AGC Advisory Group on Contraception

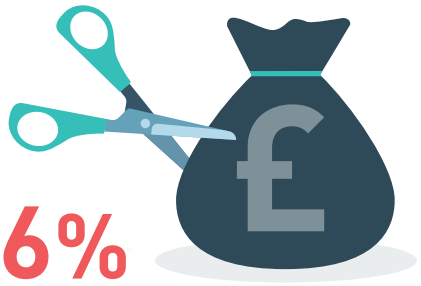
Securing sustainability

Access to contraception during and after COVID-19

The COVID-19 pandemic has put women's[1] access to contraception – which has long been damaged by year-on-year funding cuts – at significant risk. As we begin to recover from COVID-19, contraceptive provision cannot be neglected any longer.

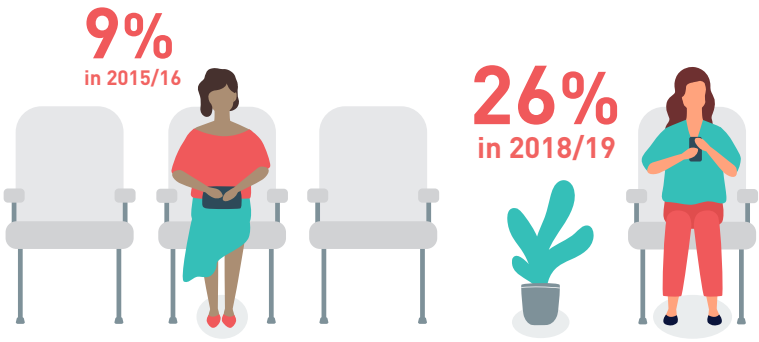
The AGC is calling on the Government to protect open access to contraception, now and in the future, through a sustainable funding settlement.

Since 2015, the Advisory Group on Contraception (AGC) has been tracking trends in funding, commissioning, and accessibility of contraceptive provision across England following a series of extensive cuts to national public health budgets. Our research has revealed that national budget cuts – which saw local-authority commissioned contraceptive provision in England experience a 20% cut in real terms and 12% cut in actual budget between 2015 and 2020[2] – have had a material impact on access to contraception:



66%

of councils have cut spending on sexual and reproductive health between 2016/17 and 2018/19[3]



The proportion of local authorities **reducing the number of sites commissioned to deliver contraception has accelerated** from 9% in 2015/16 to 26% in 2018/19[4]

These cuts are detrimental to all service users, but AGC members have long been concerned that the consequences of cuts are hitting the most vulnerable groups in society the hardest. Now – as COVID-19 has exacerbated and entrenched inequalities across the health and care system and wider society – access to contraception stands at a critical juncture. We cannot delay taking steps to protect the right of all women to access the contraception they need, no matter their postcode or background.

How has the pandemic impacted contraceptive provision?

Intensifying pressure on an already strained workforce

Throughout the pandemic, the Faculty of Sexual and Reproductive Healthcare (FSRH) – an AGC member – has tracked the impact of the pandemic on sexual and reproductive health (SRH) services in both primary and specialist community care, through regular surveys.* Each snapshot reveals a stretched – often anxious – workforce:[5]

FIRST LOCKDOWN

21 May 2020:

982 members surveyed, including both GPs and specialists

77% of GPs and **64% of specialists** reported that they had **ended or limited essential SRH services**

GPs reported that **7% of their staff were redeployed,** and that a further **15% were absent**

Specialists reported that **25% of their staff were redeployed,** and that a further **15% were absent**

END OF THIRD LOCKDOWN

23 April 2021:

25 service leads surveyed

65% reported that **waiting lists for LARC** remained **higher** than before the pandemic

Waiting times for routine LARC fittings ranged **from 24 hours to 9 months**

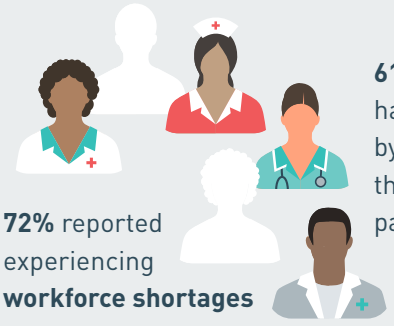
84% of respondents stated that staff at their service reported **feelings of anxiety**

