UK Health Security Agency

Appendix 4. Modified Delphi process

October 2024

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Introduction

Overview

To inform the STI Prioritisation Framework, a modified Delphi process was undertaken to build national consensus from across the sexual health system on:

- a set of guiding principles for sexually transmitted infection (STI) control interventions
- how existing and emerging interventions should be prioritised to optimise the desired outcomes of reducing adverse outcomes and inequalities related to STIs

The results from this national consensus process represent another source of information to help inform local decision making and prioritisation.

Why we undertook a Delphi consensus process

A Delphi process can be used to determine and build consensus for a defined issue or problem. The method involves an iterative process of repeated rounds of voting and is effective for determining expert group consensus and where opinion is important. The classical Delphi method starts with unstructured gathering of opinions, while the modified method initially gathers responses to a fixed set of questions. Evidence shows that using a modified Delphi method can be highly effective in building consensus on complex clinical and policy issues.

We chose to use a modified Delphi method to establish national consensus on how and what to prioritise for STI prevention and control within finite resources, while also considering the different needs of diverse population groups, including those experiencing the highest rates of STIs and those at the greatest risk of harm or facing specific challenges accessing services or support.

How we undertook a Delphi process

Our modified Delphi process on STIs involved 2 rounds of anonymous online questionnaires. Purposive sampling was used to recruit experts, ensuring balanced representation of different stakeholder groups as well as regional and geographic settings. We also recruited experts with experience in inclusion health who could provide insight on the prioritisation of STI interventions for specific marginalised or underserved populations.

The questionnaire was based on an assessment of the evidence around different STI interventions and was piloted for language, comprehension, and ease of use prior to dissemination. This exercise was supported by an expert sounding board with experience in Delphi research methods and a cross-UK Health Security Agency (UKHSA) working group to

ensure clarity, minimise bias in the interpretation of the questions and statements, and monitor the process.

In the first section of the questionnaire, experts were invited to provide their views on a set of high-level guiding principles to inform how we prioritise existing and emerging interventions to reduce STI harms and reduce inequalities. In the second section of the questionnaire, experts were invited to rate STI interventions by how important they are for different population groups including the general population, populations experiencing the highest rates of STIs, and populations who are at higher risk of harm from STIs or may face specific challenges accessing services or support.

At the start of each questionnaire round, experts received an invitation email with a hyperlink to the survey. A follow-up email was sent after 2 weeks, and a personalised reminder email on the day of the deadline. The questionnaires were built and distributed using the UKHSA SelectSurvey platform.

Round 1. First Delphi questionnaire

In Round 1, participants were invited to review a set of 12 high-level guiding principles on STI prioritisation and indicate whether they thought it should be included, modified or excluded from the STI Prioritisation Framework. Where participants indicated that they felt the principle should be modified, they were able to propose specific language modifications using an open text option. Consensus was considered reached if greater than (>) 70% of participants indicated that the principle should be included and less than 10% indicated it should be excluded.

Participants were then presented with a set of existing and emerging STI interventions. They were invited to score each intervention by how important it was for any given population group using a 5-point Likert scale from 1 (low priority) to 5 (high priority). Where participants did not feel they had sufficient evidence or knowledge to respond for a particular population group or intervention, they were asked to select 0. Participants were not required to rank interventions against each other, allowing for the identification of multiple high-priority or low-priority interventions. Consensus was considered reached if >70% of participants indicated that the intervention was high or medium-high priority, or low or medium-low priority, for a particular population group.

A total of 32 experts took part in Round 1, with representation from all key stakeholder groups and regions.

Round 2. Second Delphi questionnaire

The first-round responses informed the content and modification of an updated questionnaire for Round 2 of the modified Delphi process. Since all guiding principles reached consensus in the first round, these were not included in the Round 2 questionnaire. Instead, the focus of Round 2

was on building consensus around the prioritisation of existing and emerging STI interventions for different populations.

Feedback from Round 1 showed some emerging trends in prioritisation, with certain STI interventions already close to consensus and others with more mixed results. To help facilitate the consensus-building process, a refined methodology was used for the Round 2 questionnaire. Participants were presented with the same set of populations and interventions from Round 1, however this time they were asked to score each intervention using a 3-point Likert scale from 1 (low priority) to 3 (high priority). Consensus was considered reached if >70% of participants indicated that the intervention was high priority, medium priority, or low priority for a particular population group.

