Appendix 4 - Free Text Survey Responses

Free text comments were received under the vision and each of the themes during the consultation. These have been grouped into subject areas and illustrate where further work may be needed to inform and develop our future approaches to service delivery.

Vision

I have no issues against the strategy

Very concise

Prevention is key.

I'm glad to see it's being addressed.

Whilst overall the vision and aims are well-meaning, there are some contradictions that are illuminating.

I have only focused on the areas relevant to myself and I was positively impressed with the depth of understanding especially around the need for integrated teams, widening outreach, promoting PREP and working in partnership

Agree with need for voices of lived experience and proper consultation and involvement Is there space for co-production too, rather than just consultation?

Support the strategy but want to know how this will be implemented and no money given to UHB for providing all services.

I'd like to see a resourcing plan to support delivery of the strategy

Values and beliefs:
Stopping the pervading belief that sexual availability and activity is cool/fashionable/desirable but in a way that is not old fashioned or religious. Privacy and choice not to be sexually active is a right and not prudish or frigid.

I believe in the sanctity of life and therefore the rights of the unborn child. I therefore cannot in good conscience support abortion services.

……although the vision suggesting that it is important to reduce stigma and shame, by positioning abortion as a 'bad outcome' or 'failing at contraception', the strategy actually reinforces abortion stigma. This is extremely unhelpful, and does nothing to encourage open and meaningful conversations with healthcare providers

A key part of the vision stated is 'to enable citizens to have control' - which is exactly what it should be. However, within the strategy, there is a strong emphasis on increasing LARC take up and reducing abortions. For many this will be what they want and be welcomed, but this should not be universally assumed.

I particularly agree that the aim to see "A reduction in the high rates of teenage and unwanted pregnancy, abortion and STIs, which can have far reaching consequences for individuals and society" is very important and in part stems from the hyper-sexualised culture that teenagers now grow up in.

The Strategy should include more focus on education that includes learning and understanding about genetic literacy and the associated risks and mitigations from a non-judgemental perspective. This needs to start from primary school and in faith settings.

Gaps:
It is very focussed on female issues with little regard to issues affecting men unless they are marginalised or have a sexually transmissible disease

There is nothing for people experiencing sexual dysfunction such as impotence or vaginismus. This is a big issue for older men and men with diabetes. Education on the subject and availability of Viagra, psychosexual counselling etc should be included You mention gender dysphoria but there is nothing specific planned. Counselling outside of specialised clinic appointments that are typically 3 months apart for the index person and also for their close contacts should be available locally. They have big issues to consider regarding their reproductive health and the sexuality of their partners

You mention sexuality and disability but there is nothing specific planned

There has been very little progress in terms of developing learning for foster carers in SMBC these past years so I very much welcome this

Enable services that are local, relevant, approachable, etc while responding to human protected characteristics. I hope this also includes the consideration that some women only services as protected by sex are needed too

Current Offer:
They hold too much power already and are the Goliath in health care. They care more about their research papers than their clients.

Sexual health provision in the city is appalling and has deteriorated in recent years. Trying to get an appointment with umbrella is almost impossible. Since removal of the walk in GP centres in Birmingham if you need PEP, you have to wait 8 hours in A&E who are overstretched.

COVID has negatively impacted sexual health services everywhere. There needs to be a step change to ensure services that were reduced or removed during this period are re-established and additionally improved upon to manage vision and aims of the strategy.

Additionally, there is not enough focus on diagnosis of STIs. Approximately 80% of patient management decisions are as a result of a pathology diagnosis, this is no different in sexual health, and yet given the potential stigma and barriers, we still find it acceptable to allow patients to wait excess time for results and treatment, we still find it acceptable to assume patients will manage their own health via on-line / postal services for testing and education; some vulnerable groups need more attention.

Healthcare Sector Comments:
On behalf of NHS England I think it would be good to see reference to the commissioning of Opportunistic Cervical Screening at Sexual Health clinics. We would be keen to discuss how we move forward with this

We need to better manage testing and the time to diagnosis and treatment.
Please refer to Whitlock et al., Rapid Testing and treatment for sexually transmitted infections improve patient care and yield public health benefits. International Journal of STD and AIDS., 0(0) 1-9 https://doi.org/10.1177/0956462417736431

Gilead Sciences has worked with sexual health services across the world to ensure that people who are diagnosed with HIV and HCV have access to the most appropriate treatment as quickly and securely as possible. We therefore welcome the opportunity to provide a written submission to this inquiry and support the ambitions of Birmingham's Sexual and Reproductive Health Strategy in providing the best prevention, treatment, and care for all those living with and at risk from HIV and HCV. In alignment with Birmingham's Vision, we see four main actions that need to be undertaken across all sections of society to make progress:

1. People living with HIV are not a homogenous group, it is important that the individual concerns and needs are considered when implementing measures and actions and the voice of people living with HIV must be at the heart of any policies and actions and their voices must be heard
2. Data collection should be improved to include a greater cross-section of society, including lesbian and bisexual women, migrant communities, people who inject drugs, and people who are homeless
3. Specific measures should be introduced to tackle areas of concern for people living with HIV such as mental health, social care, stigma and discrimination, supported by education for healthcare professionals
4. Easy-to-access testing initiatives must be a key focus for sexual health services. Early access to testing plays a vital role in reducing late diagnosis for BBVs and rates of transmission.

