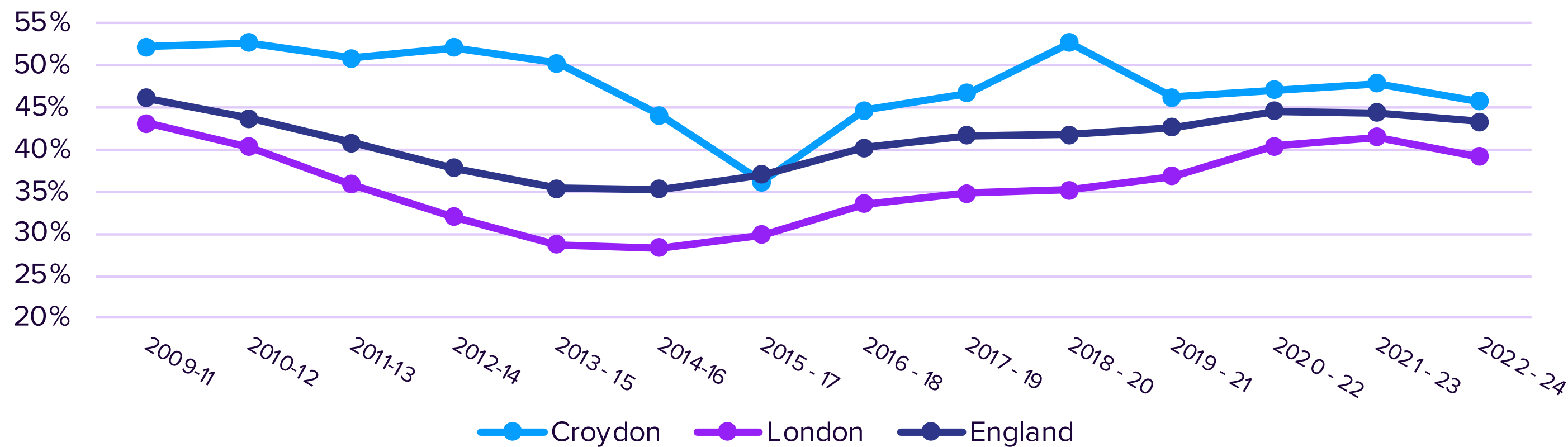
Late diagnosis

Early diagnosis of HIV has been evidenced to be cost-effective with a cost per year of life gained estimated at £1,776. This provides better anti-retro viral therapy (ART) outcomes which can provide a cost per year of life gained of up to £4,639. Further cost savings can be accumulated through preventing onward transmission and avoiding expensive late diagnosis and care³⁶.

Late diagnosis is defined as those diagnosed with a CD4 count <350 cells/mm³ within 91 days of first HIV diagnosis in the UK. This is the most important HIV indicator for HIV related morbidity and short-term mortality. People with a late HIV diagnosis in England in 2022 were 10 times more likely to die within a year of their diagnosis compared to those diagnosed promptly³⁷.

In Croydon, 2022-24 data shows that 45.7% were diagnosed late. Late diagnosis in Croydon is similar to England average (43.3%) but higher than the London region average (39.2%) when compared to statistical neighbours. This indicates a substantial number of individuals living undiagnosed and representing the 10th highest late diagnosis rate in London region.

The driving factors behind this are likely multifaceted however likely reflect the high proportion of the local population who are Black African (due to the higher prevalence in this group), missed opportunities for early diagnosis, and relatively high numbers of new arrivals to Croydon from countries/areas of high HIV prevalence, including sub-Saharan Africa.



Graph 38: Percentage of late HIV diagnoses (all CD4<350) in Croydon compared to the London region (statistical) and England: 2009-11 to 2021-23. Source: OHID Public health profiles.

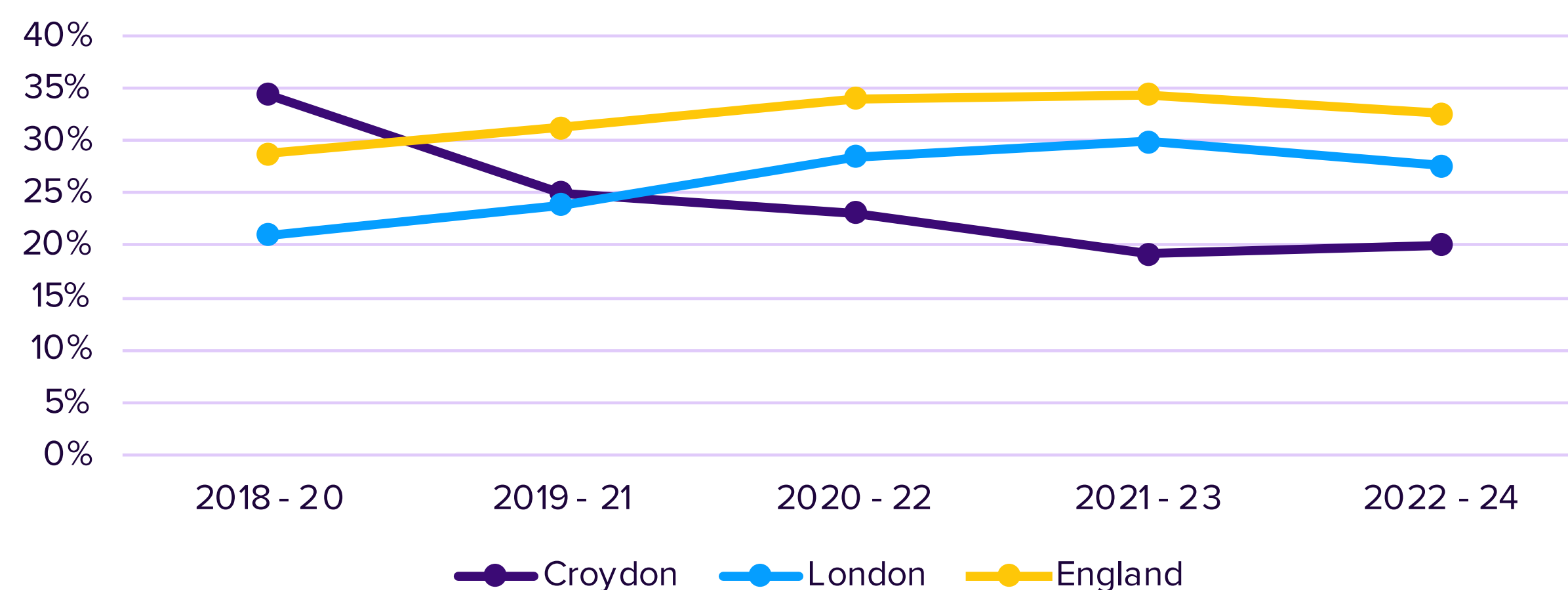
However, the trend for late diagnosis over time shows slight improvement and represents a 2.2% decrease since the period of 2021-23. Within the past decade or so, since 2009-11 late diagnosis in Croydon has shown improvement by 6.5% from 52.2% late diagnosis rate.



³⁶ The Cost-Effectiveness of Early Access to HIV Services and Starting cART in the UK 1996–2008, Beck et al 2011.
³⁷ <https://www.bhiva.org/HIV-testing-guidelines>.

In 2018-20, Croydon's late diagnosis rate suffered significantly, showing a marked increase in the percentage of those diagnosed with HIV at a late stage. Since then, the late diagnosis rate has improved by 7%.

Late diagnosis in GBMSM within Croydon has been decreasing slowly since 2018-20. In Croydon, the proportion of GBMSM on average diagnosed late is lower than across the London and England average.



Graph 39: HIV late diagnosis in GBMSM in Croydon. Source: OHID public health profiles.



³⁸ <https://www.hivpreventionengland.org.uk/e-learning/prep-training-for-professionals/what-is-prep/>.

³⁹ SPLASH report 2025.

On average heterosexual males are often diagnosed with HIV at a later stage. In Croydon in 2022-24, 63% of heterosexual males were diagnosed late. This trend has shown slight decline over time but remains higher than London and England levels of 51.2% and 54.3% respectively.

Nationally, the number of late diagnoses in heterosexual females have increased slightly between 2023-24. In 2022-24, 54% of heterosexual & bisexual females in Croydon were diagnosed late. This trend is worse than the England and London average levels however is showing steady decline since 2018-20.

Prevention (including PrEP use)

Condom use, partner notification and use of PrEP and PEP are important aspects of maintaining HIV negative status of those at risk of HIV.

HIV PrEP is a drug that can be taken to prevent acquisition of HIV before exposure to HIV. This is recommended for individuals at high risk of exposure to HIV, and is taken as part of a multifaceted approach to prevention³⁸. Routine PrEP commissioning was rolled out in England in 2020 and along with this, key indicators were added to UKHSA data to inform service improvement.

In 2023, 10.1% (132,299) of HIV-negative people (1,313,780) accessing specialist SHSs in England were defined as having a PrEP need. Among these, 73.0% (96,562) initiated or continued PrEP³⁹.

Across the UK, numbers taking PrEP through sexual health services continue to increase, with a 7.7% increase from 2023-2024. In Croydon in 2023, the proportion of all HIV negative individuals accessing specialist sexual health services who were at substantial risk for HIV and therefore have a need for PrEP was 8.2%.

Current service provision

The below table shows the variety of places HIV testing can be accessed in Croydon.

Clinical and Primary Care	Community based	Self testing/sampling
Croydon Sexual health clinic	Kunsaka - At CVA resource centre (Thursday drop in or by appointment).	Online postal kit requested through CSH.
The Point young people’s clinic (as part of CSH)	AIDS Health Foundation provides testing through - The carers support centre and the Wellness centre (CBME forum).	Freetest.me (chlamydia and gonorrhoea as standard but may be offered GUM kit).
Emergency department opt out testing		HIV Self-sampling test offer by national government (time limited; for about a month around HIV testing week).
General Practices	Spectra - Croydon Town Hall.	



Table 9: HIV testing services in Croydon. Source: Croydon Council.

Treatment and care for people living with HIV includes use of ARTs as a result of diagnosis or preventatively pre or post-exposure via PrEP or PEP within some groups, as well as wraparound support from a number of providers. The below table outlines current service provision in Croydon and key providers.

Area	Service/provider
Medical care, support and counselling	Croydon sexual health service.
PrEP and PEP	Croydon sexual health service.
Mental health support	South London and Maudsley (CASCAID) service is linked with Croydon’s HIV clinic to provide mental health support.
Peer support	Spectra and partner organisations.
Advocacy and signposting	AHF, Spectra, Kunsaka.
Prevention and support (incl. counselling, family support, group sessions, targeted outreach)	Spectra (partnered with Metro and Kunsaka by subcon-tract to deliver targeted support and online sessions).
Wider campaigns & support	CGL Drug and Alcohol support. London HIV Prevention Programme - Do It London. Outreach at local and regional events e.g. Pride and Croydon Pride, National HIV testing week, attendance at Croydon community venues e.g. Libraries & town hall.

Table 10: HIV support services in Croydon. Source: Croydon Council Public health.

ENGAGEMENT WITH STRATEGIC AND COMMUNITY PARTNERS

Discussions in the format of semi-structured interviews and focus groups with key service, community and voluntary sector partners across the sexual health and integrated services were held. The aim of this was to understand key challenges, themes and examples what has worked well. This resulted in key findings, gaps and areas of improvement as well as highlighting good practice. The below summarises the output of this consultation as it relates to HIV and STI.

Key observations

- Severe healthcare inequalities within population of cohort living with HIV, this cohort was described as ageing and largely Black African ethnicity wise, these groups are missed by traditional testing settings.
- HIV cohort presents with multiple morbidities, presenting to hospital extremely unwell with AIDS defining illness and suboptimal outcomes.
- PLWH not engaging in care often rank highly in IMD.
- High levels of stigma in the population amongst general public and healthcare workers.

Areas of good practice

- Opt-out testing in Emergency departments has been somewhat of a “life-saver” giving the chance to intervene at an early stage of HIV infection before individuals become severely unwell.
- Working in partnership with SLaM to offer mental health support for PLWH has “changed the landscape for Croydon”. There are easy, clear referral pathways and gold standard mental health care.
- HIV Peer support service works well when patients engage and seeing it as part of the service rather than opt in.
- Support providers innovative use of messaging functions on social networking apps (e.g. Grindr) to increase engagement with support services and testing offer.
- Individuals in service delivery recognised the large positive impact brought about by roll out of online testing kits.



Areas of challenge or barriers

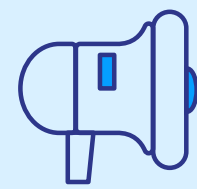
- Difficulty keeping HIV patients engaged in care – denial and stigma play a part in this.
- Not having stable housing and being able to meet food requirements of ART prevents HIV patients from being able to maintain treatment.
- HIV patients who can't engage consistently in treatment could end up with a higher mortality rate and worsened outcomes, potentially ending up in hospital.
- Tackling wider lifestyle stressors and barriers HIV patients face including immigration, mental health issues, poly-stigma. Housing is a particular issue as stable housing is required to successfully adhere to HIV treatment.
- Liaison and buy in from GPs is variable, and can be difficult to get them to engage in conversation and action around HIV.
- Tackling stigma on both sides (i.e. healthcare professionals and patients), although there was recognition that some practices are displaying HIV confident ways of working.
- Delays in the returns of STI results in the e-service – this was understood to be driven by a disruption in the Post Office in Croydon, which has since been resolved by introducing a 48-hour tracking method.
- Discussions with Croydon Age UK highlighted sexual health within the community of older people as an important issue to build more borough specific evidence around. Croydon specific insights, trends or anecdotal evidence behind this was not identified in engagement, aside from recognition of the borough having a particularly concentrated older population, with 121 care and nursing homes providing approximately 3,000 beds. Wider national evidence was drawn on from the Age UK national network and the broader literature. This broad evidence indicates that STI rates and sexual activity among older adults, particularly in care home settings, are rising. However, stigma around the topic remains significant, and a key challenge is the lack of education or training for professionals supporting this group in navigating sexual health issues. These challenges can be compounded by loneliness, emotional wellbeing and age-related physical changes that affect sexual health.



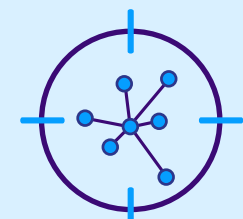
KEY RECOMMENDATIONS



STI1 - Continue efforts to successfully keep syphilis rates in the population low for example through maintaining existing screening rates, raising awareness and signposting around Doxy PEP use in key populations (e.g. MSM).



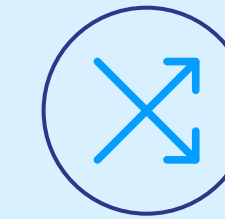
STI2 - Raise awareness around symptoms of trichomoniasis and shigella, particularly targeting GBMSM and people engaging in risky behaviours who face high burden. This will also ameliorate risks of anti-microbial resistance growing in the population.



STI3 - Enhance chlamydia detection programmes and consider broadening screening offer where possible – including encouraging more pharmacies in targeted areas (e.g. the south and west of the borough) to participate.



STI4 - Focus on mitigating STI reinfection rates in target groups with high burden or risk i.e. young people and women in the borough, and understanding key drivers behind reinfection rates.



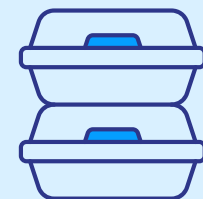
STI5 - Cross-promote programmes and campaigns across services e.g. C-Card, STI Screening, employing the Making Every Contact Count approach to maximise the reach of commissioned services.



HIV SPECIFIC RECOMMENDATIONS



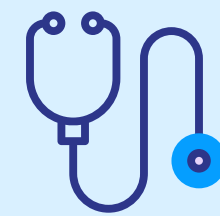
HIV1 - Consider how the HIV clinic can access and liaise with key Council departments for support with housing, benefits and care packages.



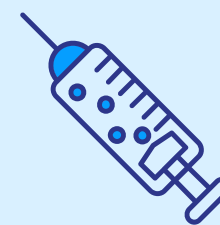
HIV2 - Map and promote wider support available around housing and food poverty (including access to food banks) particularly for people living with HIV, to enable them to meet food requirements for treatment.



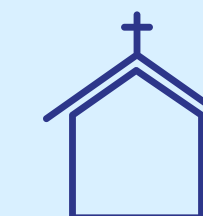
HIV3 - Expanding HIV peer support offer more broadly.



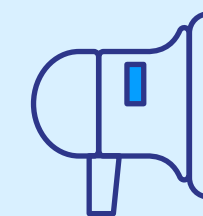
HIV4 - Engage with General Practices to empower GPs to become more HIV confident. Focus on tools/education to be able to support those at risk of HIV and people living with HIV in a non-stigmatising way.



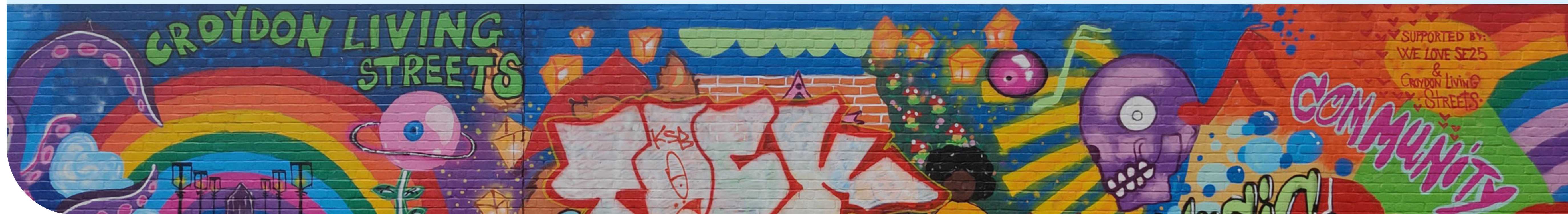
HIV5 - Work alongside health and wider partners to improve access to new opportunities in the HIV prevention and treatment landscape e.g. long acting injectables. Support delivery and workforce to ensure they are skilled and prepared to deliver injectables, ensuring equity of access in implementation.



HIV6 - Work with key community leaders such as faith leaders in Black African communities to engage these groups as a priority, amplify prevention messages and focus on tackling stigma around testing/HIV prevention e.g. working with local churches to promote testing.

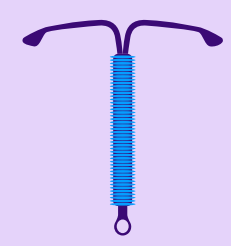


HIV7 - Raise awareness around prevalence and address stigma around HIV among healthcare workers (such as within hospital settings and social care) and amongst the general public.



5. Reproductive health

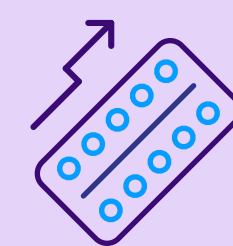
This section provides an overview of key trends, challenges and areas of good practice with regard to contraception and abortion services in Croydon while also reviewing access to LARC uptake as a focus area.



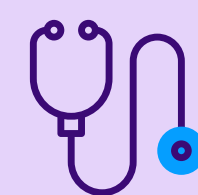
Contraception remains one of the largest areas of service demand in Croydon, although there are variations in LARC and contraception uptake.



Feedback from engagement and survey results indicate ongoing unmet need linked to ease of access, awareness, stigma and personal choice.



Other challenges include high rates of abortion and under 18 conceptions widely in Croydon across ages, compared to other areas and repeat termination, however there are indications of recent decline in these trends.



Termination services continue to face challenges with repeat terminations and engaging patients in contraception following abortion.



CONTRACEPTION

The national government guidelines and Faculty of Sexual and Reproductive Healthcare (FSRH) highlight the importance of knowledge, access and choice for all females and males to all methods of contraception with the aim of helping reduce unplanned pregnancies. Good contraception services through the evidence base have been shown to lower rates of teenage conceptions⁴⁰.

Contraception in Croydon, aligned with national policy, is available to people of all ages for free from a variety of services including specialist and non-specialist sexual health services, young people’s services, GPs and some pharmacies (registered to deliver the NHS Pharmacy Contraception Service), online through the CSH clinic Croydon e-service (only oral contraceptives) and termination services.

See table 12 which shows the number of pharmacies and GPs able to deliver LARC, EHC and contraception.

