



All Party Parliamentary Group on Sexual
and Reproductive Health in the UK

Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic

Executive Summary



A note on language

We acknowledge that not only individuals who identify as women require access to contraceptive care, and that services must be appropriate, inclusive, and sensitive to the needs of those whose gender identity does not align with the sex they were assigned at birth. The terms 'woman' and 'women's health' are used for brevity, on the understanding that trans men and non-binary individuals assigned female at birth also require access to these services.

This report is focused on contraception and reproductive health for those with a female reproductive system. Access to male contraceptives, such as male condoms and vasectomy, although an important contribution to women's reproductive health, are not the focus of this report.

Context: Access to contraception during the pandemic

- › The Covid-19 pandemic has forced many GPs and clinics to limit provision of contraception. Routine long-acting reversible contraceptive (LARC) fittings have been almost universally suspended, with 54% of SRH service providers ending or limiting the provision of emergency LARC and 39% ending or limiting provision for LARC complications. Provision of LARC in general practice has been particularly affected, increasing pressure on SRH clinics.
- › A significant increase in patients requiring LARC care, and a substantial backlog, is anticipated as service providers begin to restore face-to-face services.
- › The number of healthcare providers offering digital services, remote consultations and telemedicine has increased significantly during the pandemic. Healthcare providers report that digital services have improved access to services for some underserved and isolated individuals, including women in rural areas and women living with an abusive partner. However, potential obstacles to other marginalised groups including young people and those with limited access to telephone and internet have also been a concern.

The Faculty of Sexual and Reproductive Healthcare (FRSH) provides the secretariat to the APPG on Sexual and Reproductive Health in the UK, with support from the Royal College of Obstetricians and Gynaecologists, Marie Stopes UK, and Bayer Healthcare. Editorial control rests with the APPG alone.

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Foreword



Access to contraception is a human right. The ability to decide whether and when to have children is fundamental to the physical, psychological and social wellbeing of women. This is reflected in the UN Sustainable Development Goals, where universal access

to contraception and other sexual and reproductive healthcare underpins Goal 3 of Good Health and Wellbeing.

Since the passage of the 2012 Health and Social Care Act, the All-Party Parliamentary Group on Sexual and Reproductive Health (APPGSRH) has heard evidence of women being unable to access contraception in a way that meets their needs, and as a result being unable to fully control their reproductive lives. This Inquiry was launched in response to these concerns, and re-launched to understand the impact of the Covid-19 pandemic on women's access to contraception in the spring and summer of 2020.

We were grateful to receive over 70 written and oral evidence submissions from organisations in the public, private and voluntary sectors including the Minister for Women's Health, the Department of Health and Social Care, Public Health England, the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare and the Royal College of General Practitioners.

During the Inquiry we heard of problems associated with funding, commissioning and workforce resulting in women having to travel unacceptably long distances or wait for far too long to access contraception. Despite the best efforts of many practitioners, the Covid-19 pandemic highlighted these existing problems and further restricted access to contraception for many women. Many services face severe long-term challenges as a result of the pandemic.

We also heard of systems that artificially separate women's contraceptive needs from their other reproductive health needs, which can result in them being bounced from service to service or being required to undergo multiple examinations when only one is clinically necessary. Examples relating to cervical screening or the provision of contraception to treat medical conditions, such as heavy menstrual bleeding (menorrhagia) provide particularly stark illustrations of these failures.

The restoration of services after the Covid-19 pandemic, along with the repurposing of the functions of Public Health England, provides a unique opportunity for national and local government to reshape contraceptive services according to the needs of women themselves and to make more efficient use of NHS resources. This executive summary sets out in brief our findings and recommendations, which aim to ensure services are in place to enable women to fulfil their reproductive choices and look after their reproductive health. Collaboration between the Department of Health and Social Care and NHS England, working closely with the relevant teams in the future arrangement of Public Health England, will be paramount to meeting these goals, and addressing the structural barriers put in the paths of women.

We hope that you will find this report of value, and we especially hope it will prove useful to those with the important task of rebuilding services following the pandemic.

A handwritten signature in black ink that reads "Diana Johnson".

Dame Diana Johnson DBE MP

Chair, All Party Parliamentary Group on Sexual and Reproductive Health in the UK

This report has been formally endorsed by the Faculty of Sexual and Reproductive Healthcare, the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners.



Executive summary

Women are becoming sexually active earlier and having children later in comparison with previous generations. Taken together with women's desire to have fewer children, this means that the majority of women are trying to prevent pregnancy for most of their 30 years of reproductive life.

Since women make up 51% of the UK population, providing equitable access to contraception is a major public health priority.

Numerous studies have shown that an increased use of contraception can lead to a decrease in the number of unintended pregnancies. Contraception provision also has major economic and public health benefits: Public Health England estimates that for every £1 spent on contraception there is a £9 saving over 10 years for the public sector. This makes contraception one of the most cost-effective public health interventions.