Terminology:
Vision seems robust and appropriate. However, next to aim 1 and 3 you mention "resilience." I do not think this word is user friendly (many MH service users do not like this overused phrase), it also suggests that people "just need" to be stronger/more resilient in the face of difficulties (some of which will include very traumatic and adverse situations.) Some users of services feel that this is a way which unhelpfully only focuses on their supposed lack of resilience, rather than failures in systems, multiple disadvantage and appropriate distress responses to very traumatic and adverse situations.

Agree that Access for every resident to meet their individual needs is key. Would like to see removal of barriers and providing equity of service here instead of resilience.

Enable citizens to have control of their own sexual health with services providing support where needed, agree it is key but would like to see the word resilience replaced with something else. Alongside the client feedback, it also isn't clear of what is meant by this anyway.

Theme One: Priority groups

Older people:
I'm concerned there is a theme focused on young people but not older people (although full lifecourse is mentioned).

The relationship and sexual health needs of older people should be treated as a separate theme due to the different presenting needs and the lack of focus on this population group in previous service delivery.

Agree but need to address a broad range of ages eg: over 40's and older people within this strategy

Victims of Domestic Abuse:

Is there scope to provide training for pharmacists around domestic abuse? Birmingham currently has IRIS and an IDVA based within sexual health services to facilitate this training but pharmacists, who may provide an excellent safe space for women to disclose experiences, do not receive training as far as I'm aware

Women experiencing domestic violence and abuse also need to be a priority group, ensuring safe confidential access to services at the GP practice. STIs and repeat emergency contraception / abortions can be an indicator for DVA. DVA needs to be brought up through sexual health training for practices.

Work with Women's Refuges, Chem-Sex and Sex Worker support groups (if there are any) and HIV Support Groups

Above there is NO mention of those subjected to sexual and domestic abuse, which is referenced in the draft strategy. This is a vital priority group and the work of the last SH strategy where it was an outcome should be maintained, built on and grown. By not mentioning it here, there will be a loss of focus on this priority group which affects a large proportion of people, and as evidence shows esp those who are women, young people and those with disabilities (all 3: sex, age and disability are protected characteristics too)

HIV & Blood Borne Viruses:

To protect and support people living with HIV, it is key to understand who they are, their needs, and how they can be appropriately supported. In addition to gay and bisexual men as well as Black African communities, there are other priorities groups requiring support in order to remain on effective treatment to control their viral load. These groups include women, people who are ageing with HIV, people who are homeless, migrant communities, and people who inject drugs. To support all these groups to live well with HIV, the following steps should be taken:

Greater support should be provided for increasingly marginalised communities to ensure adherence to treatment plans is easier and these individuals can access the support they need. Advances in treatment and care have meant that the epidemic has been reduced to primarily impacting marginalised communities. The National AIDS Trust has warned that, unless action is taken to provide support to these marginalised communities, 'a larger outbreak in England is possible'. This group are likely to make up the majority of the 20% of people without viral suppression

Prioritise women living with HIV in both research and policy agendas, while ensuring greater collaboration between HIV services and sexual health and reproductive services to provide a stronger healthcare network for women with HIV. The experiences of women living with HIV are under-assessed and under-recognised. To address these inequalities, it's important that women are prioritised in policy and research agendas and community groups are included to ensure this work is community-led

To reduce the rates of HIV, the HIV Action Plan for England sets out two recommendations which should be included in Birmingham's plans:

- *Action 4: Reduce missed opportunities for HIV testing and late diagnosis of HIV*
- *Action 8: Ensure all late diagnoses are investigated as a serious incident by the National Institute for Health Protection, working with BHIVA, NHS Trusts, local authorities, and CCGs*

Early access to testing plays a vital role in reducing late diagnosis for all BBVs and reduces the number of people who are not aware of their status unknowingly passing the virus on. BBV testing in sexual health services is lowest among women (56%) and late diagnosis is highest among BAME groups, closely followed by older people and white women. With this

in mind, testing initiatives must be targeted and easy-to-access for service users, with opt-out BBV testing being the end goal.