The same experts were invited to participate in the second Delphi questionnaire and there was no attrition between rounds. Since the survey process was anonymous, participants were instructed to respond only if they had responded to the first questionnaire. Participants were able to review and adjust their prioritisation ratings considering the overall group response from Round 1, which was provided along with the questionnaire. All STI interventions and populations groups from Round 1 were included in Round 2, and participants were reminded that they did not have to change their answer from their original rating if they did not wish to do so.

Guiding principles for prioritisation

Overview

All twelve guiding principles reached consensus through the modified Delphi process. Together, they provide a strong foundation for decisions around prioritisation. The guiding principles are summarised below, along with a summary of expert feedback received.

1. The sexual health needs of the population can only be met through working in partnership; this includes identifying or establishing local structures to enable effective collaborative working

This guiding principle recognises the importance of partnership working and a collaborative approach to improving service provision and outcomes. Sexual health is part of a wider health system and collaboration is key to address these interdependencies and provide effective, person-centred care and support. Putting this principle into practice means identifying key stakeholders (including academia, public health, service users, commissioners and providers) and creating or strengthening local structures to facilitate a more effective and joined up approach to STI prevention and control.

2. It is essential that specialist sexual health services have established links and arrangements with other specialties for the management of complex cases

This guiding principle recognises the importance of ensuring there are clear service pathways in place to facilitate continuity of care and management of complex cases. This means establishing links and arrangements with other specialities, services and agencies to facilitate urgent referrals to and from other services and ensuring robust linkages with public health and safeguarding. Having robust pathways in place helps to provide focus on the needs of those groups who are at the greatest risk of negative health outcomes and often underserved.

3. It is essential that services and interventions are co-produced with local communities, ensuring that lived experience is at the heart of local planning and decision making

This guiding principle recognises the importance of co-production to improve health equity, ensuring that sexual health services and interventions are responsive to those with the highest level of need. Co-production, insight and engagement with service users and communities can facilitate the process of prioritising services and interventions to best meet the needs of the local population. It is important to recognise that it can be time consuming and resource intensive to do true meaningful co-production and approaches should be proportionate and tailored to local needs and stakeholders.

4. Services must be planned on the basis of an assessment of local need and be able to adapt to changing need and circumstances

This guiding principle recognises the importance of a needs-based approach that is informed by local data and intelligence to inform prioritisation. Needs assessments should explicitly consider equitable access to care to account for the needs of those experiencing the greatest barriers to care and at highest risk of negative health outcomes. Needs may change over time and services must be able to identify these changes and adapt their approach.

5. Local areas should draw on existing evidence, where available, to inform their practice

This guiding principle recognises the importance of an evidence-informed approach to improving sexual health and managing the prevention and control of STIs. Where evidence already exists, this should help guide service design and delivery. Where gaps in evidence are identified, partners should consider how these could be addressed.

6. Evaluation is essential to understand whether new interventions, changes in practice or service improvements have achieved their intended impact and to develop the evidence base

This guiding principle recognises the importance of evaluation to drive continuous quality improvement and reduce inequalities in access, experience, and outcomes. Sexual health service evaluation should consider both processes and outcomes and may be further supplemented by clinical audit and research.

7. Addressing health inequalities is central to our approach to STI control and therefore resources should be prioritised on the basis of need, with a focus on under-served populations

This guiding principle highlights the importance of targeting resources towards the populations with the greatest need. This includes both populations experiencing the highest rates of STIs and those experiencing greater difficulties accessing services or testing. Resources should be distributed such that the overall impact to reduce harm is maximised; populations experiencing disproportionate harm should be prioritised and interventions resourced proportionate to their need.

8. Commissioners and providers must ensure sexual health services have the capacity and skills to address safeguarding concerns in skilled and timely manner

This guiding principle emphasizes the importance of safety and ensuring that sexual health services have the resource, capacity, skills, structures, and networks to identify and manage safeguarding issues. This includes signposting and collaborating with other services as needed

to access expert safeguarding advice. Addressing safeguarding concerns should be done in a culturally competent, trauma-informed way and undertaken in consultation with the person or people affected.

