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This factsheet focuses on the effective **provision of contraception to prevent unplanned pregnancy**. Contraception is available free of charge to all who choose to prevent pregnancy and is usually provided as ‘open access’. Open access means services can be accessed via self-referral, not limited by age, place of residence or GP registration. Services are provided in general practice, sexual health clinics and from specialist services for young people. ‘Long acting reversible contraception’ (LARC) such as 'copper or hormone containing intrauterine devices’ are most effective in preventing unwanted pregnancy. The population in Tower Hamlets with the number of women of reproductive age (typically defined as 15-44 years) is comparatively larger than many other areas. Conception rates have been falling steadily and continue to decrease in Tower Hamlets. In 2017 the teenage conception rate increased slightly, yet remains below that of England and London. However, there are areas of the borough which are higher than the Tower Hamlets and national average.

**What are the key stats?**

- Women whose pregnancies are unplanned
- Nationally around 45% of all pregnancies are unplanned
- The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group
- As many as 42% of unplanned pregnancies may end in abortion.

There are around 9100 women aged 15-44 in Tower Hamlets. 83% that used EHC in 2017/18 had used it before. Tower Hamlets has amongst the lowest rates of LARC uptake in England. There were 5,828 conceptions to women aged 15-44 in 2017, a 1/4 of which led to abortion, which is similar to London. The teenage conception rate increased in 2017 although remains below that of England and London. 75.5% of under-18 pregnancies led to abortion compared to 51.8% for England. 1 ward (Bow East) has a higher than average number of under-18 conceptions.

**Who is affected?**

- Women whose pregnancies are unplanned
- Nationally around 45% of all pregnancies are unplanned
- The highest numbers of unplanned pregnancies occur in the 20 to 34 year age group
- As many as 42% of unplanned pregnancies may end in abortion.

**What is currently in place?**

36 General Practices provide contraception including LARC although provision is variable between practices. ‘All East’ provide contraception from specialist centres in East London via satellite clinics and two centres of excellence. Compass Safe East provide specialist services for young persons 10-19. 46 Pharmacies provide EHC and free condoms to under 25’s. Abortion services are available via a single point of access. There is targeted support for young parents called the ‘Family Nurse Partnership’. There are projects in progress that aim to improve access to LARC.

**How can we further tackle the issue?**

To increase the uptake of LARC in General Practice. Improve understanding of the provision of sexual and reproductive health education. To improve understanding of the cultural differences or influences on contraceptive use and acceptability. Improve upon the quality and availability of sexual health service information. To consider the quality standards by FRSH and NICE when redesigning or commissioning services. Improve upon the collection and analysis of service level data to understand the particular needs of women accessing contraception.
Setting the scene: what is contraception and why does it matter?

This factsheet focuses on the effective provision of contraception to prevent unintended pregnancy although contraception may be used for other reasons: i.e. the prevention of STIs or control of gynaecological conditions, such as heavy menstrual bleeding.

Since the 1970s, contraception has been available free of charge to all choosing to prevent pregnancy [1]. Open access contraceptive services are provided in general practice, a contraception or sexual health clinic and from young people’s services

- Open Access means individuals can access contraception via self-referral, not limited by age, place of residence or GP registration [2]. Open access services, by their nature, are non-discriminatory, ensure equitable access to care and contribute to the reduction of health inequalities.

- Access to services which provide a range of contraceptive options is a key factor in preventing unintended pregnancy. Unintended pregnancy may be viewed as a failure in contraception or inadequate contraceptive service provision.

To be effective, contraception must be used correctly and consistently, and for the long-acting methods (such as intrauterine devices) continuation rates must be high. Effective and continued use of method is directly related to its acceptability to the user. Contraception is divided into two categories:

<table>
<thead>
<tr>
<th>User dependent</th>
<th>Long acting reversible contraceptives (LARC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘can be less effective due to imperfect use’</td>
<td>‘is most cost effective when continuation rates are high’</td>
</tr>
</tbody>
</table>

The user has to remember to use and has to think about regularly or each time that they have sex, i.e.

- Male or female condoms

Do not require the user to remember to take them or use them to be effective.

There are 15 types of contraception 13 for women and 2 for men. A full list available ‘here’
Setting the scene: what is emergency contraception

Emergency contraception, can be used after unprotected sex in order to prevent pregnancy.

There are two types of emergency contraception:

**Emergency Hormonal Contraception (EHC)**
There are currently two different types of EHC, levonorgestrel (Levonelle) and ulipristal acetate or (EllaOne). These pills are most effective the sooner they are taken after unprotected sex. Within three days for Levonelle and five days for EllaOne.

**Intrauterine device (IUD)**
IUDs can also be inserted within 5 days of unprotected sex to act as emergency contraception. The IUD can then remain in place and be used as regular contraception from that point onwards.

The emergency IUD is the most effective emergency contraception. It is recommended that all healthcare practitioners (including GPs, community pharmacists, sexual health consultants and nurses) tell women who ask for emergency contraception that an IUD is more effective than an oral method. It is the role of the commissioner to ensure that practitioners unable to fit IUDs at presentation refer women to a service that can and offer them an oral emergency method in the interim (3).
Setting the scene: what is the impact of unplanned pregnancy?

Unplanned pregnancy

Nationally around 45% of all pregnancies are unplanned. Nearly two thirds of all unplanned pregnancies are to women aged 20-34 years old.

Higher risk of complications during pregnancy and birth

- Women who go onto to give birth are more likely to experience premature labour.
- To give birth to babies who have a low birth weight [4]. They are also more likely to experience pre and post-natal depression [5]. They may present later to antenatal services [6].
- and may be unable to take advantage of screening and monitoring which is offered in earlier stages of pregnancy.

Long lasting effects for both the mother and the child

Women who have an unplanned pregnancy are more likely to experience a relationship breakdown [7]. Women who become mothers at younger ages are less likely to complete education and more likely to experience future poverty [8]. There is evidence that unplanned and mistimed children exhibit more behavioural problems than their planned peers [9].

Abortion

As many as 42% of unplanned pregnancies may end in abortion [10]. Whilst abortion is a safe procedure when carried out by a medical professional, there may be longer lasting emotional consequences for women who undergo abortion, and costs and resource issues which must be borne by the NHS. Unwanted pregnancy is also associated with an increased risk of mental health problems [11].
Setting the scene: what is the known risk factors for unplanned pregnancy?

Risk factors for unplanned pregnancy are:
- Women who do not have a post 16 qualification
- Women who smoke
- Women who have used drugs in the last year
- Women who have depression
- Women who first had sex before age 16

Protective factors
- Sex education through school is associated with a lower risk of unplanned pregnancy.
- Improvement in women's lives, education and employment options are probably the strongest motivators to avoid unplanned pregnancy.

Teenage pregnancy
- Preventing teenage pregnancy is a national priority as most pregnancies are unplanned and around half end up in abortion. Teenage pregnancy is associated with poorer outcomes for both the young parent and their child.
- Teenage mothers are at increased risk of experiencing postnatal depression and poor mental health. They are more likely to have low educational attainment, to be unemployed and to be living in poverty as an adult.
- There are increased risk to the child also including a higher risk of low birth weight and infant mortality.

SRE From September 2020 all schools in England (including academies and independent schools) will provide ‘Relationships and Sex Education’ RSE. Primary schools teach ‘relationship education’ whilst secondary schools to teach ‘relationship and sex education’.* Parents will retain their right to withdraw their child from sex education* and flexibility is allowed for faith schools to teach within the tenets of their faith. New rights for children to ‘opt-in’ as they approach 16.
Policy context: current guidelines

A consensus statement by Public Health England on reproductive health sets out the scope of reproductive health, and a vision that is centred around a framework of “6 pillars of reproductive health [17].