In addition to the national actions that have been set, there are a number of other actions that should be implemented to address late diagnosis and tackle HIV, HBV and HCV in Birmingham. These can be implemented alongside the Fast Track Cities plus Project (a project aiming to reduce new cases of BBVs):
• Expand opt-out BBV testing into non-traditional settings, such as community centres, A&E, and primary care, to address late diagnosis and reduce onward transmission of HIV. Whilst Gilead notes the commitment to rolling out BBV testing in A&E and GP practices, further steps could be taken through opt-out testing. London recently launched an opt-out BBV testing approach which stipulated that all patients over 16 who require a blood test as part of their treatment at A&E departments receive a HIV test. Testing of this kind is thought to be the single most effective intervention to find most people living with HIV who are not yet diagnosed
• Expand HIV testing campaigns to raise awareness and address stigma across local areas, focusing on non-traditional settings. National HIV Testing Week (NHTW) runs once a year targeting the wider public. In 2021, NHTW had its most successful day on record with 8,200 HIV test kits requested. Due to high demand, Public Health England (PHE) funded an additional 10,000 kits to enable more people to know their HIV status. Campaigns such as NHTW could hold value if recreated in Birmingham through raising awareness of HIV among the general public, and ensuring that people are aware of their HIV status
• Ensure all HIV services are sufficiently supported to undertake a formal published review of all patients who are diagnosed late to gain better understanding of the population. A 2016 paper showed that almost a quarter (22%) of deaths in people with HIV in London were attributable to AIDS-defining illnesses, which is largely attributed to late diagnoses and/or a lack of engagement with care and treatment services.

Within the homeless [population], there's quite high rates of bloodborne viruses, but there aren't necessarily high rates of STIs

Improving testing for bloodborne viruses by blood spot testing - I think that would be well worthwhile doing.

Engagement:
I think working in partnership with other organisations is key to delivering this service to priority groups who may require these services.

Need to see more outreach provision for those hard to reach communities as there is currently lack of assertive engagement across the city due to cuts to funding over the years leaving people vulnerable and at increased risk.

More needs to be done to reach the hard to reach groups. More health promotion / education roles need to be put into place that focus on breaking barriers and negative attitudes towards sexual health .

General comments:
Sex and alcohol/drugs aren't always hand in hand and people shouldn't feel that they will be tared with the same brush….. those engaged in substance misuse support would likely need to concentrate their efforts on one issue at a time...

Curious to know why sex workers and chem-sex users are not included as priority themes in the strategy. In fact they are hardly mentions anywhere in the strategy

Recognise the need to better genetic literacy in some communities to reduce risks around consanguinity including
1. miscarriages
2. infant mortality
3. child mortality
4. child disability

Theme Two: Reducing the rates of sexually transmitted infections

Access:
Give a true 7 day service.

Pop-up clinics would be ideal

Walk in clinics are vital

Walk-in centres need to be better placed and not in Boots!!!

We are in 2022 and don't want the world to know we are going to a Sexual Health Clinic.

Needs to be better managed!!!

Need to move sexual health out of the hospitals and medical settings plus reduce shame around the topic of sexual health.

There need to be more localised places for sexual health screenings. Some of the local ones don't have blood testing functions and for some people/communities, being seen in the City Centre GUM clinic or around it would be shameful, equally, some might not have the money to travel.

If by pop-up services you mean for example clinics as gay saunas and sex clubs then yes. As a user of STI clinics and a gay man on PREP I have serious concerns about self-test Kits. I know they save time and resources but how effective are they? What research has been done on their effectiveness? I have found them to be difficult to use and have given up using them. Getting blood into the tiny vile is very tricky and messy. And I've had several comments of Umbrella staff saying that users don't like them and find them difficult and impractical to use

The Walk in (with available booked appointments) in Solihull is vital. Maintaining both walk in and self-test as part of a spectrum of options to reach the most people is key. Some people are unable to use the self test kits.

Make it 7 day testing walk in centres. The home test kit results take far too long to come through. Access to PEPSE on a Saturday or Sunday is awful.

Completely agree. There needs to be more localised offer, one that also is quicker than the current one where you sometimes have to wait quite a long time for an appointment for example when you work and can't do day time hours.

Have walk In Sexual Health Centres had their day? Is it now better to integrate them into other services?

Don't want to go to the hospital for testing or GP or even Boots in town centre. Want to have testing that is easy to get to and close to where I live.

The Hubs seems like a good idea

I would also like to see the utilisation of frontline support/outreach staff in delivering community-based sexual health link work

Inclusion:
It is important to link cross services to provide holistic services, but it is also important to not exclude those that may need sexual health but not drugs and alcohol or even if people need both to not put them off accessing one because they are not ready to talk about the other.