9. Commissioners and providers must ensure specialist sexual health services have the capacity and skills to manage complex cases and provide clinical STI expertise to non-specialist providers

This guiding principle highlights the importance of the role of specialist sexual health services in managing complex STIs including gonorrhoea, syphilis, and *Mycoplasma genitalium*, as well as supporting individuals with recurrent or persistent infections. Specialist services must be able to deliver all aspects of routine and specialist care (Levels 1 to 3) in line with the relevant guidance and standards. They also have an important role in providing clinical STI expertise to other specialties and providers.

10. Primary prevention activities such as health promotion and access to condoms should not be sacrificed when resources are limited

This guiding principle emphasizes the importance of investing in primary prevention to address STIs. This includes interventions such as health promotion, access to free or low-cost condoms, and vaccination. Resource should always be committed to ensuring primary and early prevention activities are preserved, even when finances are constrained.

11. Testing and treating those with a diagnosed infection is a mainstay of STI control

This guiding principle highlights the importance of maintaining a full spectrum of interventions across the care pathway. This must include testing, treatment, and prevention of re-infection amongst those with a diagnosed infection, alongside awareness raising, reducing stigma, and challenging community norms.

12. There is no ‘magic bullet’; no one intervention will achieve STI control; we need to use a range of prevention, testing and treatment interventions as they are all imperfect

This guiding principle emphasizes that STI control is challenging and no one intervention will achieve STI control on its own. We need to use a range of interventions as they all have a role to play in meeting the needs of a diverse population impacted differently by health inequalities. A full range and choice of interventions is important to enable each person to individualise according to their desires, needs and circumstances. These will necessarily change over time and situation.

Prioritisation of existing and emerging STI interventions

Overview

The results of the Delphi consensus process showed clear areas of consensus on prioritisation of different existing and emerging STI interventions, as well as identifying specific populations and interventions where decisions around prioritisation was more complex. Some interventions also failed to reach over 50% agreement, with no clear majority opinion on how this intervention should be prioritised.

The sections below outline the key areas of consensus, and lack of consensus, on the prioritisation of STI interventions for each population group.

General population

The Delphi consensus process looked at the level of consensus on prioritisation of different STI interventions for the general population, alongside priority populations.

Over 70% consensus was reached on 2 interventions for the general population: managing use of doxycycline post-exposure prophylaxis (dPEP) to manage bacterial STIs (low priority) and awareness of symptoms and enabling symptomatic testing (medium priority).

Emerging consensus was identified around several other interventions, all of which received over 50% majority expert agreement. The majority of experts identified asymptomatic chlamydia and gonorrhoea testing and asymptomatic syphilis testing as medium priority interventions for the general population. Meanwhile, the majority of experts identified boosting access and availability of condoms as a low priority.

No majority expert opinion was reached on: strengthening health promotion activities, improving knowledge and use of condoms, improving vaccine delivery, testing technologies that reduce time to result, improving time to treatment, or effective and appropriate partner notification for this population. This may reflect a sense that, while universal, these interventions are likely to yield a greater impact for specific priority populations.

No high priority interventions were identified for this population.

Populations experiencing the highest rates of STIs

The section below shares key findings from the national consensus process for populations experiencing the highest rates of STIs.

Gay, bisexual, and other men who have sex with men (GBMSM)

Over 70% consensus was reached on 7 interventions, all high priority: improving vaccine delivery, testing technologies that reduce time to result, managing use of dPEP for bacterial STI infections, increasing asymptomatic syphilis testing, improving awareness of symptoms and enabling symptomatic testing, improving time to treatment, and effective and appropriate partner notification.

Emerging consensus was also identified around improving knowledge and use of condoms (high priority). No majority expert opinion was reached on strengthening health promotion activities, boosting availability and access to condoms, or asymptomatic chlamydia or gonorrhoea testing.

No low priority interventions were identified for this population.

Young men

Over 70% consensus was reached on 5 interventions, 4 of which were high priority: boosting availability and access to condoms, improving knowledge and use of condoms, improving awareness of symptoms and enabling symptomatic testing, and effective and appropriate partner notification. One intervention reached consensus as a low priority: managing use of dPEP for bacterial STI infections.