The 6 Pillars of reproductive health are conceptualised as surrounding women to illustrate a person centred approach across the life course; and being encased within, and influenced by, the wider determinants of health.

Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment

Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health

Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation

Proportionate universalism: The ability to optimize reproductive health, and social and psychological well-being through support and care that is proportionate to need

User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives

Wider determinants: The opportunity to experience good reproductive health and ability to access to reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being
Policy context: current guidelines

Reproductive health is a public health issue. Contraception in the context of reproductive health – a consensus statement considers that provision should be ‘in proportion to need’ and includes:

- **Universal access** to full range of **contraception choices, pregnancy planning and preconception, and reproductive health screening** at the point of entry, regardless of service type or geographical location across all sectors including voluntary sector, community, primary care and specialist services.
- **Address disparities in access and outcomes** in reproductive health such as unplanned pregnancies in black, Asian and Minority Ethnic (BAME) groups, and sub-optimal contraceptive provision within some age groups.

Contraception services are commissioned by a range of agencies and are in the context of broader provision for reproductive health. There is considerable variation in how sexual health services are provided and commissioned.

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>Clinical Commissioning Group</th>
<th>NHS England</th>
</tr>
</thead>
<tbody>
<tr>
<td>sexual health services including most contraceptive services</td>
<td>most abortion services</td>
<td>contraception provided as an additional service under the GP contract</td>
</tr>
<tr>
<td>sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing</td>
<td>sterilisation</td>
<td>HIV treatment and care, including drug costs for post-exposure prophylaxis after sexual exposure (PEPSE)</td>
</tr>
<tr>
<td>specialist services, including young people’s sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies</td>
<td>vasectomy</td>
<td>promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs</td>
</tr>
<tr>
<td><strong>Tower Hamlets also provide contraceptive services in pharmacy and general practice via a locally determined enhanced contract</strong></td>
<td>non-sexual-health elements of psychosexual health services</td>
<td>sexual health elements of prison health services</td>
</tr>
<tr>
<td></td>
<td>gynaecology including any use of contraception for non-contraceptive purposes</td>
<td>sexual assault referral centres</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cervical screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>specialist fetal medicine services</td>
</tr>
</tbody>
</table>
Policy context: current guidelines

**Health and Social Care ACT 2012**
- Sexual health services are now the responsibility of Local Authorities
- Abortion services are commissioned by local Clinical Commissioning Groups (CCGs)
- Contraception via primary care is commissioned by NHS England via the GP contract

**A Framework for Sexual Health Improvement (2013)**
Aim: to improve SH outcomes by ensuring everyone is able to make informed choices about relationships and sex
- To reduce unwanted pregnancies, repeat abortion and pregnancy after childbirth, including post abortion LARC
- Also focus on teenage conceptions and the integration of services.

**PHE Promotion for sexual and reproductive health (2016-19)**
Aim: To minimise unplanned pregnancies and reduce the rate of teenage conception
- All women can access information about their choice of contraception
- To promote evidence and effective practice and provide data and intelligence to reduce teenage pregnancy

**The NHS Long Term Plan (2019 – 2029)**
Aim: to set out the key ambitions for the service over the next 10 years
- The plan sets out an intention to review the way that sexual health services are commissioned.
- Services are currently commissioned by the local authority through the public health grant. In the future, the NHS may be responsible for commissioning sexual health services.
What works: effective interventions

**National Institute for Health and Care Excellence (NICE) – guidelines**

**Long Acting Reversible Contraception (LARC)**
- LARC is the most effective form of contraception. An increase in LARC will reduce the number of unintended pregnancies. To be effective it is important that:
  - Women are given information and offered a choice of all methods of contraception including LARC.
  - The information is tailored to individual needs and sensitive to cultural differences and religious beliefs.
  - Healthcare professionals need better training and guidance on how to help women to make informed choices.
  - Contraceptive providers that do not provide LARC should have agreed mechanisms in place for referring women for LARC.
  - Healthcare providers and commissioners to be clear on the relative cost effectiveness of LARC compared to other methods of fertility control.

**Contraception services for under 25**
- Contraceptive services for persons aged under 25 should be both universal and inclusive.
  - Services should be coordinated, comprehensive and meet the minimum requirement of the You're Welcome criteria.
  - Services should be tailored to meet the needs of socially disadvantaged young people.
  - Assurances should be made to young people on confidentiality.
  - Advice or provision, signposting to contraception should be offered after both pregnancy and abortion.
  - Condoms should be offered alongside other methods.
  - The provision of emergency contraception does not encourage risk sexual behaviour among young people.
  - To provide school and education based contraceptive services.

**Condom distribution schemes**
- Condom distribution schemes prevent STI’s and unwanted pregnancy. There are three types. ‘multi-component’ schemes (for YP in health, education or youth settings), ‘single component’ schemes (free condoms distributed at commercial or high risk venues), and ‘cost price schemes’ (condoms distributed at cost price or reduced cost at scale i.e. online).
  - The C-Card scheme is the most widespread in the UK, and typically focus on those aged 13-24. Although there is no evidence to support this scheme or identify the components of effectiveness. NICE on balance consider that such schemes should be provided to the under 25’s.
  - Increasing condom use would help avoid some pregnancies. Increasing condom use by 22% for YP aged 14-18, in a population of 100,000, would accrue a pregnancy related saving of 11 million.

**Evidence Gaps**
- The cultural differences for women in the UK in terms of response to side effects, continuation rates and patterns of method switching in a system where women have freedom of choice and free access to contraception.
What works: effective interventions

**NICE** National Institute for Health and Care Excellence (NICE) – quality standard

**FSRH** The Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetrics and Gynaecologists

**NICE** Contraception quality statements

1. Contraceptive information and methods: Women asking for contraception are given information about, and offered a choice of, all methods ... ensure providers work together to ensure women are provided with their preferred method.
2. Emergency contraception: Women asking for emergency contraception are told that an intrauterine device is more effective than an oral method ..... ensure that referral pathways are in place for women who choose to have an emergency IUD fitted.
3. Contraception after an abortion: Women who request an abortion discuss contraception with a healthcare practitioner and are offered a choice of all methods when they are assessed for abortion and before discharge. ensure that abortion services offer women a choice of all methods before discharge, or offer a referral to a service if contraceptives are not provided.
4. Contraception after childbirth: Women who give birth are given information about, and offered a choice off all methods by their midwife within 7 days of delivery. CCG ensure that maternity services give women information about, and offer them a choice of all contraceptive methods within 7 days of delivery, or refer if unable to provide immediately.

**FSRH** Quality Standard Contraceptive Services

1. Access to services: Every individual requiring contraception should have access to contraception both from a GP and/or an alternative open access specialist provider to whom GPs can also refer for specialist advice and care.
2. Access to all methods of contraception: All individuals within the area requiring contraception should have access to all methods of contraception directly through a contraceptive provider or by effective referral pathways.
3. Access to choice of contraception: Individuals should have timely access to the method of contraception of choice and to urgent contraceptive care.
4. Service user input: The design and review of services should include input from the service users and the public.
5. Staffing: Individuals requesting contraception to minimise their risk of unintended pregnancy have the right to expect appropriately trained and competent staff.