Not just young people need safe spaces to discuss their health and relationships

You have included little for women with genital mutilation who have NRPF and may find genital examinations difficult and birth almost impossible.

There is a distinct absence of issues arising from the menopause such as vaginal dryness, loss of sexual desire

There is a much closer link to the above than ever before realised. Inequalities/substance misuse/intersectionality really affect people's choices and accessibility but also understanding of risks and accessing services.

You have to [check] what people's prime motivators are [for attending sexual health services], nd they aren't necessarily the same as ours… We might see what they need but they don't."

I am shocked how quickly CHEMSEX is on the increase. It's like a little pandemic of its own. If you go on some of the dating applications, you start seeing the number of people looking for it/selling it etc. It's really worrying for health reasons, MH reasons but also of course around safe-sex practice which tends to go out the window in those situations. I presume abuse might also take place in those situations.

STIs can be a signifier of DVA. Please ensure clinic, pharmacy and outreach teams are aware to look out for DVA.

I am a survivor of historical sexual abuse. Whilst I've been asked in a clinic about any previous such incidents and I disclosed them, once I said I didn't need help, it was left. I actually would sign up to some sort of focus group or some help around dealing with past abuse, not just sexual but I've also been subjected to emotional and physical, which has affected my whole life and still does. It'd be great to see some help offered in that space

Primary Care
Primary care (GPs) should be having more involvement in managing sexual health , currently with contracts sitting with external providers it is duplicating work, we need to share our notes and communication has to be robust, we seem to be lacking an effective communication and wonder if the new process will look into this - Best wishes, A caring GP

Pharmacies are probably better served for public use than GP's as you would have discuss private information with the receptionist first. Pharmacy staff are more helpful.

Women from many BAME communities are not allowed to attend sexual health services on their own and cannot discuss embarrassing issues in front of family members. In my experience, many will talk about such matters openly to a health professional on their own. Some worry that their husbands are gay or carrying STIs from sex outside marriage and even have symptoms of STIs that they cannot disclose in front of a relative. Some say that

their GP needs to pretend to send for them to discuss their child's health for them to be allowed to attend without a relative or insist that the consultation is just for them with no one else present.

I agree with the statements in general but would prefer more information about how it will be done e.g. item 6 ensure all pharmacies ..... Which ones will be trained first ? any priority of area or target group… how many and by when

Funding for GP practices to deliver sexual health services as part of contraception services (currently not part of the service which Umbrella GP partners can provide when fitting LARCs for non registered patients which makes no sense)

Education:
Much more needs to be done in reducing stigma and providing education - all around accessibility.

How can education AND high value reliable laboratory quality testing be achieved in outreach areas?

Testing:
Point of Care testing has developed over time and can no longer be considered lower quality than the laboratory - addressing this would improve access and discussion as well as potentially reduce time to treatment, reduce transmission of STIs and reduce stigma.

Gilead Sciences welcomes any action taken to reduce the rates of HIV transmissions, while improving the health-related quality of life for people living with HIV. The commitment of the aims set out in Birmingham's draft strategy represents a positive step in helping and supporting people living with HIV. However, in order to enact meaningful change, sexual health services must shift their focus to a wider BBV approach and consider what local steps can be taken to reach the Government's target to eliminate Hepatitis C by 2025 and end new transmissions of HIV by 2030.

More could be done in collaboration with services that already provide a rapid diagnostic and faster treatment approach, especially in PWIDS and homeless populations (refer to Midlands ODN and The Hepatitis C Trust) who already have focus and these groups and could work with other services to support (AT THE SAME TIME) STIs, as well as other infectious disease possibilities. This could save time and revenue in faster diagnosis and treatment as well as staff time with multiple services chasing the same patient.

Would self testing with a RAPID lab quality result be more appropriate for people who have been sexually abused or assaulted - to reduce the anxiety of waiting for results, why not provide laboratory quality POC testing? to provide results within hours that can then be reliably acted upon.

More needs to be included about smear tests and HPV vaccinations.

[STI] testing in other services e.g. TOP services needs to be addressed as this has really suffered with the changes in legislation and procedures which means that women are often not being seen.

Are you including tests for hepatitis and tuberculosis with the HIV test? From what is written it looks that way and if you are some people are going to object and possibly refuse any test.

Easy access to self-testing kits should be for everyone, not just under 25s.

Local clinics don't do blood tests in some cases, that should change.

The self-testing kits have not long ago changed the tube for a blood sample. It is now much bigger and it's IMPOSSIBLE to get enough blood out of the finger to provide a sample. I've given up now and so many of the people I know have - we just send the other tests off without bloods.

