



The Royal College of Midwives' written submission to the Health and Social Care Committee's Inquiry on Sexual health.

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Executive Summary:

- Data suggests access to sexual and reproductive health services is becoming constrained, restricting the ability of people to plan their families the way they wish.
- The pressures on primary care and specialist services for contraception – especially LARC methods - will have a knock-on effect upon maternity services; using the postnatal period to administer LARC¹ will not work when midwives are not suitably trained and already under pressure to perform other public health functions, which already includes contraception information and some user-dependent methods.
- We must urgently reverse the cuts to the public health budget to give all people the access to the right contraception for them, and we would like to see further investigation into how women can be better supported with contraception choices in the postnatal period with staff trained and having the time to facilitate those choices.

1. The Royal College of Midwives (RCM) is the professional organisation and trade union representing the majority of midwives and maternity support workers (MSWs) working in maternity services. We welcome this Inquiry into Sexual Health, as it has become an area where we can see clear deterioration of services due to cuts and fragmentation of public health
2. The RCM has joined with other organisations in June 2018 for a consensus statement on the six pillars of reproductive health.² The pillars are:
 - 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.

¹ Long-acting reversible contraception: contraceptive methods that require administration less than once per cycle or month. Includes copper intrauterine devices; progestogen-only intrauterine systems; progestogen-only injectable contraceptives; and progestogen-only subdermal implants.

² PHE consensus statement 2018.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/731890/A_consensus_statement_reproductive_health_is_a_public_health_issue.pdf

- 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.
3. We share the growing concern expressed by this Committee, and other health charities and bodies about the provision of sexual health services. Fragmentation of and cuts to services mean these six pillars begin to collapse. The Committee will no doubt hear about the increases in infection rates for some STIs, the tussle over the provision of PrEP, reduction in cervical screening attendees and the slow down in the uptake of LARC contraception methods. We would like to use our expertise in maternity services to highlight contraception as a key part in sexual health care and where the challenges lie for our members.
 4. Contraception is a significant contributor to people's ability to determine their lives and fulfil their potential, and as midwives and MSWs, we want to see all people begin their families at the right time for them, in optimum health for themselves and for their babies. Midwives and MSWs are uniquely placed to provide support to women with their reproductive health choices, when they are able to form trusting relationships with women during the antenatal, intrapartum and postnatal care periods.
 5. It is estimated are that every £1 spent on contraception saves over £11 to costs elsewhere in the NHS.³ Birth spacing of less than 12 months is associated with an increased risk of preterm birth, low birthweight and small for gestational age (SGA) babies,⁴ so making sure women and families get the advice and support they need after giving birth is vitally important for ensuring positive outcomes for next birth. There is little UK research into the prevalence of short-birth spacing and data on unplanned or unwanted pregnancies is variable. NICE report the estimate that 30% of pregnancies are unplanned.⁵ PHE report 1 in 6 (16.2%) pregnancies experienced in the UK are unplanned;⁶ 52% and 12% of unplanned pregnancies are assumed to end in abortion and miscarriage respectively.⁷ We agree with PHE that there is a need for a more sophisticated measure for recording whether or not a pregnancy is planned. 'Evidence suggests that pregnancy planning is not a simple 'yes or no' concept... we cannot assume that all these unintended pregnancies that do lead to live births, if avoided today, would not have occurred later as a planned birth. This has been described [as]: "Not all unintended pregnancies are unwanted; most are mistimed, and would have occurred as intended births at a later date'."⁸ Research from PHE into women's experiences also finds contraception is part of a wider set of decisions in women's lives and isn't necessarily seen in isolation, or even as the most pertinent thing, day-to-day, of their sexual and reproductive health:

³ RCN (2018) Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England. <https://www.rcn.org.uk/professional-development/publications/pdf-006962>

⁴ Faculty of Sexual and Reproductive Health (2017). Contraception after pregnancy <https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/>

⁵ NICE (2014). Long-acting reversible contraception (CG30). <https://www.nice.org.uk/guidance/cg30/chapter/Introduction>

⁶ PHE (2017). Guidance [webpage]: Healthy beginnings: applying All Our Health.

