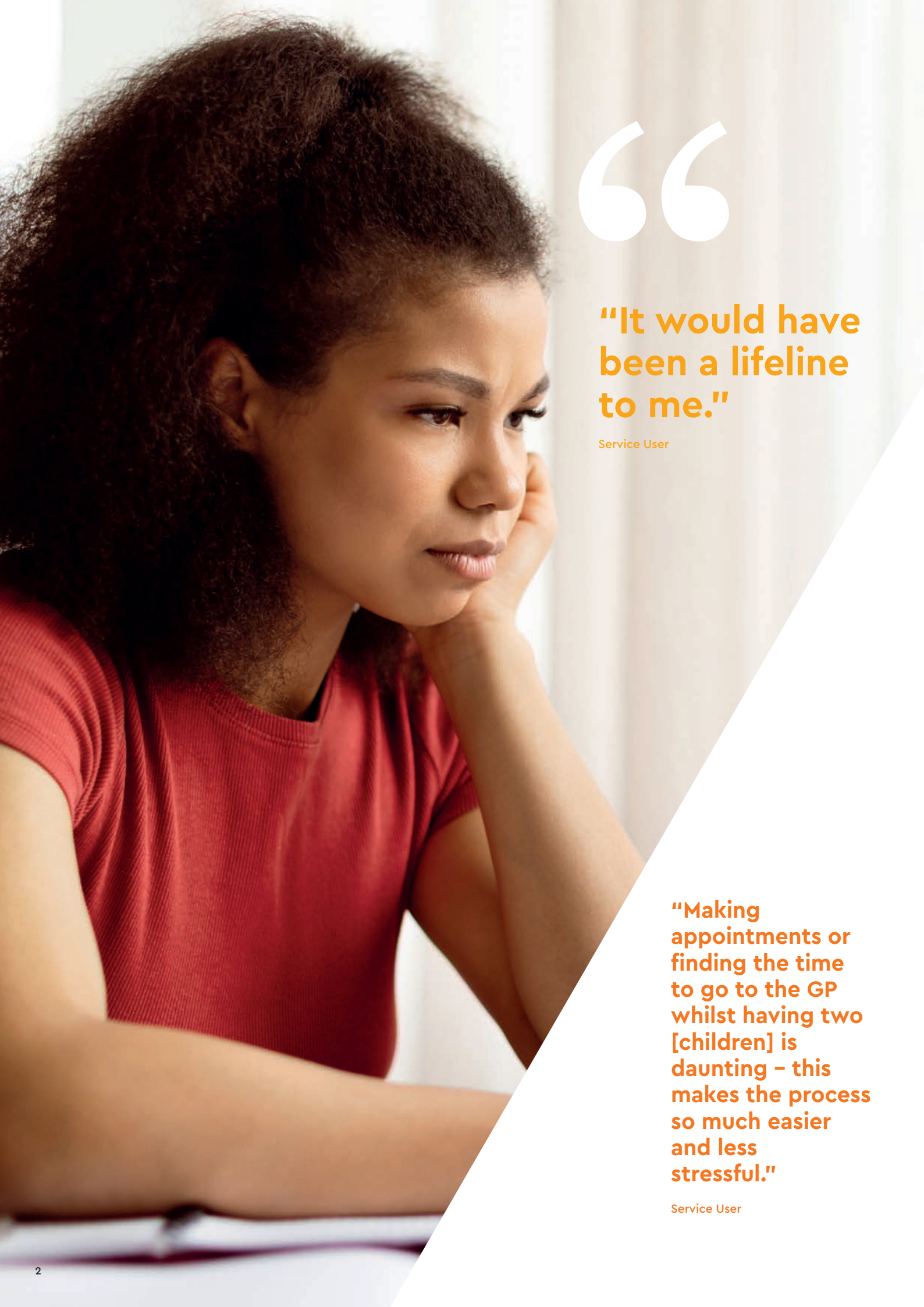


# BEYOND BARRIERS: REIMAGINING ACCESS TO POST-PREGNANCY CONTRACEPTION

THE CASE FOR CHANGE





“

**“It would have been a lifeline to me.”**

Service User

**“Making appointments or finding the time to go to the GP whilst having two [children] is daunting – this makes the process so much easier and less stressful.”**