Having a number of different STI testing kit suppliers would not support the majority of laboratory testing broad assay menus on a single platform that allows consolidation and the ability to run more tests. Maintaining multiple contracts with suppliers would be unwieldy and in many cases impractical given the primary supplier, Hologic is used by the majority of laboratories and changing would involve major costs and disruption to the current platforms used by laboratories.

Number 8 is a non sequitar and the other infections require attention outside of HIV testing. Include reference to monkey pox?

Values and Beliefs:
It would be great if we could try and promote chastity, as opposed to offering free condoms which unfortunately will be more geared to promoting promiscuity.

In addition, the drivers and motivations for sexual promiscuity also need to be looked at rather than just addressing the result (i.e STIs etc)

Your objectives and questions above seem obvious. It isn't the what, it's the how, how do you do it? how do you assess effectiveness? how do you follow up. More subtly, how do you work around political and religious nonsensical certainties?

But should be a way to reduce shame

The provision for young people to talk about healthy relationships is key as otherwise the main learning ground is likely to be the internet and/or pornography which leads to damaging and unhealthy relationships.

Effectiveness:
Once again to provide the sexual and reproductive health services in an efficient way and to reduce the rates these equipment and other services are vital to the programme.

Don't know is more "why focus this on young people only?" other than that the statements are fine.

PREP is brilliant and the service and nurses are great. More people should have it.

The PREP clinics have been really good, very friendly, informative, non-judgmental, quick, reminding of the need to test and pick up PREP - fantastic. Promotion needs to increase to prevent further HIV infection rates.

Whilst the need for ongoing partnership is recognised there needs to be an increase in funding in order to ensure that there are enough resources are in place to meet the needs of the city.

Your questions and required responses are leading. Yes to all of the above but HOW CAN THIS BE ACHIEVED DIFFERENTLY AND MORE EFFECTIVELY? You are assuming here

that when the response is YES then your approach or offer is adequate or on track - what about being better, being innovative?

Theme Three: Reduce the number of unwanted pregnancies

The name of this theme is hugely problematic – it adopts a stigmatising approach from its inception, and should be renamed. A preferable approach would be to 'Increasing contraceptive access', but even switching to 'unintended pregnancy' would help.

The phrase 'reduce unwanted pregnancies' could be interpreted as 'increase the number of abortions', which I would not agree with.

Contraception:
Want easy access like it used to be

Better information online

Needs to be like a one-stop shop

I've never heard of LARC before but the concept is sound and should be encouraged.

Free, accessible pregnancy tests are important. Accessible LARC and emergency contraception with guaranteed confidentiality and DVA awareness are also essential. Specialised DVA training and advisors for pharmacy and clinic teams is one step that could make this service more accessible. Ensuring it is culturally sensitive and aware of inequalities with a high level of anti-racism training could also make this service more accessible.

Why there is not a pharmacy contraception offer in the centre of Solihull is beyond me. Having to go to the GP or the walk-in when other services are not required does not seem to be best use of resources and possibly more stigmatising than walking into the pharmacy after the initial GP or walk-in issue.

You do not mention the removal of some of the invasive contraception. Some of it requires a doctor. You do not mention ensuring the competency of IUD fitting doctors is regularly tracked / ensured

What is the evidence that providing the same pharmacy contraception offers in Birmingham and Solihull is the most effective way of reducing inequalities, given the very different demographics?

Better access to contraception is really important, but the overemphasis on LARC is problematic. There is strong evidence that when certain populations deemed by providers and policymakers as potentially 'bad mothers' are targeted for LARCs, there is a lack of attention to the reproductive autonomy of individuals, and issues such as side effects are not properly explained. In addition, the difficulties faced by people asking for LARC removal are becoming well known, and this is also likely to contribute to a lack of uptake.

I'm a cis gender straight female no longer in need of contraception but I think services are much worse now than they were. I liked being able to get contraceptive advice and free contraception from a stand alone FP clinic. Given the impossibility now of getting appointments in GP surgeries I think I would definitely prefer that still. But as a working person the huge benefit was evening clinics so I didn't have to take time off work. I see that it is impossible to see an Umbrella practitioner after 1830 or even 1630 in some clinics. I get that there may be risks to staff that did not exist so much 30 years ago but I think more

should be done to ensure that every woman knows free contraception and advice is available outside of GPs, all men know free condoms are available (I hope they still are) and that every step is taken to extend possibility for appointments / walk in across the city at extended times.

[We need to] understand about why is it that we are so far behind [the GP LARC prescribing rate] and understanding what it is that we need to do to address that.

As women who are sexually active do we routinely test women attending for contraception for HIV? If not why not?

