Camden sexual and reproductive health engagement report 2025

Introduction: purpose and vision

This engagement report represents the culmination of extensive conversations with Camden residents and staff to shape a new trauma-informed, accessible, and equitable Sexual Wellbeing and Reproductive Health Work Programme. Recognising that good sexual health cannot be achieved without tackling stigma, inequality, cultural taboos, trauma, and systemic barriers, Camden Council and Healthwatch worked together to listen directly to both communities and professionals.

Over 190 Camden residents and staff participated between January and May 2025. These included young people, LGBTQ+ individuals, people experiencing homelessness, people who use drugs and/or alcohol, people with disabilities and neurodivergence, women from minoritised ethnic backgrounds and staff across multiple services. Their voices are at the heart of this report.

The findings highlight what makes sexual health services work, and what causes people to stay away. They also reveal where staff feel well-equipped, and where systemic, cultural and knowledge barriers limit effective support.

Who we engaged

Our engagement approach was intentional, trauma-aware, and relational. We spoke with:

- 35+ young people (11–25) across Camden schools, youth groups, and online forums
- 88+ youth survey participants, predominantly from Bangladeshi and Muslim backgrounds
- 15+ people experiencing homelessness and/or drug/alcohol use (23–71 years old)
- 10+ LGBTQ+ people, including trans, intersex, neurodivergent, and disabled participants
- 18+ women with lived experience of gendered trauma, domestic violence, period poverty, or reproductive challenges
- 7 PSHE and school leads representing mainstream and faith-based secondary schools
- Voluntary sector organisations (CLASH, Women@Well, CAP, Living Well, Positively UK)
- Sex workers, people with insecure immigration status, and others experiencing intersecting forms of marginalisation

- 27 staff survey respondents across education, NHS clinical roles, youth work and social care.

Methodology and approach

We used:

- Semi-structured interviews
- Youth workshops (single-sex, faith-sensitive, and online formats)
- Surveys and demographic mapping (Youth Project, Healthwatch, SW Questionnaire)
- In-person outreach in hostels, foodbanks, community centres
- Thematic summaries of PSHE sessions and health professional conversations
- Focus groups with HIV+ residents and older adults.

Key themes and lived experiences

Education that misses the mark

Young people consistently reported that school-based RSE is inconsistent, outdated, and does not always cover the realities of consent, pressure, and emotions.

- “It was all sperm and ovaries. They skipped feelings, pressure, everything real.” (girl, 16)
- “We didn’t get anything after year 9. That’s when people need it most.” (young person, 17)

Period health, menopause, and emotional wellbeing were widely missing. Many turned instead to TikTok or Reddit:

- “We learn more from TikTok than teachers.” (girl, 15)

Staff confirmed these gaps, noting additionally that parents sometimes withdraw children from lessons:

- “Some faith communities feel that sex is a taboo subject and will opt out of this topic.” (staff survey)

Barriers to accessing services

Residents described intimidating receptions, long waits, and gatekeeping:

- “They ask why you’re there - loudly. I turned around and walked out.” (trans person, 28)
- “The receptionist shouldn’t be too nosy… they shouldn’t stop you from seeing a health professional.” (female, 45, homeless)

Many were unaware of local services altogether.

- “I’ve never heard of anything in Camden for STDs or anything like that. Everyone I know goes to Dean Street.” (male, 54, LGBTQ+)

Staff echoed that they did not always know where to refer people for specialist support.

Stigma, cultural taboos, and privacy

Stigma remains pervasive, particularly in relation to HIV, sexuality, gender, religion, and cultural expectations.

- “The fear of being judged has made it difficult for me to speak on my condition.” (participant, HIV focus group)
- “In my culture, talking about periods and stuff is taboo, we don’t talk about it.” (female, 36)

Staff confirmed these barriers, noting:

- “There are still religious and cultural reasons that stop people talking about these issues.”
- “Shame and taboos surrounding sexuality.”

Privacy was critical, especially for LGBTQ+ residents and women in hijab attending clinics.

Trauma, violence, and the need for safe spaces

Domestic and sexual violence, trauma, and coercion were common experiences. Residents wanted sensitive enquiry and safe, female-only spaces.

- “If a female goes to the service, they should always speak to a female worker.” (female, 31, homeless)
- “They ask about DV but they are not trauma-trained... it’s a horrible experience.” (female, 45)

Staff said they often lacked training or time to explore these issues properly:

- “I do not feel trained to discuss these areas with our users.”

Contraception, menopause, and gaps in women’s health

Women described being under-informed or dismissed.

- “I asked about the coil side effects and they shrugged.” (woman, 26)
- “Menopause hit me like a truck. I thought I was going mad.” (woman, 47)

Staff also raised systemic neglect of women’s health:

- “We are a long way off women being taken seriously when it comes to pain and gynaecological issues.”
- “Once no longer fertile, women are bounced between GPs and clinics.”

Digital exclusion and online reliance

Younger participants relied on online sources, while older and more vulnerable groups were digitally excluded.