Service User

**"The discussion of contraception was helpful as I was unaware of the scheme – general feeling of relief."**

Service User

**"The sheer volume of uptake, especially among groups historically facing barriers to access such as young parents, women in care, and those with substance misuse or language highlights the critical value of integrating contraceptive care into the maternity pathway."**

Post-pregnancy contraception (PPC) Provider

**"I've seen how it empowers women – we're offering something practical and important at exactly the right time."**

PPC Provider

**"It is very difficult to understand why postnatal contraception is not prioritised across the UK, and instead left to a small group of motivated staff to try to establish a service."**

PPC Provider

**"...at no point in my life was I more scared of getting pregnant than when I just had a baby. I just couldn't think of anything more traumatic"**

BMA Women's Health Report

**"Providing contraception in maternity settings has an even greater ROI – at £32 savings to the public sector for every £1 invested – and, for many women, will offer greater convenience as it saves women from needing to arrange an appointment with their GP or other healthcare provider."**

Women's Health Strategy



## Disclaimers

### Language:

Within this report we use the terms 'woman' and 'women's health'. However, it is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services in order to maintain their sexual and reproductive health (SRH) and wellbeing.

The terms 'woman' and 'women's health' are used for brevity, on the understanding and recognition that sexual and reproductive healthcare services will be accessed by women, gender diverse individuals, and people whose gender identity does not align with the sex recorded at birth. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were recorded as at birth.

### Funders:

The College of Sexual and Reproductive Healthcare (CoSRH) Hatfield Vision is a national programme of advocacy work supported by a wide range of organisations, including charities, professional bodies, and industry leaders. Some collaborators provide funding to support the running of the programme. The monies received help the CoSRH to resource the programme in line with the CoSRH's charitable objectives and attainment of the Vision goals. The CoSRH engages with all organisations working on the programme equally and collaboratively regardless of funding. Organisations who provide funding cannot influence the direction of the Vision, nor will the CoSRH preferentially advance the aims of one supporter over any other. All monies received are used to equitably advance the work of the Vision.

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# Beyond Barriers: Reimagining Access to Post-Pregnancy Contraception

## The Case for Change

**"I've seen how it empowers women – we're offering something practical and important at exactly the right time."**

– PPC Provider

### Overview

This report outlines the strategic, policy, and funding actions needed to drive system-wide improvement in the provision of post-pregnancy contraception (PPC). The report audience is aimed at parliamentarians, Integrated Care Board (ICB) leaders, and national policymakers. It outlines the case for change and articulates the need to end the postcode lottery, with high-quality PPC services easily available in some parts of the country while in others, provision is scant or non-existent. The companion report *Beyond Barriers: Reimagining Access to Post-Pregnancy Contraception - A Guide for Best Practice* offers best practice approaches for local and regional delivery, targeting ICB leaders, PPC providers, and commissioners.

While each report stands alone, they are designed to be read together, offering a comprehensive framework for advancing PPC policy and practice across the UK.

### What is post-pregnancy contraception (PPC)?

Post-pregnancy contraception includes provision of contraception to women after childbirth, abortion, ectopic pregnancy, miscarriage, or gestational trophoblastic disease (GTD). In this report, post-pregnancy contraception also refers to the provision of contraception following stillbirth and baby loss.

### Background

Access to post-pregnancy contraception remains a luxury for many women in the UK, and in some regions, access is virtually non-existent. The statistics show:

- In Britain, around 45% of pregnancies are unplanned or ambivalent.<sup>1</sup>
- Almost 1 in 13 women presenting for an abortion or birth had conceived within a year of a previous birth.<sup>2</sup>
- 1 in 8 women who have delivered one or more children conceive and continue another pregnancy within a year of a previous birth.<sup>3</sup>

- Abortions are at a record high, with a 17% increase in comparison to the previous year in 2022.<sup>4</sup>
- Almost a fifth of women are unable to access their preferred method of postnatal contraception.<sup>5</sup>

Despite a clear incentive for PPC provision, many women face significant barriers to access. Access to PPC is currently a 'postcode lottery' due to existing commissioning structures, which mean that there is no clarity of responsibility in terms of who should provide post-pregnancy contraception.

