HARROW SEXUAL HEALTH NEEDS ASSESSMENT

May 2022

Abstract

An overview of the sexual health and contraception data in Harrow, including semi structured interviews with key stakeholders.

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Introduction

Sexual health is a key contributor to the health and well-being of our society. Maintaining a positive approach towards sexual health enables communities and individuals to have safe sexual experiences, free from stigma and discrimination (1). The term encompasses a wide array of issues, including sexually transmitted infections (STIs), relationships and sex education (RSE), contraception and termination services to name a few (2). Easy access to information and services relating to such fields is key in the prevention of sexual health complications, which is beneficial to individuals, local communities, and society.

As a field with so many facets, sexual health service provision across Harrow has many contributors (Table 1). Commissioning for these services is done through the local Public Health authority within Harrow Council.

Table 1: Service provision breakdown **Table showing structure of major sexual health service providers across Harrow, including organisations who provide outreach services**

Provider	Key Services Offered
London North-West Healthcare Trust (LNWH)	Caryl Thomas Clinic, STI testing kits, Contraception, HIV (including PEP), Community & Hospital-Led Clinics
Brook - outreach	RSE, C-card scheme (free condoms), self-referral counselling
Terrence Higgins Trust (THT) - outreach	HIV point of care (POC) testing, free condoms, free sexual health advice & signposting, peer mentoring
Spectra - outreach	HIV POC testing, education &, mindfulness & mental health services, PrEP education
SHL E-Service	Online triage, STI testing, contraception
Community Services	Primary care (GP) & Pharmacy services- long acting and emergency contraception

National Strategy and Context

Over recent years sexual health has come into focus as a key public health issue. Commissioning for sexual health (SH) services has mainly been undertaken by local authorities, working alongside CCGs (clinical commissioning groups) and the NHS commissioning board2. A framework for SH improvement was published in 2013, with the aims of reducing inequalities, building an open and honest culture , and recognising the impact of SH on all aspects of society2. The Department of Health's 'Vision for the Women's Health Strategy for England' was released in 2021, highlighting the aim of reducing disparities in sexual and reproductive health provision throughout a woman's life(3).

The Coronavirus pandemic had significant impact on sexual health service provision and behaviour during the last two years. During the initial lockdown, 54% of service sites had to close, 54% of service sites could not provide routine vaccination and long acting reversible contraception(4). There was significantly reduced capacity for face-to-face consultation. This

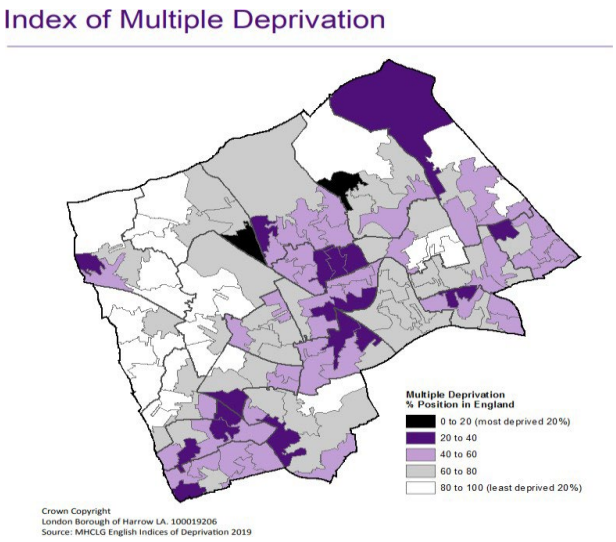
triggered a shift towards telemedicine, which has had a vital role in maintaining SH services during recent lockdowns(5). The lasting impact of this is yet to fully assessed and as one specialist stated, 'telemedicine works for some, but not everyone.' Identifying those groups with unmet need and increasing accessibility for them will be key moving forward.

Demographics of Harrow

Figure 1 illustrates the variation in deprivation within the wards of Harrow. Harrow ranks 207 out of 317 local authorities (where 1 is most deprived) when it comes to deprivation rankings nationally. Within London, Harrow is one of the least deprived boroughs (ranking 27 out of 33)6.

Figure 1: Index of Multiple Deprivation within Harrow (2019)

Figure showing a comparison of deprivation levels within the borough



Harrow represents one of the most diverse populations in the country; 61.8% of the borough's residents classify themselves as belonging to an ethnic minority group (defined as non-British)(7,8). This was projected to rise in 2019 and beyond(7). Majority of the population were between 16 to 64 years old (63.3% in 2018)(7). An estimated 10% of the UK population are lesbian, gay, and bisexual; this would indicate a figure of around 25,000 residents in Harrow(8).

Our Needs Assessment Approach

As part of the sexual health needs assessment, we adopted a mix of quantitative and qualitative analytical methods to recognise local needs and suggest improvements that can be adopted. An initial thorough approach to analysing the figures and statistics on the Fingertips website and summary profiles data helped to identify key needs within Harrow.

