UK Health Security Agency

Summary profile of local authority sexual health

Harrow

27 January 2022

Key findings

- This report summarises the latest available sexual and reproductive health data for Harrow. As a response to the COVID-19 pandemic, the Government implemented national and regional lockdowns and social and physical distancing measures since March 2020. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.
- Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Harrow in 2020 was 1,602. The rate was 635 per 100,000 residents, higher than the rate of 562 per 100,000 in England, and lower than the average of 723 per 100,000 among its nearest neighbours.
- Harrow ranked 26th highest out of 149 upper tier local authorities (UTLAs) and unitary authorities (UAs) for new STI diagnoses excluding chlamydia among young people aged 15 to 24 years in 2020, with a rate of 774 per 100,000 residents aged 15 to 64, worse than the rate of 619 per 100,000 for England.
- The chlamydia detection rate per 100,000 young people aged 15 to 24 years in Harrow was 1,289 in 2020, similar to the rate of 1,408 for England.
- The rank for gonorrhoea diagnoses (a marker of high levels of risky sexual activity) in Harrow was 37th highest (out of 149 UTLAs/UAs) in 2020. The rate per 100,000 was 111, similar to the rate of 101 in England.
- Among specialist sexual health service (SHS) patients from Harrow who were eligible to be tested for HIV, the percentage tested in 2020 was 58.0%, better than the 46.0% in England.
- The number of new HIV diagnoses among people aged 15 years and above in Harrow was 15 in 2020. The prevalence of diagnosed HIV per 1,000 people aged 15 to 59 years in 2020 was 2.4, similar to the rate of 2.3 in England. The rank for HIV prevalence in Harrow was 50th highest (out of 148 UTLAs/UAs).
- In Harrow, in the three year period between 2018 - 20, the percentage of HIV diagnoses made at a late stage of infection (all individuals with CD4 count ≤350 cells/mm^3 within 3 months of diagnosis) was 60.0%, worse than 42.4% in England.
- The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in primary care, specialist and non-specialist SHS per 1,000 women aged 15 to 44 years living in Harrow was 23.4 in 2020, lower than the rate of 34.6 per 1,000 women in England. The rate prescribed in primary care was 5.9 in Harrow, lower than the rate of 21.1 in England. The rate prescribed in the other settings was 17.5 in Harrow, higher than the rate of 13.4 in England.
- The total abortion rate per 1,000 women aged 15 to 44 years in 2020 was 21.0 in Harrow, higher than the England rate of 18.9 per 1,000. Of those women

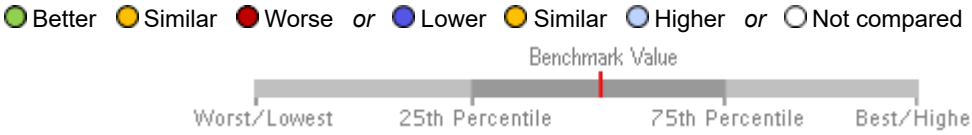
under 25 years who had an abortion in 2020, the proportion who had had a previous abortion was 28.9%, similar to 29.2% in England.

- In 2019, the conception rate for under-18s in Harrow was 8.4 per 1,000 girls aged 15 to 17 years, better than the rate of 15.7 in England.
- In 2019/20, the percentage of births to mothers under 18 years was suppressed, and not compared to 0.7% in England overall.

Figure 1. Chart showing key sexual and reproductive health indicators in Harrow compared to the rest of England

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

Compared to England:



Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
New STI diagnoses (exc chlamydia aged <25) / 100,000	2020	1,245	773.8	619.0	3,547.0	247.2
Syphilis diagnostic rate / 100,000	2020	42	16.6	12.2	147.9	0.0
Gonorrhoea diagnostic rate / 100,000	2020	279	110.6	100.9	1,024.2	9.8
Chlamydia detection rate / 100,000 aged 15 to 24	2020	346	1,289.1	1,408.4	547.8	3,407.9
Chlamydia proportion aged 15 to 24 screened	2020	3,740	13.9	14.3	4.1	36.5
STI testing rate (exc chlamydia aged <25) / 100,000	2020	8,367	5,200.4	4,549.3	940.6	19,881.8
New HIV diagnosis rate per 100,000 aged 15 years and over	2020	15	7.4	5.7	27.5	0.0
HIV late diagnosis (all CD4 less than 350) (%)	2018 - 20	30	60.0	42.4	72.7	16.7
HIV diagnosed prevalence rate per 1,000 aged 15 to 59	2020	348	2.4	2.3	13.1	0.5
HIV testing coverage, total (%)	2020	2,322	58.0	46.0	12.0	85.8
Total abortion rate / 1,000	2020	995	21.0	18.9	31.1	11.4
Abortions under 10 weeks (%)	2020	849	87.9	88.1	79.9	93.8
Under 18s conception rate / 1,000	2019	35	8.4	15.7	37.1	3.9
Total prescribed LARC excluding injections rate / 1,000	2020	1,110	23.4	34.6	5.3	60.9
Violent crime - sexual offences per 1,000 population	2020/21	351	1.4	2.3	1.0	4.4

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Introduction

Aim

This report describes sexual and reproductive health in a local area in an integrated way, including sexually transmitted infections (STIs), HIV, under-18 conceptions, abortion and Long Acting Reversible Contraception rates for women aged 15 to 44.

This is produced alongside other local HIV, sexual and reproductive health intelligence tools provided by the UK Health Security Agency (UKHSA) to help inform local Joint Strategic Needs Assessments (JSNAs) so that commissioners can effectively target service provision.

This report has been produced by the UKHSA, with support from the Office for Health Improvement and Disparities (OHID).

Information used in this report

Unless otherwise indicated this report is compiled from publicly available data on the online Sexual and Reproductive Health Profiles. Please access this tool for further data analysis and more information about the data included in this report which is described in the ‘definitions’ tab for each indicator.

Please note that City of London and Isles of Scilly are not included in the rankings in this document. Where comparisons are made to Hackney or Cornwall, please note that the data for these areas may have been combined with City of London and Isles of Scilly respectively. Please check the online Profiles.

Please note any mention of UKHSA Centre is equivalent to PHE Centres mentioned in previous versions of this report.

For an introductory guide on sexual health data sources, please access https://www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data.

Viewing this report and converting to PDF

This report has been developed for the best viewing experience in Google Chrome. It has also been tested with Internet Explorer 11 and Microsoft Edge, but some content may look different (for example, the table of contents is not available in Internet Explorer).

When viewed in Google Chrome, this report can be converted to a PDF through the Print menu. Select “Save as PDF” as the destination. For the best result, it is recommended to select the “background graphics” option, and deselect the “headers and footers” option.

Some other browsers also offer PDF conversion, but the formatting may not display as intended.

STIs

As STIs are often asymptomatic, frequent STI screening of groups with greater sexual health needs is important and should be conducted in line with national guidelines. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. Vaccination is an intervention that can be used to control genital warts, hepatitis A and hepatitis B, however, control of other STIs relies on consistent and correct condom use, behaviour change to decrease overlapping and multiple partners, ensuring prompt access to testing and treatment, and ensuring partners of cases are notified and tested.

There was an increasing trend in diagnoses of chlamydia, gonorrhoea and syphilis in England from 2010 until 2019, while diagnoses of genital warts have decreased since 2013 due to the protective effect of HPV vaccination.[1] Increasing diagnosis rates for chlamydia among people aged 15 to 24 years are largely driven by changes in testing activity through the National Chlamydia Screening Programme (NCSP), although ongoing high levels of condomless sex will have played a role. The NCSP data tables provide additional data on chlamydia testing coverage, positivity and diagnostic rates (for those aged 15 to 24 years).[2]

Since March 2020, in response to the Coronavirus Disease 2019 (COVID-19) pandemic, the UK Government implemented strict non-pharmaceutical interventions (NPIs) in the form of national and regional lockdowns, as well as social and physical distancing measures including an emphasis on staying at home. Sexual health services (SHS) in England had substantially reduced capacity to deliver face-to-face consultations but underwent rapid reconfiguration to increase access to STI testing via telephone or internet consultations. STI testing and diagnoses decreased across all infections between 2019 and 2020. Over this period, larger decreases in diagnoses were observed for STIs that are usually diagnosed clinically at a face-to-face consultation, such as genital warts or genital herpes, when compared to those that could be diagnosed using remote self-sampling kits such as chlamydia and gonorrhoea.[3] In 2020, STIs continued to disproportionately impact gay, bisexual and other men who have sex with men (MSM), young people aged 15 to 24 years, and people of Black Caribbean ethnicity.

This report has been compiled using data from SHS and ‘community-based’ settings routine returns to the GUMCAD STI and CTAD Chlamydia surveillance systems.

‘Sexual health services’ refer to services offering specialist (level 3) STI-related care such as genitourinary medicine (GUM) and integrated GUM and sexual and reproductive health (SRH) services. They also include other services offering non-specialist (level 1 or level 2) STI-related care and community-based settings such as young people’s services, internet services, termination of pregnancy services,

pharmacies, outreach, and general practice. Further details on the levels of sexual healthcare provision are provided in the BASHH Standards for the Management of STIs (Appendix B).

Burden and trend of new STIs

A total of 1,602 new STIs were diagnosed in residents of Harrow in 2020. It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour.

When interpreting trends, please note:

- The decrease in STI testing and diagnoses in 2020 due to the reconfiguration of sexual health services during the COVID-19 pandemic response
- Recent decreases in genital warts diagnoses are due to the protective effect of HPV vaccination, and are particularly evident in the younger age groups (25 and younger) who have been offered the vaccine since the national programme began

Figure 2. Chart showing key STI indicators in Harrow compared to the rest of England

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

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
All new STI diagnosis rate / 100,000	2020	1,602	634.9	562.2	224.8	3,059.9
New STI diagnoses (exc chlamydia aged <25) / 100,000	2020	1,245	773.8	619.0	3,547.0	247.2
STI testing rate (exc chlamydia aged <25) / 100,000	2020	8,367	5,200.4	4,549.3	940.6	19,881.8
STI testing positivity (exc chlamydia aged <25) %	2020	573	6.8	7.3	2.9	19.0
Gonorrhoea diagnostic rate / 100,000	2020	279	110.6	100.9	1,024.2	9.8
Syphilis diagnostic rate / 100,000	2020	42	16.6	12.2	147.9	0.0
Genital warts diagnostic rate / 100,000	2020	124	49.1	48.6	160.2	16.5
Genital herpes diagnosis rate / 100,000	2020	115	45.6	36.3	129.6	7.0
Chlamydia diagnostic rate / 100,000	2020	674	267.1	285.9	96.7	1,171.5
Chlamydia detection rate / 100,000 aged 15 to 24 (female)	2020	238	1,915.8	1,888.5	741.6	3,968.1
Chlamydia detection rate / 100,000 aged 15 to 24 (male)	2020	105	728.3	916.4	330.4	2,956.5
Chlamydia detection rate / 100,000 aged 15 to 24	2020	346	1,289.1	1,408.4	547.8	3,407.9
Chlamydia diagnostic rate / 100,000 aged 25+	2020	324	185.5	170.6	1,084.3	46.2
Chlamydia proportion aged 15 to 24 screened	2020	3,740	13.9	14.3	4.1	36.5

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Table 1. Rates per 100,000 population of new STIs in Harrow and England: 2019-2020

Diagnoses	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
New STIs	953.6	634.9	-33.4%	8	39	562.2
New STIs (exc chlamydia aged <25)[1]	1,066.1	773.8	-27.4%	8	26	619.0
Chlamydia	465.0	267.1	-42.6%	9	64	285.9
Gonorrhoea	133.8	110.6	-17.4%	11	37	100.9
Syphilis	16.7	16.6	-0.5%	7	29	12.2
Genital warts	78.8	49.1	-37.7%	13	59	48.6
Genital herpes	67.7	45.6	-32.7%	6	30	36.3

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* Percent change not provided where the value in 2019 was 0.
† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 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.
[1] Population is restricted to those aged 15-64 years

Table 2. Number of new STIs by year, Harrow

Diagnoses	2012	2013	2014	2015	2016	2017	2018	2019	2020
New STIs	1,479	1,555	1,645	1,596	1,636	1,646	1,766	2,395	1,602
New STIs (exc chlamydia aged <25)[1]	1,144	1,204	1,312	1,281	1,255	1,290	1,358	1,715	1,245
Chlamydia	532	554	566	540	626	618	723	1,168	674
Gonorrhoea	121	156	140	159	141	202	231	336	279
Syphilis	10	5	13	23	18	23	29	42	42
Genital warts	207	209	231	220	245	216	210	198	124
Genital herpes	129	122	112	114	129	128	122	170	115

[1] Population is restricted to those aged 15-64 years

Figure 3. Map of new STI diagnoses (excluding chlamydia in under 25-year olds) per 100,000 population aged 15–64 years in Harrow by Middle Super Output Area: 2020

Please note that this data is not available on the online Sexual and Reproductive Health profiles. Data is sourced from routine specialist and non-specialist sexual health services' returns to the UKHSA GUMCAD STI Surveillance System and from routine non-specialist sexual health services' returns to the CTAD Chlamydia Surveillance System. As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider this reconfiguration, especially when comparing with data from pre-pandemic years.