### Why is access to post-pregnancy contraception important?

#### 1. Women want PPC

Providing information about contraception options during pregnancy allows women to make informed decisions about if and when they wish to get pregnant again.

#### 2. PPC produces significant cost savings

Providing contraception service in maternity settings has an estimated ROI of £32 savings to the public sector for every £1 invested.<sup>6</sup>

#### 3. PPC supports safe maternity care

PPC is integral to supporting safe maternity care by ensuring women have all necessary information and can make an informed choice. Importantly, improved provision of PPC helps to tackle common myths and misconceptions around women, pregnancy, contraception and fertility.

#### 4. Access to PPC reduces health inequalities

Contributors to this report demonstrated the positive impact of PPC in tackling health inequalities in their local area. By flexibly providing contraception to women post-pregnancy in circumstances that suited them, they are improving women's outcomes, particularly those who may find it harder to access SRH services.

1 The National Survey of Sexual Attitudes and Lifestyles (Natsal-3).

2 Heller R, Cameron S, Briggs R et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. *J Fam Plann Reprod Health Care*. 2016;42(2):93-8.

3 Heller R, Cameron S, Briggs R et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. *J Fam Plann Reprod Health Care*. 2016;42(2):93-8.

4 Office for Health Improvement and Disparities. Abortion statistics for England and Wales: 2022.

5 Moffat M, Jackowich R, Möller-Christensen C et al. Demographic and pregnancy-related predictors of postnatal contraception uptake: A cross-sectional study. 2024; 131(10): 1360-1367.

6 Public Health England. PHE Women's Reproductive Health Programme 2020 to 2021.



# Recommendations

## Recommendations for Government:

- 1 Support for post-pregnancy contraception should be clearly articulated and embedded into Government's national health plans**, including a reiterated commitment in any future updates or phases of the Women's Health Strategy, and future work on maternity and neonatal safety, such as the national action plan.
  - a. This should include support for developing a 'Once for England' approach to PPC provision, reflecting the efforts in other UK nations to help standardise the PPC offer and facilitate local areas meeting the needs of their local communities. We know that newer PPC services may need to target specific patients at first, to build a strong business case for wider funding and coverage. However, universal access and the standardisation of PPC should be the ultimate objective, so that every woman can access this crucial service no matter where they live.

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- 2 The merging of NHS England (NHSE) and the Department of Health and Social Care (DHSC) and the Government's focus on integration, accountability and clarity in the health system, presents an ideal opportunity to fix the fragmented commissioning of women's health and contraception:**
  - a. The DHSC should ensure that each ICB has a named individual who is accountable for the joined-up commissioning of contraception and women's health services, including post-pregnancy contraception, in collaboration with local authority partners. This role should carry clear responsibility and authority to coordinate service delivery. This accountability is essential to empower ICBs to plan and deliver the services women need.
  - b. The DHSC should support and promote co-commissioning of PPC services, and create a national forum to share examples of best practice with ICBs.
  - c. Local Women's Health Champions and the Women's Health Ambassador/National Clinical Director for Women's Health should maintain national oversight of commissioning decisions to ensure the needs of women are met throughout the life course.
  - d. Merging NHSE and The DHSC creates an opportunity to bring together the expertise of the women's health and reproductive health policy teams which currently sit separately. This will enable joined-up policy around the holistic needs of women across the life course.
  - e. In conjunction with these changes at national level, local commissioning bodies should share budgets and contractual mechanisms to improve outcomes and facilitate simple solutions where capacity, priority, timing and relationships enable this to happen.
    - i. Local Authority Health and Wellbeing boards or Overview and Scrutiny boards should hold parties to account for local decisions and any potential risks or issues.

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- 3 The Government should consider conducting an audit of the current gaps in PPC provision across England.**

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- 4 The Government should work closely with the CoSRH and local PPC champions to establish a national resource database on PPC to share best practice of provision centrally.**
  - a. This should include the national counselling framework with scripts, and resource packs to support midwives and nurses in delivering high-quality and timely information. This should start in the antenatal period for those in maternity care and, where possible, prior to the end of pregnancy for those who need contraception after other pregnancy outcomes.