END OF ALL RESTRICTIONS

31 August 2021:

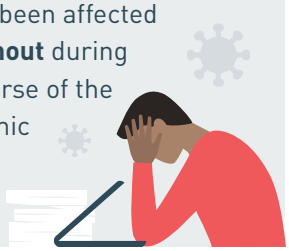
302 members surveyed, including both GPs and specialists

25% of respondents reported that **staff redeployed** during the pandemic had **still not returned** to their role



72% reported experiencing **workforce shortages**

61% of staff reported having been affected by **burnout** during the course of the pandemic



Compounding funding pressures

Successive budget cuts prior to the pandemic have left services unable to cope with the pressures of COVID-19, particularly as they face a range of competing spending priorities. Although public health funding allocations have slightly increased since the beginning of the pandemic, in real terms the uplift is marginal – and not enough to reverse the damage caused by either cuts made in previous years or the pandemic.[6]

Inadequate funding is particularly damaging for delivery of long-acting reversible contraception (LARC) – the most effective methods of contraception. Staff must be highly trained to deliver LARC – a service which requires significant time and financial resource – while face-to-face appointments and the provision of wraparound counselling are both integral aspects of the LARC pathway. In this highly strained environment, it is simply not viable for many services to continue delivering LARC, or restart LARC provision as the pandemic begins to ease. This problem is particularly acute in primary care, with many GPs underfunded, or simply not commissioned, to deliver LARC services.

In August 2021, 75% of SRH services reported that they do not receive adequate funding to provide a full range of services.[5]

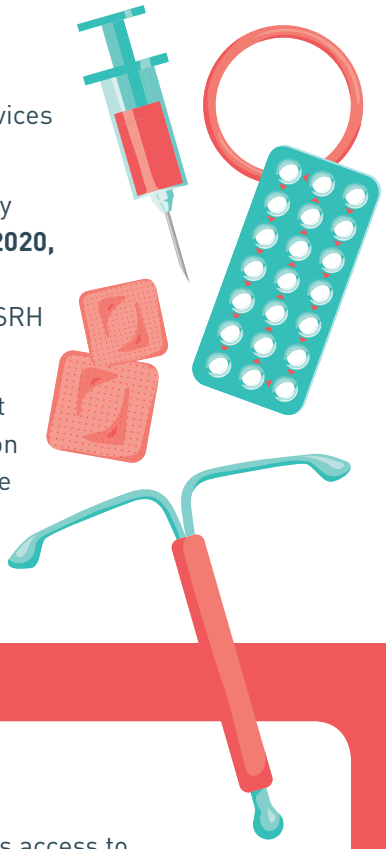
* As data provided are from different surveys, please note that these are not directly comparable.

Impeding service delivery and uptake

NHS data shows that, in 2020/21, contraception-related contacts with dedicated SRH services were almost 50% lower than 2014/15, with a particularly steep drop in 2019/20.[7]

This correlates with a stark decline in the uptake of LARC, with strains on service capacity that already existed prior to COVID-19 exacerbated by the pandemic: **between 2019 and 2020, total LARC prescribing fell from 50.8 per 100,000 to 34.6 per 100,000.** This represents a 33% decline in GP-prescribed LARC, and a 36% decline in LARC prescribed in specialist SRH services, in the first year of the pandemic alone.[8]

Delivery of LARC in the voluntary sector has also been adversely affected. During the first months of the pandemic, abortion provider MSI Reproductive Choices saw a 22% reduction in the number of LARCs it was able to provide, thanks to a forced reduction in face-to-face appointments and cancellation of post-abortion LARC appointments.[9]



What are the consequences for women?

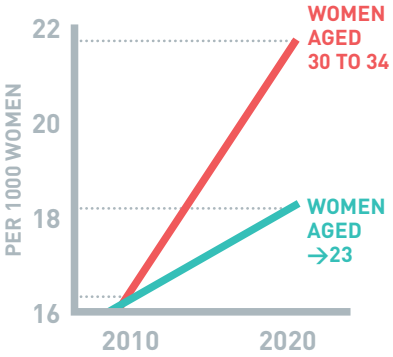
The challenges experienced in SRH provision have had a material impact on women's access to contraception. Research has found that women were **nine times more likely to have difficulties in accessing contraception** during the first lockdown than before the pandemic.[10] These challenges are likely to have been particularly acute for more marginalised communities: in FSRH surveys, 39% of SRH services reported they were not confident that their vulnerable patients could access SRH care during COVID-19, while 67% reported that they did not feel able to meet the needs of young people.[5]

Even as provision begins to recover, the pandemic will leave a lasting impact on women themselves:

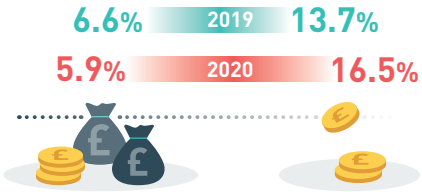
The proportion of unplanned pregnancies almost doubled during lockdown, from 1.3% to 2.1% of pregnancies.