Emerging consensus was identified for 2 other interventions, both of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving time to treatment (high priority) and asymptomatic syphilis testing (medium priority).

Experts did not reach a majority agreement on strengthening health promotion activities, which was evenly split between high and medium priority for this population. Similarly, no majority was reached on the prioritisation of improving vaccine delivery, testing technologies that reduce time to result, or asymptomatic chlamydia and gonorrhoea testing for this population.

Young women

Over 70% consensus was reached on 6 interventions, 5 of which were high priority: strengthening health promotion activities, improving knowledge and use of condoms, improving awareness of symptoms and enabling symptomatic testing, improving time to treatment, and effective and appropriate partner notification. One intervention reached consensus as a low priority: managing use of dPEP for bacterial STI infections.

Emerging consensus was identified for 3 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around boosting access and availability of condoms (high priority), while just over half of experts indicated that asymptomatic testing interventions, both asymptomatic syphilis testing and asymptomatic chlamydia and gonorrhoea testing, were a medium priority intervention for young women.

However, it should be noted that 39% of experts felt that asymptomatic chlamydia and gonorrhoea testing was actually a high priority intervention for this population.

Ethnic groups at higher risk

Over 70% consensus was reached on 6 interventions, all high priority: strengthening health promotion activities, boosting availability and access to condoms, improving knowledge and use of condoms, improving vaccine delivery, improving awareness of symptoms and enabling symptomatic testing and effective and appropriate partner notification.

Emerging consensus was also identified around asymptomatic testing; with over 50% of experts indicating asymptomatic syphilis testing and asymptomatic chlamydia and gonorrhoea as medium priority interventions for this population. The majority of experts also indicated that improving time to treatment was a high priority for this population.

No consensus was reached on the prioritisation of management of dPEP for bacterial STI prevention in this population, with expert opinion split on whether this was a low, medium or high priority.

People living in deprived areas

Over 70% consensus was reached on 4 interventions, all high priority: strengthening health promotion activities, boosting availability and access to condoms, improving knowledge and use of condoms, and effective and appropriate partner notification.

Emerging consensus was also identified, with all interventions reaching at least 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving vaccine delivery, asymptomatic syphilis testing, awareness of symptoms and symptomatic testing, and time to treatment as high priority interventions for this population. Additionally, over 50% of experts agreed on testing technologies that reduce time to result as a high priority, asymptomatic chlamydia and gonorrhoea testing as a medium priority, and managing use of dPEP for bacterial STI infections as a low priority.

Populations at a higher risk of harm or facing specific challenges accessing services or support

The section below shares key findings from the national consensus process for populations at a higher risk of harm from STIs or facing specific challenges accessing services or support.

Sex workers

Over 70% consensus was reached on 9 interventions, all high priority: strengthening health promotion activities, boosting availability and access to condoms, improving vaccine delivery, managing use of dPEP for bacterial STI infections, testing technologies that reduce time to

result, asymptomatic chlamydia and gonorrhoea testing, asymptomatic syphilis testing, improving awareness of symptoms and enabling symptomatic testing, and improving time to treatment.

Emerging consensus was also observed, with all interventions reaching at least 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving knowledge and use of condoms (high priority) and effective and appropriate partner notification (high priority).

No interventions were identified as low or medium priority for this population.

People experiencing homelessness

Over 70% consensus was reached on 5 interventions, 4 of which were high priority: boosting availability and access to condoms, testing technologies that reduce time to result, improving time to treatment, and effective and appropriate partner notification. One intervention reached consensus as a low priority: managing use of dPEP for bacterial STI infections.

Emerging consensus was identified for 3 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving awareness of symptoms and symptomatic testing (high priority) and strengthening health promotion activities (medium priority). More than half of experts also indicated that improving vaccine delivery was a high priority for this population.

Experts did not reach a majority agreement on the prioritisation of asymptomatic chlamydia and gonorrhoea testing, with views split on whether this was a low, medium or high priority. Similarly, for asymptomatic syphilis testing experts' views were split between medium and high priority. No majority view was reached on the prioritisation of improving knowledge and use of condoms for this population.