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- 5 The Government should build a repository of information to enable healthcare practitioners and all birthing people and their support networks to improve health literacy of the population around fertility, pregnancy, maternity and reproductive health.**
  - a. The NHS website and NHS app should be updated to include information about all PPC options.

**6** In line with their commitment to shift to digital NHS systems and the introduction of the Single Patient Record in 10 Year Health Plan, the Government should oversee the improvement of electronic notes systems to ensure adequate, timely documentation of contraceptive discussions with women throughout the pregnancy journey. This should include digital alerts of previous PPC discussions when admitted for delivery. Maternity is rightly being prioritised in the Single Patient Record roll-out and the Government should ensure PPC is included in this.

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**7** Better data is crucial to improving the quality and coverage of PPC services in England. National data sets should be amended to collect and record essential data related to PPC. For example, healthcare professionals delivering post-pregnancy care are currently asked to record previous pregnancies of the patient but not when they were. We recommend that:

- At a minimum, routine SRH and abortion data should include the date of the end of the last pregnancy.
- Additionally, routine maternity datasets should be modified to include fields on the London Measure of Unplanned Pregnancy, women's antenatal choice of postnatal contraception and what contraception was provided post-pregnancy.
- This will allow the better monitoring of pregnancy planning and PPC at a national level to understand the choices and services available to women at this important time of their reproductive life.

## Recommendations for the NHS, ICBs and the wider health system:

**1** National Institute for Health and Care Excellence (NICE) guidance on *Contraception after Childbirth* should be renamed *Contraception after Pregnancy* to reflect the importance of women's access to the full range of contraceptive methods in all pregnancy outcomes. This guidance has not been updated since 2016 and trends in contraception along with best practice of PPC provision have changed considerably since then.

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**2** NHS England should publish its delayed guidance on women's postnatal care, giving clear direction and recommendations for best practice including the provision of PPC.

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**3** NHS guidance should be made clearer to support information pathways at a local level. Women in the local community should know where, when and how they can access contraceptive services, either via physical or electronic guidance.

- Information outreach to pregnant women should be improved via promotion of the NHS digital inclusion framework.<sup>7</sup>

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**4** ICBs should meet their responsibilities to commission maternity services that enable safe, equitable, and personalised maternity care for local populations and commission care in line with NICE guidelines.

- As per the NICE guideline *Contraception after childbirth*, commissioners should 'ensure that maternity services give women information about and offer them a choice of all contraceptive methods as soon as possible and within 7 days of delivery, and refer them to a contraceptive service if contraception cannot be provided immediately.'
- Commissioners should establish integrated pathways of care to make sure women are provided with their preferred method of contraception in a place of their choosing, in line with the Hatfield Vision: Goal 3/Action 4.

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<sup>7</sup> Inclusive digital healthcare: a framework for NHS action on digital inclusion

- 5 Information should be provided in different formats for women to access when they feel ready, and healthcare professionals should practice compassion, empathy and sensitivity and understand why women may want to wait to receive certain information on contraception, including following pregnancy and baby loss.**
  - a. Ensure that guidance on contraception after pregnancy is available in accessible formats for all women and birthing partners (including male methods). This information must also be culturally sensitive and available in different languages.
  - b. Ensure that providers adhere to the National Bereavement Care Pathway Guidance and Sands guidance when discussing contraceptive plans with women who have experienced pregnancy or baby loss.
  - c. Ensure that contraception is discussed but never imposed on women who have needed an abortion, and that individuals are supported in selecting and using the method that best aligns with their needs and values. A non-directive, person-centred approach is essential to uphold reproductive autonomy and deliver respectful, high-quality care.

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- 6 The College of Sexual and Reproductive Healthcare should develop a service standard on post-pregnancy contraception, which aligns with the CoSRH guidance on *Contraception after Pregnancy*, and these standards should be used to audit PPC services annually.**

## Recommendations for Workforce and Training:

- 1 The NHS should continue to review the need for more resources and capacity for professionals working in maternity services,** including investing in and expanding the workforce so that staff have adequate time for education and training on contraception, and more time for contraceptive counselling and provision.