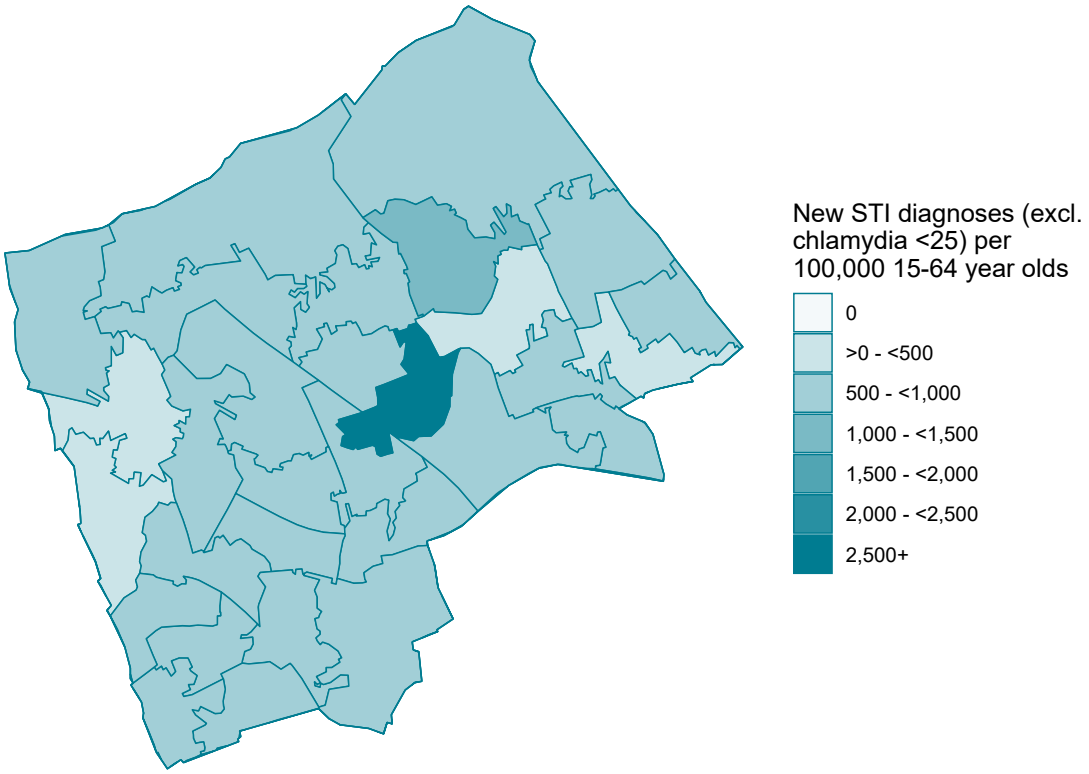

Figure 4. Rates per 100,000 population of new STIs (excluding chlamydia in under 25-year olds) in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model

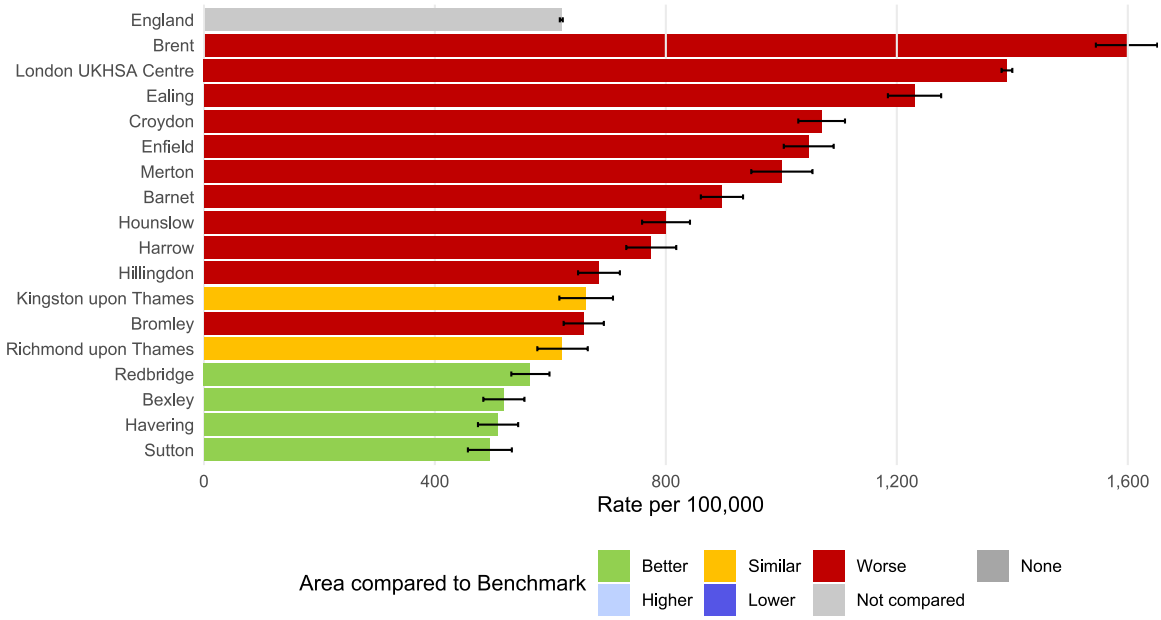

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Figure 5. Rates per 100,000 population by diagnosis by year in Harrow compared to rates in the London UKHSA Centre and England: 2012 to 2020

Please note the charts have different y axis scales.

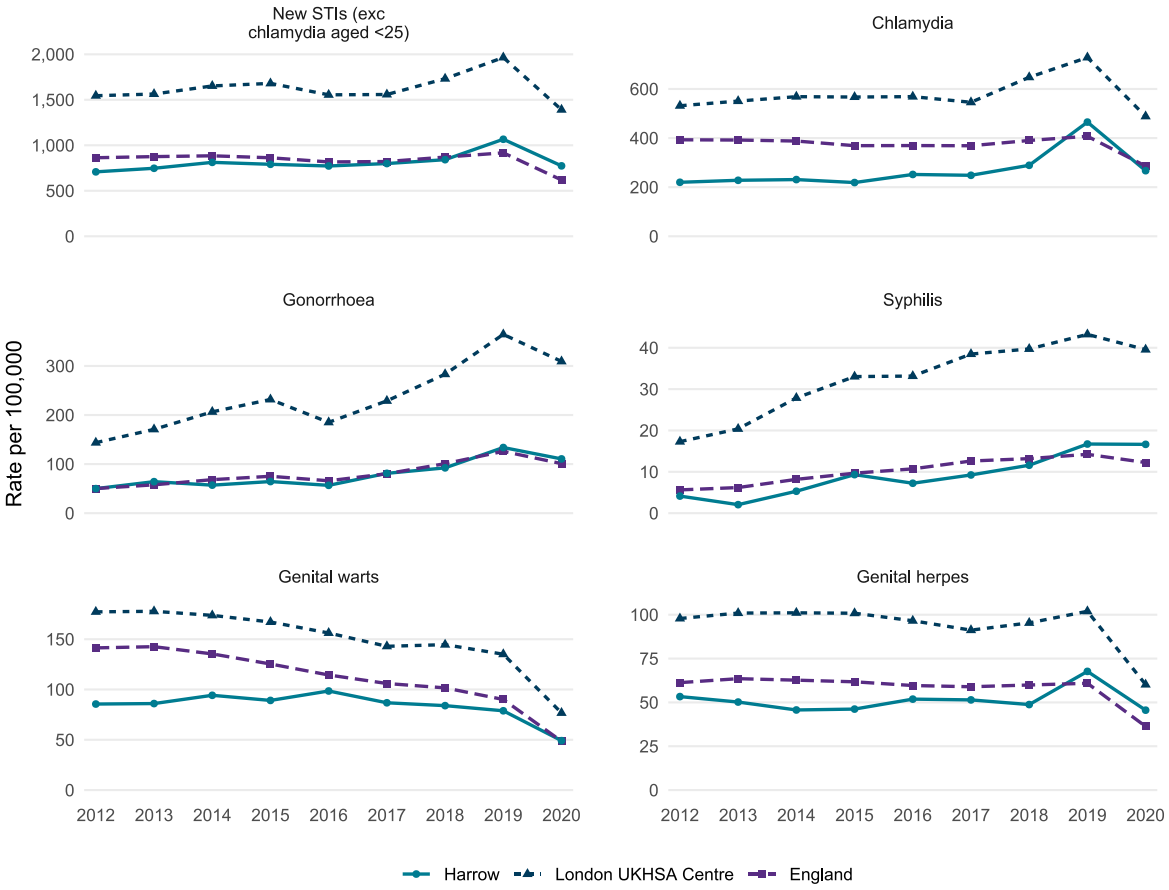

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Figure 6. Rates per 100,000 population of gonorrhoea in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model

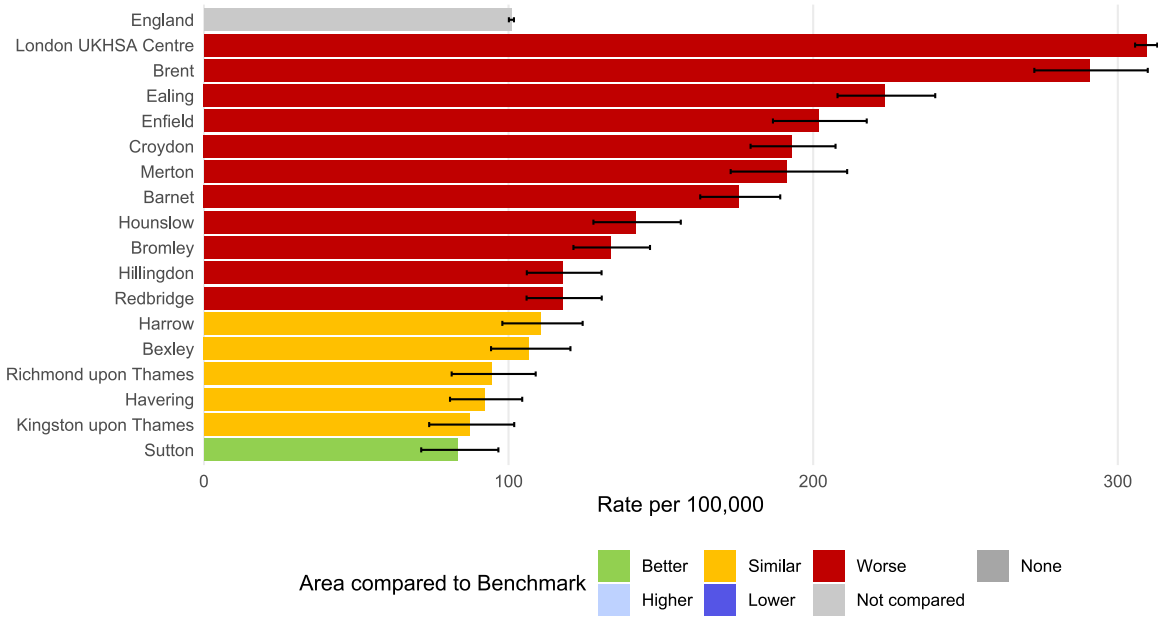

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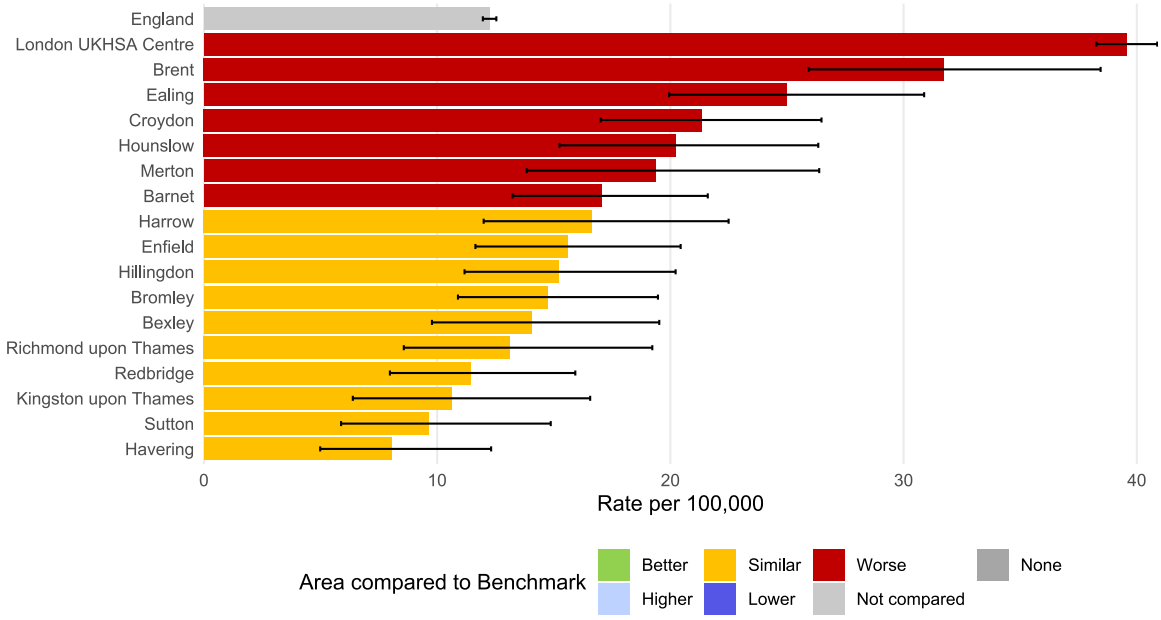
Figure 7 shows rates of syphilis per 100,000 population for Harrow, compared to national, regional, and neighbouring rates. The UKHSA has conducted an in-depth examination of the national epidemiology of syphilis from 2010-2019,[4] in alignment with the Syphilis Action Plan (2019).[5]

Figure 7. Rates per 100,000 population of syphilis in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020.

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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Chlamydia detection

In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection.[6] These harms occur predominantly in young women and other people with a womb or ovaries - this includes transgender men, non-binary people assigned female at birth, and intersex people with a womb or ovaries. Therefore, opportunistic screening should focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment.

In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.