**FSRH** Service Standards for Sexual and Reproductive Healthcare

1. all specialist SRH services should be consultant-led and should link with other contraceptive care provider.
2. There should be access to all methods of contraception or referral in a timely manner.
3. There should be patient pathways and services should adhere to FSRH Standards on Consent and Confidentiality.
4. User engagement should be encouraged on a regular basis.
5. There should be information available about the timing of services and there should be easy and non-discriminatory access for all.
6. All staff working in SRH services should be appropriately trained.
7. SRH service provision should be evidence-based, which will include the use of national and local guidelines and policies.
8. All clients seeking SRH services should be confident that their right to confidentiality will be respected.
9. Record keeping should be of a high standard.
10. Nurses working autonomously in providing SRH services should have their role supported and developed.
11. Finally, all services should continually monitor and evaluate themselves in order to maintain and improve performance.
What works: effective interventions to prevent teenage pregnancy

Teenage pregnancy and young parents

- All young people need good SRE and access to services to prevent early pregnancy and look after their sexual health
- Countries with more open approaches to young people’s sexual health, as assessed by better SRE, more parental communication and more accessible contraceptive services, have lower conception rates
- 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
- Measures to reduce teenage pregnancy need to be both universal and targeted. Some young people, however, will be at greater risk of early pregnancy and require more intensive SRE and contraceptive support, combined with programmes to build resilience and aspiration
- Advice on contraception during abortion or antenatal care and access to the chosen method immediately post pregnancy helps reduce unplanned conceptions
- Reaching young people most in need involves looking at area and individual level associated risk factors.
The local picture: population

Although contraception is the responsibility of both males and females, females are the primary users of services and by consequence for particular consideration in this JSNA. The population of Tower Hamlets is relatively young with more men and women aged between 20 and 44 as a proportion, than compared to London and England [Fig 1]. Reproductive age is typically defined as 15-44 years. There are approximately 9100 women of reproductive age in TH [18]. As a proportion, there are more women of reproductive age than London and England. The population of Tower Hamlets is predicted to grow between 2018 and 2028, although the proportion of females aged 25-44 are predicted to reduce by 2028 [Fig 2].

![Population pyramid for males and females in Tower Hamlets 2018](image)

![15-49 yrs Female Population Projection, 2018 and 2028](image)

Births over the last 10 years England and Wales

The highest proportion of births are to women aged over 25. There has been a gradual reduction in live births among women aged under 25, and an increase in births to those aged over 25 over the last 10 years+ in England and Wales. % births by age < 25 vs 25 >

<table>
<thead>
<tr>
<th>Year</th>
<th>under 25</th>
<th>over 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>2017</td>
<td>17%</td>
<td>83%</td>
</tr>
</tbody>
</table>

*This has implications for reproductive health services in Tower Hamlets, as well as when comparing Tower Hamlets to other areas.
The local picture: Ethnicity and Religion

37% of women aged 15-44 in the borough are of Bangladeshi ethnic origin. The size of the population of women by ethnicity varies according to age. 52% of women aged between 15 - 18 are Bangladeshi, compared to 17% of women aged 25-29 [Fig 3].

38% of residents (men and women) in Tower Hamlets are Muslim, compared to England and Wales as a whole where just 5% are Muslim [Fig 4]. The Muslim population is the largest single religious group in Tower Hamlets [19]. In terms of size, Tower Hamlets has the fourth largest Muslim population in England and Wales’ preceded by Birmingham, Bradford and Newham (Muslim populations are greater in number, but smaller as a proportion of all residents)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Tower Hamlets</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>20%</td>
<td>100.0</td>
</tr>
<tr>
<td>White Irish</td>
<td>0%</td>
<td>4.9</td>
</tr>
<tr>
<td>White &amp; Black Caribbean</td>
<td>1%</td>
<td>59.3</td>
</tr>
<tr>
<td>White &amp; Black African</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>White &amp; Asian</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Indian</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>52%</td>
<td>37%</td>
</tr>
<tr>
<td>Chinese</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Black African</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Other Black</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Arab</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Source: Census 2011 (Revised data issued by ONS for Tower Hamlets on 26.02.15)

The faith profile in Tower Hamlets is consistent with the unique ethnic profile of the borough’s population, which is one third Bangladeshi, which is also the largest percentage nationally.
The local picture: Emergency Hormonal Contraception (EHC)

EHC Prescribed in Pharmacy 2017-18

46 pharmacies dispensed 6,565 EHC under a ‘Patient Group Directive’ (PGD) for Levonorgestrel. EHC was dispensed most often to women that were Bangladeshi, white British, or white other [Fig 5], and to women aged 20-24 [Fig 6]. 50%+ of all EHC was dispensed to women aged between 20-29.

83% stated that they had used EHC previously

- Almost 70% stated the reason for EHC was due to ‘unprotected sex’
- just under 30% due to a ‘failed condom’
- 5% was due to missed hormonal contraceptive. [Fig 7].
The local picture: Emergency Hormonal Contraception (EHC)

**EHC Prescribed in Pharmacy**
There is wide variation in the amount of EHC dispensed under the patient group directive in the borough. Forward Pharmacy, Boots, Greenlight, Britannia, Florida, Lansbury and the Barkentine dispensed just under 50% of all EHC ranging 4.8 to 10%.

**Map of EHC dispensed darker shading indicators higher number dispensed** [Fig 8].

**Pharmacies in Tower Hamlets**

The local picture: EHC Sexual Health Service

EHC prescribed in Sexual Health Services

Both emergency contraceptive pills and emergency IUD data is provided by sexual health services (SHS). Women aged 20-34 were more likely to access EHC or have Emergency IUD fitted in a SHS than women of other ages [Fig 10]. In 2017, 790 (rounded to the nearest 5) women resident in Tower Hamlets were prescribed emergency contraception at Sexual Health Services. Of those, 4.3% were prescribed it more than once in 2017, compared to 8.6% in England* [20].

*Small numbers rounded up to 5. Frequency only counts repeat prescriptions if prescribed more than once in 2017 and if returned to the same location or service.
The local picture: EHC General Practice

- Data was provided by general practices for between Apr 2017-Mar 2018, over this time there were 512 recorded prescriptions for EHC.

- Based on the available data, women accessing EHC in general practice tended to be aged 25-39 and South Asian or white. This does seem to reflect the findings by PHE in ‘what women say’ that older women prefer to access contraception via general practice compared to women that are younger.

N.B: Only emergency contraceptive pills are reported in GP prescribing data
Ethnicity details were either not provided, or not recorded for 43 women; most were aged between 19-25.
The local picture: Long Acting Forms of Contraception (LARC) National and Regional

**National/Regional Long-acting reversible contraception (LARC)** is contraception that doesn't depend on you remembering to take or use it to be effective. When continuation rates are high, it is the most cost effective form of contraception, and can reduce the number of unintended pregnancies. It is important that women are able to choose the contraception most suited to their needs and should be offered a choice of all methods, including LARC. [21].

The graph below presents attendance to sexual health services in the community by women in England according to their level of deprivation. ‘1’ represents the most deprived. What this demonstrates is that there is an association between those most deprived and attendance to sexual health services in the community.

![Fig 14: A national picture of LARC uptake in SRH services](image)

**What we know about women who use community clinics for LARC**

- Women living in the poorest areas, are more likely to attend sexual and reproductive health services in the community [22]
- A survey of where men and women obtain contraception found that community clinics were used less often by women and also men for contraception.
- Of the women that did access contraception in the community clinic, they tended to be young and at greater sexual health risk [23]
The local picture: LARC Sexual Health Service

Attendances Sexual Health Service in Tower Hamlets

Women living in more deprived areas tend to visit sexual health services in the community more frequently than women living in the least deprived. There is no correlation between uptake of LARC and deprivation which although variable is fairly similar for all areas. The most frequently visited sexual health clinic is the Ambrose King at the Royal London Hospital*.