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- 2 The NHS and higher education institutions should launch a review of future investment in education and training, including undergraduate and postgraduate curriculums** to ensure that midwives and other healthcare professionals are equipped with the knowledge and skills to provide PPC.

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- 3 The RCOG should embed Contraception including PPC into their O&G curriculum,** recognising the need for obstetricians as well as all other maternity staff to provide advice and, where possible, postnatal contraceptive care.

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- 4 Assessments should be made of the current contraceptive training opportunities for the maternity workforce and those working in abortion-care services.** Consideration should be made to embedding specific skills into training pathways, including Long-Acting Reversible Contraception (LARC) competencies (Sub-Dermal Implant (SDI), Postpartum Intrauterine Contraceptive (PPIUC)).

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- 5 Employers should reserve time in job plans of healthcare professionals involved in delivering PPC services for training, peer support, and mentorship.**

# Foreword: Experience of a Consultant Obstetrician after Birth

## HOW THE SYSTEM WORKS AGAINST YOU: The personal experience of a consultant obstetrician trying to access contraception after birth

**I had my second baby by planned caesarean section at 39 weeks in March 2021, just as the first Covid restrictions were being lifted.**

Despite working in the Trust and being the Lead for Postnatal Contraception at the same hospital where I was having my caesarean section, I was unable to have a coil fitted at the same time, even though I knew that I didn't want further children.

This was because the service was not funded to provide this, nor did we have the community set up to support follow-up. This is despite experiencing two high-risk pregnancies and a scar opening during surgery.

This would have been a clinically logical and convenient opportunity for this procedure, which only takes a few minutes, preventing repeat appointments and wasting NHS resources.

Coils are safe to be inserted during or after the surgery and a convenient option for postpartum contraception. Research shows it is a highly effective method, with a very low failure rate.<sup>8</sup>

Six weeks after my caesarean section, I contacted my GP for a coil fitting. I was told I was unable to book this appointment without a GP consultation first. I explained I didn't think I needed to waste a GP's time on this, having had coils since 2011, and being a Consultant Obstetrician.

However, they still refused and could not tell me when they would be re-instating their LARC provision.

Instead, I contacted my local Sexual Health service. They were happy to support a coil fit, but did not have their diary planned yet for the next month and would get back to me.

They didn't. So, I chased, two weeks later, and they still hadn't confirmed their diaries, and couldn't give me a timescale, even though it is standard NHS practice of giving six weeks' notice for annual leave.

I then contacted the next nearest Sexual Health clinic in the north of my county as I am lucky enough to have my own transport to enable me to attend this appointment. They could fit me in but there was a four week wait. When I attended this long-awaited appointment, they weren't happy that I had brought my four-month old baby with me despite him being asleep in his car seat for the entire appointment. Unfortunately, this was unavoidable as I could not secure local childcare provision.

The clinician then said they were not happy to fit the coil as I was breastfeeding and advised me to come back when I had finished feeding. This is despite NHS guidance clearly outlining the safety of an Intra Uterine Device (IUD) during breastfeeding:

**"It's safe to have an IUD when you're breastfeeding, and it will not affect your baby or your milk supply."<sup>9</sup>**

I finally had my coil fitted in November at the clinic further away from my home when my baby was eight months old.

As a Consultant Obstetrician, I see patients everyday who face multiple barriers in trying to access contraception they need.

**If I had this kind of struggle – with my extensive knowledge of the health system, of the contraceptive options available to me plus the advantage of having transport, and having English as my first language – what chance do other women have of navigating this system and accessing the contraception while juggling the pressures of raising a newborn child?**

**I can only imagine what other patients go through.**

What is the cost of this illogical system, both to the women themselves and to the health system?

I see it too often in my line of work. For example, very recently in my termination of pregnancy service, I saw a 14+5 weeks pregnant woman, with her six-month-old baby in the clinic. This is not unusual – 20% of all women in termination of pregnancy service had a baby under one years old.

We need policymakers to read stories like mine and understand the importance of action to get this right, to ensure women can easily access the contraception they need in the post-delivery period.