Fragmented commissioning

- › The division of responsibility for sexual and reproductive healthcare across three separate groups – the NHS, Local Authorities and Clinical Commissioning Groups – has fragmented the commissioning landscape and created a lack of accountability. The closure of services and diversion of SRH workforces during the Covid-19 pandemic have exacerbated pre-existing barriers to contraceptive care and gaps in care pathways caused by this fragmentation.
- › The current commissioning system has resulted in services that are shaped by the source, availability and amount of funding available, rather than by women's needs. Artificial divisions drawn between contraception and reproductive health have led to a disjuncture in care pathways, which can result in women being bounced from service to service, and often having to undergo multiple consultations or even multiple examinations before accessing care.

Funding

- › In recent years the public health grant issued to Local Authorities has faced a series of significant cuts, which have translated into cuts to SRH and contraceptive care services. Evidence presented to this inquiry

suggests that SRH budgets were cut by £81.2 million (12%) between 2015 and 2017/18. During the same period, it is estimated that contraceptive budgets were cut by £25.9 million (13%).

- › Cuts to Local Authority funding have also increased pressure on other services as patients are redirected, and ultimately obstruct and reduce access to services. This has resulted in long delays for women.
- › Long-Acting Reversible Contraceptive (LARC) services are particularly underfunded in primary care, with GPs reimbursed at less than the estimated total cost of providing the service. This has meant that GPs are not financially incentivised to provide these services, leading to a reduction in the number of GPs offering LARC services and an increase in pressure on community SRH services.
- › Following the Covid-19 pandemic, there are further concerns that the cost of reinstating LARC services will prove a deterrent for many GP surgeries, leading to increased strain on the community SRH services that do provide LARC.

Workforce

- › Recruitment and retention issues within the NHS workforce raise concerns about the long-term sustainability of contraceptive services. The Inquiry heard of a succession crisis in Community SRH consultant doctors, and instability in the retention of trained SRH nurses which has a detrimental impact on planning services. The ability of employers to provide stable and attractive work environments in which staff are sufficiently trained will depend on an uplift in funding.
- › There are reduced opportunities and funding for LARC training in Primary Care. In the absence of long-term guarantees that the practice will continue to be commissioned to provide LARC, and given the lack of financial incentive to offer services, General Practices are reluctant to fund training.

Data collection

- › Current data on access to contraception is inadequate. Currently data only covers LARC provision rather than the full range of contraceptive methods in General Practice

and the annual publication of SRH service contraceptive activity is inadequate.

- › Without these data it is not possible to assess access to contraception or to efficiently plan and commission services to meet the needs of women.
- › More accurate data are needed to understand inequalities in access to contraception. Collecting data considering uptake of contraception by ethnicity and socioeconomic group, as well as sexuality and gender identity, would enable a better understanding of issues affecting these groups, for example the higher rates of unwanted pregnancy among lesbian and bisexual adolescents.

Education and information

- › The introduction of statutory Relationships, Sex and Health Education (RSHE) in all schools in September has the potential to significantly improve the sexual health and wellbeing of young people, including improving uptake of contraception, but this will only be realised through effective and funded implementation.
- › Knowledge and understanding of different contraceptive methods are fundamental to ensuring women can make an informed choice. Evidence to the Inquiry suggested significant gaps, but currently there is no national measure to assess women's knowledge and monitor improvements.

Access for marginalised groups

- › Budget cuts have led to reductions in dedicated service capacity for marginalised groups, with many clinics having limited or curtailed outreach services prior to the pandemic. During the Covid-19 pandemic, the provision of dedicated outreach services for marginalised groups has varied significantly between services.
- › During the pandemic, services have reported a drop in the number of young and Black, Asian, and Minority Ethnic (BAME) people requesting care, leading to concerns that these marginalised groups may have been particularly affected by restrictions in access to care.
- › Digital services, remote consultations and telemedicine provide a more convenient

form of access to contraceptive care for many people, including women in rural areas or those who struggle to travel to healthcare settings due to childcare responsibilities, disability, or financial constraints. They also help to alleviate stigma which, in some communities, may be associated with visiting a clinic.

- › However, while digital and telemedical services have enhanced access for some marginalised groups, closer examinations of different groups' needs in relation to digital and telemedical care must be undertaken. The resumption of face-to-face care, including walk-in clinics, will be crucial to ensuring continued access to care for some women.

