

FSRH Response to the Women and Equalities Committee inquiry on COVID-19 and the impact on people with protected characteristics

30 April 2020

1) Background to the Organisation

The [Faculty of Sexual and Reproductive Healthcare \(FSRH\)](#) welcomes the opportunity to respond to the Women and Equalities Committee inquiry on the impact of COVID-19 on people with protected characteristics. FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 doctors and nurses working at the frontline of Sexual and Reproductive Healthcare (SRH) care delivery. Our goal is to ensure that the population can access high-quality and holistic SRH services across the life course, and that essential SRH services remain available to the population during and after the COVID-19 pandemic. It is imperative that vulnerable women¹ and girls in particular can access effective contraception during this pandemic, thereby avoiding unplanned pregnancies, which put an unnecessary strain on maternity and abortion services.

2) Introduction

The outbreak of COVID-19 has resulted in a significant disruption to SRH services in the UK. To ensure patient safety as well as protect healthcare professionals, service providers have limited face-to-face consultations and increased remote consultations. As a result of reductions in staff numbers due to redeployment and illness, clinics have made difficult service provision decisions, including temporarily suspending many 'usual' functions of their service, or closing entirely.

To better understand the impact of the COVID-19 pandemic on SRH service provision, FSRH released a rolling survey for our members. We include our interim results in our response. Our findings indicate that SRH service providers have been forced to limit the provision of essential services, and that providers feel that these changes disproportionately impact the most vulnerable patients.

In the following sections, we outline the current landscape for SRH service provision before and during the COVID-19 outbreak, and the ways in which the Government can support the provision of these services in the future.

¹ We acknowledge that not only individuals who identify as women require access to sexual and reproductive healthcare services, and that services must be appropriate, inclusive, and sensitive to the needs of those individuals 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 trans men and non-binary individuals assigned female at birth also require access to women's health services.

3) SRH Landscape Prior to and During COVID-19

SRH services are needed to help women avoid unplanned pregnancies. Almost half of pregnancies in Britain are unplanned or ambivalent.² Abortion rates have generally increased by 4% since 2017, and it is estimated that more than half of unplanned pregnancies in Britain end in abortion.³

In recent years, women's reproductive healthcare has been detrimentally impacted by cuts to Public Health services. Since 2015, two thirds of councils in England have reduced or frozen their SRH budgets. Eight million women of reproductive age now live in an area where their local council has reduced their SRH budget since 2016/2017.⁴

Furthermore, women's reproductive healthcare in England has suffered from the re-organisation of NHS services that followed the implementation of the Health and Social Care Act in 2013. Commissioning of SRH services is currently split between Clinical Commissioning Groups (CCGs), NHS England and local authorities. This fragmentation of governance and commissioning responsibilities has created confusion and barriers for women when trying to access healthcare, as well as around who holds accountability for SRH services across the healthcare system.

These commissioning and funding issues have led to an overstretched and underfunded SRH service system that was not adequately supported to provide care to women and girls during a crisis. The redeployment of staff from already understaffed SRH services has resulted in service closures, and clinicians are concerned that vulnerable patients will no longer be able to access the care that they need.

The COVID-19 pandemic will put unprecedented financial pressure on public service budgets for years to come. In light of this future strain, contraceptive services are more important than ever. Public Health England (PHE) estimates that every £1 spent on publicly funded contraception saves the public sector £9 over ten years, before considering the wider societal cost and impact.⁵ This makes contraception the most cost-effective Public Health service.

² Wellings, K. et.al, 2013. [*The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles \(Natsal-3\)*](#).

³ Department of Health & Social Care & ONS, 2019. [*Abortion Statistics, England and Wales: 2018. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales.*](#)

⁴ Advisory Group on Contraception, 2019. [*At tipping point: An audit of cuts to contraceptive services and their consequences for women.*](#)

⁵ Public Health England, 2018. [*Contraception: Economic Analysis Estimation of the Return on Investment \(ROI\) for publicly funded contraception in England.*](#)

4) Impact of COVID-19 on Essential SRH Services for Vulnerable Groups

The FSRH has released guidance⁶ for healthcare providers and commissioners regarding the provision of essential SRH services during the COVID-19 pandemic. We define these essential services to be:

- Clear information about where and how to access available services
- Emergency contraception (oral and, where possible, fitting copper intrauterine device)
- Support existing, continued use of Long-Acting Reversible Contraception (LARC)
- Dealing with complication of Long Acting Reversible Contraception (LARC)
- Abortion care (and post-abortion contraception)
- Sexual assault care
- Extending the use of online contraception services across the UK
- **Contraception for vulnerable groups**

In our guidance, we specify that contraception access should be ensured for vulnerable groups during the COVID-19 pandemic. This includes under 18s, those with language barriers, homeless individuals, sex workers, victims of sexual assault, individuals with learning disabilities, and individuals with serious mental illness. We advise that local provisions should be put in place to ensure that vulnerable groups can access care, and that LARC insertion and removal services are maintained for vulnerable groups throughout the COVID-19 pandemic.

To better understand the impact of the COVID-19 pandemic on SRH service provision, we released a rolling survey for our members. As of 27 April, over half of respondents (53%) stated that they had been forced to end or limit the provision of essential SRH services, and 25% of those who had been forced to end or limit the provision of essential SRH services stated that they were not confident their patients would be able to access this care elsewhere. Respondents noted that vulnerable patients were most at risk:

“I wonder what the consequences will be on future service provision, patient expectation, unwanted pregnancies and what will happen to our vulnerable patients who we can’t see and support.”

“It is easier to see people face to face especially due to our service seeing young people and vulnerable groups.”

In addition to providing care, SRH service providers rely on face-to-face consultations to identify signs of domestic abuse. Rates of domestic abuse have increased significantly since the beginning of the COVID-19 lockdown.⁷ SRH care providers play a vital role in identifying the signs of domestic violence, and counselling vulnerable girls and women who may be victims. Respondents noted that this can be more difficult with remote consultations:

⁶ FSRH, 2020. [Essential Services in Sexual and Reproductive Healthcare](#).

⁷ The Guardian, 2020. [Revealed: surge in domestic violence during Covid-19 crisis](#).

“Concerned that remote methods are more likely to miss domestic violence and safeguarding concerns.”

“Women who can manage to contact us, travel to collect contraception and can manage a user dependent method may just be inconvenienced. Others may end up without effective contraception. There is also a potential impact on safeguarding, hidden abuse and domestic abuse.”

It is also important to highlight that remote consultation can also, however, enable vulnerable girls and women to access healthcare services in situations where they are unable to physically attend a service. Childcare responsibilities, distance from clinics, and abusive partners place significant barriers on women and girls’ access to SRH care. The availability of remote consultations removes this barrier. In our *Standards for Online and Remote Providers of Sexual and Reproductive Health Services*,⁸ we outline the ways in which providers can ensure a safe and effective approach to risk identification, assessment analysis and response in remote consultations.

Our survey respondents also noted the positive aspects of remote methods of consultation. These included being able to reassure patients who do not need to be seen, reducing wait times, and some patients feeling less self-conscious over the phone:

“Very positive form of communication with patients and waiting times reduced. Only see patients who really need to be seen”

“Can provide oral medication for dual populations without needing to travel long distances, able to plan for complex patients before they physically attend”

Taken together, these findings demonstrate that the availability of various forms of communication/consultation are necessary to provide comprehensive SRH care for vulnerable women and girls.

5) Impact of Sexual and Reproductive Healthcare Clinic Closures on Vulnerable Groups

According to the FSRH survey on SRH service provision during the COVID-19 outbreak, respondents stated, on average, that 22% of their SRH staff had been redeployed. Of those respondents working primarily in specialist services (SRH clinics and integrated SRH and sexual health services), this rose to 39%. In addition, this group stated that 26% of their staff was absent from work due to COVID-19, other illness, or self-isolation. 37% of respondents stated that they had not been supplied with adequate PPE, and that face-to-face consultations had to be curtailed as a result. Across the country, reduced capacity and reduced safety has resulted in service closures or significant restrictions in services that remain open.