- “I don’t always believe the GP, so I check online.” (young woman, 19)
- “It’s always best to speak to someone face to face. Not just a Google search.” (female, 63, homeless)

Staff highlighted that lack of interpreters, Easy Read formats, and poor online access left many unable to navigate services.

Positive experiences and peer support

Where services worked, they were described with warmth. Specialist HIV services were praised:

- “This place has been magical to me… it gave me hope.” (HIV participant)

Community spaces and peer groups were vital:

- “If you come here and there’s a menopause day and they invite a specialist in, I’d rather attend that.” (female, 47)

Staff also valued community-based solutions, calling for clearer referral directories and stronger partnerships with trusted organisations.

Cross-cutting recommendations

1. **Make services visible and accessible** – promote SRH services widely; provide walk-in and mobile options. Staff specifically requested a local SRH directory and signposting materials.
2. **Guarantee safety and choice** – expand female-only clinics and staff availability; create safe spaces for supported disclosure.
3. **Embed trauma-informed and culturally competent practice** – train all staff in trauma-aware, non-judgemental approaches; build skills in engaging with faith groups and culturally diverse communities.
4. **Expand education and information** – update RSE to include consent, menopause, coercion, LGBTQ+ inclusion, and emotional wellbeing; produce Easy Read, visual and multilingual resources; deliver family workshops.

5. **Strengthen continuity and trust** – reduce repeated disclosure through better information-sharing; enable residents to see the same GP or nurse; invest in care navigation roles.
6. **Address digital exclusion and communication barriers** – retain phone and face-to-face booking; improve interpreting services; offer digital literacy support.
7. **Support peer and community-led networks** – develop peer-led groups, youth hubs, menopause sessions, and host community drop-ins; staff emphasised partnership with voluntary groups.
8. **Normalise and destigmatise sexual health** – rebrand services to reflect holistic care; embed HIV and LGBTQ+ inclusion visibly across mainstream services; deliver community co-designed outreach.
9. **Invest in workforce development** – provide autism-informed and disability-inclusive training; develop legal and communication skills for sensitive topics; improve knowledge of women's health conditions and menopause.

Conclusion: a collective vision for Camden

Camden residents and staff have spoken clearly. Residents want services that see them, respect them, and support them without judgement. Staff want the skills, time, and systemic backing to provide this care. Both call for better visibility, stronger education, trauma-informed practice, and community-rooted approaches.

By embedding these voices into strategy, Camden can create a borough where sexual and reproductive health support is universal, empowering, and designed with people and professionals, not just for them. The below table shows examples of how the community and staff feedback presented in this report has been reflected in the work programme:

What residents and staff told us:	How this is reflected in the work programme's table of actions
Make services visible and accessible	Pillar 1: Increase access to condoms Pillar 2: Increase visibility of local sexual health sites (promotional campaign, outreach). Pillar 2: Address environmental barriers in services (e.g. via mystery shopper, interpreter access, accessibility reviews).
Guarantee safety and choice	Pillar 2: Undertake accessibility reviews and develop specialist clinics. Pillar 4: Develop a women's Health Hub that is trauma-informed, inclusive, and links with DV/sexual violence pathways).
Embed trauma-informed and culturally competent practice	Pillar 2: Staff training on trauma and cultural competence. Pillar 4: Commissioning culturally tailored women's health and menopause sessions.
Expand education and information	Pillar 1: Update RSE (e.g. to cover consent, LGBTQ+ inclusion, harmful behaviours, online harms), develop youth-led campaigns.

	Pillar 2: Co-produced a STI handbook. Pillar 2: Improve access to sexual health, cancer screening and HPV vaccination information. Pillar 4: Produce women's health campaigns and menopause education resources.
Strengthen continuity and trust	Pillar 1. Develop a network of trained 'trusted adults' across the community. Pillar 2: Embed SRH into neighbourhood models, appointing SRH leads. Pillar 4: Map women's health pathways for consistent signposting.
Address digital exclusion and communication barriers	Pillar 2: Run resident-led booking system reviews, monitor interpreter usage, provide promotional materials in multiple formats accessible to all.
Support peer and community-led networks	Pillar 1: Co-produce RSE materials with young people, develop a community of practice in VCS. Pillar 2: Develop shared care carer training on talking about sex, sexual health and relationships Pillar 3: Identify and promote peer support for people living with HIV and LGBTQ+ residents. Pillar 4: Develop women's health cafés, menopause peer programmes, and provide training for community champions.
Normalise and destigmatise sexual health	Pillar 1: Produce campaigns tackling harmful behaviours and pornography. Pillar 3: Hold an annual HIV awareness campaign and ensure Camden Together comms campaign (campaign to reduce loneliness and isolation) targets people with HIV.
Invest in workforce development	Pillar 1: Involve young people in workforce development for RSE delivery. Pillar 2: Deliver staff training in trauma, cultural competence, neurodivergence and other disabilities. Pillar 4: Undertake a skills audit and introduce a clinical lead for women's health.