Opportunities to improve contraceptive provision

- › There are multiple healthcare settings offering opportunities for effective contraception interventions that are currently not being fully explored and utilised. Maternity and abortion settings are in an ideal position to support women to make an informed choice about contraception, removing the need for women to make multiple visits to healthcare providers. Optimising these opportunities for effective contraception interventions is vital given the anticipated surge in demand for primary care provision in the next phases of the pandemic.
- › The introduction of Primary Care Networks (PCNs) is a welcome development that offers a potential solution to the current fragmented delivery of contraceptive services, and would enable more swift referrals between primary care and clinics. PCNs are in a better position to recover contraception provision capacity quickly in the next stages of the pandemic. PCNs should recognise the centrality of comprehensive reproductive healthcare to their remit of tackling inequalities (which will come into force in 2022).
- › The reclassification of the Progestogen-Only Pill (POP) to make it available over the counter without a prescription as a Pharmacy Medicine is an overdue measure. This would help to alleviate pressure on primary care, with research showing that one third of contraceptive appointments in GPs and almost half in specialist services are to maintain existing contraception.

Recommendations

These recommendations are intended to inform the forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care and ensure equitable access to high quality contraceptive care for all women, and provide guidance to the Department on maintaining and improving the important contraception workflows which have hitherto been the remit of Public Health England.

The reorganisation of Public Health England presents an opportunity for a broader review of SRH commissioning responsibilities for contraceptive provision. In light of this, the recommendations reflect five overarching ambitions for the future of contraceptive provision in England:

- › **To create accountability in co-commissioning of SRH provision, including primary care, to meet population contraceptive need**
- › **To tackle the unmet need for contraceptive care within women's reproductive healthcare, identifying and addressing the needs of underserved groups**

- › **To secure sustainable, long-term funding for contraception as a key cost-effective public health intervention**
- › **To maximise the potential of statutory Relationships, Sex and Health Education (RSHE) to equip young people with an understanding of fertility and contraception, and support easy access to services**
- › **To use learnings from the Covid-19 pandemic response to improve provision of SRH care, delivering accessible care via a collaborative approach using new and innovative means of delivery**

Maintaining access to a number of different service providers is essential to allowing women choice of contraception provision. As such, the recommendations set out measures to be adopted across all different service providers, including:

- › primary care,
- › specialist clinics,
- › pharmacy,
- › abortion and maternity settings, and the
- › voluntary sector.

1. Funding

- 1.1** The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should recognise and address the reduction in contraception funding across all areas of service provision, and the consequent impact on the most marginalised groups.
- 1.2** The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should calculate and set out necessary levels of contraceptive funding to meet both national and local population need. Accountability arrangements need to be in place to ensure local spending on contraception reflects population need.
- 1.3** All abortion contracts should include provision of the full range of post-abortion contraceptive methods. This should include the training of staff and staff time for the fitting and training of LARC methods, regardless of abortion method, whether medical or surgical.

- 1.4** Funding arrangements should be in place for routine post-partum contraception in all maternity settings.

2. Commissioning structures and accountability

- 2.1** The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should incorporate all aspects of women's sexual and reproductive health needs and recognise the changing needs of women throughout their lives. This will provide a consistent, joined up vision around which providers can work to ensure that population contraceptive needs are met.
- 2.2** Co-commissioning should be mandated to ensure that all women can access the full range of contraception via clear, streamlined and well-publicised pathways until the Department of Health and Social Care's engagement on future options for PHE, which presents an opportunity for a broader review of SRH commissioning responsibilities. In the context of the

current review of PHE responsibilities, the Department should consider introducing an integrated commissioning model for SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.

- 2.3** The use of incentivised payment systems such as CQUIN and QOF should be considered to encourage universal provision of all methods of contraception across all providers.
- 2.4** New service models, such as Primary Care Networks (PCNs), should prioritise examining how they can ensure women have good access to high quality care for their contraceptive, reproductive, gynaecological and sexual health needs. As part of this, PCNs should engage with colleagues within the voluntary, pharmacy and community sector to maximise reach according to local population need. PCNs should also prioritise optimisation of training opportunities.
- 2.5** NHS England should appoint a National Speciality Advisor for Sexual and Reproductive Healthcare to support the work of the National Clinical Director for Maternity and Women's Health and to drive improvement in the quality of contraceptive provision across the system of reproductive health commissioning.

3. Workforce and training

- 3.1** Health Education England and the Department of Health and Social Care should collaborate to develop a workforce needs analysis and strategy based on population need for the future delivery of SRH services. They should plan and publish analysis of appropriate current and future skill mix and training needs of specialist and generalist contraceptive providers. Local areas should conduct workforce capacity assessment based on their population need.
- 3.2** The Community SRH training programme should be expanded and funded to enable leadership for all local areas to meet specialist and Primary Care

contraceptive workforce needs with a recommended specialist capacity of 1:125,000 population. This should include dedicated provision for LARC training.

- 3.3** The quality and breadth of contraception provision should be improved by the introduction of national standards for specialist contraception training for nursing, and ensuring that basic contraception is a core part of nursing, midwifery and health visitor curricula.