Do not weaken family planning services and access to appropriate contraception in favour of sexual health as happening during the pandemic when PreP was still available and supported but women had to give up we'll working forms of contraception as they could not be seen in clinics!

I don't think people like pharmacists who have not had a fuller grounding in all contraceptive options and potential complications should be fitting implants. More should be done to train people thoroughly rather than just how to put an implant in

Strengthen access to post natal contraception including LARC methods and missed opportunities post ectopic/miscarriage across the city - no provision currently

Think there should be express provision for LARCs for YPs and generally opening of services for YP

Abortion:
Work to stop accidental pregnancies so that abortion becomes a thing of the past.

I do not agree with killing the unborn.

The emphasis on abortion providers providing LARCs is based on negative stereotypes of why people access abortion, which again illustrates that this strategy has been produced to further stigmatise abortion rather than increase autonomy and decision making in this area.

I think this is too weak. Does it say over 1/4 conceptions lead to abortion? Surely more should be done to tackle that. The strategy's focus is on marginalised groups. Do they make up the majority of that statistic? Agree for health inequalities that is right. But it can only happen after a really strong baseline services are in place.

Abortion services improve contraception and testing for early medical abortions needs significant overhaul, these are high risk groups

Engagement:
To Reduce the Number of Unwanted Pregnancies, working with other key stakeholders and organisations is vital.

tests should be available free where needed but the settings should be able to offer some ongoing /appropriate support

Again I would like to see the utilisation of charities such as Trident Reach, with an already established in-reach into some of Birmingham's & Solihull's most vulnerable and underrepresented communities in delivering sexual health link work, education and support.

Whereas the desire to avoid unwanted pregnancies is good and people should be encouraged to seek to have family situations (e,g marriage) that will be stable and conducive to having children.

Theme Four: Building resilience

I don't think the word resilience fits here to be the best umbrella term for these action plans and aims. It is also not liked by many users (see previous comments on earlier questions.) This section to me seems to be about breaking down stigma and barriers to services.

Education and Advice:
Education in schools important

If it's not on Insta, it doesn't exist in the world

Building Resilience, means more help and information should be put out there to raise awareness on such issues and provide advice

Abuse within young people's relationships could be key here. There are huge gaps in clarity around consent

Education around sexual health and healthy relationships needs to address the patriarchal norms of society. Men and boys need to be given more comprehensive education around contraception and the risks of not using it. Better healthy relationships education from a young age to combat the norms of abuse in relationships is also needed.

Focus on people's right to choose not engaging in sex if they want to live that way, minimise the effects coercion and peer pressure to engage in sex.

I agree that Building Resilience, means more help and information should be put out there to raise awareness on such issues and provide advice.

Provide community promotion highlighting the risks of unprotected sex under the influence of drugs and alcohol and details of where to access condoms in all venues that sell alcohol. Resilience for people living with HIV can be defined as having the ability to engage effectively with health and care services, such as taking regular treatment and seeking mental health support where necessary. While each individual living with and affected by HIV will have their own understanding of Health-Related Quality of Life. The concept is subjective and, as has been recognised by HIV Outcomes, must be assessed from an individual perspective.

I'd want to know what will be promoted and what is evidenced re resilience programmes in schools. Unsure what progs this refers to, who has evidenced it and whether young people have been consulted. So would want to know more before I can say whether I support this. Many progs in schools are not young person friendly or centred and miss the needs of young people. We need to be sure their views are heard.

Peer pressure may need to be addressed via more than consistent message info and education. It is also about providing safe spaces where over time young people can explore, undo and challenge peer pressure and also examine why they may be the ones doing the pressure of peers. We need to help young people talk and explore (safely, over weeks and in single sex and then later perhaps in mixed sex spaces) about all aspects to sexual health. E.g. consent; sexual and domestic abuse; what they have seen in pornography and undo some of what they have seen, as much porn does not support consent, safe relationships,

interactions which are free of pressure etc.

Values and Beliefs:
"Normal" sexual health has become increasingly mis-represented since the sexual revolution. Proper / appropriate sexual union only belongs within traditional marriage.

The word I pick out here is 'normal'. Good practice should be normal, unspectacular, taken for granted.

Depends what the 'social norms' are that are being challenged as some traditional values around sex and relationships are what actually lead to human flourishing as opposed to the direction that much of the current social norms are moving, which has no real vision for human flourishing but is more motivated by a 'freedom from restrictions' approach.

Domestic Abuse:
It would be good to have a programme for those affected by sexual /domestic abuse.

Availability of support for both men and women experiencing rape or other sexual violence. Joint work with the police to make reporting easier and information for victims on what to expect when they do report such as genital evidence

There needs to be an increase in accessibility for those who have been victims of domestic and sexual abuse into appropriate therapies if requested without the need to sit on waiting lists. There needs to be an increase in resources to meet the growing numbers in sexual and domestic abuse and also there needs to be clear and timely consequences for perpetrators in terms of policing and the courts.