Given the change in programme aim, the Public Health Outcome Framework (PHOF) Detection Rate Indicator (DRI) benchmarking thresholds have been revised and will be measured against females only. A new female-only PHOF benchmark DRI will be included in the PHOF from January 2022 (to be reported in 2023).

This report covers 2020 data and uses the previous population DRI recommending that local areas achieve a detection rate of at least 2,300 per 100,000 residents (aged 15 to 24 years). Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences.

The chlamydia detection rate in 15 to 24 year olds in 2020 in Harrow was 1,289 per 100,000 population (346 positives out of 3,740 screened), lower than the 2,300 target. 13.9% of 15 to 24 year olds were tested for chlamydia, compared to 14.3% nationally. The detection rate per 100,000 and its rank among CIPFA nearest neighbours and England are shown in Table 3.

Table 3. Chlamydia detection rate per 100,000 population and percentage screened in 15 to 24 year olds in Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Detection rate						
Total	2,503.5	1,289.1	-48.5%	10	84	1,408.4
Women	3,474.3	1,915.8	-44.9%	7	59	1,888.5
Men	1,628.2	728.3	-55.3%	13	107	916.4
Percentage screened						
People aged 15-24	24.2	13.9	-42.3%	11	64	14.3

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* Percent change proportional to the value in 2019, not a change in percentage points. Percent change not provided where the value in 2019 was 0.
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‡ Out of 149 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.

Variation in rates of chlamydia detection (Figure 8) may represent differences in prevalence, but are influenced by screening coverage and whether most at risk populations are being reached (i.e. the proportion testing positive).

Figure 8. Map of chlamydia detection rate per 100,000 population in 15 to 24 years in Harrow by Middle Super Output Area: 2020

Please note that this data is not available on the online Sexual and Reproductive Health profiles. Data is sourced from the CTAD Chlamydia Surveillance System (CTAD). As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider this reconfiguration, especially when comparing with data from pre-pandemic years.

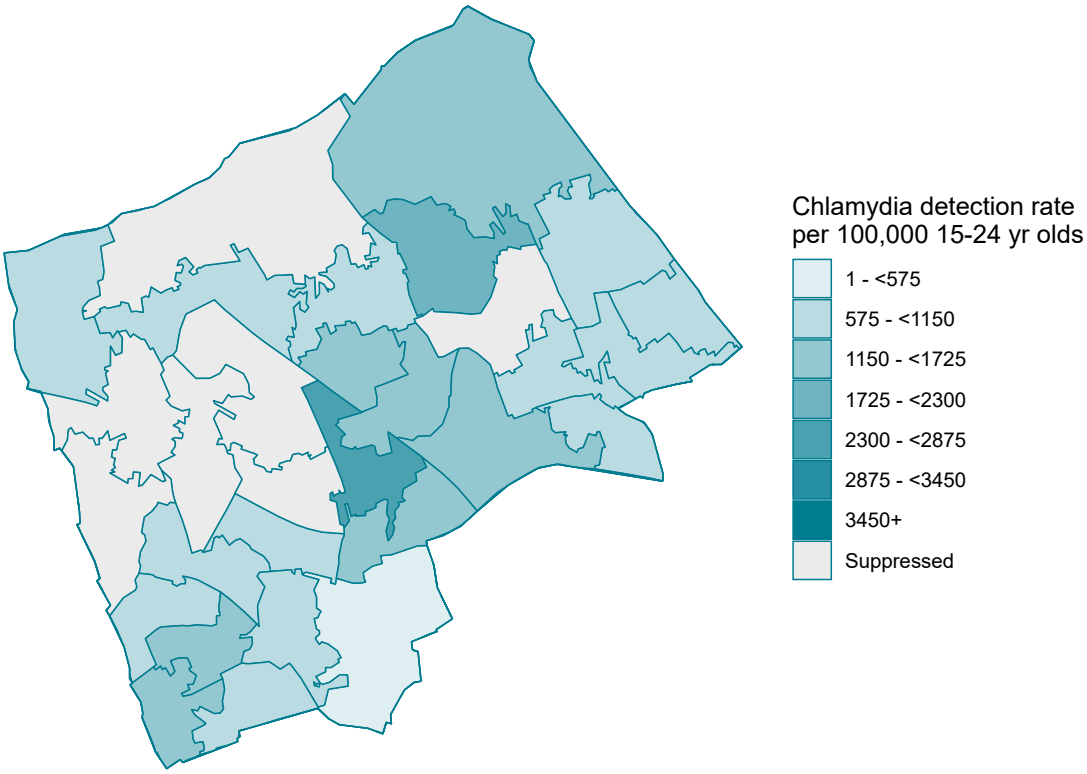
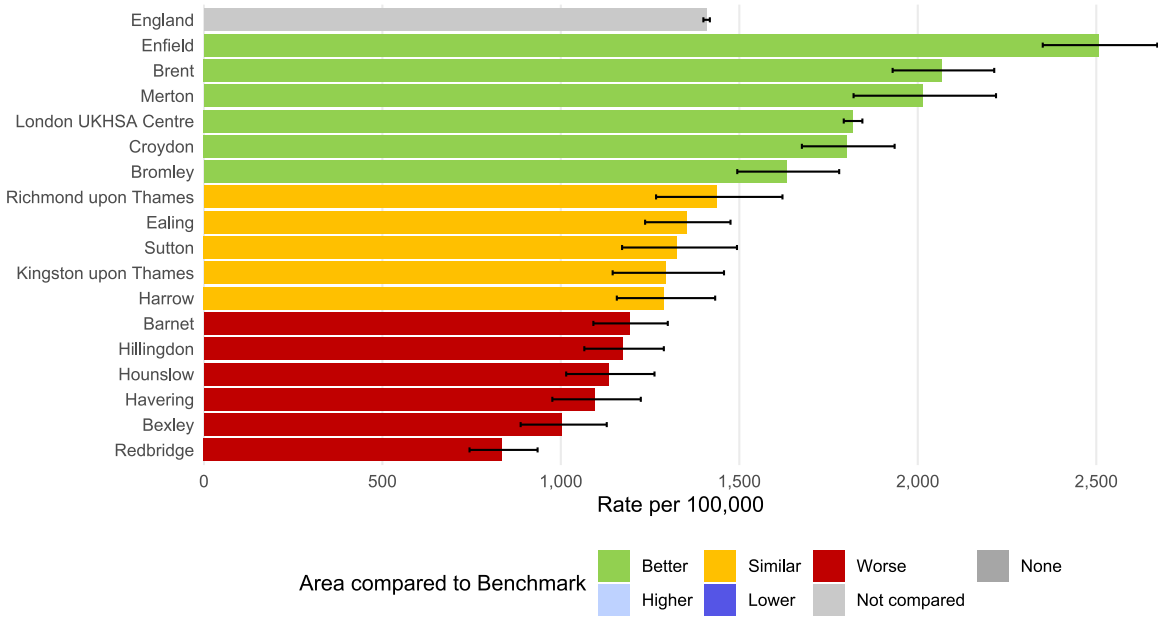


Figure 9. Chlamydia detection rate per 100,000 population in 15 to 24 year olds in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



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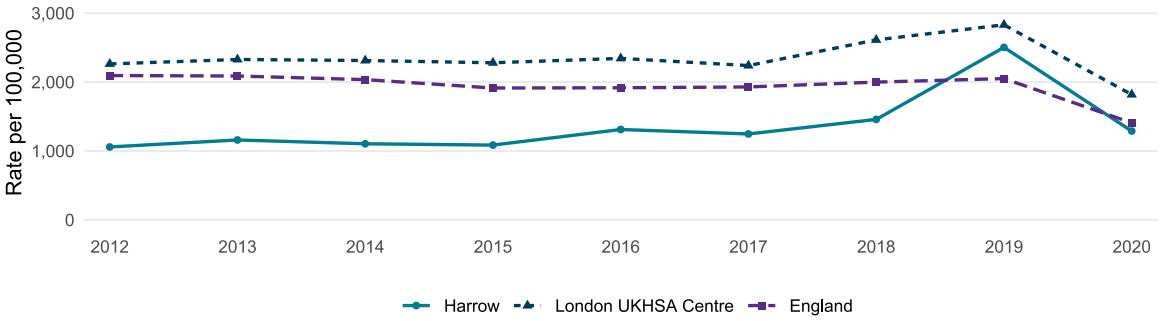
In the five years from 2015 to 2020, there was a 19% increase in the chlamydia detection rate among 15 to 24 year olds in Harrow. From 2019, the decrease was 49%.

Figure 10. Chlamydia detection rate per 100,000 population in 15 to 24 year olds by year in Harrow, the London UKHSA Centre and England



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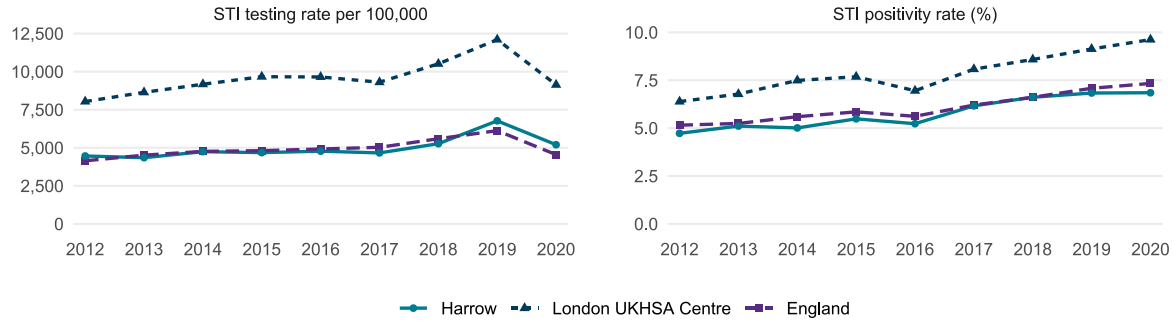
STI testing in sexual health services (SHS)

In 2020 the rate of STI testing (excluding chlamydia in under 25 year individuals) in SHS in Harrow was 5,200 per 100,000 aged 15 to 64 years, a 23% decrease compared to 2019. This is higher than the rate of 4,549 per 100,000 in England in 2020. The positivity rate in Harrow was 6.8% in 2020, similar to 7.3% in England. Positivity rates depend both on the number of diagnoses and the offer of testing: higher positivity rates compared with previous years can represent increased burden of infection, decreases in the number of tests, or both.

The methodology to calculate the STI positivity changed in September 2021 to better reflect testing within the population accessing SHS by area. More details are available on the Sexual and Reproductive Health Profiles.[7]

Figure 11. STI testing rate and positivity rate (excluding chlamydia in under 25 year olds) per 100,000 population aged 15 to 64 years by year in Harrow, the London UKHSA Centre and England: 2012 to 2020



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Other infections transmitted sexually

Some bloodborne viruses can be spread through sex as well as by other routes, e.g. hepatitis B, hepatitis C. Some gastro-intestinal infections, typically linked to contaminated food or water can also be spread faecal-orally during sexual activity: these are called sexually transmissible enteric infections (STEIs) e.g. hepatitis A and *Shigella*.

Over the last decade, the number of cases of sexually-transmitted *Shigella* among MSM in England has increased,[8] with concerning increases in antimicrobial resistance. Cases of shigellosis can be severe, leading to dehydration and sepsis. Due to its presentation as an enteric illness, most symptomatic cases present to primary care (GPs, A&E) rather than SHS. Only a minority of MSM are thought to be aware of *Shigella* and how to avoid it, however, surveillance shows transmission of these infections is commonly associated with high-risk behaviours such as sexualised drug-use (including 'chemsex') and multiple casual sex partners.

Lymphogranuloma venereum (LGV), an invasive form of chlamydia, is a sexually transmitted infection which disproportionately affects MSM. In the past decade, the number of LGV diagnoses has increased substantially in England. Historically, LGV was mainly concentrated among MSM living with HIV. However, in recent years, a greater proportion of cases have been among MSM who are HIV negative.[9]

Hepatitis A vaccination is available for MSM in SHS. In 2016 an outbreak of hepatitis A was identified among MSM in England and across Europe. Between July 2016 and April 2017 266 cases associated with the outbreak had been identified in England, 74% of these among MSM.[10] This resulted in work to raise awareness of how to prevent infection through hygiene measures (e.g. washing hands after sex)[11] and recommendations around hepatitis A vaccination of MSM attending SHS. This outbreak highlights how quickly and widely an infection can become established in key populations if prevention measures such as vaccination are not undertaken.

In England, hepatitis B is most often acquired sexually. Where information on risk exposures was recorded on acute and probable acute cases of hepatitis B, the most commonly reported risk was heterosexual exposure (50%), followed by sex between men (17%).[12] Vaccination can prevent infection and is recommended for MSM, for individuals with multiple sexual partners and for individuals who place themselves at risk through sexual activity when travelling to high prevalence countries.

Most people in England acquire hepatitis C through injecting drug use.[13] However, MSM are also a risk group for hepatitis C transmission. MSM living with diagnosed HIV, especially those reporting high risk sexual practices, are disproportionately

affected by hepatitis C compared to HIV-negative MSM; therefore guidance for hepatitis C testing in SHS has been targeted towards this group.

HIV

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment. In addition, those on treatment are unable to pass on HIV, even if having unprotected sex (undetectable=untransmissible [U=U]).

Data reported in 2020 were impacted by the changes in how people accessed health services, and their reconfiguration during the COVID-19 pandemic, which also resulted in data reporting delays.