GPs		Enhanced sexual health pharmacies
Birdhurst Medical Practice	Norbury Medical Practice	A-Z Healthcare (UK) Ltd Thornton Heath Pharmacy Fieldway Pharmacy Fishers Enmore S K Shah t/a Allcorn Chemist
Brigstock Medical Practice	Old Coulsdon Medical Practice	
Denmark Road Surgery	Parchmore Medical Centre	
East Croydon Medical Centre	Parkside Group Practice	
Eversley Medical Centre	Portland Medical Centre	
Fairview Medical Centre	Queenhill Medical Practice	
Farley Road Medical Practice	Stovell House Surgery	
Keston House Practice	The Whitehorse Practice	
Leander Family Practice	Thornton Heath Health Centre	
London Road Medical Practice	Upper Norwood Group Practice	
Mersham Medical Centre	Violet Lane Medical Practice	
Morland Road Surgery	Woodcote Medical	

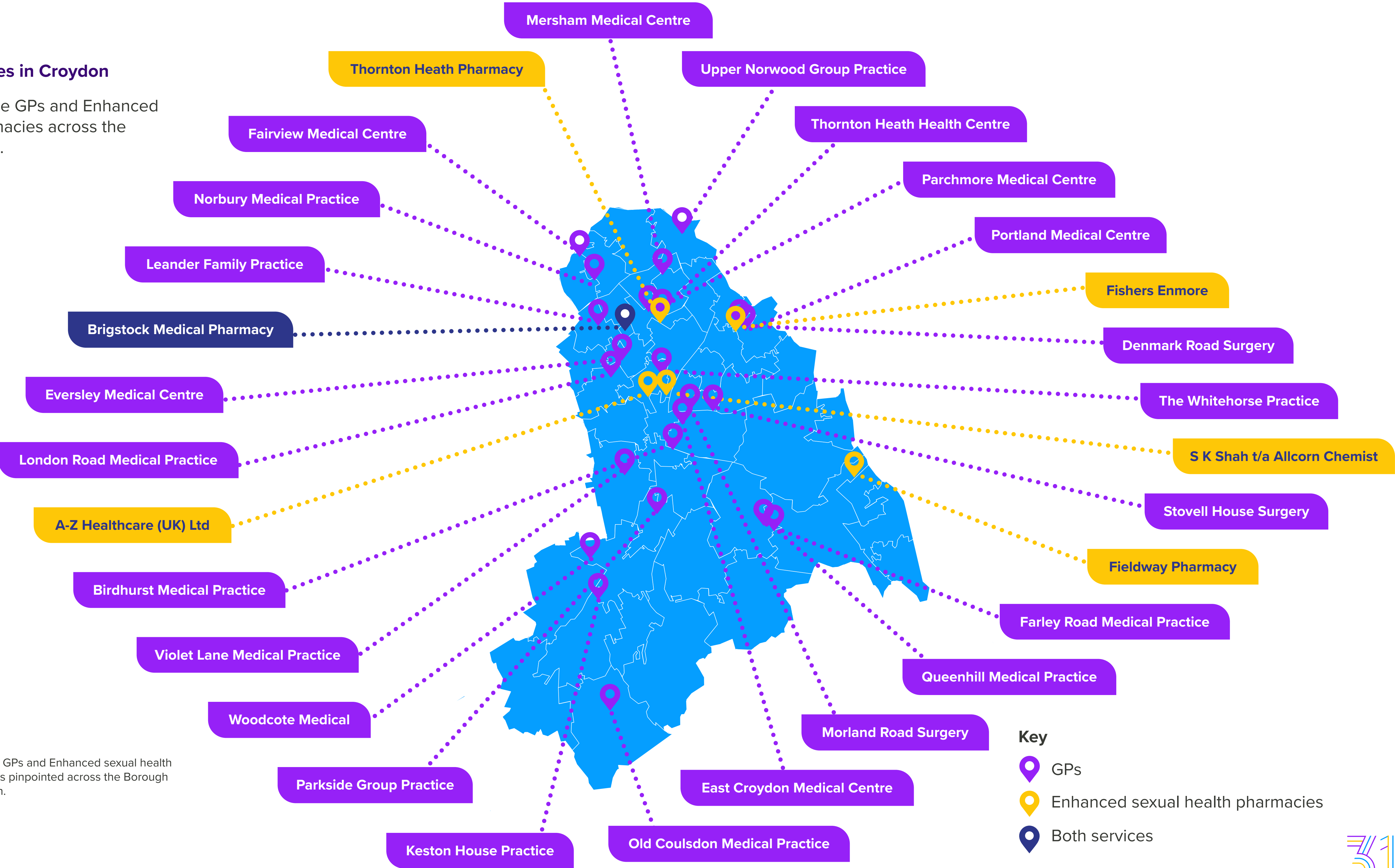
Table 11: GPs in the borough contracted to provide LARC and the pharmacies contracted to provide enhanced sexual health services including EHC and Oral contraceptives. Source: Croydon Council.

The following page includes all GPs and pharmacies mentioned in the table, pinpointed on a ward map of Croydon.

40 SPLASH Report, Croydon 2025.

GPs and pharmacies in Croydon

This map displays the GPs and Enhanced Sexual Health Pharmacies across the borough of Croydon.



Graphic 7: GPs and Enhanced sexual health pharmacies pinpointed across the Borough of Croydon.

The choice out of the options available will be guided by user-preference, clinical indications and effectiveness. This is split into the following:

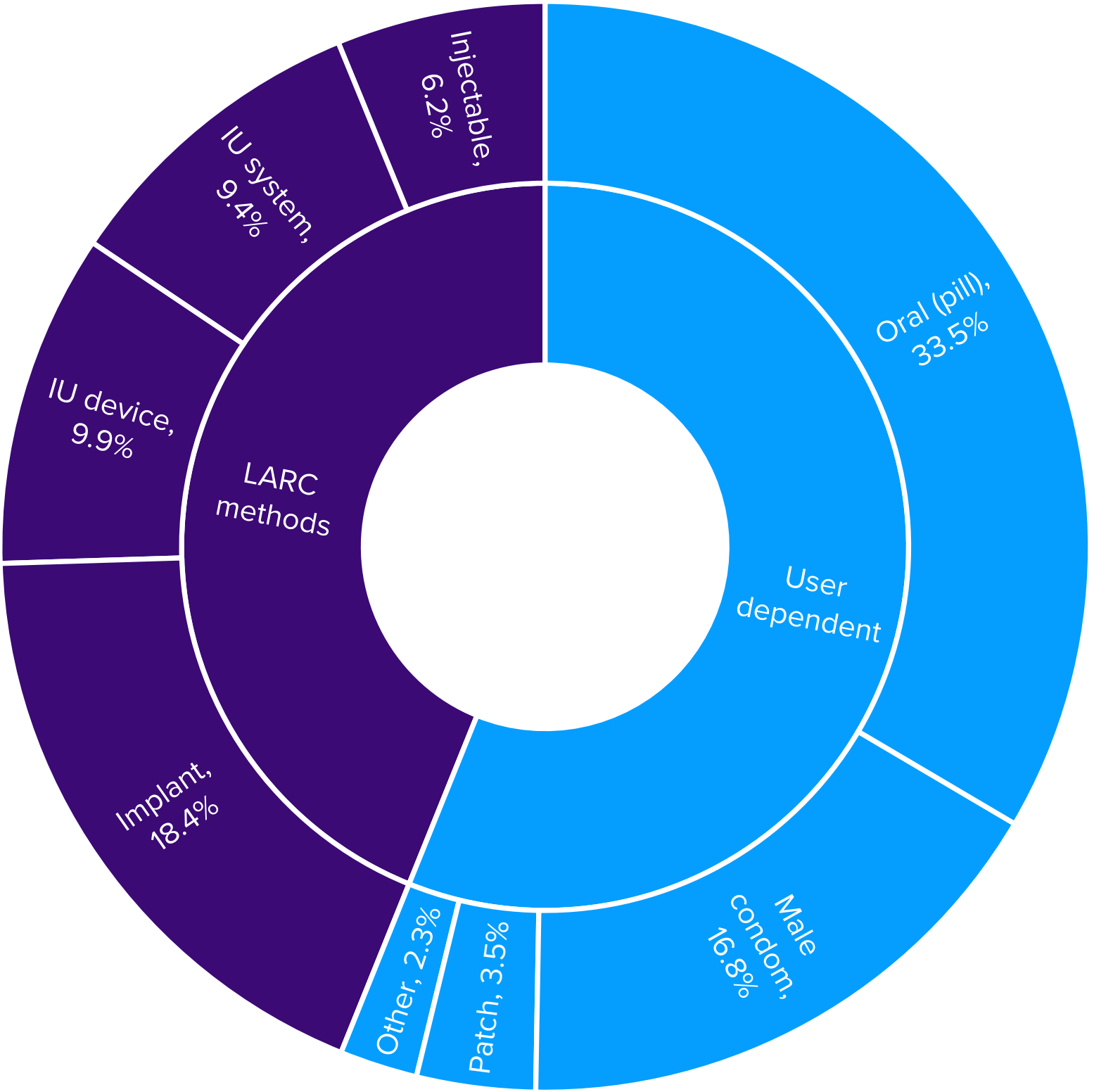
- **Non-user dependent:** Where user failure is least likely to occur, either because it is intended to be permanent, e.g. sterilisation, or due to being a long-acting reversible contraceptive (LARC) method⁴¹. These are defined in NICE guidelines as methods which require administration less than once per cycle or month, these include the intrauterine device (IUD), the intrauterine system (IUS), the contraceptive implant, and injectables. Effectiveness for these remains high even with less than perfect use.
- **User dependent:** Where user failure is more likely to occur e.g. patches, vaginal rings, oral contraceptive pills, condoms, diaphragms and fertility awareness methods, these require users to remember to use them daily, or each time they have sex, depending on the method. Effectiveness of these methods drop considerably with inconsistent or imperfect use.
- **Emergency contraception:** these include the IUD, which can be used up to five days after unprotected sexual intercourse or contraceptive failure, and two types of emergency hormonal contraceptive (EHC) pills, one for use within 3 days, and another for use within 5 days.

In 2024, 6,500 contacts with sexual and reproductive health dedicated services⁴² were made with Croydon residents for reasons of contraception⁴³. This is a 21% decrease from 2023, where 8,200 contacts were made for reasons of contraception. SHRAD data shows that 3% of all resident females aged 15 to 44 in Croydon had used services for contraception reasons. This is a drop from the previous year where 5% had used services for reasons of contraception.

⁴¹ <https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2023-24/methods-of-contraception>.
⁴² This includes family planning services, community contraception clinics, integrated Genitourinary Medicine (GUM) and SRH services, and young people's services.
⁴³ SHRAD 2024.
⁴⁴ This data excludes contraception provided in outpatient clinics and GPs, as well as contraception purchased over the counter in pharmacies or retail settings.

This data shows the main method of contraception chosen was user dependent methods with the Oral pill being the most popular option. Within LARC methods, more females chose the implant over other LARC methods⁴⁴.

2,700 females had a main contraceptive method in use in 2024. This is an estimated 3.1% percent of all resident females aged 15 to 45 (based on Census demographic data). 56% of those with a main method were using a user dependant method, whilst 44% of those were using a LARC method. Compared to England averages, 46.4% using a user dependant method and 53.6% using a LARC method nationally, Croydon's contraception split is slightly more skewed further towards User dependant methods.



Graph 40: Main Contraceptive method, Croydon residents, 2024. Source: SRHAD.

LONG ACTING REVERSIBLE CONTRACEPTION

The effectiveness of the barrier method and oral contraceptive pills are reliant on correct and consistent use. By contrast, the effectiveness of long-acting reversible contraceptive (LARC) methods are not user-dependant on daily concordance. LARC uptake in England is 17 percentage points higher than a decade ago (2014-15) with 54% of females in contact with SRH services for contraception were using a LARC method²⁶.

Research suggests LARC methods have an important role in contraception and increased uptake is said to reduce drivers of unintended pregnancy and teenage conceptions.

In Croydon, LARC is delivered by GP practices and the sexual health clinic, as well as at the termination provider (MSI) as part of a consultation or following access to a termination.

FIGURES AND TRENDS IN CROYDON

The figure on the next page (Graph 41) shows a summary of key indicators around contraception in Croydon in 2023.

In 2024, approximately 530 emergency contraceptives were provided by sexual and reproductive health services. In Croydon in 2024, overall 4 females were provided emergency contraceptives per 1,000 population (13 to 54) lower than the London rate of 8 per 1,000. Within the 13 to 15 age category the rate of females per 1,000 provided emergency contraception was 1 which was in line with the London average.



The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the London region.

Compared to England:

● Better ● Similar ● Worse or ● Lower ● Similar ● Higher or ○ Not compared



Graph 41: Showing key contraception indicators in Croydon compared to England (2023 data). Source: SPLASH Report, Croydon 2025.

FOCUS ON LARC DATA

Strategic public health priorities aim to ensure people have diverse choice of effective contraceptive methods in order to accommodate patient preference and minimise rates of unplanned pregnancy. Increases in LARC uptake and other LARC related indicators provide broader proxies for a wide level of access to the full range of contraceptive methods available to all.

The total rate of LARC (excluding injection) that was prescribed in Croydon overall (within Primary Care, specialist and non-specialist SHS settings) was 34.9 per 1,000 females aged 15 to 44 years in 2023. This was lower than the rate of 43.5 per 1,000 females in England.

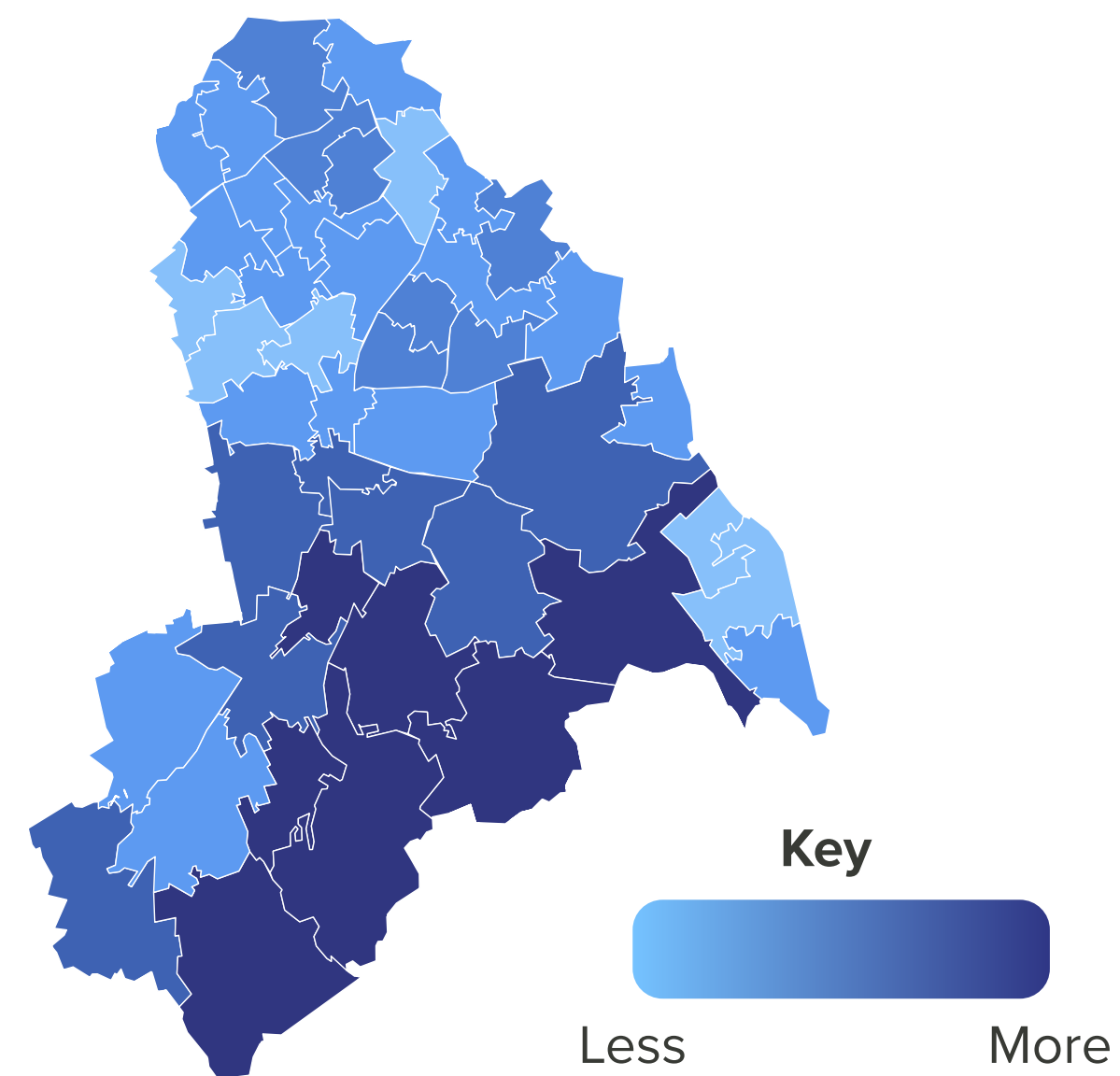
The latest OHID data from 2023 shows Croydon's rate of LARC prescribed in Sexual and Reproductive Health services (excl. injections) was 15.5 per 1,000 females aged 15 to 44. This represents a 0.2% increase from 2022 and is similar to the England average of 18.0 but significantly lower than the London average (23.8) and statistical nearby neighbours.

The rate of GP prescribed LARC (excl. injections) was 17.4, although lower than the England average of 25.6 it is much higher than the London average of 9.8 and ranks 5th out of London boroughs⁴⁵.

Of the females attending SRH services in the year who have a recorded main method of contraception, 32.6% of females under 25 had LARC as their main method, and 43.4% of females over 25 had LARC as their main method.

It is important to note that the provision of LARC is typically reflective of local service delivery models and geographies. Provision of LARC through Primary Care may be more frequent than in SRH services, this is common in rural or semi-rural areas and may reflect more access to Primary Care than SRH services. In Croydon, this data indicates that there is good access to LARC through Primary Care, however through SRH services less LARC is being delivered which may be reflective of service models, ease of access to clinic or patient preferences.

Geographically, ICB data shows that the rate of patients with coil insertions is concentrated towards the south of the borough, which overlaps with locality areas exhibits lower levels of deprivation. Further investigation may be needed to give further context and supporting evidence for underlying drivers of geographic variation beyond deprivation. Additional data analysis would be needed to support these conclusions as ICB data includes coils fitted for non-contraceptive reasons.



Graphic 8: Rate of patients with coil insertions (IUS) per 10,000 in South West London. Adapted from South West London ICB data.



⁴⁵ OHID, Public Health profiles, 2025. <https://fingertips.phe.org.uk/>.



ENGAGEMENT WITH STRATEGIC AND COMMUNITY PARTNERS

As well as discussions with key third sector and service partners, a survey was undertaken on contraception and LARC as part of the engagement process for this needs assessment. There were 28 respondents who were all resident in Croydon or who had a connection to Croydon. Demographics of these 28 respondents is included in the Appendices.

Other key observations

When asked if there was any reason they did not use contraception, 29% responded with the option “I don’t want to use it” and 50% responded with “I don’t need it”

50% had accessed this method in a sexual health clinic and 25% with their GP. This was fairly in line with the way that people reported they would prefer to access contraception in the future, 27% preferred their GP, 33% preferred through a sexual health clinic and 13% preferred through a walk in clinic.

Areas of challenges or barriers

- When asked what was difficult about their experience, the most commonly cited issues were around accessing appointments at a time that suited them (e.g. the weekend), challenges around side effects and wait times.
- Key concerns for young girls related to contraception include wanting to understand more about side effects and having the ability to choose a method based on priorities.

“Was not told about the side effects.”

“Waiting time too long.”

“Speed.”

Key quotes

“Not much consideration if you’re in pain.”

“Would have been better if I could have had this on a Sunday.”

“Given incorrect advice multiple times, doctors hung up the phone before appointment is finished or say they will call back and they don’t.”

What has worked well

- When asked what was positive about their experience, respondents mentioned good interactions with staff that were understanding and non-judgemental, respondents showed clear understanding that the pill is freely available and displayed knowledge of routes to access (e.g. GP or sexual health clinic).

“Some doctors are friendly.”

“Had a telephone call with Farley road GP an appointment was booked the week after.”

