LONDON BOROUGH OF HAVERING

Sexual Health Needs Assessment

2024

Risk Factors, Prevalence & Outcomes

Current Interventions & Service Gaps

By London Borough of Havering

Document Version Control

Version	Date	Revision Made	Author/Analysts	Comments
Draft 1.0	February 2023	First draft	Louise Dibsdall Sedina Lewis Katie Thorley Thomas Goldrick Mark Holder Anthony Wakhisi	
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Draft 4.0	February 2024	Summary of Recommendations included and development of an accompanying executive and infographic summary document	As above	
Final	September 2024	Final review	Emily Grundy Sedina Lewis	

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About this Needs Assessment

This document provides an analysis of the available information and data gathered to understand the current sexual health needs of the population, how current service provision is meeting those needs, and what gaps exist. Throughout this assessment the impact of COVID-19 on both services and populations is taken into consideration. Some of these needs are as yet hidden, so recommendations are made based on likely increased need and demand as services continue to recover from the pandemic. In addition, new and emerging needs, such as the monkeypox outbreak will have had an impact itself in the post-pandemic period, which has affected recovery of some services.

With a particular focus on inequalities in health outcomes for vulnerable or at-risk groups, the scope of this needs assessment includes:

- Sexually Transmitted Infections (STIs)
- Conception, Abortion & Maternity
- Teenage Pregnancy
- Contraception

Sexual heath is a wide-ranging and complex area, with multiple agencies responsible for commissioning, monitoring or directly providing different services, including central government, local authorities, hospital trusts, primary and community care, schools, police, clinics and voluntary sector agencies. Where possible, local data is presented, but always in the context of national data which can be used as a proxy measure for local need.

Acknowledgements

With grateful appreciation to everyone who has contributed to this needs assessment, including clinicians and service providers, commissioners, and residents.

Summary of Recommendations

Recommendations for STI Testing and Treatment
The health and social care system across NEL is recommended to support local commissioned providers for Havering (BHRUT) to increase access to and availability of sexual health appointments closer to home, e.g. by increasing the number of clinics available, and at locations closer to those with higher need.
Given the efficiency, cost-effectiveness, convenience and privacy of the e-service, it is recommended to promote and increase uptake of SHL e-service, particularly for Gonorrhoea, including increasing test-to-completion rates i.e. ensuring that those who request a test, complete the test and return it for analysis.
Increase engagement with high-risk groups to understand their views about STI screening and elicit potential barriers to testing access and uptake.
Identify barriers for uptake of chlamydia screening in young people and increase overall chlamydia screening rates.
Local commissioners and providers to work together with residents to develop a co-produced action plan to normalise HIV testing when visiting a SRH service and increase rates of HIV testing, particularly to reduce rates of late HIV diagnosis.
In order to help meet the 90-90-90 Fast Track Cities target for HIV, it is recommended that SRH services work to increase the uptake of PrEP in those identified as having a PrEP need.
In order to ensure that local service provision is targeting those most in need, it is recommended that an equity audit of local services is conducted annually to ensure equitable access for higher risk groups.

Recommendations for Conception, Abortion and Maternity
Once current workforce pressures are resolved, Sexual and Reproductive Health and Maternity services are recommended to consider whether future staffing levels will be adequate to cope with increasing caseloads where numbers of conceptions are increasing due to population increases.
The increasing age of conception (now 30-34 years) presents a different range of risks, including miscarriage, birth defects, multiple births, high blood pressure, gestational diabetes and difficult labour. Maternity services are recommended to consider how their services may need to take into account these increased risks for older mothers.
Ensure that, as a health and social care system, robust information and advice relating to conception, abortion and maternity is provided in a timely manner, is culturally sensitive and available in a variety of formats and languages across different settings in Havering and across the NEL sector as a whole
Anyone who works in sexual and reproductive health care or is in a position to provide SRH advice (e.g. health and social care professionals, volunteers, teachers etc.) should be able to access appropriate training and be culturally competent to have informed discussions about conception, abortion and maternity. The NEL ICB system is recommended to develop a network to share existing or create new training opportunities.
Rates of abortion were highest amongst 20- to 24-year-olds in Havering; access to effective contraception is key to preventing pregnancy. It is recommended that a local strategy is developed to shift in method of contraception from user-dependent to Long Acting Reversible Contraception (LARC) (see also recommendations for contraception below).
To reduce rates of repeat abortions, women and people able to get pregnant should be offered advice on and access to contraception following an abortion; in the first instance it is recommended to target this to people aged under 25 years
Termination of a pregnancy through abortion can have various effects on women, varying from physical symptoms and impacts of mental health and thus follow-up support is important. It is recommended that decision-makers and commissioners of services

undertake a review of the limited provision of specific follow-up support in Havering and consider co-production of a relevant service with current or potential future service users.

Recommendations for Teenage Pregnancy
Although there have been improvements in rates of teenage pregnancy in Havering, it is recommended that an up to date multidisciplinary, collaborative strategy is co-produced with local people in Havering to target resources effectively to those most at risk.
Access to effective contraception is key to reducing unintended pregnancy; it is therefore recommended to work with local young people to ascertain their views of contraception, particularly shifting from user-dependent to long acting reversible contraception (LARC), which is more effective.
Local partners across the multi-disciplinary health and care system, including schools and voluntary sector, to review risk factors associated with teenage pregnancy and understanding of wider determinants of health to explore how needs can be met in these populations; this may be best achieved through training and upskilling of all relevant frontline staff in contact with young people.
As mental wellbeing is a key risk factor in both teenage pregnancy and sexual exploitation, it is recommended for commissioners to consider how to provide support for mental health – work with local partnership groups focusing on mental health for children and young people.
Improve identification of high-risk individuals through closer partnership working between key frontline agencies e.g. schools, youth centres, SRH services, GPs etc and Safeguarding leads.
Improve access to youth-friendly services providing contraception and sexual health advice at locations determined by young people.
It is recommended to capture the voice of young people more frequently and consistently, e.g. via service user feedback, engagement events etc. and ensure this information is shared across relevant partners.
Enhance messaging to young people, parents and families about sexual health and ensure that services available to young people are in locations and at times most suitable to their needs.
SRH services to provide advice and information to schools and Admissions team to ensure that those who are engaged receive information and advice on relationships and sexual health.

Recommendations for Contraception
Frontline staff and service commissioners to ensure there is good quality engagement with residents to understand the barriers for accessing sexual health services local to Havering.
Support locally commissioned SRH services to increase access to appointments, particularly seeking opportunities for online appointments, whilst reducing non-attendance.
Increase awareness about the range of contraception options across Havering, targeting engagement to people and areas at higher risk of unplanned pregnancy.
Post-labour ensure that all new mothers receive and understand information about contraceptive choices and its importance in preventing rapid repeat pregnancy.
Develop collaborative targeted approach to improve the uptake of contraception within the young population, particularly utilising statutory RSE education in schools to openly discuss choices available to young people.
Engage young people in Havering to understand their contraceptive choices and identify barriers in accessing alternative and potentially more reliable LARC contraceptive services, particularly those under 25 years old.

C-Card scheme:

- Add more venues to C-Card scheme increase access
- Switch registration process to online and at outlet
- Evidence review to identify effective evidence-based approaches for the delivery of the scheme

1.0 Structure and Scope

1.1 Sexual Health and Wellbeing

Sexual Health is described by the World Health Organisation (WHO) as "…a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[1] (Fig. 1.1)

Figure 1.1. WHO framework for operationalising sexual health and its linkages to reproductive health

Attainment of good sexual health and wellbeing is dependent on a variety of factors. The ability to access sexual health services, as well as good-quality information on sexual health and the risk factors and consequences of unprotected sexual activity, combined with a supportive environment, creates a situation conducive to good sexual health.

Where sexual health and wellbeing is not achieved, a variety of negative sexual health consequences can occur, these include: sexually transmitted infections (STIs), unintended pregnancy and abortion, sexual dysfunction and sexual violence.[2] Not only can poor sexual health have serious long-term implications for the individual, but the cost of treatment for the NHS is large.

The stigma, discrimination and prejudice often associated with sexual health, (e.g. gender identity, sexual orientation, teenage pregnancy or HIV (Human Immunodeficiency Virus) status), can cause significant harm to emotional wellbeing and fracture communities. Providing accessible information and support to people about their sexual or reproductive health can allow them to make informed decisions about their options as early as possible.

1.2 Inequalities in Outcomes

It is widely acknowledged that the risk of experiencing poor sexual health is not equal. We also know that access to healthcare services accounts for only a small proportion of the inequalities in outcomes observed. Those living in areas of higher deprivation tend to first engage in sexual activity at a younger age and are more likely to have children earlier than

[1] World Health Organisation, 2006a. *Defining sexual health: Report of a technical consultation on sexual health,* 28–31 January 2002. Geneva, World Health Organization.
[2] https://www.who.int/health-topics/sexual-health#tab=tab_1

those living in less deprived areas. There are also higher rates of sexually transmitted infections amongst people living in areas of higher deprivation. Groups of people at higher risk of experiencing poorer sexual health outcomes include: young people, gay, bisexual and other men who have sex with men (GBMSM), black African and black Caribbean ethnicities, and injecting drug users [3].

These inequalities have likely been exacerbated by the COVID-19 pandemic. The COVID-19 pandemic led to disruption in the provision of health services for HIV, STIs and viral hepatitis as well as contraception[4]. Service provision changed, with an increasing proportion delivered online where possible. Testing uptake reduced, along with test positivity rates in some diagnoses which raised concerns. Concerns have also been raised regarding the implications of COVID-19 for rates of sexual violence and access to appropriate services[5]. The evidence suggests that the COVID-19 pandemic will have had implications for the sexual health of Havering residents, particularly those within the high-risk groups.

1.3 Commissioning Sexual Health Services

Improving sexual health is of national and local importance. Commissioning responsibilities for HIV and other sexual and reproductive health services have undergone major changes since April 2013, and commissioning responsibilities are currently distributed between NHS England, Local Authorities and Integrated Care Boards (ICBs).

Figure 1.2. Commissioning Responsibilities for Sexual Health Services (2013)

Local Authorities	ICBs	NHS England
• Comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally provided contraception • STI testing and treatment, chlamydia screening and HIV testing • Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies	• Most abortion services • Sterilisation • Vasectomy • Non-sexual-health elements of psychosexual health services • Gynaecology including any use of contraception for non-contraceptive purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care *– due to be delegated to ICBs from April 2025* • Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs • Sexual health elements of provision health services • Sexual assault referral centres • Cervical screening • Specialist fetal medicine services

[3] PHE (2016) Black and Minority Men who have sex with men; Project evaluation and systematic review BME MSM Report (publishing.service.gov.uk)

[4] Public Health England, 2020. The impact of the COVID-19 pandemic on prevention, testing, diagnosis and care for sexually transmitted infections, HIV and viral hepatitis in England. Preliminary data to September 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943657/Impact_of_COVID-19_Report_2020.pdf

[5] https://www.thesurvivorstrust.org/Handlers/Download.ashx?IDMF=ae2c7834-cd83-4317-807b-05c3df5a3ec6

Local Authorities (LA) are mandated to secure the provision of open access sexual health services, including for community contraception and the testing, diagnosis and treatment of STIs and testing and diagnosis of HIV. In this context, 'open access' means that residents may attend sexual health services in any part of the country, without the need for referral.

LAs are currently facing unprecedented challenges in improving sexual health services whilst addressing changing patterns of population needs and reduced funding. The London Boroughs of Barking and Dagenham (LBBD), Havering (LBH) and Redbridge (LBR) collectively referred to as BHR, jointly commission an integrated sexual health service in a tri-borough arrangement. The current sexual health services contract runs from 2018 under a 5-year agreement with an option to extend yearly beyond this point for up to 3 years.

LBH is also working as part of a wider partnership of councils in London; the London Sexual Health Transformation Programme (LSHTP), to support change. The vision for the programme is to transform the way sexual health services are provided across London, to deliver high quality, innovative, cost-efficient, equitable and accessible services that can meet population sexual health needs faced now and in the future.

In addition, there is the recent transition to the Integrated Care System (ICS) which can present an opportunity to continue to develop integrated care pathways and a whole-system approach to sexual health commissioning. From January 2024 the Provider Selection Regime (PSR) regulations come into force, which will transform the way relevant authorities can commission healthcare services, including sexual health[6]. The opportunity to conduct either a direct award or most suitable provider process will change the way that well-established existing providers can organise their services for the benefit of residents without the need for lengthy and competitive tendering processes and promote collaboration amongst providers of open access sexual health services.

1.4 National Policy and Strategy

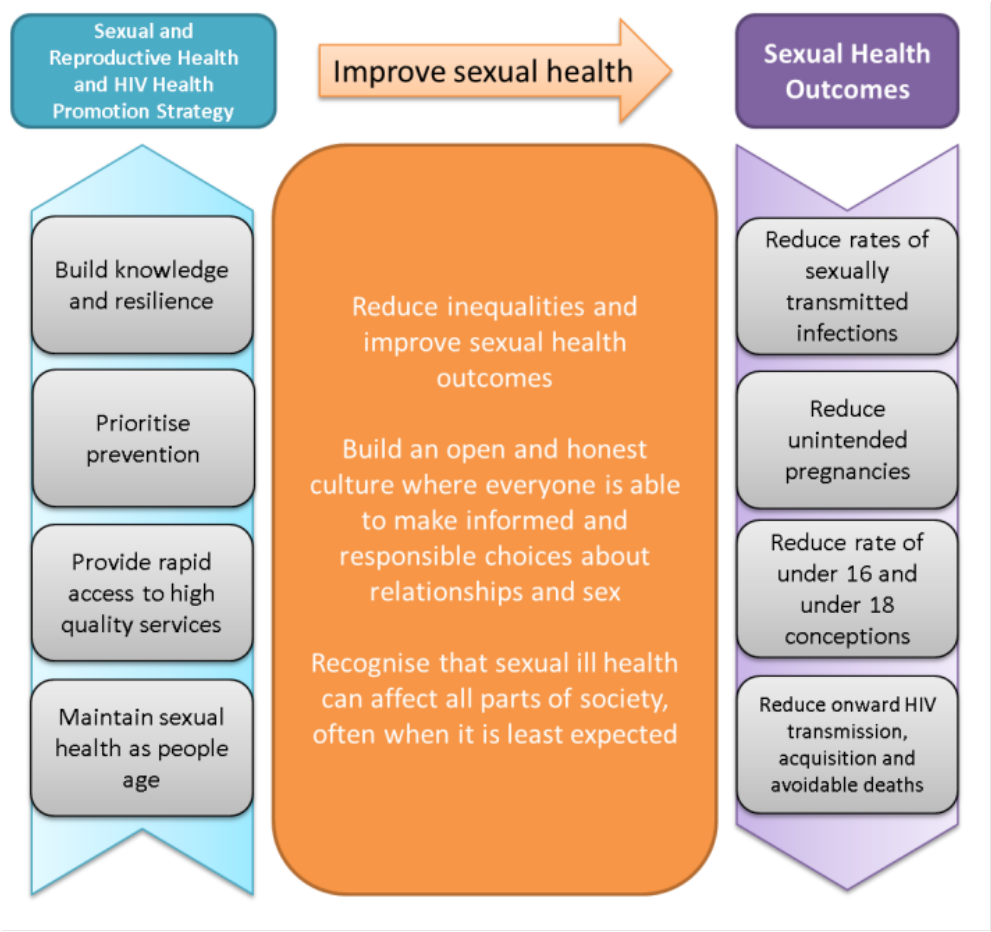
The Department of Health's publication, *A Framework for Sexual Health Improvement in England* (2013) set the national strategic approach for improvement in sexual health outcomes[7]. The key ambitions in this framework were to:

- Reduce inequalities and improve sexual health outcomes
- Build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognise that sexual ill health can affect all parts of society – often where it is least expected

Public Health England's subsequent strategic action plan 2016 to 2019 (Figure 1.3) highlighted the key objectives and outcomes required[8].

[6] NHS commissioning » NHS Provider Selection Regime (england.nhs.uk)
[7] Department of Health (2013). *A Framework for Sexual Health Improvement in England* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf
[8] PHE (2016) Health Promotion Strategy for Sexual and Reproductive Health and HIV (publishing.service.gov.uk)

Figure 1.3 Summary of Strategic Actions to Improve Sexual Health, PHE 2016



1.5 Aim and Objectives

This needs assessment draws on a range of available national and local data and information on sexual health in order to:

- Understand the current sexual health needs of the Havering population and how current service provision is meeting those needs in relation to t:
    - STIs, including associated negative sexual health outcomes (such as: RTIs, infertility, ectopic pregnancy)
    - Conception, Abortion & Maternity
    - Teenage Pregnancy
    - Contraception
- Understand how COVID-19 has impacted sexual health needs and service provision locally
- Consider and identify any opportunities presented by the transition to the ICS for better meeting sexual health needs in the population.
- Identify inequalities in sexual health outcomes and understand how the allocation of resources can be used to reduce any identified inequalities.
- Provide short, medium and long-term recommendations for the commissioning and delivery of sexual health services.

1.6 Approach

This document provides an analysis of the available information and data gathered to understand the current health needs of the population, how service provision is meeting those needs, and what gaps exist.

Each topic area includes an exploration of national, regional and local data, with a particular focus on inequalities in health outcomes for vulnerable or at-risk groups. Where data is available, the analysis includes benchmarking with geographic as well as statistically comparable neighbours.

The data was largely derived from national sources, including the Public Health Outcomes Framework (PHOF), Sexual and Reproductive Health Profile reports, Local Authority STI and HIV Epidemiology Reports (LASERs) and Summary Profile of Local Authority Sexual Health (SPLASH) reports. Service data direct from local providers, and that collected through national reporting systems has been aggregated, and small numbers suppressed to protect patient anonymity. Service user feedback from our local commissioned provider and from resident engagement surveys have been similarly anonymised.

As well as exploring key topics individually, the needs assessment seeks to consider the whole-system context, including overarching recommendations aimed at working towards more integrated sexual health services. Whilst the needs assessment is structured around the key negative outcomes of poor sexual health, consideration is given throughout to wider contributors to positive sexual health, including the prevention of discrimination and stigma across all services.

1.7 Scope

Whilst the data presented in this needs assessment focus primarily on sexual health service provision, it is recognised that achieving good sexual health is dependent both on identifying and treating or managing disease and also on supporting people to improve their sexual wellbeing. The needs assessment therefore seeks to consider how commissioned services can contribute to improving overall sexual wellbeing, including recommendations for outreach and partnership working where inequalities in sexual health and sexual wellbeing can be targeted.

Areas that will not be covered in this needs assessment are:

- Maternal health (from pre-conception to post-natal),
- Health and wellbeing of those living with HIV and their families.
- fertility service provision
- Children abuse and sexual exploitation (which will be explored in a separate supplementary need assessment)

1.8 Application of this Needs Assessment

The findings from this needs assessment will:

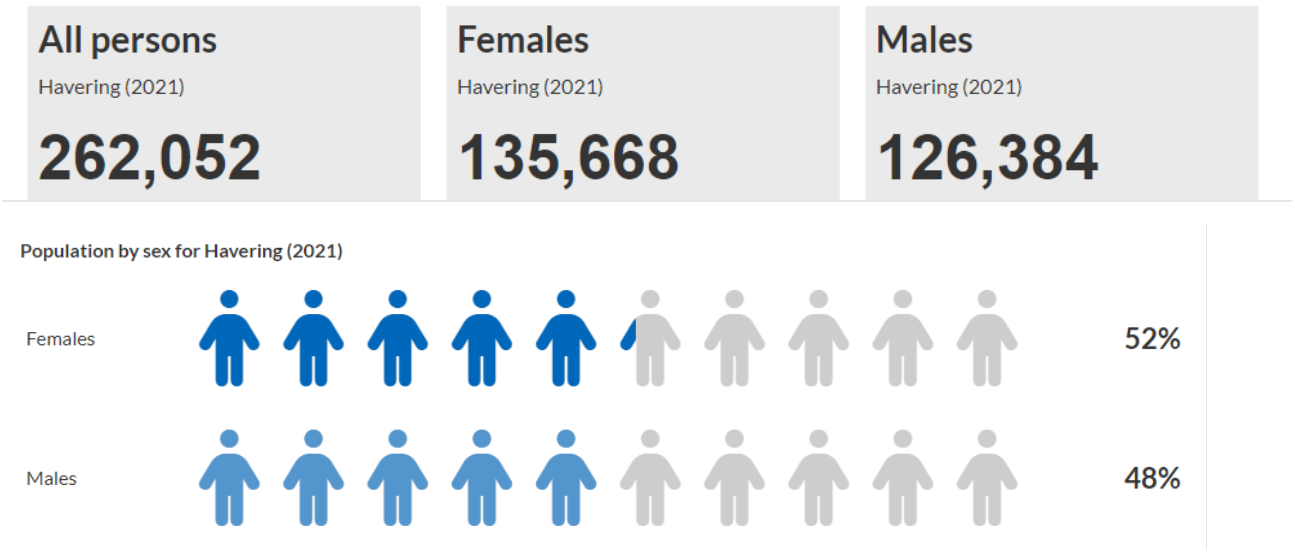
- Make recommendations to commissioners for the improvement of services
- Inform service quality improvements by providers
- Ensure that, in the context of system-wide approaches in the form of the Integrated Care Partnership (ICP), the data will inform the Havering Action Plan element of a new North East London multi-borough strategy, which is in development.

2.0 Havering's Population

To contextualise the needs of Havering population in terms of sexual health and wellbeing, the following gives a summary of key demographic information for the borough. A full report on Havering demography can be found here[9].

- According to the 2021 Census, there are now around 262,000 people living in Havering, an increase of round 14% from 1991 (Figure 2.1).
- Havering has a higher percentage of people aged 65+ (17.6%) than London (11.9%) and similar to England (18.4%)[10].
- Havering also has a higher percentage of children aged 0-14 years (18.9%), than both London (18.1%) and England (17.4%) (Figure 2.2). There was marked growth seen in the population of children and young people living in Havering between the 2011 and 2021 Census.

Figure 2.1 Population by sex for Havering (2021)



Further information about Havering's population can also be found on www.haveringdata.net

- The percentage of people identifying as White British (including English, Welsh, Scottish, Northern Irish or British) has decreased from 87.6% in the 2011 Census to 66.5% in the 2021 Census. Despite this rapid change, Havering remains the least ethnically diverse borough in London, alongside Bromley, tending to be more similar to the rest of England in this regard.
- 10.8% of Havering's population identify as Asian or Asian British in the 2021 Census, followed by 7.4% 'Other White' (including White European, Polish, Romanian etc.) and 7.2% Black or Black British (Figure 2.3).

[9] Local Insight (communityinsight.org)
[10] London Borough of Havering via Census Data (2022) Population - UTLA | Havering | InstantAtlas Reports (haveringdata.net)

Figure 2.2 Population by 5-year age bands in Havering compared to England for Males (Left) and Females (Right) (2021; ONS)

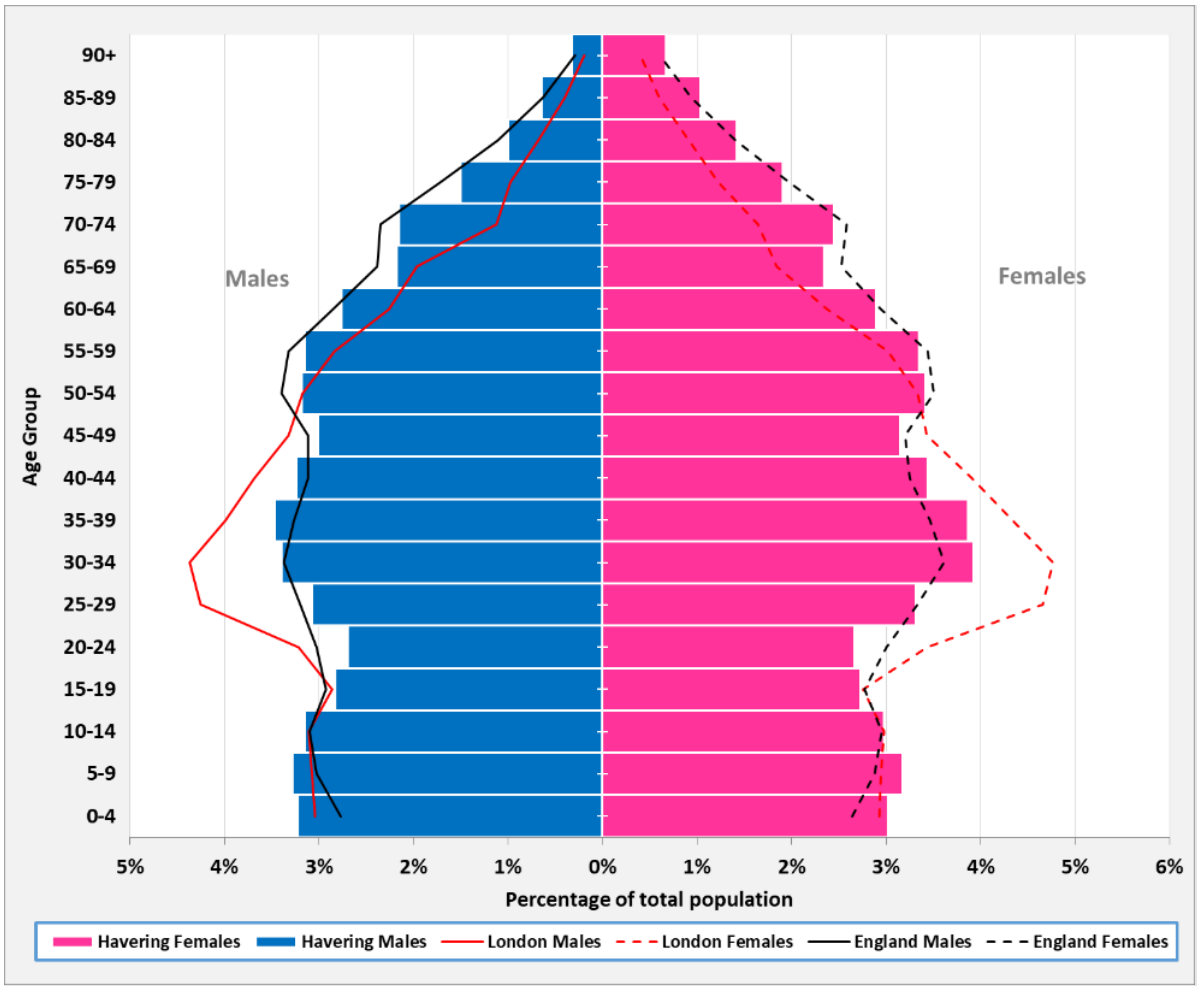
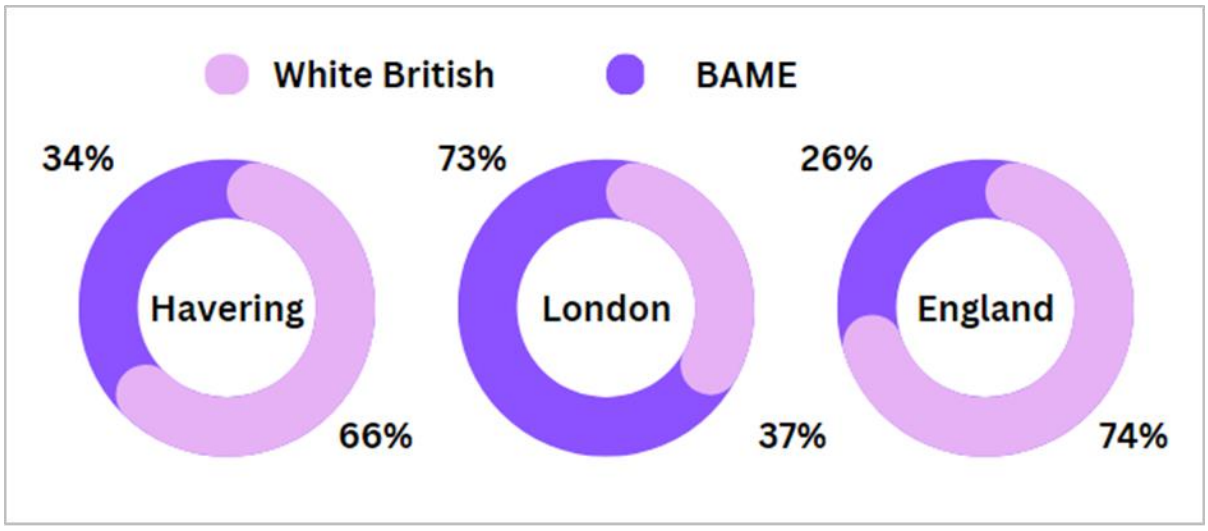
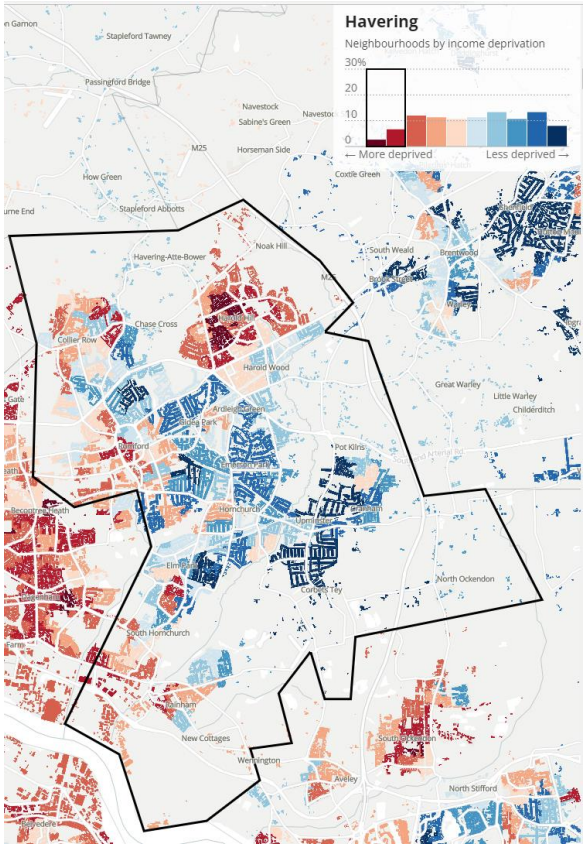


Figure 2.3 Percentage of ethnic groups in Havering 2021



- According to the Census 2011 report, 81% of the residents in Havering were born in the United Kingdom (UK). Most of the residents born outside of the UK were born in Romania and other European countries.
- The most spoken first language in Havering is English (90%) followed by other European languages (4%). The most spoken non-European language is Panjabi (0.6%).
- In 2019, 10.8% of Havering population was income deprived, ranking 160th out of the 316 local authorities for deprivation. However, deprivation is clustered to neighbourhoods, in which 14 neighbourhoods are among the 20% most deprived neighbourhoods in England (Figure 2.4)

Figure 2.4 Map of Deprivation by decile in Havering, 2021



- Of the 93% of Havering residents who answered the 2021 Census question on sexual orientation, 91.1% identified as straight or heterosexual; 1.95% identified as Lesbian, Gay or other sexual orientation (LGB+) and 6.98% did not answer the question.
- Fewer people in Havering identified as LGB+ than both London (4.27%) and England (3.2%), and also the fewest out of all the London boroughs (Figures 2.5 and 2.6).

Figure 2.5 Percentage of LGB+ residents in London Boroughs, London and England (2021)

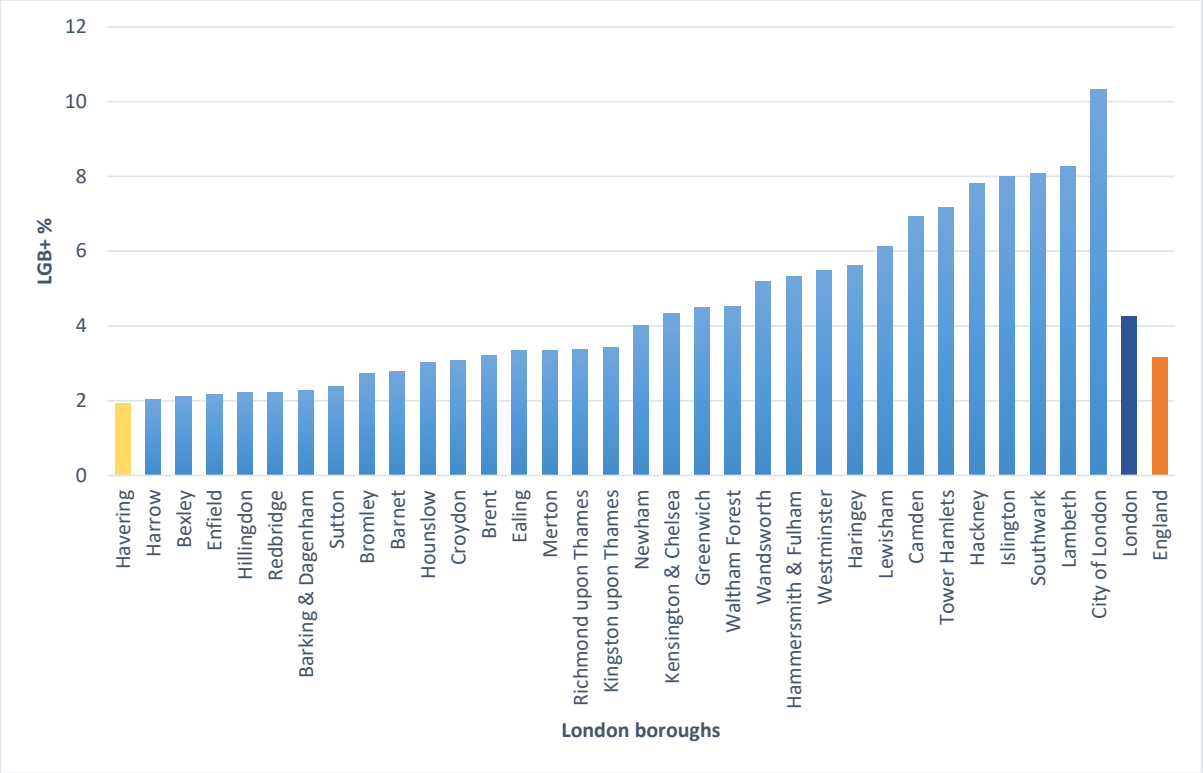


Figure 2.6 Breakdown of sexual orientation for Havering residents aged 16 and over, 2021

Sexual Orientation	Number	Percentage
Straight or Heterosexual	191,007	91.07%
Gay or Lesbian	1,993	0.95%
Bisexual	1,540	0.73%
Pansexual	436	0.21%
Asexual	56	0.03%
Queer	21	0.01%
All other sexual orientations	46	0.02%
Not answered	14,631	6.98%
Total	**209,730**	**100.00%**

3.0 Sexually Transmitted Infections

3.1 STIs as a Public Health Issue

Control of STIs is a key problem in public health policy, not only because of their high incidence, but also to the complications they cause and to their role in HIV transmission. The WHO reports that, "More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact, including vaginal, anal and oral sex. Some STIs can also be transmitted from mother-to-child during pregnancy, childbirth and breastfeeding[11]." Untreated STIs can cause complications and have long-term negative consequences such as infertility and ectopic pregnancy[12]. For more information about common STIs, including

[11] WHO (2022) Sexually transmitted infections (STIs) (who.int)
[12] UKHSA (2019) Health Matters: Preventing STIs - UK Health Security Agency (blog.gov.uk)

routes of transmission, symptoms, and treatment, visit Sexually transmitted infections (STIs) - NHS (www.nhs.uk).

Globally, there have also been emerging outbreaks of infections in which transmission has been shown to have occurred during sexual contact, including mpox, Shigella, Ebola and Zika viruses. Actions required to reduce transmission of all common STIs will also help prevent transmission of these infections.

STIs can have serious consequences beyond the immediate impact of the infection itself. For example:

- Herpes, gonorrhoea and syphilis can increase the risk of HIV acquisition.
- Mother-to-child transmission of STIs can result in stillbirth, neonatal death, low-birth weight and prematurity, sepsis, neonatal conjunctivitis and congenital deformities.
- Human papillomavirus (HPV) infection causes cervical and other genitourinary cancers.
- Hepatitis B resulted in an estimated 820 000 deaths globally in 2019, mostly from liver cirrhosis and liver cancer.
- Gonorrhoea and chlamydia are major causes of pelvic inflammatory disease and infertility in women.

While the great majority of STIs are preventable through condom or other forms of barrier protection use, they do not offer protection for STIs that cause extra-genital ulcers, such as syphilis and genital herpes. As such, action to diagnose and treat STIs quickly and effectively is an essential part of reducing levels of community transmission.

3.2 National context

3.2.1 National & Regional Data

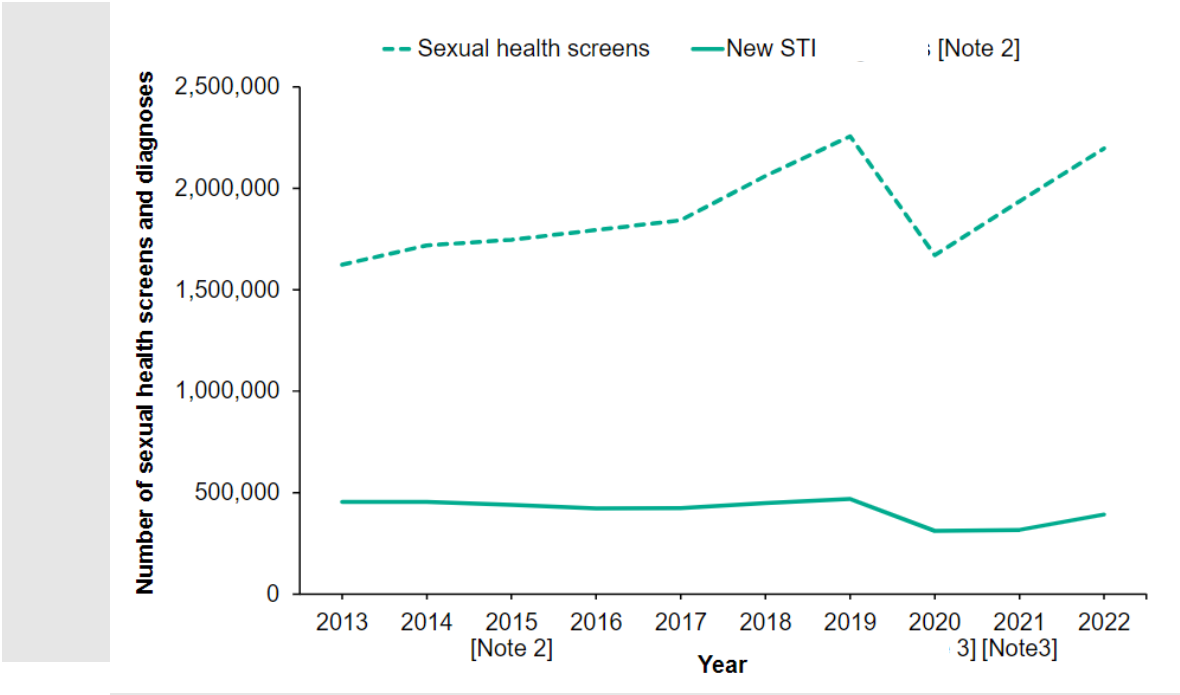
i) Numbers of Sexual Health Screens

Prior to the COVID-19 pandemic, the number of sexual health screens (diagnostic tests for a range of common infections including chlamydia, gonorrhoea, syphilis and HIV) was on a clear upward trajectory. However, the impact of the COVID-19 pandemic on both sexual health screens and new STI diagnoses was stark. Implementation of national and regional lockdowns, social and physical distancing measures were the biggest contributor to the 25% decrease observed in the number of sexual health screens between 2019 and 2020.

By 2022, the number of screens had increased, but not quite back to pre-Covid levels (Figure 3.1)[13]. The number of sexual health screens in 2022 increased by 13.4% (1,934,347 to 2,193,801) compared to 2021 but was 2.7% lower than 2019 (2,255,992).

Figure 3.1 Number of new STI diagnoses and sexual health screens among England residents accessing SHS 2011 to 2020

[13] PHE (2020) Sexually transmitted infections and screening for chlamydia in England, 2020 (publishing.service.gov.uk)



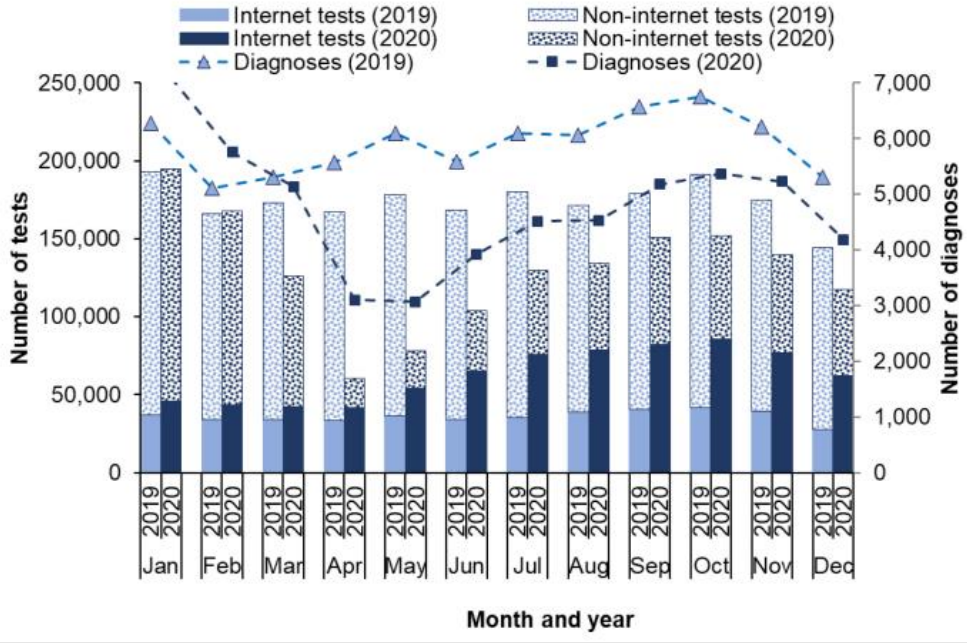
Data Source: GUMCAD STI surveillance system

The overall number of consultations at sexual health services (SHS) also decreased during Covid in 2020 by around 10% compared to 2019. However over the same period, the number of internet/e-service consultations doubled from 511,979 to 1,062,157. Similarly, fewer tests overall were conducted in March to April 2020 compared to the same months in 2019, with a corresponding decrease in number of diagnoses[14]. Whether the decrease observed during the pandemic was due to less social interaction and therefore less incidence of STIs or a lack of access to SHS clinics is unclear.

There was a clear shift in the way in which people sought STI testing - the greater proportion of tests during the COVID-19 pandemic were accessed via e-service/internet testing. Figure 3.2 demonstrates this trend for gonorrhea; this trend is repeated for syphilis and chlamydia. In May 2019, for example, less than a quarter of tests for gonorrhea nationally were ordered via e-service/internet relative to non-internet/clinic tests compared to over two-thirds in May 2020.

[14] Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)

Figure 3.2 Number of gonorrhea tests and diagnoses via the internet/e-service compared to non-internet/clinic services among England residents January 2019 to December 2020



For HIV, despite a 31% fall in the number of people having an HIV test between 2019 and 2020 at the peak of the COVID-19 outbreak, there was a 15% rise in the number of people tested in 2021. This latter increase was virtually all driven by a 32% rise in internet testing, which accounted for 98% of the total testing increase[15].

The sustained levels of e-service testing indicate that this channel shift in how people access STI screening is likely to remain.

Compared to 2021 the number of face-to-face consultations in SRH clinics in 2022 increased overall (8.2%, from 2,037,468 to 2,204,790) as did the number of online consultations (19.0%, from 1,446,001 to 1,721,132), while the number of telephone consultations decreased (18.7%, from 576,139 to 468,482). It should also be noted that he number of online consultations may be underreported where physical SHSs provide both face-to-face and online consultations. Figure 3.3 shows the percentage of consultations that were conducted face to face in clinic, online or by telephone appointment in England or london in 2022.

Figure 3.3 Proportion (%) of all Sexual Health Consultations conducted in England or London in 2022 by Channel

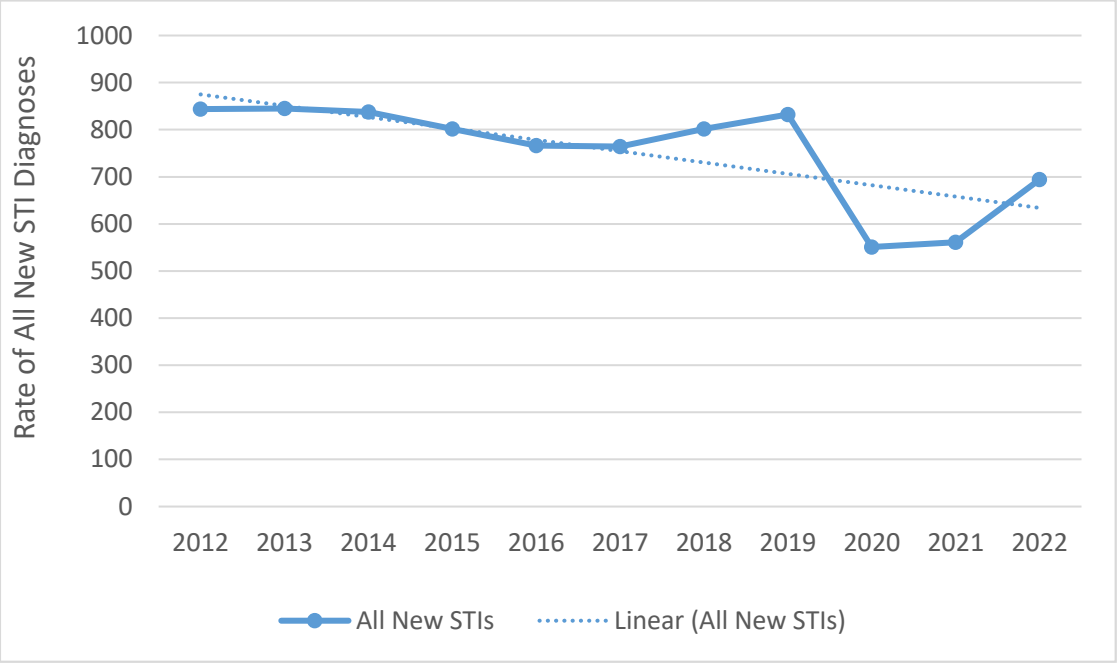
Channel	All England	London
Face to Face (SRH Clinic)	50.2%	44%
Online	39.2%	53%
Telephone	10.7%	4%

[15] UKHSA (2022) HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report - GOV.UK (www.gov.uk)

ii) STI Diagnostic Rates

Whilst the numbers (Fig. 3.1 above) and rates (Figure 3.3) of all new sexual health diagnoses in England have been steadily decreasing over the past decade, there has nevertheless been an increase in specific infections.

Figure 3.3 Change in Rate of All New STI Diagnoses in England 2012 to 2022, & linear trend



The UK Health Security Agency (UKHSA) reports that the most commonly diagnosed STIs in England in 2022 were:[16].

Figure 3.4 Percentage of All New STI Diagnoses by Infection, England, 2022

Infection	Number of Diagnoses	% of all New STI Diagnoses
Chlamydia	199,233	50.8%
Gonorrhoea	82,592	21.1%
First Episode Genital Warts	26,079	6.7%
First Episode Genital Herpes	24,910	6.4%

The gonorrhoea diagnostic rate has risen from 50 per 100,000 in 2012 to 126 per 100,000 in 2019, with a slight drop in 2020 and 2021, to 146 per 100,000 in 2022 in England[17]. Syphilis diagnosis rates have increased in a similar pattern to gonorrhea, rising from 5.6 per 100,000 in 2012 to 15.4 per 100,000 in 2022 (Figure 3.1). It is likely that sexual behaviours, including sex without a condom, or sex with new or casual partners has likely contributed to this resurgence in cases.

[16] UKHSA (2023) Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)
[17] UKHSA (2022) Fingertips; Public Health Data; Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

In 2022 there were large increases in the numbers of gonorrhoea (50.3%, from 54,961 to 82,592), chlamydia (24.3%, from 160,279 to 199,233), and infectious syphilis (primary, secondary and early latent stages) diagnoses (15.2%, from 7,543 to 8,692) compared to 2021. In line with the increasing trend over the past decade, diagnoses of both gonorrhoea and syphilis exceeded the high levels reported in 2019 (before the COVID-19 pandemic), which were 71,133 (16.1% increase) and 8,040 (8.1% increase) respectively[18].

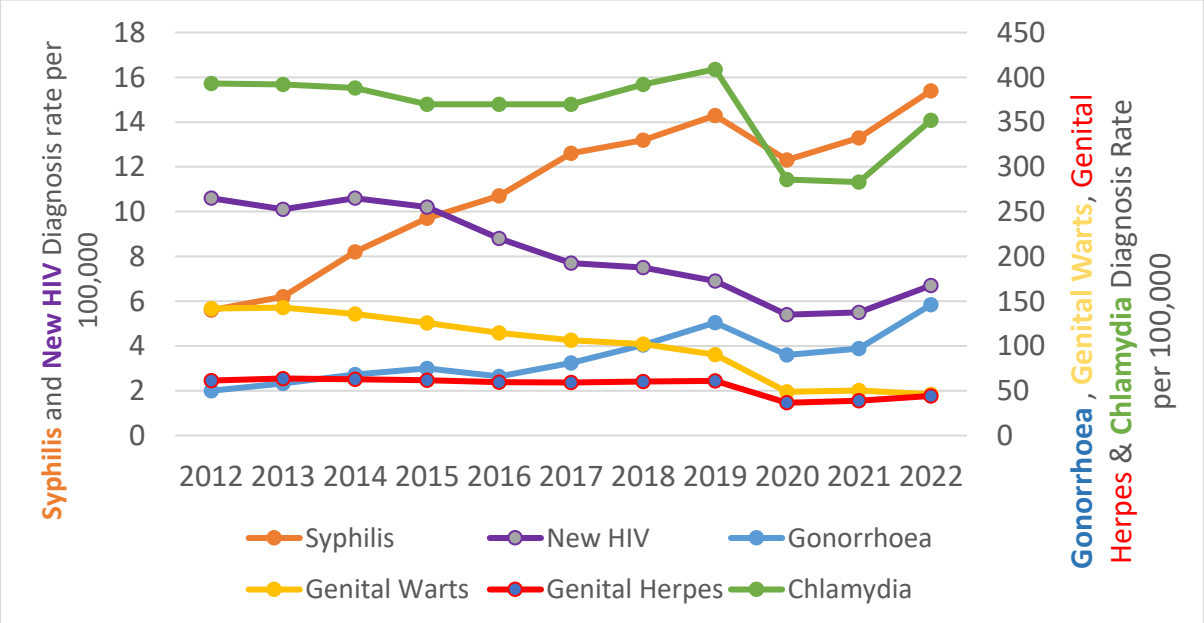
The number of gonorrhoea diagnoses in 2022 was the largest annual number reported since records began, while the number of syphilis diagnoses was the largest annual number reported since 1948.

Diagnoses of first episode genital herpes increased 13.8% (21,892 to 24,910) between 2021 and 2022, but remained 27.7% lower than 2019 (34,464). Diagnoses of first episode genital warts decreased (8.5%, from 28,497 to 26,079) between 2021 and 2022 in line with the decreasing trend over the past decade due to the HPV vaccination programme.