Fig 17

<table>
<thead>
<tr>
<th>Name of clinic</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London Hospital</td>
<td>8,755</td>
<td>44.5</td>
</tr>
<tr>
<td>Mile End Hospital</td>
<td>4,616</td>
<td>23.5</td>
</tr>
<tr>
<td>St Bart’s</td>
<td>1,745</td>
<td>8.9</td>
</tr>
<tr>
<td>Homerton University Hosp.</td>
<td>1,248</td>
<td>6.3</td>
</tr>
</tbody>
</table>
The local picture: LARC Sexual Health Service

Regional comparison of Sexual Health Services – 2017

Uptake of LARC at Integrated Sexual Health Services is concentrated on women in the north of the borough.

**Fig 19**

**Fig 20**

**2017 LARC**

727 women aged **under 25** that attended a sexual health clinic chose LARC, this is an increase on previous years, and was higher by percentage than both London and England. 7th highest in London [24].

1,788 or 35% women aged **over 25** that attended the sexual health clinic, chose LARC. Although an increase on previous years this was lower than London and England.
The local picture: LARC General Practice

Regional comparison General Practice - 2017 LARC prescribing in general practice has remained persistently lower than other many other boroughs in London, and has shown a downward trend in 2017. All local authorities were ranked according to LARC prescribed in general practice. Tower Hamlets was ranked 243/326 1st is the highest (a rate of 10.8 per 1,000 women aged 15-44 years) [25].

Fig 21

Women who are most deprived are least likely to access LARC in general practice.

Fig 22
The local picture: Long Acting Forms of Contraception (LARC) General Practice

Regional comparison General Practice – 2017

The chart below compares LARC prescriptions in general practice only and compares the percentage to London and England. Over 80% of prescriptions are for oral contraceptives, which are also prescribed more frequently.

Fig 24

Total LARC prescribed in all settings

The total rate of LARC (excluding injections) prescribed in general practice AND Sexual health services to women aged 15-44 33.6 is quite similar to London 34.2

<table>
<thead>
<tr>
<th></th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>33.6</td>
</tr>
<tr>
<td>London</td>
<td>34.0</td>
</tr>
<tr>
<td>England</td>
<td>47.4</td>
</tr>
</tbody>
</table>

GP prescribing data does not record LARC removal. Discontinuation is an important driver of relative cost effectiveness between LARC and other methods.

1. This excludes prescriptions not collected, from sexual health services, specialist young peoples services, pharmacy and any LARC prescribed under the primary care enhanced service.

2. This does not include LARC prescribed in termination of pregnancy services, which may be a significant amount.

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Key facts
Setting the scene
Policy context
What works?
Local actions
Impact on indicators
Public perspective
Knowledge gaps
Priorities
Key contacts & Appendices
The local picture: LARC General Practice

A higher rate of women that were black and aged between 19-39 had LARC fitted in Primary Care. Contraceptive implants were more common among women aged 25-39 than women of other age groups.

Fig 25

[[Graph: LARC fittings in General Practice in Tower Hamlets, 2017/18]]

Fig 26

[[Graph: LARC fittings in General Practice in Tower Hamlets, 2017/18]]

Source: CEG/GLA
The local picture: LARC General Practice

The following chart [Fig 27] summarises LARC activity in general practice according to each network and each practice. What this chart demonstrates is the variability of LARC activity by network.

There has been some activity across a number of practices in Network 6, 7 and 4. In contrast, in network 8, 2 and 1 activity is concentrated in a particular practice within that network. There is almost no LARC activity in NW3.

This chart also indicates which practices have at least 1 LARC fitter in the practice during 2017-18. Based on the information provided* there seems to be no correlation between trained LARC fitters and LARC fitting by practice.

See ‘what is being done about this issue’ section for information on a project to increase LARC uptake in Primary Care.

*NB: The information on LARC fitters per practice, may not have been up to date at the time it was provided. However, what it does indicate is that there is a need to improve equality of access to LARC fitting in general practice.
The local picture: LARC General Practice—Six Week Check

- Women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery.
- The six week post natal check provides an opportunity to discuss plans for contraceptive care and should form part of the contraceptive plan [26].

Fig 28

- Of the women that attended a six week check:
  - On average 11% of women choose to have LARC fitted
  - A higher proportion of black women opted for LARC than women of other ethnicities
  - A similar percentage chose LARC by age group*

*less than 5 persons under 18 attended a post natal check
The local picture: Sexual Health Services

Attendances to sexual health services: Based on the number of attendances, women that are ‘white’ are the largest ethnic proportion. When taking into consideration the relative size of the population, women who are ‘mixed’, ‘black’, or ‘white’ are more frequent attenders [Fig 29]. as are women aged 18-24 [Fig 30]. Women who are Somali, Chinese, Asian or Bangladeshi, are least likely to access SHS.

A higher proportion of women attending sexual health services are reported as ‘no contraception method’* than England although similar to regionally [Fig 31].

![Proportion of attendances at SRH services - by 'contraception method status' 2017](image)

*emergency contraceptive only; other SRH service only; emergency contraception and other SRH services and where no contraceptive method was recorded.
The local picture: Sexual Health Services – LARC demographic

Sexual Health Services

Women aged 18-24 attend sexual health services to have LARC fitted at a higher rate than women of other ages. This supports findings by PHE ‘What Women Say’ that women using SHS for LARC tended to be younger. Women who are Somali, Chinese, Asian or Bangladeshi are having LARC fitted at a lower rate than women of other ethnicities.

<table>
<thead>
<tr>
<th>LARC (excluding injections) by age*</th>
<th>Rate per 1,000</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 or under</td>
<td>2.3</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>7.9</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>25-40</td>
<td>5.5</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td>41 - 54</td>
<td>1.9</td>
<td>2.2</td>
<td></td>
</tr>
</tbody>
</table>

*Implant, IUS, IUD

Source: numerator Barts Health (SHS) activity data. GLA Household base population. 85% of records included ethnicity.
The local picture: Conception and abortion

**Conception:** There were 5,828 conceptions to women aged 15-44 in Tower Hamlets in 2017. Between 2009 – 2017 the population of women aged 15-44 has increased, although the number of conceptions has remained within a similar range. The conception rate was 68.0 in 2017, and has fallen year on year for the past five years for all areas. The rate in Tower Hamlets has been lower than both England and London for the last four years.

**Abortion:** Abortion rates can indicate lack of access to good quality contraception and advice as well as problems with individual use contraception method. The total number of abortions in the female population aged 15-44 years in 2017 was 1,424. The percentage change from 2016 was -0.9% [27]. In 2017, 25% of conceptions led to abortion, this is similar to London but higher than for England. Between 2009 - 2017 this indicator has ranged from the lowest value of 23.6% to the highest 25.9 [Fig 36].

![Conception and abortion trend](https://example.com/conception_abortion_trend.png)

**Trend number of conceptions to women in age group 15-44**

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tower Hamlets</td>
<td>5971</td>
<td>6058</td>
<td>6281</td>
<td>6198</td>
<td>6077</td>
<td>6043</td>
<td>6159</td>
<td>5972</td>
<td>5,828</td>
</tr>
</tbody>
</table>

![Conception rate per 1,000 women](https://example.com/conception_rate.png)

![Percentage of conceptions leading to abortion](https://example.com/abortion_rate.png)
The local picture: Abortion by ethnicity

Tower Hamlets is ranked 80 out of 149 local authorities for the total rate of abortion (1st has the highest rate) The total abortion rate was 16.6, while in England the rate was 17.2 per 1,000 [28]. For women aged under 25 and over 25, the greatest proportion of abortions are to women that are white or Asian for all ages.