People in contact with the criminal justice system

Over 70% consensus was reached on 3 interventions, all high: awareness of symptoms and enabling symptomatic testing, improving time to treatment, and effective and appropriate partner notification.

Emerging consensus was identified for 5 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around managing use of dPEP for bacterial STI infections as a low priority. Additionally, more than half of experts identified boosting access and availability of condoms, improving knowledge and use of condoms, improving vaccine delivery, and asymptomatic chlamydia and gonorrhoea testing as a medium priority.

Experts did not reach a majority agreement on the prioritisation on the strengthening of health promotion activities, which was evenly split between medium and high priority. Similarly, no majority view was reached on testing technologies that reduce time to result or asymptomatic syphilis testing.

People with drug and alcohol dependence

Over 70% consensus was reached on one intervention, which was a high priority: effective and appropriate partner notification.

Emerging consensus was identified for 6 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around testing technologies that reduce time to result (high priority) and improving time to treatment (high priority). More than half of experts also identified awareness of symptoms and symptomatic testing as high priority, improving knowledge and use of condoms and asymptomatic chlamydia and gonorrhoea testing as medium priority interventions, and managing use of dPEP for bacterial STI infections as a low priority for this population.

Experts did not reach a majority agreement on the prioritisation on the strengthening of health promotion activities, boosting availability and access to condoms, improving vaccine delivery, or improving asymptomatic syphilis testing.

Vulnerable migrants and victims of modern slavery

Over 70% consensus was reached on 5 interventions, 4 of which were high priority: strengthening health promotion activities, boosting availability and access to condoms, improving time to treatment, and effective and appropriate partner notification. Managing use of dPEP for bacterial STI infections also reached consensus as a low priority.

Emerging consensus was identified for 4 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus on awareness of symptoms and symptomatic testing as a high priority for this population. Improving knowledge and use of condoms, improving vaccine delivery, and asymptomatic syphilis testing were also identified as high priority by more than half of the expert panel.

Experts did not reach a majority agreement on the prioritisation of asymptomatic testing for chlamydia and gonorrhoea or testing technologies to improve time to result in this population, with expert opinion split across low, medium and high priority.

No interventions were identified as medium priority for this population.

People with learning disabilities

Over 70% consensus was reached on 2 interventions, both high: strengthening health promotion activities and improving time to treatment.

Emerging consensus was identified for 5 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving knowledge and use of condoms (high priority) effective and appropriate partner notification (high priority) and managing use of dPEP for bacterial STI infections (low priority). Additionally, more than half of the expert panel identified boosting availability and access to condoms as a high priority and asymptomatic testing for syphilis as a low priority.

Experts did not reach a majority agreement on the prioritisation of vaccine delivery, testing technologies that reduce time to result, asymptomatic chlamydia and gonorrhoea testing, or awareness of symptoms and enabling symptomatic testing for this population.

People with severe and enduring mental illness

Over 70% consensus was reached on 3 interventions, all of which were high priority: awareness of symptoms and symptomatic testing, improving time to treatment, and effective and appropriate partner notification.

Emerging consensus was identified for 7 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving vaccine delivery as a medium priority. More than half of experts agreed on the prioritisation of improving knowledge and use of condoms (high priority), boosting availability and access to condoms (medium priority), testing technologies that reduce time to result (medium priority), asymptomatic chlamydia and gonorrhoea testing (medium priority), asymptomatic syphilis testing (medium priority), and managing use of dPEP for bacterial STI infections (low priority).

Experts did not reach a majority agreement on prioritisation of the strengthening of health promotion activities for this population.

People with physical disabilities

No interventions reached over 70% consensus for this population.

Emerging consensus was identified for 7 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around improving time to treatment (high priority), awareness of symptoms and enabling symptomatic testing (medium priority) and managing use of dPEP for bacterial STI infections (low priority). Additionally, more than half of the expert panel identified effective and appropriate partner notification as high priority, testing technologies to reduce time to result as medium priority, and asymptomatic testing for chlamydia and gonorrhoea and asymptomatic testing for syphilis as low priorities for this population.

Experts did not reach a majority consensus on strengthening health promotion activities, boosting availability and access to condoms, improving knowledge and use of condoms, or improving vaccine delivery.