Rates of new diagnosis for HIV have reduced from 10.6 per 100,000 in 2012 to 6.7 per 100,000 between 2012 and 2022 (Figure 3.5). From 5,692 new HIV diagnoses in England in 2012, this has reduced by 33% to 3,805 new diagnoses in 2022. This recent trend for HIV has been observed mostly in fewer diagnoses among GBMSM and as a result of:

- HIV testing, particularly repeat testing among higher-risk men
- Improvements in the initiation of anti-retroviral therapy
- Treatment as prevention (TasP)
- Pre-exposure Prophylaxis (PrEP)[19]

Figure 3.5 National Trends in Diagnostic Rates for Gonorrhoea (Right hand axis, scale 0-140 per 100,000), and Syphilis and New HIV Diagnoses (Left hand axis, scale 0-16 per 100,000) in England 2012 to 2022



Data Source: UKHSA Fingertips, Sexual Health Profiles 2023

[18] Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)
[19] PHE (2019) Health matters: preventing STIs - GOV.UK (www.gov.uk)

In 2022, of the 3,805 people newly diagnosed with HIV in England, 1,361 were previously diagnosed abroad. The remaining 2,444 new diagnoses that were first made in England represent a 6% rise from 2,313 (in 2021) and a 8% rise from 2,271 (in 2020)[21]. Among these, men exposed through sex with men accounted for 30% (724), women exposed by heterosexual contact for 23% (564), men exposed by heterosexual contact for 17% (411), injecting drug use for 2% (41).

More than half those first diagnosed with HIV in England in 2022 were diagnosed at a late stage (with a CD4 count below 350 cells per mm^3). People diagnosed late have a fivefold risk of death within a year of their diagnosis compared to those who were diagnosed at an early stage of infection.

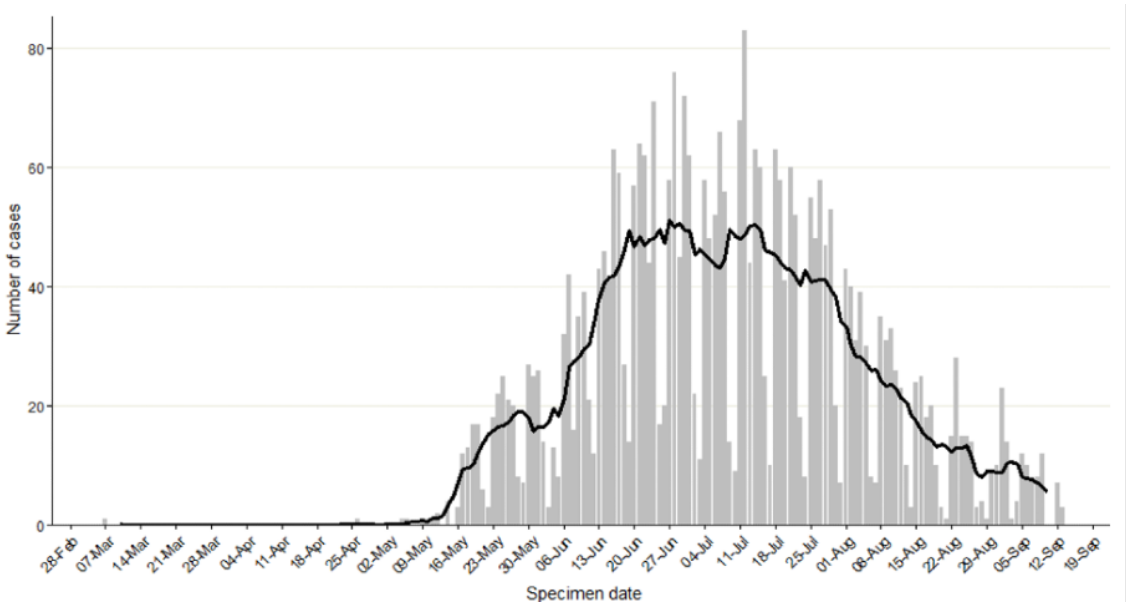
Of the estimated 99,000 (credible interval (CrI) 97,700 to 100,900) people living with HIV in 2022, an estimated 4,500 (95% CrI 3,500 to 6,200) were undiagnosed. In 2022, England again achieved the UNAIDS 95-95-95 target nationally, with 95% of people living with HIV being diagnosed, 98% of those diagnosed being on treatment and 98% of those on treatment having an undetectable viral load.

iii) New and Emerging Infections: Mpox

In May 2022, an international outbreak of mpox (previously called monkeypox) was detected with cases reported concurrently in many countries where the disease is not endemic. Mpox is a zoonotic infection (one which can spread between animals and humans), caused by the monkeypox virus, that occurs mostly in West and Central Africa. Prior to 2022, cases diagnosed in the UK had been either imported from countries where mpox is endemic or contacts with documented epidemiological links to imported cases. Between 2018 and 2021, there had been 7 cases of mpox in the UK. Of these, 4 were imported, 2 were cases in household contacts, and one was a case in a health care worker involved in the care of an imported case. There was no documented community transmission in previous outbreaks.

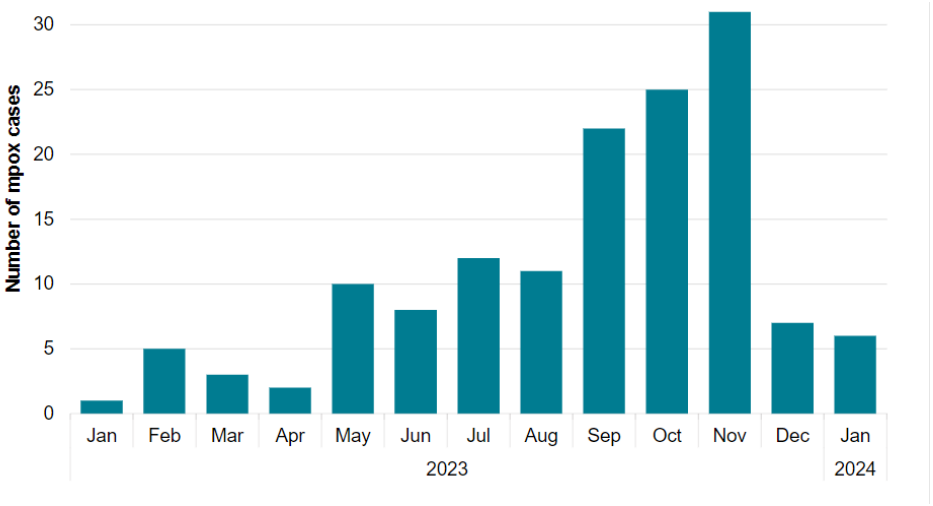
The outbreak has involved mainly, but not exclusively, GBMSM who have not had any documented history of travel to countries where Mpox is endemic. Over 3,500 individuals were diagnosed in England during 2022 (Fig 3.7) in this first wave of infections – a second, much smaller wave occurred in 2023.

Figure 3.7 Confirmed and highly probable Mpox cases by specimen date in England February to September 2022



In 2023 and 2024 (up to 31 January 2024, Fig. 3.8)) there have been a total of 143 cases of mpox reported in England (65 cases were presumed to have acquired mpox in the UK, 56 were acquired outside the UK and 22 are awaiting classification).

Figure 3.8 Number of confirmed and highly probable Mpox cases in England, by month, 2023-24



3.2.2 Groups at higher risk of STIs

NICE guidance defines people at most risk of STIs as those who are “involved in higher rates of condom-less sex with multiple partners or frequently change partners”[20]. NICE acknowledges that while ”there may be more people practicing these behaviours in some groups than others... this does not mean that everyone in the group is necessarily at higher risk. For example, GBMSM are a higher risk group for STIs and HIV but this does not mean that every person in that group is at higher risk”.

[20] Recommendations | Reducing sexually transmitted infections | Guidance | NICE

Groups at higher risk of STIs include [21]:

- GBMSM
- Young people age 16 to 24 years
- People from a Black African or Caribbean family background
- Trans people
- Sex workers
- Migrant communities
- People who are homeless
- Asylum seekers

Some groups at higher risk include those who may find it challenging to access services because of where they live, lack of familiarity with healthcare offer, physical, language or other barriers, and fear or experience of stigma.

i) Sexual Orientation - Gay, Bisexual and Men who have sex with Men (GBMSM)

GBMSM experience health inequalities related to STIs. In 2021, GBMSM men accounted for 45% of London residents diagnosed with a new STI (excluding chlamydia diagnoses reported via the Chlamydia Testing Activity Dataset (CTAD) surveillance system), including 4% of those diagnosed with syphilis and 72% of those diagnosed with gonorrhoea (where gender and sexual orientation are known) [22].

Prior to the COVID-19 pandemic, the number of STI diagnoses among GBMSM increased persistently for all common STIs except genital warts (Figure 3.10). Among GBMSM, diagnoses of STIs did not increase overall in 2021, but remained high, particularly gonorrhoea and infectious syphilis diagnoses, which suggests that rapid STI transmission was occurring in dense sexual networks, including those living with HIV. Condomless sex increases the risk of infection of a range of infections that can be transmitted sexually.

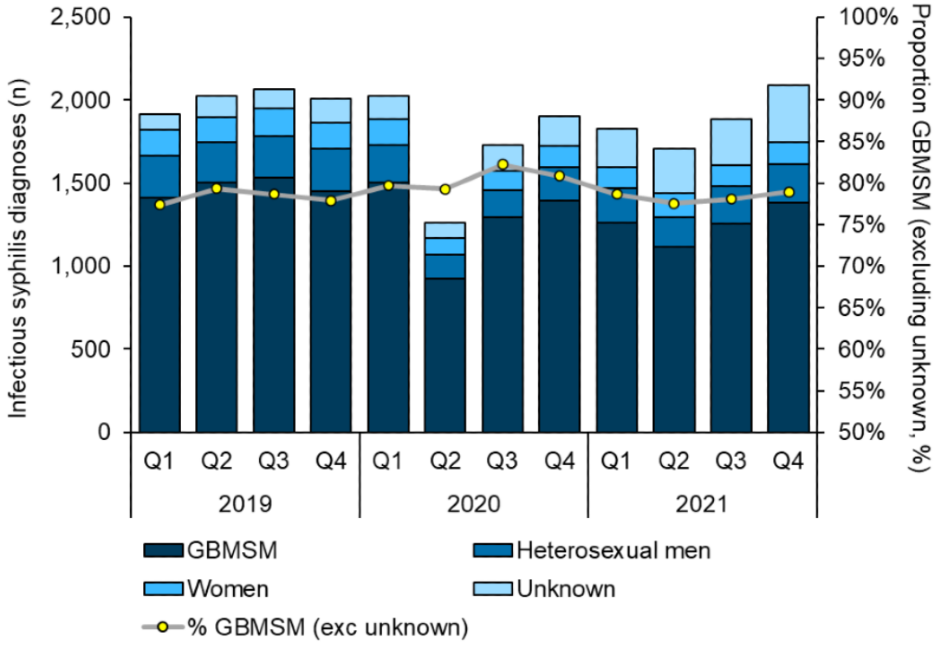
Between 2021 and 2022, amongst GBMSM, diagnoses of gonorrhoea increased by 41.3% (27,545 to 38,923), chlamydia increased by 25.3% (15,267 to 19,129), and diagnoses of infectious syphilis increased by 12.9% (from 5,316 to 6,003)[23].

As GBMSM continue to experience high rates of STIs, they remain a priority for targeted STI prevention and health promotion beyond HIV prevention, including immunisation against hepatitis A, hepatitis B, HPV and mpox.

On average across England, a disproportionate number of syphilis infections occur amongst GBMSM; by Q4 2021, 79% of all syphilis infections were in GBMSM (Figure 3.11). Syphilis diagnoses were highest in GBMSM in the 35 to 44 and 45 to 64 age groups, whilst women had the highest percentage of diagnoses in the 20 to 24 age group[24].

[21] NICE (2022) NG221 Evidence review A: interventions to reduce the acquisition and transmission of STIs in higher risk groups (nice.org.uk)
[22] UKHSA (2023) Spotlight on sexually transmitted infections in London: 2021 data - GOV.UK (www.gov.uk)
[23] UKHSA (2023) Sexually transmitted infections and screening for chlamydia in England: 2022 report - GOV.UK (www.gov.uk)
[24] Syphilis in England, 2019 to 2021 - GOV.UK (www.gov.uk)

Figure 3.11 Number of infectious syphilis diagnoses by gender and sexual orientation, 2019-2021, England



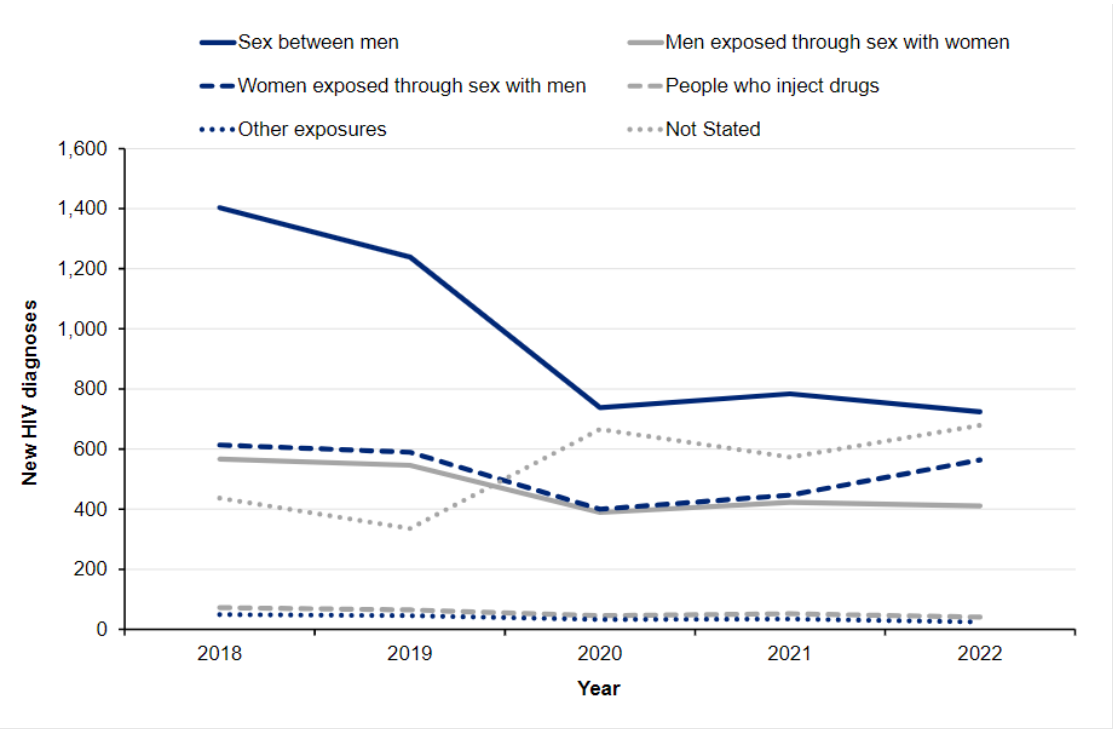
The number of people having an HIV test in sexual health services (SHSs) in England rose by 10% from 1,048,551 in 2021 to 1,155,551 in 2022, but 15% fewer people tested in 2022 compared to 2019, prior to the COVID-19 pandemic. Among GBMSM, 192,503 had an HIV test in 2022, 7% higher than the 180,236 in 2021, the highest number ever reported. Among heterosexual men and women, 792,875 were tested in 2022, compared to 1,051,391 in 2019 and 735,402 in 2021.

In 2022, almost half of eligible attendees at specialist SHSs in England were tested for HIV (48%), a rise from 45% in 2021 but still below that observed in 2019 (65%). In 2022, eligible GBMSM had the highest uptake of HIV testing (74% tested, 23% not offered a test, 3% declined a test) compared to other groups, with lowest uptake observed amongst eligible heterosexual and bisexual women (38% tested, 40% not offered a test, 22% declined a test).

The number HIV diagnoses first made in England increased by 6% from 2,313 in 2021 to 2,444 in 2022. In 2022, GBMSM exposed through sex with men accounted for 30% (724) of these diagnoses, compared to women exposed through sex with men (23%,564), and men exposed through sex with women (16.8%, 411) (with remaining new cases resulting from injecting drug use (1.7%, 41), vertical transmission from mother to baby (0.5%,13) and other exposures (0.5%). People with probable exposure not stated accounted for 28% (679) (Figure 3.12)[25].

[25] UKHSA (2023) HIV testing, PrEP, new HIV diagnoses and care outcomes for people accessing HIV services: 2023 report - GOV.UK (www.gov.uk)

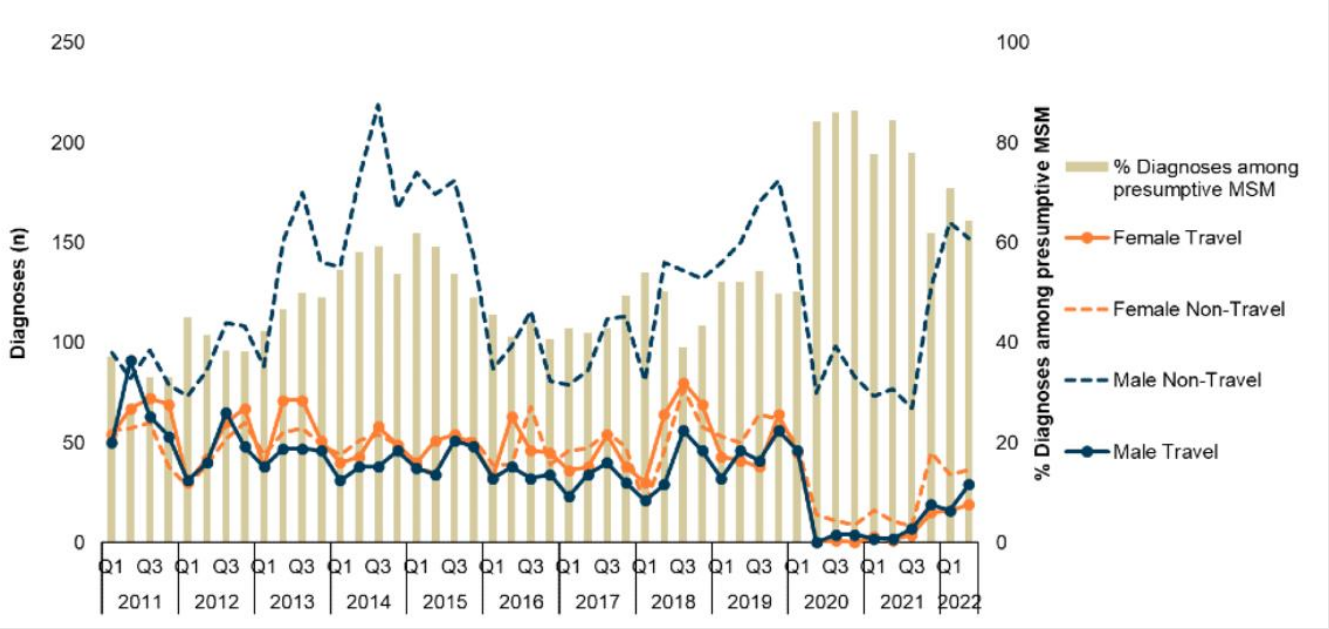
Figure 3.12 New HIV diagnoses among people first diagnosed in England by probable route of exposure, England, 2018 to 2022.



Whilst diagnoses of shigella are often associated with exposure to contaminated food or water during travel to endemic countries, they are increasingly acquired domestically in England, mainly among GBMSM via direct or indirect oral-anal contact. There was a steep decline in early 2020 and subsequent plateau of diagnoses reported to UKHSA surveillance systems, likely due to COVID-19 related control measures. Since Q3 2021 diagnoses among adults have increased by 189% to the end of Q1 2022 (222 cases to 642 cases). By Q2 2022, 68% of diagnoses were in presumptive GBMSM, which had increased by 127% (from 67 to 152) between Q3 2021 and Q2 2022 (Figure 3.13) [26].

[26] UKHSA (2022) Sexually transmitted Shigella spp. in England: data up to quarter 2, 2022 - GOV.UK (www.gov.uk)

Figure 3.13 Number of shigella diagnoses amongst adults (≥16 years) by travel association and sex, and proportion of diagnoses amongst presumptive GBMSM, England Q1 2011 to Q2 2022

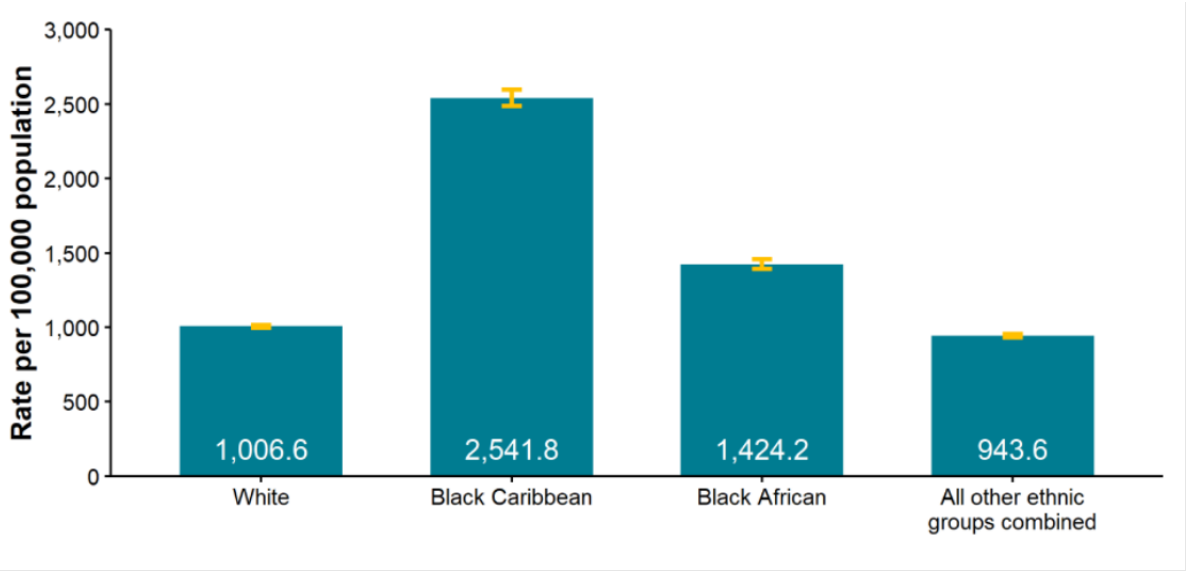


London had the highest number of shigella cases. Although numbers of cases are too small to break down by borough, the rates of shigella are disproportionately high amongst GBMSM, and so sexual orientation should be considered when targeting STI prevention programmes, particularly use of condoms and other safe sex practices.

i) Ethnicity and country of birth

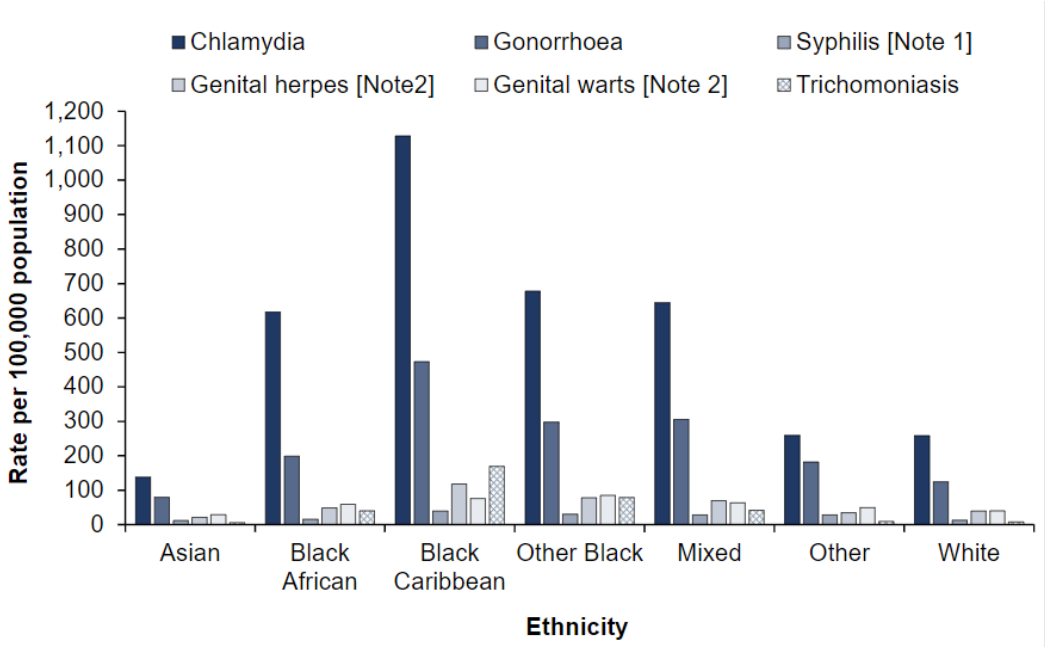
In 2021, where ethnicity was known, people from black Caribbean ethnicities represented 10% of residents in London diagnosed with a new STI and yet had the highest rate of new STI diagnosis – at 2,541 per 10,000(Figure 3.14). Whilst behaviours may be a factor in increased risk for groups who have multiple partners or engage in condom-less sex, there are no observable clinical or behavioural factors explaining the disproportionately high rates of STI diagnoses amongst people of black Caribbean ethnicity. It is therefore more likely that the wider determinants of health and wellbeing, such as where a person lives, income, type of employment and other forms of deprivation, play a more significant role in the inequality in outcomes for some groups. A similar trend is shown for women, with highest rates of chlamydia and gonorrhoea in black Caribbean, black African and of black women of other ethnicities.

Figure 3.14 Rates of new STIs by ethnic group per 10,000 residents in London, 2021



In 2022, there was a total of 36,747 diagnoses of new STIs among people of black ethnicity (9.4% of the total number of new STI diagnoses). However, people of black ethnicity had the highest diagnosis rates of all ethnic groups, although this varied among the black ethnic groups. In 2022, people of black Caribbean ethnicity had the highest diagnosis rates of chlamydia, gonorrhoea, infectious syphilis, trichomoniasis, and genital herpes, while people of black African ethnicity had relatively lower rates of STIs (Fig. 3.15).

Figure 3.15 Rates of STI Diagnoses among England Residents Accessing SRH Services by Ethnicity and STI, 2022

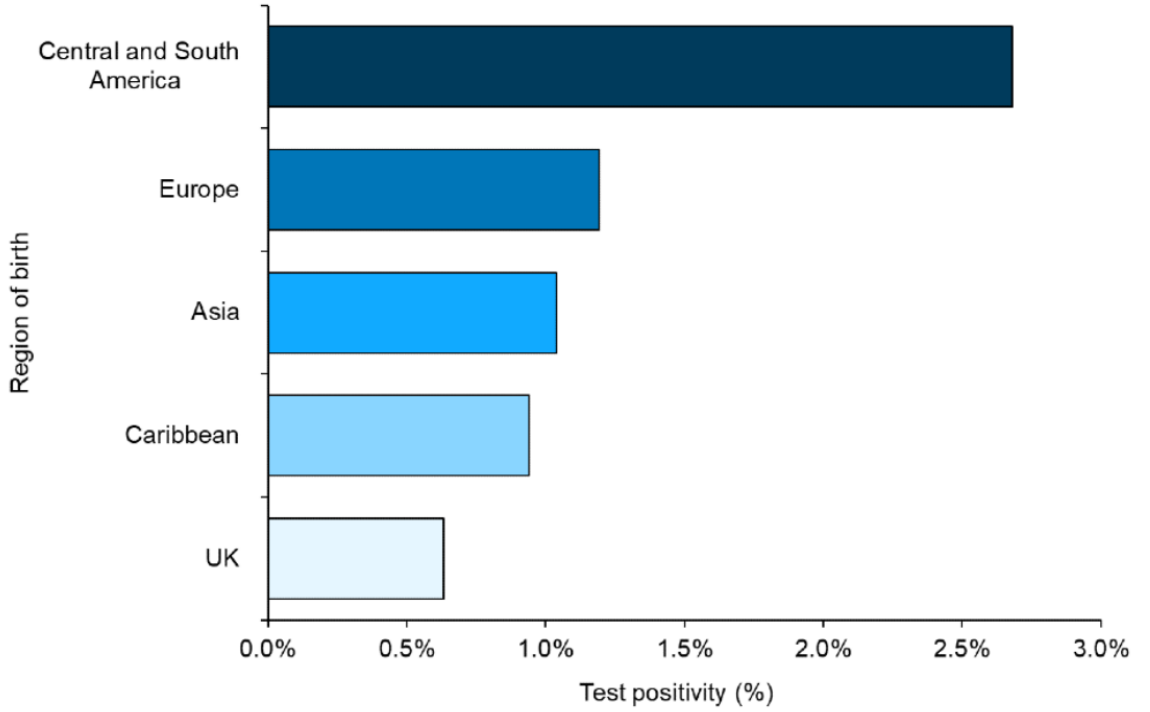


Recording of ethnicity by SRH services and other primary care services where sexual health is supported is therefore important to ensure equitable service provision.

There is also evidence of disparities in sexual health outcomes by country of birth. One example of this is observed in national rates of syphilis diagnosis. In 2021, whilst the highest

crude numbers of syphilis diagnoses occurred among individuals born in the UK, test positivity for syphilis was highest among individuals born in Central and South America (2.7%). This is also more than double the next highest test positivity for those born in Europe (1.2%) (Figure 3.16).

Figure 3.16 Syphilis test positivity by region of birth, 2021, England



ii) Deprivation

People living in areas of deprivation, with limited economic opportunities and lack of socioeconomic resources, are at greater risk of contracting an STI (Fig. 3.17 & 3.18).

Figure 3.17 Rates of New STIs per 100,000 Residents by Decile of Deprivation, London, 2022

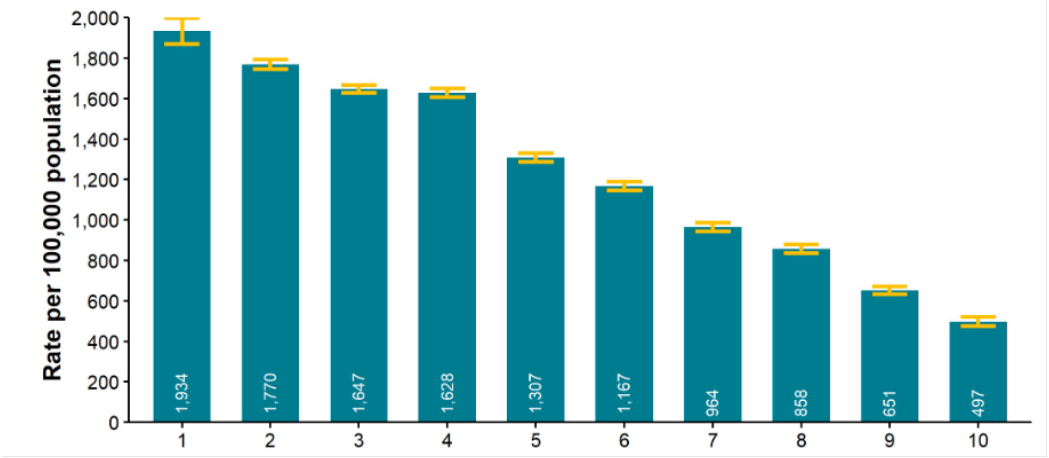
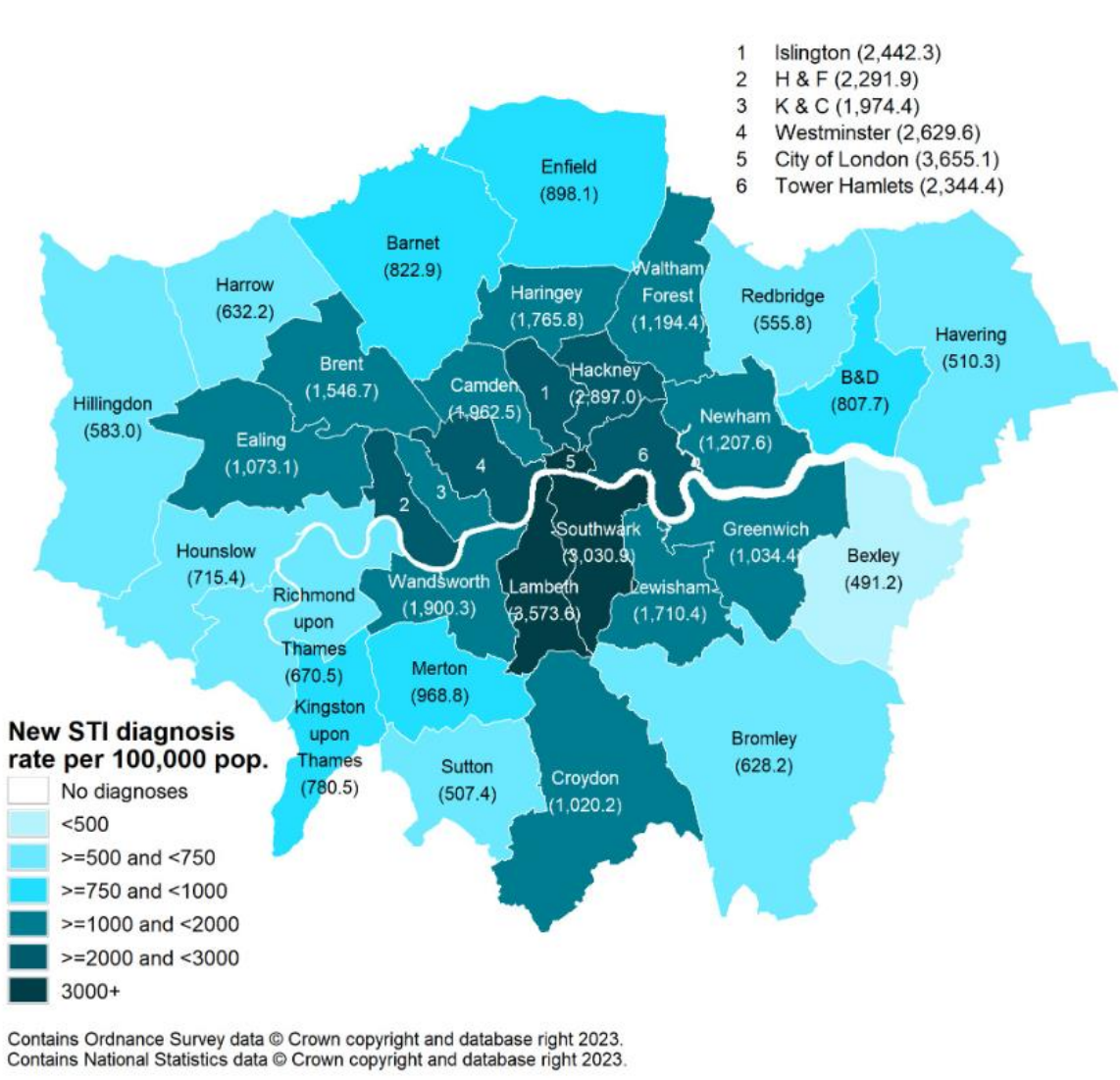


Figure 3.18 Map of new STI rates per 100,000 residents by Local Authority in London, 2022.

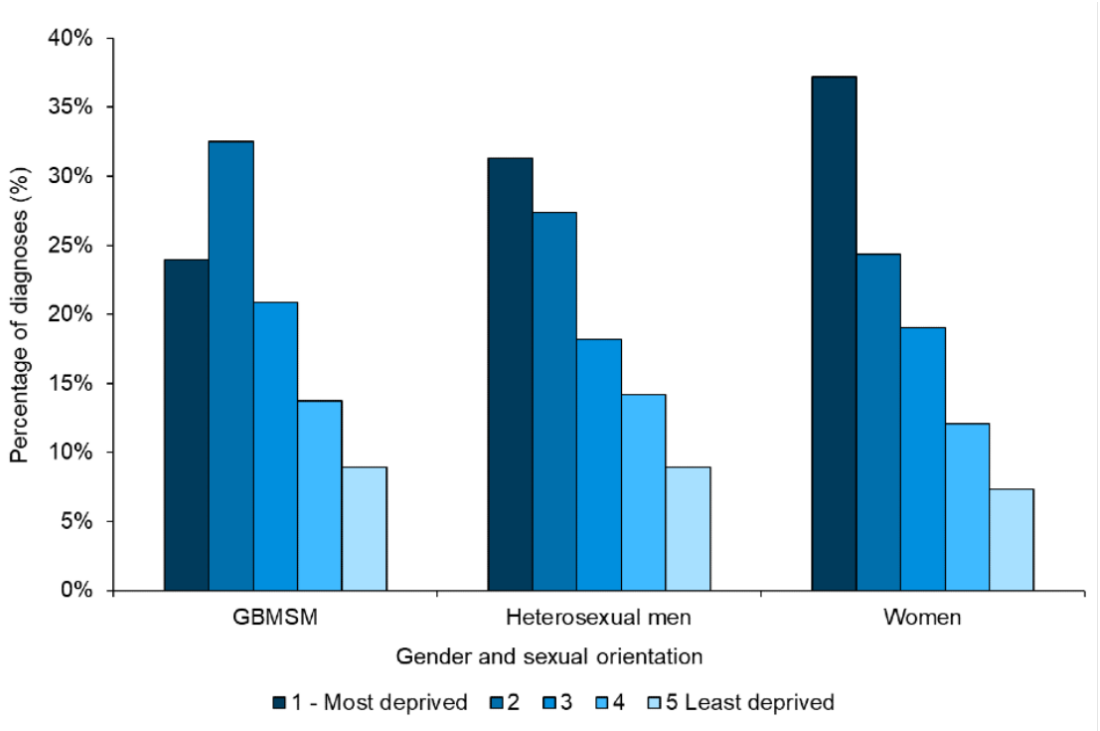


In the case of HIV, for both men and women, higher rates of poverty and unemployment and lower median household incomes are associated with a lower probability of survival after an HIV diagnosis. Income inequality is related to increased HIV risk for males, whereas poverty, health and housing circumstances increased risk for females[27].

In 2021, infectious syphilis diagnoses continued to be made more frequently among people living in more deprived areas in England[28]. Diagnoses among heterosexual men and women are most common among people living in the most deprived areas, whereas among GBMSM, diagnoses are most common in the second most deprived areas.

In women, 37% (197 out of 530) of syphilis diagnoses made in 2021 were among those living in the most deprived areas, compared to 31% (263 out of 840) and 24% (1,182 out of 4,939) in heterosexual men and GBMSM respectively (Figure 3.19).

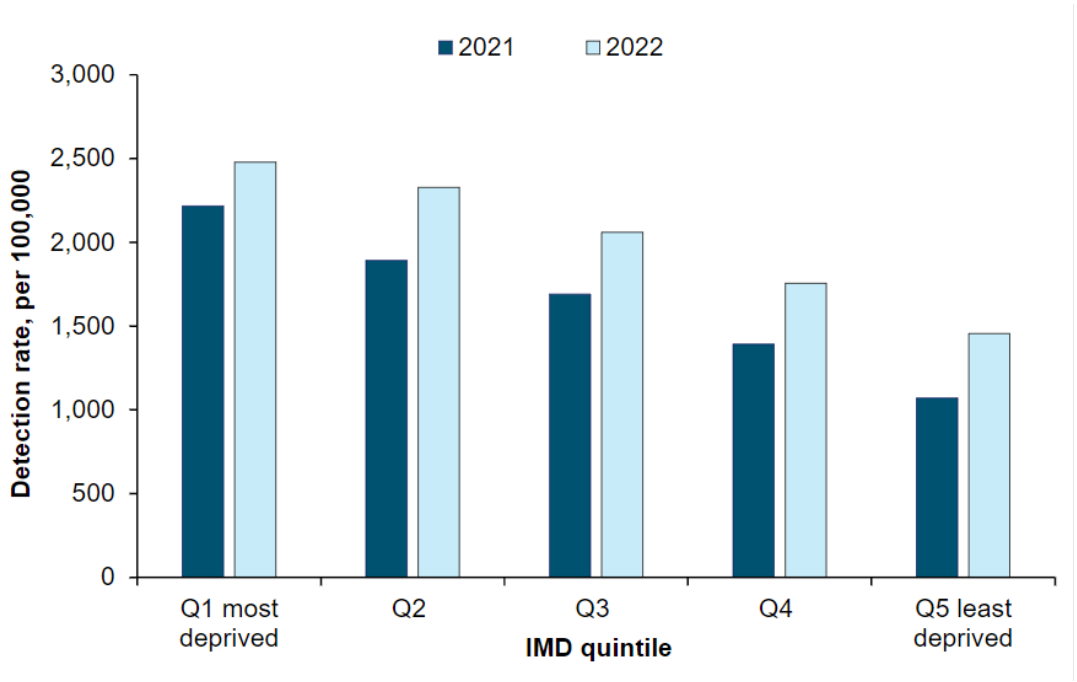
Figure 3.19 Distribution of infectious syphilis diagnoses by IMD and by gender and sexual orientation, 2021, England



Similarly, chlamydia detection rates were highest amongst those living in more deprived areas, although there was an increase in detection rates across all quintiles between 2021 and 2022. (Figure 3.20).

[27] American Psychological Association (2022) HIV/AIDS and Socioeconomic Status (apa.org)
[28] UKHSA (2022). Syphilis in England, 2019 to 2021 - GOV.UK (www.gov.uk)

Figure 3.20 Chlamydia Detection Rates Among Women aged 15-24 Years by IMD Quintile, 2021 and 2022, England

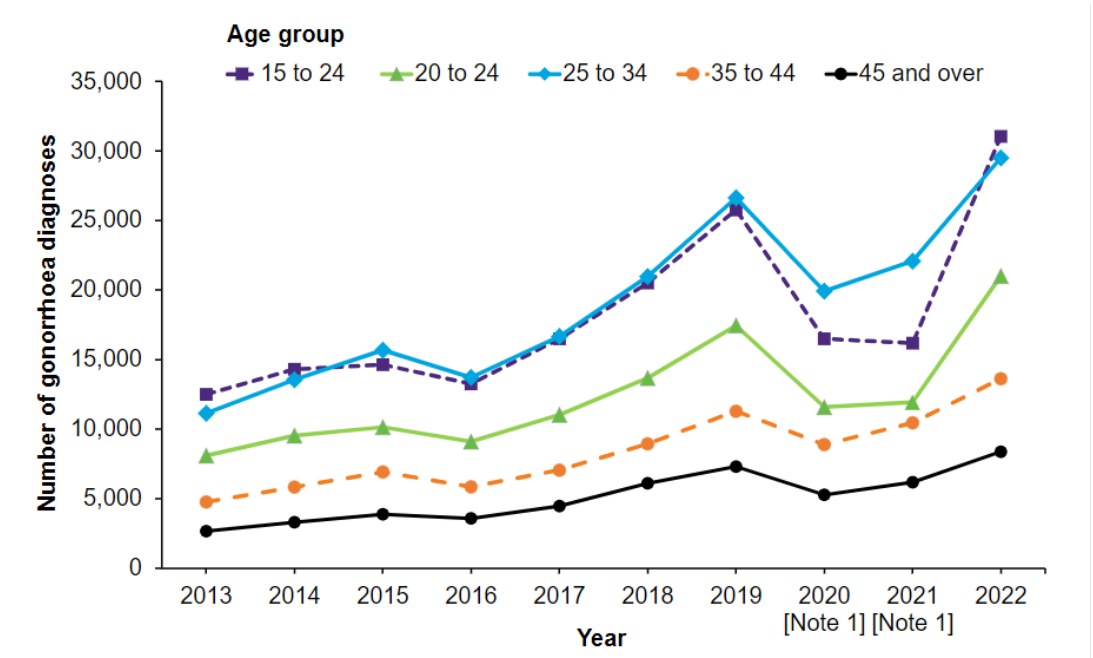


iii) Young People Aged 15-24 Years

Young people aged 15-24 years experience high rates of STI diagnoses, in part due to higher rates of partner change.

A decline in STI diagnosis amongst young people during 2020 and 2021 as a result of COVID-19 (both due to reduced social mixing and lower rates of testing) rates reduced during 2020 and 2021 was followed by a marked rise in diagnosis rates in 2022, exemplified below in the case of gonorrhoea (Fig. 3.20).

Figure 3.20 Number of Gonorrhoea Diagnoses by Age Group, 2013 to 2022, England



Despite COVID-19 lockdowns, the coverage of chlamydia tests remained stable in both men and women between 2019 and 2020, with a slight reduction in positivity rate (Figure 3.21).

Figure 3.21 Chlamydia tests, diagnoses, testing cover and positivity rate among 15-24 year old men and women in England 2020 compared to 2021

	Men		Women	
	2020	2021	2020	2021
Total Tests	255,172	258,764	676,675	695,937
Total Diagnoses	30,938	29,137	60,140	56,315
Coverage	7.5%	7.6%	21.2%	21.8%
Positivity Rate	12/1%	11.3%	8.9%	8.1%

In contrast, and due in large part to the effectiveness of the HPV vaccination programme, in 2022, the rate of first episode genital warts diagnoses among young women aged 15 to 17 years attending SHSs was 67.9% lower than the rate in this age band in 2018, (7.0 versus 21.8 per 100,000 population in 2022 vs 2018 respectively). 2018 is the first year that all young women aged 15 to 17 years attending SHSs would have been offered the quadrivalent vaccine when aged 12 to 13 years in the National HPV Vaccination Programme. A decline of 71.5% (3.1 vs 10.9 per 100,000 population) was seen in heterosexual young men of the same age over the same period, suggesting a combination of substantial herd and direct protection within this age group overall.

v) Sex workers

In England and Wales, the sale and purchase of sexual services between consenting adults is legal. However, various related activities are criminal, including activities linked to exploitation, soliciting, kerb-crawling, controlling prostitution, or managing a brothel[29]. There are an estimated 80,000 to 105,000 people who work in the sex industry, predominantly women (88%)[30].

As well as facing stigma and discrimination, sex workers also face an increased risk and burden of STIs and blood-borne infections. Globally, female sex workers are estimated to be 30 times more likely to be living with HIV than other women of reproductive age. In 2019, the Joint United Nations Programme on HIV/AIDS estimated a mean HIV prevalence of 36% among sex workers. The average reported prevalence of active syphilis among sex workers is 10.8% (range 5.8% to 30.3%) (WHO, GHO, 2020). While less is known about the prevalence or incidence of other STIs and viral hepatitis infections among sex workers, increased rates have been documented in different contexts around the globe[31].

Although the number of soliciting for prostitution offences have reduced significantly, from 2,111 in 2002/03 to 368 in 2021/22, sex workers face high levels of stigma and criminalization. International modelling studies indicate that decriminalizing sex work could lead to a 46% reduction in new HIV infections in sex workers over 10 years, while eliminating sexual violence against sex workers could lead to a 20% reduction in new HIV infections[32].

[29] House of Commons Home Affairs Committee (2016) Prostitution (parliament.uk)
[30] Home Office & University of Bristol (2019) Prostitution_and_Sex_Work_Report.pdf (publishing.service.gov.uk)
[31] Direct quote from World Health Organisation (2023) https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/sex-workers
[32] Shannon, K. *et al* (2014) Global epidemiology of HIV among female sex workers: influence of structural determinants. Lancet http://dx.doi.org/10.1016/ S0140-6736(14)60931-4

3.2.3 National Strategy & Policy

Reduction in rates of STIs among people of all ages was identified as an ambition in the Department of Health's Framework for Sexual Health Improvement in England (2013)[33] with the following aims:

- Individuals understand the different STIs and associated potential consequences.
- Individuals understand how to reduce the risk of transmission.
- Individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high-quality services, including the notification of partners.
- Individuals attending for STI testing are also offered testing for HIV

As STIs are often asymptomatic early detection and preventative measures as essential. National initiatives have been in place in England to promote better outcomes, these include:

- *National Chlamydia Screening Programme*
  Chlamydia often has no symptoms, but if left untreated, can have serious health complications in women, including pelvic inflammatory disease (PID), ectopic pregnancy and tubal factor infertility (TIF). In June, 2021, the National Chlamydia Screening Programme (NCSP) announced changes to the programme with a focus on reducing reproductive harm of untreated infection through opportunistic screening offered to young women, transgender men or non-binary (assigned female at birth) people who have not has a hysterectomy or bilateral oophorectomy, aged under 25 years[34].
- *National human papillomavirus (HPV) Immunisation Programme*
  The National HPV Immunisation programme has been in place since 2008 to protect against cancers caused by HPV, including cervical cancer, head and neck cancers, cancers of the anal and genital areas. It also provides protection against genital warts. Girls and boys aged 12-13 years olds are routinely offered the first dose of the HPV vaccine when they are in Year 8 in school and the second dose is offered 6-24 months afterwards.

In conjunction with national preventative measures, local-level measures to prevent STIs include education about using condoms correctly, the promotion of behaviour change to reduce poor sexual practices and ensuring prompt access to testing and treatment. These preventative measures should be considered in conjunction with local data.

3.3 Local context

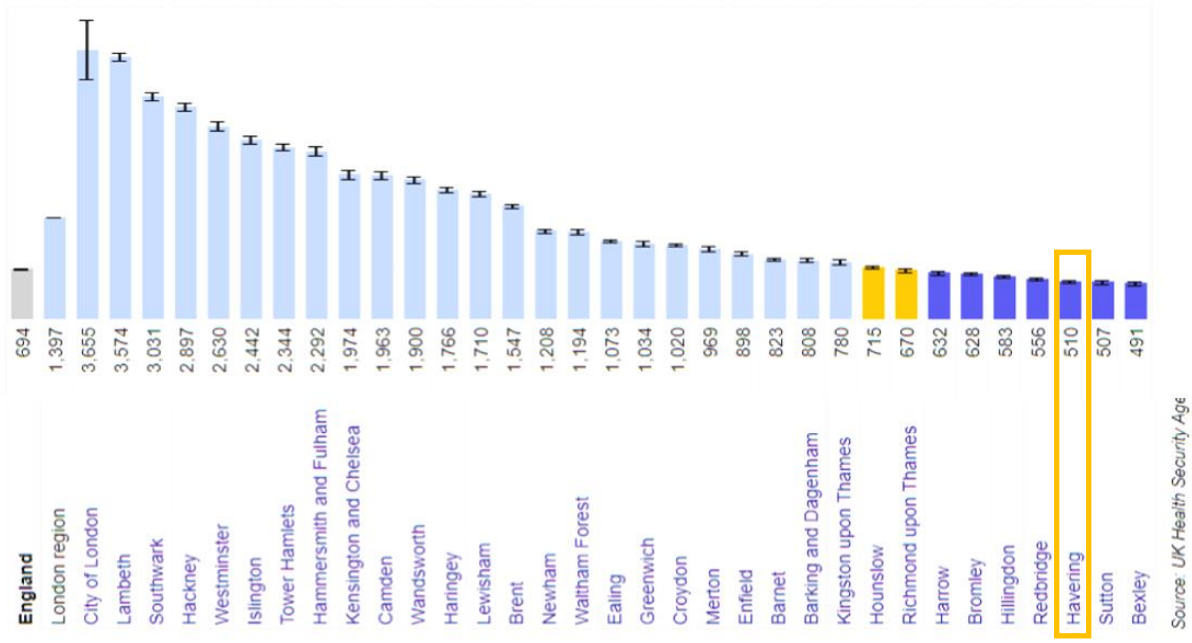
The following section presents data for Havering where possible, compared with direct neighbouring and other London Boroughs, or London-level data where this is not available at borough-level.

3.3.1 Diagnoses, testing and screening of STIs in Havering

Compared to all London boroughs, in 2022, Havering had one of the lowest rates of new STI diagnoses at 510 per 100,000, higher only than Bexley (491 per 100,000) and Sutton (507 per 100,000). The Havering rate was below the rates across London (at 1,397 per 100,000) and England (at 694 per 100,000) (Figure. 3.22).