A rate takes into consideration the relative size of the population. For women aged under 25 women who identified as ‘black’ or ‘other’ had a higher rate of abortion. For women aged over 25 this was similar with black women having the highest rate of abortion.

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</tr>
</thead>
<tbody>
<tr>
<td>White</td>
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<td>38%</td>
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<td>44%</td>
<td>42%</td>
<td>43%</td>
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</tr>
<tr>
<td>Mixed</td>
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<td>6%</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Asian</td>
<td>43%</td>
<td>42%</td>
<td>37%</td>
<td>33%</td>
<td>36%</td>
<td>36%</td>
<td>34%</td>
<td>34%</td>
</tr>
<tr>
<td>Black</td>
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<td>8%</td>
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<td>10%</td>
<td>7%</td>
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<tr>
<td>Other</td>
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<td>4%</td>
<td>7%</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
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<tr>
<td>Over 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>43%</td>
<td>47%</td>
<td>47%</td>
<td>47%</td>
<td>49%</td>
<td>51%</td>
<td>52%</td>
<td>52%</td>
</tr>
<tr>
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<td>3%</td>
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<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Asian</td>
<td>41%</td>
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<td>40%</td>
<td>33%</td>
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<td>28%</td>
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<tr>
<td>Black</td>
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<td>11%</td>
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<td>10%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
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<td>3%</td>
<td>3%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: Department of Health/LSA Population Projection
The local picture: Repeat abortions 15-44

In 2017

• Of the women aged under 25 that had an abortion in 2017, 24% had **had a previous abortion**. This ranked Tower Hamlet 102 out of 140 local authorities (1st has the highest percentage) [29].

• Of the women aged under 25 that had an abortion in 2017, 14.5% **had a previous birth**. This is lower than England 26.7% and ranks Tower Hamlets 142 out of 149 local authorities in England.

• 24% of abortions to women under 25 in Tower Hamlets, were repeat abortions. At 127, this was lowest in number than in the last five years. Since 2012, the percentage of abortions to women aged under 25 in Tower Hamlets, has been statistically lower than London but similar to England. Except in 2016 when the percentage was similar to both London and England (Fig 40).

• For women aged over 25, the number of conceptions are higher as there are more women of childbearing age over 25 than under 25. In Tower Hamlets, the proportion of women undertaking a repeat abortion is lower than both London and England (Fig 41).

![Graph showing percentage of repeat abortions under 25](image1)

![Bar chart showing percentage of repeat abortions <25 and >25 in Tower Hamlets compared to London and England 2017](image2)
The local picture: Repeat Abortions

Of the repeat abortions in 2017 and 2018 the proportion that were repeat abortions by ethnicity are represented below as +1 [Fig 42]. Comparing the repeat abortions over this period by ethnicity – there is no significant difference between women of different ethnicities on the proportion of repeat abortions.

The results include only those women that provided ethnicity information. 98% of women provided data on their ethnicity.
The local picture: Abortion – Under 10 Weeks that are medical

There are two main types of abortion

- medical abortion (the "abortion pill") – taking medication to end the pregnancy
- surgical abortion – a minor procedure to remove the pregnancy. There are two methods. Vacuum or suction aspiration or Dilatation and Evacuation (D&E)

The choice of an early medical abortion is likely to have contributed to the increase in the percentage of abortions performed under 10 weeks in England. Early medical abortions are less invasive, carry less risk, and are cheaper than surgical abortion. [30].

Women may have a personal preference for a surgical abortion under local or general anaesthetic including; a wish to be sedated, or to have LARC fitted in a single visit.

The percentage of NHS abortions under 10 weeks performed using a medical procedure in 2017 was 70% while in England it was 79.4, which has increased steadily since 2014 [fig.44]. The rank within England for Tower Hamlets was 132 (out of 149 UTLA) 1st has the highest percentage.

Tower Hamlets Abortion Services

Since 2018, women have been entitled to complete the medical abortion at home. In Tower Hamlets the NHS abortion services will be providing misoprostol for home abortion from 1st July 2019, and aim to offer local anaesthetic surgical procedure (MVA) by end 2019.

A very low or very high percentage of medical abortions compared to other areas could be an issue for concern.
The local picture: Abortion – Under 10 Weeks

Abortion under 10 weeks gestation

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 [31].

Among NHS funded abortions, the percentage of those under 10 weeks gestation was 80.9%, while in England the percentage was 76.6%. The rank within England for this indicator was 30 (out of 149 UTLA) (1st has the highest percentage).

According to data provided by the Department of Health 90% of abortions in Tower Hamlets in 2018, were performed under the NHS or NHS funded Agency which is similar to previous years range 89-90% 2012-2018.

In 2017 the number of abortions under 10 weeks as a percentage in Tower Hamlets was significantly higher than for both London and England.

Source: Fingertips Sexual and Reproductive Health Profile
Preventing teenage pregnancy is a national priority as most pregnancies are unplanned and around half end in an abortion [32].

Teenage pregnancy is associated with poorer outcomes for both the young parent and their child.

In 2017 the teenage conception rate increased from 12.6 in 2016 to 15.2. Despite the increase, the Tower Hamlets rate remains below the regional and England rate. In 2016 the rate in Tower Hamlets was 12.6, while in England it was 18.8. The rank for Tower Hamlets for under 18 conceptions was 241 out of 323 boroughs (1st is the highest).

- Between 1998 and 2016, Tower Hamlets achieved a 78.2% reduction in the under-18s conception rate, compared to a 59.7% reduction in England.
- The rate of pregnancies (conceptions) in Tower Hamlets was 36.9 in 2009 and 12.6 in 2016 per 1,000.

- The rate of 18.8/1,000 is currently at the lowest level since 1969, with the greatest reductions in the most deprived areas, and a doubling in the proportion of young mothers in education, training or employment.
- Despite the significant progress England's teenage birth rate remains higher than comparable western countries, and inequalities in the under-18 conception rate persist between and within local areas.

[Fig 48]
The local picture: Teenage pregnancy

England's teenage birth rate remains higher than comparable western countries. Over 60% of local authorities have at least one high rate ward for teenage pregnancy [33].

The two maps below compare teenage conceptions to the average for Tower Hamlets and also for England. For the period 2014-2016, Bow East has a higher than average number of conceptions and Weavers, Spitalfields and Banglatown, Whitechapel, St Katherine's and Wapping less.

This was similar to the period 2013-14 except for Whitechapel was similar to the Tower Hamlets average and Shadwell higher alongside Bow East. Compared to England, Bethnal Green was lower and Whitechapel average.

Teenage conceptions 2014-2016 by ward

Bow East (North East Locality statistics)
- Bow East and Bow West has a much higher proportion of white residents than other wards with a higher proportion having been born in the UK. Bow East and Bromley North have almost half (47%) of their youngest residents living in child poverty, the highest rates in the Borough.
- The North East Locality had the second highest number of births of the four localities Bow East has significantly higher rates of GP-recorded STIs than the Borough total, and has the third highest rates amongst all wards in the Borough.

North East Locality Profile (Tower Hamlets)
Setting the scene: what is Teenage Abortion

• The teenage abortion rate has been reducing in England since 2009. In Tower Hamlets in 2009 the rate was 24.2 and in 2017 it is 9.5 per 1,000 [Fig.48].

• In 2016, the under 18s conceptions, the percentage of those leading to abortion was 75.5%, while in England the percentage was 51.8%. This ranked Tower Hamlets 20/321 within England (1st has the highest percentage) [Fig.49].