Key quotes

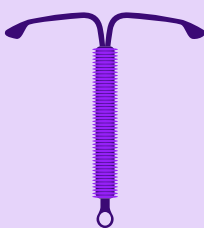
“Access and cost.”

“Staff were lovely, she made me feel like I could talk to her about what was going on. [I felt] at ease.”

KEY RECOMMENDATIONS - CONTRACEPTION (CON)



CON1 - Engaging GPs and HCPs to promote LARC at various key opportunities, as GPs were recognised as a setting in which many prefer to access contraception.



CON2 - Focused engagement specifically on LARC to increase understanding of barriers to access and context behind choices to not adopt a LARC method (e.g., education, clinic opening hours around work patterns, travel time).



CON3 - Explore models to deliver LARC or contraception in a dedicated service, aligning with preferred methods of accessing contraception identified through consultation with communities (e.g., hub models or dedicated LARC clinics within GPs).



CON4 - Conduct further investigation around variation in LARC uptake geographically in Croydon and by equity dimensions, to understand underlying factors (which may relate to multiple factors i.e., individual practice appointment availability, training or distribution of practices offering LARC).



CON5 - Improving awareness of the range of places in which contraception can be accessed. Reviewing online communications and website materials to ensure contraception pathways are clear.



CON6 - Expand opportunities to offer contraception services in line with patient preference and lifestyle needs (e.g., considering work patterns, out of hours clinics or weekend appointment availability).

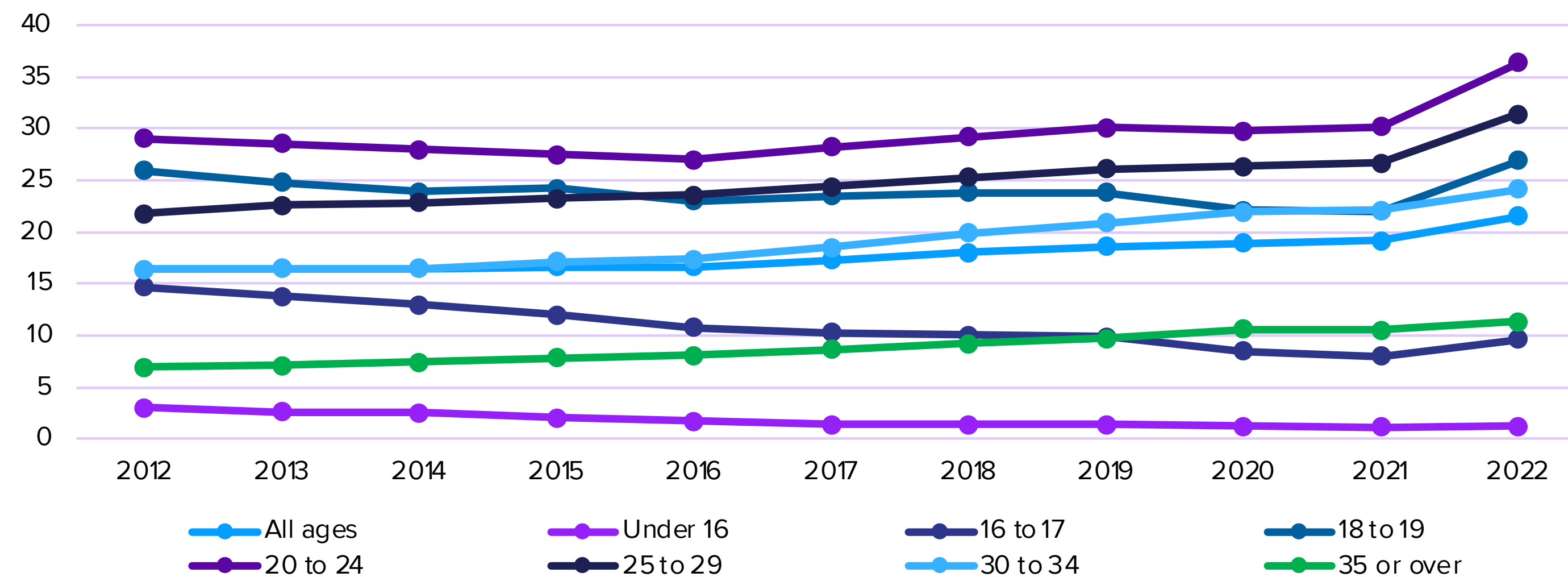


ABORTION

Safe access to abortion (also known as termination of pregnancy or termination⁴⁶) is an essential part of sexual and reproductive health and as such should be an integrated component of sexual and reproductive healthcare and be available as part of routine health services in line with RCOG and FSRH guidance⁴⁷. The National Survey of Sexual Attitudes and Lifestyles (NATSAL) indicates that 45% of all pregnancies and around 1/3 of births are unplanned or associated with feelings of uncertainty⁴⁸. Therefore it is integral for females to have awareness and easy access to abortion services. Where services are legal, readily accessible and available, abortions are considered safe. This relies on information, signposting, counselling, provision of medical/surgical abortion, recognition and management of complications and post-abortion contraception provision when desired.

Nationally, abortion statistics from 2022 show that 251,377 abortions took place among those resident in England and Wales. This is the highest number since the introduction of the Abortion Act, demonstrating an increase of 17% since the previous year. The percentage of conceptions leading to legal abortion reached a record high of 29.7% in 2022, across all ages this number has generally increased since 2015.

The crude national abortion rate in 2022 was highest for those aged 22 (at 37.6 per 1,000 females). Overall, abortion rates have declined within under 18s nationally, decreasing or staying the same each year since 2007. Rates across all age groups have remained fairly stagnant across the period between 2012-2022, except for slight drops between 2019 and 2020 and sharp increases between 2021 and 2022. 18 to 19 year olds have seen the largest increase over this period, with an 18% change.



Graph 42: Abortions across residents of England and Wales, by age, 2012-2022 (crude rate per 1000 females).

⁴⁶ The terms abortion and termination of pregnancy are generally used interchangeably in the literature and amongst professionals, for the purposes of this needs assessment we will use the term termination for consistency.

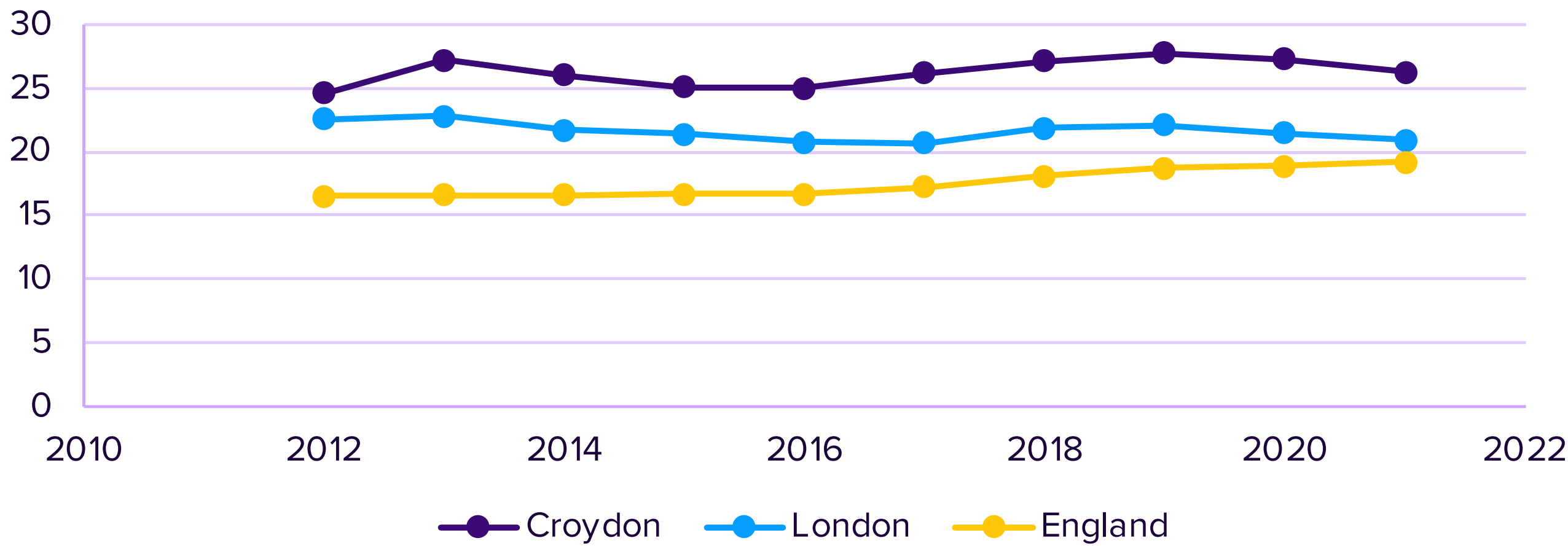
⁴⁷ <https://www.rcog.org.uk/media/awydm1e/rcog-and-fsrh-key-messages-on-safe-abortion.pdf>.

⁴⁸ <https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning>.



Croydon trends and context

In Croydon, the overall total abortion rate at 26.3 per 1,000 women remains higher than the average in London (20.9) and England (19.2). Croydon’s rank (out of 149 UTLAs/UAs) within England for the total abortion rate was 13th highest.



Graph 43: Total abortion rate per 1000 across England and Croydon. Source: OHID, Public health profiles 2025.

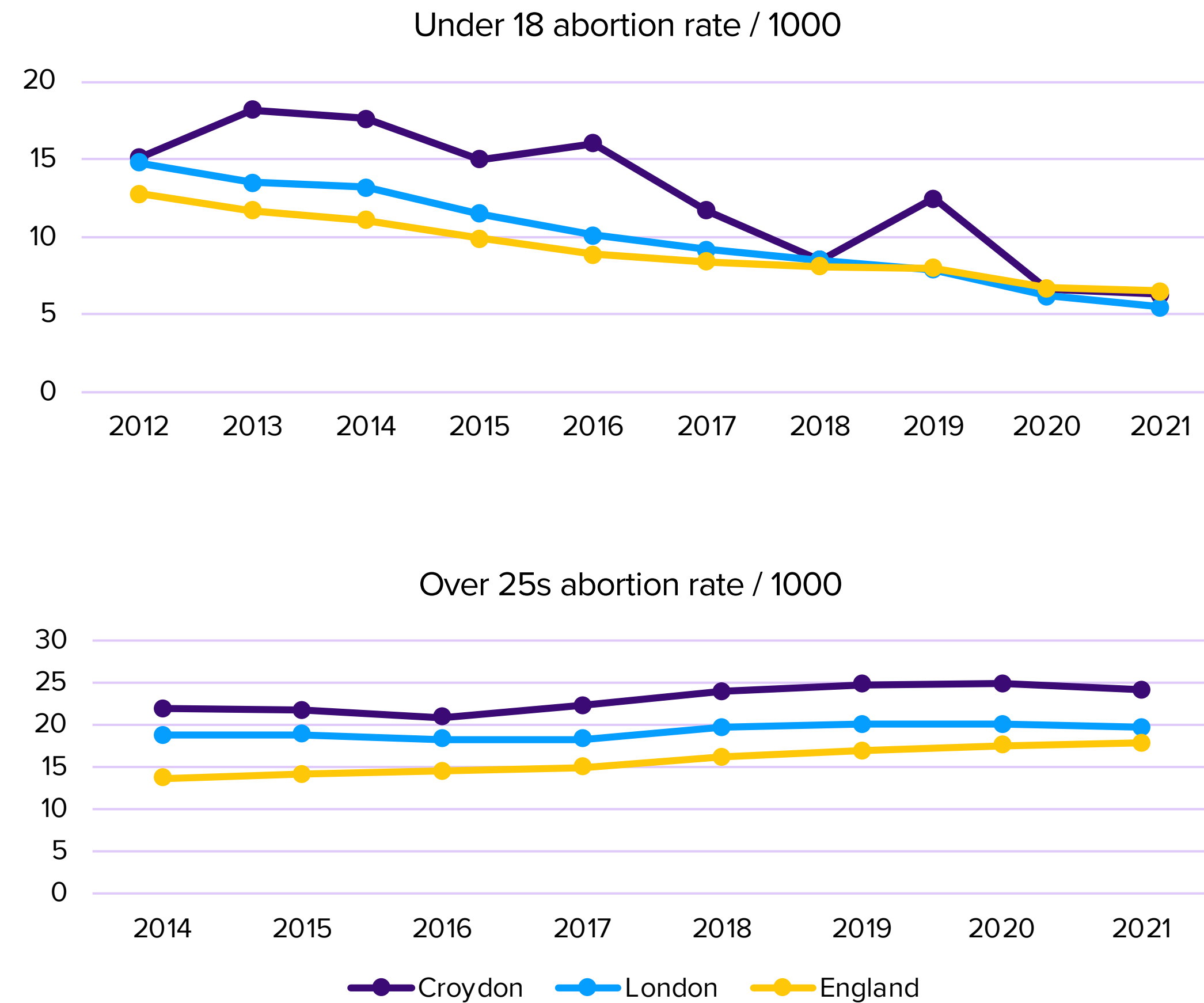
With regards to method and gestation period at termination, the most prevalent method and gestation period of terminations correlates with London-wide figures. Most abortions are via a medical route and occur between 3-9 weeks.

In Croydon in 2021, 88.5% of abortions took place under 10 weeks gestation. This remains similar to its statistical neighbours and the England average. This suggests that people seeking termination following an unplanned pregnancy are generally able to access services promptly, with minimal delays once they have made their decision.

The most recently published data on under 18 conceptions shows Croydon holds the highest rate of under 18 conceptions nationally, at 15.6 per 1,000. As compared to the England and London average (13.9 per 1,000 and 10 per 1,000 respectively) this is significantly higher. These figures may indicate that young women in Croydon may not have good awareness of contraception choices available to them or that service provision may not be meeting the needs of young people locally. This could also be indicative of gaps in sexual health education or information, especially around how to access contraception methods, or how to use them consistently and effectively.

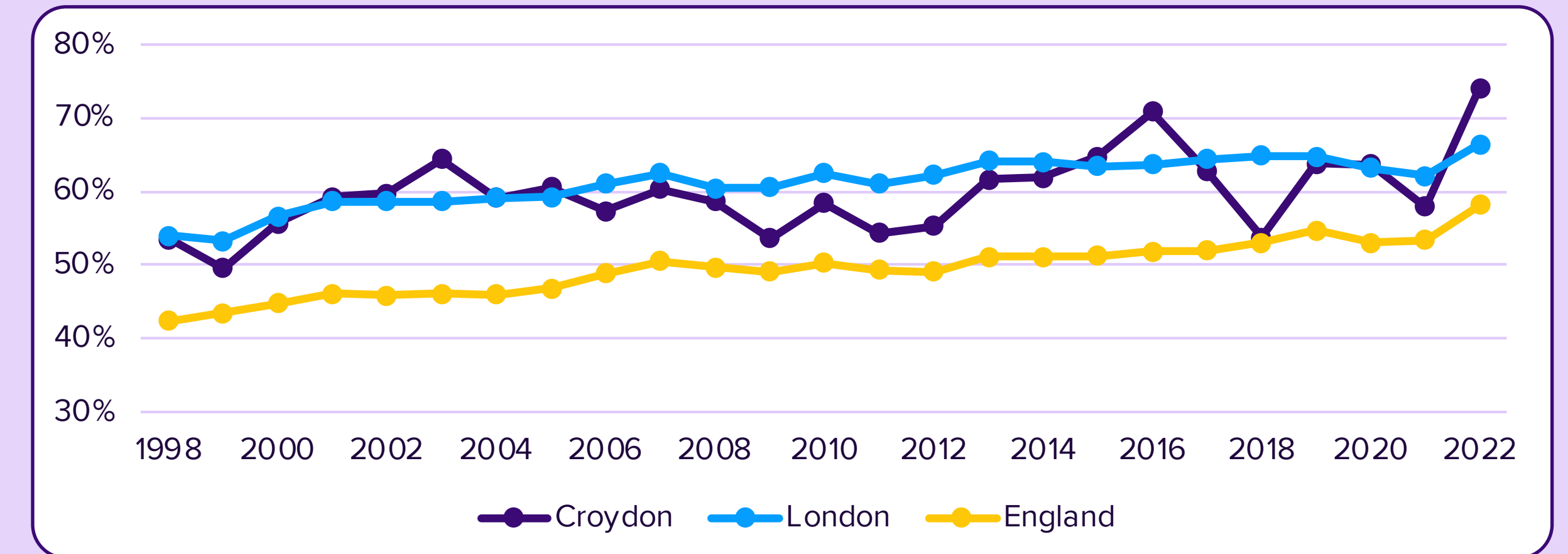
Abortion by age

Data from 2021 shows that Croydon's under 18 abortion rate (6.3 per 1,000) and over 25 abortion rate (24.1) remains higher across both when compared to London (5.5 and 19.7 respectively) and England (6.5 and 17.9 respectively). The Under 18 abortion rate displays an overall downward trend since 2019, remaining stagnant between 2020-2021 (Graph 44). The over 25 abortion rate shows an slow overall decline, in line with trends across the London region.



Graph 44: Under 18s and Over 25s abortion rate trends, Croydon and England (2012-2021). Source: OHID, based on Department of Health and Social Care and Office for National Statistics data.

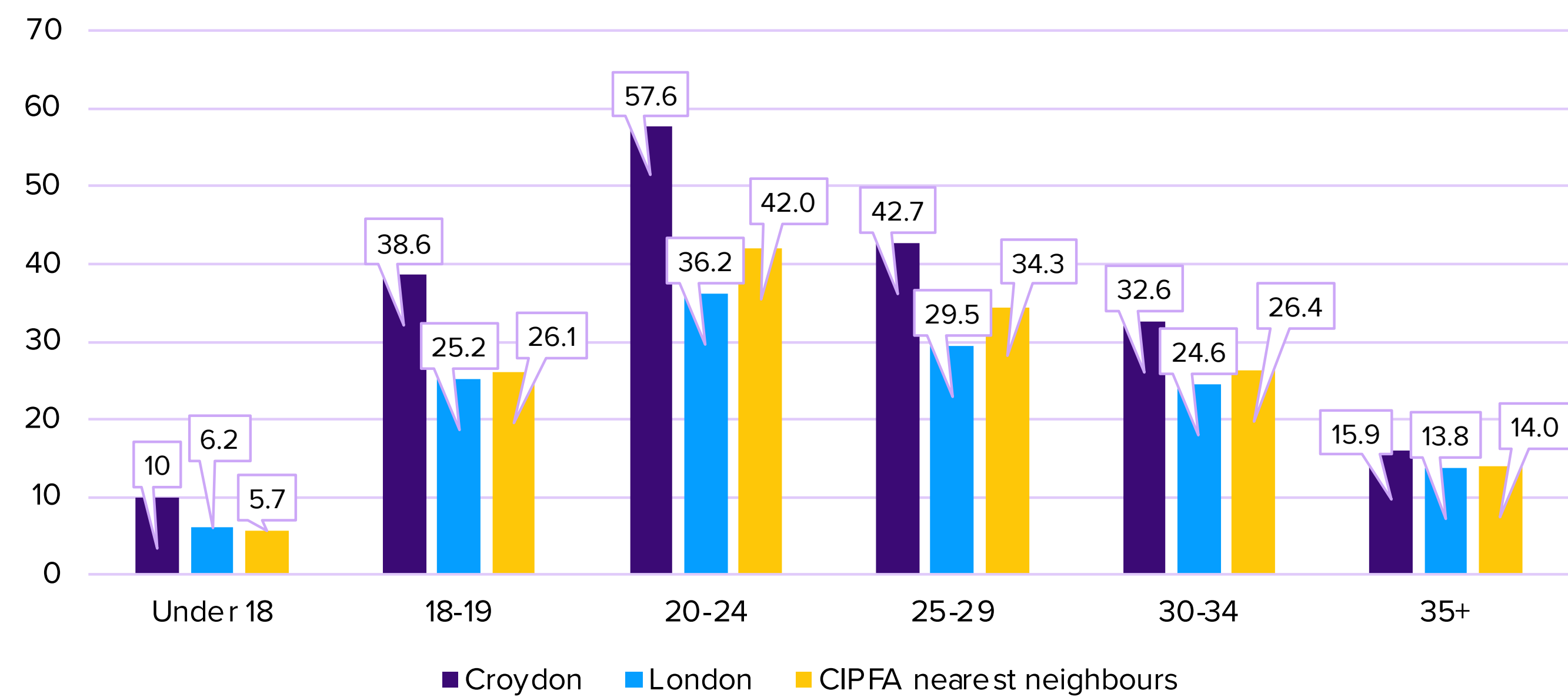
The number of under 18 conceptions leading to abortion shows an increase from 57.9% in 2021 to 74.1% in 2022, which could indicate an increase in the number of unplanned pregnancies but potentially improved likelihood that those under 18 who do conceive will choose abortion, and potentially a reflection of improved access to abortion services. Croydon's overall rate (74.1%) remains significantly higher than the England average (58.2%) for 2022.