Based on these needs, we set up a series of semi-structured interviews with local sexual health service providers. Along with the Outer North-West London Workshop, this helped to scrutinise the data further and enabled us to get an idea of the improvements frontline

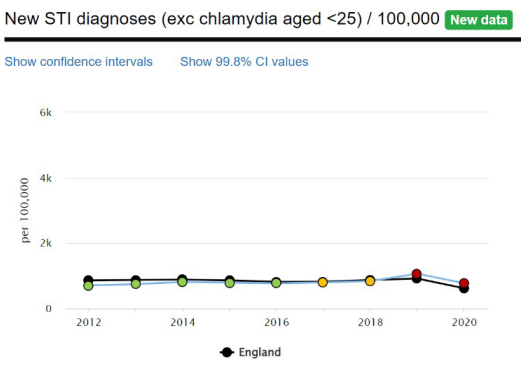
members of staff were suggesting. Based on our data analysis and the suggestions from these providers, we aimed to provide a needs assessment that has appropriately identified key areas of concern and possible solutions within Harrow over the coming years.

Sexually Transmitted Infections (STIs)

STI Diagnostic & Testing Rates

The rate of new STI diagnoses (excluding chlamydia aged <25) per 100,000 residents aged 15 to 64 in Harrow in 2020 was 774. This was higher than the England rate of 619. Harrow ranked 26th highest out of 149 upper tier local authorities (UTLAs) and unitary authorities (UAs)(9,10). In line with this, Harrow's STI testing rates in the last two years have been higher compared to England. In 2020, the testing rate (excluding chlamydia aged <25) was 5200 per 100,000 residents in Harrow, whilst in England the equivalent figure was 4549. In contrast to the comparison with England, Harrow continues to have lower STI testing and diagnostic rates when evaluated against London(10).

As illustrated in Figures 2 and 3, the general trend over recent years has been a gentle rise in STI diagnostic and testing rates in Harrow. Focusing on 2019, we can detect a rise of 224 and 1500 in the diagnostic and testing rates respectively; this was a significantly larger jump than previous years(10). This was in line with the shift of care from Northwick Park (Acute Trust) to the Caryl Thomas clinic (Community Sexual Health provision). The Caryl Thomas clinic provides an integrated sexual health service under one roof, aiming to meet people's sexual health and contraceptive needs on one site. This ensures improved accessibility and overcomes some of the barriers service users may encounter in seeking sexual health support(11). As highlighted by the specialists, another reason for the rise in rates in 2019 was the introduction of online testing kits. Online and telephone triage allows asymptomatic patients to attend the clinic and perform tests within a matter of minutes. This combination of triage testing and community provision is vital in ensuring testing rates improve in the coming years.



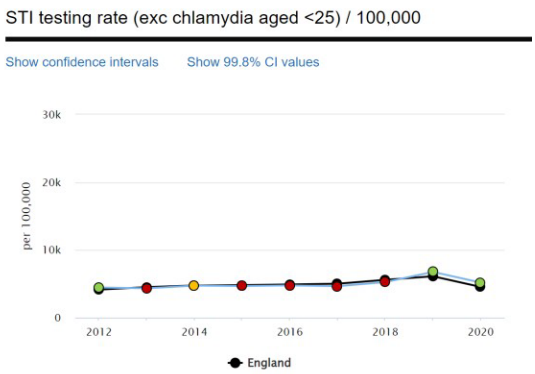


Figure 2: STI Diagnostic rate (excluding chlamydia <25yo) per 100,000 (2012 to 2020)[10]

Figure 2 shows trends in STI diagnostic rates in Harrow and England over recent years. Line withblack dots represents England. Line with green, yellow and red dots represents values for Harrow.

Figure 3: STI Testing rates (excluding chlamydia aged <25) per 100,000 (2012 to 2020)[10]

Figure 3 shows trends in STI testing rates in Harrow and England over recent years. Line withblack dots represents England. Line with green, yellow and red dots represents values for Harrow.

A percentage decrease of 27.4% and 23.2% was noted in STI diagnostic and testing rates respectively between 2019 to 2020 in Harrow(10). This is largely a consequence of the covid- 19 pandemic and its' impact on sexual health services nationally. Of note, larger decreases were found in STIs requiring face-to-face (F2F) diagnosis, such as genital warts and herpes9. During a discussion with a service provider, it was stated '95% of all testing in London was undertaken via the Sexual Health London (SHL) E-Service during the first lockdown'. Table 2 highlights the impact of the pandemic on STI testing services in Harrow.

Table 2: Covid-19 pandemic and STI services

Table highlighting the main issues and impacts of the coronavirus pandemic on STI service provision, including key consequences.

Impact of Pandemic	Consequence
Switch from walk-in clinic to telemedicine	Loss of several regular users, particularly amongst people <18 years and LGBTQI community
Increase in empirical management	Swabs & culture not undertaken so not included in diagnostic or testing numbers, but treatment provided based on clinical judgement of clinician
Reduced ability to educate	Limited F2F contact means reduced ability to provide guidance and education on key SH issues, including STI prevention and protection

We will await to assess the lasting consequences of the pandemic on STI service provision. Currently, a hybrid model of telephone triage has been adopted, and the walk-in service is yet to return. The priority will be to improve accessibility again for those groups for whom telemedicine does not work; these are the groups most adversely affected by the changes in the SH system over recent years. As discussed with a specialist, there is a specific focus on the <18-year age group. A dedicated walk-in clinic service for this demographic is being trialled with the hope of encouraging young people to seek the SH support they require without them having to worry about confidentiality issues (for example being overheard talking on the phone at home or parents accessing confidential SH clinic text messages). A similar type of service may prove beneficial for the LGBTQ.