In 2020, an estimated 97,740 (95% credible interval (95% CrI) 96,400 to 100,060) people were living with HIV in England and an estimated 4,660 in 2020 (95%CrI 3,640 to 6,980) were unaware of their infection.[14] The quality of care received by people living with HIV remained high. For the first time, the UNAIDS 95-95-95 targets[15] were met with 95% of all people diagnosed, 99% of those in care on treatment and 97% of those receiving treatment being virally suppressed in both the UK and England. This means that 91% of all people living with HIV and accessing care were virally suppressed in 2020, surpassing the 73% UNAIDS 90-90-90 substantial target as well as the 86% UNAIDS 95-95-95 substantial target.

The number of all new HIV diagnoses decreased by 33% in England (from 3,950 in 2019 to 2,630 in 2020[14]). The number of diagnoses first made in England (76% of all diagnoses) also fell by 33% (from 2,950 in 2019 to 1,990 in 2020). The remaining 24% of new diagnoses were among people who had had their initial HIV diagnosis abroad.

Among MSM, the number of HIV diagnoses first made in England decreased by 41% from 1,500 in 2019 to 890 in 2020 (adjusted for missing probable route of exposure). Taken together with only small declines in testing and a continuing availability of PrEP, the fall in diagnoses in MSM suggests a continued year-on-year reduction in transmission in this group. These declines in diagnoses were less apparent among MSM who were living outside London, those of Black, Asian, Mixed or Other ethnicity ethnic groups, and those born abroad.

In 2020, 1,010 people who probably acquired HIV through heterosexual contact were first diagnosed with HIV in England (after adjusting for missing exposure information), a 23% decrease from 1,320 in 2019. The decline was 40% among White heterosexuals (from 470 in 2019 to 280 in 2020) and 40% among Black Caribbean heterosexuals (from 50 to 30) but less pronounced among Black Africans (25%, 400 to 300) and among Asians (17%, 60 to 50). Among heterosexual men and women born abroad but diagnosed with HIV in England, 49% were estimated to have acquired HIV after arrival in England. Since there was a very large decline in HIV testing among heterosexuals in 2020 compared to

previous years, it is likely that much of the observed decline in diagnoses in this group was due to reduced testing rather than reduced transmission.

In 2020, the number of people who tested for HIV at SHS in England fell by 30% from 1,320,510 in 2019 to 927,760.[14] The number of HIV diagnoses made at a late stage of infection in England has decreased over the decade. Despite this decline, the proportion of late diagnoses remained high in 2020, particularly in Black African heterosexual men and women and those aged over 50 years.

From 2021, HIV surveillance includes three new indicators:

- HIV diagnosed prevalence rate per 1,000 population aged 15 years and over (alongside HIV diagnosed prevalence rate per 1,000 population aged 15 to 59).
- New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 aged 15 years and over (alongside all new HIV diagnoses, including those first diagnosed outside the UK).
- ART coverage in adults accessing HIV care (%).

The purpose of these indicators is to include older patients living with HIV, to measure HIV transmission in the UK more accurately and to monitor the proportion of people living with transmissible levels of virus, respectively.

England has set an ambition to end HIV transmission, AIDS and HIV-related deaths by 2030. The England HIV Action Plan 2022-2025 set out intermediate commitments for the next 4 years to achieve the 2030 ambition, including how HIV transmission will be reduced by 80% by 2025.[16] To achieve these aims, a combination prevention approach will be implemented focusing on prevent, test, treat and retain. This approach needs to be replicated for all those at risk of acquiring of HIV, whoever they are and wherever they live.

Figure 12. Chart showing key HIV indicators in Harrow compared to the rest of England

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

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

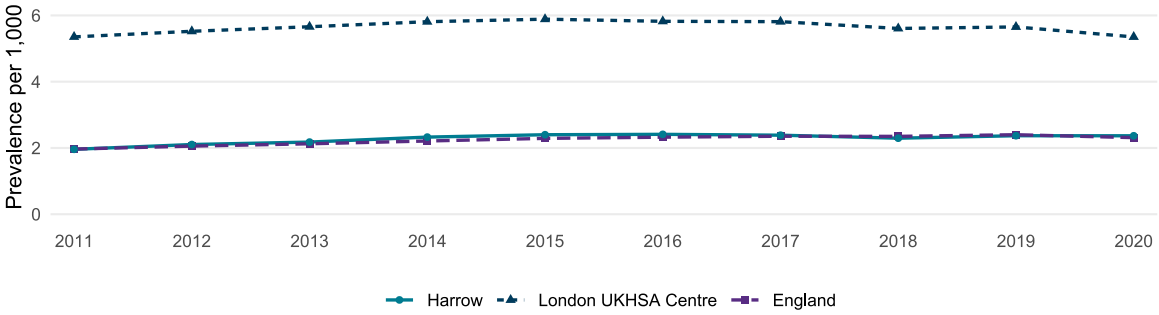
Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
HIV diagnosed prevalence rate per 1,000 aged 15 to 59	2020	348	2.4	2.3	13.1	0.5
HIV diagnosed prevalence rate per 1,000 population aged 15 years and over	2020	433	2.1	1.9	12.7	0.5
Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (%)	2018 - 20	47	79.7	83.1	58.1	100.0
Antiretroviral therapy (ART) coverage in adults accessing HIV care (%)	2020	426	98.4	98.7	91.4	100.0
Virological success in adults accessing HIV care (%)	2020	388	96.3	97.4	85.4	100.0
New HIV diagnosis rate per 100,000 aged 15 years and over	2020	15	7.4	5.7	27.5	0.0
New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 aged 15 years and over	2020	14	6.9	4.3	24.5	0.0
HIV late diagnosis (all CD4 less than 350) (%)	2018 - 20	30	60.0	42.4	72.7	16.7
HIV late diagnosis (all CD4 less than 350) (%) in gay, bisexual and other men who have sex with men	2018 - 20	12	60.0	33.7	100.0	0.0
HIV late diagnosis (all CD4 less than 350) (%) in heterosexual men	2018 - 20	9	69.2	55.6	100.0	0.0
HIV late diagnosis (all CD4 less than 350) (%) in heterosexual women	2018 - 20	7	58.3	46.8	100.0	0.0
HIV testing coverage, total (%)	2020	2,322	58.0	46.0	12.0	85.8
HIV testing coverage, gay, bisexual and other men who have sex with men (%)	2020	295	86.8	77.4	29.1	95.2
HIV testing coverage, women (%)	2020	1,159	48.7	36.9	7.5	84.4
HIV testing coverage, men (%)	2020	1,162	71.8	62.2	23.9	87.7
Repeat HIV testing in gay, bisexual and other men who have sex with men (%)	2020	153	51.7	52.0	22.2	64.6

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

HIV treatment and care

In 2020, there were 348 Harrow residents aged 15 to 59 years and 433 residents aged 15 years and over who were seen at HIV services (the prevalence of diagnosed HIV). The diagnosed prevalence per 1,000 residents aged 15 to 59 years was 2.4, similar to 2.3 per 1,000 in England. The rank of Harrow was 50th highest (out of 148 UTLAs/UAs). Since 2019, the change in Harrow was 0%; in the 5 years since 2015, the decrease was 1%.

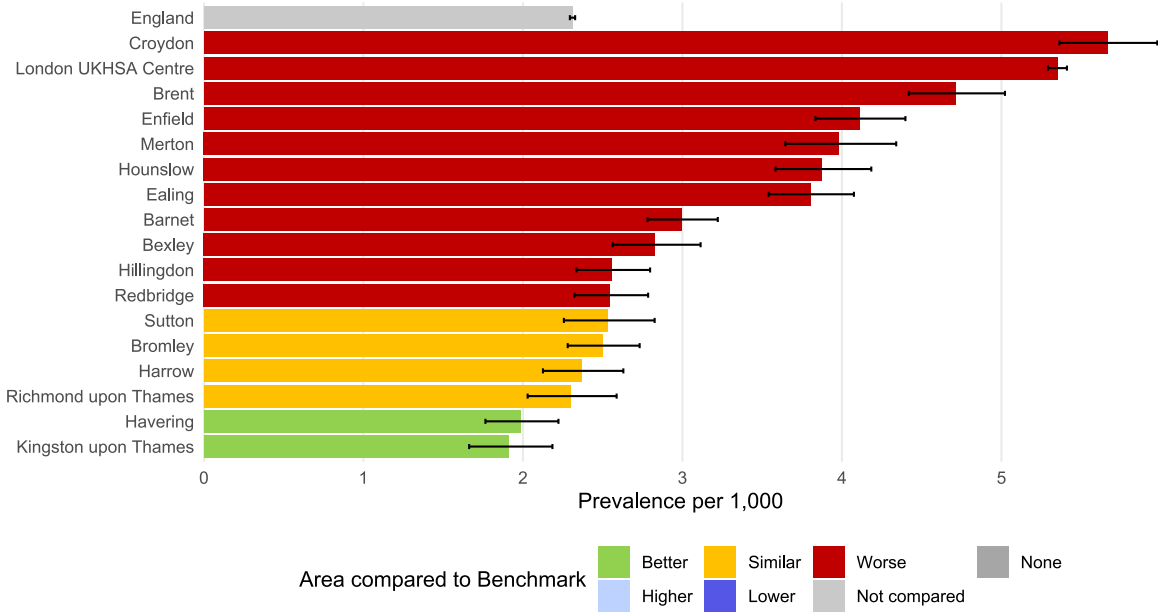
Figure 13. Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years by year in Harrow compared to rates in the London UKHSA Centre and England: 2011 to 2020.



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Figure 14. Diagnosed HIV prevalence per 1,000 population aged 15 to 59 years in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

The percentage of people (aged 15 years and over) in Harrow accessing HIV care who were prescribed ART in 2020 was 98.4%, similar to 98.7% in England. The

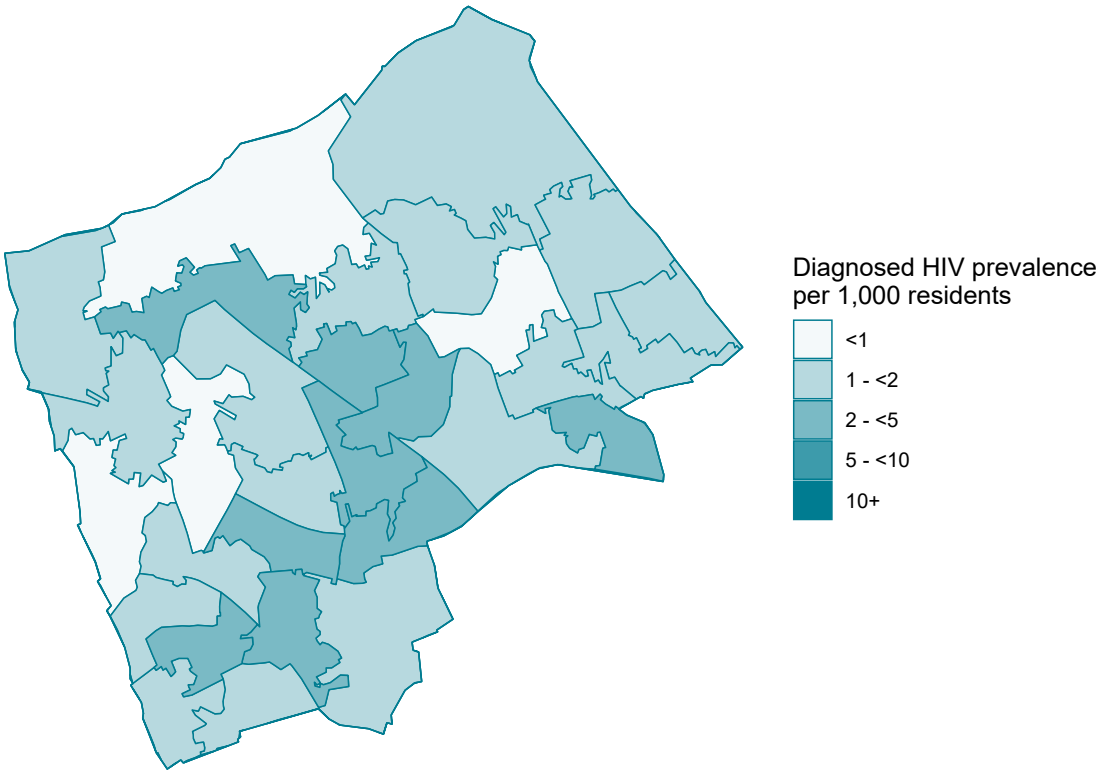
percentage of people in Harrow newly diagnosed with HIV in the three-year period between 2018 - 20 who started antiretroviral therapy (ART) promptly (within 91 days of their diagnosis) was 79.7%, similar to 83.1% in England.

The percentage of adults in Harrow accessing HIV care in 2020 who were virally suppressed (undetectable viral load) was 96.3%, similar to 97.4% in England.

The Sexual and Reproductive Health Profiles also provides these data at lower tier local authority geographies.

Figure 15. Map of diagnosed HIV prevalence among people of all ages in Harrow by Middle Super Output Area: 2020

Please note that this data is not available on the online Sexual and Reproductive Health Profiles. Data is sourced from the UKHSA HIV and AIDS Reporting System (HARS). As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

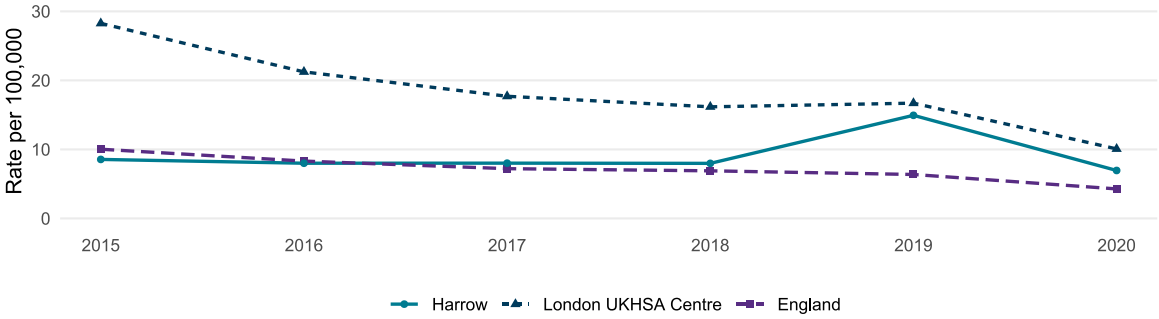


New HIV diagnoses among persons first diagnosed in the UK

To measure HIV transmission in the UK more accurately, diagnoses where the first HIV positive test occurred in the UK are considered in this section. All reports of new HIV diagnoses, regardless of country of first HIV positive test, are presented in Figure 12.