[33] Department of Health (2013) A Framework for Sexual Health Improvement in England (publishing.service.gov.uk)
[34] UKHSA (2021). NCSP: programme overview - GOV.UK (www.gov.uk)

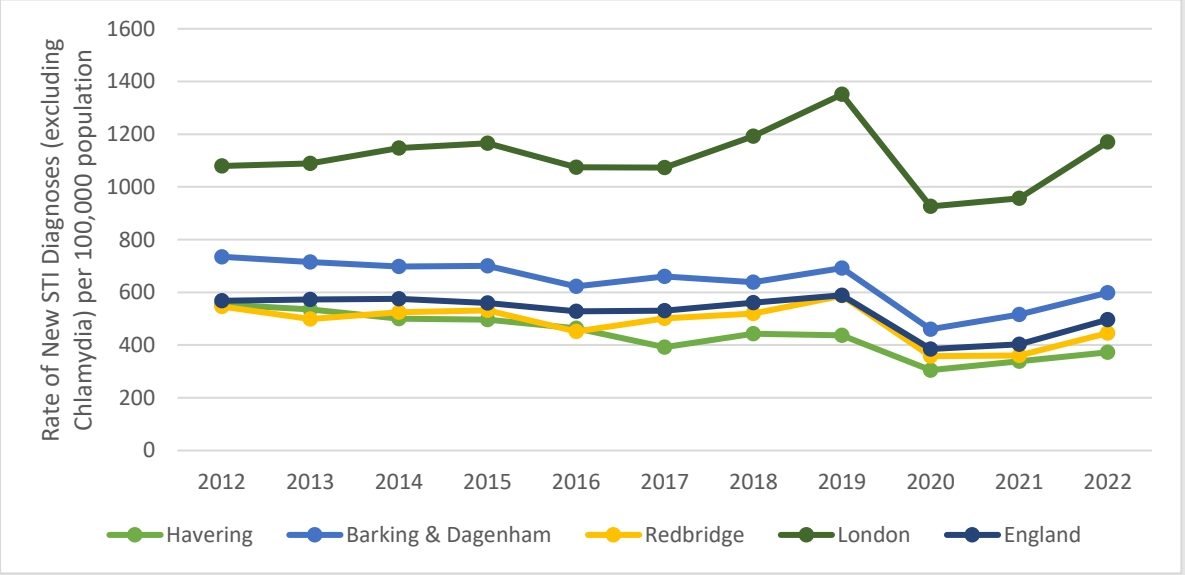
Figure 3.22 All new STI diagnosis rates per 100,000 ranked by London local authority 2022



Source:OHID Fingertips, 2023

Excluding chlamydia as the most common STI, there has been an overall reduction in new diagnoses of STIs for residents of Havering over the past 10 years (Figure 3.23). Rates in Havering have remained consistently lower than both London and England averages, lower than Barking and Dagenham rates, and similar to rates in Redbridge[35]. In 2022, Havering's rate of new STI diagnoses, excluding chlamydia aged under 25 years was 372 per 100,000, significantly lower than both London at 1,171 per 100,000 and England at 496 per 100,000.

Figure 3.23 Rate of New STI Diagnoses (excluding Chlamydia) per 100,000 population in Havering, Barking and Dagenham and Redbridge compared to London and England, 2012 - 2022



[35] OHID (2022) Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

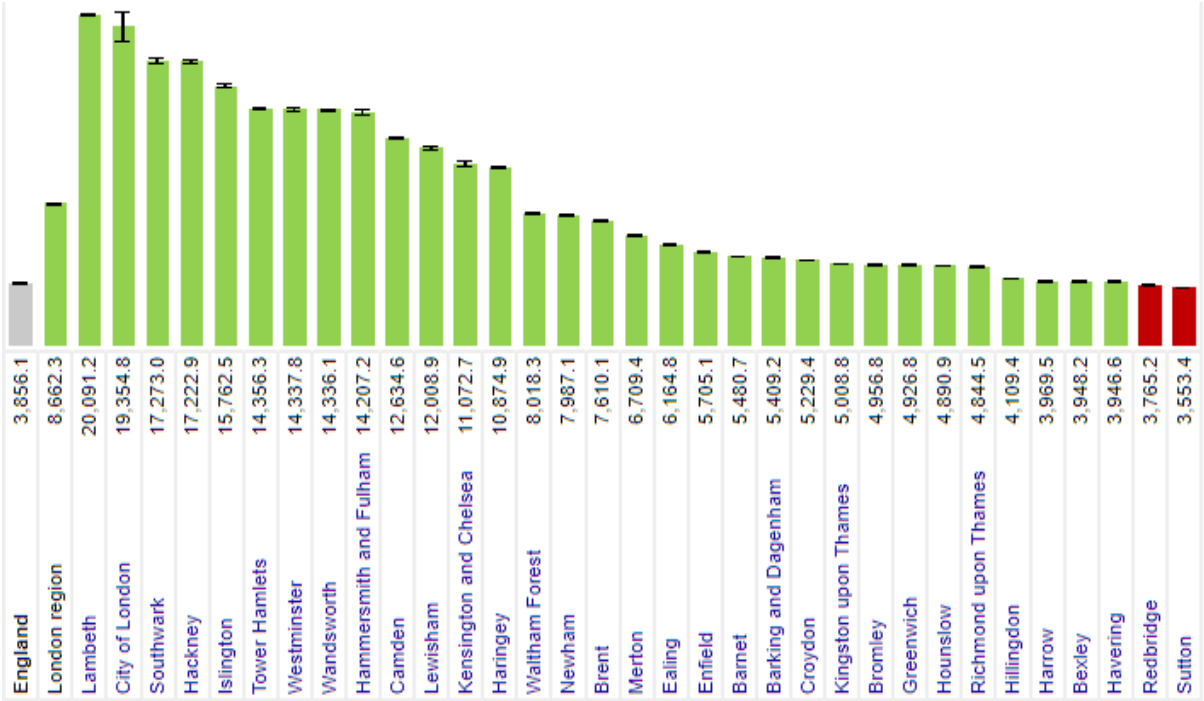
Data Source: OHID Fingertips

Rates for all boroughs dropped in 2020 compared to 2019, most likely due to the national and regional COVID-19 lockdowns, and social distancing measures. These measures affected both sexual behavior and health service provision and should be taken into account in the overall interpretation of the data presented here. In 2020, a total of 1,152 new STIs were diagnosed in Havering residents which was a 27% drop compared to the 1,571 diagnosed in 2019.

While STI diagnosis rates have declined over time, rates of testing for STIs (excluding chlamydia under 25 years) in Havering have increased over the same period, from 2,500 per 100,000 in 2012 to 3,946 per 100,000 in 2022[36].

The rate of STI testing in Havering is similar to rates across England but remains significantly lower than testing rates in London. Redbridge has a similar testing rate to Havering, but Barking and Dagenham has a higher rate (Figure 3.24). During COVID-19, there was an 18% reduction between 2019 and 2020 in the rate of STI testing (excluding chlamydia in under 25-year-olds) because of reduced access to services.

Figure 3.24 STI testing rate (excluding chlamydia aged under 25 years) per 100,000 by London borough 2022



Note: Chlamydia rates are only included in people aged 25 to 64 years as the much higher rates of chlamydia amongst people under 25 years would skew the data.

The positivity rate in Havering for all STIs (excluding chlamydia) was 5.9% in 2022, lower than the positivity rate for both England (7.6%) and London (8.8%). Positivity rates depend both on the number of diagnoses and levels of testing: higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of

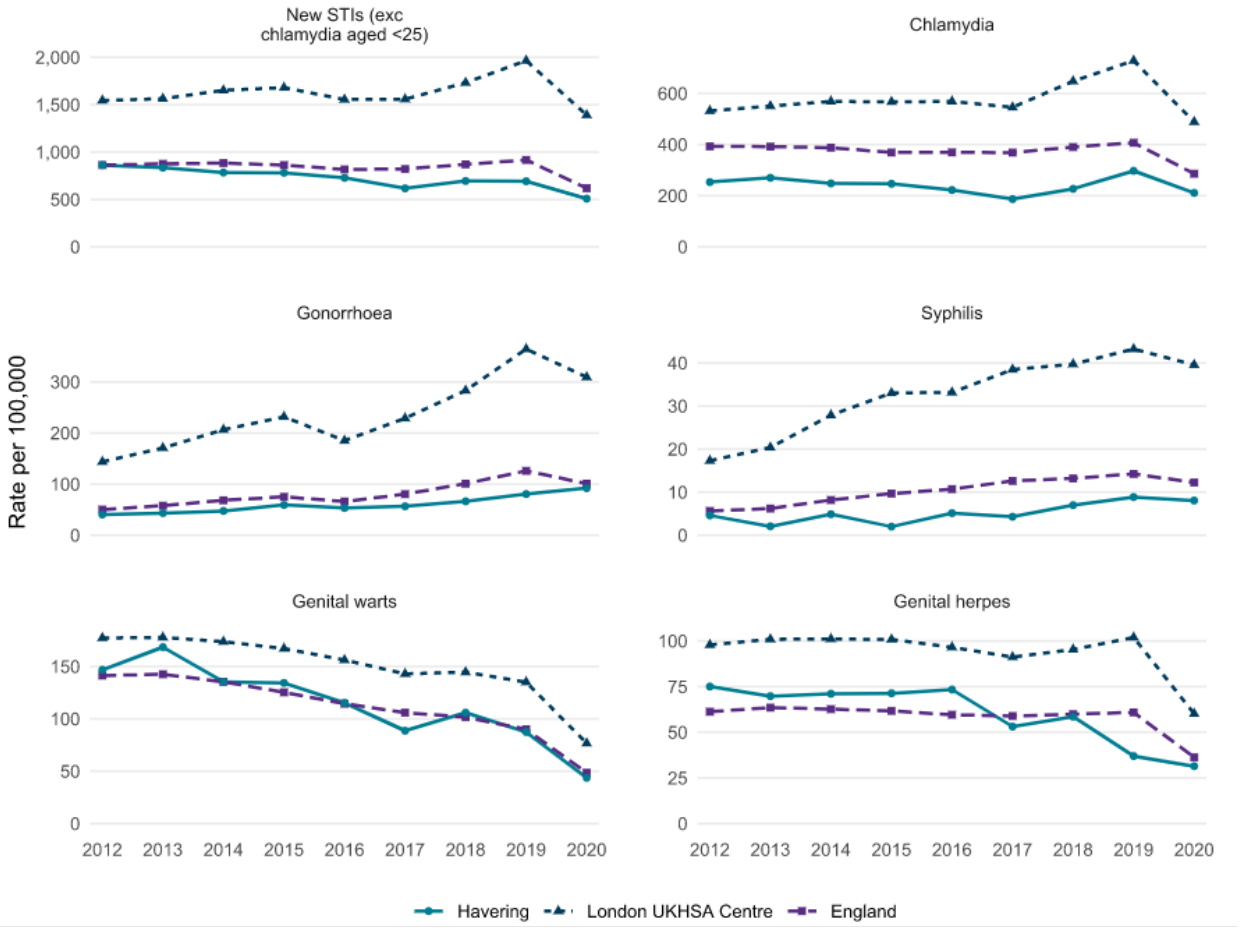
[36]OHID (2023) Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

tests, or both. Havering's low positivity rate may be due to having a relatively low risk population.

3.3.2 Prevalence of STIs in Havering

The most commonly diagnosed STIs in Havering are chlamydia followed by gonorrhoea (Figure 3.25). The rates of gonorrhoea and syphilis have been increasing in the borough since 2012, at a similar rate to England, with rates in 2021 now 76 per 100,000 for gonorrhoea and 13.8 per 100,000 for syphilis. However, genital warts and genital herpes rates have been declining since 2012. The reduction in diagnoses of genital warts may be attributed to the uptake of the HPV vaccination. Contrastingly, there was a 14.3% increase in the gonorrhea diagnostic rate in Havering in 2020.

Figure 3.25 Rates per 100,000 population by diagnosis by year in Havering compared to rates in London and England 2012 to 2020 (note different scales on y-axis)[37]



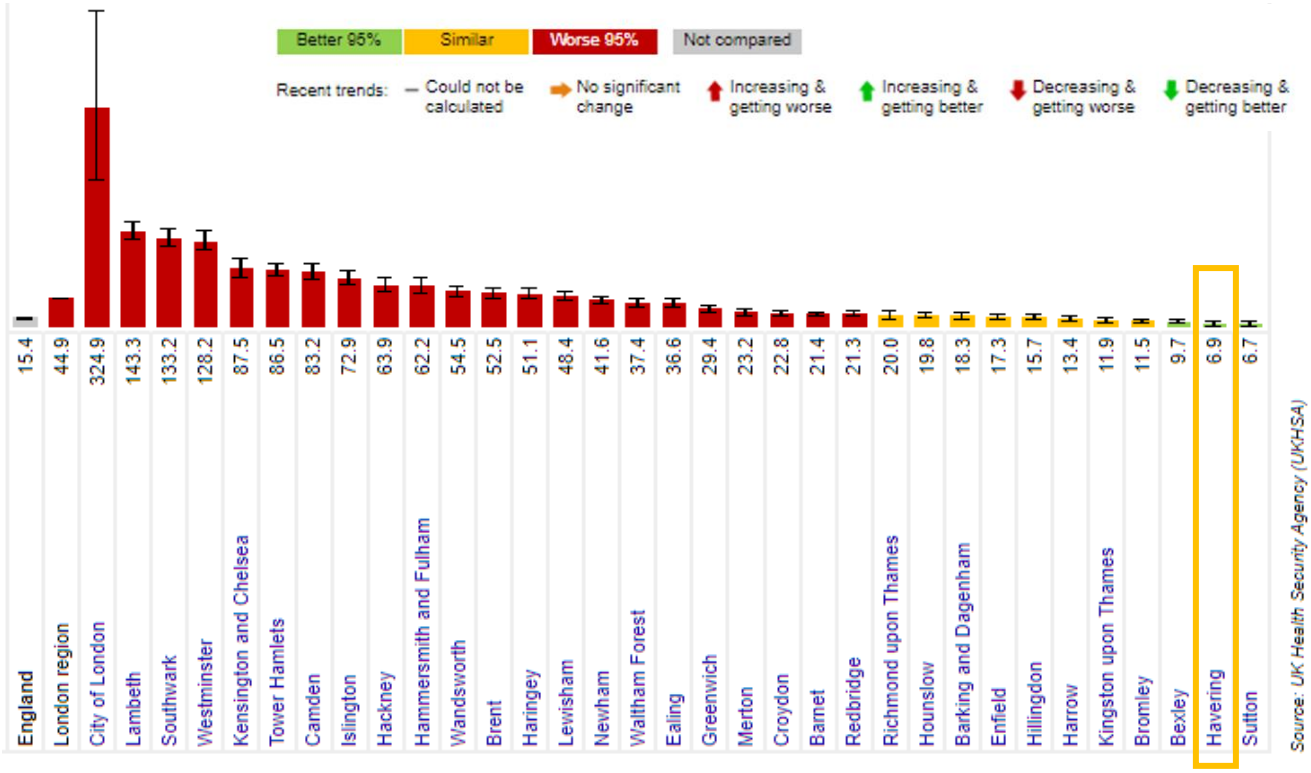
i) Syphilis

Compared to other London boroughs in 2022, Havering had one of the lowest diagnosis rates of syphilis, at 6.9 per 100,000[38], lower than London (44.9 per 100,000) and England (15.4 per 100,000). There was a huge range in rates, the highest being Lambeth at 143.3 per 100,000 (Figure 3.26).

[37] OHID Fingertips SPLASH Report for Havering (2022) SPLASH Havering 2022-01-27 (phe.org.uk)
[38] Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

In Havering, the number of syphilis infections varies from year to year, though numbers remain relatively small. There were 21, 36 and 18 cases diagnosed respectively during 2020, 2021 and 2022.

Figure 3.26 Syphilis diagnosis rate per 100,000 for all London boroughs, benchmarked against London, 2022.



ii) Gonorrhoea

Havering had a low rate of gonorrhoea diagnoses in 2022, at 104 per 100,000 population, the second lowest out of all the London boroughs, and lower than the rate for England (146 per 100,000)[39]. Nevertheless, rates of gonorrhoea have continued to increase over the past 10 years, from 40 per 100,000 in 2012 to 76 per 100,000 in 2021.

Gonorrhoea has progressively developed resistance to the antibiotic drugs prescribed to treat it, which has left few antibiotic options that are well-studied, well-tolerated and highly effective for the treatment of some infections. UKHSA actively monitors, and acts on, the spread of antibiotic resistance in gonorrhoea and potential treatment failures and when highly resistant strains are identified, implements prompt public health action to limit further spread.

iii) Human immunodeficiency virus (HIV)

Given that HIV infection may cause no symptoms for several years, testing to ensure that people are aware of their HIV status remains essential part of both preventing onward transmission and enabling earlier access to treatment for those that are living with the infection.

In Havering in 2022, 53.7% of people who were eligible for an HIV test when they attended a specialist sexual health service accepted a test. This total testing coverage for HIV is

[39] Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

significantly better than that for England (48.2%) and similar to the testing coverage in London (54.0%).

Testing amongst GBMSM in Havering in 2022 (74.4%) is similar to both London (73.3%) and England (74.1%)[40]. However, testing coverage for Havering men (71.4%) was significantly higher than testing coverage for women (44.2%).

Amongst pregnant women, 99.9% to 100% of women attending the BHRUT antenatal and newborn screening programme in 2022-23 had a confirmed screening result for HIV at the day of report (100% for Q4, January to March 2023)[41]. National data indicated that the screen positive rate for HIV was 0.96 per 1,000 women tested. Applying this rate to the 8,117 pregnant women undergoing testing at BHRUT[42] (including residents from Havering, Barking and Dagenham and Redbridge) would equate to approximately 8 women that would be found to be HIV positive. Detection of HIV amongst pregnant women is important to prevent cases of vertical transmission - with effective HIV care, taking anti-retroviral treatment and having an undetectable viral load, the risk of transmitting the HIV virus from mother to baby is very low, between 0.1% and less than 1%.

In 2022, there were 315 Havering residents aged 15 to 59 years and 382 residents aged 15 years and over who were seen at HIV services (the prevalence of diagnosed HIV) [43]. The diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.08, compared to 2.34 per 1,000 in England and 5.29 per 1,000 in London.

Pre-Exposure Prophylaxis (PrEP) is a medication used to reduce the risk of getting HIV. When taken correctly prior to unprotected sex, PrEP can prevent HIV from replicating in the body and establishing an infection. In 2022, 8.1% (336 out of 4,133) of HIV-negative people accessing specialist SHSs in Havering were defined as having PrEP need. This was lower than that for London (17.2%) and England (9.1%). Amongst those for whom PrEP need was determined in Havering, 72.6% (244 out of 336) initiated or continued PrEP, similar to both London (77.6%) and England (71.0%). A summary of key HIV data is given in Figure 3.27 below.

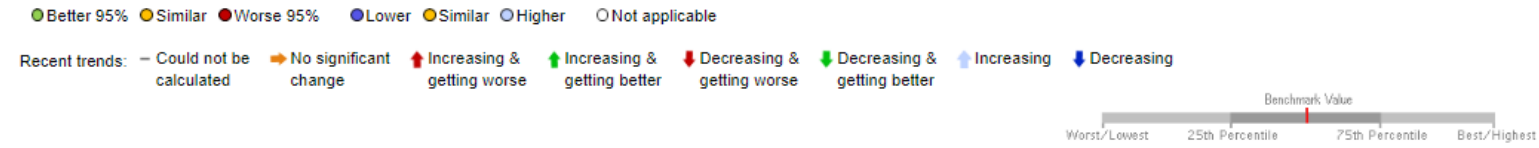
Despite this low prevalence rate, Havering nevertheless has a worse rate of HIV late diagnosis than England, and especially amongst heterosexual men (Figure 3.29). Late diagnosis means that a person has tested positive for HIV after the virus has already started to damage their immune system. In the period 2020-2022, 57.1% of heterosexual men first diagnosed with HIV in Havering were diagnosed late, compared to 60.0% in London and 58.9% in England. However, this represents very small numbers (less than 10 people) and so should be interpreted with caution. Amongst GBMSM men (12 people), 50.0% were diagnosed late in Havering in the same period compared to 29.4% in London and 34.2% in England[44].

To help end the HIV epidemic, UNAIDS set the target of 90-90-90 by 2020 (90% of all people living with HIV to know their HIV status, 90% of all people with diagnosed HIV infection to receive sustained treatment, and 90% of all people receiving treatment with viral load suppression) and 95-95-95 by 2025. For those diagnosed with HIV in Havering, 100%

[40] Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[41] Q4 KPI Screening Data (1 January to 31 March) - GOV.UK (www.gov.uk)
[42] Total of all women screened at BHRUT, summed from each quarter reported; NHS ANNB KPI Screening data. NHS population screening programmes: KPI reports 2022 to 2023 - GOV.UK (www.gov.uk)
[43] SPLASH Havering 2024-01-30 (phe.org.uk)
[44] Sexual and Reproductive Health Profiles - OHID (phe.org.uk)

of people accessing HIV care received Antiretroviral Therapy (ART) in 2022, of which 74.4% started their ART within 91 days of their diagnosis. For those on ART, 96.5% had an undetectable viral load, which means the infection is untransmissible.

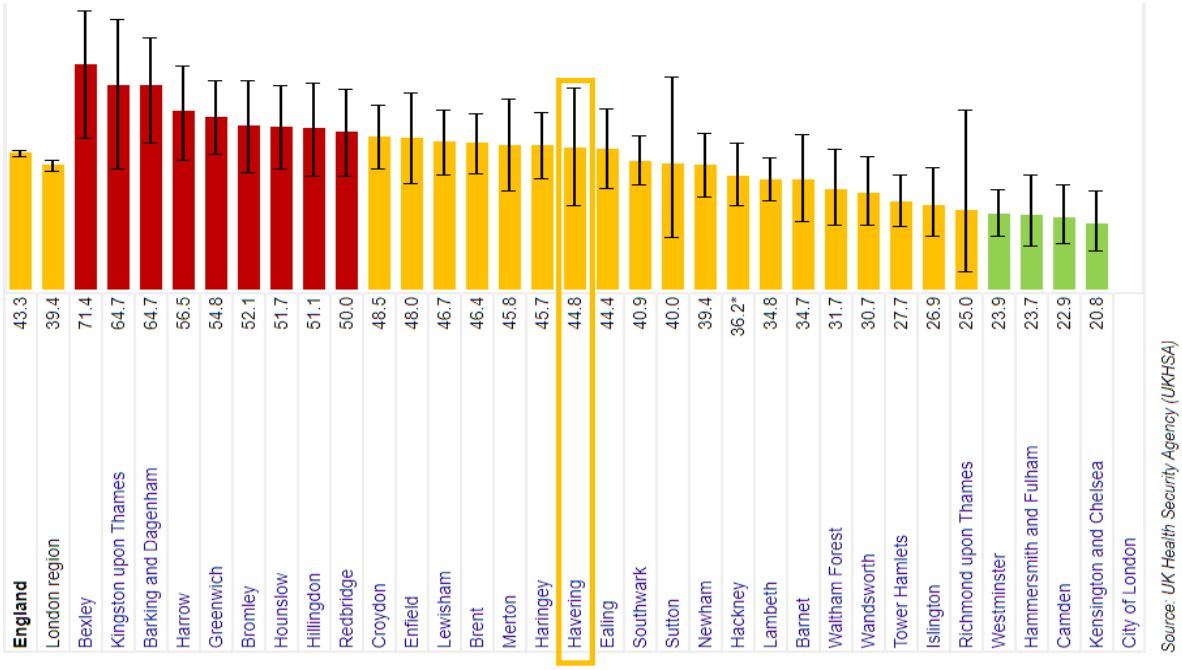
Figure 3.27 Key indicators for HIV in Havering, Benchmarked again England and against London, 2022.



Indicator	Period	Havering			Region England	England	England		England	London		London
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest	Range	Best/ Highest
HIV testing												
HIV testing coverage, total	2022	↓	2,112	53.7%	54.0%	48.2%	20.4%		75.1%		70.2%
HIV testing coverage, gay, bisexual and other men who have sex with men	2022	↓	270	74.4%	73.3%	74.1%	45.3%		92.5%		81.6%
HIV testing coverage, men	2022	↓	996	71.4%	67.7%	65.1%	27.6%		85.6%		78.4%
HIV testing coverage, women	2022	↓	1,099	44.2%	42.4%	38.5%	13.2%		71.5%		62.0%
Repeat HIV testing in gay, bisexual and other men who have sex with men	2022	→	124	45.9%	49.3%	47.3%	22.0%		62.4%		56.7%
Proportion of TB notifications offered an HIV test <90% 90% to 100% ≥100%	2021	–	13	100%	98.9%	98.4%	80.0%		100%		100%
Infectious Diseases in Pregnancy Screening: HIV Coverage	2017/18	–	-	-	99.9%*	99.6%*	-	*Insufficient number of values for a spine chart*	-	*Insufficient number of values for a spine chart*	-
HIV diagnoses												
New HIV diagnosis rate per 100,000	2022	→	11	4.2	15.5	6.7	52.7		0.5		4.2
New HIV diagnoses among persons first diagnosed in the UK rate per 100,000	2022	→	8	3.1	11.3	4.3	34.1		0.0		2.8
HIV late diagnosis in people first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2020 - 22	–	13	44.8%	39.4%	43.3%	100%		0.0%		20.8%
HIV late diagnosis in gay, bisexual and other men who have sex with men first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2020 - 22	–	6	50.0%	29.4%	34.2%	100%		0.0%		0.0%
HIV late diagnosis in heterosexual men first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2020 - 22	–	4	57.1%	60.0%	58.9%	100%		0.0%		0.0%
HIV late diagnosis in heterosexual and bisexual women first diagnosed with HIV in the UK <25% 25% to 50% ≥50%	2020 - 22	–	2	33.3%	55.8%	49.9%	100%		0.0%		0.0%
HIV diagnosed prevalence rate per 1,000 aged 15 to 59 <2 2 to 5 ≥5	2022	→	315	2.08	5.29	2.34	12.18		0.60		1.95
HIV diagnosed prevalence rate per 1,000 <2 2 to 5 ≥5	2022	→	382	1.46	4.24	1.67	10.60		0.41		1.46
HIV treatment and care												
Determining PrEP need	2022	–	336	8.1%	17.2%	9.7%	1.4%		31.9%		31.9%
Initiation or continuation of PrEP among those with PrEP need	2022	–	244	72.6%	77.6%	71.0%	26.1%		83.3%		83.2%
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV	2020 - 22	–	32	74.4%	82.3%	85.4%	0.0%		100%		93.3%
Antiretroviral therapy (ART) coverage in people accessing HIV care ≤ 90% 90% to ≤ 95% > 95%	2022	–	382	100.0%	97.9%	98.1%	72.0%		100.0%		100.0%
Virological success in adults accessing HIV care	2022	–	-	96.5%	97.4%	97.7%	94.6%		100%		98.7%

Figure 3.28 Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years by year in Havering compared to rates in the London UKHSA Centre and England: 2011 to 2022

Figure 3.29 HIV late diagnosis in people first diagnosed with HIV in the UK 2019-2021



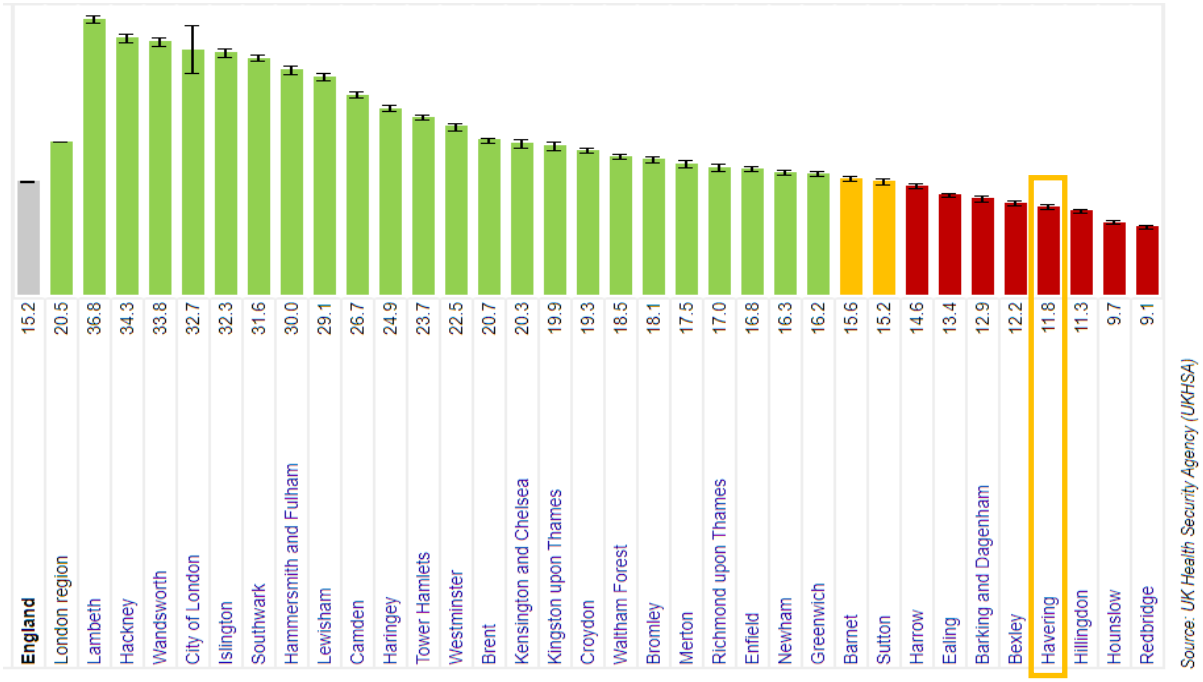
iv) Chlamydia

The NCSP recommends that opportunistic screening should be offered to sexually active women, transgender or non-binary (assigned female at birth) people aged under 25 years. Ideally, people should be tested at least annually and/or after having sex with a new partner. The chlamydia detection rate is a measure of the chlamydia control activity; an increased detection rate is indicative of increased control activity, not a measure of infection. More testing and a higher detection rate in an area will lead to better control of the infection in the population. A good positivity rate alone will not lead to the recommended detection rate if an insufficient proportion of the population is being tested.

The proportion of under 25 years screened via the NCSP for chlamydia and the subsequent detection in Havering rate are lower than both the London and England averages.

The proportion of under 25 year olds screened for chlamydia in Havering was 11.8% in 2022 compared with 15.2% across England and 20.5% across the London region. Lambeth achieved the highest proportion screened, at 36.8% (Figure 3.29).

Figure 3.29 Chlamydia proportion (%) aged 15 to 24 screened in 2022, benchmarked against all in London region



A high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The PHOF Detection Rate Indicator (DRI) benchmarking thresholds recommend that local authorities work towards a chlamydia detection rate of at least 3,250 per 100,000 residents aged 15-24 years[45]. The detection rate for Havering in 2021 was 1,095 per 100,000 compared to the England average of 1,408 per 100,000 and 1,673 across London (Figure 3.30).

Between 2012 and 2017, there was a steady decrease in the chlamydia detection rate in 15-24 year olds in Havering (Figure 3.31). Although improvements were made between 2017 and 2019, there was a clear impact of the COVID-19 pandemic whereby there was a 27.8% reduction in detection rate between 2019 and 2020. Given that the number of e-service tests significantly increased over the COVID-19 period (see section 3.2.1), it is likely that there was less transmission of chlamydia over this period.

[45] UKHSA (2022) Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

Figure 3.30 Chlamydia detection rate per 100,000 population aged 15 to 24 years in 2021 by London local authority and England

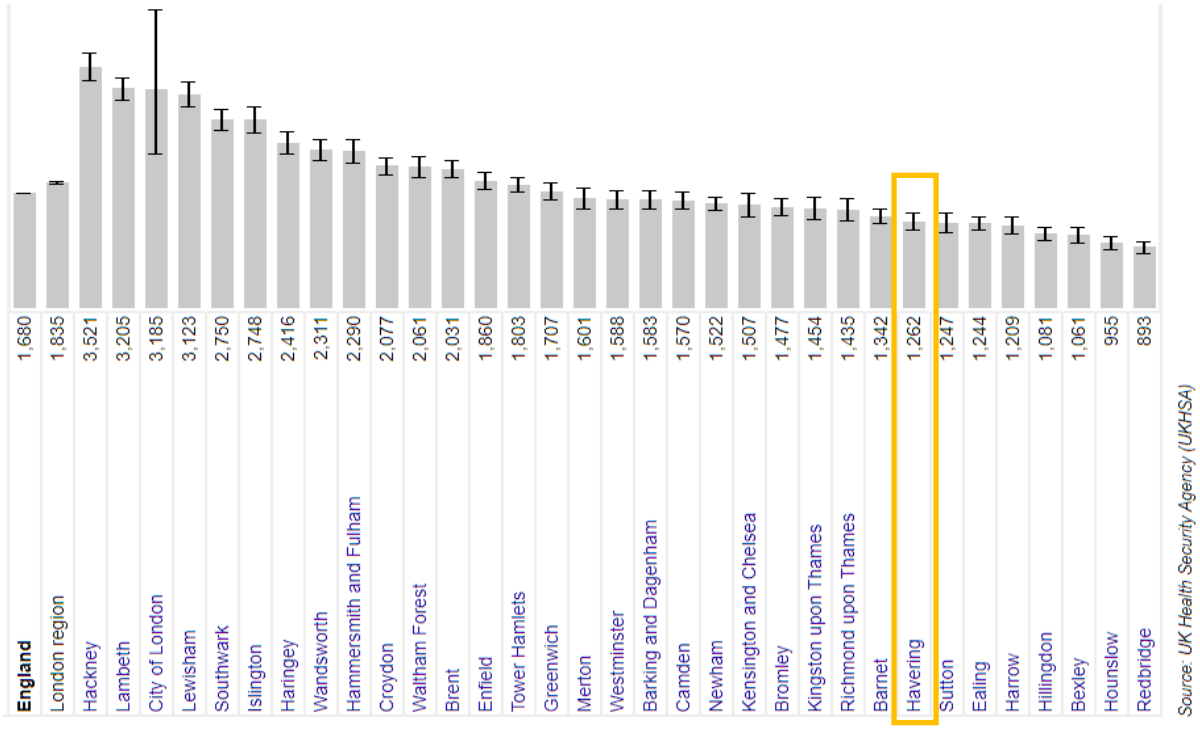
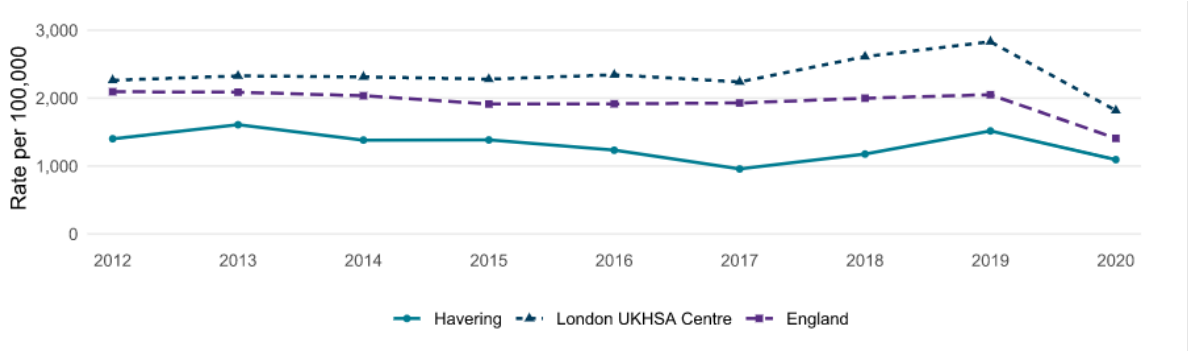
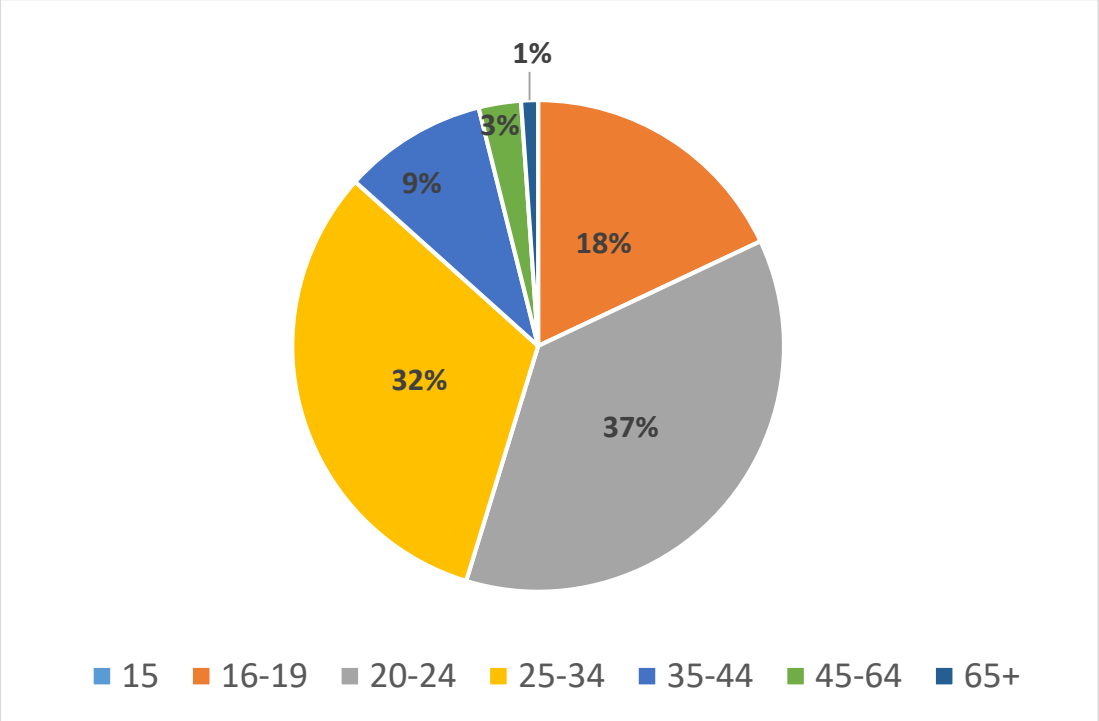


Figure 3.31 Chlamydia detection rate per 100,000 population in 15-24 year olds by year in Havering, the London UKHSA Centre and England, 2012 - 2020



Although screening programmes are focused towards 15–24-year-olds, it should nevertheless be noted that chlamydia can be caught at any age, by anyone who is sexually active. Data from the genitourinary medicine clinical activity dataset (GUMCAD) shows that from April 2021 to end March 2022, our locally commissioned sexual health service saw 540 patients for chlamydia aged upwards from 15 years. Figure 3.32 shows the age profile of these patients; whilst the majority (55%) of patients attending for chlamydia were within the target age range of 15 to 24 years, a further 31% were aged 25 to 34 years and 45% were 25 years or older.

Figure 3.32 Ages of Havering patients attending sexual health services with diagnosis of Chlamydia, April 2021 to end March 2022



v) Human Papilloma Virus (HPV)

Since the introduction of the HPV vaccination programme in 2008, the prevalence of HPV in sexually active 16-18 year old females has decreased significantly in England[46] (Figure 3.33).

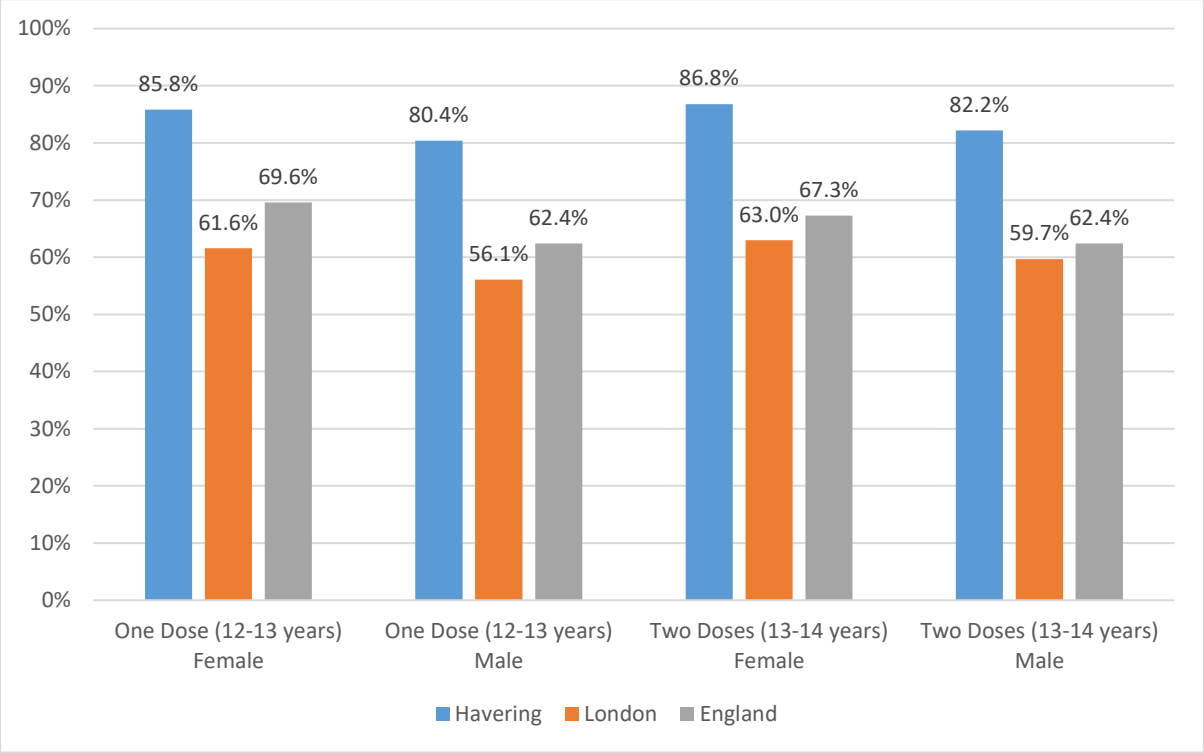
Figure 3.33a Prevalence of HPV by type of HPV virus in England in 2018 compared to 2020 and percentage difference in prevalence.

Type of HPV	Prevalence in 2010	Prevalence in 2018	Percentage Change
HPV16/18	15%	0%	-15%
HPV6/11	7-10%	4.1%	-3% to -6%
HPV31/33/45	6.5%	1.9%	-4.6%

Vaccination uptake for the HPV vaccination in Havering is good, and has remained consistently above both london and England since 2015/16 (Fig. 3.33b)[47]. Uptake is equally good in young men as women, at 82 to 86%, but remains below the national target of 90% uptake for both doses.

[46] PHE (2018) Surveillance of type-specific HPV in sexually active young females in England, to end 2018 (publishing.service.gov.uk)
[47] Public health profiles - OHID (phe.org.uk)

Figure 3.33b HPV Vaccination coverage for one or two doses by gender, Havering London or England 2021/22



vi) Mpox

Mpox, a zoonotic infection, caused by the monkeypox virus has historically occured mostly in West and Central Africa. Previous cases in the UK had been either imported from countries where Mpox is endemic or contacts with documented epidemiological links to imported cases. Between 2018 and 2021, there had been only 7 cases of monkeypox in the UK. Of these, 4 were imported, 2 were cases in household contacts, and one was a case in a health care worker involved in the care of an imported case. There was no prior documented evidence of community transmission.

However, in May 2022, cases of Mpox were confirmed in an outbreak predominantly amongst GBMSM without documented history of travel to endemic countries. Up to 14th November 2022, there were 3,561 confirmed and 149 highly probable Mpox cases detected in the UK: 3,710 in total. Of these, 95 were in Scotland, 34 were in Northern Ireland, 47 were in Wales and 3,534 were in England. A high proportion of England cases were London residents (69%, 2,428 of 3,521 with location information). For confirmed and highly probable cases in the UK, where gender information was available, 3,635 (98.6%) were men and 52 were women. The median age of confirmed and highly probable cases in the UK was 37 years (interquartile range 30 to 44).

In Barking and Dagenham, Havering and Redbridge, by the end of October 2022, there have been 29 cases (Figure 3.34). The SH service at BHRUT has been providing welfare visits as well as offering vaccinations with a modified smallpox vaccine to staff as well as eligible at risk people.

Figure 3.34 Mpox cases, welfare support and vaccinations given across BHR May to November 2022

	Total no. of monkeypox cases	No. of welfare visits /contacts made by BHRUT	Total no. of vaccinations given by BHRUT (in eligible persons)
Barking & Dagenham	13	50	126
Havering	8	38	101
Redbridge	8	27	133
Out of Area (OOA)	N/A	16	567
Grand Total	29	131	927

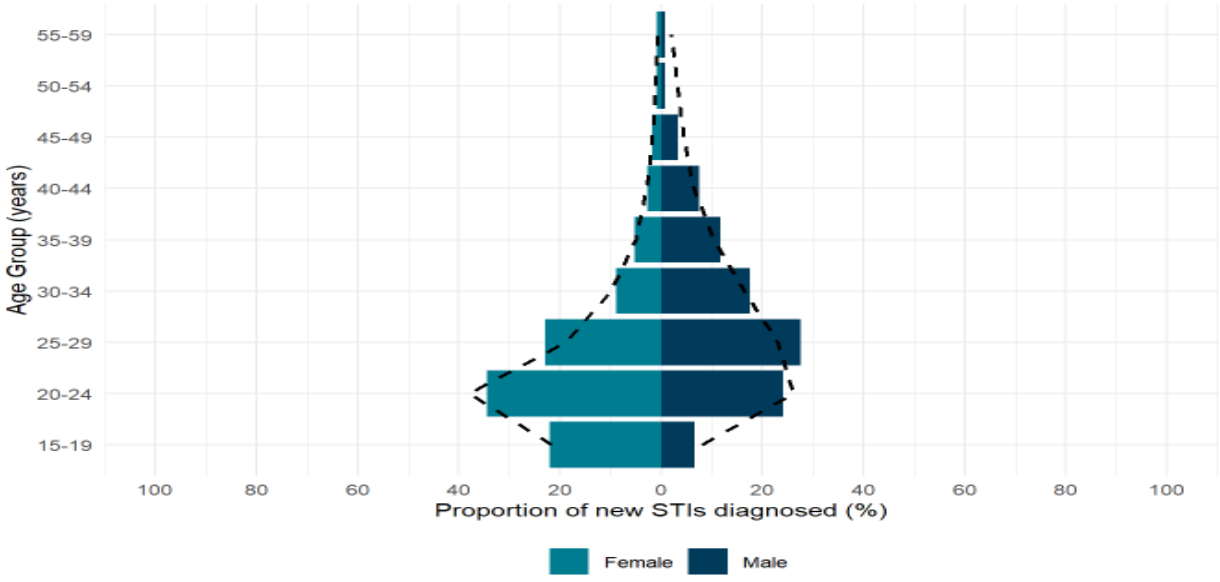
3.3.3 Inequalities in STI Prevalence in Havering

i) Age and Gender

In 2020, 43.5% of diagnoses of new STIs made in SHSs and non-specialist SHSs in Havering residents were in young people aged 15 to 24 years old. This compares to 45.7% in England (Figure 3.35).

Although men were more likely overall in Havering to be diagnosed with a new STI in 2020 (51.6% of men compared to 48.4% women) the age of diagnosis differed between genders. Women were more likely to have an STI between 15-19 years and 20-24 years, whilst men were more likely to have a new STI diagnosis at 25 years+ (Figure 3.35)[48].

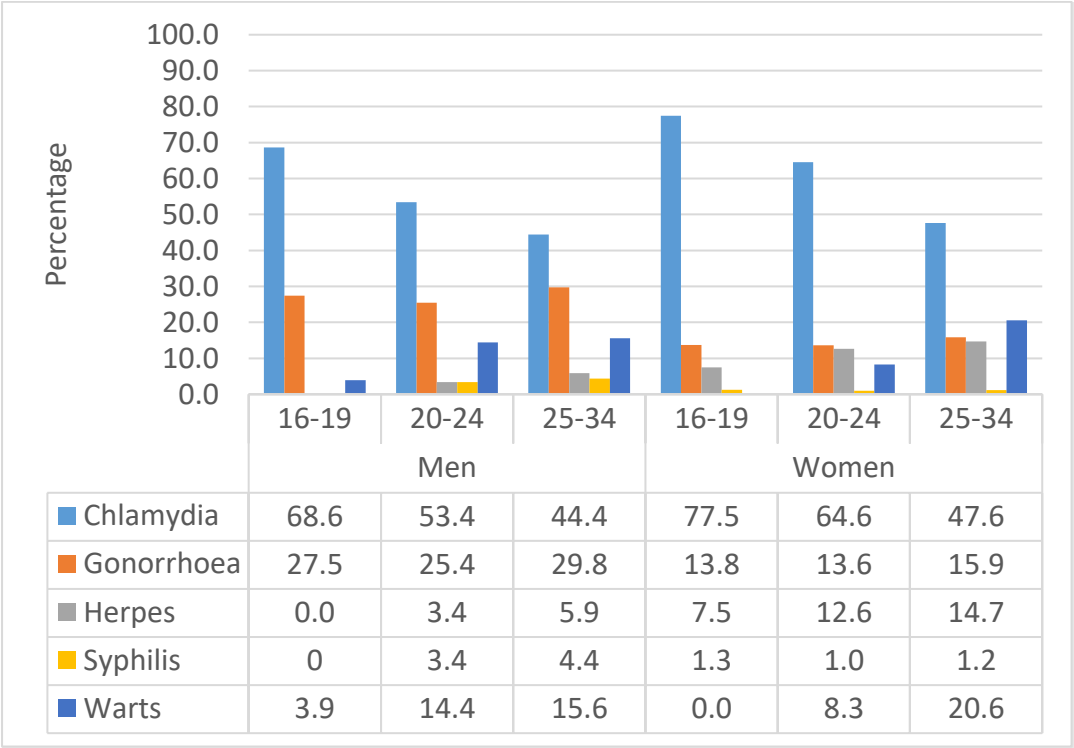
Figure 3.35 Proportion of new STIs by age group and gender in Havering (bars) compared to England (lines) (2020).



[48] SPLASH Supplement Report Havering (June 2022). GUMCAD data. SPLASH Havering 2022-01-27 (phe.org.uk)

Young women, aged 16-19 and 20-24 years were more likely to get diagnoses for chlamydia and herpes than men of the same age. However, men were more likely to get diagnoses of gonorrhea, syphilis and warts (Figure 3.36).

Figure 3.36 Percentage of STI diagnoses by age group (16-19, 20-24 or 25-34) in men compared to women in Havering April 2021 to end March 2022



	Men			Women		
	16-19	20-24	25-34	16-19	20-24	25-34
Chlamydia	68.6	53.4	44.4	77.5	64.6	47.6
Gonorrhoea	27.5	25.4	29.8	13.8	13.6	15.9
Herpes	0.0	3.4	5.9	7.5	12.6	14.7
Syphilis	0	3.4	4.4	1.3	1.0	1.2
Warts	3.9	14.4	15.6	0.0	8.3	20.6

ii) Deprivation

New STI diagnoses were more likely to be made in people (aged 15-64 years old) living in areas of higher socio-economic deprivation. Figure 3.37 shows higher rates of new STI diagnoses in the North and East of the borough, coinciding with the wards of Gooshays, Hilldene and South Hornchurch, which are among the 20% most deprived LSOAs in the country. Similarly, Figure 3.38 shows that areas of higher deprivation also have greater rates of diagnosed HIV prevalence.