• In summary: In Tower Hamlets, the rate of conceptions are similar to that of England, but lower than regionally. Of those young women that do get pregnant, a higher rate will opt for abortion that England, although this is similar to London.
Local actions: what is being done to address the issue

Sexual health services are currently commissioned across all three service tiers using an integrated approach along a care pathway.

Since 2013 Local Authorities are mandated to provide ‘open access’ confidential contraception services this includes: contraceptive advice, provision of medical examination for a person seeking advice, treatment if required and the supply of contraceptives.

**Level 1/Tier 1** oral and emergency contraception, pregnancy testing and referral to specialist services. Contraception services provided in primary care and community settings.

**Level 2/ Tier 2 enhanced contraception services.** Long-acting reversible contraception (LARC) e.g. implants and IUDs. These services tend to be delivered in community contraception, sexual health clinics and some GP practices.

**Level 3/ Tier 3 specialist contraception and sexual health services, including; complex contraception and abortion*.**

Tower Hamlets uses an ‘hub and spoke’ model ‘hubs’ provide both contraception and sexual health services with other services, such as general practice, pharmacies etc. to be the ‘spokes’. It is intended that primary care and community settings will increase level 1&2 provision enabling level 3 services to the focus of specialist providers.

*Abortion services are commissioned by the CCG
Local actions: what is being done to address the issue

Contraceptive services in Tower Hamlets are provided via Centres of Excellence (CoE), satellite clinics, voluntary sector and primary care, including both general practice and pharmacy.

Contraceptive Services in Tower Hamlets

All East (provided by Bart’s Health) provide integrated sexual health and contraception services at specialist centres in Whitechapel and Stratford. Most services are accessible via walk-in or via a booked appointment. In Tower Hamlets there are four satellite clinics providing contraception. For women with more complex needs such as implant fitting/removal of coils these are by appointment at specialist contraception clinics. There are two centres of excellence available to Tower Hamlets residents: The Ambrose King Centre in Whitechapel and the Sir Ludwig Guttmann Health and Wellbeing Centre in Stratford.

Compass Safe East provide contraceptive services to persons aged 10-19 who live or study in Tower Hamlets*. Provide access all types of contraception for free including LARC, emergency hormonal contraception and coils as well as a range of information, advice and support including for drugs and alcohol. Services are available five days per week until late evening, there is one clinical hub based in Whitechapel and five drop in clinics in various locations in Tower Hamlets.

Come Correct condom distribution scheme (C-card) – is a pan London scheme where young people can register for free condoms. The scheme can be accessed via multiple access points in the borough, displaying the ‘Come Correct’ logo.

*Services are available up to 25 for those in the care system or have special educational needs or a disability.
Local actions: what is being done to address the issue

Contraceptive services in Tower Hamlets

**General Practice**
There are 36 general practices in Tower Hamlets providing contraceptive care to people in Tower Hamlets. GP’s and pharmacies are funded by councils to provide ‘uncomplicated sexual health services’ to their patients. The service provided for contraception should be comparable to most satellite services.

**Community Pharmacy**
46 sites provide access to emergency hormonal contraception (EHC), and free condoms, for persons aged under 25.

**Community Pharmacy (Enhanced Service)**
Public Health commission community pharmacies in Tower Hamlets to provide an enhanced service for sexual health. The EHC care pathway aims to reduce repeat EHC and signpost to services for long-acting contraception. Those presenting for two or more episodes are issued with EHC and referred to a service that provide long term contraceptive methods via referral.

**Abortion Services**
Women in Tower Hamlets seeking a termination are encouraged to call the Tower Hamlets Single Point of Access (SPA) line on **0300 033 5000**. The line is available 24 hours a day, 365 days of the year and all women registered with a Tower Hamlets GP are eligible. Abortion services are located at Mile End Hospital on Bancroft Road.

Family Nurse Partnership (FNP) works with parents aged 24 and under, partnering them with a specially trained family nurse who visits them regularly, from early pregnancy until their child is two. Family nurses also use specific approaches derived from the world of motivational interviewing. Family nurses listen, guide and advise using these skills to support parents to make positive changes for themselves and their baby.
Local actions: what is being done to address the issue

Programmes and Interventions

LARC uptake in General Practice

As part of the Tower Hamlets Together Living well work stream there is a programme of work which is focused on improving the reproductive health of women living in Tower Hamlets. One area of work aims to improve LARC provision in Primary Care.

- Take stock of LARC fitters and training needs
- Offer of tailored training to support clinical staff & Practice Nurses as fitters of IUDs, including protected learning time for clinical staff
- Increasing access of contraception through postnatal care across the system

- Lead clinicians championing and involvement in planning pilot reproductive health and sexual health provision
- Offer LARC provision through GP extended hours hubs in two networks where provision is currently low
- Practices across networks referring and booking LARC appointments into extended hour hubs

- To establish a more collaborative, co-ordinated approach for women’s reproductive health, by seeking the views of women through the establishment of a women’s reference group.

Timeline

Nov 19
- Five month pilot of hub model

Dec 19
- Review pilot outcomes

Jan 20
- New Specification

Apr 20
- Full implementation of service spec
Public perspective:

What do women say? PHE obtain the views of 48 women via a focus group and 7,367 women through an online survey. The participants were asked about their reproductive health and illness across the life-course. The participants were representative of the population of England, although may not be representative of the diverse population of Tower Hamlets.

Public Health England

Protecting and improving the nation’s health

Findings

“Contraception service use also varies with age and the method of contraception women are using. Overall most women are happy with their source of contraception but a significant proportion of women we surveyed would have preferred to access different services”

75% of women that need contraception across all age groups, were using at least one method.

- Around one third of women currently using contraception reported use of a long-acting method such as an IUD or implant and one third were using a pill. The proportion of women who used IUD increased with age, whereas the proportion of women who used the implant or pill/patch decreased.
- Of women who used ‘user dependent methods’ 95% of women using pills or injections reported ‘always use’ compared to 75% of women using condoms.
- Women aged 34-44 had the highest preference for IUD. Half of those using IUD received it in general practice and 41% from a Sexual Health Clinic (SHC). Preference for implant use was highest in women aged 16 to 24 (45%) 
- Younger women preferred the SHC (including for LARC) whilst for older women the GP was the common source. Women using their GP were usually the most satisfied with their place of care
- Women who had an unmet need for contraception were most likely to say that they would visit their GP in the future if they wanted to obtain supplies.
Jan – Mar 2019 – Healthwatch undertook ‘enter and view’ visits across three services, speaking to 48 persons. Most attendees were female and of those that stated their sexuality – the majority were heterosexual. 13% attended to access contraception.  

**Public perspective:**

**Key stats**

- **Gender:**
  - Female: 21%
  - Male: 29%
  - Not Mentioned/Other: 46%

- **Sexuality:**
  - Homosexual: 8%
  - Heterosexual: 46%
  - Other: 46%

**Reason for Visit**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Tests</td>
<td>2%</td>
</tr>
<tr>
<td>Termination</td>
<td>4%</td>
</tr>
<tr>
<td>Screening</td>
<td>2%</td>
</tr>
<tr>
<td>PrEP</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
</tr>
<tr>
<td>Infection</td>
<td>4%</td>
</tr>
<tr>
<td>Contraception</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>25%</td>
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</table>

- **Recommended actions:**
  - Clarify the process, if any, that women can go through to expedite the termination process – e.g. priority appointment booking.
  - Make it clearer and easier for people to book available contraception and sexual health appointments online at GP Practices.

**Other related recommendations included:**

- To improve privacy by locating the reception away from waiting areas.
- To develop systems to improve communication of; delays and wait times; the location and services available at satellite clinics. To modernise the test notification service to be text and/or web based.