⁷ PHE (2018). Contraception: Economic Analysis. Estimation of the Return on Investment (ROI) for publicly funded contraception in England. <https://www.gov.uk/government/publications/contraceptive-services-estimating-the-return-on-investment>

⁸ PHE (2018). Contraception: Economic Analysis. Estimation of the Return on Investment (ROI) for publicly funded contraception in England. <https://www.gov.uk/government/publications/contraceptive-services-estimating-the-return-on-investment>

- a. 'Reproductive wellbeing for women throughout life is multi-faceted and findings from the focus groups and online survey demonstrate that women's lives are affected significantly by a wide range of reproductive health issues. There is a juxtaposition between the need to plan and/or prevent pregnancy across the lifecycle against the day-to-day realities of managing symptoms associated with reproductive functions such as periods, the menopause and the impacts of childbirth. Because these are all part of a normal lifecycle, reproductive difficulties or morbidities can be under-reported and overlooked by wider society.'⁹
6. Midwives' role in providing contraception is well defined. The NICE postnatal care guideline recommends that methods and timing of resumption of contraception should be discussed within the first week of the birth. Further, 'the coordinating healthcare professional should provide proactive assistance to women who may have difficulty accessing contraceptive care. This includes providing contact details for expert contraceptive advice.'¹⁰ Targets from the Faculty of Reproductive and Sexual Health are for 97% of women to be informed about and offered a choice of contraception within 7 days of delivery.¹¹ The CQC survey of maternity experiences in 2017 found 89% of women said they were given information about contraception. This figure was 91% in 2015.¹² Women's notes record that contraception options and women's decisions have been discussed, and some units routinely provide the 'min-pill' and condoms to women upon their discharge from a maternity unit. It is worth noting that there no imperative here to speak with fathers and partners about contraception but perhaps their choices and options too need to be supported too.
 7. The RCM for many years has outlined our concerns with postnatal care. It is the part of maternity care which has consistently been rated less satisfactory compared to other areas. In the UK, there is no recommended minimum length of stay in hospital after birth for healthy mothers and babies, and the average length of stay is consequently one of the lowest in the world.¹³ The decision about when a woman goes home after birth is one that should be made through discussion with the woman, midwives and medical staff. The length of time and the care of the woman should be based on her needs, not on resources or availability of beds. Provided the woman is medically fine, has the support she needs at home and the right postnatal care plan in place, and a good community midwife service, then going home six hours after birth may be ok. What is crucial to realise is that women who do stay beyond the average are usually there because they are sick, rather than well. Pressure on beds contributes to this trend to not keep well women in postnatal wards.
 8. The challenge for midwives and MSWs is to use that time with women the most effectively, whether that be to support bonding and feeding, post-birth care of women and neonatal observations. From the CQC survey we can see midwives are not quite managing to make the FSRH target. We would like the Committee to note the tariff for postnatal care for a woman without complications is £252, which covers the 6 week period until handover to the GP and health visitor.
 9. However, because of the cuts and fragmentation of contraception services in other primary care settings, there have been calls from Public Health England (PHE) recently for more to be provided in the immediate postnatal period: 'The FSRH guideline states that a woman's chosen method of

⁹ PHE survey of women: PHE (2018). What do women say?: Reproductive health is a public health issue. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/731891/What_do_women_say_reproductive_health_is_a_public_health_issue.pdf

¹⁰ NICE Postnatal care guideline: <https://www.nice.org.uk/guidance/qs37>

¹¹ Faculty of Sexual and Reproductive Health (2017). Contraception after pregnancy <https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/>

¹² CQC National findings from the 2017 survey of women's experience of maternity care

¹³ National Maternity and Perinatal Audit (2017). Clinical report 2017 - revised version. <http://www.maternityaudit.org.uk/downloads/NMPA%20Clinical%20Report%202018.pdf>

contraception can be initiated immediately if desired and she is medically eligible.¹⁴ The Royal College of General Practitioners (RCGP) has highlighted that any cuts made to the public health funded elements of sexual health provision is often felt by other parts of the system which are paid for by different commissioners. We risk this happening to midwifery, as postnatal care comes under pressure to include more and more services, including the insertion of LARCs.

10. This presents a number of challenges for our members. Firstly, the provision of LARCs is not a core midwifery practice, and neither is insertion of IUDs immediately after birth. Changing this would require significant resources to support delivery of effective quality care for women. Currently, in order to provide LARC, doctors and nurses must undergo additional training provided by FSRH trained doctors and nurses and they need to maintain competency levels – they must seek accreditation from the FSRH every five years in order to practise.¹⁵
11. The RCM understands the huge financial pressures on local authorities and primary care which the Committee will no doubt take evidence on. We agree with the RCGP that reductions to specialist services from local authorities increase the workload on general practice and other core contraceptive services. The Primary Care Woman's Health Forum reports that 37% of their GP members had experienced a recent increase in women seeking appointments for contraception as specialist services appointments became harder to obtain.¹⁶
12. The Royal College of Nursing surveyed its members working in Sexual health last year and found that because LARC training is generally provided by specialist services, 'any reduction in such training opportunities could have drastic effects for the future workforce both in specialist services and well as in general practice.' The RCN reported the Advisory Group on Contraception's research which found cuts to specialist services risks 'potentially reducing access for women and the skills gained could be lost for some doctors and nurses forever.'¹⁷ It is hard to see where midwives would be able to be routinely and safely trained in the provision of LARC when the existing workforce needed for this practice is under threat from cuts to services in primary and community healthcare already. The latest FSHR Guidelines stipulate that 'maternity services should ensure that there are sufficient numbers of staff to provide IUC¹⁸ or IMP¹⁹ so that women who choose these methods and are medically eligible can initiate them immediately after childbirth.'²⁰ PHE too this year state 'Women are also well placed to receive contraception immediately following the delivery of their baby and before they leave the place of birth. This ensures that the issue does not slip through the net at a time when the focus is often on the baby.'²¹ We understand the need to make services accessible to women and to make the most of the contacts we have with them. This would be a gold standard