Figure 3.37 Map of new STI diagnoses (excluding chlamydia in under 25 year olds) per 100,000 population aged 15-64 years in Havering by Middle Super Output Area (MSOA): 2020

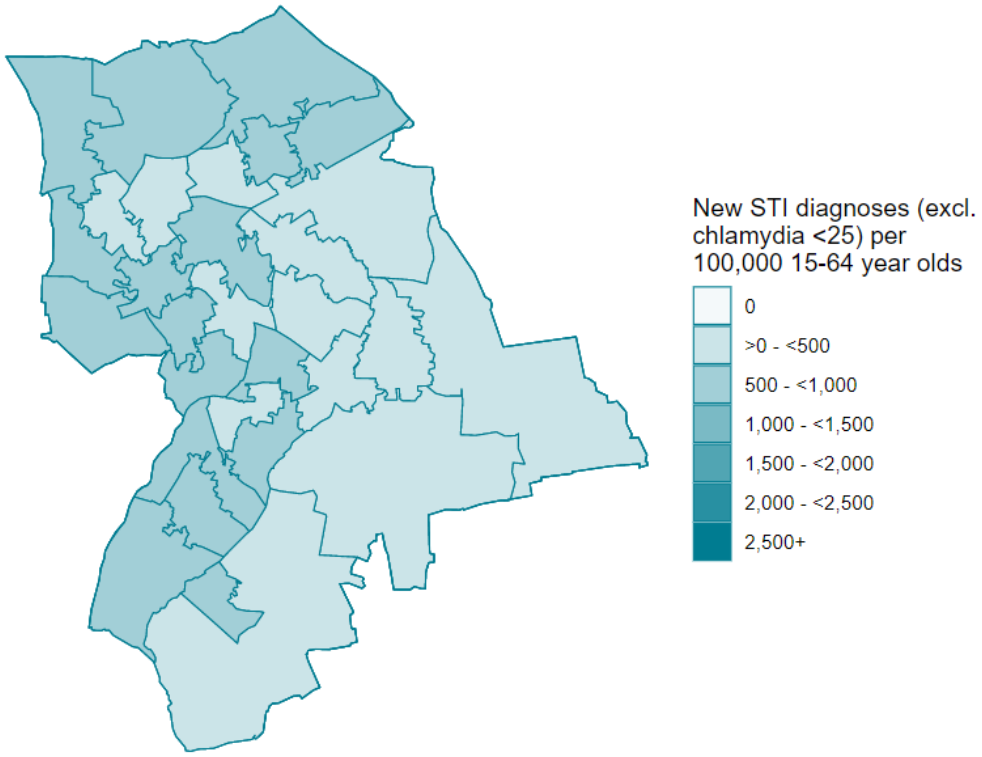
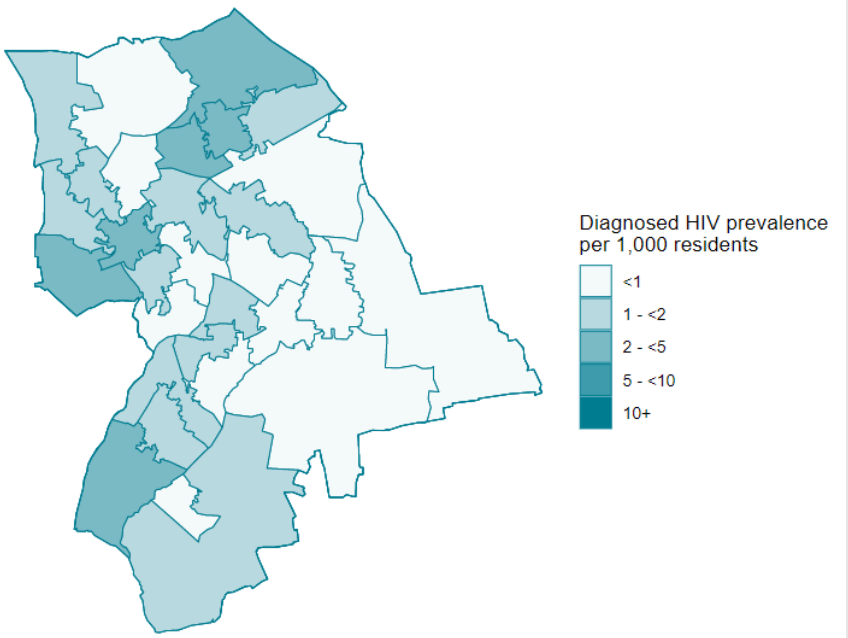


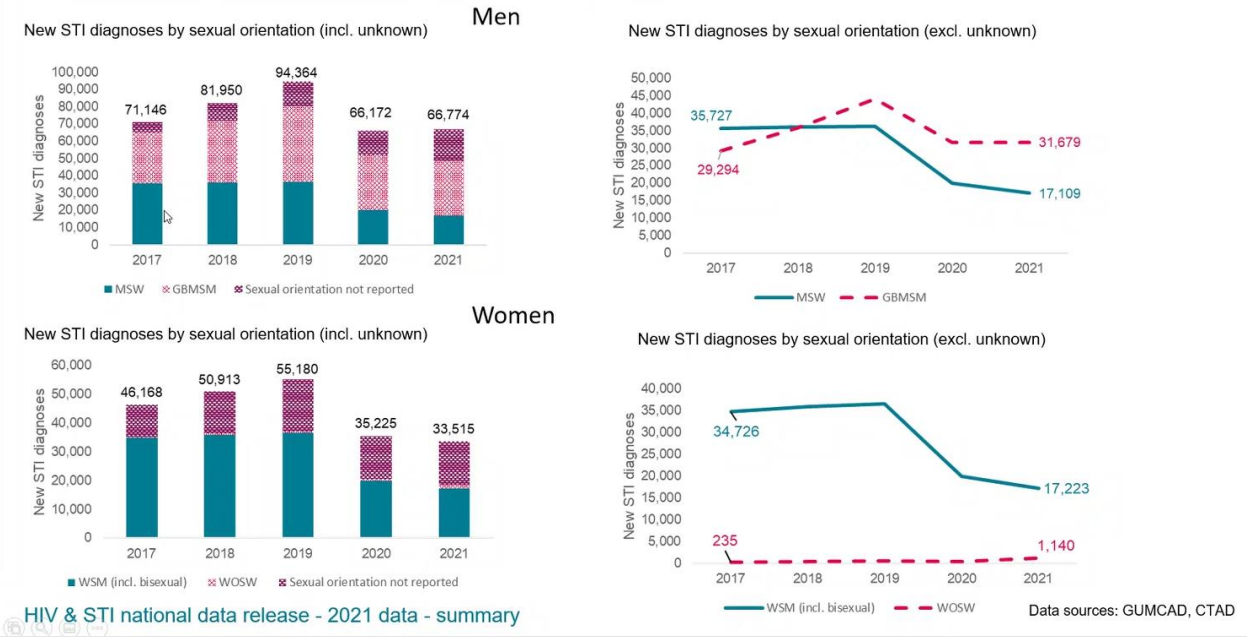
Figure 3.38 Map of diagnosed HIV prevalence among people of all ages in Havering by Middle Super Output Area (MSOA); 2020.



iii) Sexual orientation

Since 2017, there has been a clear shift in the number of new STI diagnoses amongst men. In London, GBMSM had more STI diagnoses in 2021 than Men who have Sex with Women (MSW) (Figure 3.39). In contrast, whilst Women who have Sex with Men (WSM) remain the majority of new STI cases amongst females, this number is decreasing, whilst diagnoses of STIs amongst Women who have Sex with Women (WOSW), while still relatively small in number, have been increasing.

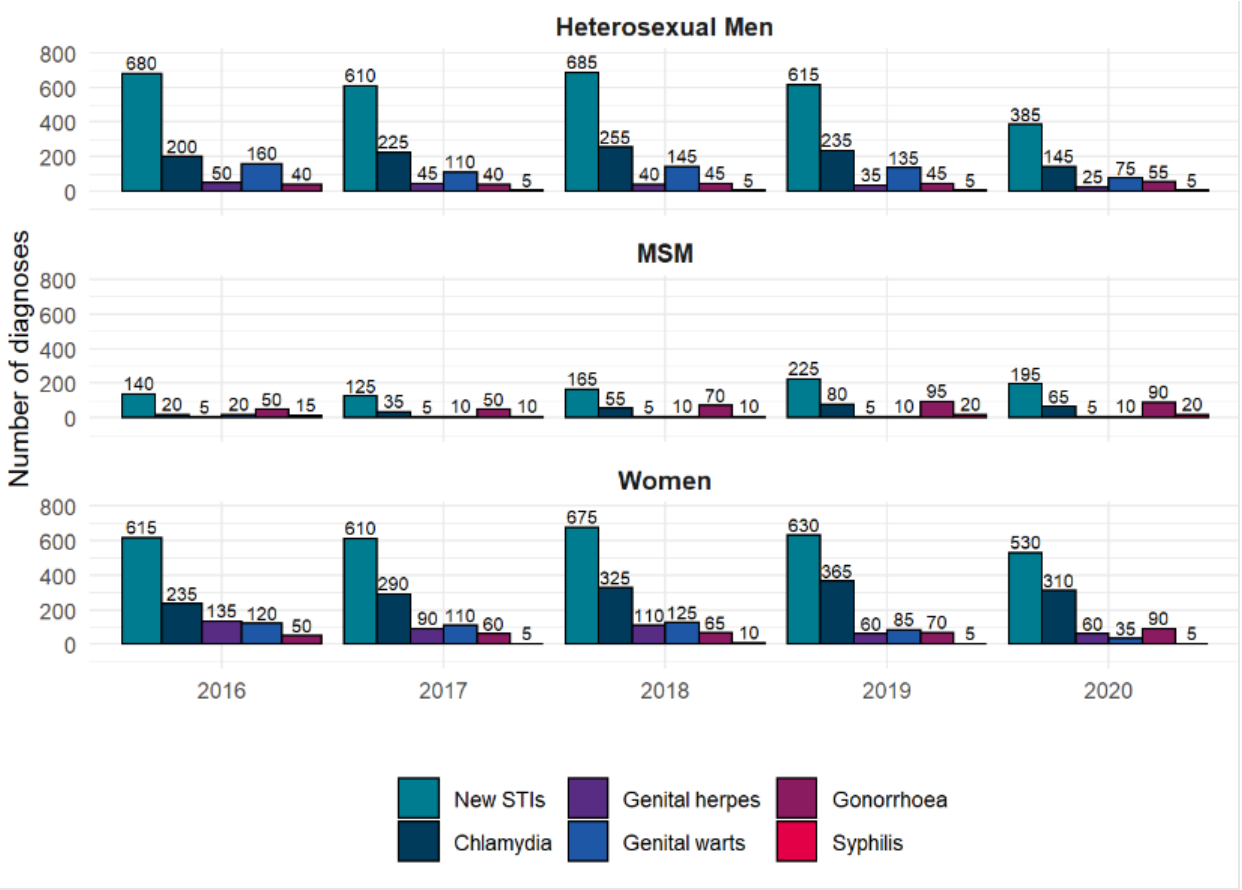
Figure 3.39 New STI diagnoses by gender and sexual orientation, London Residents



Data for Havering shows that numbers of new STI diagnoses are increasing in GBMSM, from 140 in 2016 to 225 in 2019, with a slight decrease in 2020 to 195 most likely due to access to testing being affected by the COVID-19 pandemic (Figure 3.40). The most diagnosed STI in GBMSM was Gonorrhea, whilst for heterosexual men and women chlamydia was the most common.

Numbers of syphilis infections were also higher in GBMSM than men who have sex with women (MSW) and women who have sex with men (WSM) (Figure 3.40).

Figure 3.40 Number of new STIs, chlamydia, genital herpes, genital warts, gonorrhea and syphilis in heterosexual men, MSM and women in Havering 2016-2020.



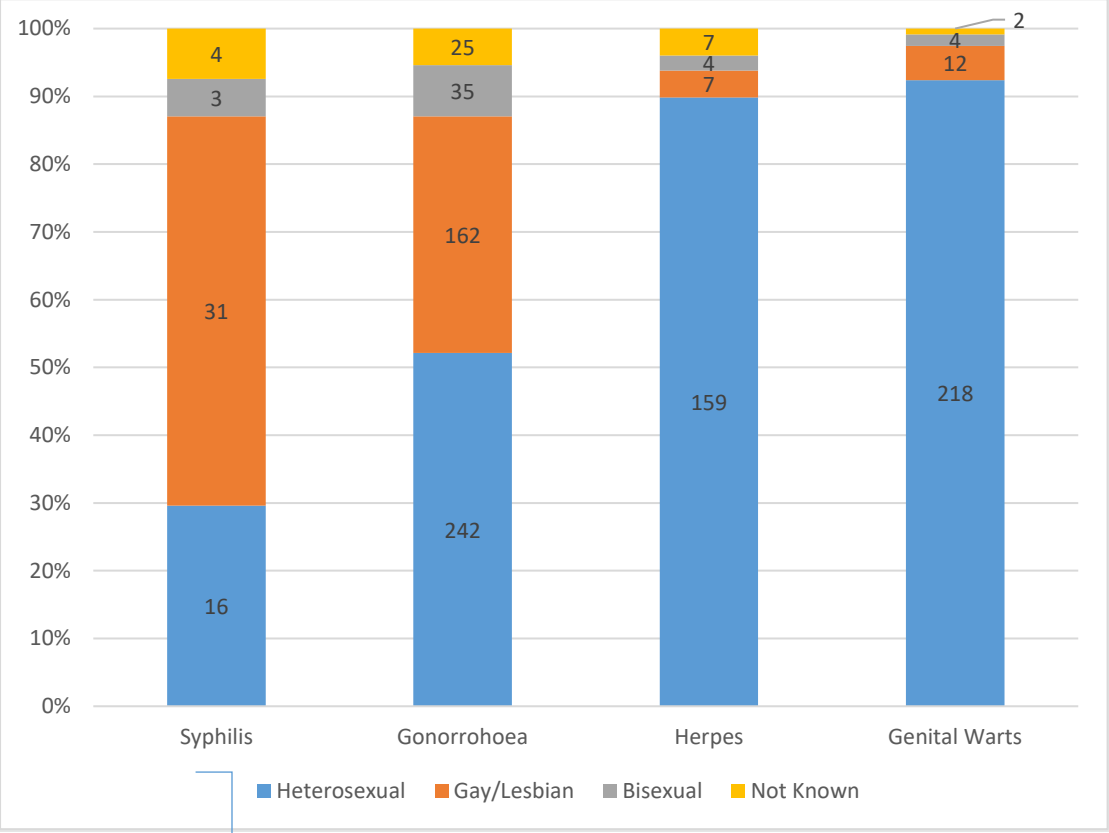
Compared to the relative proportions of people who identify as gay or bisexual with those who identify as heterosexual or straight, there is a disproportionate number of STI diagnoses among gay and bisexual persons (Figure 3.41)[49].

Applying the percentage of people who identify as heterosexual, gay or bisexual in Havering from the 2021 Census (0.95% identifying as gay, 0.73% bisexual; 0.27% pansexual, asexual, queer or all other sexual orientations; and 91.1% heterosexual)) to the numbers of new STI diagnoses in Figure 3.40 above, there is a considerable over-representation of people identifying as gay and bisexual being diagnosed with an STI, particularly for gonorrhoea and syphilis.

Using Figure. 3.41, for example, 57% of diagnoses of Syphilis in Havering over the two years January 2021 to December 2022 were amongst people who identified as Gay/Lesbian, compared to 30% amongst heterosexuals, which is an over-representation compared to the percentage population. In contrast, 92% of diagnoses of genital warts in Havering in the same period were to people identifying as heterosexual compared to 5% gay or lesbian[50].

[49] HIVSTI Reports (ukhsa.gov.uk)
[50] HIVSTI Reports (ukhsa.gov.uk)

Figure 3.41 Number and Relative Percentage of New STI diagnoses amongst people who identify as heterosexual, gay bisexual, or sexuality not known, Havering, 2021-2022



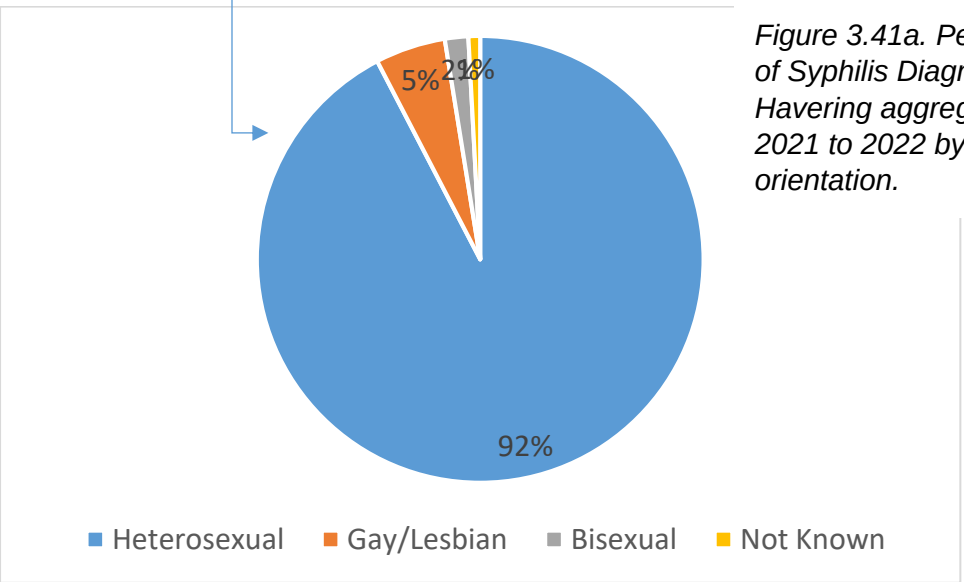


Figure 3.41a. Percentage of Syphilis Diagnoses in Havering aggregated for 2021 to 2022 by sexual orientation.

Data Source: GUMCAD

3.4 Current Service Provision, Gaps and Unmet Needs & Impact of COVID-19

3.4.1 Access to Sexual Health (STI) Services

As per the commissioning responsibilities outlined in Figure 1.2, in 2019, Havering awarded the delivery of local open access sexual health service provision to BHRUT. In addition, Havering participates in Sexual Health London (SHL), a London-wide e-service that provides free and easy access to sexual health testing via the internet and local venues. These two services are described further below:

i) BHRUT Specialist Sexual Health Services

The primary aims of the open access clinic services are to improve sexual health outcomes, improve service user experience and provide cost effective delivery of high quality sexual health services across the tri-borough region of Barking & Dagenham, Havering and Redbridge (BHR). These services should be/are provided through the operation of an open access, confidential, integrated sexual health service, and provide sexual health clinical governance oversight and leadership across each of the three boroughs regardless of setting or provider.

The contract specifies that in addition to a named primary/hub site, in this case Barking Hospital, satellite services should be located in the boroughs of Barking and Dagenham, Havering, and Redbridge, providing core and non-specialist services, delivered primarily by nursing and other non-medical staff under the clinical leadership of the consultants. As a minimum, there should be a site located each in Havering and Barking and Dagenham and in Redbridge two sites located at Hainault and Loxford. A satellite may be collocated with the Hub in the borough hosting the Hub.

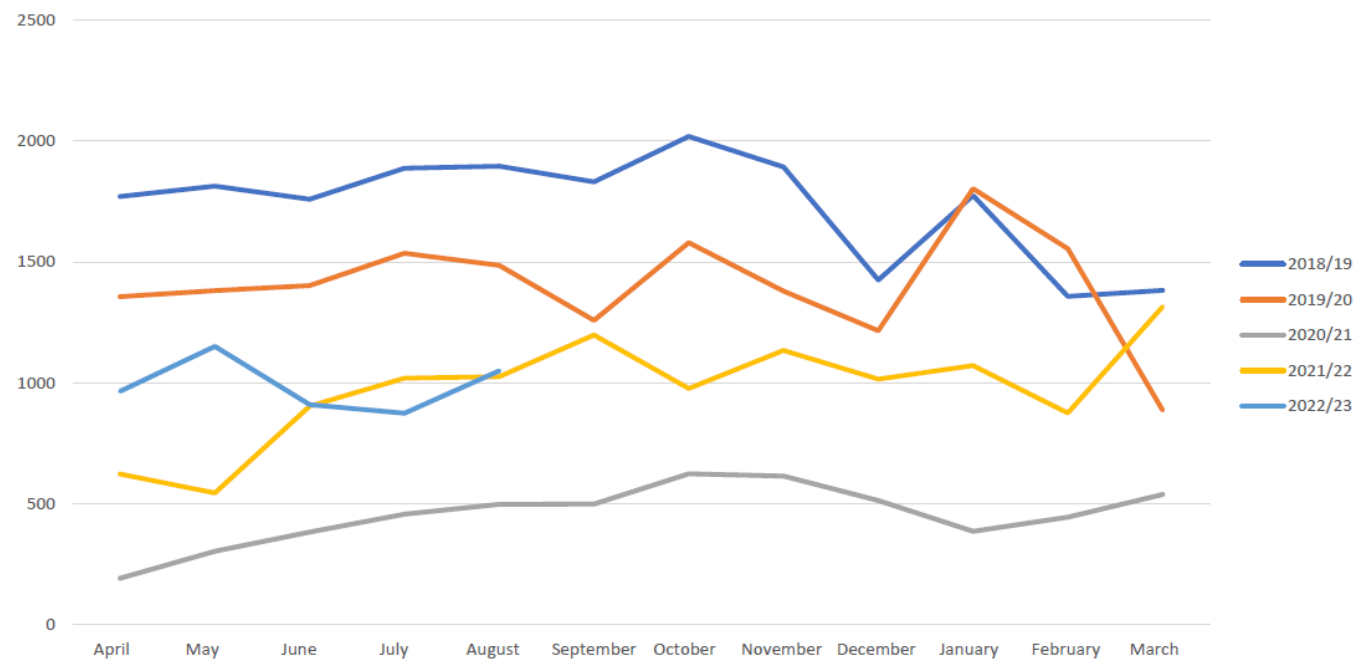
Each satellite should be easily accessible in terms of public transport, fully accessible and service user friendly including to young people, BME and LGBTQ+. Services to be delivered by Satellites across BHR are:

- Innovative approaches to delivering sexual health services, such as peripatetic services/partnerships with e.g. maternity services, may be required in order to meet service targets e.g. LARC.
- The Provider will be required to work with any targeted programme for high risk individuals.
- A particular focus of satellite clinics is ensuring the borough meets the LARC targets contained within this service specification. This will require close liaison and cooperation with GP and community pharmacy providers of sexual health and contraceptive services with the intention of maximising overall provision and minimising any local barriers to access.

However, during the COVID-19 lockdowns, the satellite clinics were paused, and relocated to Barking Hospital, thus affecting all BHR residents in accessing SRH services. Whilst the current service provision overall meets these above requirements, the satellite clinic in Hainault and frequency of clinic in Queen's Hospital have not yet returned to pre-covid pandemic levels of accessibility Services have now recovered for the most part to pre-covid activity levels. Commissioners are working with the providers to ensure more clinics are opened up as soon as possible, but currently represent a gap in accessible provision.

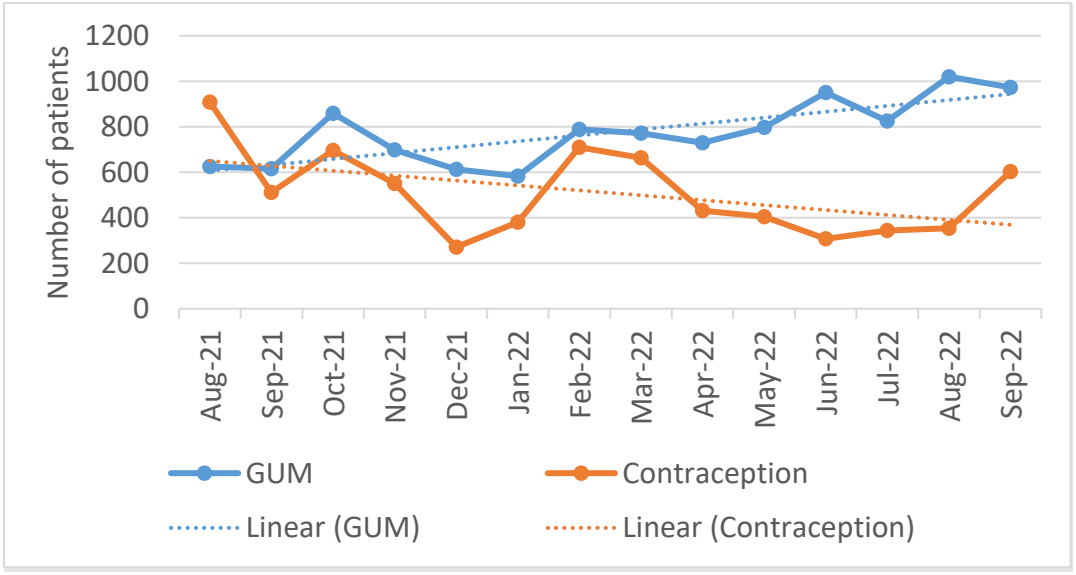
STI testing activity at BHRUT was significantly reduced during the key COVID-19 lockdowns in 2020/21 and 2021/22 and is now showing signs of recovery (Figure 3.43). However, it should be noted that the development of online testing services has created a significant channel shift in how people access STI testing. This channel shift was planned for, but has taken place sooner than anticipated due to the impact of COVID-19 lockdowns, and with the e-service now in place, it is hoped that overall testing levels will continue to increase.

Figure 3.43 STI testing activity (numbers of patients) at BHRUT April 2018/19 to August 2022/23



Unmet demand in the context of SRH services refers to those patients requesting an appointment for a service who were not able to get one on their first call. Over the past year, unmet demand for GUM services has risen, particularly from May 2022, which appears to have coincided with the impact of Mpox outbreak (Figure 3.44). Conversely, unmet demand for contraceptive services at BHRUT has decreased, primarily due to opportunistic contraceptive advice being delivered during sexual health consultations. A key service improvement need will be to reduce unmet demand and increase access to clinical sexual health services.

Figure 3.44 Unmet demand at BHRUT for Genitourinary Medicine (GUM) and Contraceptive services for patients in Barking & Dagenham, Havering and Redbridge.

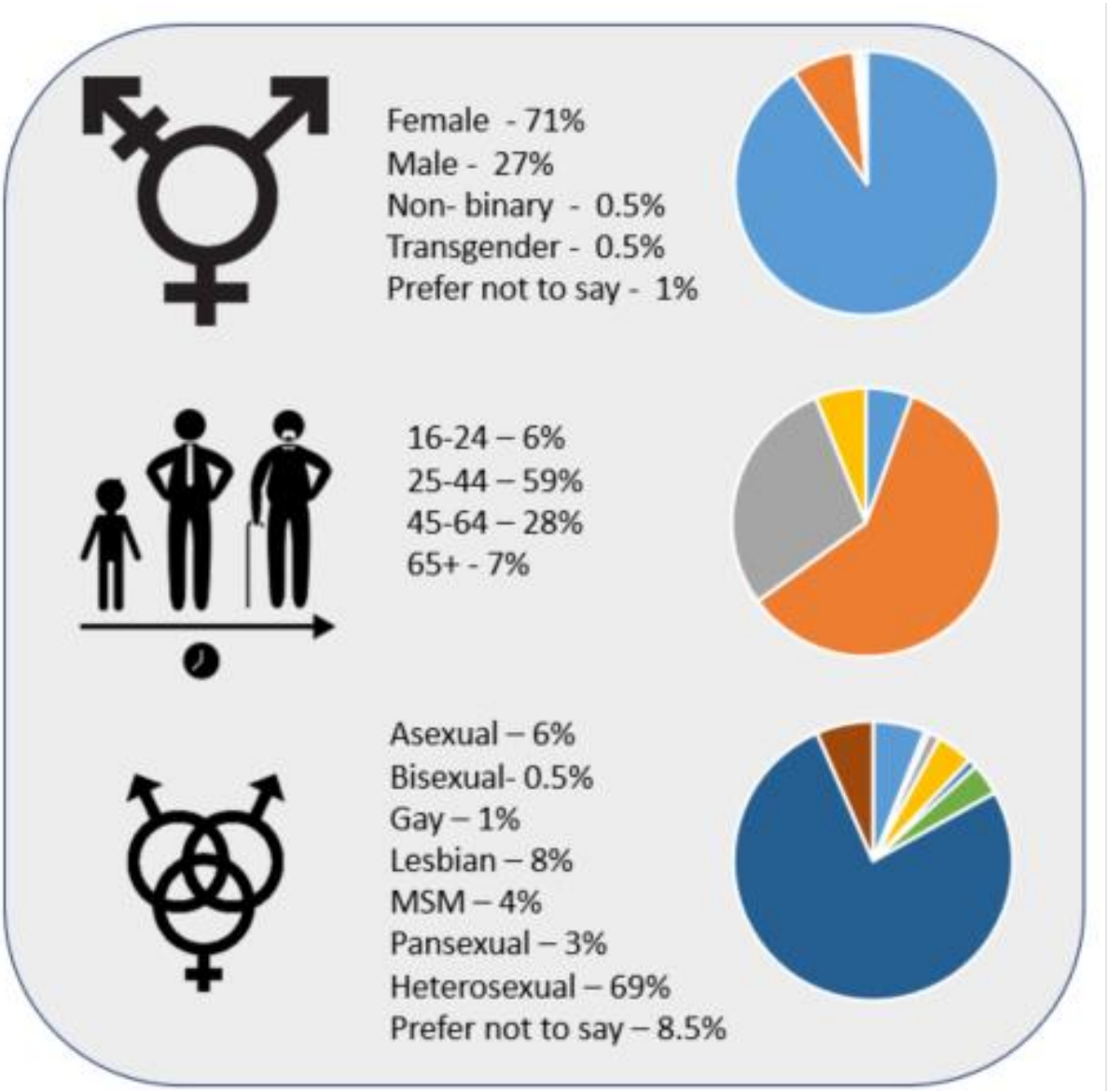


Feedback from service users of the sexual health clinic sites has been predominantly positive (Figure 3.45). However, access to sexual health services is acknowledged as a key issue, and has been identified as a problem during a recent mystery shopper exercise conducted across all the North East London services by an independent agency. However, there is a lack of information on how service users themselves would prefer to have their services organised, which represents a significant gap in local intelligence.

Figure 3.45 Service User feedback from BHRUT patients in 2022.

In Summer 2023, a survey across all 7 North East london boroughs was conducted as part of resident engagement for the development of a NEL-wide Sexual and Reproductive Health Strategy (Fig. 3.46). The survey showed that across NEL, 60% of respondents had accessed any sexual health service - 46% of 631 respondents had accessed their local sexual health service and 14% had accessed a service outside of NEL. However, of the 78 respondents from Havering alone, only 46% had accessed a sexual health service – 35% had accessed their local service, i.e. BHRUT whilst the remaining 11% had accessed a service outside of North East London (Fig. 3.47).

Figure 3.46 Demographics of Residents Who Responded to the NEL-wide Engagement Survey for the Sexual and Reproductive Health Strategy for NEL.



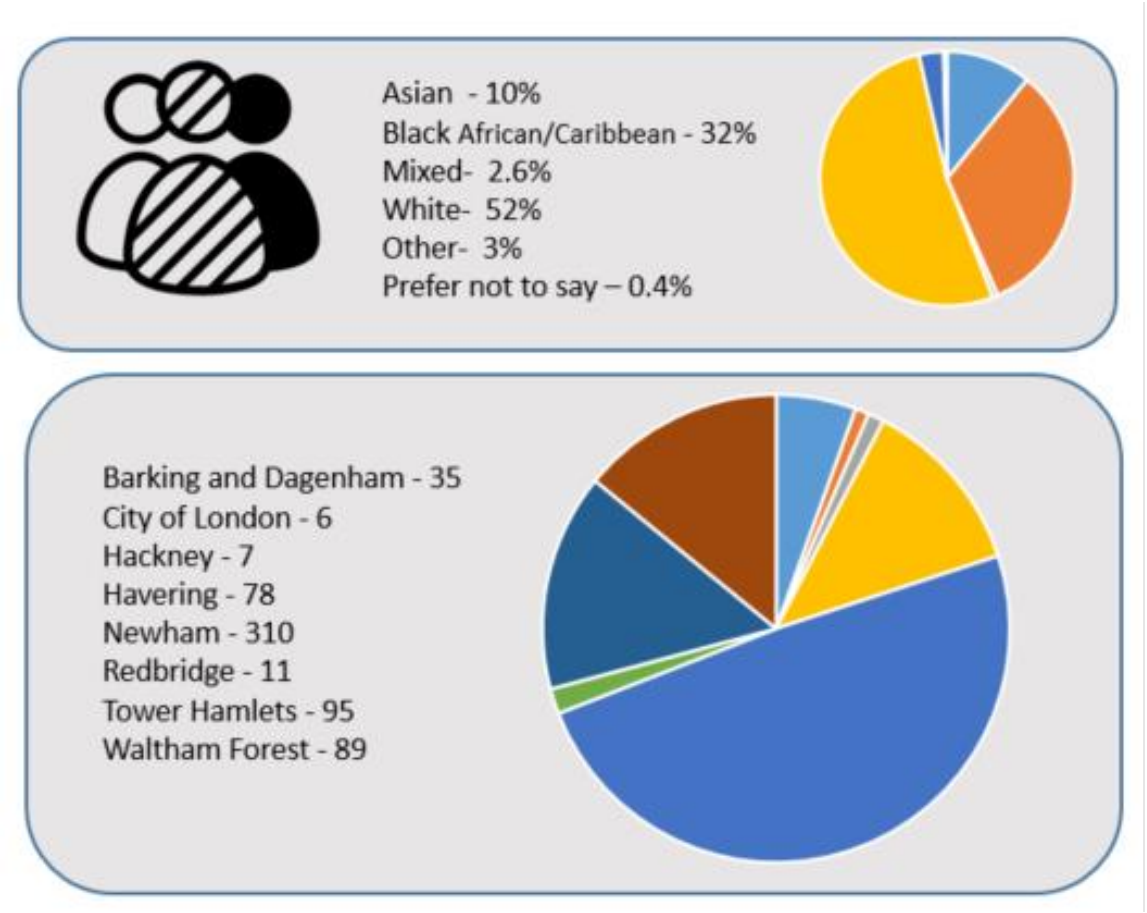


Figure 3.47 Percentage of Residents Across NEL (Left hand chart) or Havering (Right hand chart) who had accessed a Sexual Health Service, 2023

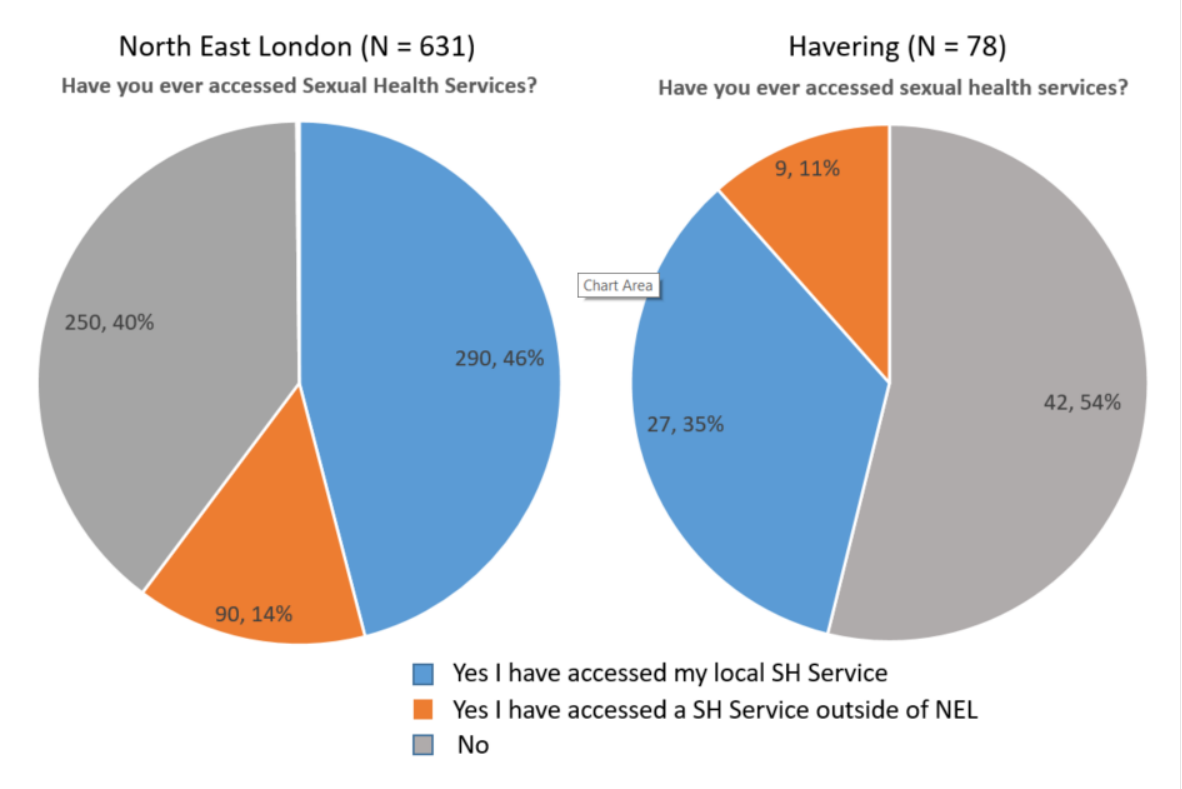


Figure 3.48 Havering Resident Responses to SRH Survey Question "Is there anything that could be improved in your current local SRH service provision?"

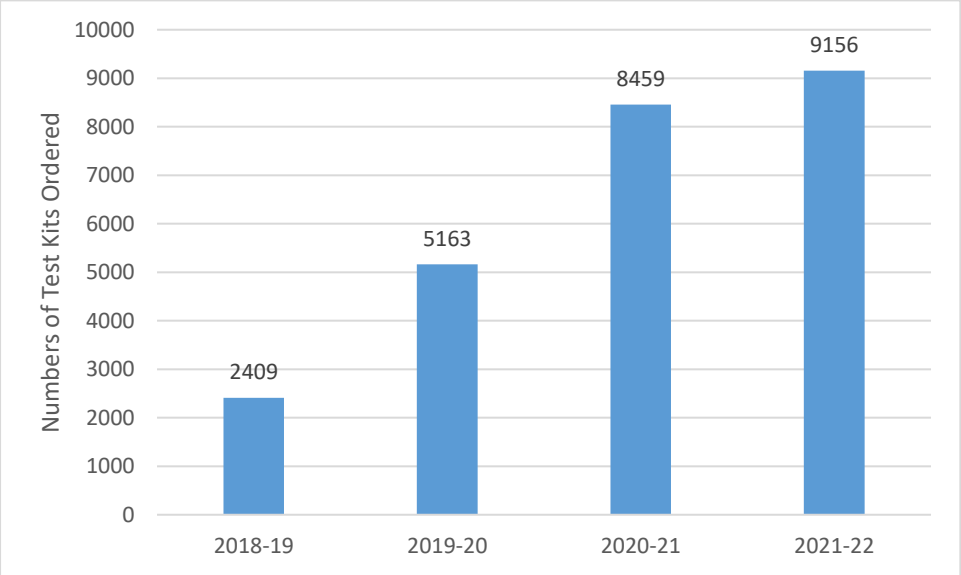
Location	Appointments	Promotion
"easier location to get to" *"Have clinics at Queens and myplace"* *"Better access to sexual health services across all of the boroughs not just in some."* *"More local provision for young people"*	*"There must be walk-in on the day testing and treatment for STIs. The morning after pill should be immediately available."* *"More appointments"* *"Easier to make appointments"* *"Longer opening hours at local sexual health clinics. Majority of appointments are during the day when people are at work and may struggle to attend those. Most appointments should be available in the evenings and weekends when most people are free.*	*"Should be more widely advertised"* *"Letting people know more easily where they are"* *"I haven't seen any advertising or targeted support in Havering. I hadn't really thought about it until I saw this survey."*

ii) Sexual Health London (SHL) STI E-service

SHL is available to people aged 16 and over who are resident in most boroughs in London (except Hillingdon, Croydon and Greenwich). The service provides testing for a range of STIs including chlamydia, gonorrhoea, HIV, syphilis, hepatitis B, and hepatitis C. Self-sampling kits are ordered over the internet with full instructions on how to take either a urine or vaginal swab sample along with a finger-prick blood sample to test for blood-borne viruses. Samples are returned freepost via normal mail. Results are delivered via the patient's method of choice.

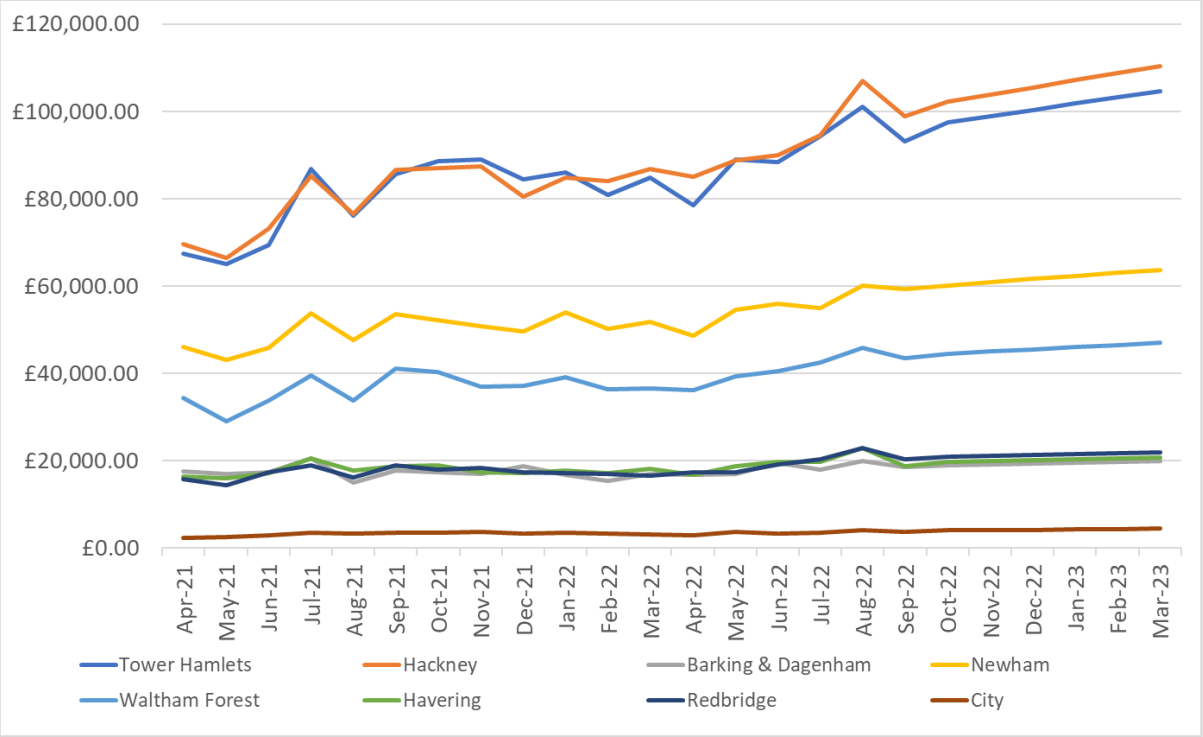
Since its initiation in early 2018, the numbers of test kits ordered by Havering residents has tripled. The largest jump in test kits being ordered via the internet was between 2019-20 and 2020-21, coinciding with the national COVID-19 lockdowns (Figure 3.49). As can also be seen from Figure 3.33 above, the increase in test kits being ordered via the e-service appeared to be concurrent with the reduction in testing activity conducted at SH clinics. The e-service appears to continue to be a preferred service as the number of test kits ordered online has not reduced since the face to face clinics have been reintroduced. This suggests the intended channel shift in where to access STI testing kits took place earlier than intended due to the pandemic, but is proving to be an acceptable method such that overall testing rates have increased.

Figure 3.49 Number of STI test kits ordered by Havering residents through the SHL E-service 2018-19 to 2020-21



Compared to other North East London boroughs, who have different populations and therefore different risk profiles, fewer people in Barking and Dagenham, Havering and Redbridge overall order e-service STI kits (Fig. 3.50). The forecast is for a slight increase in e-service use to the end of this financial year, but with the return of clinic services not having a significant impact on request for kits, this growth is likely to remain moderate.

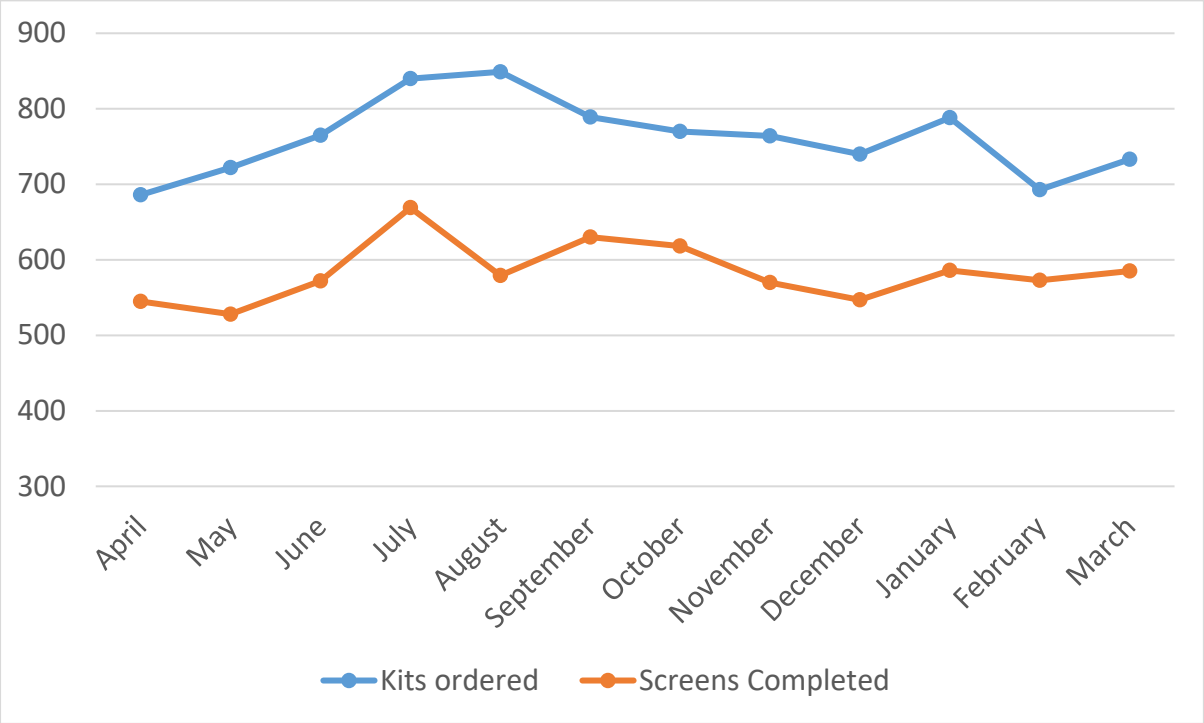
Figure 3.50 Expenditure by North East London Borough on E-service by month, April 2021 to September 2022 and forecast till end March 2023.



In terms of efficiency of the e-service, an average of 76.7% of screens were actually completed compared to the number of test kits ordered in Havering (Figure 3.51). This return rate is good compared to other e-service providers, where studies have found that up to 60% of test kits were not returned[51].

[51] STI testing and subsequent clinic attendance amongst test negative asymptomatic users of an internet STI testing service; one-year retrospective study - PMC (nih.gov)

Figure 3.51 Numbers of E-service kits ordered compared with completed screens for Havering April 2021 to March 2022



iii) Local Voluntary and Community Sector Sexual Health and Advice Services

In addition to the sexual health clinics provided by BHRUT, there are a number of community assets where young people and indeed anyone in need of sexual health advice can go. Figure 3.52 below outlines these key assets, including youth centres, relationship counselling and sites for condom distribution via the C-card scheme (see also Contraception Section 6 below). Use of condoms are essential for preventing the transmission of STIs and thus provide opportunities for brief interventions on staying sexually safe and well.

Figure 3.52 *Sexual Health and Relationship Assets across North East London*

In this increasingly digital age, websites are a key source of information for all ages. Havering Council's Family Services Directory provides a one-stop shop for information about sexual health and links to a range of other websites and services.

3.4.2 Relationship and Sex Education (RSE) in Schools

International evidence is clear that comprehensive relationships and sex education (RSE) protects young people from STIs and unplanned pregnancy, as well as some of the behaviours that make them more at risk, including non-consensual sex. Natsal-3 found young people who cited school as their main source of RSE were less likely to acquire an STI or experience an unplanned pregnancy.

In March 2017, Parliament made it law for all secondary schools in England to teach Relationship and Sex Education (RSE) and primary schools to teach Relationship Education; the new RSE curriculum was implemented from September 2020. High quality, comprehensive and contemporary RSE in schools has been found to reduce early sexual activity, teenage conceptions and STIs and empower young people to engage in healthy sexual relationships[52]. It also raises awareness of the dangers of child sexual exploitation, cyber-bullying and abuse.

Statutory guidance for schools, developed by the DfE for the RSE curriculum[53], specifically requires that students at secondary level learn about:

- the prevalence of some STIs and the impact they can have on those who acquire them
- how the different STIs, including HIV and AIDs, are transmitted
- how risk can be reduced through safer sex (including through condom use)
- the importance of and facts about testing and treatment
- how to get further advice, including how and where to access confidential sexual and reproductive health advice and treatment

[52] Sex Education Forum (2015) SRE - the evidence - March 2015.pdf (sexeducationforum.org.uk)
[53] DfE (2019) Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk)

However, data from the Young People's RSE Poll 2021 showed that the quality of education received by the 1,000 young people aged 16 and 17 years who participated was highly inconsistent across different schools nationally.

- 35% rated the quality of RSE in their school as 'good' or 'very good' compared to 22% who rated it as 'bad' or 'very bad'
- 28% had NOT learnt about 'how to tell if a relationship is healthy, including online'
- 29% had NOT learnt about 'how to recognise when someone is being groomed for sexual exploitation'
- 40% had NOT learnt about FGM; and 25% felt they had not learnt enough

An identified gap would therefore be in terms of ensuring the quality of RSE across the range of schools in Havering meets a yet to be agreed-upon standard.

3.4.3 National sexual health promotion

The following assets contribute to the prevention of transmission of STIs by raising awareness and signposting people in Havering to available help and support:

- PHE's national HIV Prevention and Sexual Health Promotion programme supports national and local health promotion activities to improve sexual and reproductive health and prevent HIV.
- Sexwise is a sexual health and reproductive health information programme that seeks to provide clear, impartial, up-to-date information for the general public and healthcare professionals, to enable informed sexual health choices and support healthy sexual behaviour.
- Protect Against STIs Use a Condom is a sexual health campaign launched by PHE in 2017, to encourage condom use by young adults aged 16-to-24 years to reduce the rates of STIs. It aims to raise awareness of the serious consequences of STIs, as well as normalise and encourage condom use. See the range of campaign advertising and images.
- PHE also commissions specialist programmes to address HIV prevention and sexual health improvement, including multimedia and local outreach programmes.
- National HIV Testing Week is a part of the national HIV Prevention England Programme aimed at GBMSM, black African communities and other groups in whom there is a higher or emerging burden of infection.
- PHE recognises that voluntary and community organisations play a key role in tackling STIs and improving HIV and sexual health. In 2015, PHE set up an HIV Prevention Innovation Fund, and in 2019 and 2020 the fund has been expanded to support projects that offer new and innovative ways of improving reproductive and sexual health (including STI prevention), as well as HIV.
- The new Reproductive Health, Sexual Health and HIV Innovation Fund[54]. is a grant scheme which aims to reduce the impact of HIV and improve sexual and reproductive health in England by supporting voluntary sector organisations to deliver innovative interventions. The fund supports volunteer organisations spearheading new, innovative community-led interventions through:
  - online campaigns
  - outreach
  - patient support
  - testing and media
  - art projects.

[54] PHE (2018) Innovative HIV prevention projects reached 170,000 people in 2018 - GOV.UK (www.gov.uk)

3.5 Recommendations

Recommendations for STI Testing and Treatment
The health and social care system across NEL is recommended to support local commissioned providers for Havering (BHRUT) to increase access to and availability of sexual health appointments closer to home, e.g. by increasing the number of clinics available, and at locations closer to those with higher need.
Given the efficiency, cost-effectiveness, convenience and privacy of the e-service, it is recommended to promote and increase uptake of SHL e-service, particularly for Gonorrhoea, including increasing test-to-completion rates i.e. ensuring that those who request a test, complete the test and return it for analysis.
Increase engagement with high-risk groups to understand their views about STI screening and elicit potential barriers to testing access and uptake.
Identify barriers for uptake of chlamydia screening in young people and increase overall chlamydia screening rates.
Local commissioners and providers to work together with residents to develop a co-produced action plan to normalise HIV testing when visiting a SRH service and increase rates of HIV testing, particularly to reduce rates of late HIV diagnosis.
In order to help meet the 90-90-90 Fast Track Cities target for HIV, it is recommended that SRH services work to increase the uptake of PrEP in those identified as having a PrEP need.
In order to ensure that local service provision is targeting those most in need, it is recommended that an equity audit of local services is conducted annually to ensure equitable access for higher risk groups.