In 2020, the number of Harrow residents aged 15 years and older who were newly diagnosed with HIV in the UK was 14. The rate of new diagnoses per 100,000 residents was 6.9, similar to the rate of 4.3 per 100,000 in England. This represented a 53% decrease since 2019 and a 19% decrease in the 5 years since 2015. The rank of Harrow for the rate of new HIV diagnoses was 32nd highest (out of 148 UTLAs/UAs).

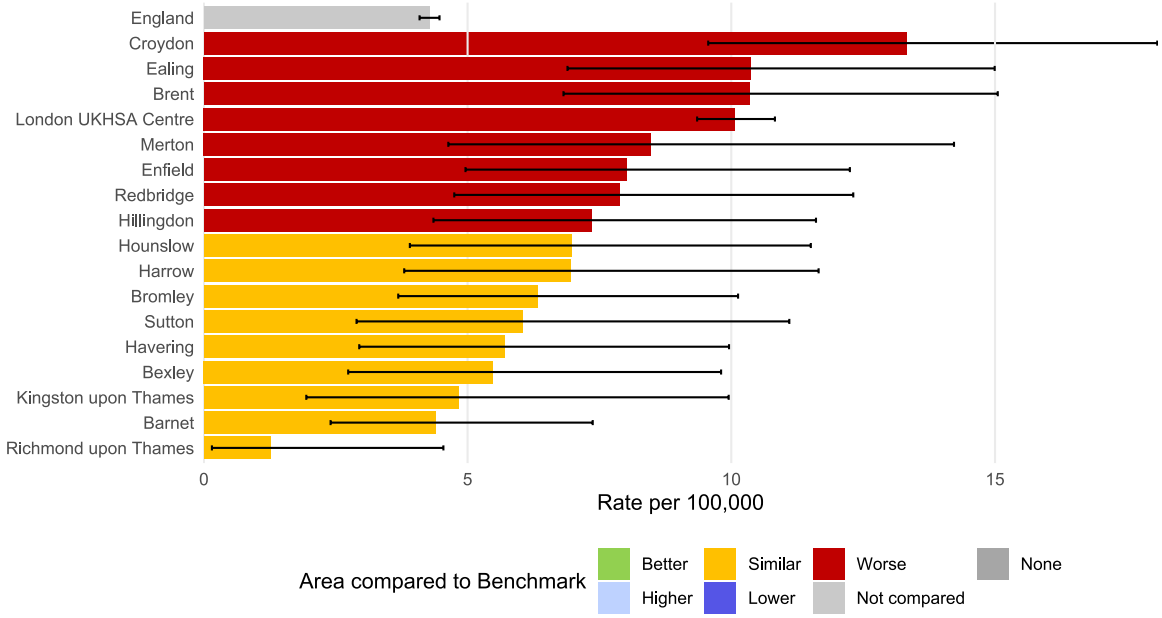
Figure 16. Rate of new HIV diagnoses per 100,000 population among people aged 15 years or above first diagnosed in the UK by year in Harrow compared to rates in the London UKHSA Centre and England: 2015 to 2020.



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Figure 17. New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 population aged 15 years and above in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

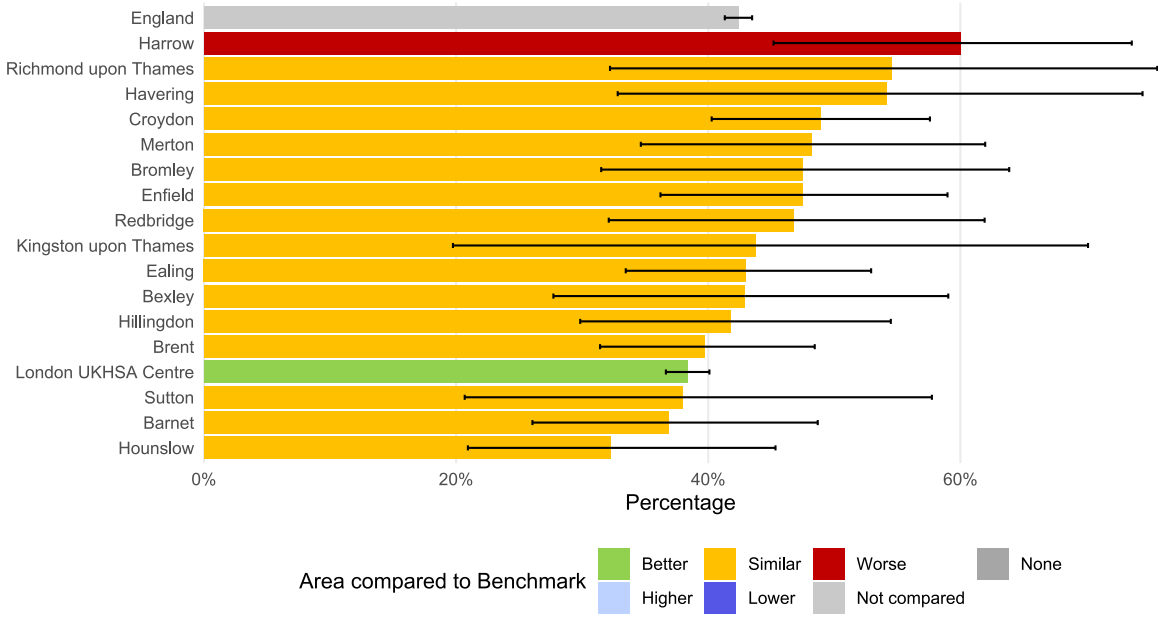
Late HIV diagnosis

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a PHOF indicator, and monitoring is essential to evaluate the success of local HIV testing efforts. Late diagnosis is defined here as having a CD4 count <350 cells/mm^3 within 91 days of first HIV diagnosis in the UK. An updated definition of late HIV diagnosis which incorporates evidence of recent seroconversion has also been published in other outputs.

In Harrow, the percentage of HIV diagnoses made at a late stage of infection in the three-year period between 2018 - 20 was 60.0%, worse than 42.4% in England.

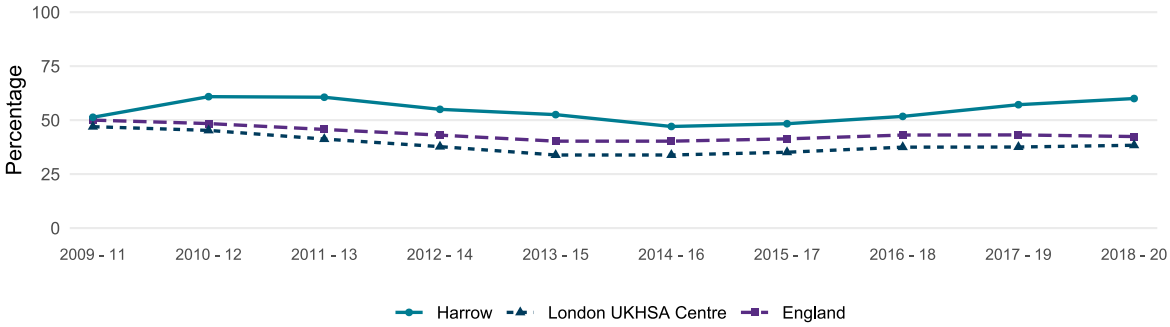
Figure 18. Percentage of late HIV diagnoses (all CD4<350) in 16 similar local authorities and London UKHSA Centre, compared to England: 2018 - 20

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Figure 19. Percentage of late HIV diagnoses (all CD4<350) in Harrow compared to the London UKHSA Centre and England: 2009-11 to 2018-20



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

For Harrow residents, the percentage of HIV diagnoses made at a late stage of infection for different risk groups in the three-year period between 2018 - 20 was as follows: MSM - 60.0%, worse than 33.7% in England; heterosexual men - 69.2%, similar to 55.6% in England; heterosexual women - 58.3%, similar to 46.8% in England.

HIV testing

In 2020, among Harrow residents, the percentage of eligible SHS attendees who received an HIV test was 58.0%, better than 46.0% for England. This represented a 23% decrease since 2019, and a 31% decrease since 2015. For 2020, the percentage of MSM in Harrow who had tested more than once in the previous year was 51.7%, similar to 52.0% in England.

Table 4. Coverage of HIV testing among eligible patients at specialist SHSs for Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Total	75.8	58.0	-23.5%	6	38	46.0
Women	68.6	48.7	-29.0%	6	39	36.9
Men	84.9	71.8	-15.5%	8	38	62.2
MSM	88.9	86.8	-2.5%	4	14	77.4

When calculating these rates, eligibility for HIV testing is determined by reviewing previous HIV diagnosis and testing history for each patient. Those who are known to be HIV positive, based on their GUMCAD history, are not considered eligible for testing. Those who have been tested already are not considered eligible to be tested again until six weeks have passed (i.e. eligibility for testing occurs only once every six weeks).
As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.
* Percent change proportional to the value in 2019, not a change in percentage points. Percent change not provided where the value in 2019 was 0.
† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.
‡ Out of 149 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.

Reproductive health

The COVID-19 pandemic and reproductive health

During 2020, the UK government responded to the COVID-19 pandemic with national lockdowns which directly impacted SRH service provision in England. The long-term impact is still under investigation, however, initial data relating to service impact suggest several areas of reproductive health care were directly impacted by the pandemic and its associated control measures.

Access to long acting reversible contraception (LARC) fittings and removals have been particularly impacted by the pandemic due to the requirements for face-to-face interactions. As well as a lack of access to services, people may have avoided seeking contraception due to fear of acquiring COVID-19 or due to changes in sexual behaviour. 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.[17]

Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Unplanned pregnancy

Unplanned pregnancies can end in maternity, miscarriage or abortion. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures, negative health impacts and have impacts on existing children. Restricting access to contraceptive provision by age can therefore be counterproductive and ultimately increase costs.

The Third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3), which was carried out in Britain in 2010-12, found that 16.2% of all pregnancies in the year before the study interview were unplanned. This survey found that:

- Pregnancies among 16 to 19 year old individuals accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned.
- The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group.
- 42% of the unplanned pregnancies ended in an abortion, 32% ended in a miscarriage and 25% went on to a full term pregnancy.

The survey included a pregnancy analysis of 5,686 women aged 16 to 44 years. The survey used a psychometrically-validated London Measure of Unplanned Pregnancy (LMUP), which assigned a score to each multiple choice answer, to questions on contraceptive use and intention of getting pregnant. The total score of 0-3 is categorised as unplanned, 4-9 as ambivalent and 10-12 as planned. The survey estimated that 54.8% (95% CI 50.3-59.2) of pregnancies were planned. The remaining 45.2% of pregnancies were described as 29.0% (95% CI 25.2-33.2) ambivalent and 16.2% (95% CI 13.1-19.9) unplanned.

Prevalence of unplanned pregnancies was also strongly associated with lower educational attainment, current smoking, recent drug use, lack of sexual competence at first sex and with receiving sex education mainly from sources other than school, supporting the importance of the recent statutory RSHE requirement for all schools in England.

Abortion

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates may be indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

In Harrow the total number of abortions in 2020 was 995. The total abortion rate per 1,000 female population aged 15 to 44 years was 21.0, higher than the rate in England of 18.9 per 1,000. The rank (out of 149 UTLAs/UAs) within England for the total abortion rate was 50th highest.