Graph 45: U18s conceptions leading to abortion OHID, Public health profiles.



The below graph and table show the split of abortions in Croydon across age ranges as well as Croydon’s rank across these age rates compared to other areas. This shows that in 2022, most abortions took place across the 20 to 24 age bracket followed by the 25 to 29 year old age bracket in Croydon. The Under 18 bracket had the lowest abortion rate in Croydon. Figures in Croydon are significantly higher than the London region and CIPFA nearest neighbours.



Graph 46: Abortion rate by age group in Croydon and London, 2022.

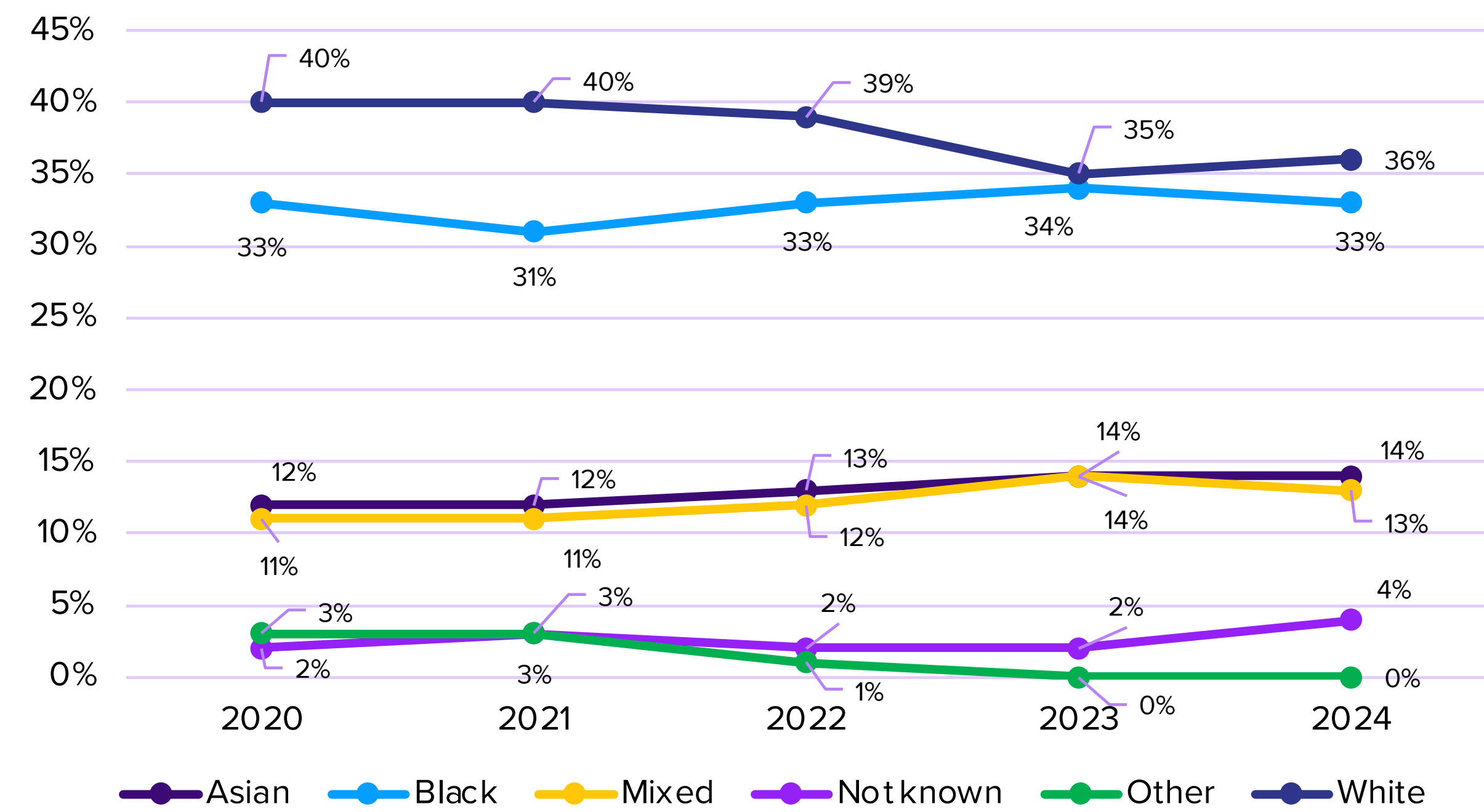
Age group	Under 18	18 to 19	20 to 24	25 to 29	30 to 34	35+
Number of abortions	71	143	600	598	550	507
Abortion rate	10	38.6	57.6	42.7	32.6	15.9
Rank within London	1	2	1	3	3	3

Table 12: Data from Croydon showing Abortion rate and number of abortions by age group (2022). Red indicates a very high ranking whilst yellow indicates a high ranking compared to other London boroughs.



Abortion by ethnicity

According to provider data (MSI), the percentage of abortions from Asian, Black and Mixed-ethnic groups have increased year on year while abortions from those of White background have dropped. Black females receiving abortion and repeat abortions were significantly overrepresented in Croydon. Rates in this group have been increasing since 2021.



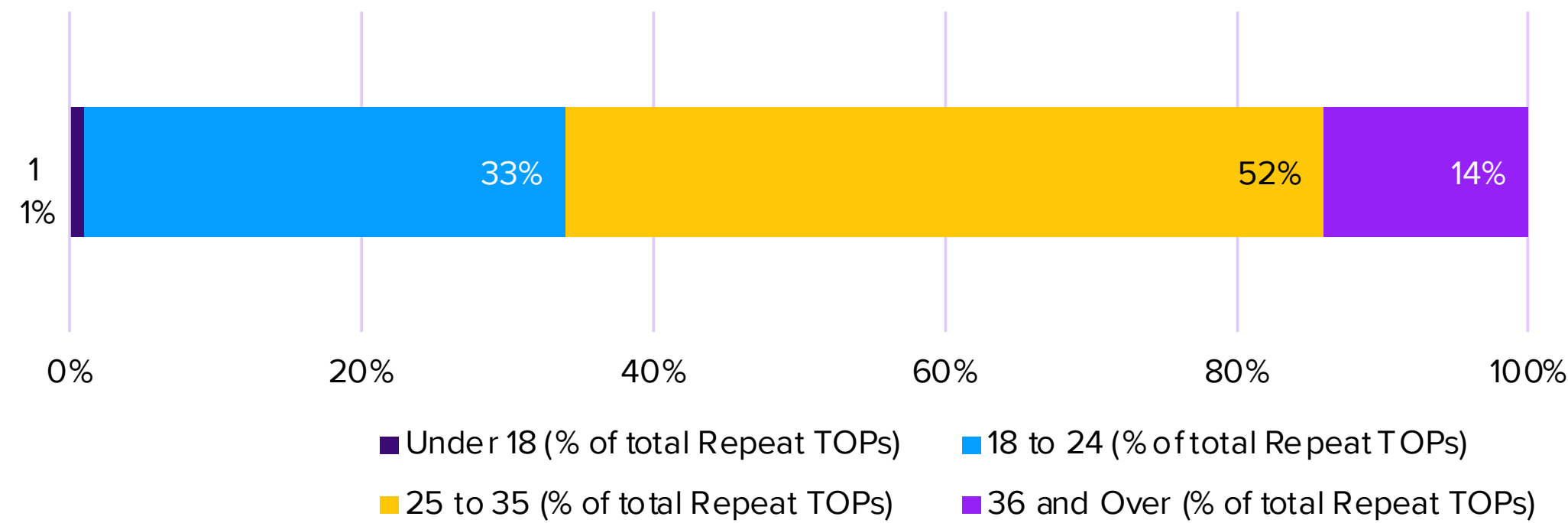
Graph 47: % of terminations, between 2020 and 2024, by ethnic group. Source: MSI data.

Repeat termination

National abortion statistics show that 50.9% of all terminations in Croydon in 2022 were repeat terminations⁴⁹. This data also indicates that Croydon had the highest percentage of repeat terminations across all age ranges within London, with the second highest rate in England⁵⁰.

Among the under 25 age group, Croydon had the second highest percentage of repeat terminations compared to all other London boroughs, at 35.9% in 2022.

More recent MSI data from 2022-2023 shows that 29% of all terminations in Croydon were repeat terminations (within last 3 years) and data from the first quarter of 2023-2024 shows 31% of all terminations in Croydon were repeat terminations (within last 3 years). This service level data indicates a decline in repeat terminations since the 2022 national dataset was published. Additionally, this correlates with the bulk of repeat terminations in Croydon taking place in the 18 to 24 and 25 to 35 year old age group.

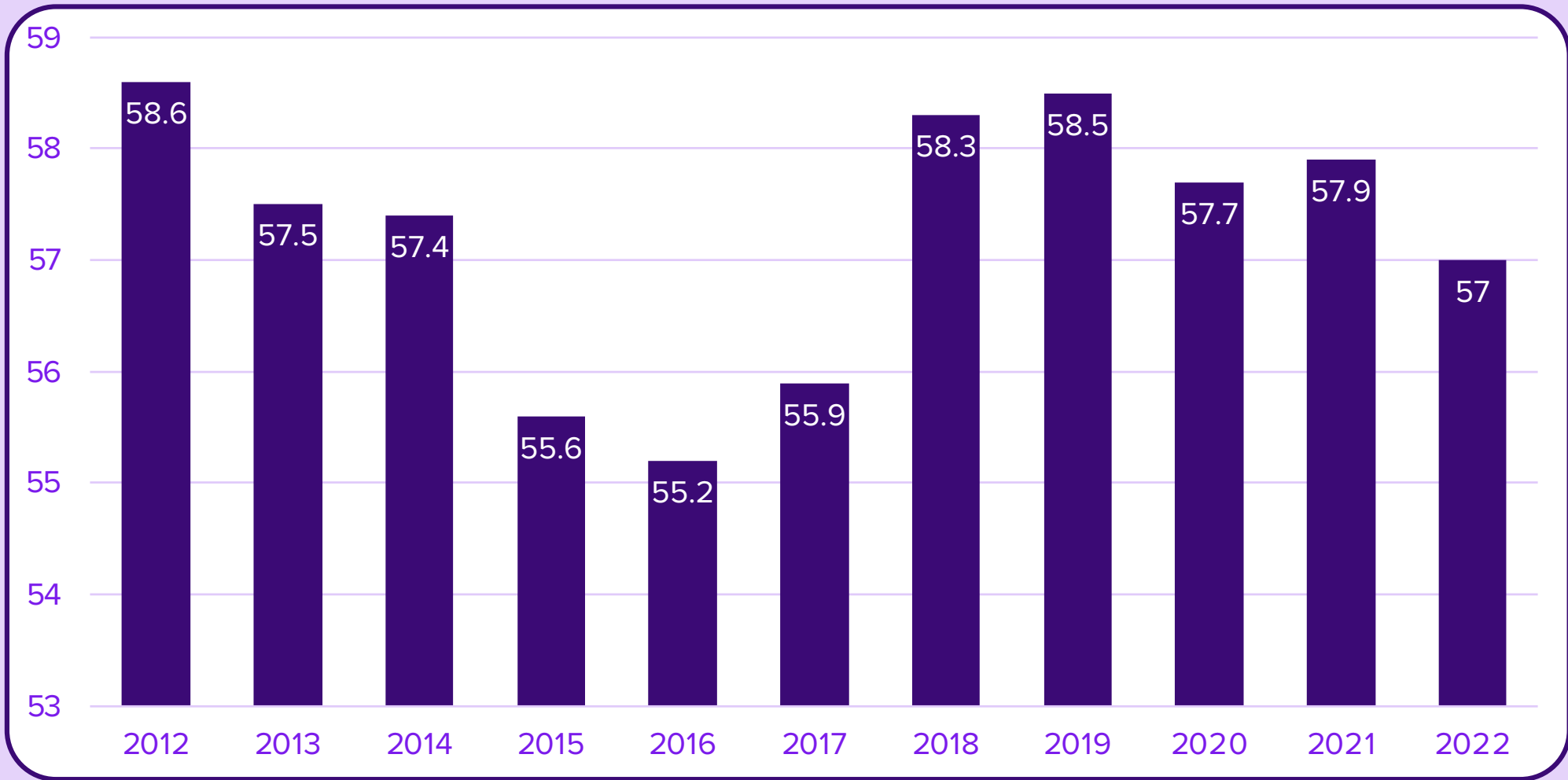


Graph 48: Repeat terminations in Croydon by age group. Source: MSI data, 2023-2024.

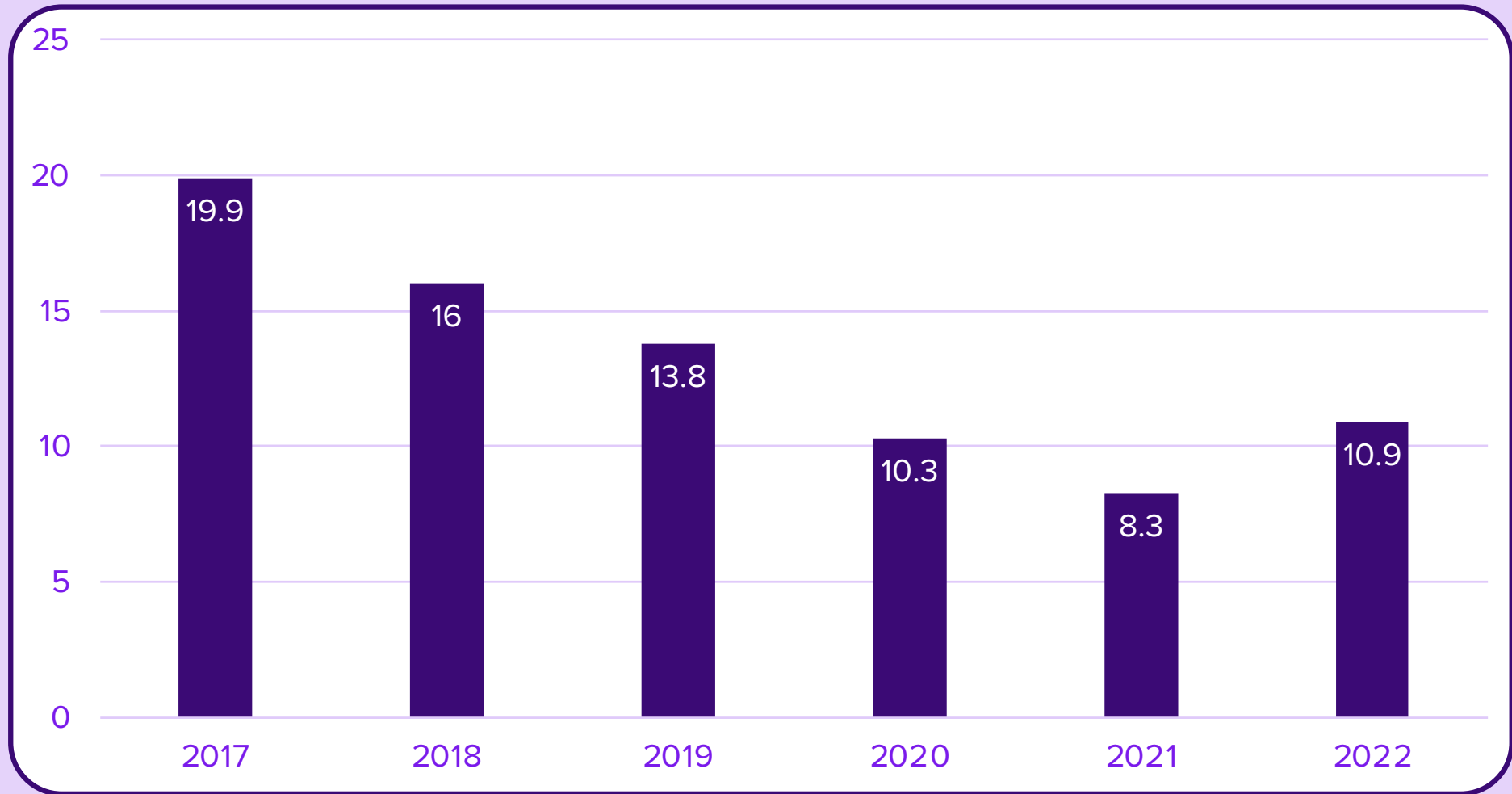
⁴⁹ Note that in the context of National Abortion statistics from OHID a repeat termination is defined as a patient ever having had a previous termination of pregnancy in their lifetime, and Croydon data comes from all residents of Croydon, meaning it includes patients who may have accessed TOP out of borough.
⁵⁰ Abortion statistics, England and Wales: 2022, OHID.

Tracking repeat abortion rates from the national dataset over time shows a downward trend in Croydon until 2021, when rates began to rise slowly. This appears to have been driven by the 19 to 24 age group, where rates have started to climb since 2020.