4.0 Conception, Abortion & Maternity

4.1 Reproductive Health as a Public Health Issue

Reproductive health is a public health issue with far reaching impacts, especially for women, throughout the whole of life, with intergenerational effects on children and families, and economic impacts through lost hours of work and school absenteeism as a result of unwanted reproductive symptoms. Stigma, embarrassment and taboos all surround reproductive issues making it difficult to talk about them. The National Survey of Sexual Attitudes and Lifestyles (NATSAL) found that 10% of women have experienced non-volitional sex but often do not tell anyone; more than one third of women did not plan to have or were ambivalent about their pregnancies that continued to term and are therefore more likely to result in complications[55]. It is often difficult for women to reach information or care that they need because of these and many other barriers.

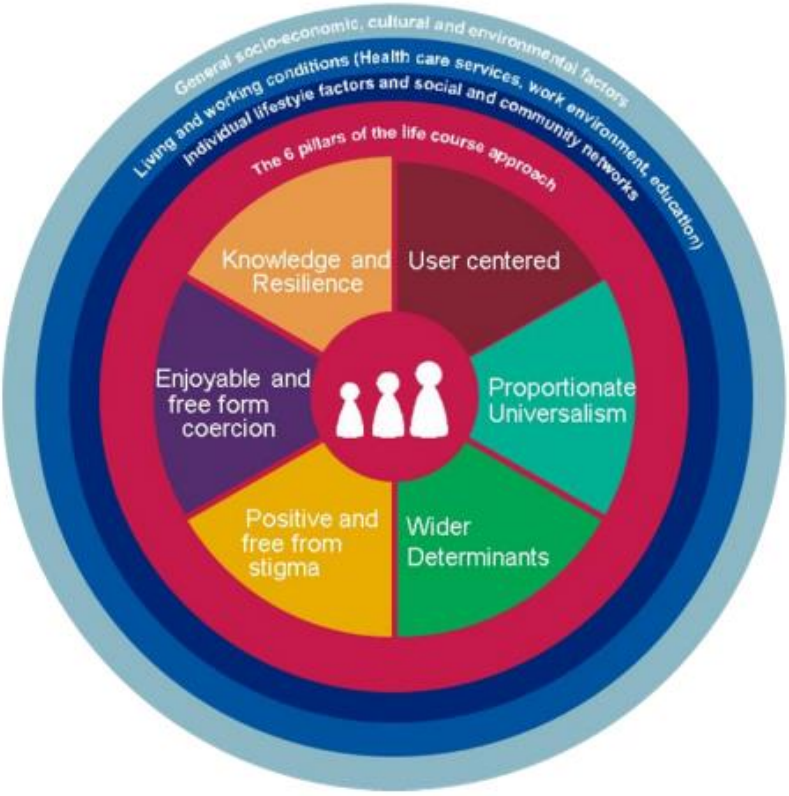


Figure 4.1 The 6 pillars of Reproductive

4.2 National context

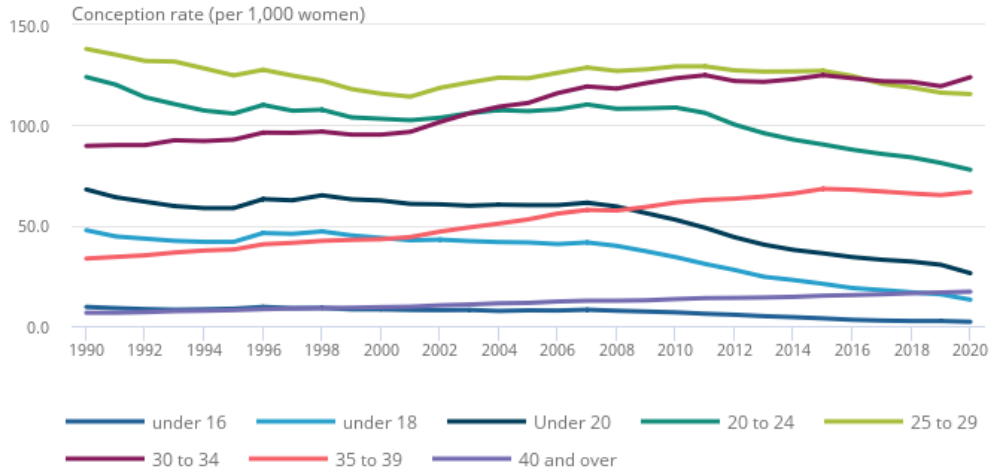
Conceptions/pregnancy can end in maternity, miscarriage or abortion. Whether planned, unplanned or as a result of non-consensual sex, a woman has the right to choose whether to go ahead with a pregnancy. Conception rates differ from fertility rates; conception is the ability to conceive a pregnancy, whether or not the foetus is carried to term, whereas fertility rate is the number of live births occurring in a respective calendar year per 1,000 females aged 15-44 in a population. Conception statistics do not, however, include conceptions resulting in miscarriages or illegal abortions; figures are derived from combining numbers of maternities and abortions using information recorded at birth registration and abortion notification. In addition, it is estimated that around 1 in 8 pregnancies will end in miscarriage, so the actual conception figures are higher than reported here.

[55] Macdowell, W. et al (2013) Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) - The Lancet

4.2.1 National Conception Rates

The number of conceptions in England and Wales has reduced over the last few years. The conception rate for women of all ages in England and Wales slightly fell in 2019, from 73.8 per 1,000 women to 73.4 per 1,000 women[56]. This is the smallest year-on-year decrease seen over the last five years. In 2020, for all age groups 30 years and over, there was an increase in conception rates, with the highest rate seen in women in the 30-to-34 age group (123.9 per 1,000 women) (Figure 4.2). There was a reduction in conception rate for the under 30 years age groups, including reductions in rates for teenagers (under 18s and under 16s). For more data relating to teenage pregnancy, refer to Section 5: Teenage Pregnancy.

Figure 4.2 Conceptions per 1,000 women by age group, England and Wales, 1990 to 2020



4.2.2 National Abortion Rates

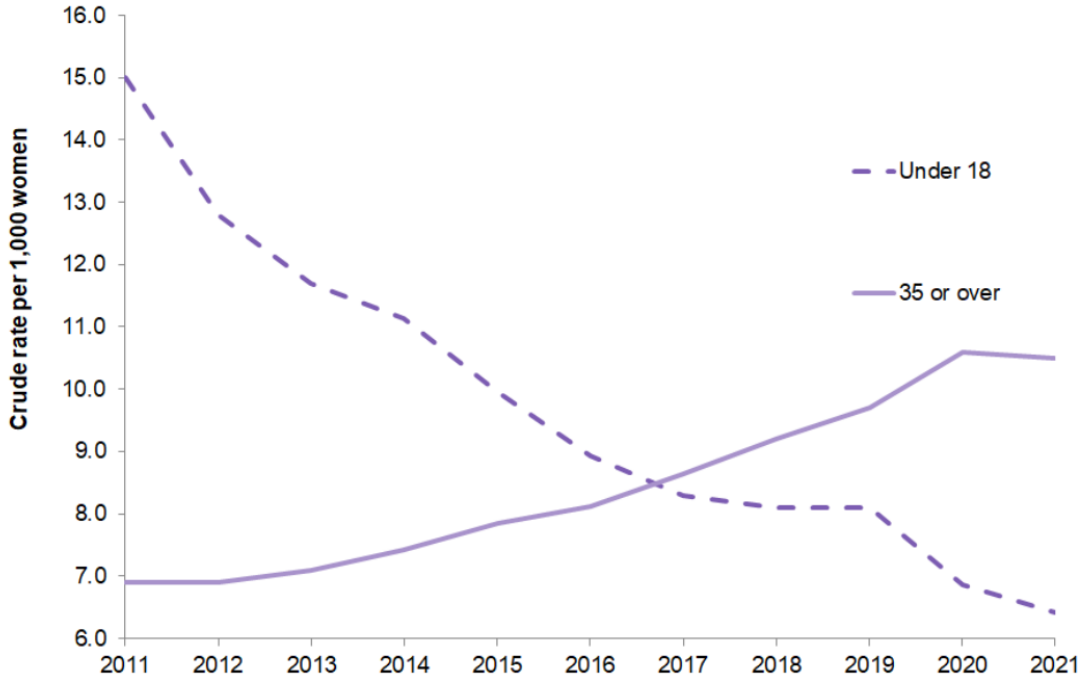
The Third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3) conducted in Britain in 2010-12 found that 16% of all pregnancies were unplanned[57]. f these unplanned pregnancies, 57% ended in an abortion. In 2020, the percentage of conceptions in England and Wales leading to legal abortions increased for the sixth year in a row, with around a quarter (25.3%) of conceptions leading to abortion[58]. Whilst the number of conceptions and births continued to decrease from 2015 to 2020, at the same time the number of abortions increased.

The Abortion Act (1967) made abortion legal in England, Scotland and Wales up to 23 weeks and 6 days of pregnancy (gestation). However, if there is significant risk to a mother's life as a result of the pregnancy, or a fatal fetal abnormality, there is no gestational limit to an abortion.

In 2021, there were 214,256 abortions for women resident in England and Wales, the highest number since the Abortion Act was introduced. However, the abortion rate for women aged under 18 has continued to decrease (from 15.0 in 2011 to 6.9 in 2020 and further decreased to 6.4 per 1,000 in 2021) (Figure 4.3). The rate has remained stable for women aged 35 or over (from 10.6 to 10.5 per 1,000 between 2020 and 2021). This represents an age-standardised abortion rate (ASR) of 18.6 per 1,000 women aged 15 to 44 compared to a rate of just over 5 per 1,000 in 1969[59].

[56] ONS (2020) Conceptions in England and Wales - Office for National Statistics
[57] Wellings, K. et al (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) - PMC (nih.gov)
[58] ONS (2020) Conceptions in England and Wales - Office for National Statistics
[59] ONS (2020) Conceptions in England and Wales - Office for National Statistics

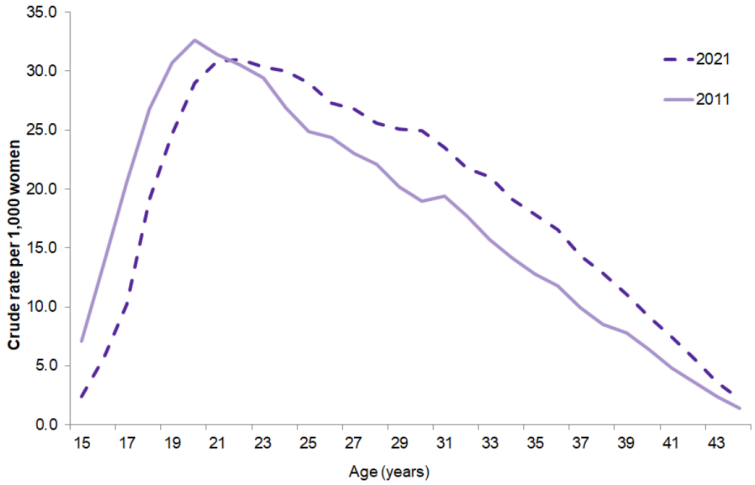
Figure 4.3 Abortion rates in women aged under 18 years compared to women aged 35 and over, 2011 to 2021



99% of abortions in England and Wales were funded by the NHS in 2021, with 77% of abortions taking place in the independent sector.

The peak age at which abortions occur has also been increasing: the abortion rate in 2021 was highest for women aged 22 (at 31.0 per 1,000 women). Previously, in 2020 the highest rate was for women aged 21 (30.6 per 1,000 women), and in 2011 it was highest for women aged 20 (at 32.6 per 1,000 women) (Figure 4.4). The peak of the curve has shifted to the right over the past 10 years, suggesting that women are choosing abortion at a slightly older age.

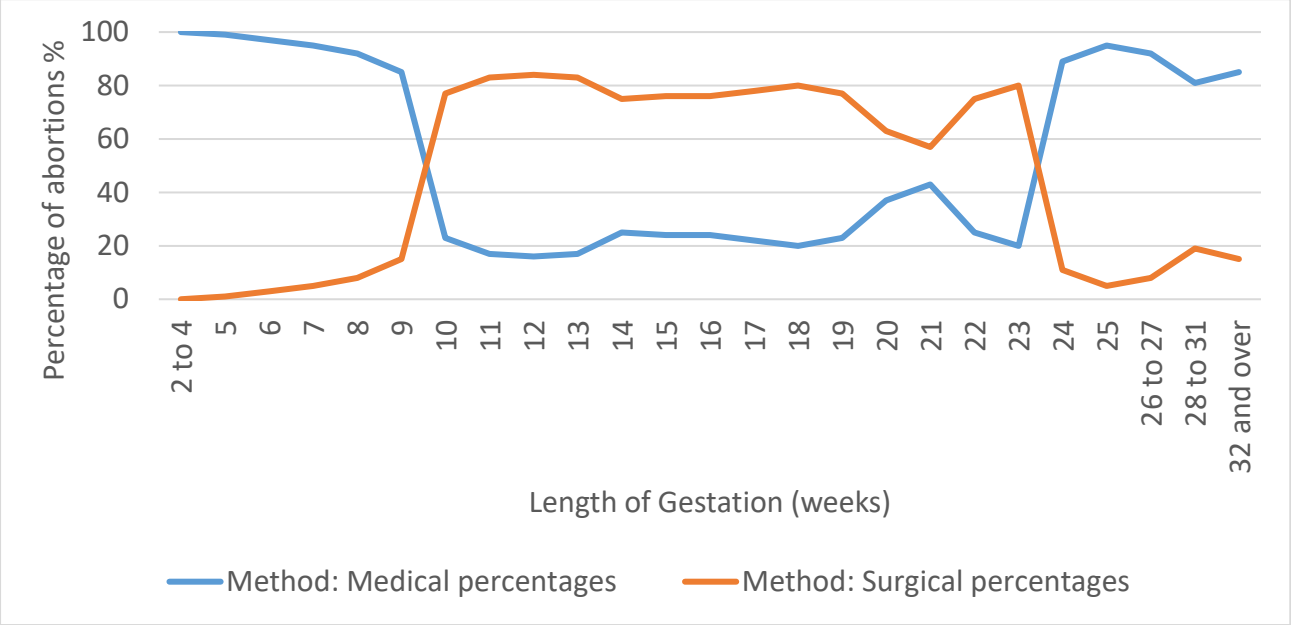
Figure 4.4 Age of women choosing abortion in 2021 compared to 2011



There are two methods available for abortion in England and Wales: medical abortion ("abortion pill") and surgical abortion. Medical abortions are early abortions (under 10 weeks)

facilitated by easy access to abortion services is recommended to reduce the risk of complications and may be used as indicator for service quality[60] (Figure 4.5).

Figure 4.5 Percentage of Medical vs Surgical Abortions by weeks of gestation in England and Wales (2021)



n response to the COVID-19 pandemic, the UK government put in place a temporary approval for women to take both early medical abortion pills (up to 10 weeks gestation) at home following a consultation with a clinician. In 2021, the government ran a public consultation to gather views on whether to revert to the pre-pandemic position or to make the temporary COVID-19 measure permanent; these were made permanent in November 2022[61] [62]. Prior to the COVID-19 pandemic, women had to first attend a hospital or clinic. NATSAL-3 survey found that the remaining 34% of unplanned pregnancies ended in a miscarriage and 5.7% went on to a full term pregnancy[63].

Once women have decided to take a pregnancy to full-term, a midwife or GP should be contacted in order to start a supported antenatal care process. National guidance has been published by Public Health England and NICE, to encourage support for women regarding their reproductive health and improve outcomes for women and their children if pregnancy is taken to full-term[64].

4.3 Local context

4.3.1 Conception Rates in Havering

Overall conception rates per 1,000 women aged 15 to 44 years in London and boroughs in North East London have all been steadily declining since 2010 (Figure 4.7). Between 2011 and 2021, across England, women aged 35 to 39 years and aged 40 years and over were

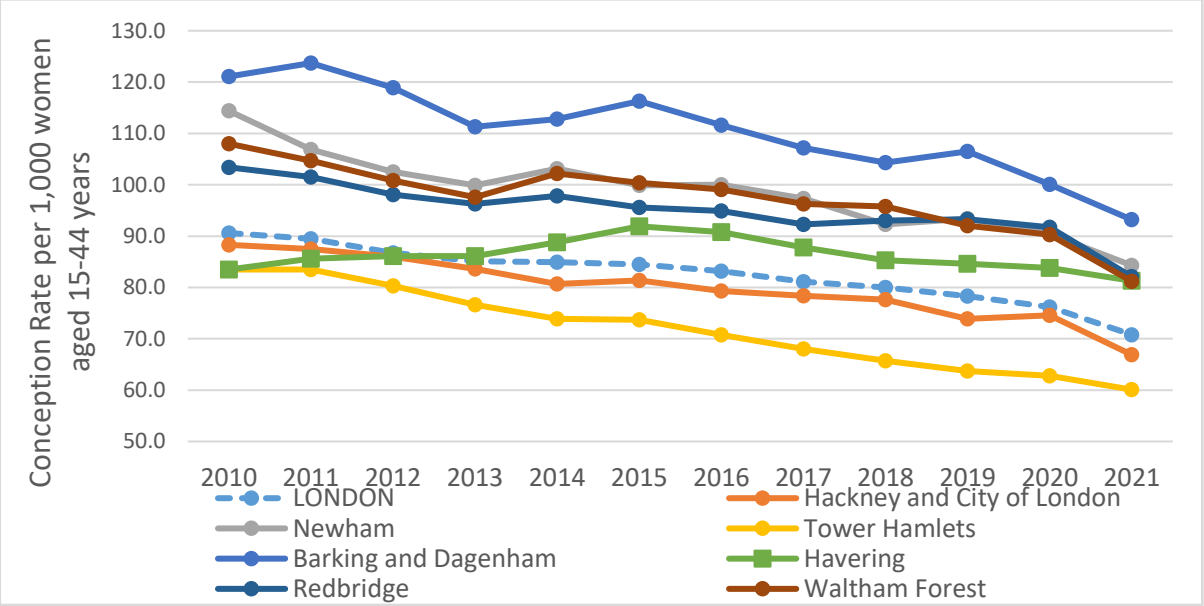
[60] NICE (2019) Recommendations | Abortion care | Guidance | NICE
[61] Gov.uk (2021) Home use of both pills for early medical abortion - GOV.UK (www.gov.uk)
[62] Gov.uk Research Briefing (2022) CBP-9496.pdf (parliament.uk)
[63] Wellings, K. et al. (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) - PMC (nih.gov)
[64] PHE (2020) Maternity high impact area 1: Improving planning and preparation for pregnancy (publishing.service.gov.uk)

the only groups to see an overall increase in conception rates; this means that mothers are likely to be older when having children.

Despite this overall decline in conception rates, as a rapidly growing borough, Havering has an increasing number of women of reproductive age within the population. Havering has a higher conception rate than London or England and there has been an increase in absolute numbers of young children.

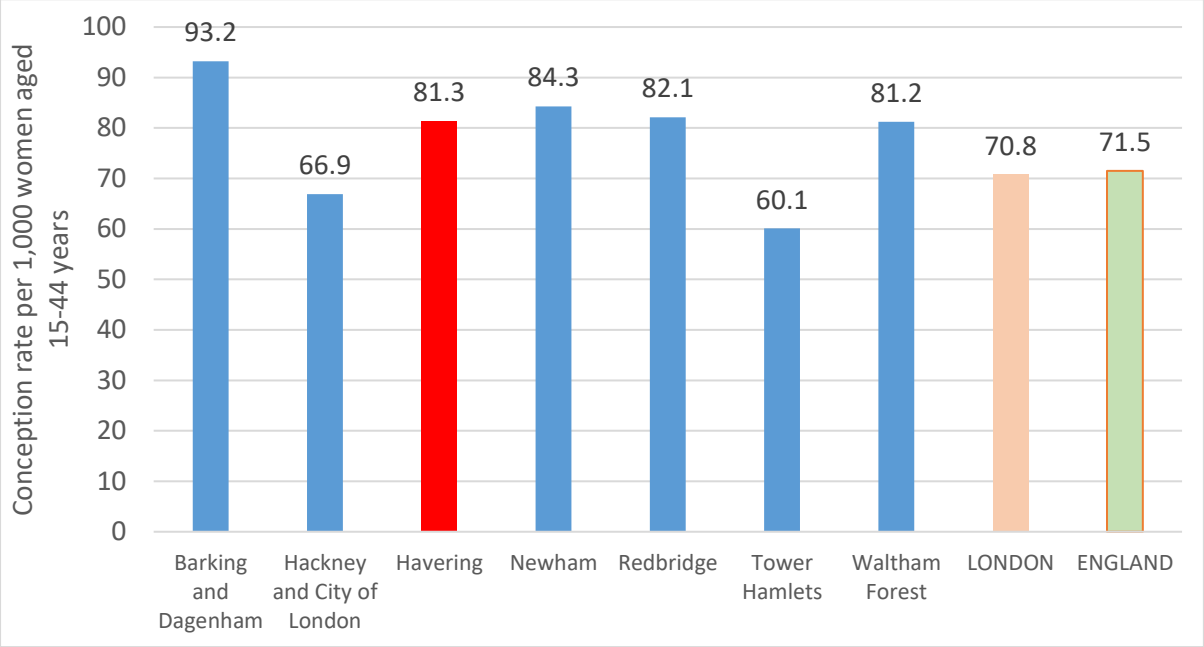
Havering's conception rates in 2021 (81.3 per 1,000) remained above both London (70.8 per 1,000) and England (71.5 per 1,000) rates (Fig. 4.6)[65]. Compared to other North East London boroughs, in 2021 Havering had a lower conception rate (81.3 per 1,000) than Barking and Dagenham (93.2 per 1,000), but higher than Tower Hamlets (60.1 per 1,000) (Fig.4.7). When compared with Havering's statistically similar neighbours in London according to demographic and deprivation profile, it had a higher conception rate than both Bexley (79.5 per 1,000) and Barnet in 2021 (72.5 per 1,000)[66].

Figure 4.6 Conception Rates for North East London Boroughs 2010 to 2021, rate per 1,000 women aged 15-44 years (including linear trend line for Havering)



[65] ONS (2022) Conceptions in England and Wales - Office for National Statistics
[66] ONS (2023) Conceptions in England and Wales - Office for National Statistics

Figure 4.7 Conception rates in females aged 15 to 44 years in Havering compared to NEL Boroughs, London and England, 2021

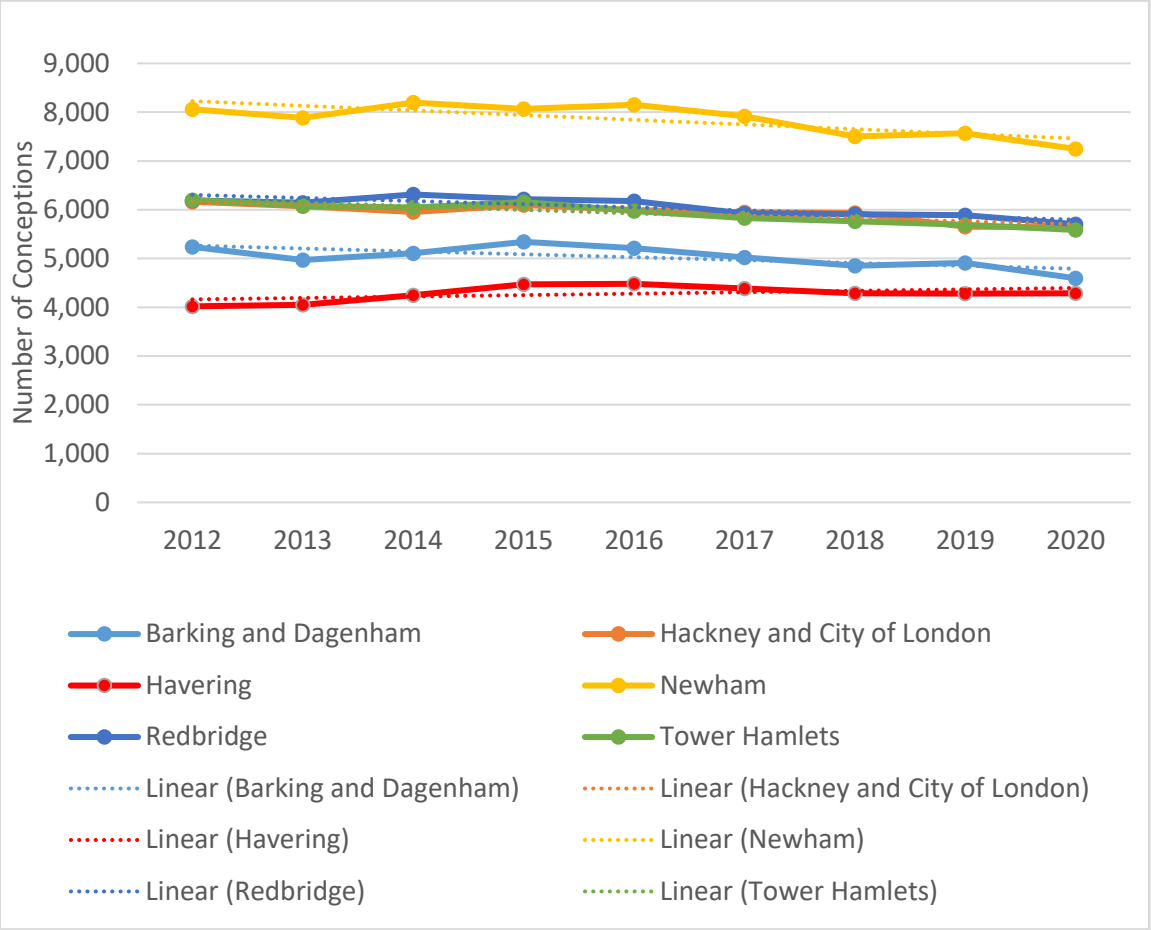


This trend in declining conception rates may be explained by more widespread use of, better access to, and development of more effective forms of contraception, including long acting reversible contraception (LARC). Use of contraception is further discussed in Section 6: Contraception.

However, unlike the other North East London boroughs, the actual number of conceptions has been increasing (Figure 4.8)[67]. This may be due to high levels of population growth in the borough; since 2011, the population size in Havering has increased by 10.4%, higher than the overall increase for England (6.6%) and for London (7.7%)[68].

[67] ONS (2022) Conceptions in England and Wales - Office for National Statistics
[68] ONS (2022) Havering population change, Census 2021 – ONS

Figure 4.8 Number of conceptions in Havering compared to other NEL boroughs, 2012 to 2020



The largest rise in Havering is amongst the 30-34 year old population (33% increase) and 35 to 39 year olds (30%) (Fig. 4.9), who are also the most likely to conceive (refer to Figure 4.2)[69]. However, for women aged over 30, the risks of miscarriage, birth defects, multiple births, high blood pressure, gestational diabetes and difficult labour are also increased[70].

Figure 4.9 Population change (%) by age group in Havering 2011 to 2021, compared to neighbouring boroughs and England

Age (years)	Havering	Barking and Dagenham	Redbridge	Newham	England
15 to 19	-6%	+20%	+8%	+8%	-4%
20 to 24	-6%	+1%	+1%	-13%	-5%
25 to 29	+15%	+2%	-9%	-11%	+2%
30 to 34	+33%	+19%	+4%	+15%	+13%
35 to 39	+30%	+28%	+27%	+38%	+7%
40 to 44	+2%	+25%	+26%	+29%	-8%

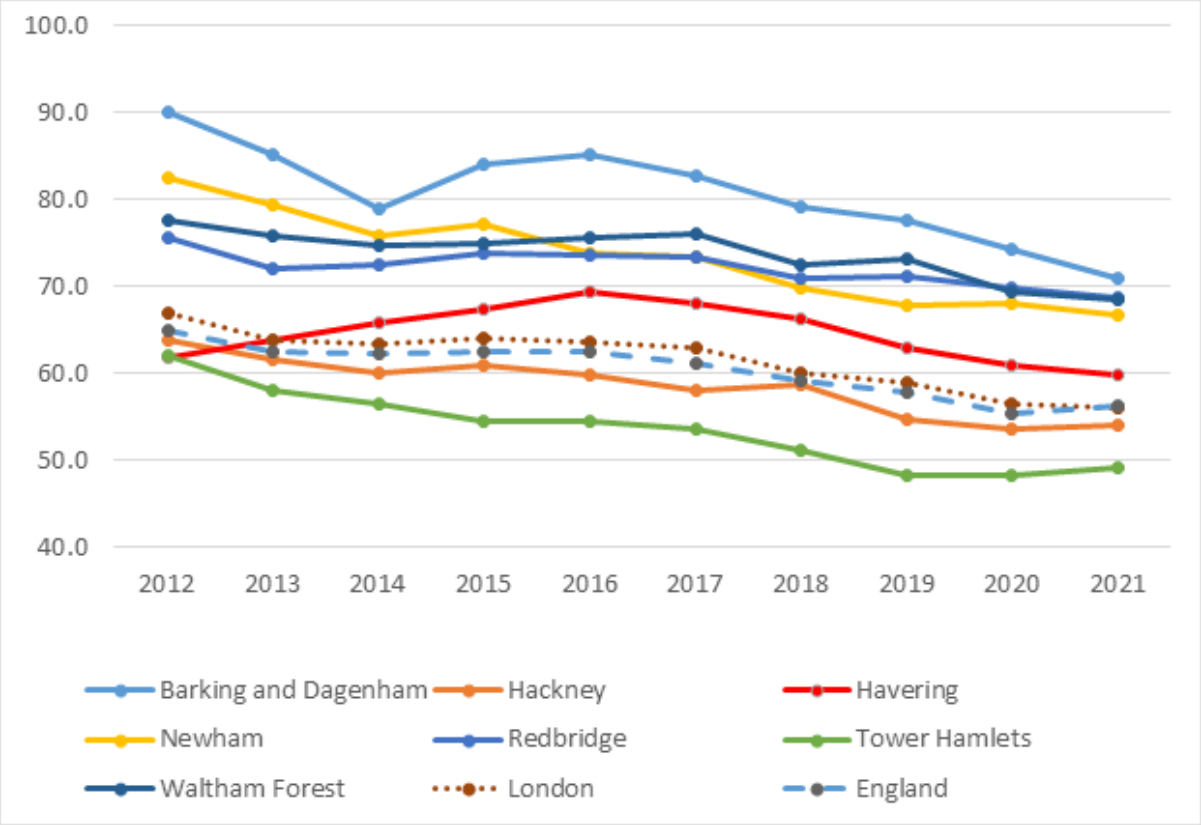
[69] ONS (2022) Havering population change, Census 2021 – ONS
[70] Risks of Pregnancy Over Age 30 - Health Encyclopedia - University of Rochester Medical Center

4.3.2 Maternity, Live Births and Stillbirth rates in Havering

The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15-44 years. Since 2012, the GFR has been reducing in London, England and across all North East London boroughs (Figure 4.14)[71].

Havering's General Fertility Rate (GFR, 2021) was also higher (58.5 per 1,000) than London (52.9 per 1,000) and England (54.3 per 1,000); Havering has the 8th highest GFR out of the London boroughs[72].

Figure 4.14 General Fertility Rate for North East London Boroughs, 2012 to 2021



There were 3,089 live births in 2022 in Havering[73], which equates to a crude birth rate of 11.7 per 1,000 population of all ages.

In 2021, Havering had the 7th highest rate of multiple births (17.2 per 1,000) in London (14.6) and was higher than England (13.7 per 1,000).

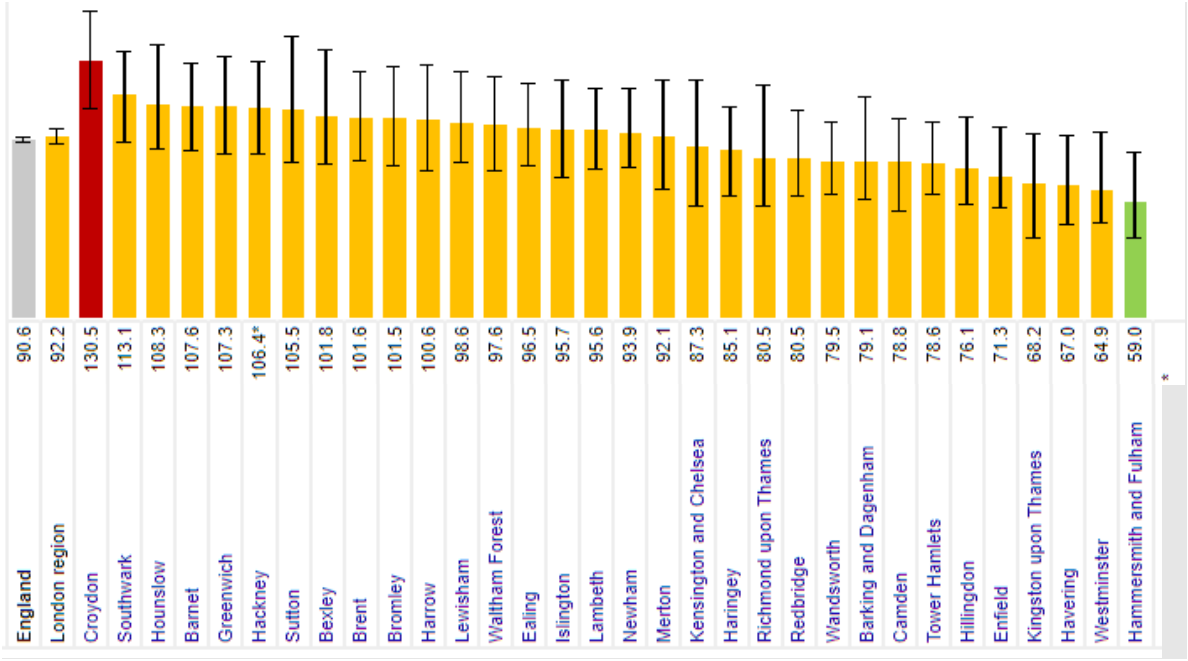
57% of babies born in 2020-2021 in Havering were from women whose ethnicities were other than White British or White other 18% of babies were from mothers of Asian ethnicity (Bangladeshi, Indian, Pakistani or any other Asian group), 8.7% from Black (African/Caribbean/Other) and 8.0% from Mixed/multiple ethnic groups. In 2022, 40.4% of all live births were to mothers who were not born in the UK; this is lower than London (58.0%) and higher than England (31.1%).

[71] ONS (2022) Births and Fertility Rates, Borough - London Datastore
[72] Public health profiles - OHID (phe.org.uk)
[73] ONS 2022 Live Birth Data by Local Authority

Compared to the proportion of all ethnic groups in Havering, more women from global majority groups had babies in 2021/22 than the relative proportion of people from white ethnicities.

In 2021-22, Havering had a low rate of ectopic pregnancies compared to other London boroughs (67.0 per 100,000), and was statistically similar to the rate for London (92.2 per 100,000) and England (90.6 per 100,000) (Fig. 4.15).

Figure 4.15 Ectopic Pregnancy Admissions Rate per 100,000, 2021/22 for Havering compared to London Boroughs and England



It is not possible to prevent ectopic pregnancy but there are a number of ways that women can reduce their risk including stopping smoking, limiting the number of sexual partners to reduce the risk of sexually transmitted infections and pelvic inflammatory disease:

- 4.8% of pregnant mothers were recorded as smoking at the time of delivery (SATOD) in Havering in 2022-23; this is significantly better than the rate for England (8.8%) and similar to rates in London (4.6%)[74].
- In 2018/19, 9.5% of mothers smoked in early pregnancy in Havering; this is significantly better than the rate for London (12/8%) and England (29.1%)[75].
- Havering's rate of Pelvic Inflammatory Disease (PID) in 2021-22 was 181.8 per 100,000, similar to London (196.8 per 100,000) and England (224.4 per 100,000)[76].

4.3.3 Abortion rates in Havering

Figure 4.10 shows the key abortions data in Havering benchmarked against England, whilst Figure 4.11 is benchmarked against all in London; note that this data from OHID Fingertips is for 2020 only.

[74] Child and Maternal Health - Data - OHID (phe.org.uk)
[75] Public health profiles - OHID (phe.org.uk)
[76] Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

Figure 4.10 Key indicators for conception and abortion in Havering benchmarked against England, 2020

Indicator	Period	Havering			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Under 18s conceptions leading to abortion (%)	2020	→	44	63.8%	63.2%	53.0%	24.3%		82.9%
Under 25s repeat abortions (%)	2020	→	129	30.8%	32.3%	29.2%	38.6%		0.0%
Total abortion rate / 1000	2020	↑	1,265	24.7	21.5	18.9	31.1		9.5
Abortions under 10 weeks (%)	2020	↑	1,123	89.3%	88.5%	88.1%	79.9%		100%
Under 18s abortions rate / 1,000	2020	→	40	9.0	6.2	6.7	1.9		16.7
Under 25s abortion after a birth (%)	2020	→	98	23.4%	20.0%	27.1%	48.4%		9.6%
Over 25s abortion rate / 1000	2020	↑	846	22.7	20.1	17.6	29.7		10.2
Abortions under 10 weeks that are medical (%)	2020	↑	1,013	90.2%	90.7%	93.1%	69.4%		99.6%

Figure 4.11 Key indicators for conception and abortion in Havering benchmarked against England, 2020

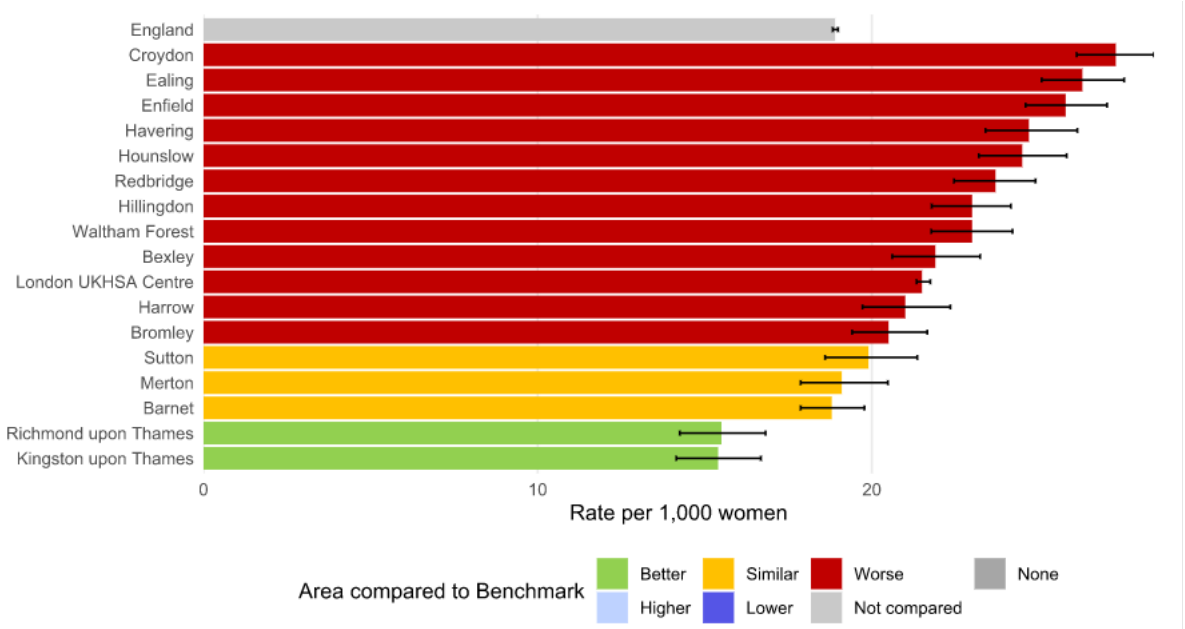
Indicator	Period	Havering			Region England	London	London		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Under 18s conceptions leading to abortion (%)	2020	→	44	63.8%	63.2%	53.0%	45.2%		80.6%
Under 25s repeat abortions (%)	2020	→	129	30.8%	32.3%	29.2%	38.6%		0.0%
Total abortion rate / 1000	2020	↑	1,265	24.7	21.5	18.9	31.0		9.5
Abortions under 10 weeks (%)	2020	↑	1,123	89.3%	88.5%	88.1%	86.4%		100%
Under 18s abortions rate / 1,000	2020	→	40	9.0	6.2	6.7	1.9		9.3
Under 25s abortion after a birth (%)	2020	→	98	23.4%	20.0%	27.1%	31.3%		9.6%
Over 25s abortion rate / 1000	2020	↑	846	22.7	20.1	17.6	29.7		12.8
Abortions under 10 weeks that are medical (%)	2020	↑	1,013	90.2%	90.7%	93.1%	86.5%		93.6%

There were 1,208 abortions in Havering in 2021, which equates to a rate of 23.3 per 1,000 women aged 15-44 years[77]. This rate is higher than both England (18.6 per 1,000) and London (20.3 per 1,000). The highest rate of abortions in London was in Barking and Dagenham at 29.4 per 1,000, and the lowest in Camden, at 12.4 per 1,000. Across London, 16 similar local authorities' abortion rates per 1,000 women were compared against England and ranked; Havering was 4th highest out of these 16 local authorities (Figure 4.12).

Rates of abortion in women aged under 25 years following a birth were higher in Havering (23.4%) than London (20.0%), but lower than England averages (27.1%). Amongst women aged under 25 years who had an abortion, 30.8% had previously had an abortion (under 25 repeat abortions); this was higher in Havering than England (29.2%) but lower than London (32.3%).

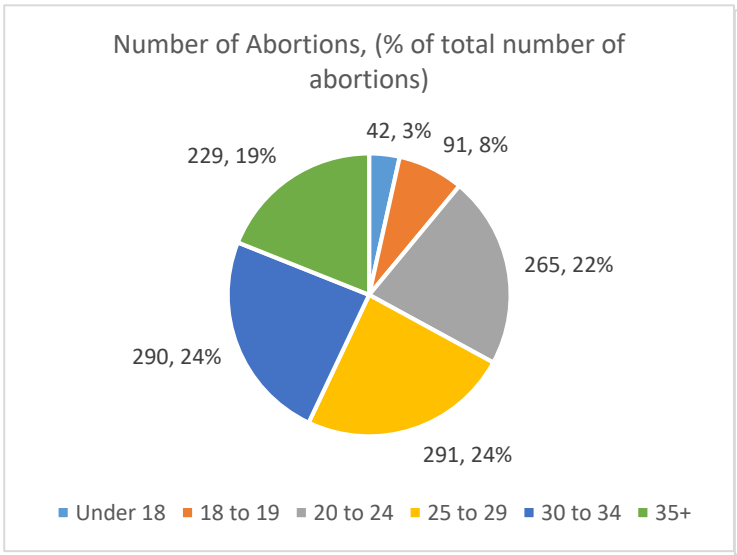
[77] Gov.uk (2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1125274/Abortion_Statistics_2021_data_tables_revision.ods

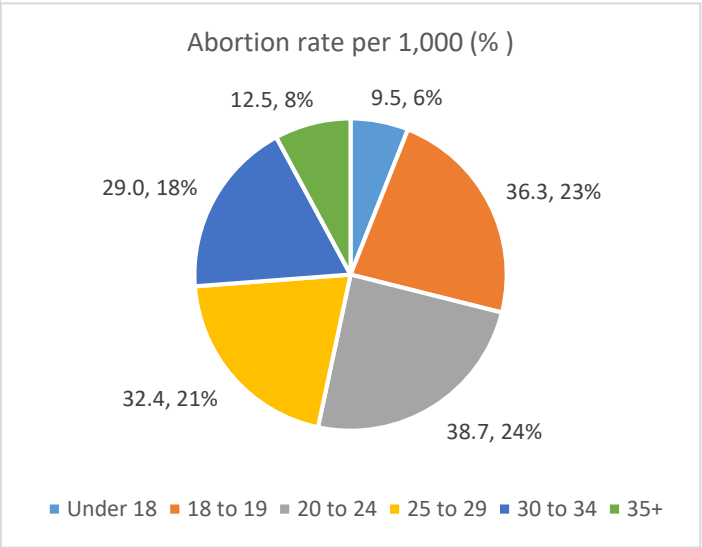
Figure 4.12 Abortion rate per 1,000 women in 16 similar local authorities and London UKHSA Centre, compared to England, 2020



Within Havering, in 2021 there was a similar number of abortions amongst women aged 25-29 and 30-34 years: 24% of total abortions (Figure 4.13)[78]. However the rate of abortions per 1,000 women was lowest in those under 18 years (9.5 per 1,000) and highest amongst 20 to 24 year olds (38.7 per 1,000). This may be reflective of unplanned or unintended pregnancies amongst these younger age groups. It suggests that access to effective contraception is important for this age group.

Figure 4.13 Relative proportions of absolute number and rate of abortions in Havering by age group, 2021





[78] Gov.uk (2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1125274/Abortion_Statistics_2021_data_tables_revision.ods

In Havering, the majority of abortions are completed through early medical abortion. The percentage of those under 10 weeks gestation that were performed using a medical procedure in 2020 was 90.2%, lower than the percentage in England of 93.1%, but has increased since 2019.

It has been recommended that women are offered a choice of contraception following abortions and after giving birth in order to prevent unplanned pregnancies.

Rates of repeat abortion and abortion after birth is available for those aged under 25 years old in Havering. These rates are similar to the England average but higher than similar local authorities. This is especially the case for abortions after birth in under 25 year olds where the Havering is ranked as having the 5th highest rate for this indicator when compared to other similar local authorities. The initiation of contraception after birth in those aged under and over 25 years old should be encouraged in healthcare settings and community settings in Havering.

4.3.4 Higher risk groups for unplanned pregnancies and the extent and impact of need

Most unplanned pregnancies lead to positive outcomes for both women and children when pregnancies go to full-term, however some unplanned pregnancies can have adverse impacts including[79]:

- Impact on women - obstetric complications, delayed antenatal care and perinatal mental health concerns
- Impact on children – lower birthweight, poor mental and physical health and poorer outcomes in cognitive tests

There are multiple risk factors for unplanned pregnancies and abortion which can contribute to inequalities in health outcomes for residents in Havering, some of which are highlighted in Figure 4.16.

Figure 4.16 Summary of key risk factors for unplanned pregnancies and abortion and application in Havering

Women over 35 years old and younger women

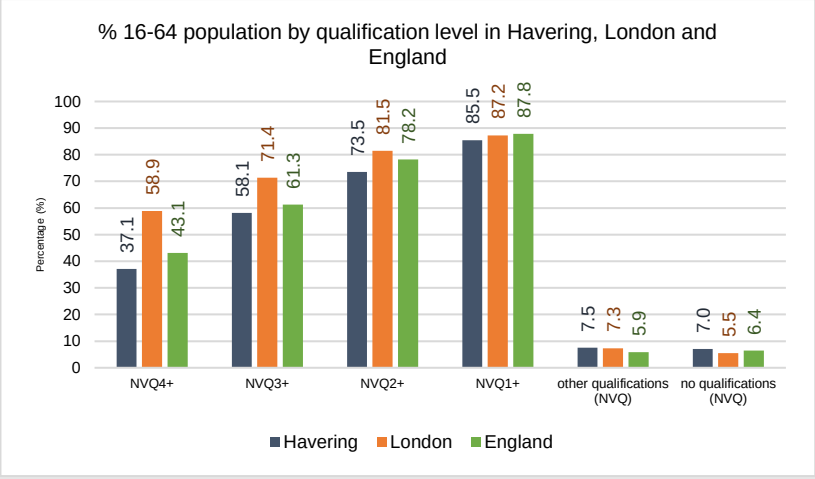
This group are the least likely to be using adequate contraception, despite being sexually active and not wanting to conceive. Rising rates of abortion in this age group support this finding. Most of the women living in Havering are aged over 30 years old, with a slightly higher proportion of those aged 30-39 years compared to England (see table below).

Younger women are also at risk of unplanned pregnancies, rates of teenage pregnancy in Havering is an area of concern (see Section 5: Teenage pregnancy, for more information).

Low educational attainment

Research has found that lower educational attainment (having no qualifications beyond those associated with minimum school-leaving age) was strongly associated with unplanned pregnancy. Residents in Havering have predominantly at least NVQ Level 2 equivalent level of education, but lower levels of higher education compared to London and England.

[79] PHE (2018) Health matters: reproductive health and pregnancy planning - GOV.UK (www.gov.uk)



NVQ Level 1 equivalent – 3-4 GCSE grades 1 - 3 (D-G)

NVQ Level 2 equivalent – 4-5 GCSE grades 4 - 9 (A*-C)

NVQ Level 3 equivalent – 2 A Levels

NVQ Level 4 equivalent – Higher Education Certificate/BTEC

B.A.M.E groups

Abortion rates are higher amongst some BAME groups, which may indicate either higher rates of total unplanned pregnancies or greater proportions that culminate in abortion[80]. Whilst Havering has a predominantly White population, the borough is expected to become more ethnically diverse over the coming years. The changing population needs to be considered when reviewing the impacts of risk factors on the local population

Substance misuse

Evidence suggests that people that misuse substances may be more likely to engage in behaviours that increase their risk of unplanned pregnancy. Havering has the highest number of hospital admissions due to substance misuse (in 15-24 years) in London for period 2018/19 – 20/21 with 117.4 per 100,000 admissions.

4.3.5 Complications associated with pregnancies – high risk groups

Some risk factors are inherently associated with increased risk of having adverse pregnancy outcomes regardless if the pregnancy is planned or unplanned. It is important that these risk factors are considered when professionals engage with residents in Havering about conception, abortion and maternity, and explore approaches to mitigate such health inequalities.

i) Teenage Pregnancy

The children of teenage mothers are associated with higher risk of low birth weight, complications in mother's pregnancy and delivery, perinatal death, lower IQ and academic achievement, greater risk of having a fatal accident before age of 1 year and a greater

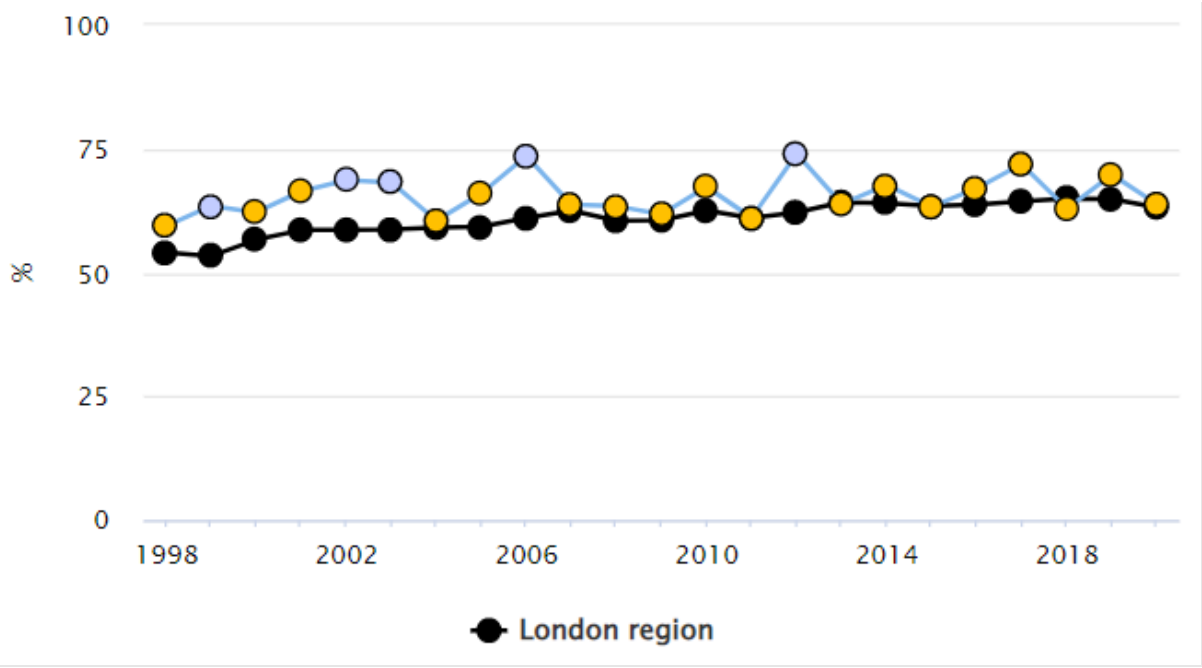
[80] Health matters: reproductive health and pregnancy planning - GOV.UK (www.gov.uk)

likelihood of being a teen parent themselves (refer to Section 5: Teenage Pregnancy, for information about adverse impacts)[81].