Trans and gender-diverse people

Over 70% consensus was reached on 7 interventions, all high: strengthening health promotion activities, improving knowledge and use of condoms, improving vaccine delivery, managing use of dPEP for bacterial STI infections, improving knowledge and use of condoms, asymptomatic chlamydia and gonorrhoea testing, asymptomatic syphilis testing, improving awareness of symptoms and enabling symptomatic testing, and improving time to treatment.

Emerging consensus was identified for 3 other interventions, all of which reached over 50% majority expert opinion on prioritisation. There was strong emerging consensus around effective and appropriate partner notification as a high priority intervention for this population. Additionally, more than half of the expert panel identified boosting availability and access to condoms and testing technologies that reduce time to result as a high priority. No majority opinion was reached on asymptomatic chlamydia and gonorrhoea testing.

No interventions were identified as medium or low priority for this population.

Figure 1 and Figure 2 summarise the results described above for the Delphi STI intervention prioritisation exercise. The coloured data bars indicate which prioritisation level was closest to reaching consensus at the end of Round 2.

Figure 1. STI intervention prioritisation for the general population and groups experiencing the highest rates of STIs

		General population	GBMSM	Young men	Young women	Ethnic groups at higher risk	People living in deprived areas
Boosting availability and access to condoms.	High	19%	50%	75%	63%	74%	81%
	Medium	25%	34%	22%	31%	26%	16%
	Low	56%	16%	3%	6%	0%	3%
Boosting awareness of benefits of condoms, teaching and negotiating condom use.	High	16%	53%	81%	78%	74%	74%
	Medium	50%	38%	13%	19%	26%	23%
	Low	34%	9%	6%	3%	0%	6%
Boosting awareness of symptoms and enabling symptomatic testing.	High	19%	78%	72%	72%	71%	68%
	Medium	72%	19%	28%	28%	29%	32%
	Low	9%	3%	0%	0%	0%	0%
Implementing testing technologies that reduce time to result (may include, point of care testing, self-tests as they become available).	High	37%	81%	47%	47%	60%	53%
	Medium	37%	13%	34%	34%	33%	37%
	Low	27%	6%	16%	19%	7%	10%
Improving delivery of vaccination in line with recommendations [note 1].	High	9%	94%	22%	19%	81%	65%
	Medium	41%	6%	44%	47%	19%	32%
	Low	50%	0%	34%	31%	0%	6%
Improving time to treatment.	High	50%	72%	59%	72%	63%	68%
	Medium	34%	25%	38%	25%	34%	26%
	Low	16%	3%	3%	3%	3%	6%
Managing doxycycline post-exposure prophylaxis (dPEP) for bacterial STI prevention in line with current and forthcoming recommendations.	High	10%	91%	6%	3%	20%	3%
	Medium	17%	6%	23%	19%	43%	40%
	Low	77%	3%	71%	75%	37%	57%
Providing asymptomatic chlamydia and gonorrhoea testing (excludes national chlamydia screening programme).	High	3%	25%	28%	38%	37%	32%
	Medium	59%	50%	50%	53%	57%	55%
	Low	38%	25%	22%	9%	7%	16%
Providing asymptomatic syphilis testing (does not include antenatal testing).	High	10%	88%	19%	34%	41%	65%
	Medium	55%	13%	66%	56%	56%	29%
	Low	35%	0%	16%	9%	4%	6%
Providing effective and appropriate partner notification (contact tracing).	High	44%	72%	72%	72%	75%	71%
	Medium	44%	28%	19%	19%	22%	23%
	Low	13%	0%	9%	9%	3%	6%
Strengthening the development, content and delivery of health promotion activities.	High	19%	50%	50%	72%	75%	78%
	Medium	50%	44%	50%	28%	25%	22%
	Low	31%	6%	0%	0%	0%	0%

Note 1: Includes human papillomavirus, mpox, hepatitis A virus, hepatitis B virus and 4CMenB vaccine for gonorrhoea.