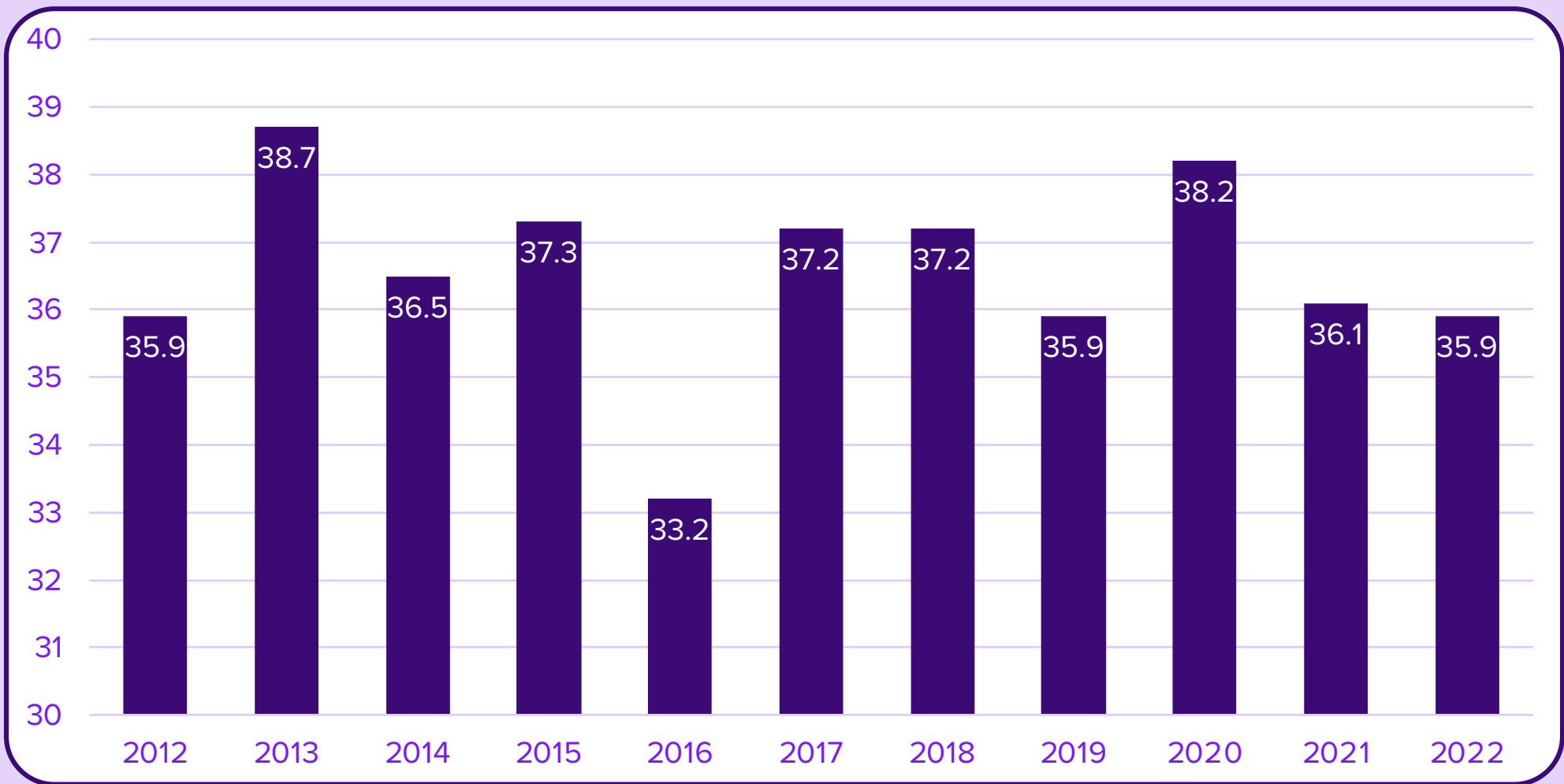
Percentage of repeat terminations under 25 - Croydon



Percentage of repeat terminations under 19 - Croydon

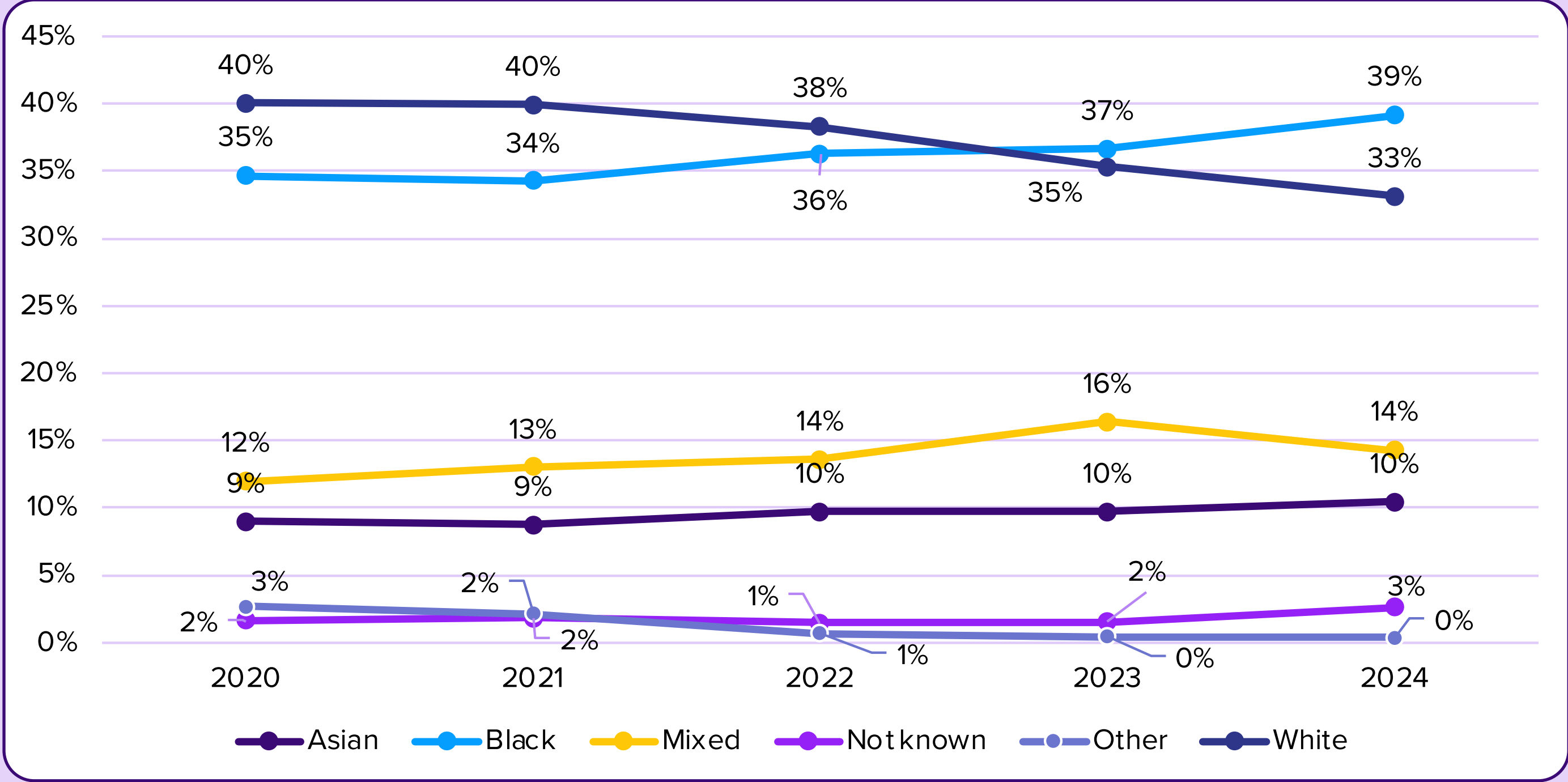


Percentage of repeat terminations 25+ - Croydon



Graph 49: Repeat terminations in Croydon by age groups. Source: MSI data, 2012-2024.

Repeat terminations across Black ethnic groups in Croydon have been increasing since 2021, while rates across other groups such as White ethnic background have been decreasing or remaining stagnant. This demonstrates a potential higher need for good and easy access to contraception care and LARC methods within Black ethnic females in the borough.



Graph 50: % of repeat terminations, between 2020 and 2024, by ethnic group. Source: National Abortion Statistics.

The below table demonstrates the difference in ethnic split of repeat terminations in Croydon compared to the 2021 national ethnic split according to census data, demonstrating Black ethnic groups being overrepresented in termination rates in Croydon.

Ethnic group	2021 MSI repeat termination data	2021 national ethnic split
Asian	9%	17.5%
Black	34%	22.6%
Mixed	13%	7.6%
Not known	2%	N/A
Other	2%	3.9%
White	40%	48.4%

Table 13: % of repeat terminations by ethnic group 2021. Source: MSI data and ONS data.

ENGAGEMENT WITH STRATEGIC AND COMMUNITY PARTNERS

Discussions in the format of semi-structured interviews or focus groups were held with key partners and organisations from across the reproductive health landscape including the key provider in the borough.

Key observations

- MSI provides an established local offer through the Norbury clinic, operating five days a week. Patients mainly access services via central call centre or webchat, ensuring convenience and privacy.
- The service sees high rates of safeguarding disclosures, particularly related to domestic abuse and mental health, reflecting the vulnerability of many service users.
- Socioeconomic pressures, especially post-COVID and during the cost-of-living crisis continue to influence decisions around termination, with many patients citing financial hardship as a key factor.
- Rates of repeat termination in Croydon are declining, post pandemic as seen in service level data, although national data does not always reflect this due to the lag in statistics being published.

Areas of good practice

- Introduction of advanced safeguarding practitioners and clear referral routes for vulnerable patients has improved ability to deal with safeguarding referrals and appropriate escalation or support, particularly for those experiencing domestic violence or poor mental health.
- Relationships and partnership working between TOP provider and the integrated service are areas of positive collaboration, working together to improve obstacles in the referral process and pathways.
- MSI's 999 Club partnership supporting homeless women through providing care packs demonstrated a successful outreach programme, offering an opportunity to signpost into TOP and other SRH services as needed.

Areas of challenges or barriers

- While LARC access and uptake have improved in other regions (notably in SEL, where repeat terminations dropped from 40% to 19%), Croydon faces limited post-termination LARC uptake, with provider data indicating 1 in 10 women not attending follow-up appointments. This appears to be linked to awareness and promotion gaps rather than access constraints.
- Patients supported by TOP services often do not engage in the post-TOP contraception offer (available up to 6 months after a termination) due to various barriers. This is often related to the recent potentially stressful experience of having undergone a termination which mean they may not want to re-engage with TOP services.



KEY RECOMMENDATIONS - ABORTION (ABR)



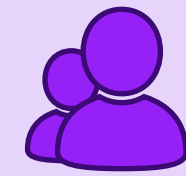
ABR1 - Explore strategies to provide online avenues to initiate a termination consultation, aiming to expand access to terminations through an alternative pathway for contact that is open all hours.



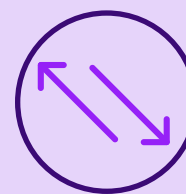
ABR2 - Work with local pharmacies to understand the impact of EHC pharmacy offer, with focus on groups experiencing disproportionate burden to inform future commissioning decisions.



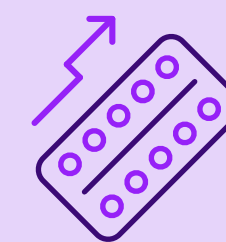
ABR3 - Regular local analysis of repeat terminations data to build evidence around trends and inform targeted action/prevention in this area. This can support views from partners that trends are declining.



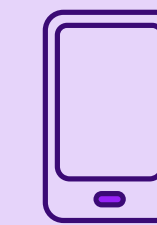
ABR4 - Provide age-specific support towards age groups with high burden of repeat TOP (25 to 35 year olds), utilising cross-service promotion and the “Making Every Contact Count” approach to engage this age group in wider settings.



ABR5 - Strengthening partnership working and explore opportunities for data sharing with TOP and other providers through tools such as dashboards.



ABR6 - Explore the local need and demand for increased contraception provision and appointments. Assess feasibility of pilot opportunities for contraception/LARC provision collaborating with partner organisations.



ABR7 - Explore active recall systems (text reminders, follow-up calls) for those less likely to engage (e.g., non-attendance at post-TOP contraception appointments) drawing on regional pilot models of data-sharing that enable clinics to follow up with these patients.



6. Outreach and health promotion

This section provides an overview of the needs and feedback from engagement with priority groups in the borough.



This covered young people, ethnic minorities, people seeking asylum or of refugee status, people experiencing homelessness or rough sleeping, gay and bisexual men who have sex with men, LGBTQIA+ communities and people living with SEND, mental health or other disabilities.



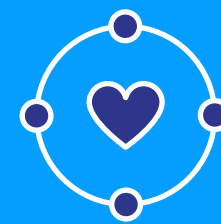
Key priorities for communities include anonymity/confidentiality, local and flexible services that people can easily access (based on their location, preferences and life commitments), going out to meet communities where they are at and knowing what is available to them.



Sexual health is also often deprioritised for vulnerable people due to complex life stressors such as homelessness, substance use and mental ill-health.



Activity and engagement with the C-Card scheme among young people and providers is an opportunity for review and strengthening in future.



Stigma around sexual and reproductive health remains high across communities.

SPOTLIGHT ON - YOUNG PEOPLE

Young people aged 15 to 24 face disproportionate outcomes when it comes to sexual health and higher risk of STIs, presenting later to services and experiencing poorer outcomes. Therefore, being an at-risk group, it is integral to engage and co-produce insights into their needs alongside them and develop further understanding on design and delivery of targeted services from their perspective.

C-Card scheme analysis

Details of the C-Card condom distribution scheme is detailed at section 3.

Currently there are 8 providers registered under the scheme, with 6 as points for both registration and distribution points, whilst 2 are distribution points only.

Analysis of uptake of this scheme shows that in the 2024, there was 437 encounters recorded across all providers/distributors in the scheme. The majority of these were the CHS Outreach team (213 encounters), followed by Croydon drop in (22 encounters). Pharmacies and other providers signed up to the scheme represented a small number of encounters and registrations.

Overall since 2022, encounters with the scheme have dropped by 48.5% (from 848 to 247) and registered

young people have decreased year on year by 65.1% (from 665 to 232).

Although consultation undertaken for this needs assessment with young people does provide some insight into levels of awareness and knowledge within young people of where to access condoms for free under the scheme, further engagement would help develop insight and context behind these trends and help understand how to obtain best value for money of the commissioned scheme and assess whether current volume and distribution of providers is sufficient to support the population of young people in the borough in areas accessible to them.

C-CARD PROVIDERS

Currently there are 8 providers registered under the scheme, with 6 as registration and distribution points and 2 as distribution points only.

Thornton Heath - Croydon Integrated Sexual Health Centre
Chlamydia, Screening, Condoms, Contraceptive Advice, Emergency Contraception, HIV Testing, Pharmacy, Pregnancy Testing, Sexual Health Clinic.

Croydon - A-Z Pharmacy
Chlamydia Screening, Condoms, Contraceptive Advice.

Croydon - A-Z Pharmacy
Chlamydia, Screening, Condoms, Contraceptive Advice.

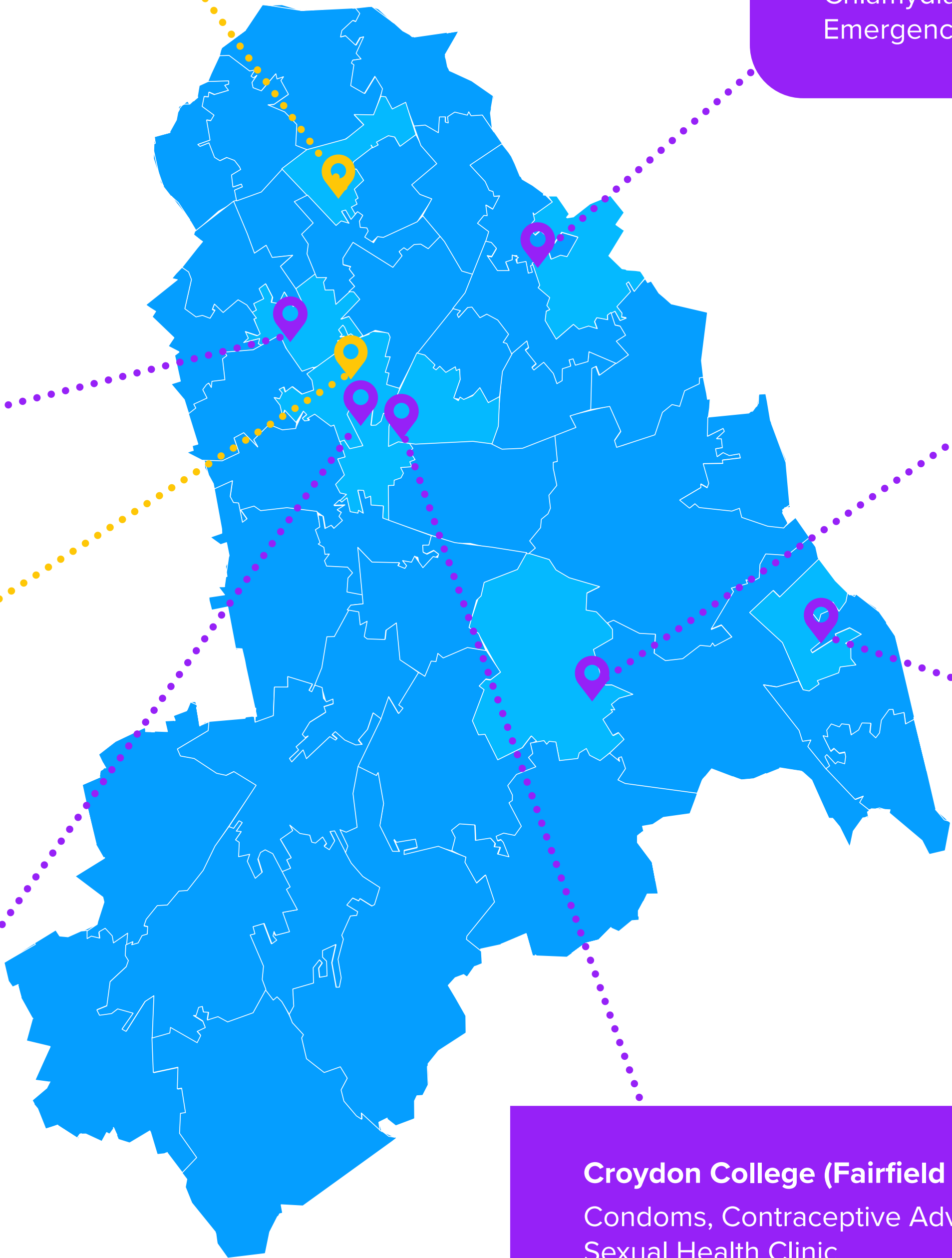
Thornton Heath - Thornton Heath Pharmacy

South Norwood - Fishers Chemist
Chlamydia Screening, Condoms, Emergency, Contraception, Pharmacy.

South Croydon - John Ruskin College
Condoms, Contraceptive Advice.

Fieldway, New Addington - Fieldway Pharmacy
Condoms.

Croydon College (Fairfield Campus)
Condoms, Contraceptive Advice, Sexual Health Clinic.



Key
📍 Registration and Distribution Point
📍 Distribution Point only

Graphic 9: C-card outlets pinpointed across the Borough of Croydon.



Consultation and engagement with young people

A number of scenario-based questions were asked to young people in sixth forms/schools visited as part of the engagement and outreach process. These included using prompts about hypothetical scenarios related to sexual health issues around contraception, STIs and service delivery to allow young people to share their perspectives and experiences in a confidential and anonymous way.

Young people were asked to respond to hypothetical scenario prompts such as:

“Your friend went to the sexual health clinic and had a positive experience. What made this a good experience?”

“Your friend thinks they might have an STI, what might stop them from going to get help about this?”

“A student heard there’s a local sexual health outreach van but isn’t sure what it offers or if it’s for them. What could help improve awareness for this type of service?”

“Your friend wants to get a reliable form of contraception, but they are hesitant. What might be stopping them?”

Results from responses to these prompts were analysed to understand key recurring themes and priorities for young people when it comes to sexual health services, preferences for service delivery barriers, facilitators and levels of awareness. These are summarised on the following pages.

Comfort, respect and non-judgemental environment

Most respondents emphasised wanting to feel comfortable, accepted, and not judged when accessing services. Staff described as “understanding”, “respectful”, “chill”, and “supportive” contributed to a sense of safety and ease. This suggests that these factors are key determinants of a positive experience for young people.

“They felt comfortable speaking to them.”

“Respectful and non-judgemental people.”

“There was no judgment from the doctor.”

Key quotes

“No judgement, felt comfortable.”

“They weren’t Judgy.”

“Made them feel accepted, made them feel supported.”

East Croydon



Confidentiality and privacy

Confidentiality was one of the most frequently cited enablers of a positive experience with services. Respondents valued that if interactions were private, one-to-one, and kept confidential, it would help them open-up about sensitive topics. Several responses mentioned feelings of relief when accessing care, being supported, and having their worries addressed.

Ways of accessing help and information

There was a strong preference for accessing help and information either online or on the internet (31%) or through a professional (43%), rather than through school (7%) or young people specific services (1%). This might be due to trust in trained professionals or perceptions of increased confidentiality involved in speaking to someone in a health setting and via the internet.

Embarrassment and fear of judgement

Young people feared judgement by peers, staff and family. Many respondents reported feelings of stigma around seeking contraception or discussing sexual activity. Acceptance of individual identity or sexual orientation and worries that they would not receive identity affirming care were seen as a barrier to accessing services.



Concern & support around side effects of contraception

Side effects, hormone changes, infertility, pain, or weight gain were key deterrents to using contraception. These reflect both legitimate concerns and misinformation, highlighting a potential gap in education around contraception and the need for clearer, youth-friendly resources about options and their effects.

“Getting fat on the pill.”

“Afraid for their parents to find out, or scared of side affects of taking it.”

Key quotes

“Side effects i.e. infertility, heavy period.”

Family related barriers

Fear of parents finding out, their family members negative attitudes towards sexual activity and contraception, or religious beliefs were recurring themes. These pressures may limit young people’s ability to access contraception safely or confidentially. Family stigma is a key area for community education and parental engagement efforts.

Lack of knowledge and awareness

Respondents cited not knowing where to go, how to access contraception, or which method is best. Related to accessing condoms as contraception, there was a perception that price /cost is a barrier, meaning there may be poor awareness of services like the C-Card scheme where young people can access condoms for free until the age of 25.

“Not enough knowledge on contraception.”

“Price of condoms.”

“Uneducated on where to go, fear of feeling judged.”

“They don’t know everything about the different types of contraception.”

Key quotes

Promoting services and increasing awareness

Students overwhelmingly mentioned social media (especially Instagram, TikTok and online ads) as a key opportunity to promote services in a person-centred way familiar to young people. They felt online platforms are where young people get information and are most likely to engage. Examples included talks, assemblies, presentations, and lessons at school which can normalise the subject and dismantle stigma. Traditional media and methods of advertisement were also mentioned, such as “posters around school” or “leaflets”.