¹⁴ PHE (2018). Health matters: reproductive health and pregnancy planning. Published 26 June 2018 <https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning>

¹⁵ RCN (2018) Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England. <https://www.rcn.org.uk/professional-development/publications/pdf-006962>

¹⁶ Royal College of General Practitioners (2017). Sexual and Reproductive Health Time to act. <http://www.rcgp.org.uk/campaign-home/updates/blogs/2017/august/time-to-act-onsexual-reproductive-health.aspx>

¹⁷ RCN (2018) Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England. <https://www.rcn.org.uk/professional-development/publications/pdf-006962>

¹⁸ intrauterine contraception

¹⁹ progestogen-only implant

²⁰ Faculty of Sexual and Reproductive Health (2017). Contraception after pregnancy <https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/>

²¹ PHE (2018). Health matters: reproductive health and pregnancy planning. Published 26 June 2018 <https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning>

service which we should all aspire to. But without the training, and the staffing to train – England is still 3,500 midwives short²² – this is impossible to achieve, to women’s detriment. We need the government to fund the service to meet the guidelines being produced for practitioners.

13. We agree with PHE that ‘there is a need to pilot a service in England to offer all methods of contraception, including LARC, to all women on a postnatal ward. This should include effective, tailored contraceptive choices discussions with every woman during pregnancy as well as integrated planning for postnatal provision of her chosen method.’²³ We would like to see a service like this tested and fully costed so we know what it takes to train the midwives, or other professionals, in these practices and what the impact is on other essential postnatal care.
14. We also need more research on how women react to midwives’ contraceptive interventions, as the current evidence is conflicted. Whilst PHE and FSRH report that women are well placed to talk about and receive contraception after birth, research from Cardiff University has simultaneously found women are less receptive to contraceptive advice in the immediate postnatal period. Focus groups of midwives, student midwives and MSWs explored the public health role in maternity services. Contraception came up as a topic routinely and frequently discussed with women. However, focus group participants felt that discussing contraception at discharge and in the weeks after birth was ‘inappropriately timed’ and not taken seriously by women:
 - a. *Contraception advice is quite high on the agenda. However a lot of ladies laugh it off and don't really take it too seriously, mainly because they are 10-14 days after giving birth, not really the first activity on most ladies’ minds. I believe the health visitors discuss it in more detail.*
 - b. *I agree. It's also mentioned in discharge talks but most women laugh or give the impression they don't need to hear it because they've heard it all before!*
 - c. *Oh yes contraception comes up too but in a postnatal setting it is generally met with laughter!*
15. Similarly, a survey of midwives in Scotland by McCance and Cameron found a lack of expertise, a high workload with many competing priorities, lack of privacy in birth and postnatal wards, as well as low level of interest of the women themselves, presented barriers for midwives’ attempting to give advice and provide contraception.²⁴
16. Understandably, the recent reduction in the provision of LARCs in primary care has prompted others to look to maternity services where women are located, albeit for a short space of time. But for the reasons above, we need make sure our time with women in the postnatal care setting is used to the fullest, and not simply to plug the gaps elsewhere. Giving midwives the job of inserting LARCs immediately postpartum without the right training and resources will simply replicate the problem we currently have in primary care. GPs and sexual health clinics can’t do this work without being supported to do it, and maternity services are no different. We urge the Committee to use this Inquiry to investigate what more we can do to improve reproductive and sexual health services for

²² RCM (2018). State of Maternity Services. <https://www.rcm.org.uk/sites/default/files/ENGLAND%20SOMS%202018%20-%20FINAL%20%2803.09.2018%29.pdf>

²³ PHE (2018). Health matters: reproductive health and pregnancy planning. Published 26 June 2018 <https://www.gov.uk/government/publications/health-matters-reproductive-health-and-pregnancy-planning/health-matters-reproductive-health-and-pregnancy-planning>

²⁴ Kirsty McCance and Sharon Cameron (2014). Midwives’ experiences and views of giving postpartum contraceptive advice and providing long-acting reversible contraception: a qualitative study. *J Fam Plann Reprod Health Care*, 40:177-183. <https://srh.bmj.com/content/40/3/177.info>

all people in whatever part of the NHS they choose. We must fund specialist posts, or fund training for midwives in post, or fund other health care professionals, then we can give women better choice and control over their sexual and reproductive health.