4. Data and monitoring

- 4.1** Consideration should be given to the system-wide collection of demographic data on gender, age, socio-economic status, ethnicity and sexual orientation. This should include fit-for-purpose ethnicity data which is sufficiently specific to account for the diversity of cultural experiences. Inequalities in access and outcomes should be routinely monitored at national and local level.
- 4.2** DHSC should evaluate current data collection processes (GUMCAD, SHRAD and routinely entered GP SNOMED data) to assess and optimise usefulness and coverage and to examine ways to develop a population lens on use of contraception. Measures should be taken to explore how to unite different data sets to enable a comprehensive view of population contraceptive provision.
- 4.3** A survey capturing women's experiences of contraceptive provision, including whether or not they are able to access their preferred method of contraception, should be developed for national and local use. The survey should extend to women with an unmet need for contraception and should be used to monitor quality of access and choice over time.
- 4.4** To provide a better outcome indicator for all ages, the London Measure of Unplanned Pregnancy should be adopted as primary data standard, collected at front line by maternity, early pregnancy and abortion services. The data should subsequently be utilised as part of the Public Health Outcomes Framework.

5. Improving access to contraception

- 5.1** The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should prioritise the need for local streamlined women-centred contraceptive service provision for underserved populations, who are less likely to have frequent and easy access to contraceptive services.
- 5.2** The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should consider how best to integrate SRH care into existing women's healthcare pathways in the NHS. Integrating care around the needs of individual women would improve access by removing the institutional silos which create obstacles for women seeking care.
- 5.3** Local authorities should embrace the introduction of evidence-based technologies to improve access to contraceptive provision. They should also assess the impact of technology on marginalised groups.
- 5.4** The Department of Health and Social Care should consider the development of a national digital contraception service. At a minimum, commissioners should ensure there is a dedicated digital contraceptive offer to widen access, and to preserve access if face to face services are suspended. Commissioners should identify digitally excluded groups and ensure they are reached through outreach and other means.
- 5.5** The full range of immediate post pregnancy contraception should be made available in abortion, maternity and early pregnancy settings.
- 5.6** The role of pharmacy Independent Prescribers and of Patient Group Directions (PGDs) should be maximised for a wider range of prescription-only contraceptives to increase access to these methods of contraception.

- 5.7** Progestogen-Only Pills should be reclassified as pharmacy medicines (made available over the counter without a prescription) to widen access while maintaining public funding for this contraception.
- 5.8** A single national commissioning specification for Emergency Hormonal Contraception services should be established to ensure patients experience consistent ease of access across the country.
- 5.9** Guidance should be offered on the improvement of pharmacy settings to make it easier for women to access contraception. This may include:
- More privacy for women to discuss needs;
 - Making information about contraception more visible in pharmacies.
- 5.10** DHSC should publish the revised You're Welcome standards for young people friendly health services to provide clear criteria for local commissioning of accessible SRH services and outreach work.

6. Information and education

- 6.1** The forthcoming Sexual Health, Reproductive Health and HIV Strategy should ensure all women have access to a national source of up-to-date, woman-centred information on the methods of contraception and how to access them. This digital resource should be well-publicised to women via search engine optimisation.
- 6.2** The forthcoming Sexual Health, Reproductive Health and HIV Strategy should ensure assessment of population level understanding of contraception, by incorporating questions on knowledge on contraception in future reproductive health surveys. Additional research should be conducted to assess the specific information needs of underserved groups, with action taken to address identified needs.

7. Education settings

- 7.1** The Department for Education should provide information about the teacher training strategy for the implementation of statutory Relationships, Sex and Health Education (RSHE), including how many schools have completed training, quality assurance of providers, and funding for effective delivery. A set of teacher competencies for RSE should be developed, drawn from international evidence, to help ensure the quality and impact of training programmes.
- 7.2** The Department for Education and the Department of Health and Social Care should ensure teachers are able to access a national source of medically accurate, up to date and evidence-based information on contraception.
- 7.3** Local authorities should support schools to fulfil their statutory duty to ensure students know how and where to access confidential sexual and reproductive health advice and treatment, by providing up to date information about local SRH services. The requirement to liaise with schools and publicise services should be within specialist SRH clinics service contracts.
- 7.4** The delivery of RSE within RSHE should be included in routine OFSTED inspections from 2020. Inspectors should be sufficiently trained to ensure they understand the key components of RSE, prior to inspections. The OFSTED subject reports for RSE should be re-established to provide a more in-depth understanding of the quality of RSE provision. The findings should be used to inform the three-year review of the statutory guidance.
- 7.5** Considering the higher rates of sexual activity among older teenagers, information about contraception and service access should be continued in sixth form and further education colleges and university settings.



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