Young people also expressed wanting to understand more about what to expect when visiting a clinic, perhaps through video content or communications through the clinic website.

“Promote it on social media.”

**“Talks in school.”
“Assemblies at school.”
“Speakers come into school.”
“Education in schools.”**

Key quotes

“Online advertisement / social media.”

“TikTok, Insta.”

“Being told about it by teachers or making it public with ads.”

“Educational videos online.”

Peer influence

Some referenced friends or word-of-mouth as a means of spreading awareness and gaining information on sexual and reproductive health issues, particularly around contraception. This indicates that peer influence and relatable stories can foster trust and reduce stigma among young people. Services professionals also cited the role and influence of anecdotal stories from people they trust and relate to, whether indicative of negative or positive experiences.

“Spreading the news with your friends.”

“A friend’s advice.”

“People that have used it before can reach out.”

Key quotes

“Examples of what the process looks like.”

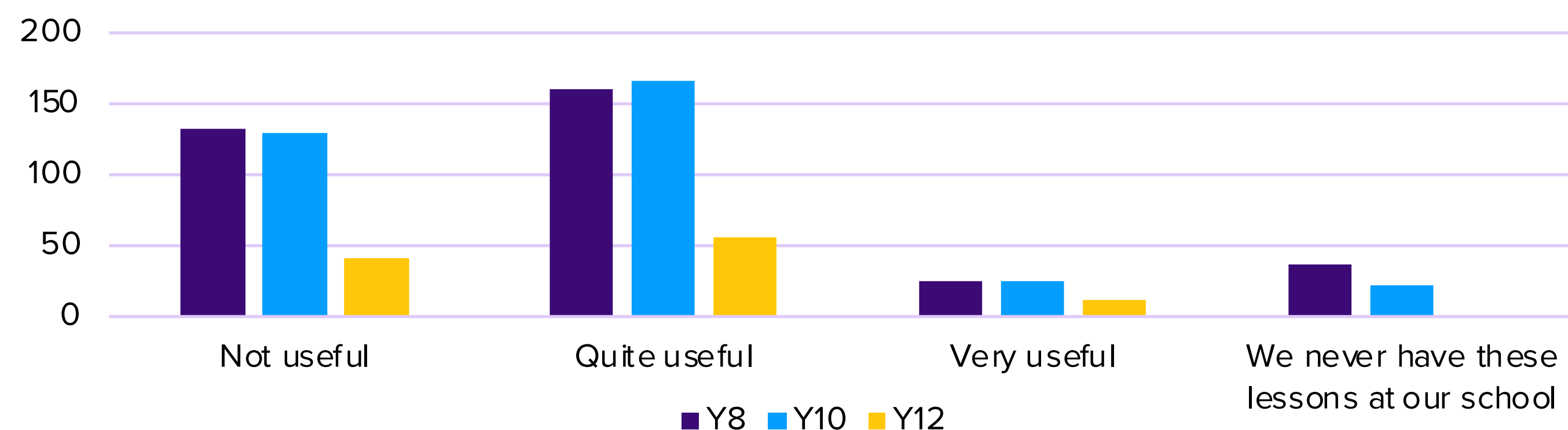
Analysis of school survey data

A survey was distributed to primary and secondary schools in Croydon by the Public Health team in 2024. A number of questions on sexual health and healthy relationships were included in this survey for secondary school pupils in years 8, 10 and 12. These questions aimed to better understand young people's knowledge, attitudes, and experiences relating to health and wellbeing more widely.

An analysis of the responses to these questions was carried out for the purpose of this needs assessment. This aimed to understand young people's satisfaction with the sexual health and outreach offer as well as their awareness and understanding of these topics.

The school survey had 1,122 secondary pupil responses overall, however it is important to note that the section on sexual health and healthy relationships had a variable response rate within each question.

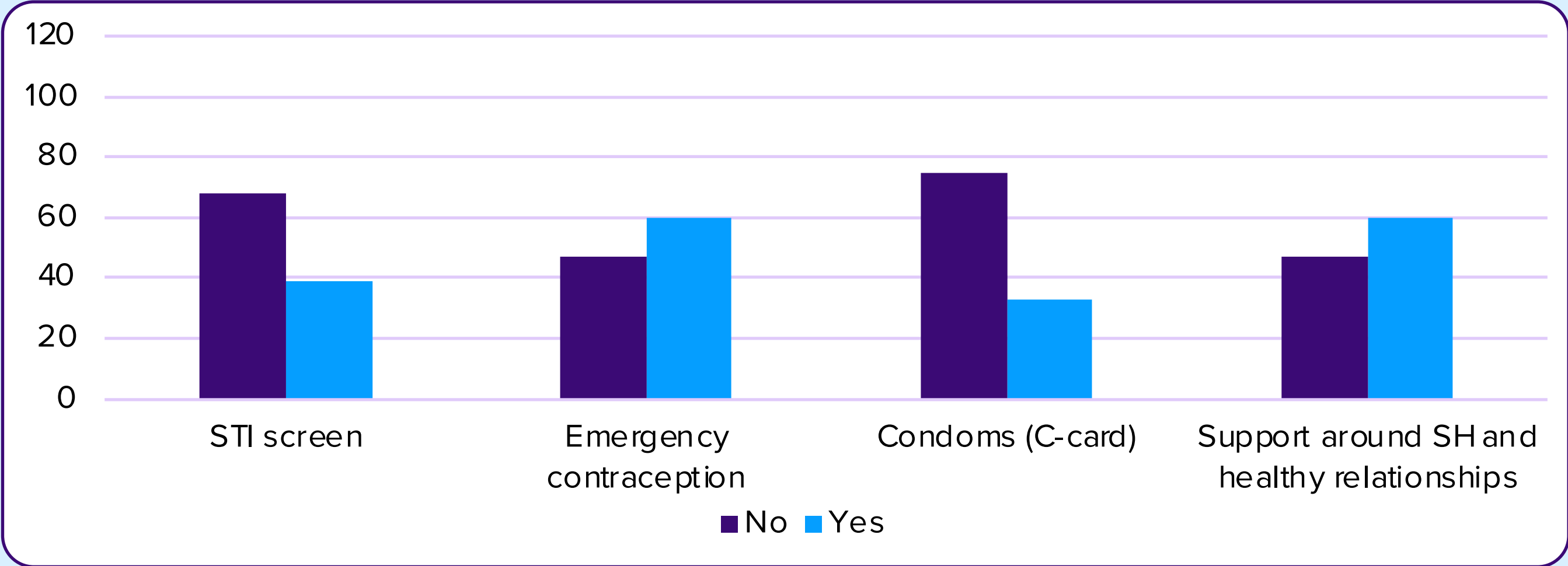
When asked how useful they find RSE lessons at school, more pupils rated this as "Quite useful" or "Not useful". The chart below displays the variation in responses across age groups.



Graph 51: How useful have you found RSE lessons at school? Source: 2024 Croydon School Survey.



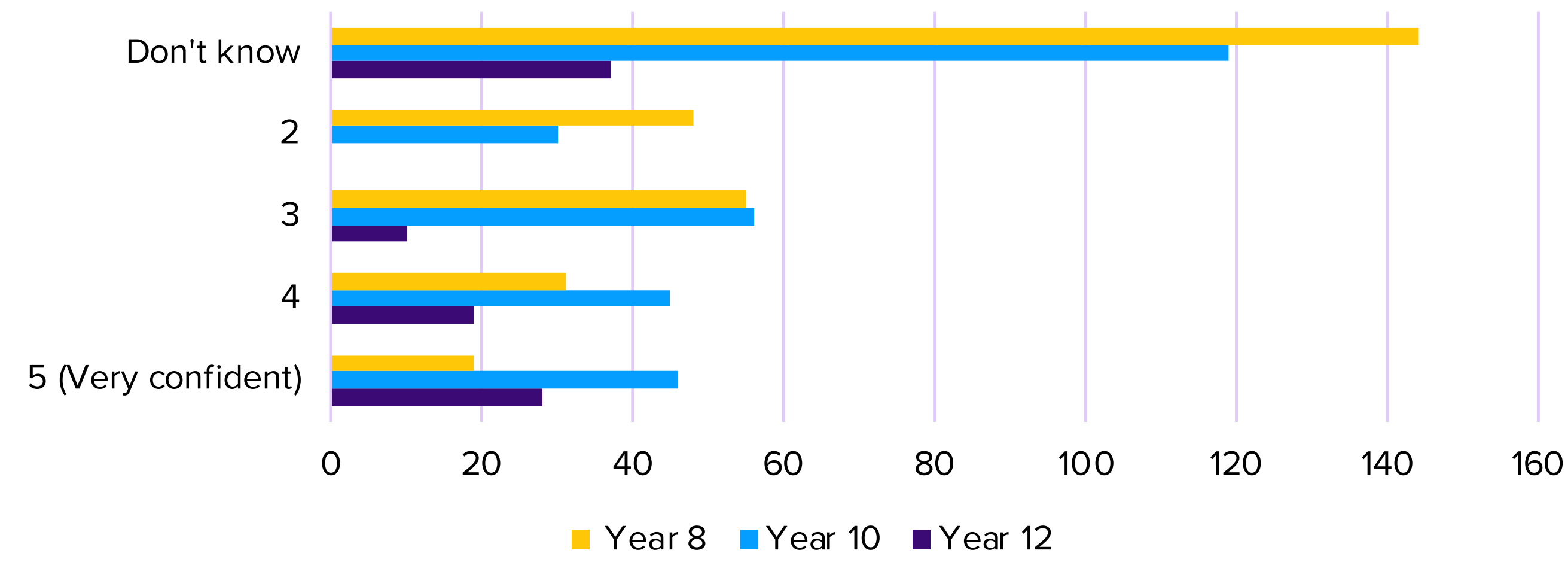
When asked whether they know where to access the following services, Y12 responses indicate poor understanding of where to access condoms under the C-Card scheme. Interestingly, this correlates with findings from the engagement conducted with schools for this needs assessment. These results also indicate low awareness of places to access an STI screen. However, comparatively it shows good understanding of where to go when seeking Emergency contraception or wider support around health relationships and sexual health amongst Y12 students.



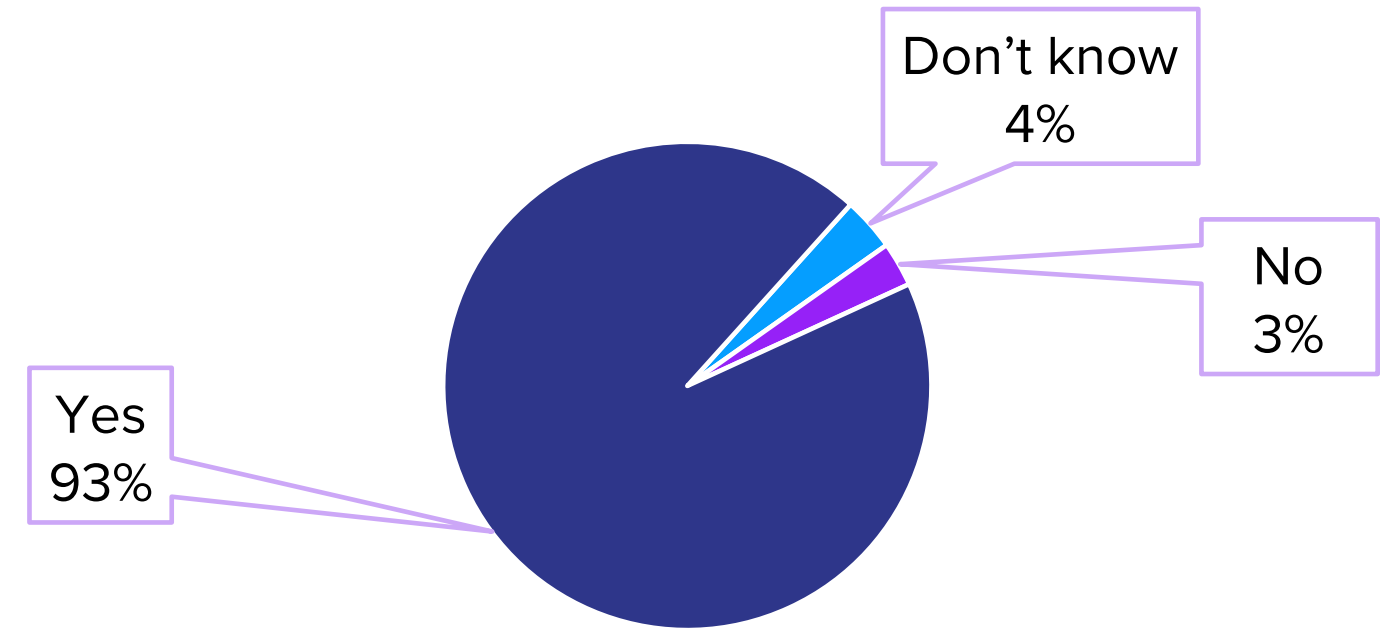
Graph 52: Do you know where to access the following services? (Year 12 only). Source: 2024 Croydon School Survey.



When asked how comfortable they felt discussing safe sex with a partner, pupils were able to opt for an answer on a scale of 1 to 5, with 5 being very confident and 1 being Not at all confident. They also had the option to select “Don’t know” as an alternative. Findings showed that the majority of students were unable to answer, selecting “Don’t know” in response to this question. For year 8s, this may be reflective of their age, and most likely not yet being sexually active. For those that did select an answer, most year 10s rated their confidence discussing safe sex with a partner as 3 out of 5, 5 being Very confident. Most year 12s rated 5, Very confident, to discuss safe sex with a partner. The responses indicate that education around communicating safe sex within relationships for those that participated in this age group is being delivered effectively.

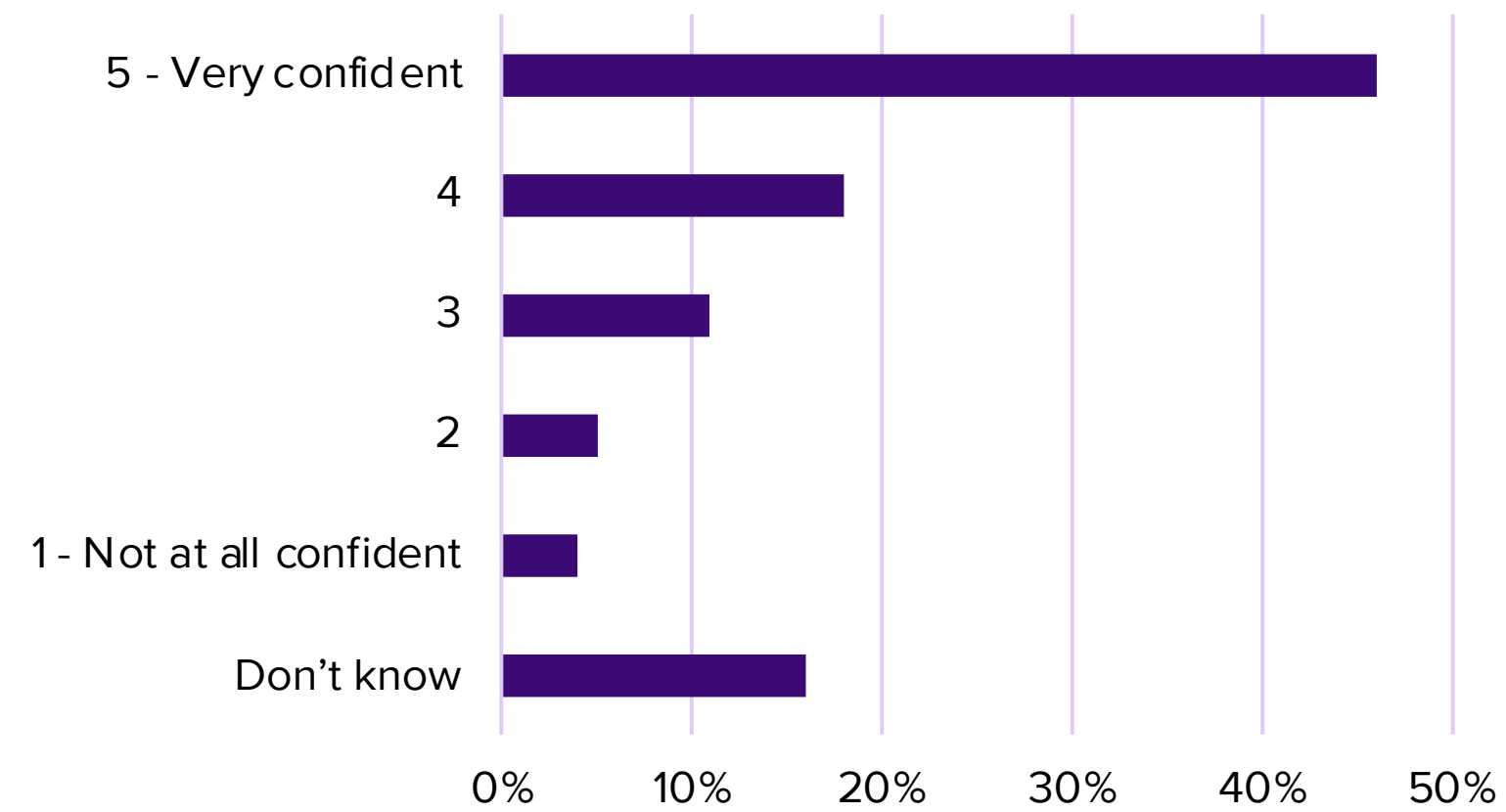


Graph 53: Feel confident discussing safe sex with a partner? Source: 2024 Croydon School Survey.



Graph 54: Y10's answering yes to understanding of consent in relation to sexual activity. Source: 2024 Croydon School Survey.

Whilst results showed that 93% of year 10 students demonstrated good understanding of consent when it comes to sexual activity, over one-third of students (36%) may lack confidence in communicating their consent. This potentially demonstrates that knowledge of consent does not always translate into behaviour or empowerment to exercise consent, highlighting a potential area for improvement in sexual health and relationships education. However, it is also important to consider that some students in the age category may not have engaged in sexual activity, indicating a potential reason behind a lack of confidence to say no to sexual activity.



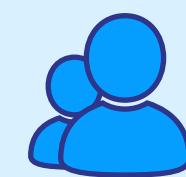
Graph 55: Y10s confident to say no to sexual activity at any point. Source: 2024 Croydon School Survey.

Consultation with young people, school survey results and engagement with partners working with young people have therefore revealed the following key themes and priorities for accessing sexual health services in the borough:

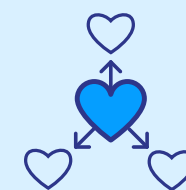
- Services they can access at a time that suits them (e.g. around school/work commitments).
- Accessing information online and having services promoted through social media.
- Assurance that services are both free and confidential including free access to condoms and STI testing.
- More information around where to access condoms and STI screens in the borough.
- Risk that their parents will find out they are sexually active and accessing services as a barrier.
- Education around the side effects of contraception.
- Having to travel too far and risks to their personal safety (for example, due to violence or organised gang activity) as threats or barriers to accessing services.
- Preference for services delivered online, by other young people or professionals rather than teachers in school settings.
- Nuanced education regarding communicating consent to ensure young people feel confident and empowered to practice consent.



KEY RECOMMENDATIONS - YOUNG PEOPLE (YP)



YP1 - Explore opportunities to co-develop services with young people and involve them in delivery, e.g., Peer Health Champion programmes for children and young people.



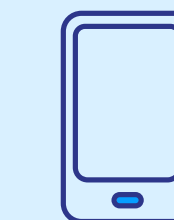
YP2 - Increase provision of outreach and health promotion to young people, exploring family hubs (particularly new Samuel Coleridge-Taylor FH) as an opportunity to link with or deliver support.



YP3 - Conduct review of C-Card scheme to facilitate expansion of the commissioned scheme, increased activity and assessment of whether current volume and spread of distribution points/providers is sufficient to meet local population of young people in places accessible to them. Involve or engage young people, outreach teams and providers/distributors to understand effective promotion and methods of access (e.g., explore digital C-Card offer) and increase understanding around registration/distribution locations.



YP4 - Review alignment of services with young people's priorities and needs (including lifestyle patterns, location, mode of access and safety concerns), considering solutions to these barriers such as out-of-hours clinics, anonymous entrances, satellite locations.