Syphilis and Gonorrhoea

A rise in the rates of syphilis and gonorrhoea has been identified in recent years, both in Harrow and nationally(10). Better testing is partly responsible for this. The introduction of the E- service in 2018 has helped to identify and re-direct patients for specific STI testing (HIV, chlamydia, syphilis, and gonorrhoea)(12). The development of a standard operating procedure in Harrow meant most patients with symptoms of syphilis and gonorrhoea (even during the pandemic) were being asked to come to clinic for testing prior to treatment.

Aside from improved testing systems, a specific cohort with high transmission has been identified: HIV positive men who have sex with men (MSM). With combination antiretroviral therapy (ART) and pre-exposure prophylaxis (PrEP), the need to have sex with a condom in this cohort has declined, resulting in the increased transmission rates of these STIs (13,14). In addition, during the pandemic, high levels of sexual contact were still occurring despite the lockdowns in place. This was indicated by the rising rates of gonorrhoea and early syphilis; both indicating high levels of sexual activity and recent acquisition of these two STIs. As discussed with a specialist, the concurrent difficulty in accessing condoms during the lockdowns also played a role. Educating HIV positive MSM in Harrow on the importance of condom use despite satisfactory HIV control will be crucial in reducing the transmission cycle of syphilis and gonorrhoea over the coming years.

Four cases of ceftriaxone-resistant gonorrhoea have been identified in England in recent months(15). As of the time of writing, no cases have been found in Harrow. Culture testing prior to empirical treatment and ongoing effective use of the partner notification service (SST2) will need to continue in Harrow to manage resistance going forward(16).

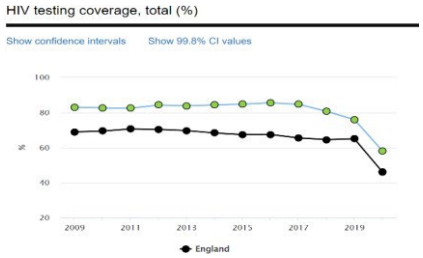
Human immunodeficiency virus (HIV)

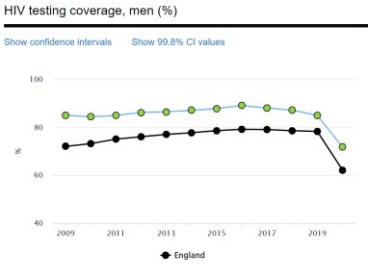
HIV is a communicable disease associated with significant morbidity and mortality(17). The UK has achieved the UNAIDS 90-90-90 target for the past three years; >90% of all HIV positive people were diagnosed, >90% of those diagnosed were provided antiretroviral therapy (ART) and >90% of those treated achieved viral suppression. An action plan updated by the Department of Health in 2021 has reiterated key commitments(18) :

- Aiming for an 80% reduction in HIV transmissions by 2025
- Targeting zero new HIV transmissions by 2030
- Investment of £3.5 million to deliver a National HIV Prevention Programme between 2021 to 2024
- Scale up HIV testing to ensure early identification of infection
- By achieving these goals over the coming years, this will bring enormous social, emotional, and financial relief.

HIV Testing Coverage

Figure 4 illustrates the drop in HIV testing coverage over recent years in Harrow and nationally, both in general and in the specific cohorts highlighted.





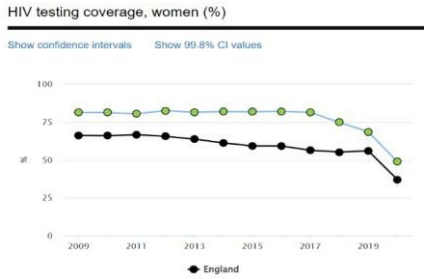


Figure 4: HIV testing coverage in total, men, and women in Harrow and nationally between 2009 and 2020[10]

Graphs depicting the percentage of eligible people attending health services who receive an HIV test. The green line represents Harrow, black line represents England.

Although Harrow consistently performs better than London and England, the data shows clear evidence of a decline in percentage HIV testing coverage. Large drops were witnessed as a consequence of the Covid-19 pandemic; however, trends of decrease were seen prior to 2020 as well. This pre-pandemic decline is most pronounced in women; from 74.7% in 2018 to 68.6% in 2019. Possible reasons identified for these trends include:

- People refusing or declining an HIV test on attendance at a service- factors behind this include the stigma amongst certain cultures associated with STIs and misconceptions around HIV and risk (some people may believe HIV only affects certain groups, for example young men). Addressing the stigma associated with HIV and educating the public will help to reduce inequalities in HIV testing coverage and improve testing rates across Harrow.