**Key findings for contraception:**

- There is a general confusion as to what services are available in the GP practice as opposed to sexual health centres, particularly cervical screening and contraception.
- Wait times to access appointments are frequent, which is particularly concerning for women trying to access terminations.

**Related findings:**

- A lack of clarity regarding walk-in versus booked appointments
- Difficulties getting through on the phone lines at AKC, unreasonable wait times (2-3 hrs AKC)
- Problems with the online booking service due to limited availability of appointments
- Limited access to satellite clinics due to perception, distance, and lack of information.

**Sexual Health Services 2019**
Jan – Mar 2019 – Healthwatch held a workshop discussion on ‘sexual health and access to information and support’ with 15 young people from Tower Hamlets. They were aged 16-21, with six males and nine females. Sexual Health Services 2019

Key findings

▪ Privacy is a concern for patients, particularly the lack of privacy available at reception.

▪ Young people are very hesitant about accessing sexual health services in the Borough – they feel that their confidentiality and anonymity will be compromised. They are also unfamiliar with the young person sexual health services available (Safe East).

▪ Young People do not feel that they are given enough training and education about sexual health, particularly at the right time (e.g. year 12 instead of year 9)

“Sexual health is an awkward topic for most participants, partially because of their age and partially because they don’t feel they have received adequate education about it”.

Only two out of 15 students felt that they could speak to their parents about sexual health, or that their parents would be ok if they were sexually active”.

“Confidentiality is a huge issue, most students say they would not feel comfortable accessing services “

“Outside of sexual health education, young people are unclear of where they would go if they needed additional help”.

“None of the young people were familiar with Safe East, the sexual health and substance misuse for young people in Tower Hamlets”.

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Only two out of 15 students felt that they could speak to their parents about sexual health, or that their parents would be ok if they were sexually active”.

“Confidentiality is a huge issue, most students say they would not feel comfortable accessing services “

“Outside of sexual health education, young people are unclear of where they would go if they needed additional help”.

“None of the young people were familiar with Safe East, the sexual health and substance misuse for young people in Tower Hamlets”.

Public perspective:

Jan – Mar 2019 – Healthwatch held a workshop discussion on ‘sexual health and access to information and support’ with 15 young people from Tower Hamlets. They were aged 16-21, with six males and nine females. Sexual Health Services 2019

Key findings

▪ Privacy is a concern for patients, particularly the lack of privacy available at reception.

▪ Young people are very hesitant about accessing sexual health services in the Borough – they feel that their confidentiality and anonymity will be compromised. They are also unfamiliar with the young person sexual health services available (Safe East).

▪ Young People do not feel that they are given enough training and education about sexual health, particularly at the right time (e.g. year 12 instead of year 9)

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Public perspective:

**Accessing Contraception in Tower Hamlets: What do women say?**

Healthwatch spoke to 12 mothers over two primary school coffee mornings of their experiences accessing contraception and sexual health advice. 10/12 were Bangladeshi and 2 were Somali. Their ages ranged from 26-40.

What we learned

- The mothers spoken to preferred to access contraceptive advice via their GP
- The potential impact on their bodies in terms of hormones and side effects influenced contraceptive choice.
- Discussing contraception after giving birth is considered helpful
- Mothers were reluctant to use sexual health clinics such as the Ambrose King due to the lack of privacy. Services at Sylvia Pankhurst Centre were considered good.

Conclusion and recommendations

- There may be unmet need in terms of accessing contraception, information and advice.
- More input from the midwife/GP during ante-natal check-ups or post-natal check-ups may be beneficial.
- A sexual health advisor visiting baby clinics to provide advice and information may be beneficial.
- There is a preference for condoms because of the side effects from other contraceptive methods.

Some participants had previously used (LARC), but voiced issues of heavy bleeding, weight gain or mood swings. To manage side effects they stopped using LARC and moved onto other methods.... such as condoms.

Decisions on contraception were also influenced by their desire for more children. Two of the mothers had the coil fitted for medical reasons and the fact they were unlikely to have any more children.

The majority of mothers said they chose the method of contraception, but they would discuss it with their partners once they have decided.

Mothers talked of contraceptive advice after giving birth, from the midwives and then by the Health visitor at the six week check. The women said that the midwife taking the onus meant it was one less thing for them to think about.
Public perspective:

Sexual health services, mystery shopping programme. Newham, Tower Hamlets and Waltham Forest. Nine mystery shoppers (MS) presented at 11 sexual health clinics with one of three reasons for attendance (RFAs). 31 visits were made between Jun – Jul 2019. The two sites in Tower Hamlets visited by MS for contraception were the Ambrose King Centre (AKC) and Mile End Hospital (MEH).

Reasons for attendance (RFAs)
1. emergency hormonal contraception (EHC)
2. an asymptomatic screen for sexually transmitted infections (STI)
3. advice on contraception

Overall feedback
MS overall feedback to accessing contraception at either the Ambrose King or Mile End Centre was largely positive. However, there were reported issues with the online booking service, in finding the Mile End clinic and insufficient signage outside AKC.

LARC and emergency contraception summary
• Twelve MS requested a LARC appointment.
• Of these four were offered an appointment within five days, and one within two weeks.
• Two MS who requested emergency contraception were offered an emergency IUD.
• One MS who requested emergency contraception reported that the clinician discussed ongoing contraception (Inc. LARC methods) with them.

AKC ‘The service was very organised and put together. All members of staff were professional and non-judgemental…’

AKC ‘More signposting as it was difficult to tell what building was the correct one…’

MEH ‘It was very difficult finding out information about the clinic. The All east website dos not provide sufficient information’
Knowledge gaps: what more do we need to know?

LARC
- The cost effectiveness of long acting forms of contraception is dependent upon continued use. What are the continuation rates for LARC fitted in SHS and General Practice?
- Why is LARC uptake concentrated in the north of the borough?

Preventing pregnancy and in teens
- What is the uptake of Relationship and Sex Education in schools? How consistent is the learning and what preparation is being made to respond to the new legislation on SRE? What is the level of opt out and can this be compared to other areas?
- What do we know of the protective effects of culture and religion on the number of teenage pregnancies in Tower Hamlets? And how does the number of pregnancies that occur within/outside of marriage compare to other areas?
- How well do services in Tower Hamlets meet the ‘You’re Welcome’ criteria – how is this evaluated and monitored?
- Although under 18 conceptions are low- what are the characteristics of the women under 18 that had an abortion so that preventive interventions can be targeted?
- The rate of teenage pregnancy in Bow East is higher than the average for the borough and England. What prevention approaches are undertaken currently? Are they in line with national guidelines? Could prevention approaches be better targeted or improved upon?
- How well informed are young people about Safe East services? What can/should be done to increase knowledge?

NICE Guidelines and Quality Standards – recommendations
- What is offered to women after pregnancy and abortion in terms of contraceptive advice, referral or fitting?
- How effectively do providers in Tower Hamlets work together to ensure that women are provided with their preferred method of contraception – NICE Quality Standard.
- What service requirements are in place to ensure that women accessing EHC are informing women that Emergency IUD is more effective – and that referral pathways are in place? - NICE Quality Standard.
- What are the service requirements to ensure that women are offered a choice of all methods of contraception following abortion and are either provided or referred onto an appropriate service?
- What proportion of women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within 7 days of delivery? NICE Quality Standard.
Knowledge gaps: what more do we need to know?

NICE Guidelines – known gaps in evidence
- What are the cultural differences for women in the UK in terms of: response to side effects, continuation rates, and patterns of method switching in an open access context – NICE Guidelines.
- What are the interventions and models that enable young people of diverse faiths and cultural communities to access contraception services? - NICE Guidelines.
- What are the effective components of a multi component condom distribution scheme. How do you increase condom use amongst high risk groups. – NICE Guidelines.