Figure 20. Chart showing key abortion indicators in Harrow UTLAs/UAs compared to the rest of England

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

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Total abortion rate / 1,000	2020	995	21.0	18.9	31.1	11.4
Under 18s abortions rate / 1,000	2020	15	3.5	6.7	1.9	16.7
Over 25s abortion rate / 1,000	2020	711	20.3	17.6	29.7	10.2
Under 25s repeat abortions (%)	2020	82	28.9	29.2	38.6	17.9
Under 25s abortion after a birth (%)	2020	49	17.3	27.1	48.4	9.6

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Table 5. Abortion figures in Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Rates						
Total abortion rate / 1,000	21.1	21.0	-0.5%	10	50	18.9
Under 18s abortions rate / 1,000	4.1	3.5	-13.7%	15	138	6.7
Over 25s abortion rate / 1,000	20.4	20.3	-0.4%	10	43	17.6
Percentages						
Under 25s repeat abortions (%)	28.8	28.9	0.3%	13	82	29.2
Under 25s abortion after a birth (%)	20.1	17.3	-14.1%	11	127	27.1

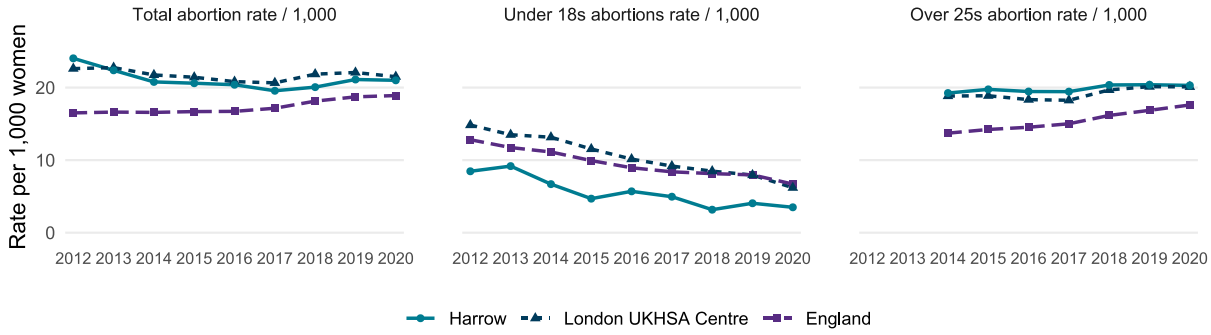
As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change proportional to the value in 2019, not a change in percentage points. Percent change not provided where the value in 2019 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

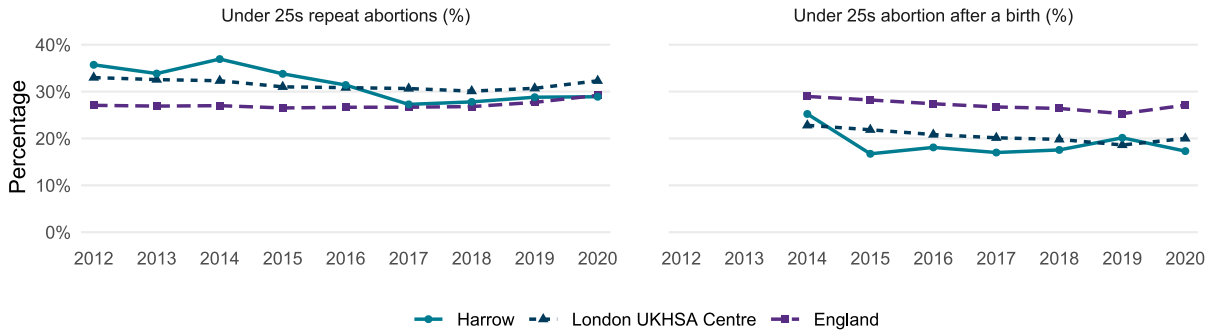
‡ Out of 149 UTLAs/UAs in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 21. Abortion rates per 1,000 women by age in Harrow compared to the London UKHSA Centre and England: 2012 to 2020



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

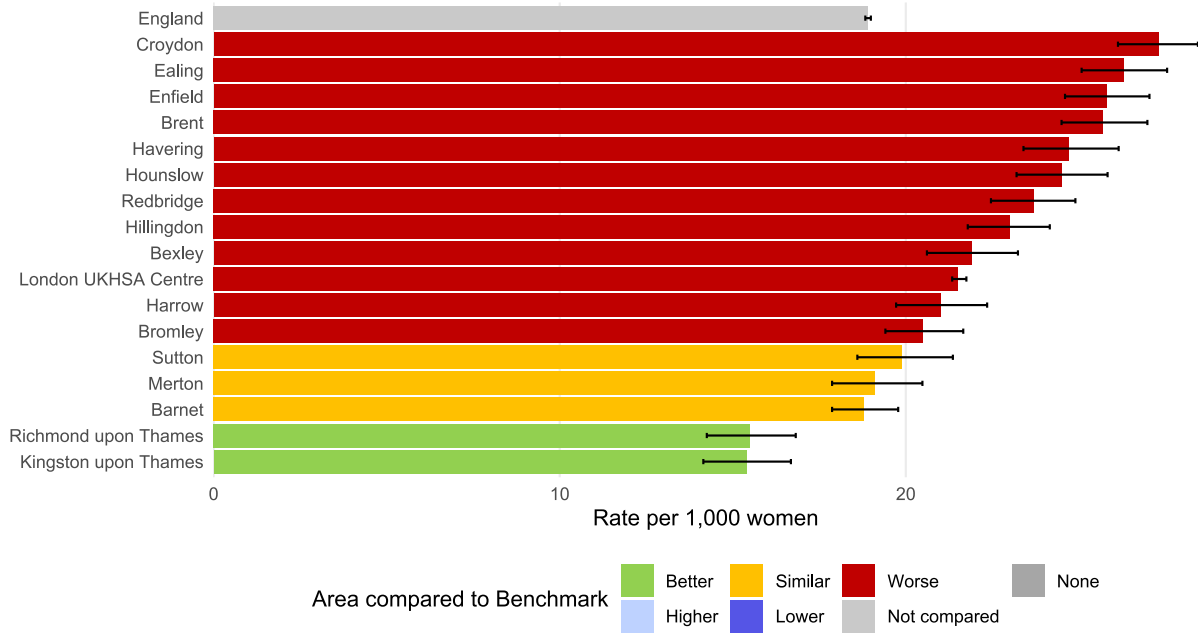
Figure 22. Characteristics of abortions over time in Harrow compared to the London UKHSA Centre and England: 2012 to 2020



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Figure 23. Abortion rate per 1,000 women in 16 similar local authorities and London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality.

In Harrow, the percentage of NHS-funded abortions that were under 10 weeks was 87.9% in 2020, similar to the percentage in England of 88.1. The rank within England for this indicator was 89th highest (out of 149 UTLAs/UAs).

Since the introduction of early medical abortion (EMA) methods, there has been an increase in the overall percentage of abortions performed at under 10 weeks gestation in England. Early medical abortion is less invasive than a surgical

procedure and carries less risk as it does not involve instrumentation or the use of anaesthetics.

However, women may prefer a surgical abortion under local or general anaesthesia/conscious sedation for a variety of reasons, including wishing to avoid the experience of going through an induced pregnancy loss and having the procedure carried out during a single visit. Ensuring women have access to a method of contraception of their choice post-abortion is recommended practice. Provision of LARC methods post-abortion has been shown to lower subsequent unintended pregnancy rates.[18]

An indicator relating to the use of medical procedures will help to improve transparency at a local level on the extent of medical and surgical services available to women, and will thus be an indicator of patient choice. A very low or a very high percentage of medical abortions compared to other areas could be an issue for concern.

Among NHS-funded abortions in Harrow, the percentage of those under 10 weeks gestation that were performed using a medical procedure in 2020 was 91.2%, lower than the percentage in England of 93.1%. The rank within England for this indicator was 114th highest (out of 149 UTLAs/UAs).

Table 6. Abortion figures for Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Abortions under 10 weeks (%)	85.5	87.9	2.8%	11	89	88.1
Abortions under 10 weeks that are medical (%)	84.2	91.2	8.4%	7	114	93.1

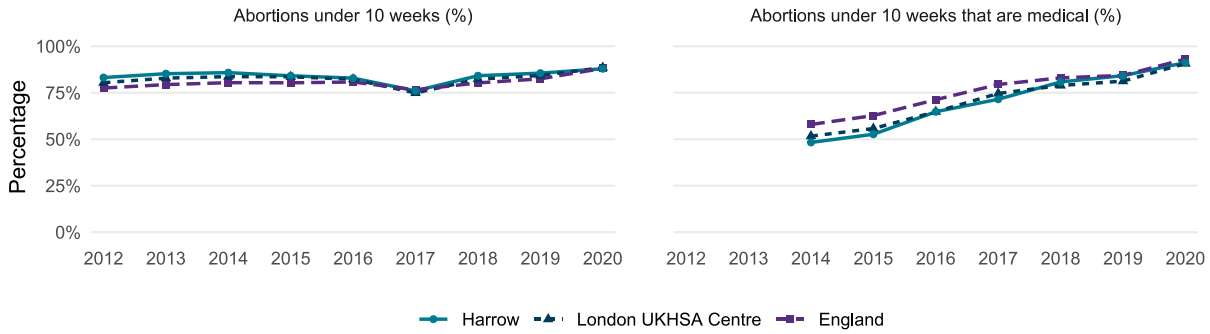
As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change not provided where the value in 2019 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 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.

Figure 24. Early abortion over time in Harrow compared to the London UKHSA Centre and England: 2012 to 2020



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

During the COVID-19 pandemic the UK government put in place a temporary approval in England, enabling women to take both pills for early medical abortion (EMA) up to 10 weeks (9 weeks and 6 days) gestation in their own homes, following a telephone or e-consultation with a clinician, without the need to first attend a hospital or clinic. This measure was put in place during the pandemic to reduce the risk of transmission of COVID-19 and ensure continued access to abortion services. It is time limited for 2 years, or until the pandemic is over – whichever is earliest.

Under-18s Conception

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Babies born to mothers under 20 years consistently have a higher rate of stillbirth, infant mortality and low birthweight than average, though the difference fluctuates from year to year due to relatively low numbers. The inequality in low birthweight increased from 2012-2016 and has remained similar from 2016-2019.[19] Rates of low birthweight in younger mothers are 30% higher than average, and this inequality is increasing. Children born to teenage mothers have a 63% higher risk of living in poverty.[20] Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years,[21] are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over.[22] Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation.[23]

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 66.3% reduction in the under-18 conception rate between 1998 and 2019. The success of the Strategy's approach has been recognised by the World Health Organization with the lessons being shared internationally with countries seeking to address high rates.[24] However, despite the significant progress, England's teenage birth rate remains higher than comparable Western countries,[25] and inequalities in the under-18 conception rate persist between and within local areas. Over a quarter of local authorities have an under-18s conception rate significantly higher than the England average and 80% have at least one high rate ward. Further progress in both

reducing the under-18s conception rate and improving the outcomes for young parents is central to improving young people's sexual health and narrowing the health and educational inequalities experienced by young parents and their children.

Maintaining the downward trend is a priority in the Department of Health Framework for Sexual Health Improvement in England[26] and addresses a number of key public health priorities including reducing health inequalities, ensuring every child gets the best start in life, and improving sexual and reproductive health. The Public Health Outcomes Framework (PHOF) includes the under-18 conception rate and a number of other indicators disproportionately affecting young parents and their children. International evidence identifies the provision of high quality, comprehensive relationships and sex education (RSE) linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates.[27] [28] [29] In September 2020, Statutory Guidance was introduced that requires 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.[30] This includes specific reference to ensuring all secondary school pupils know about local services providing confidential SRH advice and care.

Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice, with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects, and support young people to choose and use their preferred method. Some young people will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration, providing the means and the motivation to prevent early pregnancy. Reaching young people most in need involves looking at area and individual level associated risk factors. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates.[31] At an individual level, the strongest associated factors for pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care leaver.[32] [33] [34]

Teenagers are more likely to present late for abortion and to book late for antenatal care.[35] The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services.[36] Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays.[37] Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions.[38]

Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Figure 25. Chart showing under-18s conception indicators in Harrow compared to the rest of England

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

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

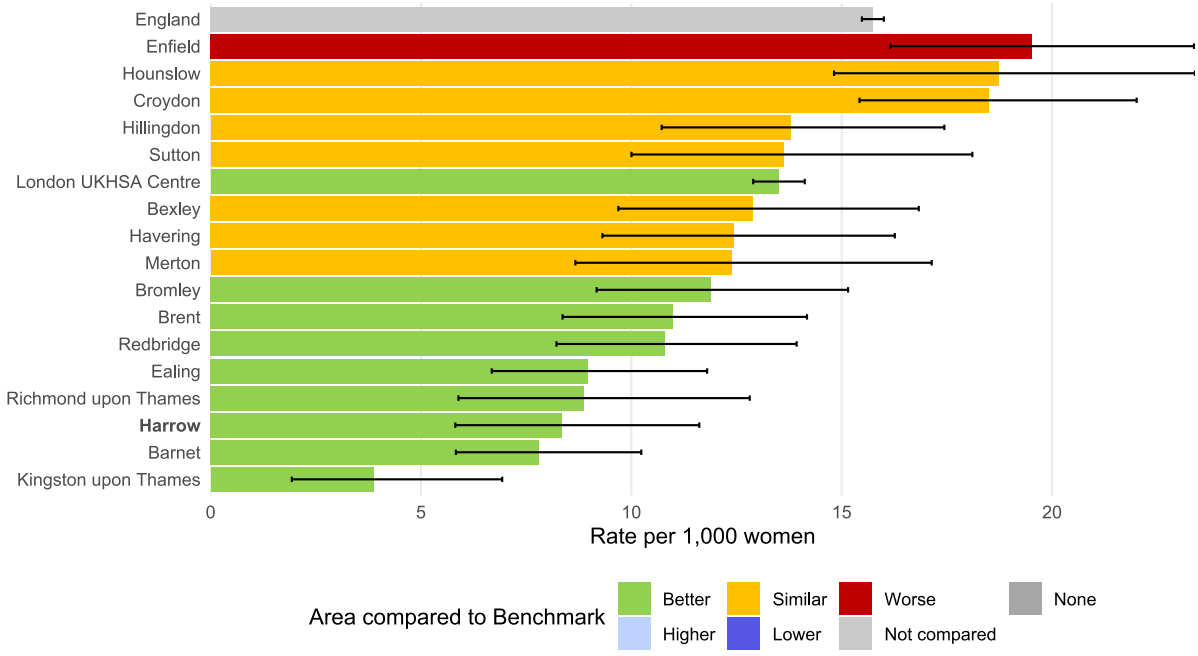
Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Under 18s conception rate / 1,000	2019	35	8.4	15.7	37.1	3.9
Under 16s conception rate / 1,000	2019	5	1.1	2.5	8.2	0.0
Under 18s births rate / 1,000	2019	4	1.0	4.1	17.4	0.3
Teenage mothers	2019/20			0.7	2.3	0.2
Under 18s conceptions leading to abortion (%)	2019	19	57.1	54.7	32.5	91.3

Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

In 2019, the under-18s conception rate per 1,000 females aged 15 to 17 years in Harrow was 8.4, better than the rate of 15.7 per 1,000 in England. The increase from 2018 was 37%. The rank within England for the under-18s conception rate was 140th highest (out of 149 UTLAs/UAs). Between 1998 and 2019, the decrease in the under-18s conception rate in Harrow was 69%, compared to a 66% decrease in England.