- Women often have more difficulty and reluctance in accessing HIV testing than men19. HIV testing coverage values for 2019 show16.3% fewer women were tested than men in Harrow10. Over the coming years it will be key to ensure women are fully informed that HIV can affect them and to encourage testing in this cohort.

- Pandemic factors - as stated previously, the shift to telemedicine and the lack of face-to-face contact during lockdown meant many regular SH service users were lost. This also meant limited opportunity for healthcare profession also to advocate to the public the importance of HIV testing during routine visits.

- Coding system issues were identified during discussions with specialists in Harrow. For example, for people attending the SH clinic for contraception or coil fitting, an HIV test would likely be inappropriate. However, on the system it can get coded as ‘HIV test not

done'. Ensuring correct coding on the GUMCAD system will give a more accurate representation of coverage.

Education and addressing misinformation are the key aspects which can help to improve HIV testing coverage rates in Harrow. Focusing this education on specific cultures and on women will be vital to reducing inequalities. Additionally, the plan to introduce opt-out HIV testing in A&E department in Harrow during 2022 will help pick up more undiagnosed cases and will be discussed further in the next section.

HIV Late Diagnosis

Linked to the fall in HIV testing coverage, Harrow is ranked 11th worst of the 149 unitary authorities in England in reference to late HIV diagnosis in the period between 2018 to 202010. Late HIV diagnosis is defined as 'all individuals with a CD4 count </=350 cells/mm3 within 3 months of diagnosis'(9). The percentage of HIV diagnoses made at this late stage was 60.0% between 2018 to 2020, compared to 38.4% in London and 42.4% in England(10). The issue is most marked in the MSM group, but even in heterosexual women and male cohorts Harrow is performing worse in this category (Table 3).

	Total- all cohorts (% late HIV diagnosis)	Gay, bisexual & other MSM (% late HIV diagnosis)	Heterosexual men (% late HIV diagnosis)	Heterosexual women (% late HIV diagnosis)
England	42.4%	33.7%	55.6%	46.8%
London	38.4%	29.1%	54.5%	51.4%
Harrow	60.0%	60.0%	69.2%	58.3%

Table 3: Percentage HIV diagnoses made at a late stage of infection across Harrow, London, and Englandbetween 2018 to 2020

Table showing the percentages of late HIV diagnoses in total and across specific cohorts. The National target for the percentage of late HIV diagnosis is less than 25%[10,18].

There are a few possible reasons why Harrow is not reaching the national target and is performing comparatively worse than London and England. Primary HIV infection has a somewhat non-specific presentation(20), which can make the diagnosis in non-sexual health clinic settings more challenging. This translates to patients often having numerous contacts with the health service before an HIV test is done. As one sexual health specialist stated, 'making HIV a normal part of the initial battery of tests can go a long way to picking up cases earlier.' Educating primary and secondary case physicians on the importance of testing and how to have such conversations with patients will enable this.

The opt-out testing system in accident and emergency (A&E) departments is due to be rolled out in 2022 as part of the national drive to reduce late HIV diagnosis(21). This will mean all patients who attend the Northwick Park Emergency Department will receive an HIV test unless they state otherwise. The test will be an add-on blood test to those already taken, meaning there is no additional blood test requirement. Posters in the emergency department will signpost and explain the testing process further, thereby reducing any additional workload on busy A&E staff. The combination of A&E testing and improved testing in GP/

non-SH secondary services are key factors in improving coverage and reducing late diagnosis of HIV.

Another contributor to the late HIV diagnosis in Harrow is the presence of a specialist infectious diseases (ID) unit at Northwick Park Hospital. This unit accepts referrals for patients with late HIV diagnoses or concurrent infections (for example- tuberculosis) from neighbouring boroughs. In addition, discussions with outreach organisations highlighted the difficulties in reaching specific cohorts, including women and older age groups. Accessing the MSM group has improved using social media and dating applications. Linking outreach organisations with local women's and elderly organisations could help to address any misconceptions and issues and help to improve access for these groups.

Chlamydia

Chlamydia is a bacterial infection primarily spread via sexual contact. When not detected early, this infection can bring significant complications and morbidity (22). The importance of good screening programmes and high chlamydia detection rates (CDR) cannot be emphasised enough in enabling early treatment, thereby 'avoiding morbidity such as pelvic inflammatory disease, ectopic pregnancy and chronic pelvic pain(23)'. Chlamydia remains the most common STI in England(24).

Chlamydia detection rate (CDR) in Young People

Figure 5 illustrates the trend in CDR over recent years in people aged 15-24 years. A high CDR indicates good screening coverage and suggests that the most at-risk populations are being reached. The national target for CDR per 100,000 people aged 15-24 years is 2300; Harrow's CDR for 2020 in this cohort was 12899. A key component of good chlamydia detection is raising awareness in schools. In Harrow, a significant amount of this work is done via outreach programmes. A discussion with one such local outreach organisation highlighted that many schools are now requesting topics other than the traditional STI and contraceptive sessions, including gender and sexuality. This translates to students getting less information and advice on STIs, including information on how to obtain a chlamydia test. Putting an emphasis on STIs within the relationships and sex education (RSE) curriculum in schools is one factor that may help improve CDR in Harrow.