Sexual Health Services
- Why is there a lower number of repeat EHC in sexual health services? Is this due to the effectiveness of information, advice, provision or referral to contraception? Or due limitations in the data recording?
- What account for the low uptake of LARC in sexual health services by women that are Somali, Bangladeshi, Asian or of Chinese origin?
- What improvements are planned for the telephone service and online booking system for the Ambrose King Centre?
- What actions will be taken to improve the signposting of satellite clinics and services in Tower Hamlets?

General Practice
- How can/should the availability of contraception services in general practice be improved?
- What needs to be done to improve public information about services for sexual health available in general practice for contraception?

Abortion:
- Why is the abortion rate higher amongst women that are black, mixed or of unknown ethnicity?
- Are waiting times in termination of pregnancy services measured, can steps be taken to improve?
- Is LARC provided for women attending abortion and what are the uptake rates?

Quality improvement projects in TH reproductive health
- What will be the outcome of the quality improvement project in Tower Hamlets to reduce repeat EHC in pharmacy?
- What will be the outcome of the quality improvement project in Tower Hamlets to increase uptake of LARC.
## Priorities: what are the priorities for improvement?

<table>
<thead>
<tr>
<th>Priority</th>
<th>Reason for this priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve knowledge of the characteristics of persons attending sexual health services and the reasons for attendance</td>
<td>Service level data can provide insight into service use and the differences in service use between different groups. Further data requests should include reason for attendance ‘new’, ‘change’ and maintain. Age categories should reflect the LASER for comparison and ethnicity data should be comparable to GLA ethnic profile summarised.</td>
</tr>
<tr>
<td>To increase access to and uptake of LARC in General Practice</td>
<td>NICE Guidelines consider LARC to the most effective form of contraception. Uptake of LARC in general practice is much lower than for other areas. Nationally women are more satisfied with general practice as a place of care. This preference was also expressed by women in Tower Hamlets although data is limited.</td>
</tr>
<tr>
<td>To capture data on discontinuation of LARC that is not dependent on return to same location as fitting</td>
<td>The cost effectiveness of LARC is dependent on the rate of continuation. Capturing data on continuation rates would improve commissioners understanding of the relative cost effectiveness of LARC interventions within and between services.</td>
</tr>
<tr>
<td>To improve understanding of the provision of Sexual and Reproductive Education in Tower Hamlets in terms of quality and reach particularly in areas of higher risk of teenage pregnancy</td>
<td>Sex education through school is associated with a lower risk of unplanned pregnancy. Provision of services should be proportionate to need. SRE is a statutory requirement – it is important that the provision of this across Tower Hamlets is understood, but that further prevention resources are concentrated towards those with the highest need.</td>
</tr>
<tr>
<td>To undertake more detailed local analysis to understand how to continue to prevent teenage pregnancy in Tower Hamlets and to target interventions at those most in need of preventive intervention</td>
<td>More needs to be understood about those teenagers that are getting pregnant so that services can be targeted. Recommended a data request is made to ONS for more detailed data on ethnicity and location for targeted intervention.</td>
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### Priorities: what are the priorities for improvement?

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<td>For commissioners to ensure that services are working together effectively to ensure that women and girls are provided with their preferred method of contraception</td>
<td>This is recommended in NICE Quality Standards as an effective approach at increasing access to contraception.</td>
</tr>
<tr>
<td>For commissioners of services that provide EllaOne to ensure that women are informed that Emergency IUD is more effective and have referral pathways in place</td>
<td>This is recommended by NICE Quality Standards. To examine LARC uptake. A high proportion of women and girls, are using emergency hormonal contraception more than once.</td>
</tr>
<tr>
<td>For commissioners of abortion services to ensure that women and girls attending for an abortion are offered a choice of methods of contraception and are either provided with or referred to an appropriate service</td>
<td>Data and information on LARC fitting may be obtained via audit. It is unknown if this is currently a KPI for abortion services in Tower Hamlets and is recommended by NICE Quality Standards.</td>
</tr>
<tr>
<td>For commissioners of maternity and midwifery services to ensure that women who give birth are provided with information, and offered a choice of all contraceptive methods by their midwife within seven days of delivery</td>
<td>It is unknown if this is common practice or is recorded and reported to commissioners of maternity and midwifery services. This is a recommendation in the NICE quality standards for contraception.</td>
</tr>
<tr>
<td>To commission local research to understand any cultural differences for women in the UK in terms of: response to side effects, continuation rates, and patterns of method switching in an open access context</td>
<td>Tower Hamlets is in a unique position to improve upon gaps in knowledge identified by NICE and to support the local population and commissioners in provision of services that are appropriate and in line with the needs of female residents in Tower Hamlets.</td>
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<td>To improve upon the quality and availability of service information and advice for sexual health services in Tower Hamlets</td>
<td>Feedback from ‘enter and view’ visits and ‘mystery shopping’ indicate a need for improvement in public facing information of the services and what can be accessed and where in Tower Hamlets including for satellite services. Feedback on the online booking system also indicated that there is room for improvement.</td>
</tr>
<tr>
<td>For the JSNA process on understanding contraceptive needs be informed by more up to date – data and information on contraception that is joined up and can be compared between types of service provision. A standard approach to defining ethnicity and age should be agreed between primary secondary care and the data be expressed as a rate.</td>
<td>For commissioning purposes data on activity is analysed via Power BI. Power BI could be developed to capture timely data to understand the equalities of access to services.</td>
</tr>
<tr>
<td>When recommissioning or redesigning contraceptive services to use the quality standards by FSRH and NICE to act as a framework for service requirements and to identify gaps in service provision</td>
<td>FSRH quality standards for contraception services (2014) is a strategic document that should be used alongside FSRH Service Standards for SRH (2016) which are clinically focused with auditable outcomes. All quality standards by FRH should be reflective of NICE quality standards. FSRH standards are updated every three years.</td>
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</table>
Key contacts and stakeholder involvement

- This publication was produced by [Nicola Donnelly, Public Health Programme Manager Young Adults] and approved by [name, job title] in [month, year]
- This publication was signed off by [name, job title] in [month, year]
- Any queries regarding this publication should be sent to [email address]
- Stakeholders who contributed to this publication include: The sponsor group is the Integrated Sexual Health Advisory Forum (I.S.H.A.F) established January 2019. Other stakeholders include:
  - Integrated Sexual Health Services in Tower Hamlets: Janet Barter (Consultant in sexual and reproductive health), Vanessa Apea (Clinical Lead – Sexual Health), Jill Zelin (GUM Consultant), Shyma Huq (Operational Lead, Abortion Services). Primary Care Sexual Health Service, Jane Hutchinson (Primary Care Facilitator for sexual health), Archna Spahn (General Practitioner), Sukhjit Sanghera (Commissioner Primary Care NIS)
  - London Borough of Tower Hamlets: Reha Begum (Commissioner YP Sexual Health Service), Chris Lovitt (Associate Director of Public Health), Abimbola Lucas (Programme Manager Public Health)
  - GP Care Group: Ruth Walters (Director of Quality and Assurance)
  - Other Provider Services: Jennifer Fear, Step Forward (Chief Executive), Lisa Sturrock safeEAST Compass (Service Manager), Brenda Coughlan (Family Nurse Partnership)
  - Public Health England: Oluakemi Olufon (Nurse Consultant in Health Protection)
  - Healthwatch: Diane Barham (Chief Executive)
Appendices

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Appendices

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Appendices

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