Pregnant teens themselves have a higher risk of pregnancy induced hypertension (high blood pressure), premature labour, higher risk of post-partum depression and are less likely to seek prenatal care.

Although under 18 and under 16 years conception rates are reducing, Havering still has a higher rate of both under 18 (15.5 per 1,000) and under 16 (2.6 per 1,000) conceptions than both London and England (this is expanded further in Section 5: Teenage pregnancy). Despite this reduction in teenage pregnancy rates, the rate in under 18s conceptions leading to abortion continues to increase (Figure 4.17).

Figure 4.17 Trend in under 18's conception rate leading to abortion (%) in Havering compared to all in London region 1998 to 2020



ii) Deprivation

Lower level occupation/social class is associated with a significantly increased risk of stillbirth, neonatal mortality, perinatal mortality, preterm birth and low birth weight by approximately 40%[82].

In 2021, there were a total of 421 stillbirths across the whole of London, a rate of 4.3 per 1,000 live births and stillbirths, which would be an estimated 13 stillbirths in Havering[83].

[81] NICE & Pilgrim, H. et al (2010) Systematic review of the long term outcomes associated with teenage pregnancy in the UK. contraceptive-services-for-socially-disadvantaged-young-people-additional-consultation-on-the-evidence-review-of-teenage-pregnancy-outcomes2 (nice.org.uk) ScHARR

[82] Thomson, K. et al (2021) Socioeconomic inequalities and adverse pregnancy outcomes in the UK and Republic of Ireland: a systematic review and meta-analysis | BMJ Open

[83] ONS (2023) Births in England and Wales: summary tables - Office for National Statistics (ons.gov.uk)

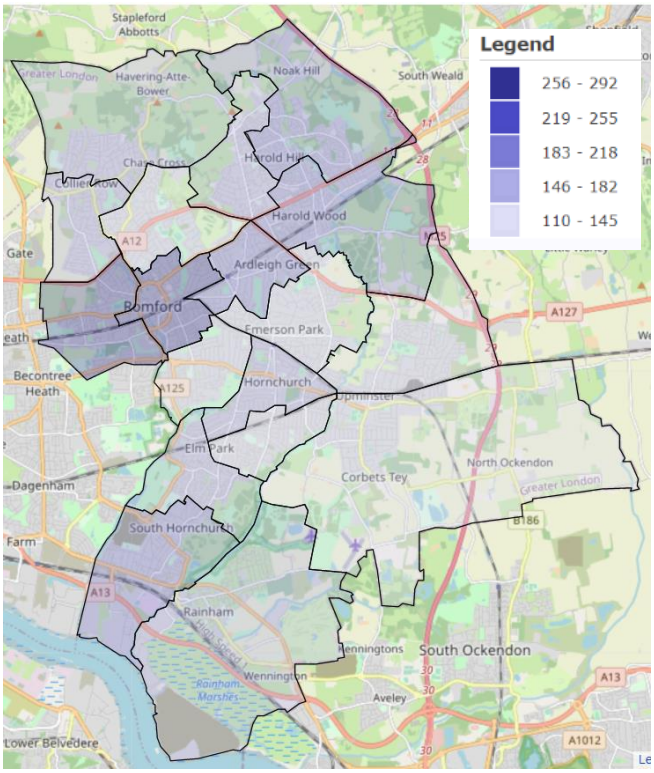
In the pooled period 2019-2021, Havering had the second lowest rate of neonatal mortality and stillbirth (3.52 per 1,000) in London, with only Westminster better (2.54 per 1,000).

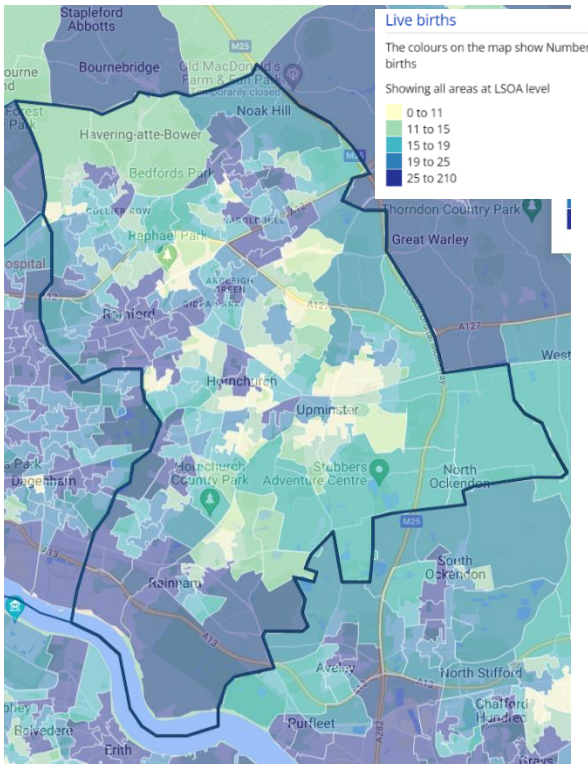
3.0% of babies born in Havering in 2021 were low birth weight; this means they had a recorded birth weight of under 2,500g and a gestational age of at least 37 weeks. This is similar to London (3.3%) and England (2.8%). 0.6% of babies born in 2021 were very low birth weight, <1,500g[84] in Havering, this is better than London (1.1%) and England (1.0%).

Women living in more deprived areas are around twice as likely to have abortions than women living in less deprived areas. In Havering, in 2021, there were higher numbers of births in areas of greater deprivation. Figure 4.18 shows the wards where there are higher numbers of live births, and also by Lower Super Output Area (LSOA). The LSOA map corresponds strongly to high numbers of live births with areas of higher deprivation.

Figure 4.18 Live Births by ward and by LSOA in Havering, 2021

Data Source: ONS[85]





[84] Public health profiles - OHID (phe.org.uk)

[85] ONS (2021) Live Births in England and Wales for Small Geographic Areas 2021

iii) Ethnicity

People from global majority ethnicities (formerly described as Black and Minority Ethnic) women may be disproportionately impacted by pregnancy complications, with estimated 12% of all stillbirths, 1% of preterm births, and 17% of births with fetal growth restriction attributed to ethnic inequality[86].

Across NEL in 2021, there were 90 stillbirths in 2020/21. The rate of babies born stillbirth was higher for babies born to Black women (3.8 per 1000) and Asian women (4 per 1000) compared to the rate for those both to White women (2.6 per 1000). This compares with the national average of 3.8 per 1000 babies[87]. In addition, on average at NEL level, Asian and Black ethnicities had the highest percentage of babies admitted to neonatal care (27% for both), compared with 22% for babies born to White women.

4.3 Implications of COVID-19

Research suggests that the COVID-19 pandemic may have impacted sexual behaviour through the enforcement of national lockdowns and consequently potentially impact conception rates[88]. National data for 2020, has shown different conception rates across different age groups as described above, this provides some indications about the impacts of the pandemic in different populations[89]. Whilst the local data for conception rates in Havering is limited, it is expected that similar impacts may also be seen in the borough. In addition to impacts on sexual behaviour, the COVID-19 pandemic impacted access to contraception and changes in the abortion policy.

4.3.1 Reduced access to contraception and sexual health services

The COVID-19 pandemic impacted LARC fitting and removements due to the requirements for face-to-face interactions[90] [91]. Sexual health services also revised the way they operated by providing remote appointments instead of face-to-face appointments to reduce the transmission of COVID-19[92]. Reducing access to sexual health services may also reduce opportunities for residents to access accurate advice and information about conception, abortion and maternity. NICE guidance recommends that professionals should provide information about the various aspects of abortion including contraception following the procedure. Seeking information for areas such as abortion from other sources may lead to misinformation which can cause unnecessary distress. More information about local impact of the COVID-19 pandemic on access to contraception can be found in Section 6: Contraception.

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[86] Jardine, J. et al (2021) Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study - The Lancet

[87] PowerPoint Presentation (northeastlondonhcp.nhs.uk)

[88] Masoudi, M. Maasoumi, R. & Bragazzi, N.L. (2022)Effects of the COVID-19 pandemic on sexual functioning and activity: a systematic review and meta-analysis | BMC Public Health | Full Text (biomedcentral.com)

[89] ONS (2022) Conceptions in England and Wales - Office for National Statistics

[90] BASHH (2021) BASHH COVID-19 Clinical Thermometer Survey - First Round Results Snapshot .pdf

[91] BASHH (2020) FSRH COVID-19 SRH Service Survey - interim results 07 May 2020 - Faculty of Sexual and Reproductive Healthcare

[92] Dema, E. et al (2022) Initial impacts of the COVID-19 pandemic on sexual and reproductive health service use and unmet need in Britain: findings from a quasi-representative survey (Natsal-COVID) (thelancet.com)

4.3.2 Changes in abortion policy

During the COVID-19 pandemic the UK government enforced a temporary approval in England for EMA at home to ensure continued access to abortion services and reduce the transmission of COVID-19. This enabled women to take both pills for EMA up to 10 weeks (9 weeks and 6 days) gestation at home without the need for any face-to-face consultations. These changes were made permanent in November 2022[93] [94].

Nonetheless, changes in contraception use in Havering between 2019 and 2020 may have contributed to increased abortions. This may be demonstrated by the reductions in LARC uptake and increases in short-acting and user-dependent contraception which are less effective at preventing pregnancy. More data is needed to explore this further.

4.4 Current service provision, unmet needs & gaps in service provision

4.4.1 Conception/Fertility Services

Infertility is a recognised medical condition which can have a real impact on individuals' mental health. Failure to address infertility and commission appropriate treatments can lead to a significant economic burden on the health sector. Infertility affects 1 in 7 heterosexual couples in the UK. Commissioning fertility treatment can have positive economic effects because it:

- Reduces rates of mental health issues relating to infertility in couples, and the costs associated with this.
- Reduces the incidence of multiple births, which can be very costly to neonatal services and long-term health and social care services.
- Reduces reproductive tourism, where people travel abroad for fertility treatment, which often leads to health complications or multiple births absorbed by the NHS.
- Generates long-term financial gain, as the resultant child makes a significant contribution to the economy

In 2017, there were around 54,700 patients who sought fertility treatment in England. There were approximately 70,000 cycles of IVF treatment and around 5,500 cycles of donor insemination treatment. For IVF treatments, about 40% were funded by the NHS (compared to around 16% of DI treatments)[95].
The Integrated Care Board (ICB; formerly CCG) is responsible for commissioning fertility services, which are provided locally by the Fertility Unit at Queen's Hospital (BHRUT). The clinic is available for both NHS (via referral from a GP) and privately funded patients and offers counselling and support services. There are a number of additional private clinics who offer fertility support/infertility services, but no further clinics are located in Havering.

4.4.2 Abortion Services in Havering

Referral by a GP/other qualified doctor is required to get an abortion for free on the NHS. There are usually three stages to the referral process:

- First, the pregnancy is discussed with a GP or contraception clinic. The clinic/doctor can refer a woman to NHS abortion services where options are discussed. Young person's services are also available to anyone aged under 25 years, such as Brook.
- The next stage is an assessment appointment at the clinic or hospital where the abortion will be carried out. At this appointment, the doctor or nurse will explain the

[93] Gov.uk (2021) Home use of both pills for early medical abortion - GOV.UK (www.gov.uk)
[94] Gov.uk Research Briefing (2022) CBP-9496.pdf (parliament.uk)
[95] HFEA (2021) Commissioning guidance for fertility treatment (hfea.gov.uk)

different types of abortion and offer counselling and support to enable the person to make their decision.

- The third stage is an appointment to carry out the abortion at a hospital or clinic.

Alternatively, a woman can opt to go directly to an independent abortion provider such as bpas (the British Pregnancy Advisory Service) or Marie Stopes International (msichoices), which can provide abortions for free on the NHS, as well as privately funded abortions. The typical cost for an abortion is around £400, depending on the type of abortion and number of weeks gestation.

The available contraceptive clinics or genito-urinary medicine (GUM) clinics can be found by using the sexual health service search or on the FPA website. Young people can visit the Brook website to find their nearest Brook centre.

Service Details	Services offered	Opening Times
MSI Reproductive Choices Romford Community treatment Centre Tel: 0345 300 8090 St. Edwards Medical Centre 7 St Edwards Way Romford Greater London RM1 3AB 0.3 miles away	MSI Reproductive Choices is a leading reproductive healthcare provider with over 60 clinics throughout England. We have been providing NHS-funded and private abortion care and vasectomy services for more than 40 years. We offer medical abortion care (also known as abortion with pills) at our Romford Clinic. We also offer an abortion telemedicine service (also known as abortion pills at home or abortion pills by post)	Appointments available on Mondays, Tuesdays and Fridays (may vary). To visit our clinics, you will need to arrange an appointment with us - visit our website to find out how you can make an appointment.
Queen's Hospital Tel: 01708435000 Rom Valley Way Romford Essex RM7 0AG 0.6 miles away	Termination of pregnancy services (TOPS) Counselling	No information
MSI Reproductive Choices Dagenham Community treatment Centre Tel: 0345 300 8090 Broad Street Medical Centre Moreland Road Dagenham Greater London RM10 9HU 3.1 miles away	MSI Reproductive Choices is a leading reproductive healthcare provider with over 60 clinics throughout England. We have been providing NHS-funded and private abortion care and vasectomy services for more than 40 years. We offer medical abortion care (also known as abortion with pills), and vasectomy services for more than 40 years. We offer medical abortion care (also known as abortion with pills) at our Dagenham Clinic. We also offer an abortion telemedicine service (also known as abortion pills at home or abortion pills by post)	Appointments available Monday-Friday (may vary). Vasectomy appointments 1 Thursday per month (may vary). To visit our clinics, you will need to arrange an appointment with us - visit our website to find out how you can make an appointment.
Essex Unplanned Pregnancy Advisory Service Tel: 0333 004 6666 Marks Gate Health Centre Lawn Farm Grove Romford Greater London RM6 5LL	Offers treatment to both NHS and private patients, including: • Abortion information and consultation • Free pregnancy testing • Full contraception service • Free walk-in chlamydia testing for under 25s	For more information call the 24 hour helpline on 0333 004 6666.

1.8 miles away		
Tel: 020 8970 5724 417 Ilford Lane Ilford Greater London IG1 2SN 4.8 miles away	Advice about unplanned pregnancy offered as well as STI and contraception services.	Opening times are subject to change, please call 020 8970 5724 for up to date information.Monday to Friday 08:00-16:00

4.4.3 Maternity Services

Maternity services have a range of initiatives in place to help meet resident's needs and address inequalities in health outcomes for vulnerable/disadvantaged communities. This includes e.g. advocacy and support for pregnant women and pregnant people, personalized care and support plans, continuity of carer, maternal mental health services, and digital transformation.

It is acknowledged from NEL ICB reports that workforce pressures in the NHS have led Trusts to pause or scale back their plans to implement Continuity of Carer in maternity services. These fundamental workforce pressures will need to be resolved before consideration can be given to future workforce/caseload levels to meet demand.

4.5 Recommendations

Recommendations for Conception, Abortion and Maternity
Once current workforce pressures are resolved, Sexual and Reproductive Health and Maternity services are recommended to consider whether future staffing levels will be adequate to cope with increasing caseloads where numbers of conceptions are increasing due to population increases.
The increasing age of conception (now 30-34 years) presents a different range of risks, including miscarriage, birth defects, multiple births, high blood pressure, gestational diabetes and difficult labour. Maternity services are recommended to consider how their services may need to take into account these increased risks for older mothers.
Ensure that, as a health and social care system, robust information and advice relating to conception, abortion and maternity is provided in a timely manner, is culturally sensitive and available in a variety of formats and languages across different settings in Havering and across the NEL sector as a whole
Anyone who works in sexual and reproductive health care or is in a position to provide SRH advice (e.g. health and social care professionals, volunteers, teachers etc.) should be able to access appropriate training and be culturally competent to have informed discussions about conception, abortion and maternity. The NEL ICB system is recommended to develop a network to share existing or create new training opportunities.
Rates of abortion were highest amongst 20- to 24-year-olds in Havering; access to effective contraception is key to preventing pregnancy. It is recommended that a local strategy is developed to shift in method of contraception from user-dependent to Long Acting Reversible Contraception (LARC) (see also recommendations for contraception below).
To reduce rates of repeat abortions, women and people able to get pregnant should be offered advice on and access to contraception following an abortion; in the first instance it is recommended to target this to people aged under 25 years
Termination of a pregnancy through abortion can have various effects on women, varying from physical symptoms and impacts of mental health and thus follow-up support is important. It is recommended that decision-makers and commissioners of services undertake a review of the limited provision of specific follow-up support in Havering and consider co-production of a relevant service with current or potential future service users.

5.0 Teenage Pregnancy

5.1 Teenage Pregnancy as a Public Health Issue

Teenage pregnancy, also known as adolescent pregnancy, can have prominent impacts on young parents and their children across both life courses; these impacts can contribute to increased health inequalities. Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children[96].

Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. By age 30, an estimated 20% of teenage parents are likely to have no qualifications, and 22% to be living in poverty, be unemployed or living with a partner[97]. An estimated 1 in 5 young women aged 16 to 18 who are not in education, employment or training (NEET) are teenage mothers. Young fathers are also more likely to have poor education and have a greater risk of being unemployed in later life[98].

Babies of teenage mothers are 30% more likely to have a low birthweight. Infant mortality rates for babies born to teenage mothers are around 60-75% higher than for babies born to older mothers[99]. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child[100].

5.2 National context

5.2.1 National Prevalence Data

At an international-level, the UK's adolescent birth rate for women aged 15 to 19 years was 9th highest in 2019 compared to other European countries, at 10.9 per 1,000 (Figure 5.1)[101]. Eastern European countries had the highest rates in 2019, with Bulgaria having the highest at 39.3 per 1,000, whilst Western European countries had lower rates than the UK. Across other Western nations, the US and New Zealand both had rates higher than the UK (21.1 and 13.3 respectively), whilst Australia and Canada were lower.

Data for teenage pregnancy in the UK is presented as under-18 and under-16 conception rates.

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[96] PHE (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/836597/Teenage_Pregnancy_Prevention_Framework.pdf

[97] Department of Health (2013) *A Framework for Sexual Health Improvement in England* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

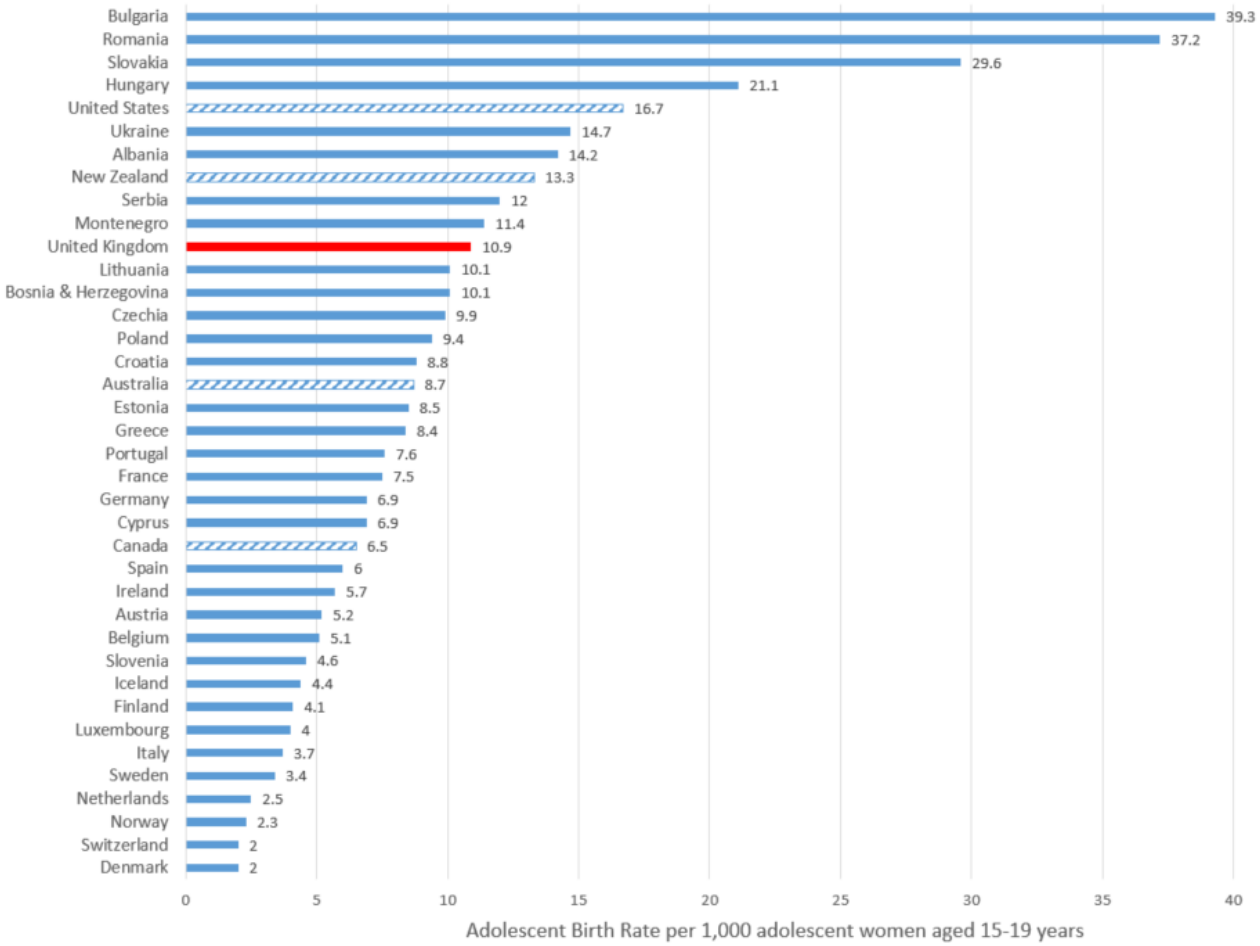
[98] LGA (2018) https://www.local.gov.uk/sites/default/files/documents/15.7%20Teenage%20pregnancy_09.pdf

[99] Nuffield Trust (2022) https://www.nuffieldtrust.org.uk/resource/teenage-pregnancy

[100] OHID (2022) https://fingertips.phe.org.uk/profile/health-profiles/data#page/6/gid/1938132701/ati/15/iid/20401/age/173/sex/2/cid/4/tbm/1/page-options/car-do-0

[101] Unicef data (2022). https://data.unicef.org/indicator-profile/MNCH_ABR/

Figure 5.1 Adolescent birth rate; number of live births to adolescent women aged 15-19 years per 1,000 women, by European Country and select Western nations (North America, Canada, Australia and New Zealand), 2019.



Over the last 30 years, the age of conception has risen, with those aged 30-34 years having the highest conception rate for 4 years consecutively between 2017 and 2020. The greatest increase has been amongst 35- to 39-year-olds. However, both under 16 and under 18 conceptions in England and Wales have declined, and both now groups now have the lowest proportion of conceptions compared to older age groups (Figure 5.2).

Following the introduction of the Teenage Pregnancy Strategy in 1999, the under-18 conceptions rates have successfully reduced from 44.8 per 1,000 to 13.0 per 1,000 by 2020 (Figure 5.3), a total reduction of around 72%. These rates have continued to fall in England and Wales such that in 2020 they fell by 17% from the previous year (15.8 per 1,000 women aged 15 to 17 years in 2019 to 13.1 conceptions per 1,000 in 2020)[102]. However, high rates of teenage pregnancy (under-18s conception rates) are still present within local areas in England with over a quarter of local authorities having an under-18s conception rate significantly higher than the England average and 60% have at least one high-rate ward[103].

In 2021, 0.83% of all live births in the UK were to parents where both the mother and father were under 20 years old[104]. The most common age for parents was where both the mother

[102] ONS (2022) Conceptions in England and Wales - Office for National Statistics
[103] ONS (2022) ; 2020 dataset Conceptions in England and Wales - Office for National Statistics
[104] ONS (2022) 2021 dataset

and father were aged 30 to 34 years (18.1%); 34.8% of live births were to mothers aged 30-34 years.

Figure 5.2 Conceptions per 1,000 women by age group, England and Wales, 1990 to 2020.

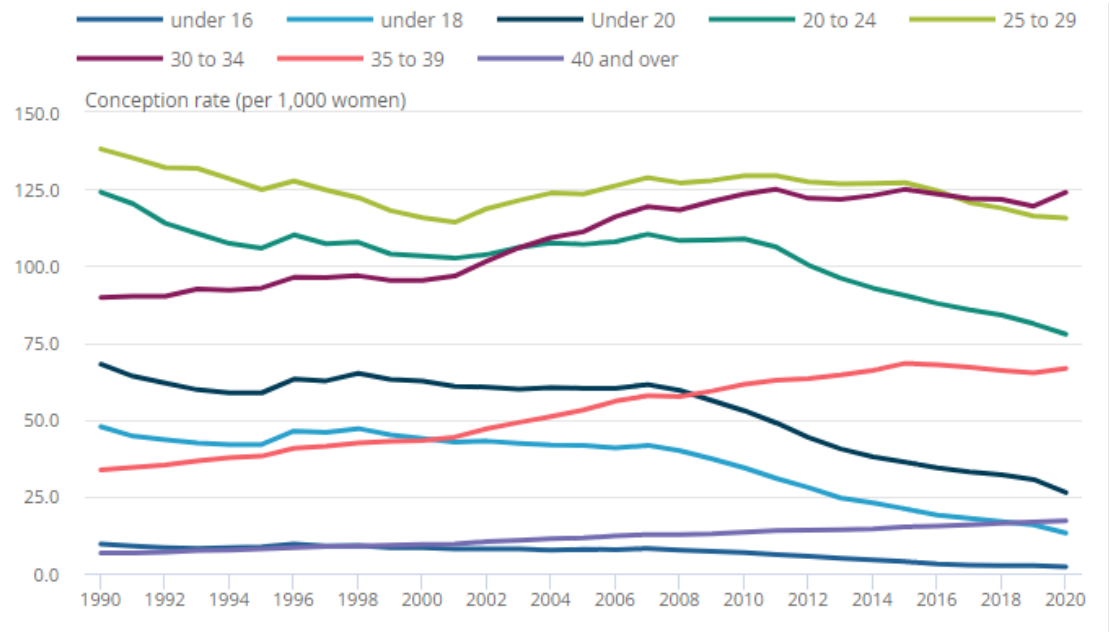
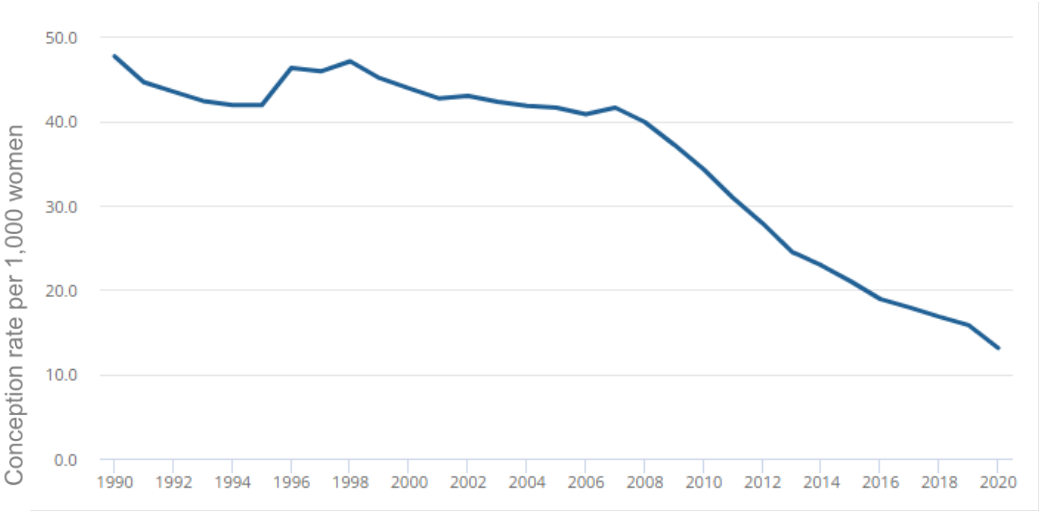


Figure 5.3 Under-18 conception rate per 1,000 women aged 15 to 17, England and Wales, 1990 to 2020



5.2.2. Higher Risk Groups

Key risk factors that increase the likelihood of teen pregnancy include[105]:

- living in poverty
- limited maternal educational achievement
- having a mother who gave birth before the age of 20
- being from a single-parent home
- living in a home with frequent family conflict
- early sexual activity
- early use of alcohol and drugs

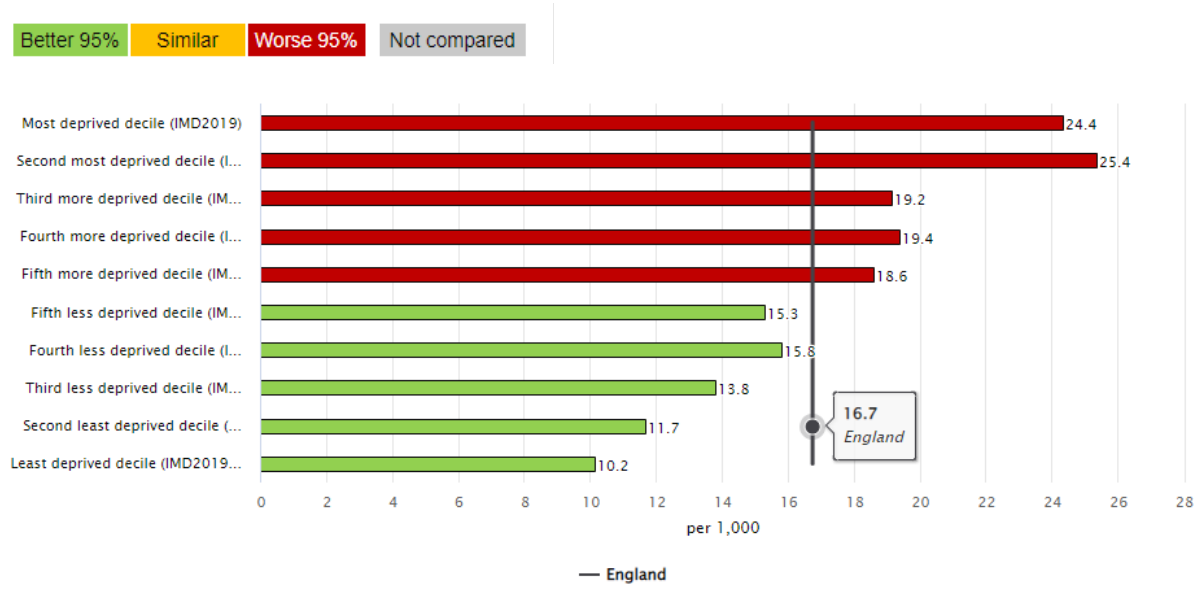
[105] Royal College of Paediatric and Child Health () https://stateofchildhealth.rcpch.ac.uk/evidence/health-behaviours/conceptions-in-young-people/

- low self-esteem
- race and ethnicity

i) Deprivation

Although the conception rate has fallen overall, the conception rates for women under 18 years living in deprived areas remain more than twice as high as those in more affluent areas[106]. In 2018, there were 24.4 and 25.4 conceptions per 1,000 women aged 15 to 17 years usually resident in the two most deprived areas of England respectively, whereas there were 10.2 conceptions per 1,000 women aged 15 to 17 years in the least deprived areas of England.

Figure 5.4 Conception rates for women under 18 years by deprivation decile, England, 2018.



ii) Ethnicity

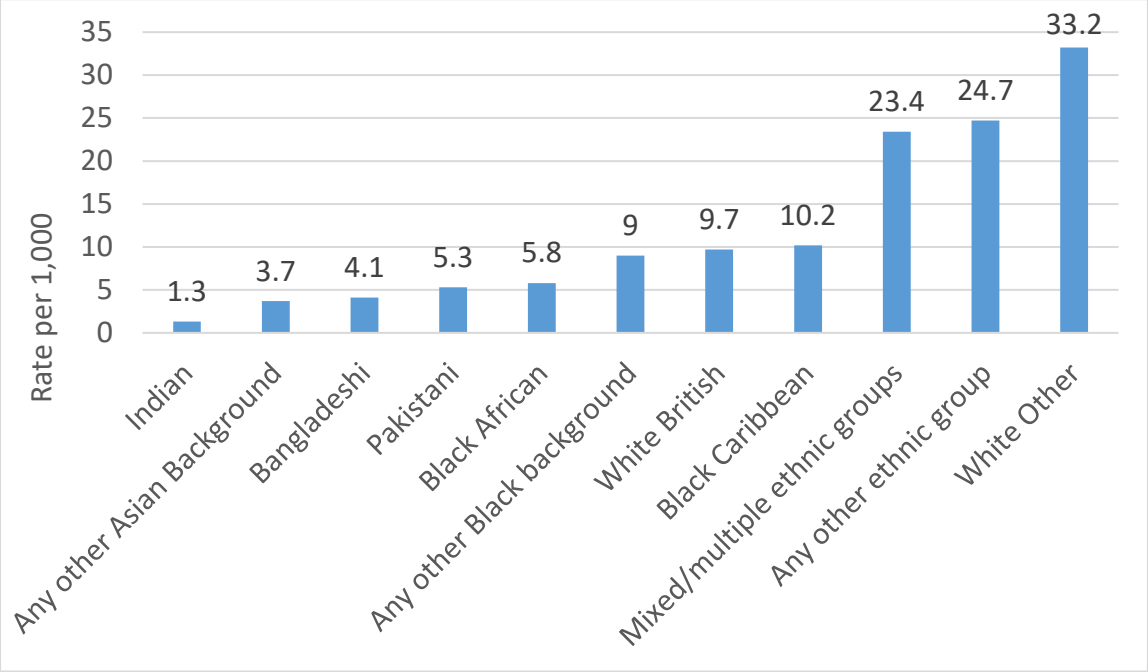
Historical analyses of birth rates by ethnic group showed that women of Black Caribbean, Pakistani and Bangladeshi women in the UK were more likely to have been teenage mothers than white women. Figure 5.5 below, taken from ONS data on population size and numbers of births by teenage women by ethnicity for 2020, estimates that disadvantaged ethnic groups are over-represented amongst teenage parents. White other (including Irish, Gypsy, Roma and traveler communities), minority ethnic groups (such as Somali, Arab), mixed or multiple ethnic backrounds and Black Caribbean women had higher rates of under 18 conceptions than White British and other ethnicities.

Such increases in rates generally correspond with higher levels of deprivation and inequality experienced by these groups. People in Bangladeshi, Pakistani and Black ethnic groups are the most likely to live in deprived neighbourhoods, have lowest unemployment rate, and twice as likely to experience child poverty[107].

[106] ONS (2019) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018#conceptions-by-index-of-multiple-deprivation

[107] Commission on Race and Ethnic Disparities (2001) https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities-supporting-research/ethnic-disparities-in-the-major-causes-of-mortality-and-their-risk-factors-by-dr-raghib-ali-et-al#fnref:2

Figure 5.5 Estimated teenage pregnancy rates in women aged 16 to 19 years old by ethnicity[108]



iii) Sexual Orientation

Despite a lack of national data, research evidence from the United States suggests that lesbian and bisexual young women are more likely to get pregnant than their heterosexual peers [109]. This may be explained partly by childhood maltreatment, bullying or social stigma for their sexual orientation. As with the inequalities experienced by people living in deprived areas, LGBTQ+ people experience disproportionately worse health outcomes than their heterosexual counterparts. There may also be structural or social barriers that need to be addressed to ensure all young people feel confident to access the care they need or choose, particularly sexual health services[110].

5.2.3 National Strategy & Policy

Reducing teenage pregnancy was highlighted as a priority within the Department of Health's *Framework for Sexual Health Improvement*[111] where it was recommended that:

- All young people receive appropriate information and education to enable them to make informed decisions
- All young people have access to the full range of contraceptive methods and where to access them

[108] Data based on ONS 2011 Census data for age (16 to 17 and 18 to 19 year old women combined) by ethnicity https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/populationbyethnicityageandsex and live births by ethnicity 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/adhocs/14198livebirthsbysexandethnicityofbabyandageofmotherin2020englandandwales

[109] Charlton et al (2018). Teen pregnancy risk factors among young women of diverse sexual orientations. *Pediatrics* 141, (4) e 20172278 https://publications.aap.org/pediatrics/article/141/4/e20172278/37722/Teen-Pregnancy-Risk-Factors-Among-Young-Women-of

[110] UKHSA (2021) https://ukhsa.blog.gov.uk/2021/07/09/understanding-disparities-in-reproductive-health

[111] Department of Health (2013). A Framework for Sexual Health Improvement in England (publishing.service.gov.uk)

Evidence suggests that the provision of high quality, comprehensive relationships and sex education (RSE) can positively impact teenage pregnancy rates. PHE's Teenage Pregnancy Prevention Framework[112] argued that supporting young people to develop safe, healthy relationships and prevent unplanned pregnancy is key to enabling them to fulfil their aspirations and potential. Getting prevention right:

- is integral to safeguarding, emotional health and wellbeing and early help
- integrates with Chlamydia screening and STI prevention
- maximises cost effectiveness of sexual and reproductive health services
- is key to giving every child the best start in life
- breaks inequalities
- helps address young people's alcohol and substance misuse
- reduces future demand on health and social services
- contributes to Public Health and NHS Outcomes

From September 2020, new UK legislation required all primary schools to provide relationships education, all secondary schools to provide relationships and sex education and both primary and secondary schools to provide health education, including puberty. This statutory guidance was published in June 2019 and stated that all secondary school pupils should be made aware about local services providing confidential sexual health and relationship advice and care[113].

5.3 Local context

5.3.1 Prevalence

The key indicators used to measure teenage pregnancy are: under 18s conception rate/1,000, under 18s birth rate/1,000, under 18s conceptions leading to abortion (reported as a percentage), under 18s abortion rate/1,000 and under 16s conception rate/1,000 (Figure 5.6).

Figure 5.6 Summary of Key Teenage Pregnancy Indicators for Havering compared to London and England, 2019/2020

Indicator	Year	Point estimate	Lower CI	Upper CI	England value	London value
Under 18 years conception rate/1,000	2021	12.5	9.4	16.1	13.1 (similar)	9.5 (similar)
Under 16 years conception rate/1,000	2021	1.7	0.7	3.4	2.1 (similar)	1.5 (similar)
Under 18s births rate/1,000	2021	2.6	1.4	4.6	3.2 (similar)	1.9 (similar)
Teenage mothers (Percentage of delivery episodes, where the mother is aged under 18 years)	2019/20	0.4	0.2	0.7	0.7 (similar)	0.4 (similar)

ǂ Out of 151 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names

[112] PHE (2018) Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)
[113] Department for Education (2019) Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk)

+ These are Havering and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers.

Over the past 20 years, the teenage pregnancy rates for females under 18 year (Figure 5.7) and under 16 years (Figure 5.8) have decreased in Havering, following the trend shown across London and England.

Figure 5.7 Trend in under 18's conception rate per 1,000 females aged 15-17 in Havering 1998 to 2020

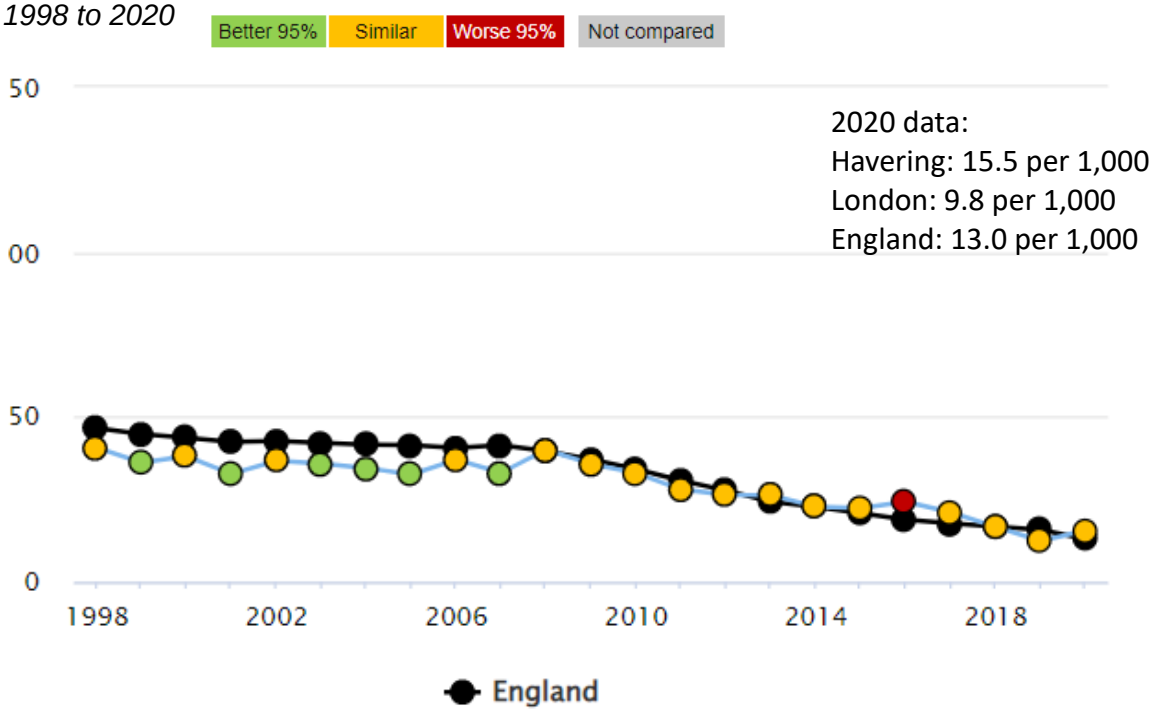
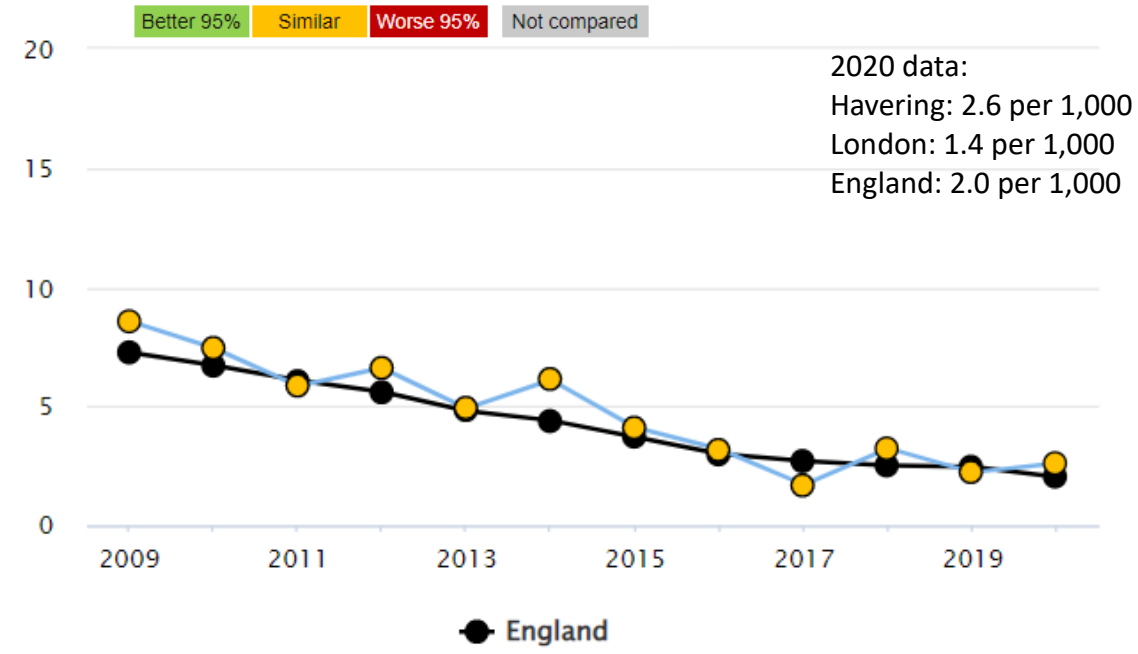


Figure 5.8 Trend in under 16's conception rate per 1,000 females in Havering 1998 to 2020



However, Havering has a higher rate of under 18s conception than England, and when compared to other local authorities in London, Havering has some of highest rates of

teenage conception. Havering ranks third out of the 33 London local authorities for under 18 years conception/1,000 (Figure 5.9 and Figure 5.10). Havering ranks second out of the 33 local authorities for under 16 years conception/1,000 (Figure 5.11). It is important that rates of conception in under 16 year olds and 18 years olds are reduced as teenage pregnancy can have adverse impacts across the life course. Learning from strategies implemented in similar local authorities may be useful in tackling these higher rates.

*Figure 5.9: Under-18s conception rates /1,000 in London local authorities benchmarked against **England**, 2020*

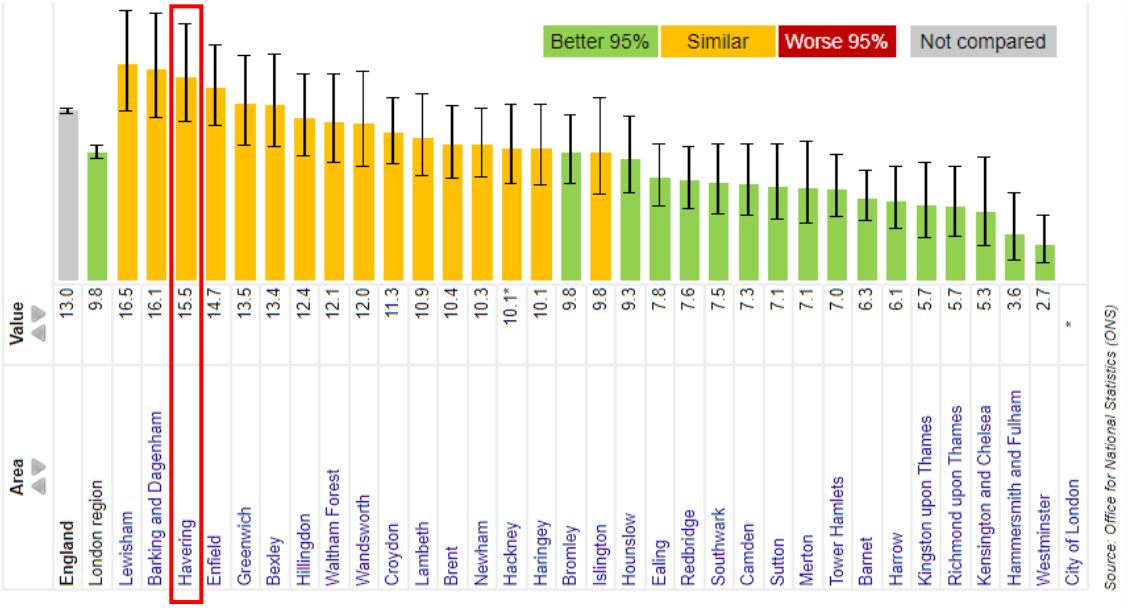
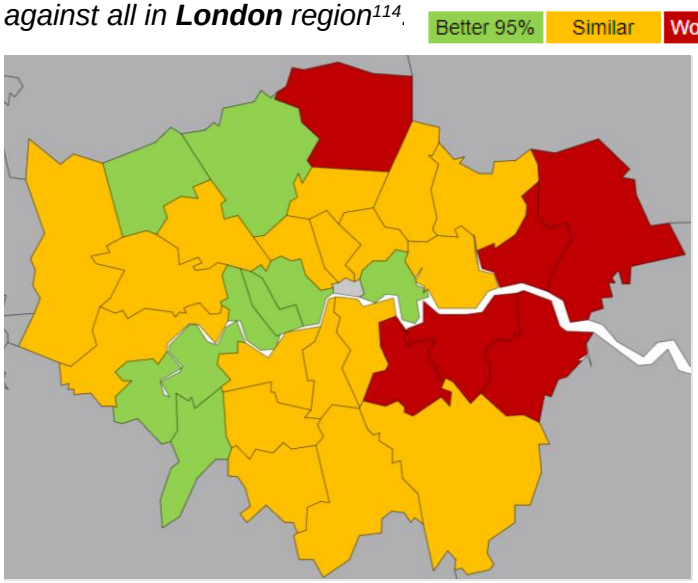


*Figure 5.10 Under 18 conception rate per 1,000 by London borough, 2020, benchmarked against all in **London** region*[114]



114 https://fingertips.phe.org.uk/profile/sexualhealth/data#page/8/gid/8000057/pat/6/par/E12000007/ati/402/are/E09000002/iid/20401/age/173/sex/2/cat/-1/ctp/-1/yrr/1/cid/1/tbm/1/page-options/map-ao-1

In 2021 in Havering, there were 57 known conceptions to women aged under 18 years[115] and 12 live births. The birth rate for under 18s was 2.6 per 1,000 women, similar to England (3.2 per 1,000) and London (1.9 per 1,000).

5.3.2 Risk Factors for Teenage Pregnancy

The current evidence-base indicates that there are wider determinants of health which increase the risk of teenage pregnancy. These have been summarised in Figure 5.11, which also demonstrates the complex and interconnected nature of teenage pregnancy[116]. Young people who have experienced a combination of these factors will be at significantly higher risk of teenage pregnancy[117]. The perceived overarching factor which contributes to rates of teenage pregnancy in Havering is *childhood vulnerability*. Public Health England states that "a child can be vulnerable to risks and poor outcomes because of individual characteristics; the impact of action or inaction by other people; and their physical and social environment"[118].

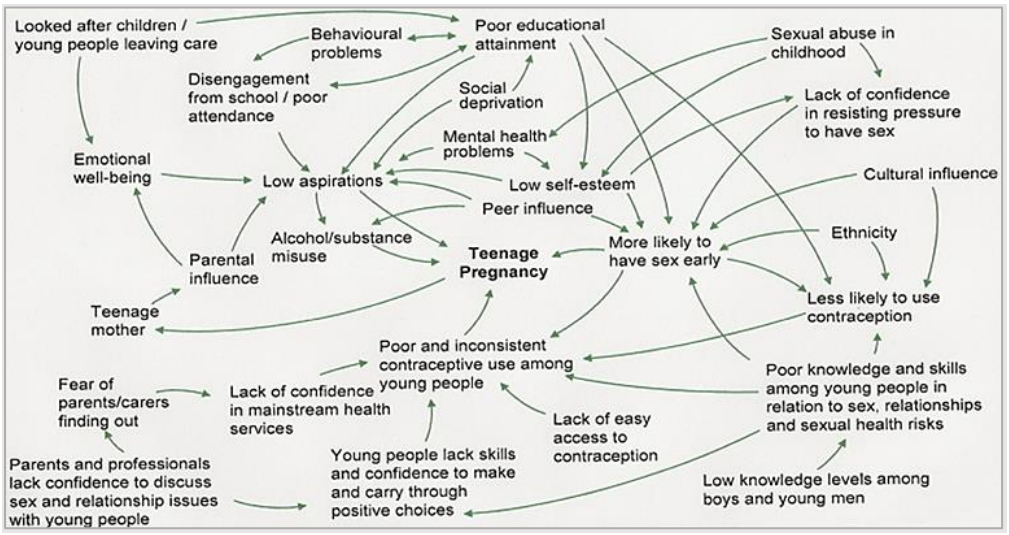
These can include factors such as:

- the child's physical, emotional, health and educational needs
- any harm the child has experienced or may be at risk of experiencing – these can include a specific set of childhood experiences known as 'adverse childhood experiences (ACEs)'
- the wider community and social conditions beyond the family including crime, the built environment, community cohesion and resilience.