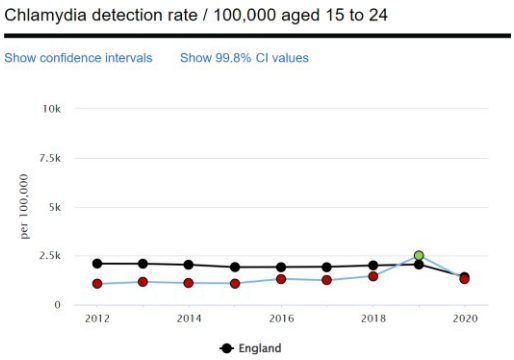


Figure 5: CDR in young people aged 15-24 years in Harrow and England (2012-2020)

Graph highlighting the chlamydia detection rates in Harrow and England between 2012 and 2020 in young people. Line withred & green dots represents Harrow, line with black dots represents England.

As seen in the graph above in Figure 5, the rise in CDR between 2018 to 2019 coincided with the rise in general STI diagnostic and testing rates. This was related to reasons mentioned earlier including the shift of care to the community integrated SH clinic and the expansion of the SHL E-service and online testing in 2019. A 49% drop was subsequently seen in the CDR in young people from 2019 to 202010. This reflects the importance of bringing young people into clinic for face-to-face consults and testing; the roll-out of the walk-in clinic for this age group mentioned previously will help to improve detection rates for chlamydia and other STIs. Confidential testing is a key component for this age group; having separate facilities in schools to encourage testing in an anonymous, non-judgemental environment can be a positive factor.

A final factor contributing to the lower rates in 2020 involved third sector voluntary organisations. During the pandemic, SH outreach organisations found it more difficult to access the younger population. These organisations would normally provide extensive face-to-face teaching on STIs to schools, but this was not possible in 2020. The consequence of this was reduced education and information given to young people on STI information and services, as well as non-specialist professionals (such as teachers) trying to provide the answers. This can lead to misinformation being spread. The pandemic highlighted the vital work of outreach in delivering face-to-face education on STI testing as well as the importance of ensuring professionals who work with young people are appropriately and accurately informed in order to pass on the correct messages to their students.

Contraception

Access to contraception remains a major topic of concern in many areas of the world (25, 26). Lack of contraceptive use or inadequate contraceptive use is directly linked to rises in unplanned pregnancies, thereby inevitably leading to further terminations(27). This carries significant emotional burden to women and families involved, as well as significant economic impact on a societal level. As stated in the Faculty of Sexual and Reproductive Healthcare

report, ‘equitable access to contraception is seen as fundamental to achieving the Sustainable Development Goals by 2030, and in 2012 the United Nations declared contraception a human right’(28). For healthcare providers working in sexual health and beyond, allowing people to have their choice of contraception and reducing barriers to access in Harrow remains a priority.

Table 4: *Summary of the Main Contraceptive Methods available*[28]

Contraceptive Type	Further Detail
Long-Acting Reversible Contraception (LARC)	Require administration < once per month/ cycle- (IUDs- intrauterine devices & subdermal implants)
Emergency Contraception	Used after intercourse to prevent pregnancy- emergency contraceptive pill or IUD
Oral Contraception	Includes POP (progestogen-only pill) & CHC (combined hormonal contraceptive)
Permanent Methods	Surgical procedures causing sterilisation
User-dependent Methods	Oral contraception, condoms & patch

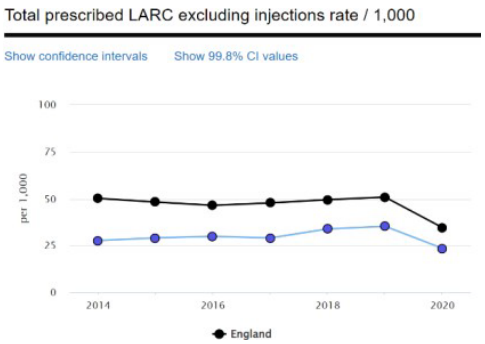
Long-Acting Reversible Contraception (LARC)

LARC is the most effective form of contraception; good prescribing and uptake of LARC has significant positive implications for reproductive health(29). There is clear evidence of demand for LARC amongst the community in Harrow. Lower rates of women are choosing injections and hormonal short-acting contraceptives at sexual health services. There is a rising percentage of under 25-year-olds choosing LARC at sexual health services in Harrow: 14.5% in 2014 compared to 19.5% in 202010.

There is a clear discrepancy between this rising demand for LARC and the rates of prescribing. Figure 6 illustrates the total rates of prescribing (excluding injections) across primary and secondary care services. Prescribing rates have consistently been lower in Harrow as compared to England. In 2020, Harrow’s total prescribed LARC rate per 1,000 women aged 15 to 44 years was 23.4; equivalent figures in London and England were 27.0 and 34.6 respectively(9).