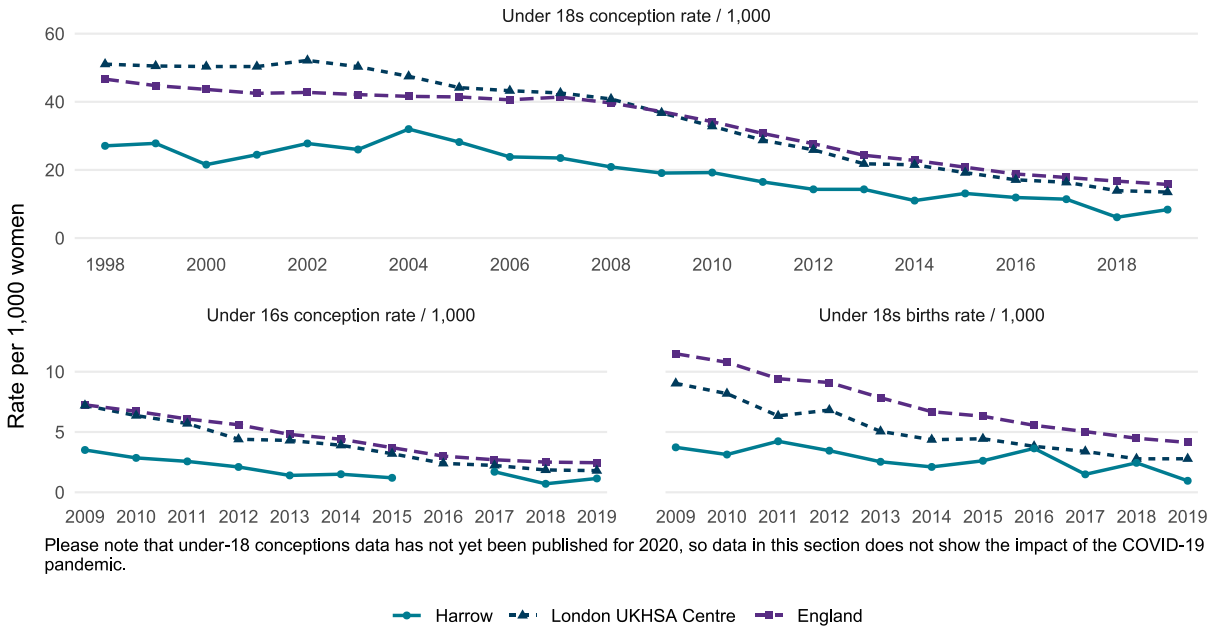
Figure 26. Under-18s conception rate per 1,000 women in 16 similar local authorities and the London UKHSA Centre, compared to England: 2019

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



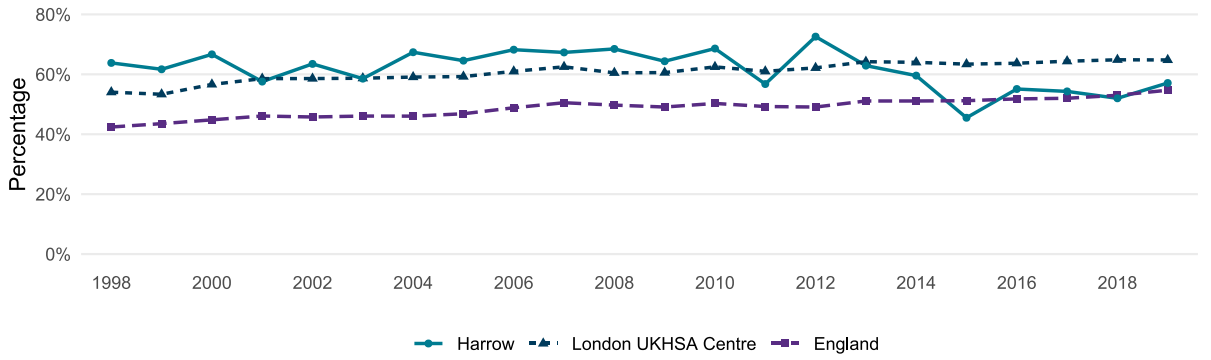
Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Figure 27. Rates of under-18s conception and births over time in Harrow compared to the London UKHSA Centre and England



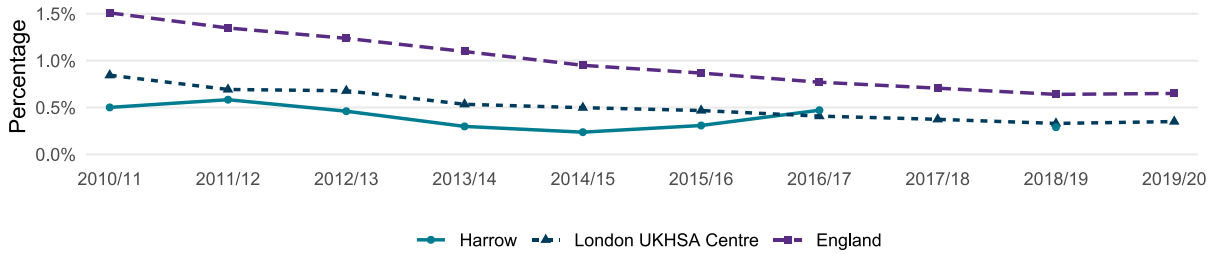
Among the under-18 conceptions in Harrow, the percentage of those leading to abortion in 2019 was 57.1%, similar to the percentage in England of 54.7%. The rank for the percentage of conceptions leading to abortion in Harrow was 70th highest (out of 149 UTLAs/UAs). A lower than average percentage may indicate a higher proportion of young women choosing to continue the pregnancy, but can also reflect barriers to accessing abortion care.

Figure 28. Percentage of under-18 conceptions leading to abortion, over time in Harrow compared to the London UKHSA Centre and England: 1998 to 2019



Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Figure 29. Percentage of births where the mother is aged under 18 years, over time in Harrow compared to the London UKHSA Centre and England: 2010/11 to 2019/20



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Table 7. Under-18s conception and birth figures in Harrow and England: 2019

	2018	2019	% change 2018 to 2019*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2019‡	Value for England: 2019
Under 18s conception rate / 1,000	6.1	8.4	36.8%	14	140	15.7
Under 16s conception rate / 1,000	0.7	1.1	63.1%	12	127	2.5
Under 18s conceptions leading to abortion (%)	52.0	57.1	9.8%	12	70	54.7

Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

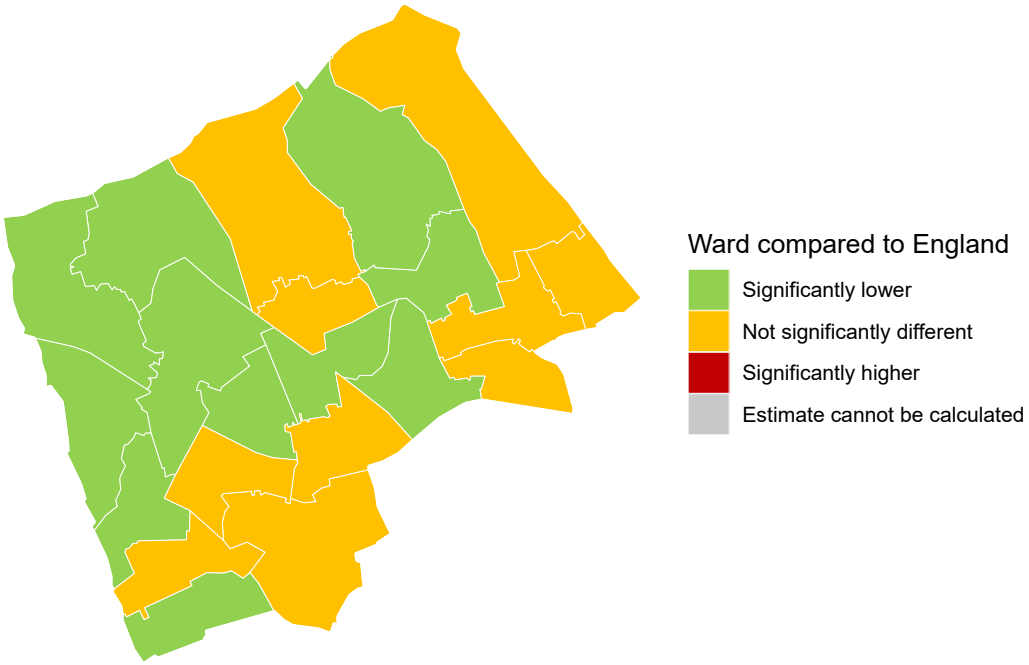
* Percent change not provided where the value in 2018 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 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.

Figure 30. Under-18s conception in Harrow by ward, compared to England: three-year period between 2017 - 19

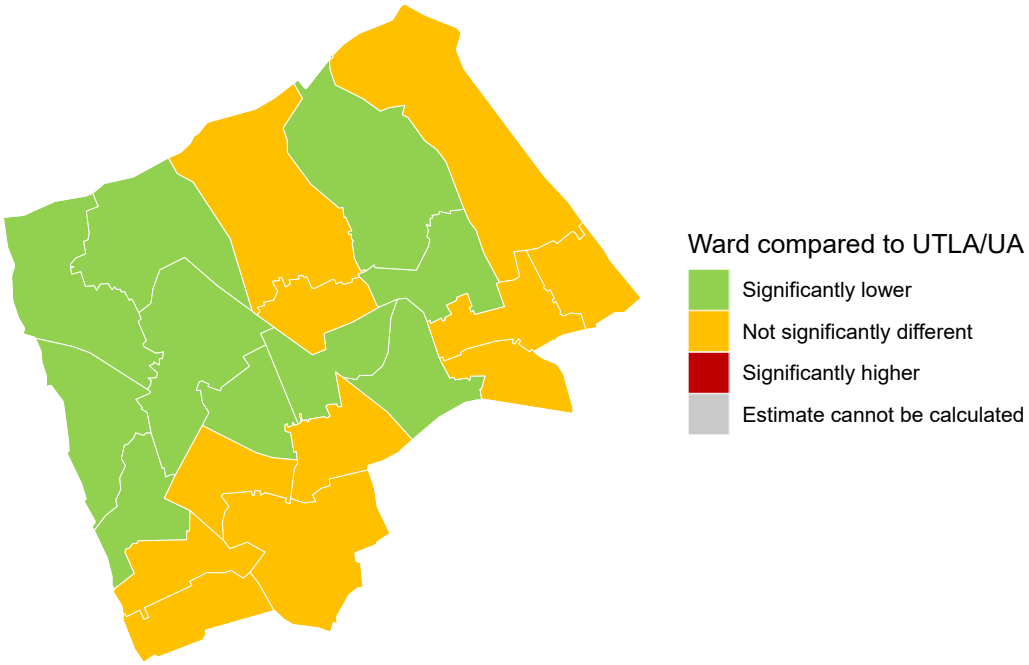
Please note that this data is not available on the online Sexual and Reproductive Health profiles. Data is sourced from Conception Statistics, England and Wales, ONS



Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Figure 31. Under-18s conception in Harrow by ward, compared to the rate for Harrow: three-year period between 2017 - 19

Please note that this data is not available on the online Sexual and Reproductive Health profiles. Data is sourced from Conception Statistics, England and Wales, ONS



Please note that under-18 conceptions data has not yet been published for 2020, so data in this section does not show the impact of the COVID-19 pandemic.

Contraception

The government and the Faculty of Sexual and Reproductive Healthcare (FSRH) both highlight the importance of knowledge, access and choice for all women and men to all methods of contraception to help reduce unwanted pregnancies. Good contraception services have been shown to lower rates of teenage conceptions.

Contraception is widely available in the UK from a number of sources, and is provided free by the NHS for women and men of all ages. Contraception is available free of charge from: general practices, level 2 sexual and reproductive health (SRH) services, young person's clinics, NHS walk-in centres (emergency contraception only), integrated SHS, some specialist SHS (emergency contraception and male condoms) and some pharmacists under a Patient Group Direction. Provision of contraception at the time of abortion is recommended practice and is almost always commissioned as part of this service; a significant proportion of this is thought to be the most effective long acting reversible contraception (LARC) methods (implants, intra-uterine systems [IUS] and intrauterine devices [IUD] but not injections).

Condoms are free at SHS as well as for young people through local condom distribution schemes. Around 85% of local authorities provide a c-card or other

condom distribution scheme. Condoms can also be purchased from pharmacies, supermarkets, and other retailers. Emergency hormonal contraception (levonorgestrel and ulipristal acetate) may be provided free through pharmacy depending on commissioning arrangements and is also available for over the counter purchase at some pharmacies and private clinics.

Currently, data on contraception provision are only 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. Data sources used in this report are SRHAD and Prescribing Analysis Cost Tabulation (ePACT2). ePACT2 data is available by number of prescriptions and is therefore a more useful indicator of use for LARC than short acting methods that require repeated prescription. However, there is no way of measuring method continuation, so the LARC data reflects method initiation only. The way in which this report presents total amount of contraception used in England should therefore be interpreted with care.

Attendance indicators provide a measure of young people's access to specialist contraceptive services. The indicators are split by sex and unique attendances because there are different patterns of service access and recording relating to each sex. Females access services more than males, and make more repeated visits in a year.