YP5 - Co-develop communications materials with young people (e.g., through workshops or focus groups), aiming to understand communication methods they want to engage with (i.e., social media). Content could work to destigmatise sexual health and explain what they can expect when visiting a clinic.



YP6 - Clarity and agreement regarding roles and responsibilities of different partners involved in sexual health education including the education system, council and health partners.

SPOTLIGHT ON - VULNERABLE GROUPS

Various groups are understood to experience disproportionate barriers and poor outcomes when it comes to sexual health, meaning good sexual health is not equally distributed across the population.

There is evidence for strong links connecting deprivation and STIs, teenage unplanned pregnancy and repeat terminations. The highest burdens of sexual health need are often amongst females, men who have sex with men (MSM or GBMSM), the trans community, young people, and people of ethnic minority backgrounds. Further, HIV infection in the UK disproportionately affects gay, bisexual and other MSM, and black African ethnicity communities. Some groups at higher risk of poor sexual health face high levels of stigma and discrimination, which can create barriers to accessing services.

This section aims to explore sexual and reproductive health needs prioritising underserved groups including but not limited to:

- Young People.
- GBMSM.
- LGBTQIA+ community.
- Minoritised ethnic groups.
- People seeking asylum and refugees.
- Sex workers.
- People living with HIV.
- People living with SEND needs or disabilities.

For this needs assessment, a consultation and engagement process was undertaken across various community settings. The aim was to understand awareness of services and key barriers to access within vulnerable populations and to facilitate co-production of insights with community members and co-development of suggested recommendations.

It is estimated that approx. 300+ members of the community in Croydon were reached as part of this exercise.

Outreach survey

Engagement and delivery of a survey (face to face and online) was conducted in the following settings:

- Colleges
- Sixth forms
- Drug & alcohol centres
- Town centre/high street
- Temporary/initial accommodation centres (hotels for people seeking asylum)
- Supported accommodation buildings.

All respondents were either living in Croydon or had a connection to Croydon (e.g. working or studying within the borough).

The outreach survey had 65 respondents in total.

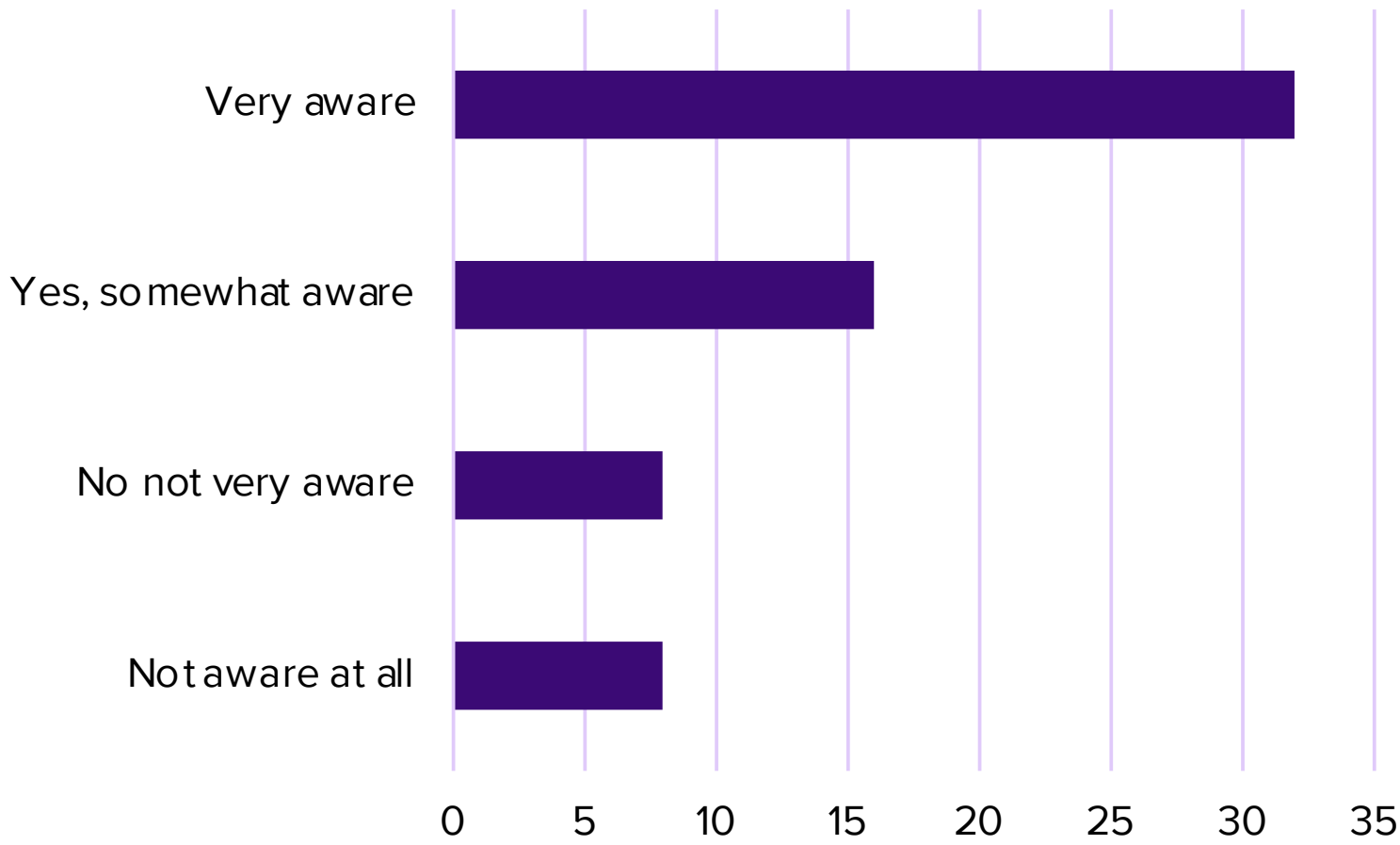
- 69% lived in Croydon, 9% did not live in Croydon and 22% did not answer this question.
- Most respondents were 18 to 24 (34%), 25% were under 18, 15% were 25 to 34, 6% were 35 to 44 and 20% did not answer this question.
- Respondents were 43% female (including trans females), 40% Male (including trans males), 5% non-binary and 12% did not answer this question.
- When asked whether they identify with the following statements;
 - » I have experience of being homeless or a rough sleeper, I have engaged in sex work, transactional sex, selling sex, or exchanging goods or money for sexual services, I have experienced mental health issues, I am a

migrant, refugee or am seeking asylum, I have special education needs or a disability, I have experienced problems with using drugs or substances, I am living with HIV.

88% of respondents to the survey identified with at least one of these vulnerable groups, with many identifying with more than one. When interpreting the findings of this engagement, it is important to note that within the engagement process during vox pop style face-to-face qualitative discussions, demographic information was not captured for all individuals engaged with due to the nature of the engagement methodology. As well as this, not all survey respondents chose to disclose demographic information.

Findings from the survey have been triangulated with insights from service and third sector partners as well as with quantitative data to draw key themes and conclusions. These findings are summarised below.

Self reported awareness of where to access services was generally quite high.



Graph 56: Responses to the question: “Are you aware of where you can access services or help and advice on sexual health locally?”. Source: Bespoke outreach survey.

Key enablers

Positive aspects of people's experiences with services included feeling that they were understood, feeling comfortable and reassured, being supported in a non-judgemental way. When asked about the most important factors when it comes to sexual health help or support, most people rated not having to travel far as important, as well as short wait times and accessing support online.

Key barriers

Recurring themes related to challenges when accessing sexual health care were linked to negative past experiences, which sometimes led to them wanting to access services online, location/geographically driven barriers meaning it takes time to get care, and feelings of embarrassment and judgement.

"Staff were very nice, they give free condoms, the process was good, good experience, communication was good."

"Everything was good very easy and comfortable."

"Positive attitude."

"Good GP."

"The distance I have to travel to now to get a service in Croydon."

"The length of time to get an appointment."

"They understand."

"Difficult to find in Croydon, takes 20-30 minutes of time."

"Felt embarrassing and judged by the GP."

"Took a while."

"The GP was nice and not judgemental."

"I felt like I had to fight to get seen by anyone which has put me off going to professional services and start to go on free online services more."

"Took a lot of prompting to get the baby needles."

"Effective."

"Reassured me."

"It was honest and the truth."

"It was quick."

"The staff were great."

"Nothing."

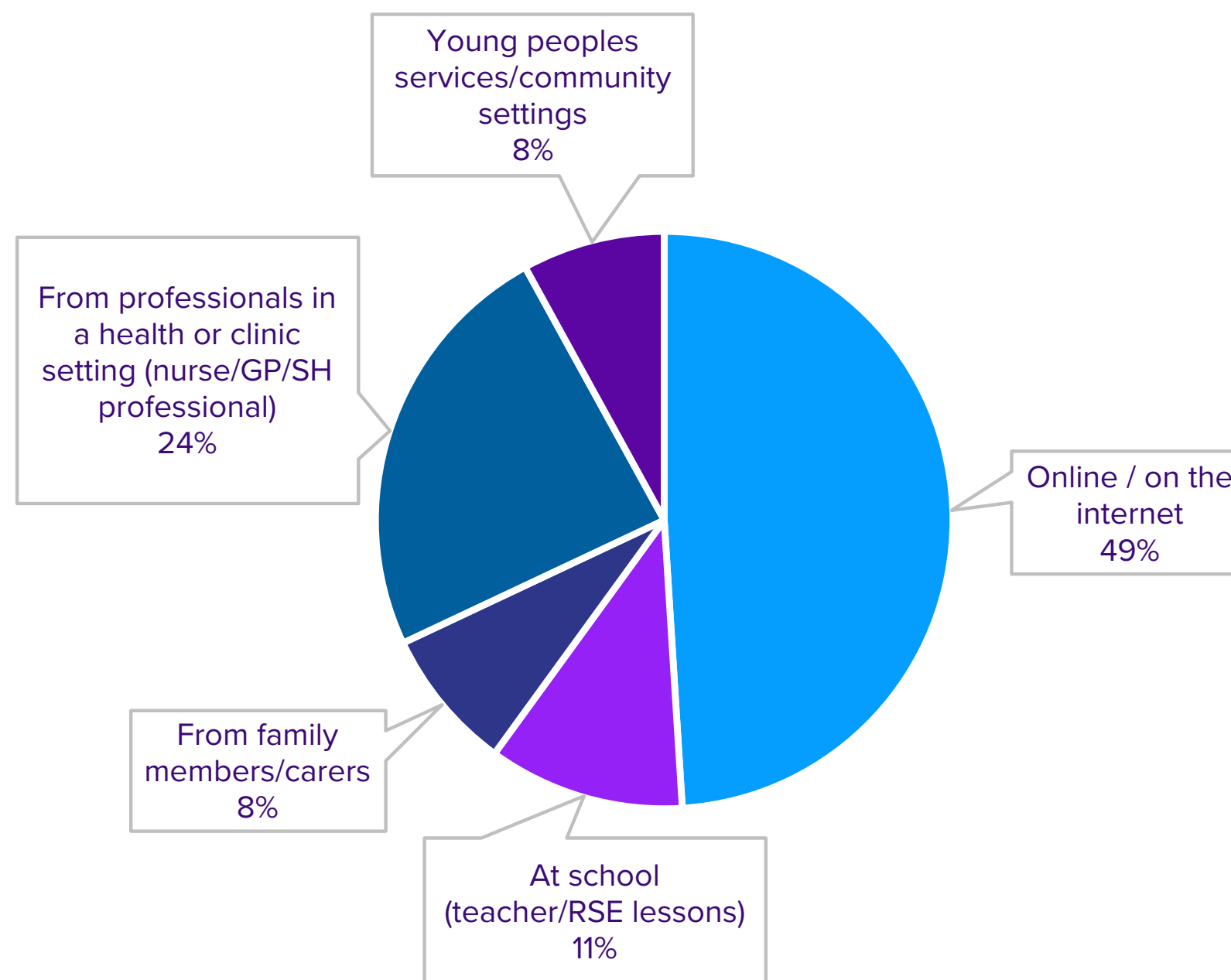
Key quotes

Key quotes

When asking about people's experience and feelings towards the information and advice they have received around sexual health, most expressed that they found information and advice quite useful (46%). 17% found information and advice very useful, and 8% found it not useful. 30% said they had not received information or advice (either via school or other settings).

Preferred methods of accessing information

Individuals had a preference to access information and advice either via the internet (49%) or via professionals in a clinic or health setting (e.g. nurse/GP/sexual health professional) (24%) (Graph 56).



Graph 57: How would you prefer to access information and advice on sexual health and relationships?

When asked what might stop them looking for the help and support that individuals want or need, key barriers from respondents predominantly covered location related barriers or things that would reduce ease of accessing services such as long travel or wait times as well as stigma and embarrassment.

“If it is hard to get to - location based.”
 “Having to travel far.” “Nothing.”
 “Depends on the person but I would be open about it because I wouldn't want to be unwell.”
 “Long wait times.” “Agoraphobia.”

Key quotes



Opportunities and areas for improvement

Various opportunities and areas where services can improve emerged from findings. These related to having a wider variety of locations to access/ geographical coverage, more days to access services, having services online, reducing stigma and normalising discussions around sexual health. Representation and wanting to see people of their age and ethnicity was a commonly cited area expressed individuals.

Methods for increased promotion of services were mentioned, which individuals thought would improve awareness of what's available. Suggested appropriate sites for promotion of services was within communities, living spaces or housing settings, as well as within broader services or health settings through flyers and posters.

"Promote services through flyers in other services or community hubs."

"Advertise and promote them more in certain hubs."

Key quotes

"Promoting services better - there is nothing to promote services in my block of flats for example."

"Have more availability to see people over 25."

"More health services around Croydon."

"More clinics in Croydon."

"Normalise talking about it."

"Them being online."

"Age and when it's introduced into schools."

"Make it more aware."

"QR codes."

"More days of access."

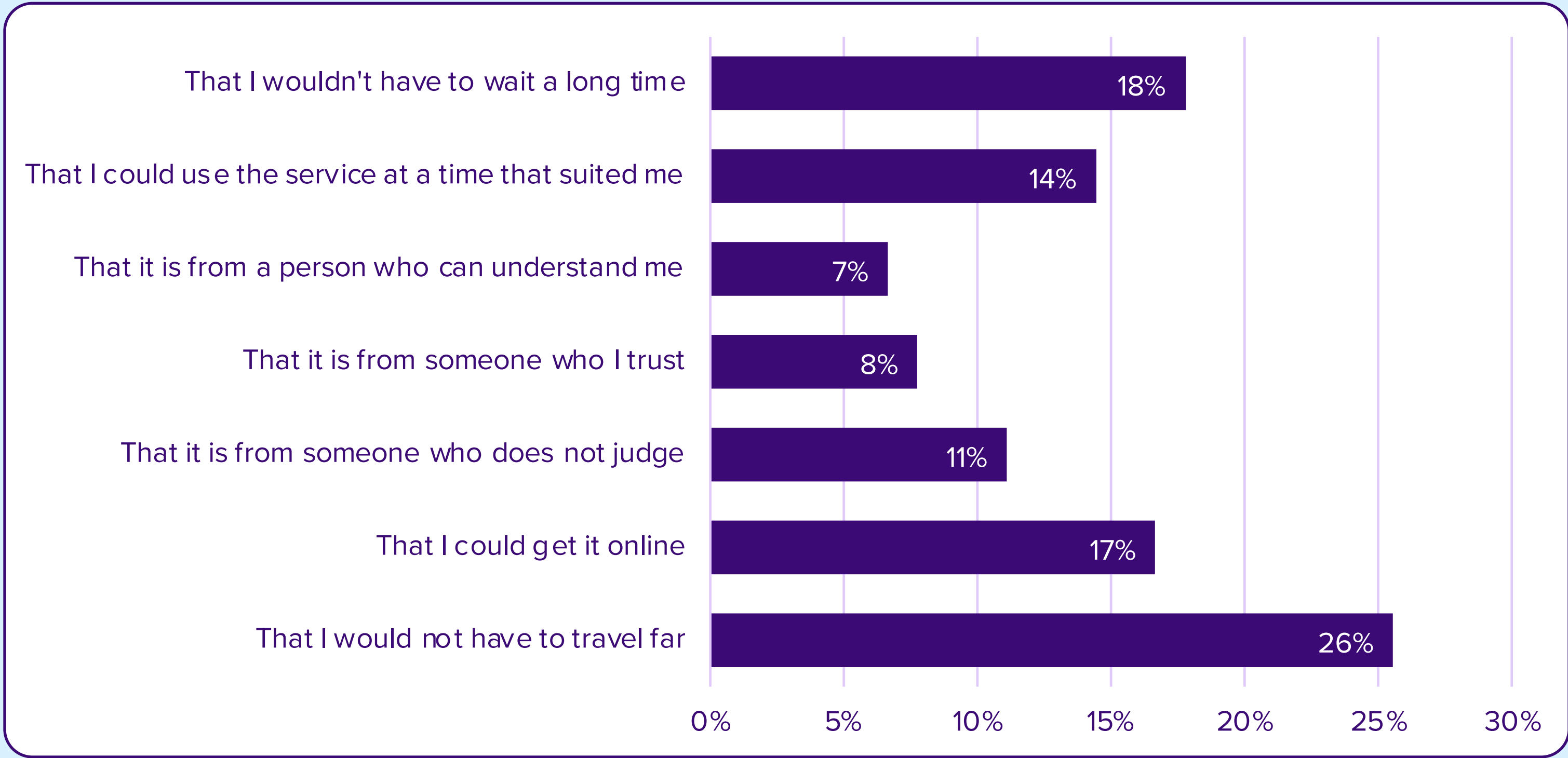
"Initiatives for young people."

"Sexual health clinic in Crystal Palace."

"Confidential and appointment times to avoid embarrassment. More teaching and openness about this stuff as it still is considered a taboo when it should be something people can talk and advise each other about."

"Being more free about it."

"More time to call during the day if needed."



Graph 58: What would be important to you about the help or support that you receive (asked to select all that apply)? Source: Bespoke outreach survey.

ENGAGEMENT WITH STRATEGIC AND COMMUNITY PARTNERS

We engaged with various partners across the voluntary sphere, service landscape and community organisations to further understand and contextualise key areas of challenge and opportunity around vulnerable people and groups at higher risk of poor SH outcomes.

The key findings are summarised as follows:

Key observations

- **Young people** – Increases in the use of AI or Chatbot tools for support around health and wellbeing more widely.
- **Young people** – The increasing influence of media, social media apps, internet, pornography and technology on ideas around routes to access information, attitudes around consent, healthy sexual relationships and body image perception. This has been reflected in service demand around psychosexual service within the clinic.
- **Cross-cutting** – Sexual health is often low priority for vulnerable groups who are often experiencing multiple complex life stressors such as addiction, homelessness or housing issues.

Areas of challenge

- **Young people**
 - » Support and provision for over 18s is a key gap where young people may be slipping through the crack but still facing poor SH outcomes.
 - » High levels of co-existing mental health challenges and overweight in this group which influences choice and hesitance around contraceptive methods associated with mood or weight side effects.
 - » Challenges engaging young people in contraception on a long-term basis, discontinuation can be common within a few months due to negative side effects.
 - » Young girls involved in organised crime, gangs or exploitation as a particularly vulnerable group, where understanding of healthy relationships is a key issue.

- **People with complex needs and SEND** – Potential gap within provision of support around sexual health for young people and adults with complex needs, learning disability and skills within workforce to handle this.
- **Asylum seekers and refugees** – Concerns around privacy, discretion and confidentiality of services, challenges with accessing appropriate interpreters more widely and a lack of available spaces specifically for this group to engage in sexual and reproductive health discussion.
- **Cross-cutting** – Key barriers are geographical positioning of clinics and being able to access them within school or work schedules.
- **Cross-cutting** – Addiction and problems using substances and alcohol were recognised as a cross-cutting barrier that underpins poor SH outcomes. This often has strong links to housing issues and other co-morbidities or risky behaviour.
- **People who are rough sleeping or homeless** – Current status of housing and temporary accommodation availability within the borough, as well as lack of emergency shelter identified as a wider problem and driver of poor sexual health outcomes. This makes it difficult for people to prioritise sexual health. Women often having transactional sex in exchange to couch surf were identified as a particular group of concern as they often do not self-identify as sex workers.