⁸ FSRH, 2020. [Standards for Online and Remote Providers of Sexual and Reproductive Health Services](#)

SRH clinic closures disproportionately impact the most vulnerable patients. SRH clinics are most commonly used by young people, and by those at greater risk of poor sexual and reproductive health.⁹ The likelihood of young women aged 13-15 using SRH services for emergency contraception increases with the deprivation level of their area of residence. In 2018/2019, 2 per 1,000 population accessed these services in the least deprived areas, compared to 8 per 1,000 population in the most deprived areas.¹⁰ Community SRH clinics offer a local, confidential, and accessible setting for individuals seeking advice. These services are vital, as the perceived or real lack of such characteristics from alternative provision often inhibit vulnerable girls and women from using such services.

While GPs have taken on some of the workload from SRH services, they face barriers to delivering comprehensive care to vulnerable people. This is because GPs are underfunded and often not commissioned to provide LARCs, the most effective methods of contraception, and because vulnerable women and girls are less likely to be registered with a GP. Thus, vulnerable women and girls may be unable or unwilling to attend a GP practice to access much-needed care when community clinics are closed.

These findings are supported by our survey results. For example, one respondent stated:

“The young people we see are usually very reluctant to attend their own GPs for contraception and feel that a drop-in service is most appropriate as they can attend without their parents/carers knowing”

Impact of COVID-19 on SRH Staff Members

The majority of frontline healthcare staff in the UK are women. This makes women disproportionately susceptible to contracting COVID-19 in the healthcare sector.¹¹ Women also make up the majority of the SRH workforce.¹² Pregnant staff are particularly vulnerable at the moment, as many services do not have adequate PPE available. In our survey, 85% of respondents stated that vulnerable staff members, including pregnant women, worked at their service. Of these respondents, 12.5% stated that they did not believe there were adequate measures in place to protect vulnerable staff members.

⁹ BMJ Sexual Health, 2018. [Where do women and men in Britain obtain contraception? Findings from the third National Survey of Sexual Attitudes and Lifestyles \(Natsal-3\).](#)

¹⁰ NHS Digital, 2019. [Sexual and Reproductive Health Services \(Contraception\).](#)

¹¹ Wenham, Smith, & Morgan, 2020. [COVID-19: The gendered impacts of the outbreak.](#)

¹² Health Education England, 2015. *Small Specialty Community Sexual and Reproductive Health.*

6) Addressing the Impacts of Covid-19 on the SRH of Vulnerable Groups

The Role of Local Authorities and Central Government

Local authorities carry the responsibility for commissioning contraception in community services in England. They are mandated to ensure that these services are open access and available to all. As set out in the Local Authorities Regulations 2013, all local authorities have a duty to maximise the wellbeing of the people living in their locality¹³. Local authorities must also have due regard to the need to reduce inequalities in their area - one of the conditionalities for Public Health grant expenditure, which is used to fund SRH services. Therefore, they are well positioned to address the impacts of Covid-19 on the SRH of vulnerable people.

To support local authorities to fulfil their duty of care to vulnerable people, the Government must work together with local authorities to ensure that as many SRH services as possible remain accessible during the COVID-19 pandemic, and that these services are adequately funded after the pandemic. According to the Government's coronavirus action plan:

Local authorities will still be expected to do as much as they can to comply with their duties to meet needs during this period and these amendments would not remove the duty of care they have towards an individual's risk of serious neglect or harm.¹⁴

It is crucial that the Government and arms-length bodies such as Public Health England (PHE) work with local authorities to support them to implement guidance from professional medical organisations such as FSRH on how SRH services can be effectively delivered during the pandemic¹⁵. It is also crucial that the Government work with medical professional organisations to devise a post-Covid-19 plan to restore SRH services.

Regulatory Changes During and After COVID-19 to Support Access to SRH by Vulnerable People

Some of the health-specific challenges that have arisen for vulnerable people during the crisis have been the result of social-distancing. This is the case with SRH care, specifically abortion care. This is why, since the COVID-19 outbreak, regulations have been modified for abortion care in England, Wales and Scotland to allow the remote provision of abortion care, so that women would not have to risk their own health to access essential SRH care. Remote consultations as well as the use of both drugs for medical abortion at home are now permitted. In addition, based on medical evidence from the National Institute for Health and Care Excellence (NICE)¹⁶ and professional bodies, consultations have been simplified by reducing

¹³ The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. <http://www.legislation.gov.uk/uksi/2013/351/contents/made>

¹⁴ Department of Health & Social Care, 2020. [Guidance: What the coronavirus bill will do.](#)