In order, to prevent further health inequalities, it is crucial that these factors are tackled at the population-level and carefully considered when designing and delivering interventions for young people around sexual health, as outlined in the Teenage Pregnancy Prevention Framework[119].

[115] Office for National Statistics, 2021 Quarterly statistics on conceptions to women aged under 18 years
[116] Crawford, C. , Cribb, J. & Kelly, E. (2013) Teenage Pregnancy in England | Institute for Fiscal Studies (ifs.org.uk)
[117] Ford, K. et al (2016). 2016-05-adverse-childhood-experiences-in-hertfordshire-luton-and-northamptonshire.pdf (ljmu.ac.uk)
[118] PHE (2020) No child left behind: understanding and quantifying vulnerability (publishing.service.gov.uk)
[119] Gov.uk (2018) Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)

Figure 5.11 Wider determinants of health associated with teenage pregnancy

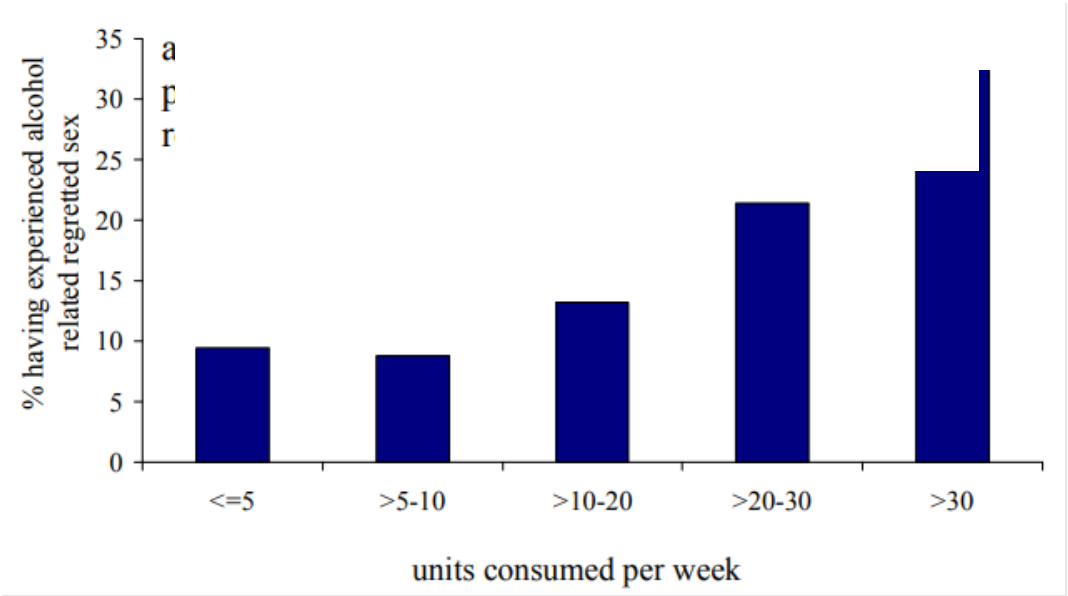


There are various specific factors which could be included in childhood vulnerability. The main factors of concern for Havering are:

i) Substance misuse

Substance misuse in teenagers is often associated with poor engagement with education and poor wellbeing, both of these are also risk factors for teenage pregnancy[120]. Evidence suggests that substance misuse in teenage girls is associated with teenage pregnancy[121]. For example in a survey of 9,833 children aged 15 and 16 years in the North West of England, there was a clear correlation between number of units of alcohol consumed per week and those who engaged in alcohol-related regretted sex (Figure 5.12)

Figure 5.12 Relationship between units of alcohol consumed per week and having ever experienced alcohol related regretted sex



[120] Phillips-Howard, P. (2010) Wellbeing, alcohol use and sexual activity in young teenagers: findings from a cross-sectional survey in school children in North West England | Substance Abuse Treatment, Prevention, and Policy | Full Text (biomedcentral.com)
[121] Bellis, M.. et al (2009) Contributions of alcohol use to teenage pregnancy (allcatsrgrey.org.uk)

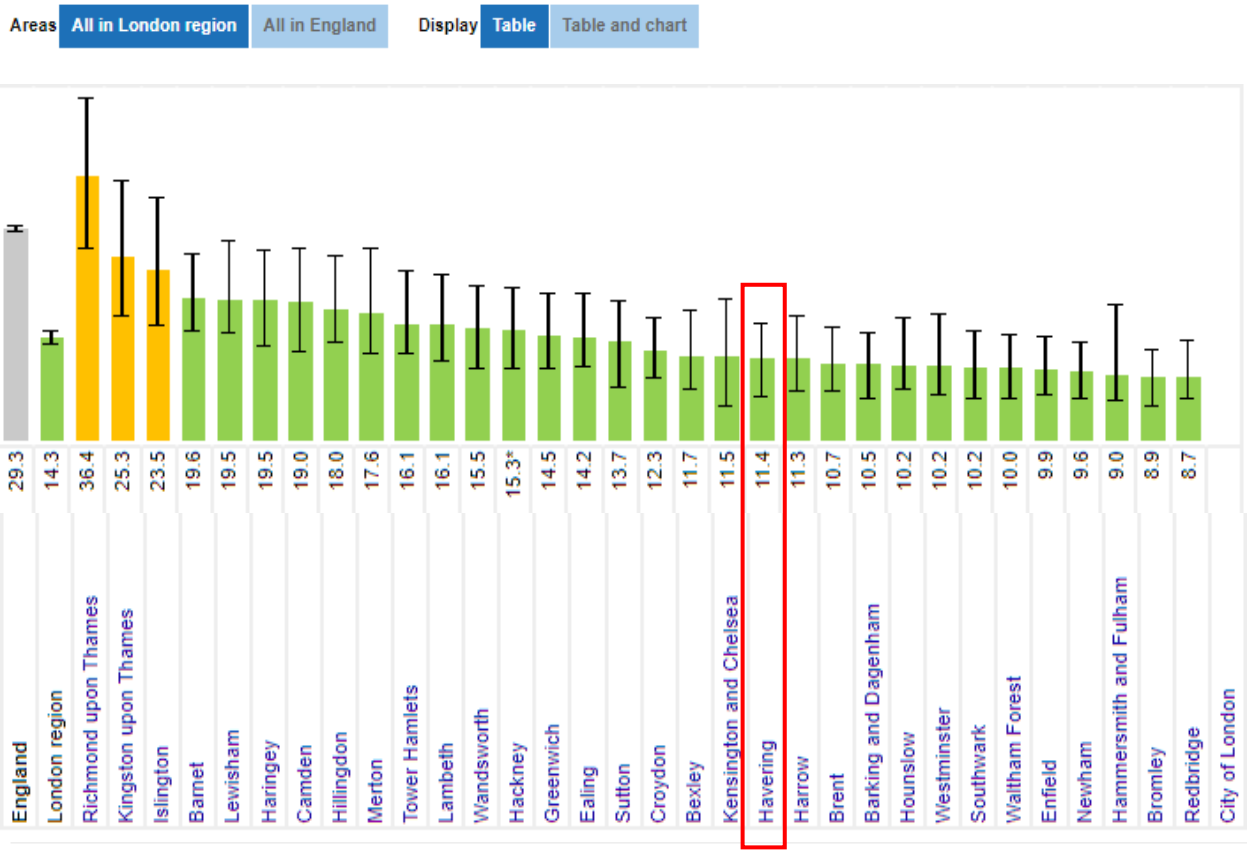
In Havering, there has been significant changes in the number of hospital admissions due to substance misuse in 15-24 year olds. Latest data presents in an increase in the number of hospital admissions due to substance misuse with Havering having the highest number of hospital admissions in London for period 2018/19 – 20/21 (Figure 5.13).

Figure 5.13 Change in rate of Hospital Admissions due to substance misuse, Havering, London and England

	Number of hospital admissions due to substance misuse in 15-24 year olds (per 100,000)		
	Havering	**London**	**England**
2018/19 – 20/21	116.3	53.4	80.5 (**-4%**)
2019/20 – 21/22	167.1(**+44%**)	52.9 (**-0.9%**)	71.0 (**-11.8%**)
2020/21 – 22/23	171.4 (**+2.6%**)	49.9 (**-5.7%**)	58.3 (**17.9%**)

In young people under 18 years, the rate of admission episodes for alcohol-specific conditions was 11.4 per 100,000 in Havering, compared to 14.3 per 100,000 in London and 29.3 per 100,000 in England (Figure 5.14).

Figure 5.14 Admissions episodes for alcohol-specific conditions – under 18s, 2018/19 – 2020/21, Havering, benchmarked against England



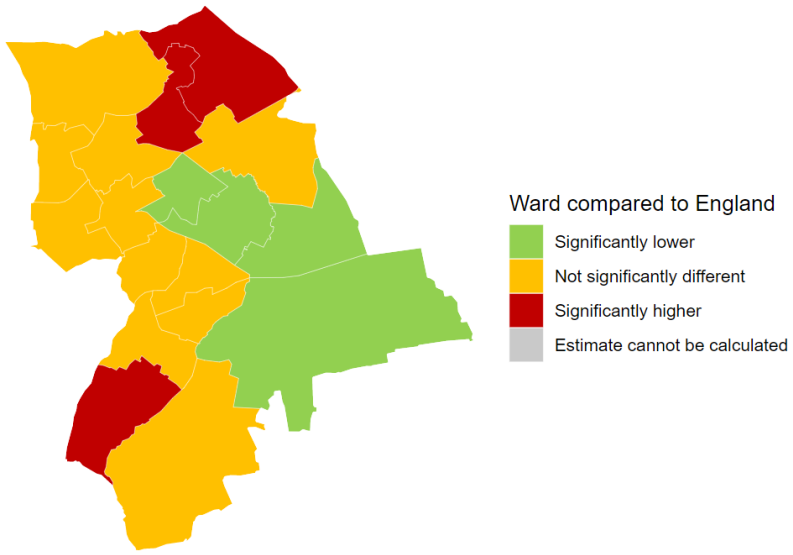
Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

ii) Deprivation

Higher teenage pregnancy rates and lower rate of abortion are associated with higher deprivation[122] [123]. It has been reported that this difference may be due to poor opportunities for stable employment within these areas which can lead young people to shift their aspirations from the arena of work to parenthood. This may result in a wider neighbourhood acceptance of early motherhood and low acceptance of abortion.

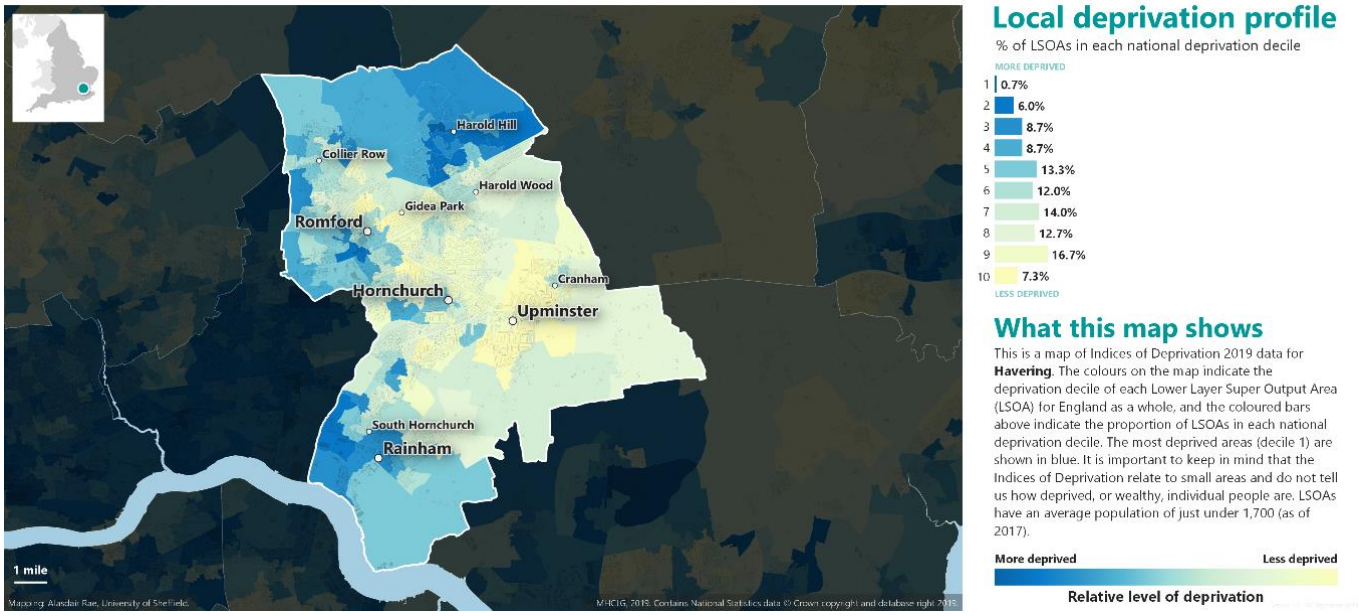
The rates of under 18s conceptions across the Havering wards are largely similar to the rate for England (Figure 5.15). There are however, specific wards north of the borough with significantly higher rates of conceptions in under 18 years old. These wards are also significantly more deprived than the others in Havering. (Figure 5.16). Interestingly, there are some deprived areas where rates of under-18s conception are similar to the England average.

Figure 5.15: Under-18s conception in Havering by ward, compared to England: 2017-2019



[122] Cook, S.M.C, Cameron, A.T. (2015) Social issues of teenage pregnancy - ScienceDirect
[123] Bradshaw, J. Finch, N., Miles, JVN. (2005) Deprivation and variations in teenage conceptions and abortions in England | BMJ Sexual & Reproductive Health

Figure 5.16 Index of Multiple Deprivation (IMD) in Havering by ward. Map is colour coded to display which decile the neighbourhood falls into nationally. Dark blue indicating relatively more deprived and pale green indicating relatively less deprived.



iii) Children in the justice system

It is widely acknowledged that young offenders are a complex population with various needs, for example, mental health support needs[124]. It has been reported that teenage boys and girls who have been in trouble with the police can have twice the risk of becoming a teenage parent[125]. Research has also found that 25% of young men in prison are fathers or expectant fathers[126].

Latest data available (2019/20) reports that there were more children in the justice system in Havering (4.4 per 1,000 children) compared to 3.5 per 1,000 children in England but similar to the London average (4.4 per 1,000 children)[127]. There was a decline in children entering the youth justice system for 2020/21, a reduction to 2.6 per 1,000 children. This is similar to England (2.8 per 1,000 children) and lower than the London average (3.5 per 1,000 children). However, there should be some caution when interpreting the data for 2020/21 due to the impact of COVID-19 on the courts and policing. The reducing rate may not accurately reflect the level of needs emerging from this population within Havering.

5.3.3 Impacts of teenage pregnancy

Teenage pregnancy is associated with negative outcomes for young parents and their children, further increasing health inequalities. Teenage pregnancy has particular impacts on education, deprivation and health outcomes (Figure 5.17).

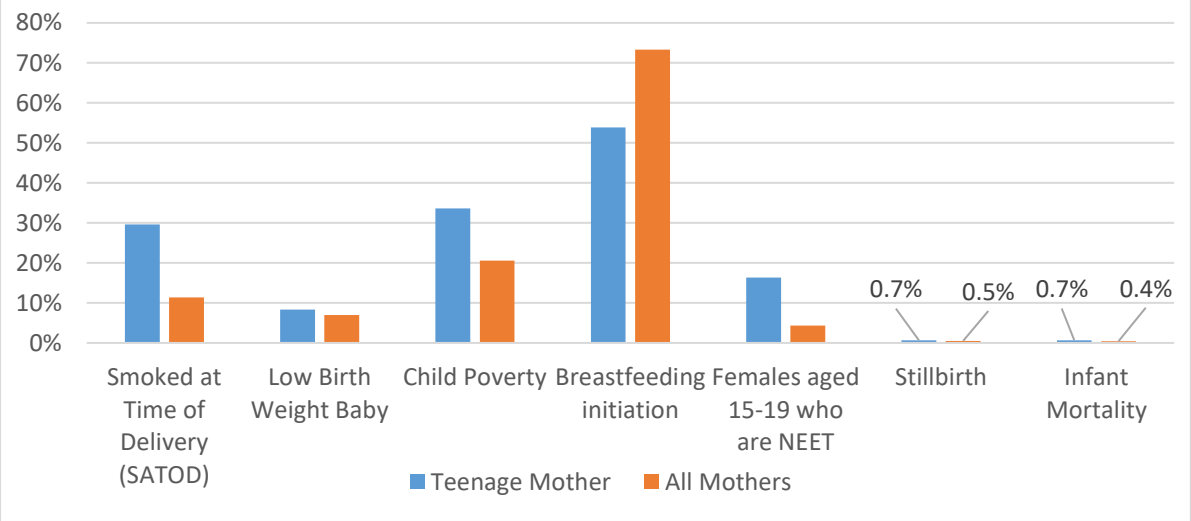
Figure 5.17 Outcomes for young parents and children of young parents

Outcomes for young parents[128]	Outcomes for children of young parents[129] [130]
• Mothers under 20 years have a 30% higher risk of poor mental health 2 years after giving birth. This affects their own wellbeing, and their ability to form a secure attachment with their baby, recognised as a key foundation stone for positive child outcomes • Teenage parents are 20% more likely to have no qualifications at age 30 • Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years, are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over. • Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation.	• The infant mortality rate for babies born to teenage mothers is 60% higher than the rate for all mothers. • Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems • Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child

[124] Chapter 12 Youth Justice (publishing.service.gov.uk)
[125] DfE Teenage Pregnancy Unit (2004) Enabling young people to access contraceptive and sexual health information and advice. enabling_yng_ppl.pdf (proceduresonline.com)
[126] Ministry of Justice (2012) Prisoners' childhood and family backgrounds (publishing.service.gov.uk)
[127] OHID (2021) Public health profiles - OHID (phe.org.uk)
[128] Gov.uk (2016) Teenage parent outcomes modelling tool - GOV.UK (www.gov.uk)
[129] ONS (2018) Child and infant mortality in England and Wales - Office for National Statistics (ons.gov.uk)
[130] Gov.uk (2014) Child Poverty Strategy http://www.gov.uk/government/publications/child-poverty-strategy-2014-to-2017

In Havering, the Teenage Pregnancy Outcomes Modelling Tool showed that outcomes were worse for children of teenage mothers than for all mothers (although it should be noted that this data is from 2013; Figure 5.18).

Figure 5.18 Child outcomes for children of teenage mothers in Havering compared to all mothers in Havering, 2013



5.4 Current service provision, unmet needs & gaps in service provision

OHID's Teenage Pregnancy Prevention Framework contains 10 key factors for effective local strategies (Figure 5.19)[131]. Applying these 10 key factors and strategically reviewing the local service provision can play a role in reducing teenage pregnancy in Havering. At a strategic level, getting prevention right can reduce inequalities, improve health and wellbeing, helps address young people's alcohol and substance misuse, cost-effectiveness and impact of sexual and reproductive health services.

Figure 5.19: Teenage Pregnancy Prevention Framework (10 key factors of effective local strategies) and review of local application in Havering

Key factor within the Teenage Pregnancy Prevention Framework	Local application in Havering	Gaps in Service Provision/Delivery
Strategic leadership & accountability	• Public Health / Havering local authority commission local sexual health service provision. • Barking and Dagenham, Havering and Redbridge jointly commission the open access sexual health service. • A Framework for Sexual and Reproductive Health priorities for North East London is in development to align sexual health provision across the whole of NEL. • Each borough has a Borough Partnership set up to provide local	• There is no current Teenage Pregnancy Strategy in Havering. • The last teenage pregnancy strategy covered 2019-2023. • There are few/no teenage pregnancy champions in each partner agency.

[131] PHE (2018) Teenage Pregnancy Prevention Framework (publishing.service.gov.uk)

	strategic leadership and collaboration.	
Strong use of data for commissioning and monitoring of progress	• Update of the needs assessment to collate relevant data, including use of data from stakeholders.	• The last Young People's Sexual Health Survey was conducted in 2010. • Lack of local data on teenage parents, including fathers. • Lack of data on population characteristics of those young people engaging with SH services .
Relationships and sex education in schools and colleges	• From September 2020 relationships education in primary schools, RSE in secondary schools, and health education in both primary and secondary has been statutory in all schools. • The Healthy Schools London Silver and Gold awards include criteria for sexual health and positive relationships; over 70 Schools are participating in the scheme currently, 35 of which have achieved at least Silver.	• Audit and monitor improvements in RSE delivery. • Support and encourage more schools to achieve Silver and Gold award status.

Youth friendly contraceptive & SH services + condom schemes	• Sexual health services apply the You're Welcome[132] quality criteria for making health services young people friendly
	  ○ involving young people in their care
	  ○ making young people welcome
	  ○ improving staff skills
	  ○ supporting young people's changing needs
	• Havering has an active C-Card scheme which includes condom demonstrations, advice and free condoms to young people aged 13 – 25 years (see section 6.4.1 for more information)
	• Best Beginnings (National Teenage Pregnancy Midwifery Network).
	• Settings providing LARC.
	• Youth workers are trained C-Card assessors and Havering's Youth Centres are distribution outlets for the C-Card scheme.
	• Youth workers are trained in Child Sexual Exploitation (CSE); they offer 1:1 support to young people at risk and have developed the Phoenix programme to support
		• Increase the number of outlets as well as registered users of the C-Card scheme.
		• There is an apparent barrier around provisions of additional resources for sexual health, such as chlamydia testing kits, pregnancy testing kits and dental dams.
		• Havering's Youth Centres, including MyPlace in Harold Hill, which is located in one of the most deprived areas of the borough, are well positioned to able to offer sexual health advice to young people; however currently the closest specialist SRH provision they are directed to is out of borough in Dagenham.
		• There are currently no support programmes for parents to discuss relationships and sexual health with their CYP.
		• Whilst there is a parenting officer available in the Local Authority's IASS team, the

[132] You're Welcome Quality Criteria (ouh.nhs.uk)

	young women survivors of exploitation. • The Youth Service workforce have received specific training in relationships and sexual health; it is part of the youth work curriculum set by the National youth Agency which provides the service with updated guidance to build into termly activity plans.	links between this officer and programmes such as Empowering Parents, Empowering Communities (EPEC) need to be made more effective. • Specific support is not currently available for pregnant teenagers; feedback from teenage parents is that they do not feel comfortable to access adult support groups. • After-care for young people who choose to undergo a termination procedure requires significant strengthening, and to include a clear discussion on post-termination birth control.
Targeted prevention for young people at risk	• Where young people are at greater risk of early pregnancy, Havering's Youth Service delivers targeted programmes. These aim to build resilience and aspiration, providing the means, the motivation and the support ○ Go Girls ○ Goodfellas ○ DELAY ○ Barnardo's, funded by the Mayor's Office for Policy and Crime (MOPAC), run Taith and TIGER Light which focus on preventing and dealing with CSE respectively[133][134].	• The Youth Service intends to build on this offer; ensuring young men are equally included with approaches tailored to their needs[135].
Support for parents to discuss relationships and sexual health	• Empowering Parents, Empowering Communities (EPEC) is a programme designed to improve child development and outcomes, parenting and family resilience. • EPEC Living with teenagers is available in Havering through the Family Services Hub.	• Greater support may be explored in schools to facilitate discussions between parents and teenagers in talking about relationships and sex.
Training on relationships and sexual health for health and non-health professionals	• Youth workers receive training to ensure that professionals are confident in having conversations with young people about sexual health and relationships.	• Explore options for more accessible e-learning to expand the workforce trained in discussing RSE.

[133] Barnardo's. 2018. Taith. Specialist service for children and young people with harmful or problematic sexual behaviour. Online leaflet.
[134] Barnardo's. 2019. TIGER Light. Barnardo's website. [online]. [Accessed 22/08/2019].
[135] Trivedi D, Brooks F, Bunn F and Graham M. 2009. Early fatherhood: a mapping of the evidence based relating to pregnancy prevention and parenting support. Health Education Research. 24. pp. 999-1028.

Advice and access to contraception in non-health education and young settings	• There are currently 17 C-Card distribution centres that are non-health settings including education settings and youth settings.	• A greater variety of C-Card distributors, in settings frequented by young people, are needed.
Consistent messages & service publicity to young people, parents and practitioners	• There are a number of websites and digital resources accessible by young people. • Havering's Family Services Hub provides a one-stop site for advice and information, signposting to youth centres, C-Card scheme and sexual health services.	• Havering Health Champions could be trained in discussing relationships and sex with parents, signposting to sexual health and family planning services to reduce teenage pregnancies.

Support for pregnant teenagers and young parents – including prevention of subsequent pregnancies	• There is evidence that interventions which focus upon enhancing maternal mental health and wellbeing and promoting positive parent and child relationships may have positive long-term benefits.
	• In particular, holistic support programmes using trusted staff members who assess individual need and provide support for health, benefits, housing, education and employment opportunities appear to improve outcomes for young mothers and their children.[136] [137] [138]
	• However, such support programmes do not directly tackle issues such as financial hardship, lack of appropriate housing or childcare and this may limit their effectiveness in the long term.[139]
	• In Havering, there are a number of programmes and initiatives to support young parents, including:
	  ○ Mellow Babies
	  ○ Strengthening Parenting Course.
	  ○ School nurses offer advice to schools on provision for young parents and can also signpost young parents to other support services.
		• A updated co-ordinated teenage pregnancy strategy is needed to reduce the rates of under 18 and under 16 conceptions; the strategy should focus on the wider determinants of wellbeing for teenagers to reduce their risk of becoming teenage parents.

[136] Wiggins M Rosato M Austerberry H et al. (2005) Sure Start Plus National Evaluation: Final Report. London: Social Science Research Unit, Institute of Education, University of London
[137] Barnes J (2010). From evidence-base to practice: implementation of the Nurse Family Partnership programme in England. J Child Services 5:4–17
[138] Barlow J Smailagic N Bennett C et al. (2011) Individual and group based parenting programmes for improving psychosocial outcomes for teenage parents and their children. Cochrane Database Systematic Review, Issue 3. Art. No.: CD002964. DOI: 10.1002/14651858.CD002964.pub2.
[139] Harden A Brunton G Fletcher A et al. (2006) Young People, Pregnancy and Social Exclusion: A Systematic Synthesis of Research Evidence to Identify Effective, Appropriate and Promising Approaches for Prevention and Support. London: EPPI-Centre, University of London

5.5 Impact of COVID-19

5.5.1 Impact on relationship and sex education (RSE) in education settings

The COVID-19 pandemic has impacted on young people throughout the UK in various ways, including changes in the delivery of education. The Institute for Fiscal Studies (IFS) reported that secondary school pupils spent 4.5 hours per day on learning in the first lockdown, compared with 6.6 hours before the pandemic[140]. IFS also found that pupils who were more deprived were spending less time learning than less deprived.

The UK legislation for the compulsory teaching of RSE was initiated from September 2020 in primary and secondary schools, during the COVID-19 pandemic. The Department of Education recognised that the implementation of RSE may be challenging in some schools and gave schools flexibility within the first year of the compulsory teaching of RSE[141]. It is unclear to what extent schools within Havering were able to implement RSE teaching over the pandemic. However, anecdotal feedback from Designated Safeguarding Leads in secondary schools was that whilst RSE was may have been delivered virtually, it was not always possible to gauge engagement from pupils with the educational material and their level of understanding.

High risk groups for teenage pregnancy (e.g. those who are more deprived and misuse substances) who are less likely to engage with learning are also generally more likely to miss out on RSE teaching in schools. The potential reduction in RSE teaching over the COVID-19 pandemic has reduced opportunities for education on sexual health and relationships further. Consequently, this may exacerbate inequalities in outcomes related to sexual health in these populations.

In addition to the direct impacts of the COVID-19 on education, Mercer et al suggests that lockdown restrictions may have meant a delay to sexual debut from some young people[142]. Coupled with the limited RSE, adverse outcomes may present for those with delayed sexual debut.

5.5.2 Access to community services for sexual health advice and contraception

Before the COVID-19 pandemic young people were able to access support and contraception through various routes including school nursing teams, sexual health clinics, GP services and pharmacies. The COVID-19 pandemic introduced barriers for those wishing to access sexual health services, with services themselves closing, limiting access and/or moving to remote services. The C-Card scheme has been operating within Havering since 2013, use the service has been declining over the years with the lowest uptake during the COVID-19 pandemic. Action is needed to improve uptake of the C-Card scheme especially as research demonstrates that it can be an effective route for young people wishing to access contraception. Refer to Section 6.4.1 for further information about impact of COVID-19 pandemic on the C-Card scheme.

[140] The Health Foundation (2021) How are generation COVID-19 experiencing the pandemic? - The Health Foundation

[141] DfE (2021) Implementation of relationships education, relationships and sex education and health education 2020 to 2021 - GOV.UK (www.gov.uk)

[142] Mercer, C. et al (2021) Impacts of COVID-19 on sexual behaviour in Britain: findings from a large, quasi-representative survey (Natsal-COVID) | Sexually Transmitted Infections (bmj.com)

5.6 Recommendations

Recommendations for Teenage Pregnancy
Although there have been improvements in rates of teenage pregnancy in Havering, it is recommended that an up to date multidisciplinary, collaborative strategy is co-produced with local people in Havering to target resources effectively to those most at risk.
Access to effective contraception is key to reducing unintended pregnancy; it is therefore recommended to work with local young people to ascertain their views of contraception, particularly shifting from user-dependent to long acting reversible contraception (LARC), which is more effective.
Local partners across the multi-disciplinary health and care system, including schools and voluntary sector, to review risk factors associated with teenage pregnancy and understanding of wider determinants of health to explore how needs can be met in these populations; this may be best achieved through training and upskilling of all relevant frontline staff in contact with young people.
As mental wellbeing is a key risk factor in both teenage pregnancy and sexual exploitation, it is recommended for commissioners to consider how to provide support for mental health – work with local partnership groups focusing on mental health for children and young people.
Improve identification of high-risk individuals through closer partnership working between key frontline agencies e.g. schools, youth centres, SRH services, GPs etc and Safeguarding leads.
Improve access to youth-friendly services providing contraception and sexual health advice at locations determined by young people.
It is recommended to capture the voice of young people more frequently and consistently, e.g. via service user feedback, engagement events etc. and ensure this information is shared across relevant partners.
Enhance messaging to young people, parents and families about sexual health and ensure that services available to young people are in locations and at times most suitable to their needs.
SRH services to provide advice and information to schools and Admissions team to ensure that those who are engaged receive information and advice on relationships and sexual health.

6.0 Contraception

6.1 Contraception as a Public Health Issue

Contraception aims to prevent pregnancy and some forms can also help protect against STIs. Unintended pregnancy threatens public health as it can have a range of health, social, economic and cultural consequences including[143]:

- Abortion, which in itself poses a risk to the mother of medical complications.
- Mental health and wellbeing of deciding what to do in the case of an unintended pregnancy, managing partner as well as families' expectations.
- Socio-economic impact of raising a child, which is particularly challenging for those already disadvantaged, especially teenage and/or single parents.
- Physical wellbeing of the mother, where the risks to the mother and baby are greater in younger teenage or much older (40+) age groups.
- Ambivalence towards seeking pre-natal care, particularly in younger or disadvantaged groups experiencing unintended pregnancy.
- Social norms of different cultural groups where unintended pregnancy or pregnancy outside of marriage may result in ostracising the parent(s), lack of support etc.

Contraception, where it is socially and culturally acceptable, provides a method for people to potentially control their fertility and have some choice over when to start a family. However, access to contraception is in itself plagued with inequalities, which will be further explored in this section.

Contraception is widely available in the UK and is provided free of charge by the NHS for all ages. Open-access contraceptive services are available from several settings: general practices, family planning clinics, sexual and reproductive health (SRH) services, young person's clinics, NHS walk-in centres (emergency contraception only) and some pharmacists. There is a range of options available for those seeking contraception, these include:

- Long-acting reversible contraception (LARC) methods; including contraceptive implant, intrauterine device (IUD), intrauterine system (IUS) and contraceptive injection.
- Short acting contraception methods, dependent on the user to remember to take/administer the contraceptive method; including oral contraceptive pills, contraceptive patch, contraceptive ring and condoms.

Contraception methods each have various levels of effectiveness in preventing pregnancy and STIs. The effectiveness in preventing pregnancy of short acting contraception methods depends on their correct and consistent use. LARC, however, does not depend on daily concordance and is recommended as highly effective method to prevent unplanned pregnancy[144]. Condoms can be effectively used to prevent the transmission of STIs as well as prevent unplanned pregnancy[145].

[143] Institute of Medicine (1995) *The Best Intentions: Unintended Pregnancy and the Wellbeing of Children and Families* National Academies Press Consequences of Unintended Pregnancy - The Best Intentions - NCBI Bookshelf (nih.gov)
[144] NICE (2019) Long-acting reversible contraception. Clinical Guideline CG30. Overview | Long-acting reversible contraception | Guidance | NICE
[145] Public Health England (2019). Health Matters: Preventing STIs. https://www.gov.uk/government/publications/health-matters-preventing-stis/health-matters-preventing-stis

When choosing which method of contraception is right for an individual, they should be given information about and offered a choice of all methods and then provided with the method of contraception that is most acceptable to them, provided it is not clinically contraindicated. Appendix 1 gives an overview of all available contraceptive methods, and their relative effectiveness.

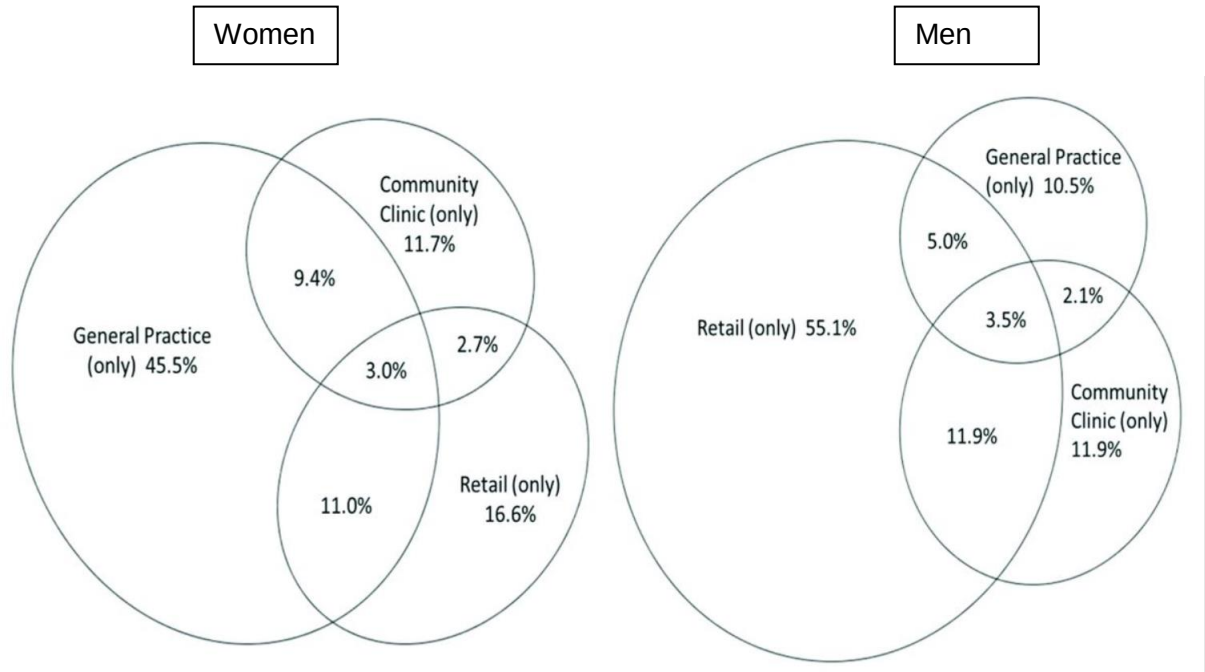
6.2 National context

In England, data on the provision of contraception is centrally collected from specialist SHS, level 2 SRH services and some young person's clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care. In addition, supplementary data are available from the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3).

6.2.1 Natsal-3 Findings (2017 data), including data on higher risk groups

Out of the 4571 women and 3142 men (total = 7713) survey respondents, 87% of women and 73.8% of men had obtained contraception from at least one source in the past year (Figure 6.1). Women were much more likely than men to obtain their contraception from general practice, whereas men predominantly bought their own contraception (condoms) from retail outlets, including pharmacies (33%), petrol stations and supermarkets (24.8%)[146]. Note that a Community Clinic includes SRH services/GUM clinics.

Figure 6.1 Where women and men respondents to the Natsal-3 survey chose to obtain their contraception



There was a marked difference between different groups of women in where they chose to access contraception:

[146] French, R. et al (2018) Where do women and men in Britain obtain contraception? Findings from the thirst National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *BMJ Sexual and Reproductive Health* 44; 1, 16-26. Where do women and men in Britain obtain contraception? Findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) (bmj.com) http://dx.doi.org/10.1136/jfprhc-2017-101728

- *Age*: Among women in their 20s, around 2/3 obtained their contraception from general practice , compared to around half of 16-17 year olds and half of 35-44 year olds.
- *Geography*: 65.7% of women living in rural areas used general practice for contraceptive supplies compared to 57.6% of women in urban areas.
- *Relationship Status*: those in cohabiting or 'steady' relationships (65%) as opposed to those who were single or married (52-57%), and childless women (62%) compared with mothers (55-58%), all more commonly used general practice for contraceptive supplies.
- *Education*: Women with minimum educational qualifications (63%), or none, more commonly used general practice compared with those who were more highly qualified (58%).
- *Ethnicity*: Compared with women identifying as 'White' (61%), considerably lower proportions of women in black and minority ethnic groups obtained contraception from general practice (29-46%). Black Caribbean women were the least likely to use general practice for contraception (29.2%) and instead more likely to use Community Clinics (57.9%). Mixed/other ethnic groups were most likely to use no contraception (19.3%).

6.2.2 Sexual and Reproductive Health Service Use Data (2021-22)

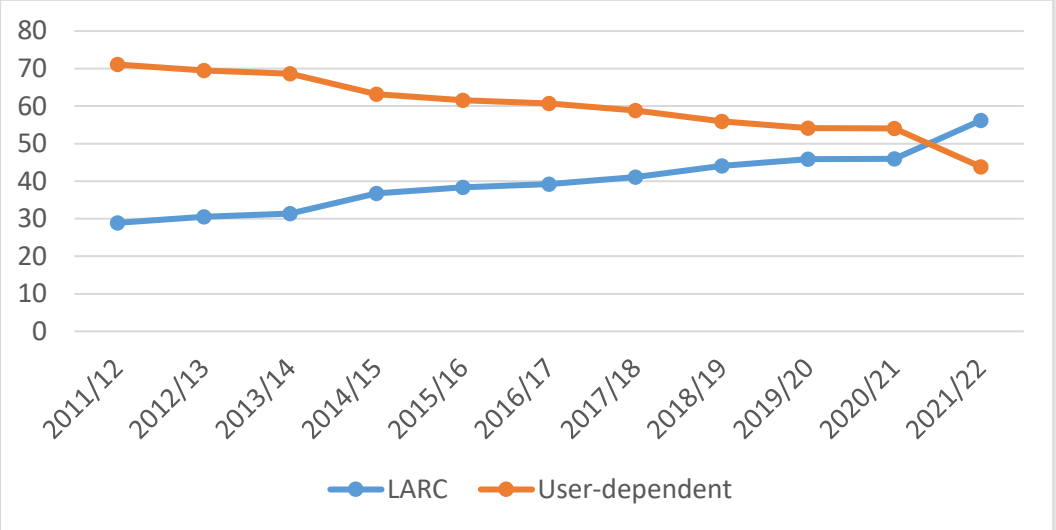
In 2021-22, women accounted for 77% of visits to SRH services whilst men accounted for 20%. Amongst women visiting SRH services, 56% of visits were for reasons of contraception: 9% requesting a new main method; 14% a change of method and 33% maintenance of an existing method. However, only 6% of visits by males were for reasons of contraception: 3% to supply or maintain a main method and 3% for pre-contraception advice.

Data from SRH services shows that for the first time since 2011-12, LARC options have taken over as the dominant forms of contraception requested by people using SRH services above user-dependent methods in 2021-22[147]. Across England, 56% of females chose LARC as their main method in 2021-22 compared to 46% choosing user-dependent methods (Figure 6.2). This is a 10 percentage point increase from 2020-2021.

However, it should also be noted that at the end of July 2021, progesterone-only oral pills became available to purchase over the counter at pharmacies without a prescription. This is likely to have impacted the number of women attending SRH services for the contraceptive pill, which has reduced from 39% in 2020/21 to 27% in 2021/22.

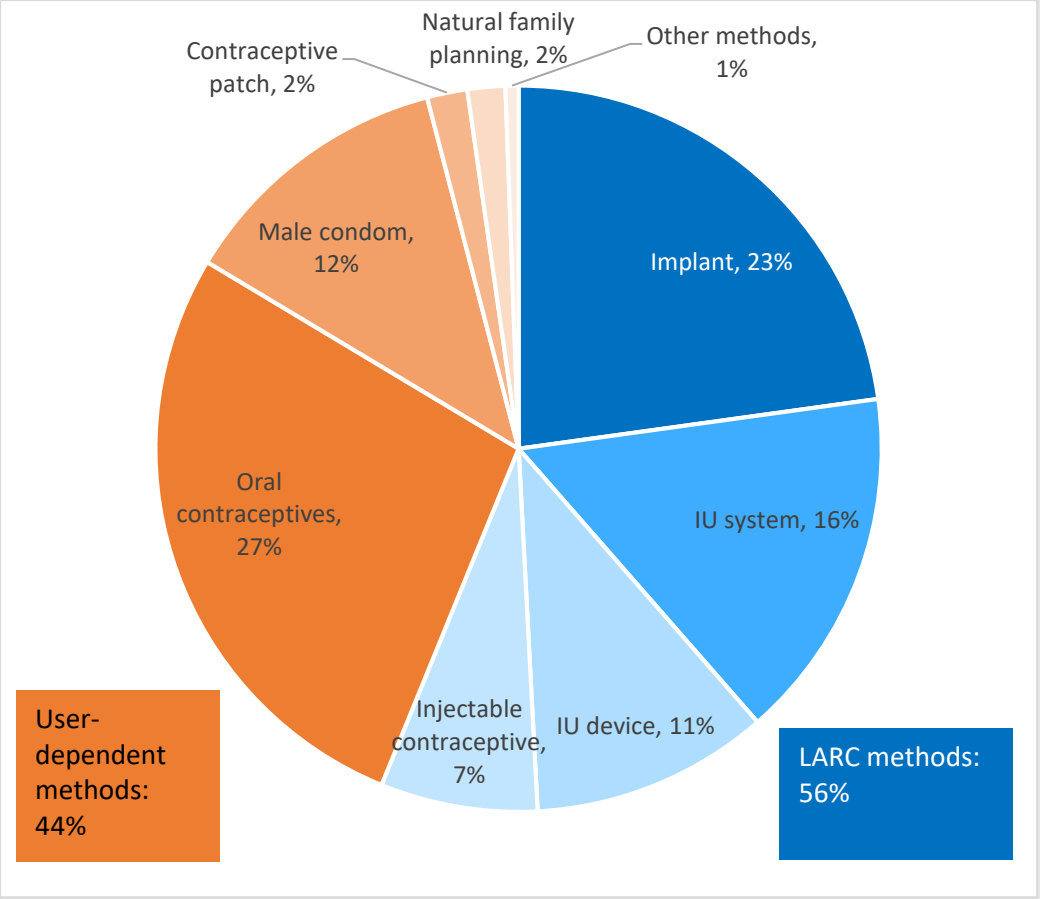
[147] NHS Digital (2022) Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS Digital

Figure 6.2 Percentage of females whose main method of contraception requested at SRH services is LARC compared to those whose main method is user-dependent 2011-12 to 2021-22 in England.



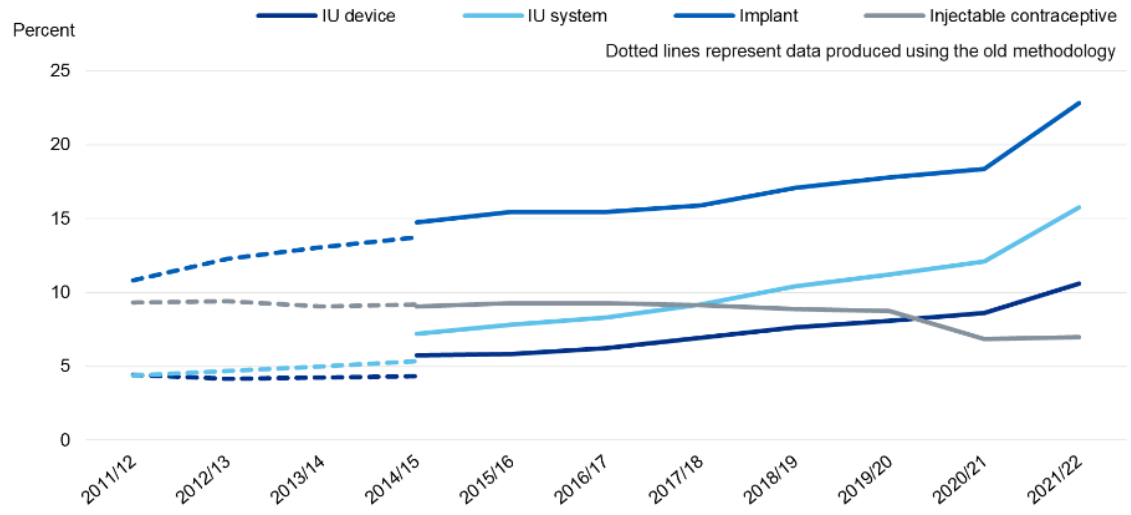
Although LARC forms a bigger share of contraceptive methods, oral contraception in the form of the pill, remains the single most common method of contraception requested at SRH services, at 27% (Figure 6.3).

Figure 6.3 Percentage of LARC (shades of blue) and User-Dependent (shades of orange) methods requested by users of SRH services, 2021/22, England.



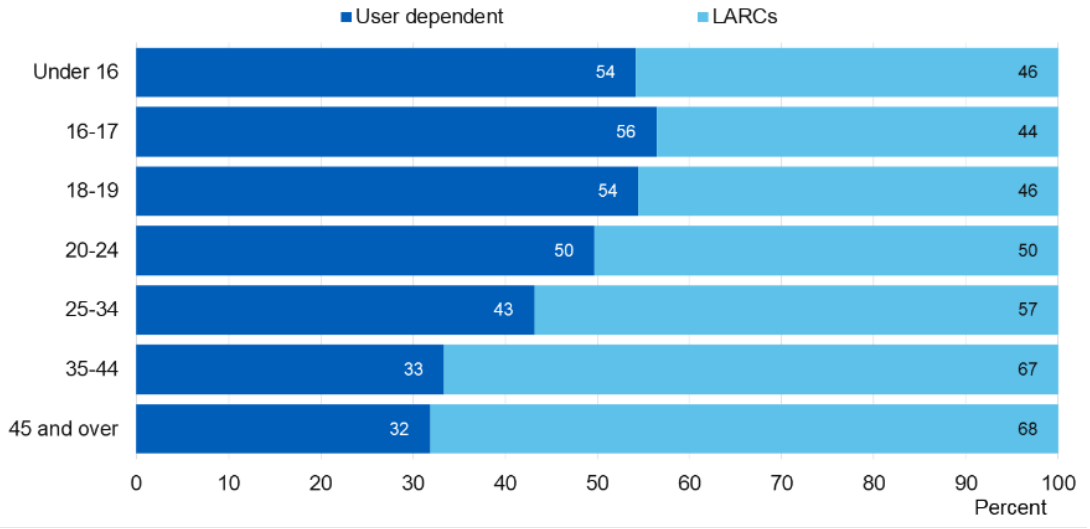
LARC use has increased since 2014/15 for IU devices, IU systems and implants, but has reduced for injectable contraceptives (Figure 6.4); studies suggest that injectable contraceptives are less reliable, have a higher failure rate, and are less cost effective than the other LARC methods available.

Figure 6.4 Trend in use of LARC method 2014/15 to 2021/22, England (dotted lines represent different methodology for collecting data in earlier years 2011/12 to 2013/14)



Use of LARC varies by age group, with those younger age groups under 16 years to 19 years tending towards use of user-dependent methods (Figure 6.5).

Figure 6.5 National uptake of user-dependent contraceptives compared to use of LARC by age group, 2021-22



However, amongst those who do choose LARC, under 16's were more likely to choose implants (38%) compared to 16% of those aged 45 and over. Use of intra-uterine (IU) devices increases with age, with 50% of those aged 45 and over using IU device or IU system compared to 19% of 20-24 year olds, 11% of 18-19 year olds and 5% of 16-17 year olds.

Based on Sexual and Health Service use data only, the numbers of women who requested Emergency Hormonal Contraception from their SRH has reduced from 136,000 in 2011/12 to 55,000 in 2021/22. In addition, there were around 9,800 female sterilisations (of which 100 were reversed) and around 8,500 vasectomies performed in 2021/22.

6.2.3 Higher Risk Groups

Findings from the second and third National Surveys of Sexual Attitudes and Lifestyles (Natsal-2 and Natsal-3) indicates that the uptake of contraception is lower in specific populations including young people, those who are more deprived and BAME individuals[148]. People in lower levels of deprivation are more likely to use sterilisation and short acting contraception (SAC) than those in higher deprivation. Those more deprived are most likely not to use any form of contraception (Figure 6.6, 6.7 and 6.8).