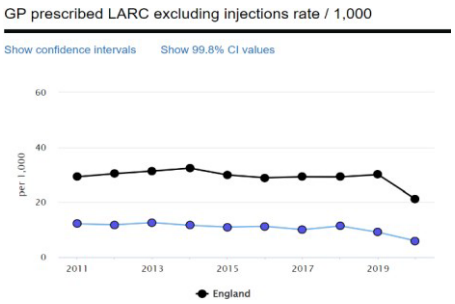
Figure 6: Total prescribed LARC (excluding injections) per1,000 women in Harrow and England (2014 to 2020)

Blue line shows Harrow, black line shows England.



The main area of concern in LARC prescribing is in Primary Care. As shown in Figure 7, Harrow has consistently lower rates of GP prescribed LARC in

comparison with England over recent years. For 2020, the rate of GP prescribing per 1,000 women in Harrow was 5.9, while in England the rate was 21.1. Similar data has been identified for neighbouring boroughs, including Ealing and Brent(10). There has been a steady decline in LARC prescribing rates in General Practice, including in the years pre-pandemic. During this time, LARC prescribing in sexual and reproductive health services has remained similar to or above national values (figure 8)(10).



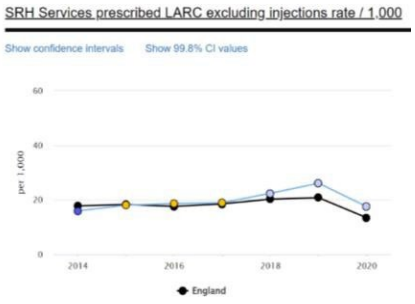


Figure 7: LARC prescribing in GP per 1,000 women (2011 to 2020)

GP prescribed LARC in Harrow (blue line) and nationally (black line). Includes IUDs and implants, excludes injections.

Figure 8: LARC prescribing in Sexual & Reproductive Health (SRH) services (2014-2020)

SRH prescribed LARC in Harrow (yellow/grey dotted line) and nationally (black dotted line). Excludes injections.

The semi-structured interviews carried out with clinicians and sexual health organisations as part of the needs assessment revealed a few reasons behind the lower rates of GP LARC prescribing in Harrow:

- Competing workload on busy General Practitioners (GPs) (30)
- Impact of the pandemic on Primary Care face-to-face consultations
- Impact of the pandemic on training programmes- reduced ability to train GPs in LARC prescription over the last 2 years
- Lack of timely payment and remuneration to GPs for the work done, as highlighted by a specialist
- Senior GPs in Harrow who are trained in LARC insertion retiring and not being adequately replaced

To improve rates of LARC prescribing in the community, certain actions and measures can be taken. One specialist stated a 3-step process would be required. Step 1 would be to

strengthen the commissioning; this would involve working closely with GPs and making LARC prescribing an attractive proposition to them. Ensuring timely and adequate remuneration is a crucial part of this.

Step 2 involves the training element. Several staff members in the sexual health service have been re-deployed or retired during the pandemic, which has meant a shortfall in LARC trainers. In addition, identifying GP members who are passionate about this field but cannot partake for genuine reasons is important. Targeting training and extra funding or resources to such GPs will help in the long-term as they would be trained to then provide this service for a long period of time. Another important factor is the age of trainees and trainers; one specialist stated if we can get younger healthcare staff on board with LARC prescribing, the positive outcomes will be felt over many years to come.

Step 3 relates to the motivation and incentivisation of GPs. With such a diverse and competing workload, primary care physicians are currently having to identify their local priorities and population needs under significant financial and time restraints. The question remains of how to encourage GPs to dedicate their valuable time to LARC prescribing.

Financial incentivisation remains vital. Furthermore, encouraging conversations and education about LARC within local areas is important. During a discussion with a specialist, we spoke about the domino effect in healthcare31. If GPs see fellow colleagues in their local areas partaking in LARC training and schemes, it can in turn propagate the numbers interested. Raising the profile of LARC and reaching the critical threshold for enthusiasm amongst GPs in Harrow in this way can help improve rates of prescribing.

Other methods of improving community LARC prescribing rates may be as follows:

- Involvement of other members of the Primary Care Network team, including pharmacies32
- Extended hours schemes to make contraception (including LARC) more accessible
- Maximising opportunities to educate women in Harrow on the importance of long-acting contraception- ‘Making Every contact count’

Termination of Pregnancy

Termination of pregnancy (TOP) is a topic very much linked to the issues with contraception and access discussed in the previous section. Many studies illustrate that the use of contraception leads to a lower number of unintended pregnancies28. There are wide-ranging consequences of unintended pregnancy across the world, including maternal morbidity and mortality, negative impact on maternal mental health and risks to the unborn child(33).

Harrow's total termination rates per 1,000 women aged 15 to 44 years has consistently been slightly higher than that of England (Figure 9). Rates in Harrow in 2020 were 21.0 in comparison to 18.9 for England(10). Figure 10 demonstrates that termination rates amongst under 18s in Harrow are falling and have consistently been better and lower than nationally. This is consistent with falling and lower rates of teenage conceptions locally 34. The age group of prominent concern in relation to rates of termination are specifically the over 25 demographic in Harrow (Figure 11)(9).