¹⁵ All FSRH guidance for SRH services during Covid-19 can be found here: <https://www.fsrh.org/fsrh-and-covid-19-resources-and-information-for-srh/>

¹⁶ NICE, 2019. [Abortion care: NICE guideline NG140.](#)

routine measurements and investigations and by omitting ultrasound scanning where possible (so-called 'no touch' procedures).¹⁷

However, in Northern Ireland, inequalities in access to abortion care pre and post-Covid-19 persist. The same measure introduced in England, Wales and Scotland that allows telemedicine for abortion care has not been introduced in Northern Ireland. The abortion regulations introduced by the UK Government in Northern Ireland on 25th March¹⁸ allow for the use of the second abortion pill, misoprostol, at home, but not the first pill, mifepristone, which impedes the establishment of telemedicine for abortion care in Northern Ireland. We thus recommend that Northern Ireland adopts a similar model of care to the rest of the UK, and permits telemedicine for abortion care, enabling women to effectively access abortion care in Northern Ireland.

Regulatory change is also essential to alleviate the pressure on contraceptive services and make it easier for vulnerable people to access services. FSRH has urged the Medicines and Healthcare Products Regulatory Agency (MHRA) to reclassify the progestogen-only pill (POP) from 'prescription-only' to 'pharmacy product', thereby making them easily accessible over the counter in pharmacies, while reducing any unnecessary pressures on GPs and enabling women who are not registered with a GP to access contraception more easily. FSRH has also asked for regulations for contraceptives to be amended so that pharmacists can legally supply a 6-month supply of oral contraception without a prescription instead of the current one-month supply limit.

7) Recommendations

SRH services can better meet their potential to serve vulnerable people if the below recommendations are implemented.

Between May 1st and May 22nd, FSRH calls on the Government to:

- Work together with local authorities to ensure that essential SRH services as outlined by FSRH guidance remain accessible during the COVID-19 pandemic, ensuring that SRH clinics are adequately staffed, and that PPE is provided to all staff.
- With arms-length bodies such as Public Health England (PHE), support local authorities to implement guidance from professional medical organisations such as FSRH on how SRH services can be effectively delivered during the pandemic, with a focus on vulnerable and hard-to-reach populations. Department of Health and Social Care (DHSC) to support PHE's evolving work with partners such as FSRH and civil society organisations to minimise impacts of CoVID-19 on most vulnerable.

¹⁷ Royal College of Obstetricians and Gynaecologists, 2020. [Coronavirus \(COVID-19\) infection and abortion care](#).

¹⁸ The Abortion (Northern Ireland) Regulations 2020. <http://www.legislation.gov.uk/uksi/2020/345/made>

- Increase investment into current SRH services to ensure their continued operation. This includes scaling up existing digital infrastructure, so that regional digital services can provide better and more comprehensive care.
- Work together with commissioners and professional membership bodies, including FSRH, to devise post COVID-19 plans to restore SRH services. Support these services through investment and guidance.
- Urge MHRA to reclassify POP from 'prescription-only' to 'pharmacy product', thereby making them easily accessible, while reducing any unnecessary pressures on GPs. Girls and women should also be able to order them online, again to reduce pressure on services.
- Develop a national digital service platform for SRH across the UK, which will serve as a one-stop point of access for the general public and will support the maintenance of access to essential care – including contraception, STI and HIV testing and treatment, and abortion care. This service should operate seamlessly with regional face-to-face services – providing effective triage and a streamlined care pathway for those patients referred for face-to-face treatment.

In Six Months, FSRH calls on the Government to:

- Enhance the local authority mandate in relation to contraceptive services.
- Increase long-term investment in SRH services, to ensure that service provision can be restored and improved in the years ahead.
- Amend contraceptive regulations so that pharmacists can legally supply a 6-month supply of oral contraception instead of the current one-month supply limit. This will reduce strain on services, and enable vulnerable women and girls to access contraception without needing to attend a contraceptive service.
- Integrate the option for remote care as a permanent feature of abortion care across the UK.
- Urge the UK public health authorities - Public Health England, Public Health Wales, Public Health Scotland, and the HSC Public Health Agency – to monitor and publish real time trends of conception, abortion, and birth rate, so the extent of the impact of COVID-19 on these trends is monitored and can be responded to accordingly.

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