Figure 6.6 Percentage of respondents to Natsal-3 survey who used the most or least effective form of contraception, or no contraception, by level of deprivation, England

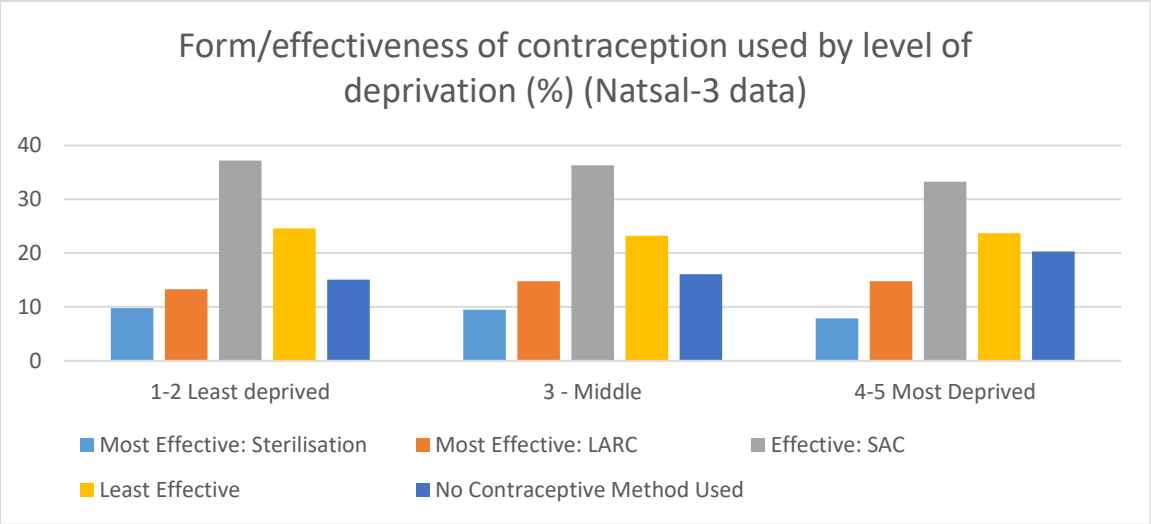
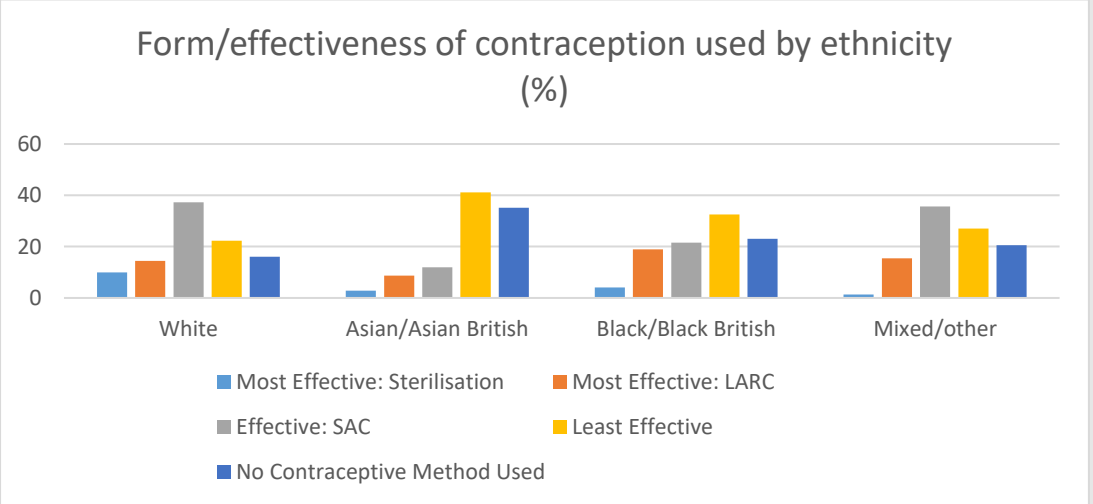
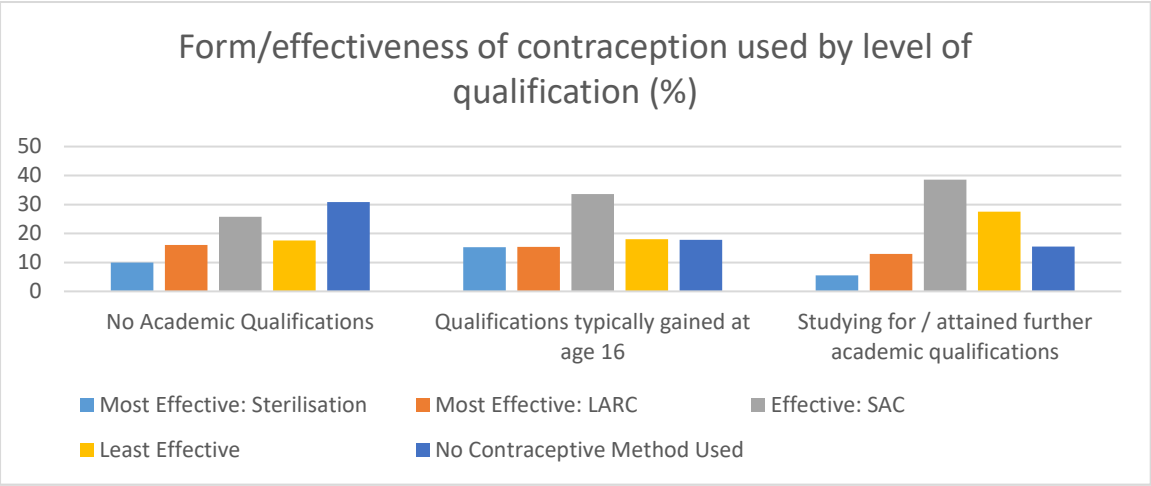


Figure 6.7 Percentage of respondents to Natsal-3 survey who used the most or least effective form of contraception, or no contraception, by ethnicity, England



[148] French R. et al. (2020). Changes in the prevalence and profile of users of contraception in Britain 2000–2010: evidence from two National Surveys of Sexual Attitudes and Lifestyles (bmj.com)

Figure 6.8 Percentage of respondents to Natsal-3 survey who used the most or least effective form of contraception, or no contraception, by level of qualification, England



The National Guideline 68 published by NICE in 2017[149] has recommended on the use of condom distribution schemes for specific population groups to make contraception more easily accessible. These schemes should couple the distribution of condoms with information and advice about sex and reproductive health. The C-Card scheme is a widely adopted scheme used throughout England which is aimed at young people between 13-24 years old. The scheme improves access to contraception, information and advice. See section 6.4.1 for more information on this service.

6.3 Local context

The latest available published local data (for 2020) presents initiation rate for various contraceptive methods: prescribed LARC excluding injections, use of user-dependent methods and hormonal short-acting contraceptives (Figure 6.9). Data on prescribed contraception is for females only, as most contraception provided to males is the male condom (99%). Data also covers attendance at specialist contraceptive services by under 25 year olds for both females and males.

In 2021-22, just under 15,000 contacts were made at BHRUT sexual health services by Havering residents; however, Havering represented the least number of contacts to any SH service from residents from any of the NEL boroughs. 64.2% of visits to BHRUT sexual health services were by females in Havering, with 35.8% by males. Of those contacts, 97% of visits for reasons of SRH (sexual and reproductive health) services, were made by Havering females. For SRH Advice only, females represented 81% of visits and males 19% of visits.

[149] NICE (2017) Recommendations | Sexually transmitted infections: condom distribution schemes | Guidance | NICE

Figure 6.9 Key indicators for contraception in Havering and England, 2020-21

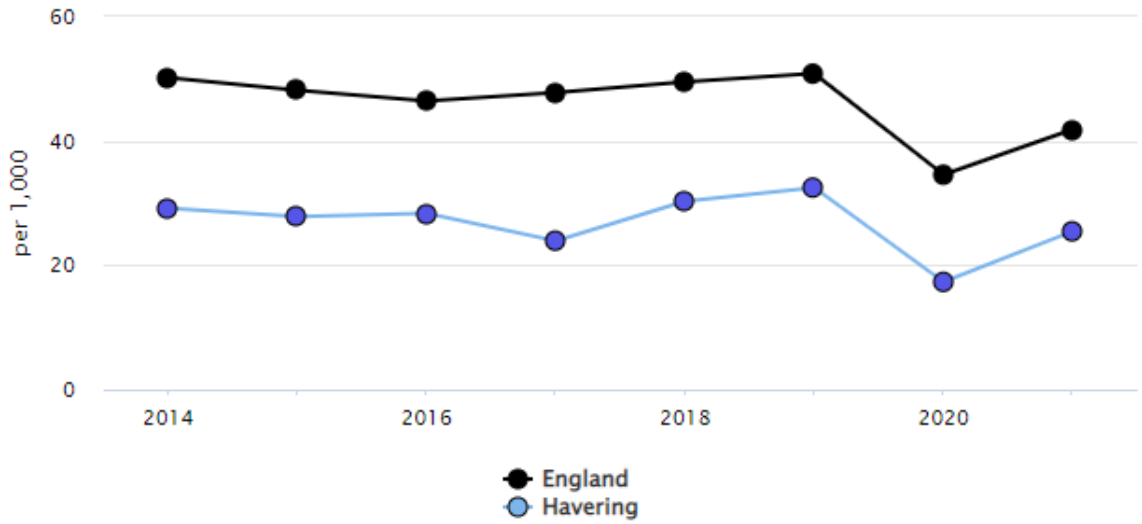
Better 95% Similar Worse 95% Lower Similar Higher Not applicable

	Year	Havering Value	London Value (Havering compared to London)	England value (Havering compared to England)	% change 2019 to 2020	Rank within England: 2020‡	Rank among 16 similar UTLAs/UAs+
Total prescribed LARC excluding injections rate/1,000	2020	17.3	27.0	34.6	-46.7	140	14
GP prescribed LARC excluding injections rate/1,000	2020	9.0	9.1	21.1	-39.5	109	9
SRH services prescribed LARC excluding injections rate/1,000	2020	8.3	17.9	13.4	-52.7	125	16
Under 25s choose LARC excluding injections at SRH services (%)	2020	24.8	29.6	28.8	+23.9	114	13
Over 25s choose LARC excluding injections at SRH services (%)	2020	39.8	44.5	43.5	-8.3	112	13
Women choose injections at SRH services (%)	2020	10.4	4.9	8.1	-43.6	37	1
Women choose user-dependent methods at SRH services (%)	2020	55.7	55.7	54.9	+16.4	54	6
Women choose hormonal short-acting contraceptives at SRH services (%)	2020	48.3	39.5	41.7	+25.3	28	1
Under 25s individuals attend specialist contraceptive services rate / 1,000 Females	2020	70.7	124.0	97.6	-48.4	107	13
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	2020	12.8	21.0	13.0	-35.9	64	8

6.3.1 LARC excluding injections

Havering's rate of total prescribed LARC (excluding injections, and irrespective of where it was prescribed) has remained consistently below the rate for England (Figure 6.10) since 2014. It also shows a commensurate dip in LARC uptake rates in 2020 coinciding with the COVID-19 pandemic; by 2020 Havering's rate was 17.3 per 1,000 women compared to 34.6 per 1,000 in England. This improved to 25.5 per 1,000 in 2021. The best/highest rate of LARC in London was in Kingston-Upon-Thames, at 40.1 per 1,000, whilst Havering was 4th lowest in London (Figure 6.11).

Figure 6.10 Total prescribed LARC excluding injections rates per 1,000, Havering (represented by the blue line) compared to England (represented by the black line), 2014-2021

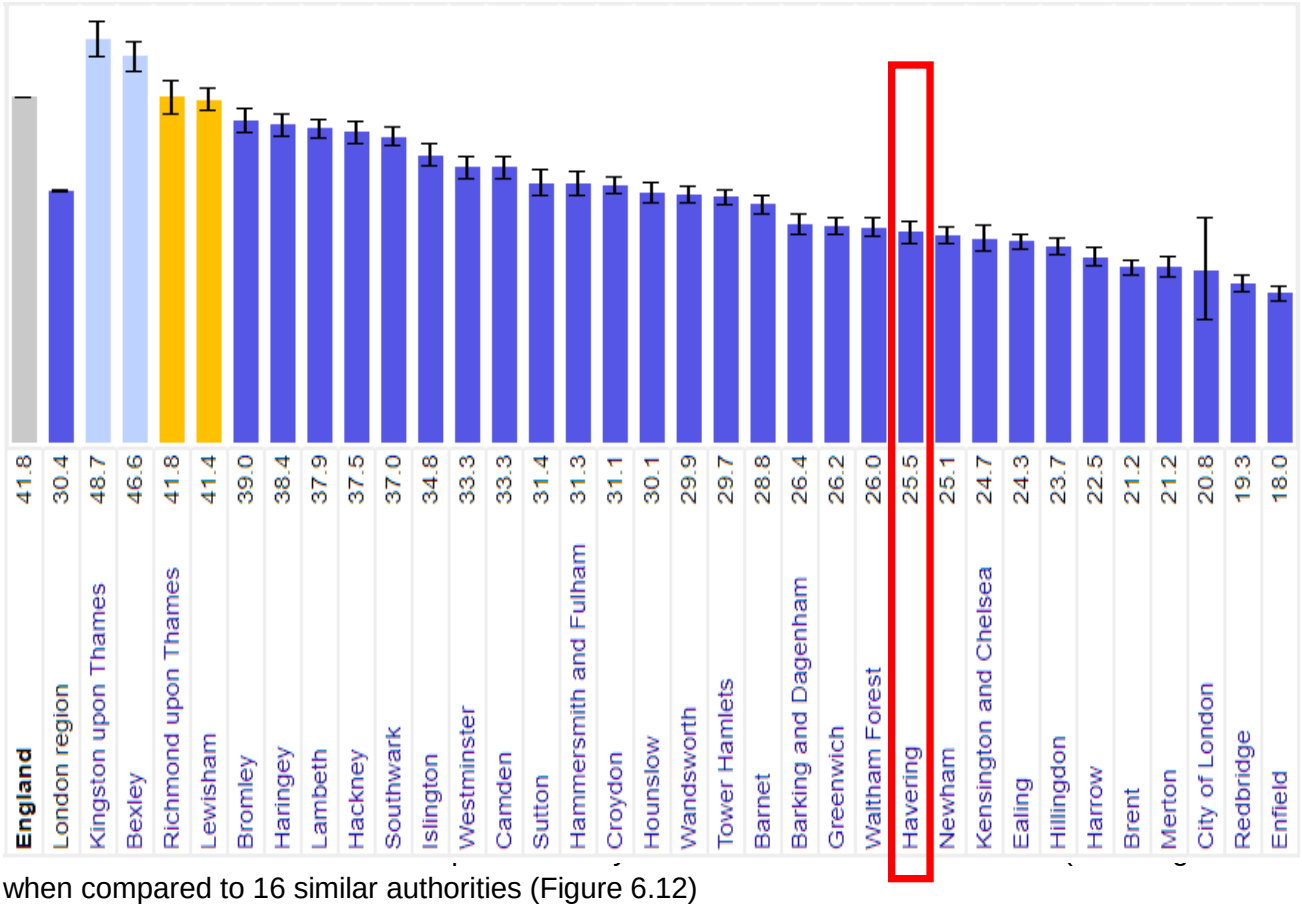


There was a higher rate of LARC fitting at GP surgeries (excluding injections) in Havering (9.0 per 1,000; 13th Highest in London), compared to LARC fitting at SRH services (8.3 per 1,000). However, this may be partly due to the impact of COVID-19, in which SRH services at our local provider, BHRUT, were relocated to Barking Hospital. This is a much longer distance for many residents in the borough to travel, particularly those who live in the north of the borough, Collier Row and Harold Hill.

Limited access to healthcare settings for contraception was the most important implication of the COVID-19 pandemic during the first lockdowns in March 2020. As a result, there was a reduction in the initiation of LARC prescribed by both GP services and SRH services at this time across England; this was also seen in the data for Havering. In March 2020, the Faculty of Sexual and Reproductive Health (FSRH) advised that when individuals were not able to access LARC methods because of the impact of COVID-19 on services, other bridging methods should continue to be readily available e.g. progestogen-only pill. Further detail on the impact of COVID-19 on LARC provision is available from the Wider Impacts of COVID-19 on Health (WICH) tool[150].

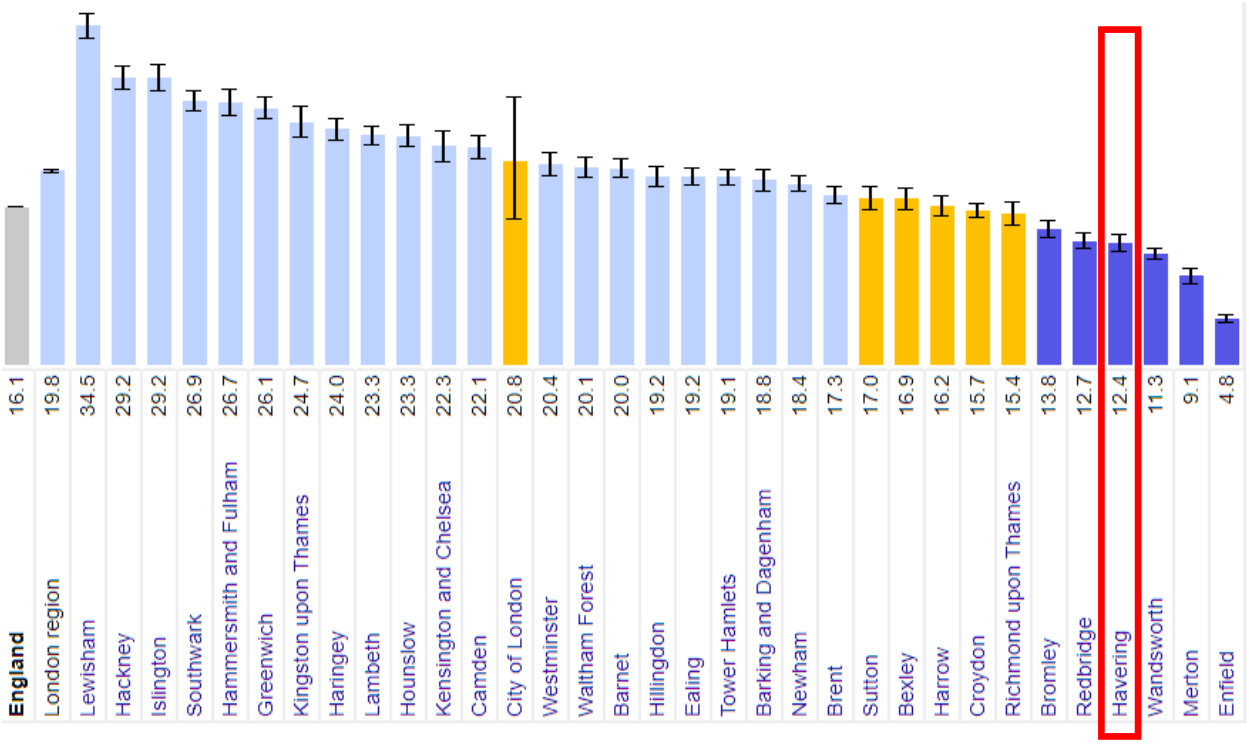
[150] OHID (2022) Wider Impacts of COVID-19 (phe.gov.uk)

Figure 6.11: Total prescribed LARC (excluding injections) rate per 1,000 for Havering compared to London Boroughs, 2021



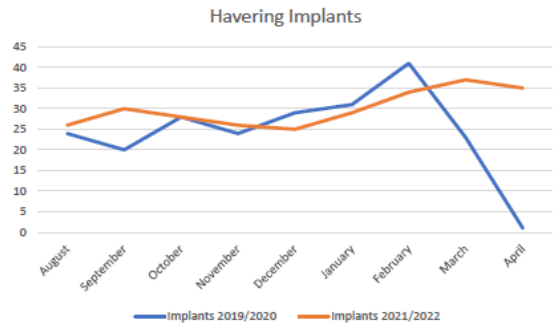
when compared to 16 similar authorities (Figure 6.12)

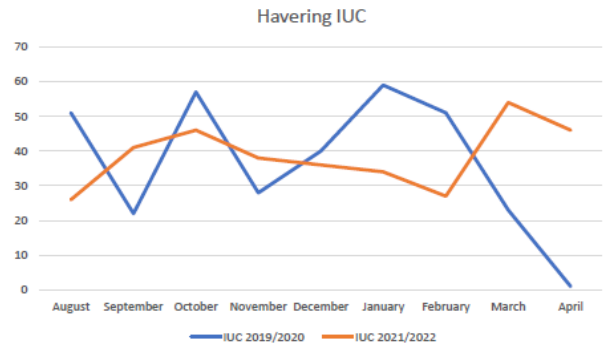
Figure 6.12 SRH prescribed LARC (excluding injections) rate per 1,000 for Havering compared to London Boroughs, 2021



For both Implants and Intra-Uterine Coils (IUC), there was a significant drop in fitting activity at specialist SRH services in Havering in March/April 2020 (Figure 6.13). However, activity had recovered by September 2021.

Figure 6.13 LARC activity at BHRUT for Havering residents for Implants and IUC, 2019-20 to 2021-22





6.3.2 Other contraceptive methods

In 2020, proportions of women in Havering choosing injections and hormonal short-acting contraceptives at SRH services was higher than the England averages. There was a decrease in women choosing injections between 2019 and 2020, this is highly likely due to the requirement for a face-to-face appointment. Between 2019 and 2020, there was an increase in hormonal short-acting contraceptives chosen at SRH services.
The proportion of women choosing user-dependent methods at SRH services in Havering was similar to the England average, 55.7% versus 54.9% respectively, but similar to

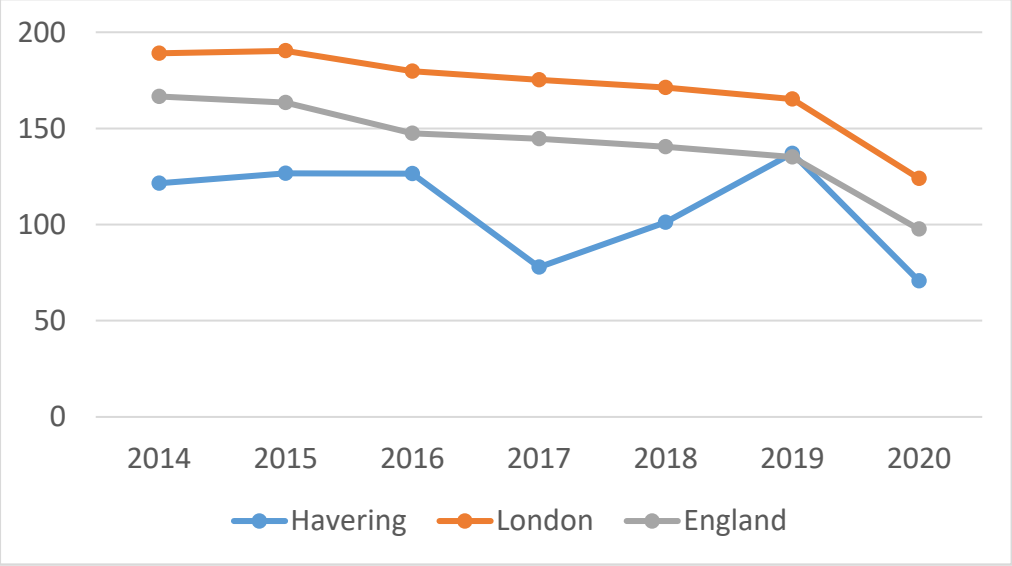
hormonal short-acting contraceptives there was an increase in the percentage in Havering between 2019 and 2020.

It can be inferred from the latest available data that the COVID-19 pandemic has impacted the contraceptive methods used in Havering. More residents seemingly chose to use short-acting and user-dependent methods over LARC, possibly due to the reduced access to face-to-face appointments and further proximity away from the nearest SRH service, but also due to the FSRH advice described above (section 6.3.1). This change in contraceptive methods chosen by residents may also be linked to the increased abortions reported in Havering in 2020 as LARC is more effective at preventing pregnancy. More information about abortion rates in Havering can be found in Section 4: Conception, abortion & maternity.

6.3.3 Attendance at specialist contraceptive services in under 25 years olds

In 2020, the rate of attendance at specialist contraceptive services by females aged under 25 years olds in Havering was lower than the average rate for England, 70.7 per 1,000 residents compared to 97.6 per 1,000. This rate for under 25 year old females has been decreasing since 2014 for Havering, London and England (Figure 6.14). Contrastingly, the rate of attendance at specialist contraceptive services by males aged under 25 years olds in Havering is similar to the average rate for England, 12.8 per 1,000 residents compared to 14.8 per 1,000. There was a reduction in attendance for both females and males between 2019 and 2020. This is likely due to changes in service delivery in response to the COVID-19 pandemic and is discussed further in section 6.4.

Figure 6.14 Rate of attendance at specialist contraceptive services by females aged under 25 years, 2014 to 2020, Havering, London and England



Whilst the proportion of under 25 year olds who choose LARC excluding injections at SRH services in Havering (24.8%) was lower than the England average (28.8%) in 2020, there has nevertheless been an increase between 2019 and 2020 by 23.9% in LARC prescribed for this age group. An increase in this indicator has been consistent nationally and locally. The second and third National Surveys of Sexual Attitudes and Lifestyles (Natsal-2 and Natsal-3) suggests that this increase may be due to increased knowledge and shift in

attitude about the use of LARC in the local younger population who had traditionally used more user-dependent methods including condoms and short acting hormonal contraception[151].

Feedback from a mystery shopping exercise conducted across NEL highlighted that access to appointments was a key concern for service users. However, they were satisfied with the quality of care provided once an appointment has been made.

6.3.4 Who is at increased risk, the extent and impact of need

Evidence has shown that the use of contraception and the setting where contraception is preferably sought can vary across population groups (Figure 6.15). Some of these population groups include young people, those with learning disabilities, those living in lower socioeconomic groups and B.A.M.E individuals.

Factors which may contribute to differences in use of contraception include[152]

- Misinformation about impacts on health
- Stigma associated with contraception
- Culture and religious beliefs
- Language barriers limiting the ability to access or understand information

These factors need to be explored further within Havering to understand their application to the local population in order to reduce barriers for accessing effective contraceptive methods. For instance, with the increasing ethnic diversity within Havering, services may consider providing information in different languages. In addition, using simple English for those who are not English speaking and/or have learning disabilities may better equip residents with information to make an informed decision about contraception.

The decisions residents make about contraception directly impacts on other topic areas covered within other chapters in this needs assessment - conception, abortion, maternity, STIs and teenage pregnancy. Effective use of contraception can prevent unplanned pregnancies and the transmission of STIs in Havering.

[151] French, R.S et al (2022) Changes in the prevalence and profile of users of contraception in Britain 2000–2010: evidence from two National Surveys of Sexual Attitudes and Lifestyles | BMJ Sexual & Reproductive Health
[152] Ayorinde, A.A. et al. (2021) Enabling women to access preferred methods of contraception: a rapid review and behavioural analysis | BMC Public Health | Full Text (biomedcentral.com)

Figure 6.15 Contraception Issues for Vulnerable Groups

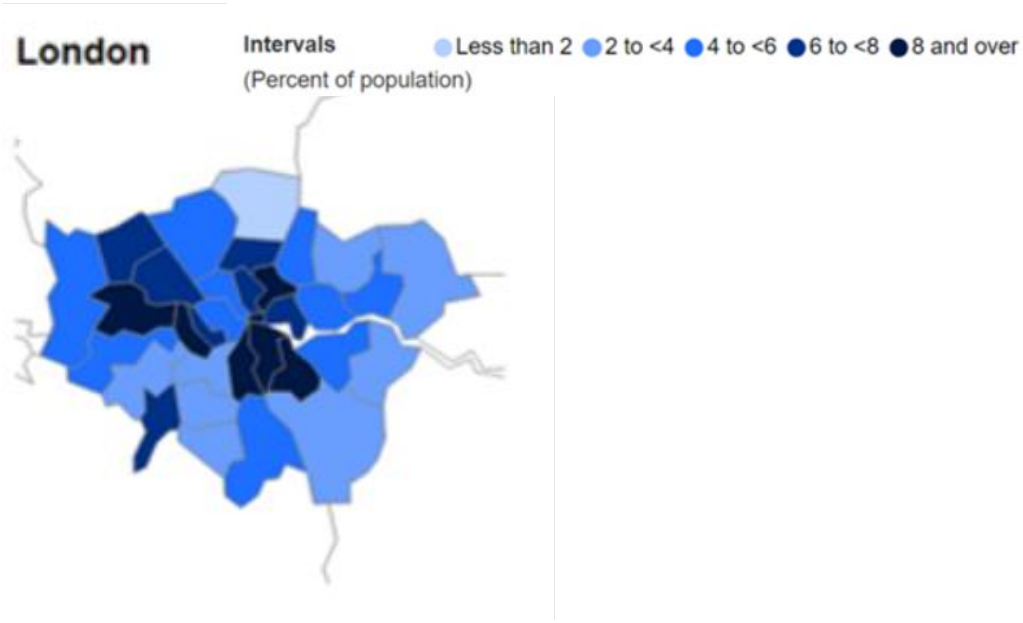
Young people	Women with learning disabilities
Natsal-3 study found that the young women who completed a survey preferred healthcare sources for contraception, particularly GP and young men preferred the retail sector[153]. Natsal-2 and Natsal-3 found that use of oral contraceptive pill and condom were the most commonly used contraceptive methods for young people[154]	It has been reported that women with learning disabilities have different patterns of contraceptive use to women in the general population with significantly greater use of non-barrier methods such as depot injection, oral contraceptive, intrauterine device or sterilisation[155]. It is unclear their women with learning disabilities prefer to go to access contraception, further evidence is needed.
Those living in areas of higher deprivation	**B.A.M.E individuals**
Women living in areas of higher deprivation may be less likely to use contraception than those living in less deprived areas[156]. Evidence about the type of contraception used is limited but some evidence suggests that LARC uptake in higher areas of higher deprivation[157].	Contraceptive use may be lower in all ethnic minority groups than in white women. Women from all ethnic minority groups were less likely than white women to report using hormonal contraception and permanent methods and were more likely to use barrier methods[158].

6.4 Current service provision, unmet needs & gaps in service provision

Across London, it is estimated that between 2 to <4% of Havering's female population were likely to visit an SRH service for reasons of contraception (Figure 6.16). This is similar to other outer London boroughs such as Bexley and Bromley, but much lower than inner London boroughs including Hackney & City of London, and Lewisham both at 10%[159].

[153] Geary, R.S. et al (2016) Actual and preferred contraceptive sources among young people: findings from the British National Survey of Sexual Attitudes and Lifestyles | BMJ Open
[154] French, R.S. et al (2020) Changes in the prevalence and profile of users of contraception in Britain 2000–2010: evidence from two National Surveys of Sexual Attitudes and Lifestyles | BMJ Sexual & Reproductive Health
[155] Ledger, S. et al (2016) Contraceptive decision-making and women with learning disabilities - Susan Ledger, Sarah Earle, Elizabeth Tilley, Jan Walmsley, 2016 (sagepub.com)
[156] Bentley,R. Kavanagh, A. & Smith, A. (2009) Area disadvantage, socioeconomic position and women's contraception use: a multilevel study in the UK - PubMed (nih.gov)
[157] Morgan, C.R. & Liu, H. (2017) The relationship between area deprivation and prescription of long-acting reversible contraception in women of reproductive age in Lothian, Scotland, UK - PubMed (nih.gov)
[158] Saxena, S. et al, (2006) Ethnic variations in sexual activity and contraceptive use: national cross-sectional survey - Contraception (contraceptionjournal.org)
[159] NHS Digital (2022) Part 1: Contacts with Sexual and Reproductive Health Services - NDRS (digital.nhs.uk)

Figure 6.16 Likelihood of contacts for reasons of contraception by females by London Local Authority patient residence



6.4.1 Access to condoms/C-Card Scheme

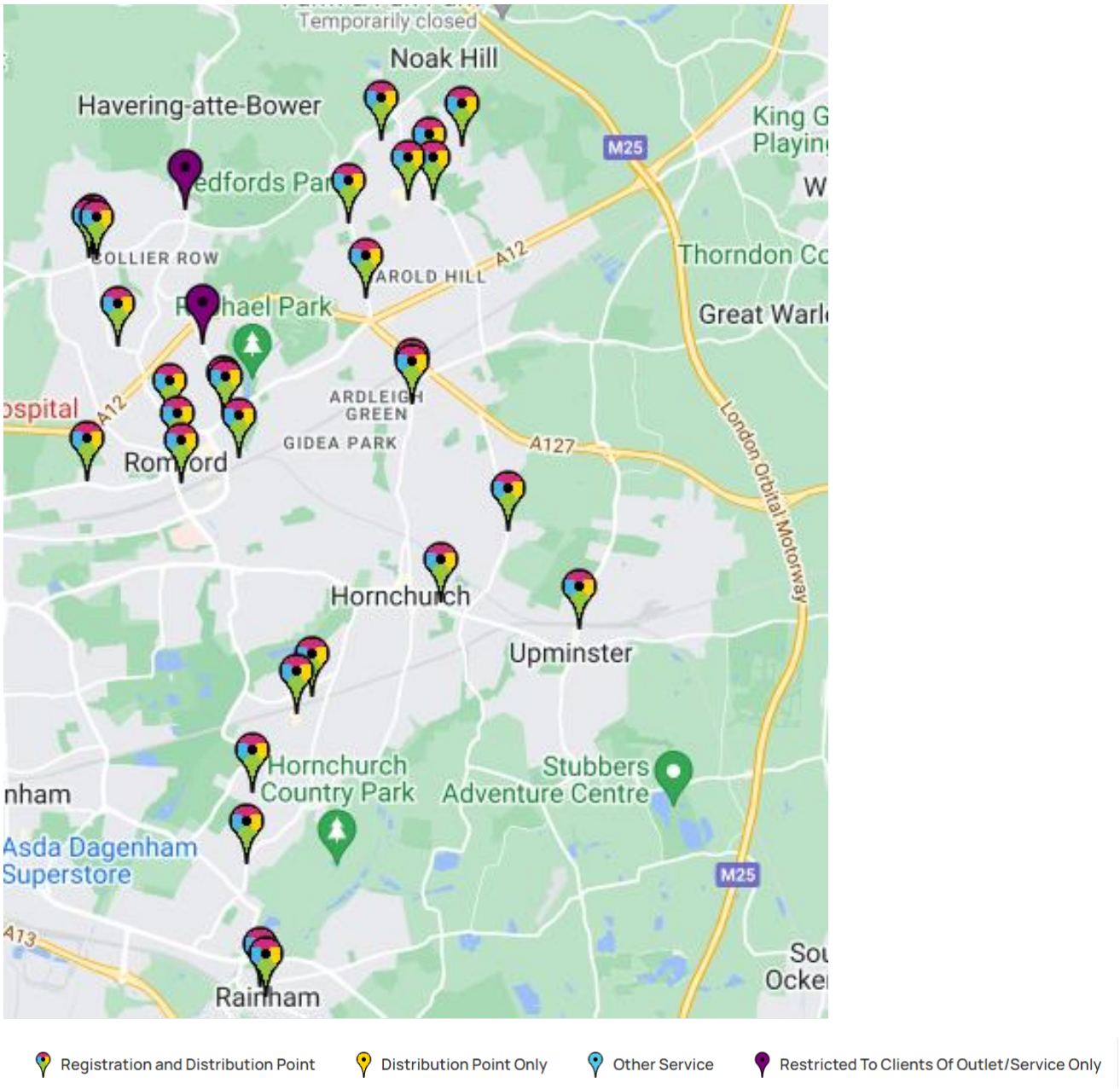
External (male) and internal (female) condoms are available for free at sexual health clinics and at some GP surgeries. Havering operates a C-Card scheme, a free condom-distribution scheme in which participating outlets can register and distribute condoms to young people aged 13-25 years[160]. The Havering scheme is currently being developed throughout the borough (Figure 6.17).

Existing outlets include:

- 5 Education settings
- 14 Healthcare settings – mainly pharmacies and NELFT
- 7 Children's Centres
- 4 Youth settings

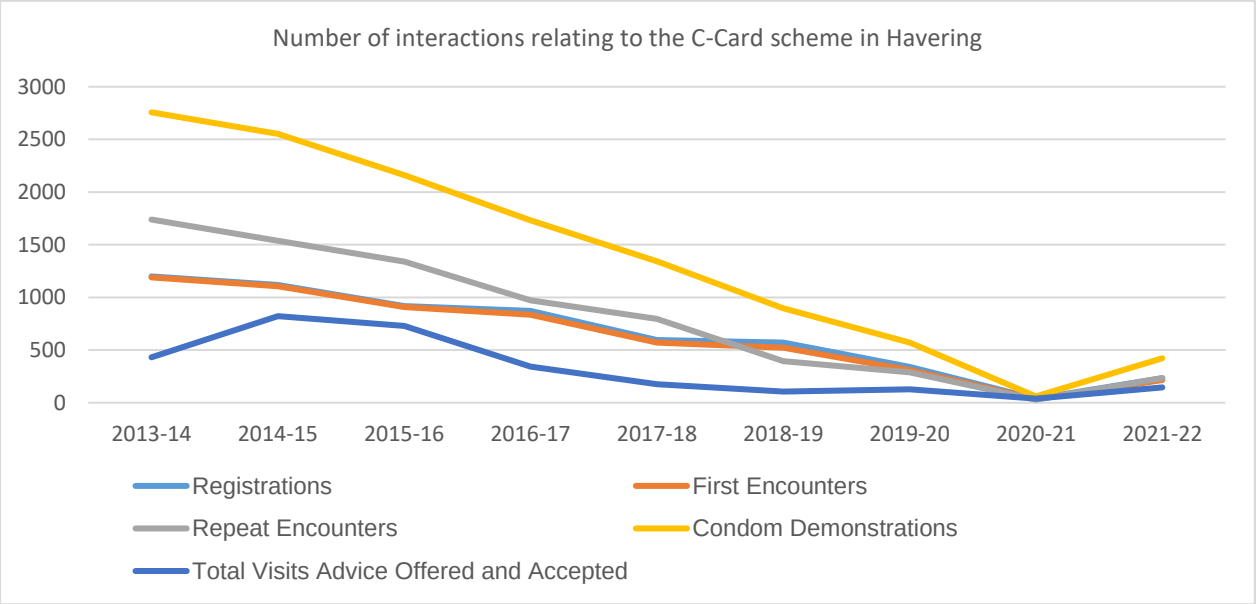
[160] Havering - Come Correct

Figure 6.17 Locations of C-Card Registration and Distribution Points Across Havering



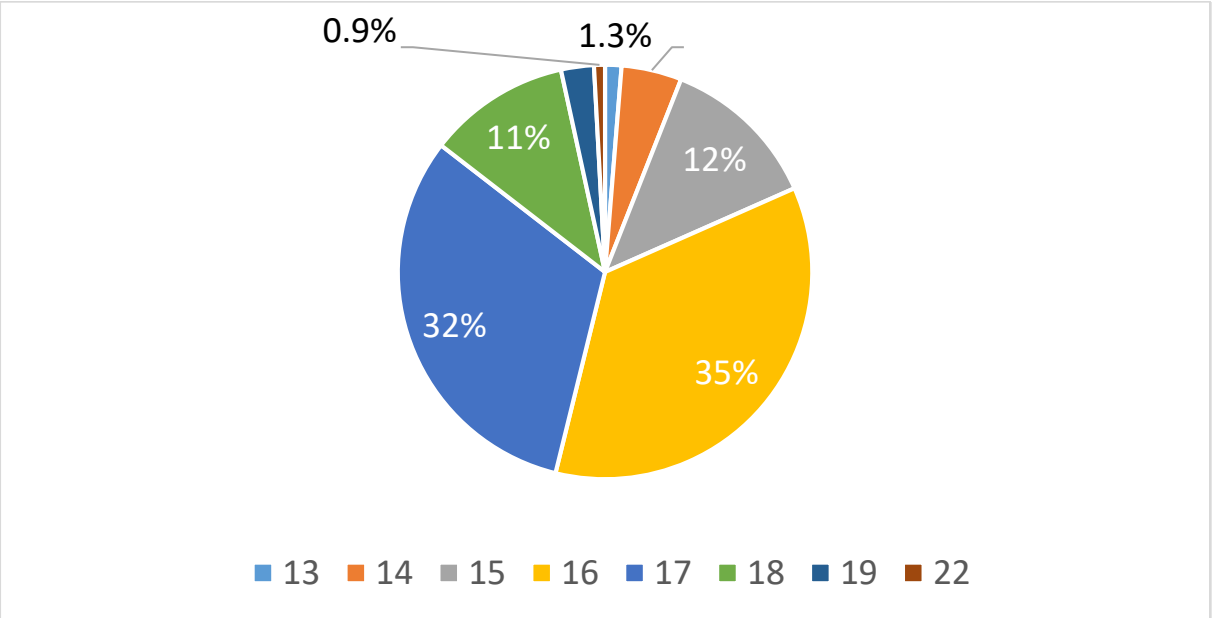
In 2021-22 there were a total of 234 registrations, a significant improvement from the 38 achieved during the height of the COVID-19 pandemic in 2020-21. However, despite this recent improvement, the overall trend in use of the C-Card scheme has declined since its inception in 2013 (Figure 6.18). Renewed effort in increasing the number and range of C-Card outlets is recommended to increase access to condoms, as an effective method of preventing STIs as well as reducing the number of teenage conceptions.

Figure 6.18 Number of C-Card Interactions in Havering 2013 to 2022



In 2021-22, the scheme had a total of 234 registrations, of which 69% were male, 29% were female, and 2% were non-binary or transgender. Just over one third of registrations were for young people aged 16 (Figure 6.19). Over this same period, 3,659 condoms were distributed; 79% of these were distributed to males, 21% to females. The most popular condom distribution site was Havering College, Ardleigh Green Campus, which distributed 75% of all condoms given out by the scheme that year.

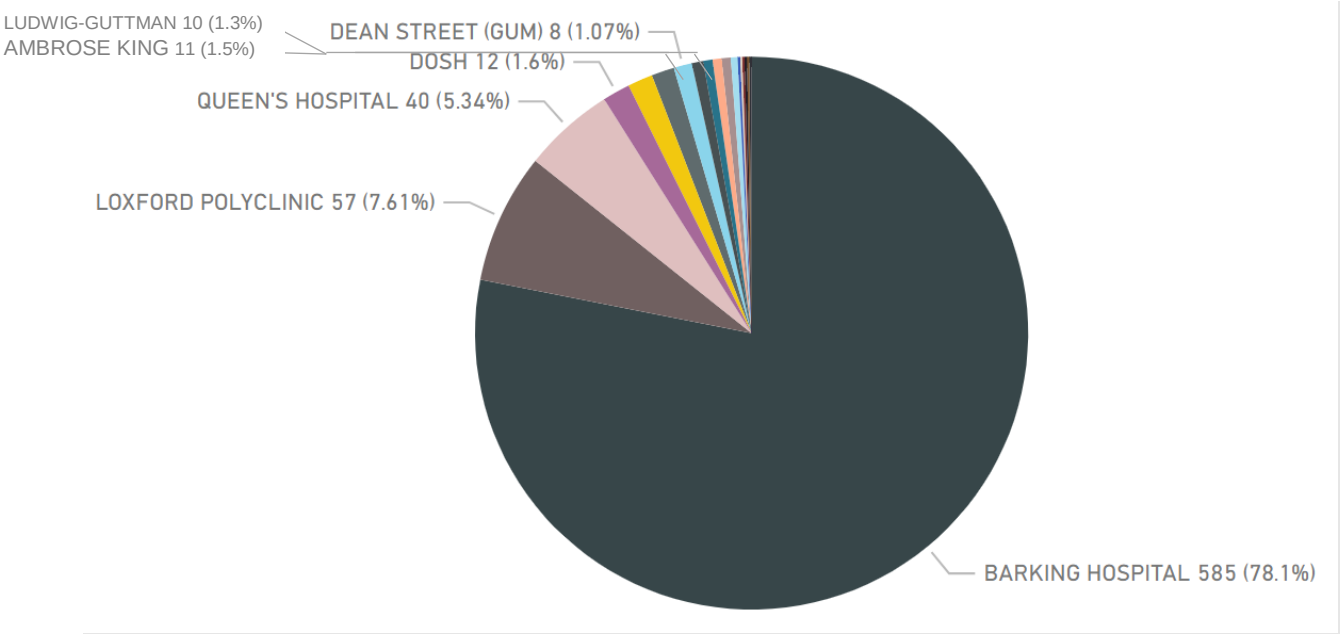
Figure 6.19 Age at Registration (%), 2021-22, Havering



6.4.2 Provision of LARC Services at Sexual Health Clinics

In 2021-22, 78.1% of Havering women choosing LARC services from sexual health clinic visited their local service at Barking Hospital; 7.6% went to Loxford Polyclinic in Redbridge; 5.4% went to Queen's hospital, and the remainder chose out of area clinics (Figure 6.21).

Figure 6.21 Location of where Havering residents chose to access LARC through Sexual Health Services, 2021-22



6.4.3 Provision of LARC Services in GP Settings

Provision of LARC services in Havering was contracted in 2019 with a total of 11 GP practices comprising a total of 17 individual GPs who were able to provide a variety of LARC devices (IUS/IUD, Implant, Injection) (Figure 6.22). The aim of this service was to provide women with a more informed choice about their contraception, and encourage a longer lasting, more effective method of contraception and reduce levels of discontinuation by:

- Raising awareness of the benefits of LARC by providing high quality advice, support and information on the full range of contraception methods to all women on or seeking contraception.
- Providing appropriate counselling to ensure side effects are known and understood before the patient's choice is made.
- Increasing the availability of LARC through primary care and contribute to improved uptake rates of LARC.
- Increasing access to post-coital IUD for emergency contraception for those who choose this method.

Figure 6.22 Havering GPs who are contracted by LBH to provide LARC services

Practice - LARC	
The Greenwood Practice	The Rosewood Medical Centre
The New Medical Centre	Wood Lane Medical Centre
North Street Medical Care	Modern Medical Centre
Western Road Medical Centre	Cranham Village Surgery
Central Park Surgery	Hornchurch Healthcare

Accreditation for LARC fitting, to ensure GPs and practice nurses are suitably qualified, is available via BHRUT SH services as part of their standard contract. However, there is a gap

in the number of GPs currently providing LARC services, and it is recommended that more GPs are sought as LARC fitters.

6.4.4 Access to Emergency Hormonal Contraception (EHC)

Emergency Hormonal Contraception is available for free when accessed at GPs, sexual health services and family planning clinics. In addition, currently 2 pharmacies are contracted to provide free EHC specifically for 13 to 25 year olds with the aim of increasing access to sexual health to reduce unintended pregnancies.

- Crescent Pharmacy
- MIM Pharmacy

In addition, the services aim to increase knowledge by providing information and advice as appropriate on sexual health issues including STIs, avoiding unplanned pregnancy, contraception and delaying sex (as appropriate). Clients, especially those from hard to reach groups, or groups who experience inequalities in health outcomes, are also referred on to mainstream contraceptive and sexual heath services. The contract allows the provider to supply Levonorgestrol or Ulispristal EHC to appropriate clients in line with relevant guidance and patient group directions (PGDs), by accredited pharmacists.

In addition, EHC can be bought over the counter at most of the pharmacies in Havering.

6.5 Recommendations

Recommendations for Contraception
Frontline staff and service commissioners to ensure there is good quality engagement with residents to understand the barriers for accessing sexual health services local to Havering.
Support locally commissioned SRH services to increase access to appointments, particularly seeking opportunities for online appointments, whilst reducing non-attendance.
Increase awareness about the range of contraception options across Havering, targeting engagement to people and areas at higher risk of unplanned pregnancy.
Post-labour ensure that all new mothers receive and understand information about contraceptive choices and its importance in preventing rapid repeat pregnancy.
Develop collaborative targeted approach to improve the uptake of contraception within the young population, particularly utilising statutory RSE education in schools to openly discuss choices available to young people.
Engage young people in Havering to understand their contraceptive choices and identify barriers in accessing alternative and potentially more reliable LARC contraceptive services, particularly those under 25 years old.
C-Card scheme: • Add more venues to C-Card scheme increase access • Switch registration process to online and at outlet • Evidence review to identify effective evidence-based approaches for the delivery of the scheme

List of Abbreviations

Abbreviation	Description
AIDS	Acquired Immune Deficiency Syndrome
BASHH	British Association of Sexual Health and HIV
CSE	Child Sexual Exploitation
CTAD	Chlamydia Testing Activity Database
GUM	Genito-Urinary Medicine
GUMCAD	Genito-Urinary Medicine Clinic Activity Dataset
HepB	Hepatitis B virus
HIV	Human Immunodeficiency Virus
ICP	Integrated Care Partnership
ICS	Integrated Care System
IUD	Intra-Uterine Device
IUS	Intra-Uterine System
LARC	Long Acting Reversible Contraceptive
LASER	Local Authority SExual health Reports
LGBTQ+	People who are Lesbian, Gay, Bisexual, Trans, Queer, Questioning and Intersex
GBMSM	Gay, bisexual and other men who have sex with men
NATSAL	National Attitude Survey and Lifestyle Survey
NHSE	NHS England
NICE	National Institute for Health and Clinical Excellence
OHID	Office for Health Improvement and Disparities
PHE	Public Health England
PEP	Post-Exposure Prophylaxis
PEPSE	Post-Exposure Prophylaxis after Sexual Exposure to HIV
PrEP	Pre-Exposure Prophylaxis
RSE	Relationship and Sex Education
SARC	Sexual Assault Referral Centre
SHNA	Sexual Health Needs Assessment
SPLASH	Summary Profile of Local Authority Sexual Health

SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
WHO	World Health Organisation
WSW	Women who have Sex with Women

Appendix 1: Contraceptive Methods at a Glance

Contraceptive methods that don't depend on you remembering to take or use them.

	 Contraceptive implant	 Intrauterine device (IUD)	 Intrauterine system (IUS)	 Contraceptive injection	 Sterilisation
What is it?	A small, flexible rod put under the skin of the upper arm releases progestogen.	A small plastic and copper device is put into the uterus (womb).	A small, T-shaped, progestogen-releasing, plastic device is put into the uterus (womb).	An injection of progestogen.	The fallopian tubes in women or the tubes carrying sperm in men (vas deferens) are cut, sealed or blocked.
Effectiveness	Perfect use: over 99%. Typical use: over 99%.	Perfect use: over 99%. Typical use: over 99%.	Perfect use: over 99%. Typical use: over 99%.	Perfect use: over 99%. Typical use: around 94%.	Overall failure rate is about 1 in 200 for females and 1 in 2,000 for males.
Advantage	Works for 3 years but can be taken out sooner if you choose.	Works for 5 or 10 years depending on type but can be taken out sooner if you choose. Can be used as emergency contraception and left in place as an ongoing method.	Works for 3, 5 or 6 years but can be taken out sooner if you choose. Periods often become lighter, shorter and less painful.	Works for 8 or 13 weeks depending on which type is used – you don't have to think about contraception during this time.	Sterilisation is permanent with no long or short-term serious side effects.
Disadvantage	It requires a small procedure to fit and remove it.	Periods may be heavier, longer or more painful.	Irregular bleeding or spotting is common in the first 6 months.	Can't be removed from the body so side effects may continue while it works and for some time afterwards.	Shouldn't be chosen if in any doubt about having children in the future.

Contraceptive methods that you have to use and think about regularly or each time you have sex.

	 Contraceptive patch	 Contraceptive vaginal ring	 Combined pill (COC)	 Progestogen-only pill (POP)	 External condom	 Internal condom	 Diaphragm/cap with spermicide	 Fertility awareness methods
What is it?	A small patch stuck to the skin releases estrogen and progestogen.	A small, flexible, plastic ring put into the vagina releases estrogen and progestogen.	A pill containing estrogen and progestogen, taken orally.	A pill containing progestogen, taken orally.	A very thin latex (rubber) polyurethane (plastic) or synthetic sheath, put over the erect penis.	Soft, thin polyurethane sheath that loosely lines the vagina and covers the area just outside.	A flexible latex (rubber) or silicone device, used with spermicide, is put into the vagina to cover the cervix.	Fertile and infertile times of the menstrual cycle are identified by noting different fertility indicators.
	PERFECT USE MEANS USING THE METHOD CORRECTLY EVERY TIME. TYPICAL USE IS WHEN YOU DON'T ALWAYS USE THE METHOD CORRECTLY.							
Effectiveness	Perfect use: over 99%. Typical use: around 91%.	Perfect use: over 99%. Typical use: around 91%.	Perfect use: over 99%. Typical use: around 91%.	Perfect use: over 99%. Typical use: around 91%.	Perfect use: 98%. Typical use: around 82%.	Perfect use: 95%. Typical use: around 79%.	Perfect use: 92–96%. Typical use: 71–88%.	Perfect use: up to 99%. Typical use: around 76%.
Advantage	Can make bleeds regular, lighter and less painful.	One ring stays in for 3 weeks – It usually makes bleeding regular, lighter and less painful.	Often reduces bleeding and period pain, and may help with premenstrual symptoms.	Can be used if you smoke and are over 35. Can be used if you can't take estrogen.	Condoms are the best way to help protect yourself from sexually transmitted infections.		Can be put in before sex.	No physical side effects, and can be used to plan as well as prevent pregnancy.
Disadvantage	May be seen and can cause skin irritation.	You must be comfortable with inserting and removing it.	Missing pills, vomiting or severe diarrhoea can make it less effective.	Late pills, vomiting or severe diarrhoea can make it less effective.	May slip off or split if not used correctly or if wrong size or shape.	Not as widely available as external condoms.	You need to use the right size. If you have sex again extra spermicide is needed.	Need to avoid sex or use a condom at fertile times of the cycle.