Sexual health has done a lot to build on support for anyone affected by domestic and sexual abuse. E.g. IDVA and ISVA services are excellent. ASC is a brilliant service. As reports of sexual violence are increasing this needs to be maintained as a minimum and built on, developed and expanded as best practice.

Stigma:
Agree that shame and embarrassment about services including abortions is a barrier.

As my previous comments, the vision to reduce stigma is good, but the strategy actually reinforces abortion stigma and makes judgements about conceptions that it doesn't feel are appropriate rather than focusing on improving access and autonomy for individuals.

Stigma and discrimination have a myriad of impacts on individuals living with HIV, including (but not limited to): poor mental health, reluctance to access medical care, and poorer health choices, these in turn can lower resilience. It is important to realise that, while stigma and discrimination affects all people living with HIV, it can be worse for certain groups, including those from lower socioeconomic backgrounds, communities where English may not be their first language, ageing populations, and groups with high HIV prevalence. viii
To improve health-related quality of life and build resilience, Gilead welcomes Birmingham's commitment to developing a stigma-reducing campaign as part of the Fast Track Cities plus Project, and believe it is key that people living with HIV are at the heart of any campaign and their voices are heard and valued. The following recommendations could create these improvements:

• Ensure all people living with HIV are supported to manage any co-morbidities, including from primary care and sexual health services. People living with HIV are disproportionately vulnerable to a wide range of other conditions (co-morbidities), including cardiovascular disease and chronic kidney disease and are more likely to develop certain types of cancer at

a younger age. All people living with HIV need ongoing support from across the care continuum to manage co-morbidities
• Make available appropriate and accessible mental health support with professionals who have knowledge and understanding of HIV. Around half of people living with HIV express mental health concerns, compared to 24% of the general public. A wide spectrum of mental health and support services such as peer support, counselling, psychology and health and wellbeing-related services should be made available to all who need them
• Work with local health services across primary care, dental, and secondary health services to eliminate HIV-related stigma, allowing people living with HIV to access healthcare without discrimination. People living with HIV continue to experience stigma and discrimination. These attitudes transgress to healthcare, with one in nine people with HIV having been refused healthcare or had their treatment delayed because of their HIV status.viii Quality of life will not be improved unless these attitudes change. Public awareness campaigns, training for NHS staff, and education in schools would help tackle stigma and discrimination
• Implement the National Standards for Peer Support in HIV when developing peer support networks for people living with HIV to develop mutual learning and understanding of HIV, while enabling people to develop communities and support networks. Peer support is a relationship through which people are seen as equals and the focus is on 'mutual learning and growth'. Peer support can improve the confidence, well-being and overall quality of life for people living with HIV. As the population living with HIV is so diverse it is important that this diversity is recognised in both the people providing the peer support, and the locations of the sessions

Take a look at Dean Street and Dean Street Express - this service has transformed the attitude to STIs and testing in Soho by making it acceptable, approachable and accessible. Do the sexual health clinics in Birmingham and Solihull provide the same in the current format / environment? or are they still very sterile and have negative perception, would you want to go to Whitthall Street?

General Comments:
Also where it states develop champions where engagement is difficult. I would rephrase this. Usually engagement is difficult because the right approach, right engagement, right people, right methods or appropriate engagement has not been followed. It is usually about seldom heard groups, multiple disadvantaged or discriminated against groups that are so called "hard to engage with". I would change this to seldom heard or marginalised groups.

Need to add older people into the strategy

Need to integrate with the voluntary sector

Theme Five: Children and young people

Similar to previous comments - I'd like all services for all ages…

Better funding in GP services would support this. Primary care staff outreach to local schools would encourage young people to realised they can approach GPs and practice nurses.

Age Appropriate:
Theme Five - should not refer to Children only Young People since Sexual Health Services do not cover Children. Children should be managed within Paediatric services.

Unsure of response to under 13's. Not sure of what is meant here and what an integrated pathway for under 13's would look like. Whatever it is, needs to be age appropriate, mindful of age of consent and lack of ability for u-13's to consent and also high risk that under 13's will face sexual abuse, coercion and control. U-13's do need safe spaces where they can

continue to come to discuss consent, relationships, healthy relationships, explore their sexuality, ask questions, etc.

Design an appropriate integrated sexual health service pathway for under 13s with child focussed sexual health provision" - this seems odd phrasing as sexual activity under 13 is abuse so agree provision should be made but could rephrase

The increase the provision of good quality contraception, advice and information should not include children, but should include young people, parents and carers

Safeguarding issues relating to Children that are identified within Sexual Health are reported to the correct safeguarding agencies.