Figure 2. STI intervention prioritisation for populations at a higher risk of harm or facing specific challenges accessing services or support

		People experiencing homelessness	People in contact with the criminal justice system	People with drug and alcohol dependence	People with learning disabilities	People with physical disabilities	People with severe and enduring mental	Sex workers	Trans and gender-diverse people	Vulnerable migrants and victims of modern slavery
Boosting availability and access to condoms.	High	73%	34%	30%	52%	19%	22%	84%	55%	70%
	Medium	23%	59%	43%	41%	44%	56%	13%	39%	17%
	Low	3%	7%	27%	10%	37%	22%	3%	6%	10%
Boosting awareness of benefits of condoms, teaching and negotiating condom use.	High	50%	41%	27%	62%	33%	54%	65%	77%	53%
	Medium	37%	52%	57%	41%	37%	25%	13%	19%	33%
	Low	13%	10%	17%	0%	30%	21%	23%	3%	13%
Boosting awareness of symptoms and enabling symptomatic testing.	High	62%	71%	55%	45%	25%	71%	81%	70%	68%
	Medium	34%	25%	45%	48%	61%	25%	16%	30%	25%
	Low	3%	4%	0%	10%	14%	4%	3%	0%	7%
Implementing testing technologies that reduce time to result (may include, point of care testing, self-tests as they become available).	High	77%	48%	63%	29%	19%	32%	77%	53%	46%
	Medium	17%	41%	27%	43%	59%	57%	16%	33%	32%
	Low	7%	10%	10%	29%	22%	11%	6%	13%	21%
Improving delivery of vaccination in line with recommendations [note 2].	High	53%	34%	50%	31%	19%	11%	90%	77%	57%
	Medium	33%	55%	40%	28%	33%	68%	6%	19%	30%
	Low	13%	10%	10%	41%	48%	21%	3%	3%	13%
Improving time to treatment.	High	77%	72%	67%	70%	62%	70%	90%	71%	71%
	Medium	17%	21%	27%	20%	24%	20%	6%	23%	23%
	Low	7%	7%	7%	10%	14%	10%	3%	6%	6%
Managing doxycycline post-exposure prophylaxis (dPEP) for bacterial STI prevention in line with current and forthcoming recommendations.	High	11%	7%	7%	4%	4%	4%	80%	71%	10%
	Medium	18%	32%	36%	31%	31%	38%	17%	19%	19%
	Low	71%	61%	57%	65%	65%	58%	3%	10%	71%
Providing asymptomatic chlamydia and gonorrhoea testing (excludes national chlamydia screening programme).	High	25%	19%	11%	12%	4%	8%	83%	48%	25%
	Medium	46%	52%	57%	38%	38%	54%	13%	45%	43%
	Low	29%	30%	32%	50%	58%	38%	3%	7%	32%
Providing asymptomatic syphilis testing (does not include antenatal testing).	High	43%	35%	41%	11%	8%	16%	87%	73%	54%
	Medium	50%	50%	41%	37%	35%	54%	13%	27%	36%
	Low	7%	15%	19%	53%	58%	30%	0%	0%	11%
Providing effective and appropriate partner notification (contact tracing).	High	70%	72%	70%	67%	52%	71%	70%	65%	71%
	Medium	20%	14%	17%	17%	31%	18%	20%	23%	16%
	Low	10%	14%	13%	17%	17%	11%	0%	13%	13%
Strengthening the development, content and delivery of health promotion activities.	High	29%	46%	48%	70%	35%	48%	70%	73%	77%
	Medium	61%	46%	41%	20%	42%	30%	20%	23%	17%
	Low	11%	7%	21%	10%	23%	22%	10%	3%	7%

Note 2: Includes human papillomavirus, mpox, hepatitis A virus, hepatitis B virus and 4CMenB vaccine for gonorrhoea.

Abbreviations

Abbreviation	Meaning
dPEP	doxycycline post-exposure prophylaxis
GBMSM	gay, bisexual, and other men who have sex with men
STI	sexually transmitted infection
STIs	sexually transmitted infections
UKHSA	UK Health Security Agency

About the UKHSA

UKHSA is responsible for protecting every member of every community from the impact of infectious diseases, chemical, biological, radiological and nuclear incidents and other health threats. We provide intellectual, scientific and operational leadership at national and local level, as well as on the global stage, to make the nation health secure.

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