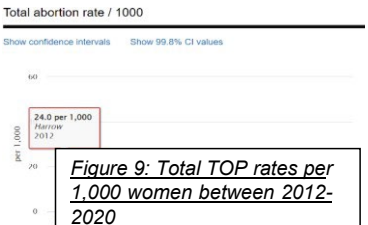


Figure 9: Total TOP rates per 1,000 women between 2012-2020

Graph showing total termination rates. Black dotted line represents England, red dotted line represents Harrow.

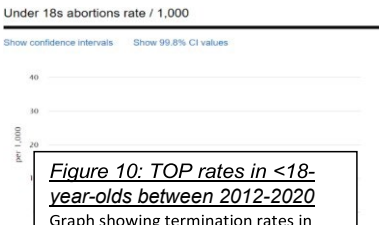


Figure 10: TOP rates in <18-year-olds between 2012-2020

Graph showing termination rates in the teenage group. Black dotted line represents England, blue dotted line represents Harrow.

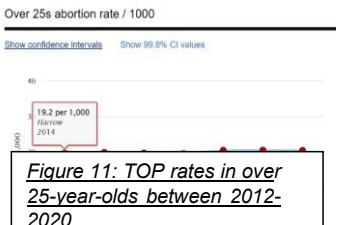


Figure 11: TOP rates in over 25-year-olds between 2012-2020

Graph showing termination rates in older age group. Black dotted line represents England, red dotted line represents Harrow.

With the higher rates of termination being in the older age groups, it is safe to assume that a lack of knowledge is not the main cause behind this. As one specialist stated, 'we have to assume a lot of this is down to access rather than ignorance'. Many women know the importance and types of contraception available but do not know the actual procedures and processes to access it. Raising awareness of where to obtain contraception and minimising the barriers will be important. With Harrow's very ethnically diverse population, for many residents English is not their first language. This represents a major barrier to access.

Provision of contraceptive advertising and advice can be done on numerous platforms (online, telephone, face-to-face, billboards etc) in a language-friendly manner to ensure this becomes more accessible to all women. In addition, during the pandemic the shift to online testing and telemedicine means less opportunistic ability to educate women on contraception and access.

A key issue which has been identified during the qualitative analysis is the follow up care received by women underground terminations at the Marie Stopes clinic in Harrow. The local CCG (Harrow) provides funding for Marie Stopes to provide contraception and follow up advice after a termination. A discussion with one specialist revealed that during their conversations with users of the Marie Stopes clinics, many service users would prefer to attend a sexual health service for ongoing contraception. Reasons for this include:

- Inappropriate timing- soon after a termination, many women and families are not in the right mental state to receive contraceptive advice immediately. Giving time for them to deal with the emotional impact is the first crucial step post-termination.

- Inappropriate location- returning to the centre where they underwent their termination often brings back painful memories and makes women feel vulnerable

- Inappropriate devices- some of the contraceptive mechanisms (for example intrauterine devices) remind women of the termination so they remove the device voluntarily

Based on this feedback, it is vital to address the needs of these women, particularly because many of them are in the over 25-year age bracket with higher rates of TOP. Setting up a clearly outlined contraceptive referral pathway from the Marie Stopes termination clinic in Harrow to the Sexual and Reproductive health clinic (Caryl Thomas) may help to reduce termination rates. This ensures these women are followed up for a period of time after their termination, and guidance on contraception can be provided in a time-friendly, patient-friendly and location-friendly manner.

Additional Service Needs

Voluntary Sector Organisation- Relationships & Sex Education (RSE)

The major organisation providing RSE within schools and youth organisations is Brook within the Harrow Borough. Brook is a charity and outreach organisation which aims to provide free, confidential sexual health and wellbeing advice nationally (36). Between August 2020 and July 2021, six schools in Harrow were provided RSE by Brook. For the latest six-month period (August 2021 to January 2022), three schools were accessed with a total of seven sessions delivered. Brook is currently contracted to deliver 34 sessions across Brent, Harrow & Ealing; this suggests they are meeting current numbers targets within Harrow.

Despite this, the major issue identified is capacity. There is evidence of demand for more RSE; there are 39 primary schools and 12 secondary schools in Harrow. Assessing ways of engaging more schools with Brook's programme and enabling Brook to provide more sessions will help spread advice of sexual health topics to young people. In addition, targeting the campaigning and advertising of such sessions to schools who normally engage less will be important; this includes religious schools locally. Finally, a discussion with a voluntary sector worker revealed that with the limited sessions that can be arranged, schools are often asking for RSE outside the core SH topics. Although other topics are important, ensuring the core curriculum of STIs and contraceptive advice is provided to young people is key. The programme delivered should primarily be guided by Brook as opposed to the school's requests.