Attendance and service provision at SRH services is likely to be reflective of local service models and local geography e.g. more urban areas may have greater attendance at specialist SRH services as they may be easier to access, whereas in more rural areas it may be easier to attend general practice than travel to a specialist clinic.

Figure 32. Chart showing key contraception indicators in Harrow compared to the rest of England

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

Compared to England:

Better Similar Worse *or* Lower Similar Higher *or* Not compared

Indicator names	Period	LA count	LA value	England value	England lowest/worst	England highest/best
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	2020	1,640	132.0	97.6	6.0	312.2
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	2020	85	5.9	13.0	0.3	53.8
Women choose injections at SRH Services (%)	2020	205	4.7	8.1	1.6	25.7
Women choose user-dependent methods at SRH Services (%)	2020	2,880	65.8	54.9	34.2	72.4
Women choose hormonal short-acting contraceptives at SRH Services (%)	2020	1,935	44.2	41.7	20.3	66.4
Under 25s choose LARC excluding injections at SRH Services (%)	2020	290	19.5	28.8	11.2	46.8
Over 25s choose LARC excluding injections at SRH Services (%)	2020	1,000	34.6	43.5	19.8	72.7
Total prescribed LARC excluding injections rate / 1,000	2020	1,110	23.4	34.6	5.3	60.9
GP prescribed LARC excluding injections rate / 1,000	2020	281	5.9	21.1	0.0	51.5
SRH Services prescribed LARC excluding injections rate / 1,000	2020	830	17.5	13.4	0.8	32.0

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Attendance and service provision at sexual and reproductive health (SRH) clinics

Table 8. Attendance at specialist contraceptive services per 1,000 residents under 25 by gender, in Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	181.4	132.0	-27.2%	5	37	97.6
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	10.9	5.9	-45.8%	14	92	13.0

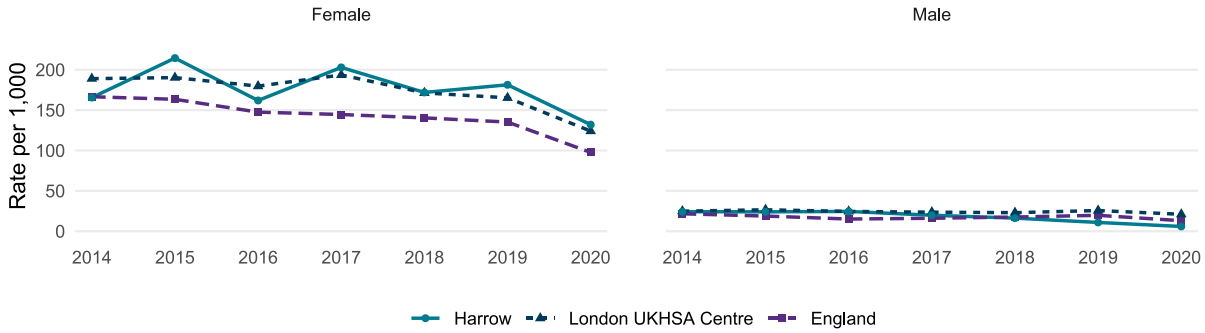
As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change not provided where the value in 2019 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 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.

Figure 33. Attendance at specialist contraceptive services among under 25s by gender, in Harrow compared to the London UKHSA Centre and England: 2014 to 2020



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Contraceptive care

Table 9. Women's choice of contraception at SRH services in Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Women choose injections at SRH Services (%)	5.5	4.7	-14.2%	11	118	8.1
Women choose user-dependent methods at SRH Services (%)	66.9	65.8	-1.6%	1	10	54.9
Women choose hormonal short-acting contraceptives at SRH Services (%)	44.3	44.2	-0.2%	2	46	41.7
Under 25s choose LARC excluding injections at SRH Services (%)	18.9	19.5	3.6%	16	140	28.8
Over 25s choose LARC excluding injections at SRH Services (%)	33.0	34.6	5.0%	16	132	43.5

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

* Percent change proportional to the value in 2019, not a change in percentage points. Percent change not provided where the value in 2019 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 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.

Focus on long-acting reversible contraceptives (LARCs)

National GP and SRH Long Acting Reversible Contraception prescribing data[39] shows that there was a significant drop in prescribing of IUD, IUS and implants from April 2020 with significant national recovery in prescribing by December 2020. However, no month during 2020 was prescribing above 2019 baseline rates, so significant backlogs in provision likely remain. National recovery masks significant regional and local variation.

The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in Harrow primary care, specialist and non-specialist SHS was 23.4 per 1,000 women aged 15 to 44 years in 2020, lower than the rate of 34.6 per 1,000 women in England.

LARC provision is likely to reflect local geography and service models e.g. there may be more provision in primary care in more rural and semi-rural areas. In Harrow, the rate prescribed in primary care was 5.9 in 2020, lower than the rate of 21.1 in England. The rate prescribed in the other settings was 17.5 in 2020, higher than the rate of 13.4 in England.

Table 10. Rate of LARCs (excluding injections) prescribed per 1,000 women aged 15-44 years by setting, Harrow and England: 2020

	2019	2020	% change 2019 to 2020*	Rank among 16 similar UTLAs/UAs†	Rank within England: 2020‡	Value for England: 2020
Total prescribed LARC excluding injections rate / 1,000	35.3	23.4	-33.5%	12	118	34.6
GP prescribed LARC excluding injections rate / 1,000	9.1	5.9	-34.7%	14	126	21.1
SRH Services prescribed LARC excluding injections rate / 1,000	26.2	17.5	-33.0%	7	37	13.4

As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

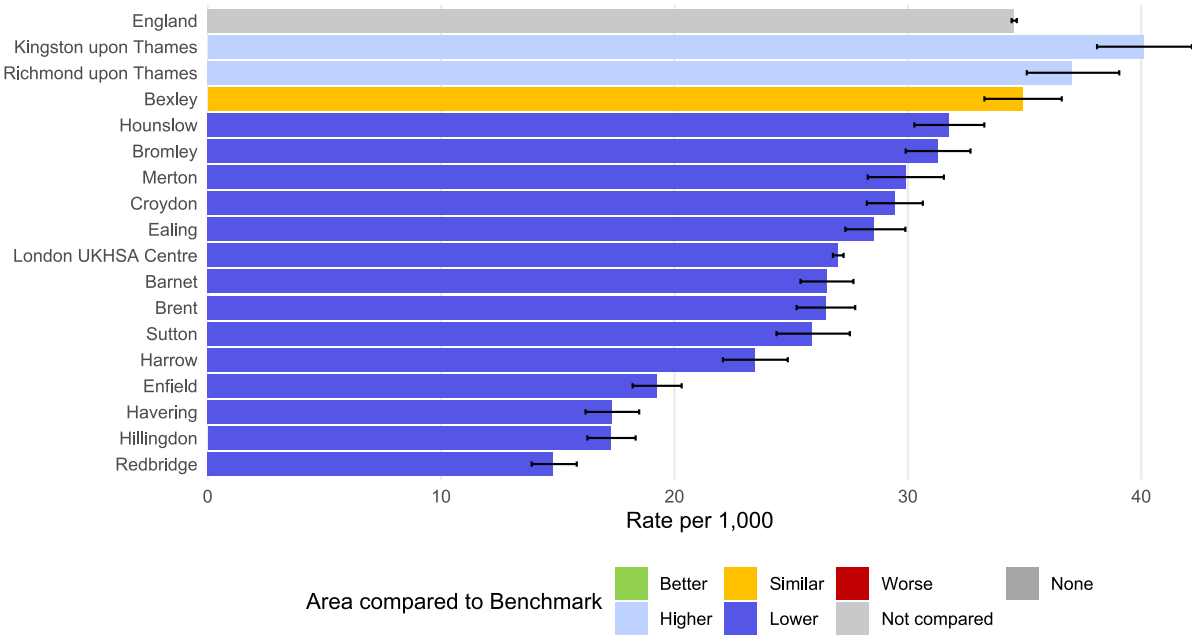
* Percent change not provided where the value in 2019 was 0.

† These are Harrow and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from CIPFA's Nearest Neighbours Model.

‡ Out of 149 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.

Figure 34. Total rate of LARC (excluding injections) prescribed in primary care and in SRH services per 1,000 women aged 15 to 44 years in 16 similar local authorities and the London UKHSA Centre, compared to England: 2020

Similar refers to statistical nearest neighbours, derived from CIPFA's Nearest Neighbours Model



As a response to the COVID-19 pandemic, since March 2020 the Government implemented national and regional lockdowns and social and physical distancing measures. These measures affected sexual behaviour and health service provision, which is reflected in sexual and reproductive health indicator data. Interpreting data from 2020 should consider these factors, especially when comparing with data from pre-pandemic years.

Data sources

Abortions under 10 weeks (%). Data source: Department of Health based on data from abortion clinics

Abortions under 10 weeks that are medical (%). Data source: Department of Health based on data from abortion clinics

All new STI diagnosis rate / 100,000. Data source: Public Health England

Antiretroviral therapy (ART) coverage in adults accessing HIV care (%). Data source: UK Health Security Agency (UKHSA)

Chlamydia detection rate / 100,000 aged 15 to 24. Data source: Public Health England

Chlamydia detection rate / 100,000 aged 15 to 24. Data source: Public Health England

Chlamydia diagnostic rate / 100,000. Data source: Public Health England

Chlamydia diagnostic rate / 100,000 aged 25+. Data source: Public Health England

Chlamydia proportion aged 15 to 24 screened. Data source: Public Health England

Genital herpes diagnosis rate / 100,000. Data source: Public Health England

Genital warts diagnostic rate / 100,000. Data source: Public Health England

Gonorrhoea diagnostic rate / 100,000. Data source: Public Health England

GP prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Business Services Authority ePACT2 prescribing data and Office for National Statistics mid-year population estimates

HIV diagnosed prevalence rate per 1,000 aged 15 to 59. Data source: UK Health Security Agency (UKHSA)

HIV diagnosed prevalence rate per 1,000 population aged 15 years and over. Data source: UK Health Security Agency (UKHSA)

HIV late diagnosis (all CD4 less than 350) (%). Data source: UK Health Security Agency (UKHSA)

HIV late diagnosis (all CD4 less than 350) (%) in gay, bisexual and other men who have sex with men. Data source: UK Health Security Agency (UKHSA)

HIV late diagnosis (all CD4 less than 350) (%) in heterosexual men. Data source: UK Health Security Agency (UKHSA)

HIV late diagnosis (all CD4 less than 350) (%) in heterosexual women. Data source: UK Health Security Agency (UKHSA)

HIV testing coverage, gay, bisexual and other men who have sex with men (%). Data source: UK Health Security Agency (UKHSA)

HIV testing coverage, men (%). Data source: UK Health Security Agency (UKHSA)

HIV testing coverage, total (%). Data source: UK Health Security Agency (UKHSA)

HIV testing coverage, women (%). Data source: UK Health Security Agency (UKHSA)

New HIV diagnoses among persons first diagnosed in the UK rate per 100,000 aged 15 years and over. Data source: UK Health Security Agency (UKHSA)

New HIV diagnosis rate per 100,000 aged 15 years and over. Data source: UK Health Security Agency (UKHSA)

New STI diagnoses (exc chlamydia aged <25) / 100,000. Data source: Public Health England

Over 25s choose LARC excluding injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data

Over 25s abortion rate / 1000. Data source: Department of Health based on data from abortion clinics

Prompt antiretroviral therapy (ART) initiation in people newly diagnosed with HIV (%). Data source: UK Health Security Agency (UKHSA)

Proportion of TB cases offered an HIV test. Data source: Enhanced Tuberculosis Surveillance System (ETS)

Repeat HIV testing in gay, bisexual and other men who have sex with men (%). Data source: UK Health Security Agency (UKHSA)

SRH Services prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates

STI testing positivity (exc chlamydia aged <25) %. Data source: Public Health England

STI testing rate (exc chlamydia aged <25) / 100,000. Data source: Public Health England

Syphilis diagnostic rate / 100,000. Data source: Public Health England

Teenage mothers. Data source: Hospital Episode Statistics (HES) Copyright © 2020, Re-used with the permission of NHS Digital. All rights reserved.

Total abortion rate / 1000. Data source: Department of Health based on data from abortion clinics

Total prescribed LARC excluding injections rate / 1,000. Data source: OHID based on NHS Digital SRHAD data, NHS Business Services Authority ePACT2 prescribing data and Office for National Statistics mid-year population estimates

Under 16s conception rate / 1,000. Data source: Office for National Statistics (ONS)

Under 18s abortions rate / 1,000. Data source: Department of Health

Under 18s births rate / 1,000. Data source: Office for National Statistics (ONS)

Under 18s conception rate / 1,000. Data source: Office for National Statistics (ONS)

Under 18s conceptions leading to abortion (%). Data source: Office for National Statistics (ONS)

Under 25s abortion after a birth (%). Data source: Department of Health

Under 25s choose LARC excluding injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data

Under 25s individuals attend specialist contraceptive services rate / 1000 - Females. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates

Under 25s individuals attend specialist contraceptive services rate / 1000 - Males. Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates

Under 25s repeat abortions (%). Data source: Department of Health

Violent crime - sexual offences per 1,000 population. Data source: Figures calculated by OHID's Population Health Analysis Team using crime data supplied by the Home Office and population data supplied by Office for National Statistics (ONS).

Virological success in adults accessing HIV care (%). Data source: UK Health Security Agency (UKHSA)

Women choose hormonal short-acting contraceptives at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data

Women choose injections at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data and Office for National Statistics mid-year population estimates

Women choose user-dependent methods at SRH Services (%). Data source: OHID based on NHS Digital SRHAD data

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