Unplanned pregnancies are known to carry significant financial costs for individuals, the health and care system, and the economy[11]

2020 saw the highest abortion rate since the Abortion Act was introduced, at 18.2 per 1,000 women.



There has been an increase in the abortion rates for all ages 23 and above, with the highest rise amongst women aged 30 to 34 (from 16.5 per 1,000 in 2010 to 21.9 per 1,000 in 2020)[12]



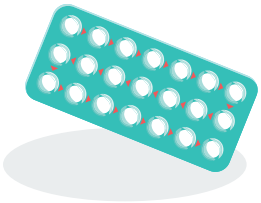
COVID-19 has had a particular impact on pregnancy decision making for women from lower socio-economic backgrounds.

Analysis by the British Pregnancy Advisory Service has shown that, in 2020, women from the most deprived backgrounds accounted for 16.5% of all abortions, whereas women from the wealthiest backgrounds accounted for 5.9%. The gap has widened considerably from 2019, when the figures were 13.7% and 6.6% respectively[13]

While the reasons for rising abortion rates are complex and multi-faceted, for many women they may point to challenges in accessing their contraception of choice in a timely and convenient manner. For these women, disruption to contraceptive provision due to COVID-19 will last far beyond the close of the pandemic.

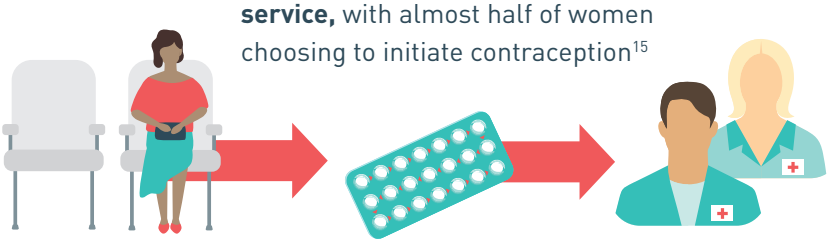
What lessons can we take from COVID-19?

Set against these critical challenges, both providers and commissioners across the SRH landscape have taken innovative steps to safeguard women's access to contraception throughout the pandemic. These innovations, including remote consultations, integrated working and targeted outreach are concepts that can and should be taken forward as we recover and build back provision.



Alongside Government-led innovations, such as the decision to make the progesterone only pill (POP) available to purchase over the counter in pharmacies, we now have a unique opportunity to break down longstanding barriers and fragmentation in the provision of holistic reproductive healthcare.

	COVID best practice example	How can this be taken forward?
Remote consultations	**In April 2020, 90% of SRH services reported delivering consultations remotely,** a rise from only 18% prior to the pandemic[14]	• SRH services should retain digital innovation to enhance accessibility of contraceptive services, particularly for women who experience challenges or stigma in attending face-to-face services • Services should recognise that digital is just one access point, and therefore must be part of a broader mixed model tailored to individual need
Integrated working	In Birmingham, community SRH trainees were redeployed to the **local maternity unit to set up a post-natal contraception (PNC) service,** with almost half of women choosing to initiate contraception[15]	• Establishment of a multi-disciplinary approach to PNC provision should be encouraged • PNC provision should be considered in particular for effective reach of vulnerable women, who may experience more challenges accessing contraception outside of the maternity setting
Targeted outreach	In Bristol, SRH services have offered **outreach support to under 19s who have already had a pregnancy,** through **remote counselling and provision** of a comprehensive contraception service (including LARC services upon the reintroduction of face-to-face appointments) Supported by digital communications, early evidence suggests a reduction in the number of under 19s presenting for a termination[16]	• Systems should consider the use of remote counselling and provision to enable or improve targeted outreach • Outreach interventions should be individually designed to best meet the needs of different communities, whether younger women and girls or vulnerable groups