Sexual health pathways need to include monitoring of provision to guard against abuse of vulnerable children and young adults

……safe spaces for young people to discuss health etc... should also give consideration to physical and emotional safety and how they can feel safe discussing consent, when they have been subjected to domestic and sexual abuse, when they are uncertain of what may have happened in a relationship etc. Location is important here, it needs to be a safe environment that is young person centred and friendly (boots was not experienced by young people as safe.) Also training and approach of staff is important for safety too (do they know how to respond when a young person discusses when they are not safe for example). For some safety will be about specialised service provision, sex worker clinics, where only sex workers are seen; women only spaces and services; LGBT specific spaces etc.

Education:
Importance of specialists supporting schools and colleges around educating children and young people on positive sexual health.

Healthy relationships programmes need to have an understanding of the role that gender plays, need to have a VAWG context

Work with schools and colleges - commission out RSE service.

Education is key, help young children to understand what British law says about adults trying to engage in sex with children so they know it's wrong and how they can get help to stop sexual interference by adults or other ages, family or stranger.

For Children and Young People is imperative that children and young people are supported to health clinic like sexual clinics to get this service when it's needed for them at a time when they may require the service and can also be easily accessible in contacting.

Bystander Intervention programme Not enough information to make a judgment

I don't know what Bystander Intervention is but the name sounds right for much of our society. My qualified approval of the concept.

Consideration should be given to The Bystander Intervention Programme being delivered in all educational settings (Secondary, Colleges, 6th Form Centres and University) and not just Universities

More information and training awareness is required on the Bystander Intervention programme1 before it can be rolled out.

RSE needs to be updated in the schools, youth clubs and sports clubs

Better sex education across all organisations

The age appropriate content is very important as much of what is reportedly taught to children in some schools does not seem age appropriate and contains adult content. support and training for foster carers will support this

This is so key, if we can promote effective sexual health education at schools then it will pave the way for other services for this demographic later on.

Child friendly genetic literacy education around risks and mitigations to be delivered in school as part of the curriculum and access to support services made available

RSE is needed and support to schools and colleges. BUT... We can't leave teachers to do it all, they are often not trained, lack experience to do this and lack confidence too. Also for young people their teachers doing this work are the wrong people. Outside RSE is often better. BUT... RSE external providers should have consistent standards though and your strategy could have a role in ensuring that all RSE is 1. NOT victim blaming and instead puts responsibility on those who harass, abuse, pressure to change; 2. Supports correct messages re consent; 3. Offer challenges to males who don't treat females right and perpetuate sexism/misogyny and safe spaces for them to share their views, explore, change and also share where these views may have developed (e.g. in response to what they have seen in porn, in response to what the adults around them have modelled about relationships and in response to what they may have witnessed/been subjected to at home-e.g. domestic abuse in home. This gives proper chances for behaviour to be changed and better relationships to be developed. Girls also need space to discuss what is consent, health relationships, red flags etc. Both need to be informed and supported to call out sexual harassment, red flags, sexual abuse, domestic abuse, so called "banter" which is sexist and derogatory etc.

It was nice to have a [drop-in] clinic available [in certain schools] because we could talk to the school and talk to social workers who were attached to the school, not just from a contraception and sexual health point of view but also from a safeguarding point of view… Teenage pregnancy rates within those schools did drop significantly once these services were put in place.

Better education around the diagnosis and management of PCOS and sexual health from early teens. Affecting 1 in 10 females. See https://daisypcos.com/

HIV:

Young people and children with HIV, must be recognised as a distinct group. Growing up with HIV presents a unique set of challenges and experiences, different from any other cohort living with HIV. In the UK, as of 2019, levels of viral suppression were lowest for individuals aged 15-24 and about a third of all young people will experience virological failure within two years of beginning treatment. Such statistics highlight the need to continue to focus on improving HIV care, treatment, and education for young people both in the UK and abroad. The cohort of young people (under 25s) living with HIV is among the most marginalised of groups of people living with HIV

In order to fully support children and young people living with HIV, it is important that the following are taken into consideration alongside the points previously regarding a reduction in stigma and discrimination and accessible mental health support:
Young people living with HIV must be given autonomy to manage their own care by healthcare professionals. Children and young people should be better supported as they

transition to adult services, this includes the need to ensure continuity in healthcare professionals. Moving from paediatric to adolescent and adult clinics presents a range of complex challenges as young people adapt to new medical teams, changing routines and unfamiliar environments. Challenges relating to daily medicine adherence are common at this time. Patients who switch from paediatrics to adult HIV care have an increased risk of being lost to follow-up which increases the risk of treatment non-adherence.