Key observations

- **Outreach team** – Consistently recognised as a compassionate service with dedicated leads who deliver good quality support across the borough to vulnerable communities, especially with their mobile van.
- **Community events** – Attendance at key community events such as Croydon Pride were identified as having a wide reaching positive impact, where services are able to make contact with a large volume of community members and reach those who may not traditionally attend a clinic.
- **Links with community organisations** – Community partners raised potential opportunities to develop and strengthen links with trusted community organisations which deliver tailored support for key vulnerable groups such as LGBTQ communities in the borough e.g., Queer Croydon.

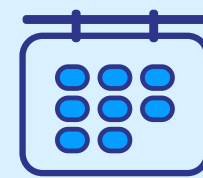
KEY RECOMMENDATIONS - VULNERABLE GROUPS (VG)



VG1 - Explore different modalities or delivery models for outreach service provision and identify appropriate venues for outreach activity run by commissioned partners. Review evidence and existing evaluations conducted on such interventions e.g., vending machines or mobile services for condoms or test kits.



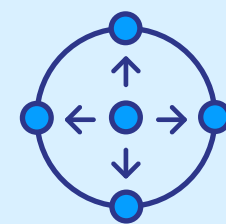
VG2 - Strengthen engagement with Black African ethnic groups, with women being a priority within this group to focus on tackling stigma around HIV and sexual health, linking with relevant community organisations and advocates.



VG3 - Raise profile and visibility of services in the borough by participation at key community events that are already attended e.g., Pride and World AIDS Day and beyond.



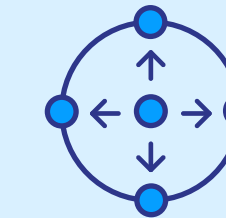
VG4 - Explore opportunities for relatable and representative communication campaigns utilising key websites and social media that vulnerable groups use and engage with.



VG5 - Explore ways to utilise opportunities within the trusted voluntary sector as neutral, stigma-free spaces for sexual health outreach to key communities such as refugees and asylum seekers.



VG7 - Exploring opportunities to operate the integrated service from satellite sites to increase reach across the borough's large geographical area (e.g., Hub and spoke model).



VG6 - Further expansion of the CHS Outreach team's reach and impact, to enable increased coverage of Croydon's large geography and diverse community.



7. Conclusion and recommendations

CONCLUSION

This Needs Assessment has identified various areas of good practice and what has been working well in LBC's sexual health services whilst also recognising some areas where there may be gaps or room for increased understanding and engagement. This presents various opportunities in the sexual health landscape for Croydon and to prioritise specific areas of unmet need or improvement in services.



RECOMMENDATIONS

Based on the findings from this Needs Assessment, the following focused recommendations are proposed, split across the areas assessed and overarching strategic areas.

Strategic overarching recommendations



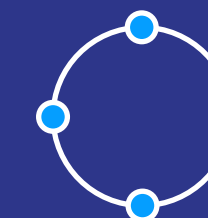
Establish a steering group

to strengthen partnership working, drive the proposed recommendations, prioritise areas of focus in the short term and develop ownership of an action plan to take these forward.



Explore opportunities

across services, providers and the council to jointly deliver the action plan.



Identify the best approach

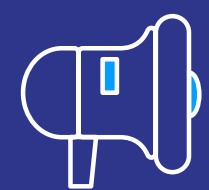
to data-sharing to facilitate monitoring outcomes.

Area specific recommendations

The following pages outline specific recommendations for each sexual health area, including Sexually Transmitted Infections (STI), Human Immunodeficiency Virus (HIV), Contraception (CON), Abortion (ABR), young people (YP) and vulnerable groups (VG).

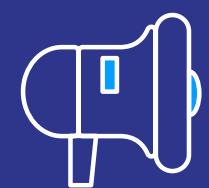


RECOMMENDATIONS - SEXUALLY TRANSMITTED INFECTIONS (STI)



STI1

Continue efforts to successfully keep syphilis rates in the population low for example through maintaining existing screening rates, raising awareness and signposting around Doxy PEP use in key populations (e.g. MSM).



STI2

Raise awareness around symptoms of trichomoniasis and shigella, particularly targeting GBMSM and people engaging in risky behaviours who face high burden. This will also ameliorate risks of anti-microbial resistance growing in the population.



STI3

Enhance chlamydia detection programmes and consider broadening screening offer where possible – including encouraging more pharmacies in targeted areas (e.g. the south and west of the borough) to participate.



STI4

Focus on mitigating STI reinfection rates in target groups with high burden or risk i.e. young people and women in the borough, and understanding key drivers behind reinfection rates.



STI5

Cross-promote programmes and campaigns across services e.g. C-Card, STI Screening, employing the Making Every Contact Count approach to maximise the reach of commissioned services.

RECOMMENDATIONS - HUMAN IMMUNODEFICIENCY VIRUS (HIV)



HIV1

Consider how the HIV clinic can access and liaise with key Council departments for support with housing, benefits and care packages.



HIV2

Map and promote wider support available around housing and food poverty (including access to food banks) particularly for people living with HIV, to enable them to meet food requirements for treatment.



HIV3

Engage with General Practices to empower GPs to become more HIV confident. Focus on tools/education to be able to support those at risk of HIV and people living with HIV in a non-stigmatising way.



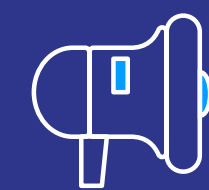
HIV4

Work alongside health and wider partners to improve access to new opportunities in the HIV prevention and treatment landscape e.g. long acting injectables. Support delivery and workforce to ensure they are skilled and prepared to deliver injectables, ensuring equity of access in implementation.



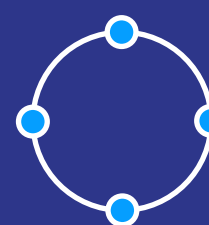
HIV5

Work with key community leaders such as faith leaders in Black African communities to engage these groups as a priority, amplify prevention messages and focus on tackling stigma around testing/HIV prevention e.g. working with local churches to promote testing.



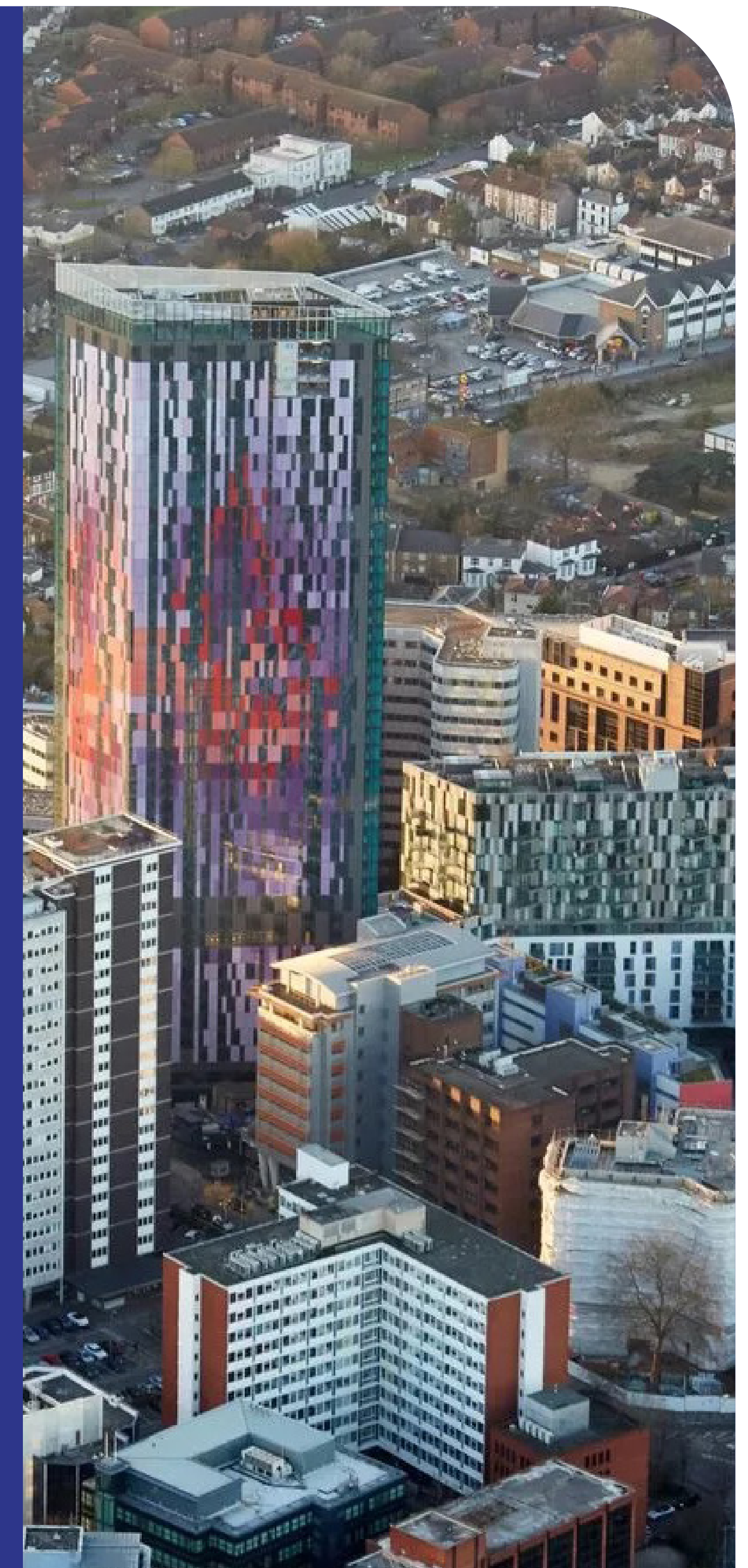
HIV6

Raise awareness around prevalence and address stigma around HIV among healthcare workers (such as within hospital settings and social care) and amongst the general public.



HIV7

Expanding HIV peer support offer more broadly.

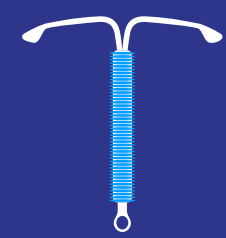


RECOMMENDATIONS - CONTRACEPTION (CON)



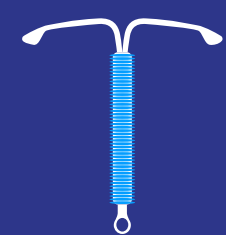
CON1

Engaging GPs and HCPs to promote LARC at various key opportunities, as GPs were recognised as a setting in which many prefer to access contraception.



CON2

Focused engagement specifically on LARC to increase understanding of barriers to access and context behind choices to not adopt a LARC method (e.g., education, clinic opening hours around work patterns, travel time).



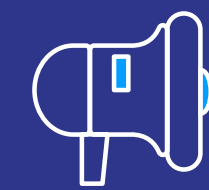
CON3

Explore models to deliver LARC or contraception in a dedicated service, aligning with preferred methods of accessing contraception identified through consultation with communities (e.g., hub models or dedicated LARC clinics within GPs).



CON4

Conduct further investigation around variation in LARC uptake geographically in Croydon and by equity dimensions, to understand underlying factors (which may relate to multiple factors i.e., individual practice appointment availability, training or distribution of practices offering LARC).



CON5

Improving awareness of the range of places in which contraception can be accessed. Reviewing online communications and website materials to ensure contraception pathways are clear.



CON6

Expand opportunities to offer contraception services in line with patient preference and lifestyle needs (e.g., considering work patterns, out of hours clinics or weekend appointment availability).



RECOMMENDATIONS - ABORTION (ABR)



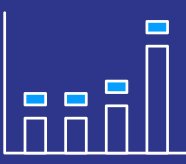
ABR1

Explore strategies to provide online avenues to initiate a termination consultation, aiming to expand access to terminations through an alternative pathway for contact that is open all hours.



ABR2

Work with local pharmacies to understand the impact of EHC pharmacy offer, with focus on groups experiencing disproportionate burden to inform future commissioning decisions.



ABR3

Regular local analysis of repeat terminations data to build evidence around trends and inform targeted action/prevention in this area. This can support views from partners that trends are declining.



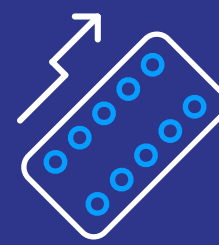
ABR4

Provide age-specific support towards age groups with high burden of repeat TOP (25 to 35 year olds), utilising cross-service promotion and the “Making Every Contact Count” approach to engage this age group in wider settings.



ABR5

Strengthening partnership working and explore opportunities for data sharing with TOP and other providers through tools such as dashboards.



ABR6

Explore the local need and demand for increased contraception provision and appointments. Assess feasibility of pilot opportunities for contraception/LARC provision collaborating with partner organisations.



ABR7

Explore active recall systems (text reminders, follow-up calls) for those less likely to engage (e.g., non-attendance at post-TOP contraception appointments) drawing on regional pilot models of data-sharing that enable clinics to follow up with these patients.

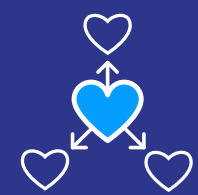


RECOMMENDATIONS - YOUNG PEOPLE (YP)



YP1

Explore opportunities to co-develop services with young people and involve them in delivery, e.g., Peer Health Champion programmes for children and young people.



YP2

Increase provision of outreach and health promotion to young people, exploring family hubs (particularly new Samuel Coleridge-Taylor FH) as an opportunity to link with or deliver support.



YP3

Conduct review of C-Card scheme to facilitate expansion of the commissioned scheme, increased activity and assessment of whether current volume and spread of distribution points/providers is sufficient to meet local population of young people in places accessible to them. Involve or engage young people, outreach teams and providers/distributors to understand effective promotion and methods of access (e.g., explore digital C-Card offer) and increase understanding around registration/distribution locations.



YP4

Review alignment of services with young people's priorities and needs (including lifestyle patterns, location, mode of access and safety concerns), considering solutions to these barriers such as out-of-hours clinics, anonymous entrances, satellite locations.



YP5

Co-develop communications materials with young people (e.g., through workshops or focus groups), aiming to understand communication methods they want to engage with (i.e., social media). Content could work to destigmatise sexual health and explain what they can expect when visiting a clinic.



YP6

Clarity and agreement regarding roles and responsibilities of different partners involved in sexual health education including the education system, council and health partners.



RECOMMENDATIONS - VULNERABLE GROUPS (VG)



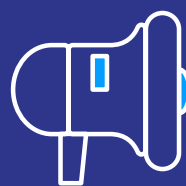
VG1

Explore different modalities or delivery models for outreach service provision and identify appropriate venues for outreach activity run by commissioned partners. Review evidence and existing evaluations conducted on such interventions e.g., vending machines or mobile services for condoms or test kits.



VG2

Strengthen engagement with Black African ethnic groups, with women being a priority within this group to focus on tackling stigma around HIV and sexual health, linking with relevant community organisations and advocates.



VG3

Raise profile and visibility of services in the borough by participation at key community events that are already attended e.g., Pride and World AIDS Day and beyond.



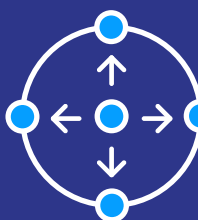
VG4

Explore opportunities for relatable and representative communication campaigns utilising key websites and social media that vulnerable groups use and engage with.



VG5

Explore ways to utilise opportunities within the trusted voluntary sector as neutral, stigma-free spaces for sexual health outreach to key communities such as refugees and asylum seekers.



VG6

Further expansion of the CHS Outreach team's reach and impact, to enable increased coverage of Croydon's large geography and diverse community.



VG7

Exploring opportunities to operate the integrated service from satellite sites to increase reach across the borough's large geographical area (e.g., Hub and spoke model).



APPENDICES

i. Breakdown of demographic information for survey respondents

Outreach survey respondent demographic information

Age

Under 18	24.6%
18 to 24	33.8%
25 to 34	15.4%
35 to 44	6.2%
45 to 54	0%
55+	0%
Blank	20%

Gender identity

Female (including Trans women)	43%
Male (including Trans men)	40%
Non-binary	5%
Other	2%
Blank	11%

Trans history

When asked “Is your gender identity the same as your gender assigned at birth?” respondents answers are broken down as follows:

Yes	65%
No	6%
Prefer not to say	3%
Blank	26%

Sexual orientation

When asked “How do you describe your sexuality?” participants answers are broken down as follows:

Queer	<10%
Pansexual	<10%
Straight or Heterosexual	50.8%
Bisexual	9.2%
Lesbian or Gay	7.7%
Blank	21.5%
Prefer not to say	1.5%

Ethnicity

When asked “How do you describe your ethnic group or background?” participants selected the following:

White - British	9.2%
White - Irish	0%
White - Gypsy or Irish Traveller	0%
White - Roma	0%
Black - African	9.2%
Black - Caribbean	23.1%
Black - Any other Black, Black British or Caribbean background	4.6%
White - Any other White background	7.7%
Asian - Pakistani	1.5%
Asian - Indian	3.1%
Asian - Bangladeshi	0%
Asian - Chinese	1.5%
Asian - Any other Asian background	3.1%
Mixed - White and Black Caribbean	0%
Mixed - White and Asian	7.7%
Mixed - White and Black African	1.5%
Mixed - Any other Mixed/Multiple back-ground	0%
Other- Hispanic or Latin American	3.1%
Other- Arab	1.5%
Other - Any other ethnic background	1.5%
Prefer not to say	1.5%
Left this question blank	20%

Vulnerable identities

When asked, “Do you identify with any of the following statements? (please select all that apply),” participants selected the following:

Percentages represent the proportion of participants who selected each statement, and participants could select more than one option.

I have experience of being homeless or a rough sleep-er	30.8%
I have engaged in sex work, transactional sex, selling sex, or exchanging goods or money for sexual services	7.7%
I have experienced mental health issues	24.6%
I am a migrant, refugee or am seeking asylum	7.7%
I have special education needs or a disability	6.2%
I have experienced problems with using drugs or substances	23.1%
I am living with HIV	1.5%
Blank	13.8%
None	12.3%
Total number of participants who identified with at least one statement	87.7%

Contraception specific survey respondent demographics

Age

Under 18	37%
18 to 24	19%
25 to 34	33%
35 to 44	4%
45 to 54	7%
55+	0%
65+	0%

Gender identity

Female (including Trans women)	96%
Male (including Trans men)	0%
Non-binary	4%
Other	0%
Prefer not to say	0%
Blank	0%

Trans history

When asked “Is your gender identity the same as your gender assigned at birth?” respondents answers are broken down as follows:

Yes	100%
No	0%
Prefer not to say	0%
Blank	0%

Sexual orientation

When asked “How do you describe your sexuality?” participants answers are broken down as follows:

Queer	0%
Pansexual	0%
Straight or Heterosexual	75%
Bisexual	21.4%
Lesbian or Gay	0%
Blank	3.6%
Prefer not to say	0%

Vulnerable identities

When asked, “Do you identify with any of the following statements? (please select all that apply),” participants selected the following:

Percentages represent the proportion of participants who selected each statement, and participants could select more than one option.

I have experience of being homeless or a rough sleeper	25%
I have engaged in sex work, transactional sex, selling sex, or exchanging goods or money for sexual services	0%
I have experienced mental health issues	24.6%
I am a migrant, refugee or am seeking asylum	50%
I have special education needs or a disability	7.1%
I have experienced problems with using drugs or substances	25%
I am living with HIV	14.3%
Blank	0%
None	21.4%
Total number of participants who identified with at least one statement	71.4%

Ethnicity

When asked “How do you describe your ethnic group or background?” the breakdown of respondents answers were as follows:

White - British	32.1%
White - Irish	0%
White - Gypsy or Irish Traveller	0%
White - Roma	0%
Black - African	3.6%
Black - Caribbean	14.3%
Black - Any other Black, Black British or Caribbean background	3.6%
White - Any other White background	3.6%
Asian - Pakistani	0%
Asian - Indian	3.6%
Asian - Bangladeshi	7.1%
Asian - Chinese	0%
Asian - Any other Asian background	0%
Mixed - White and Black Caribbean	7.1%
Mixed - White and Asian	0%
Mixed - White and Black African	14.3%
Mixed - Any other Mixed/Multiple back-ground	0%
Other- Hispanic or Latin American	3.6%
Other- Arab	0%
Other - Any other ethnic background	0%
Prefer not to say	0%
Left this question blank	7.1%



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