Expanded provision

During COVID-19, NHS England launched a pilot to **expand capacity in primary care and specialist SRH services** by making oral contraception access available in community pharmacy, thereby providing improved access for patients

Following positive evaluation, the pilot may expand to the following subsequent tiers:

- **Tier 2:** initiation of oral contraception via a community pharmacist
- **Tier 3:** ongoing management of LARCs, such as implants, vaginal rings, injections, patches
- **Tier 4:** initiation of LARCs via a community pharmacist[17]

- Opportunities to better utilise the expertise of the wider primary and community care workforce – in particular community pharmacy – to enhance provision of contraception should be leveraged wherever possible at national and system levels
- NHS England should explore opportunities to expedite evaluation and expansion of the community pharmacy pilot, ensuring that training and development is in place to meaningfully empower community pharmacists to expand their role

Call to action

While the upcoming Women's Health and Sexual and Reproductive Health strategies are a welcome indication of the Government's commitment to women's reproductive health, truly delivering on these ambitions will require urgent action to put contraceptive provision on a sustainable footing, now and in the future. Highly stretched and underfunded even prior to the pandemic, services across primary and specialist settings now need targeted financial support to get provision of contraception back on track. This must enhance delivery of the full range of contraceptive options in all settings, with a particular focus on improving access to LARC: service providers must have confidence that they can invest in the development of their workforce to provide LARC counselling and fittings to all women who prefer these methods.

While the pandemic has sparked welcome examples of innovation and collaborative working in the provision of contraception, these cannot be harnessed more widely without investment to safeguard the essential building blocks of contraceptive care. Neither service providers, nor the women who rely on them, should have to wait any longer.

If you would like further information on the work of the AGC, or to discuss the issues raised in this briefing in more detail, please get in touch via AGC@incisivehealth.com

REFERENCES 1 ***The AGC recognises that access to contraception is essential for everyone who can become pregnant, no matter how they identify, and therefore supports and advocates for the right to access contraception for trans, non-binary and intersex people that need it. It is essential that there is an understanding of intersectionality to help minimise inequalities in care and the provision of essential service. We use the word women for simplicity but also in recognition that the majority of those requiring access to contraception identify as women.*** 2 Ministry of Housing, Communities and Local Government, ***Local authority revenue expenditure and financing: outturn data from 2015 to 2016 and 2019 to 2020*** 3 Advisory Group on Contraception, ***Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015,*** September 2018, accessed April 2022 4 Advisory Group on Contraception, ***Shining a light on access to contraception in England: an overview of 2019-2020 data,*** September 2020, accessed April 2022 5 Faculty of Sexual and Reproductive Healthcare, COVID-19 SRH service surveys, 2020-2022, accessed April 2022 6 The King's Fund, ***Local government public health funding: putting the jigsaw together without the picture on the box,*** March 2022, accessed April 2022 7 NHS Digital, ***Sexual and Reproductive Health Services, England (Contraception) 2020/21,*** September 2021, accessed April 2022 8 Office for Health Improvement and Disparities, ***Sexual and Reproductive Health Profiles,*** accessed April 2022 9 MSI Reproductive Choices, ***Cross-Party Group on Sexual and Reproductive Health: Access to Contraception in England Inquiry,*** June 2020, accessed April 2022 10 UCL, ***Unplanned pregnancies nearly doubled during lockdown,*** October 2021, accessed April 2022 11 Public Health England, ***Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England,*** 2018, accessed April 2022 12 Department of Health and Social Care, ***Abortion statistics, England and Wales: 2020,*** January 2022, accessed April 2022 13 British Pregnancy Advisory Service, ***ONS report on conceptions in England and Wales in 2020 released today,*** April 2022, accessed April 2022 14 Advisory Group on Contraception, ***Shining a light on access to contraception in England: an overview of 2019-2020 data,*** September 2020, accessed April 2022 15 Campbell et al., ***'Our COVID-19 cloud silver lining': the initiation and progress of postnatal contraception services during the COVID-19 pandemic in a UK maternity hospital,*** July 2021, accessed April 2022 16 Public Health England, ***Teenage pregnancy outreach support during COVID-19: enabling contraceptive choice for under 19s who have already had a pregnancy,*** July 2020, accessed April 2022 17 NHS England, ***NHS Community Pharmacy Contraception Management Service Pilot: Access to Ongoing Management of Oral Contraception (Tier 1),*** accessed April 2022.

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