Sexual Health London (SHL) E-Service

The SHL E-service is an online portal which aims to mirror what happens in a SH clinic, which aims to move a third of activity online. It is contracted by the City of London across 30 different London boroughs and provides the following services(36):

- STI testing for people with mild symptoms or asymptomatic- syphilis, HIV, chlamydia & gonorrhoea

- Free regular contraception via online consultation
- Emergency contraception via online consultation

The E-service's activity significantly rose during the lockdown, with 95% of all testing in London being done via this online platform during the first lockdown (April 2020). Pre-pandemic the E-service was undertaking one-third of total STI testing; the e-service is carrying out two-thirds currently. The remainder is performed within the sexual health clinic settings.

STI diagnoses for the period between 1st April 2021 to 1st April 2022 reveals the following in Harrow(37):

- Most common age group utilising E-service were aged 25 to 34 years – 2,426 screens were performed. Second fewest screens amongst the 15-19 year age bracket (273 screens). Highlights the issue of adolescents most likely preferring face- to-face contact in confidential SH clinics as opposed to online.
- Ethnicity - large spread of ethnicities utilising the service consistent with Harrow population. Number of screens performed in Harrow: White: 668, Other Asian 292, Caribbean 694, Other Black 59, Indian 583, African 481. This suggests people from all ethnicities are comfortable accessing the online portal, meaning the E-service has opened access to groups of people who previously would not have sought sexual health support

The E-service has been vital in enabling Harrow's sexual health provision during the pandemic years to keep up with the demand. We will await to see the full impact of this in the coming years, however the last two years have very much highlighted the importance of a hybrid model of online and face-to-face consultation and testing in order to meet the needs of Harrow's population.

Additional Comments from Qualitative Service Provider Interviews

As part of this needs assessment, service providers across various sexual health organisations were asked to input their experiences and opinions on what improvements can be made. Many of these have been included in the stem of the needs assessment. Some additional comments from this qualitative analysis and sexual health workshop are further detailed in Table 5.

Table 5: Additional Service Improvement Recommendations from Qualitative Analysis

PrEP= pre-exposure prophylaxis.

Additional Service Improvement	Further Detail
Extended hours & weekend services	Targeting a 7-day service- would help encourage testing on weekends, early mornings & late evenings. Improved access for the local population

Intermediary gynaecology clinic	Introduction of community gynaecology service, working alongside contraceptive service to aid women with heavy menstrual periods needing investigation. Currently, significant inefficiency and long referral times
PrEP amongst sexual minority groups	Gap in numbers of transgender and bisexual people accessing PrEP. Need to make this more visible and accessible to this demographic
Increased digitalisation for contraceptive access	Specifically for emergency hormonal contraception in pharmacies. Reduce the consultation time if online form filled out before appointment. Pharmacist/ clinician then has all the information before-hand in order to make decision. Improves efficiency and gives more opportunity to meet rising demand.

Conclusion

Sexual health needs in Harrow and nationally are a dynamic and constantly changing field. Over the last few years, health systems across the UK and globally have had to make significant alterations and adaptations to service provision in order to account for the impact of the pandemic whilst continuing to meet population needs. Through the hard work of numerous people and organisations across Harrow, sexual health provision continued to meet the demands placed on the service whilst working under substantial constraints.

In this needs assessment, we have aimed to highlight key themes and issues that have arisen in the years leading up to the coronavirus pandemic and during the pandemic itself. These include but are not limited to improving LARC prescribing rates, encouraging access to STI services for young people, reducing rates of late HIV diagnosis and addressing high termination rates in women over 25 years. Addressing these core needs in sexual health within Harrow will bring positive consequences to individuals and society on an emotional, financial, and physical level.

Recommendations

Based on the data analysis and qualitative interviews undertaken in this needs assessment, the following are the key summary recommendations we advise:

1. Improving accessibility for those groups that are less suited to telemedicine-specifically young people (< 18 years) and LGBTQI community

2. Education and addressing misinformation amongst Harrow residents to improve HIV testing coverage, especially in the female cohort

3. Raising awareness of the importance of HIV testing among non-sexual health clinicians (GPs & other secondary care doctors). Along with opt-out A&E testing, this will help to reduce late diagnosis

4. Ensuring voluntary outreach organisations are teaching core sexual health topics within the curriculum, including STIs and contraception

5. Following the 3-step process to improving LARC prescribing in primary care; strengthen commissioning, engage in training, and incentivise GPs

6. Create adequate referral pathways between the TOP clinic and sexual health clinic, to reduce rates of termination in over 25s

7. Develop an intermediary gynaecology service within the community to work alongside the community contraceptive service to aid in investigation and management of women with heavy menstrual bleeding

Appendix

Key interviewees and providers we would like to thank whose input was vital for this needs assessment:

- Shelly Roberts, LNWH
- Kamy Dosajh, LNWH
- Dr Naomi Hampton, Consultant in Sexual Health, LNWH
- Dr John Mcsorley, Consultant in Sexual Health, LNWH
- Dr Dawn Friday, Consultant in Sexual Health, LNWH
- Dr Priya Thayaparan, Consultant in Sexual Health, LNWH
- Dr Hugh Caslake- GP, Harrow CCG
- Dr Isha Coombes- GP, Harrow CCG
- Adrian Kelly, London E-Service
- Amber Newman-Clark- Brook
- Janice Oh- Terrence Higgins Trust
- John Dugdale- Spectra

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