8 Goldstuck ND, Steyn PS. Insertion of intrauterine devices after caesarean section: a systematic review update. *Int J Womens Health*. 2017 Apr 18;9:205-212.

9 NHS.uk, Who can get the IUD (coil)?

# Introduction

By Dr Janet Barter and  
Prof Raneë Thakar

**As Presidents of the College of Sexual and Reproductive Health and Royal College of Obstetricians and Gynaecologists (RCOG) we are deeply committed to ensuring every woman has access to contraception and can make informed choices about when and if to have a child. This is fundamental for women to be able to live well and pursue ambitions in every aspect of their lives.**

Today, women across the UK are becoming sexually active earlier and are having children later in comparison to previous generations. With a preference for having fewer children, women now spend decades of their reproductive life trying to prevent or plan pregnancy.

However, despite this, we also know from our own experience as clinicians and from the thousands of members delivering front-line services across the UK that we represent, that too many women still face obstacles in accessing the contraception they need.

In Britain, it is estimated that around 45% of pregnancies are unplanned or ambivalent,<sup>10</sup> abortion statistics are at a record high, with the latest data recording a 17% increase in procedures in comparison to the previous year.<sup>11</sup> Data also shows that more than half of women accessing abortion care have children, and 41% have had one or more previous abortions.<sup>12</sup>

We firmly believe that abortion is an essential component of healthcare and a vital aspect of women's reproductive rights and autonomy. Yet, these statistics suggest an unmet need for effective contraception, including after pregnancy.

## The Importance of Access to Post-Pregnancy Contraception (PPC)

Pregnancy is a significant reproductive event during which women are in regular contact with healthcare services, creating an opportunity to discuss contraceptive choice with women and their partners and to provide contraception to help them plan or avoid future pregnancies.

**Fertility returns soon after pregnancy, as early as three weeks after birth, even before the return of menstruation.**<sup>13</sup>

Fertility also returns quickly after an abortion, with ovulation occurring as soon as 8 to 10 days and typically within three weeks of the procedure, regardless of the method of abortion.<sup>14</sup> Additionally, more than half of women resume sexual activity within two weeks of a termination of pregnancy.<sup>15</sup>

A UK study reported that almost 1 in 13 women presenting for an abortion or birth had conceived within a year of a previous birth, and 1 in 8 women with children conceive and continue another pregnancy within the same time frame.<sup>16</sup>

Without access to timely information and a method of choice, women may be at risk of an unplanned pregnancy soon after birth, abortion, or baby loss.

Post-pregnancy contraception refers to the methods used to plan and prevent pregnancy after childbirth, and crucially after miscarriage, pregnancy loss, abortion, ectopic pregnancy, or gestational trophoblastic disease. It is integral to supporting women to have all necessary information and informed choice of methods no matter the pregnancy outcome.

Importantly, the experiences of bereaved mothers must also be considered in this discussion. Miscarriage is the most common adverse pregnancy outcome with estimates rates of 10-15% in the UK. The NHS advises women that they "will need to use contraception from day 5 after a miscarriage or ectopic pregnancy" if they do not wish to conceive immediately.<sup>17</sup> Yet, it is rare for units managing early pregnancy loss to be able to provide this contraception.<sup>18</sup>

Additionally, improved provision of PPC helps to tackle common myths and misconceptions around women, pregnancy, contraception, and fertility. For example, providers of PPC in Greater Manchester (Manchester, Trafford and Salford (SSCMS)) found that in asking women on the postnatal ward when they thought they could get pregnant again after birth, answers varied from "straight away" to "150 days" to "2 years."<sup>19</sup> National statistics support this need for improved access to accurate knowledge and counselling on contraception.

It is therefore crucial that women are able to make informed choices about contraception and access the support they need post-pregnancy. We also know that this is what women want. One study of women on postnatal wards found nearly 97% of the women stated that they were not planning a baby in the next year.<sup>20</sup>

Furthermore, providing PPC offers a significant opportunity to reduce health inequalities by enabling access to contraception for women who may not engage with sexual health services.

Yet, despite these opportunities and demand for PPC, too many health services are not set up to facilitate this, and women face a postcode lottery of provision across England.

We strongly welcome the recognition of the importance of PPC in the Women's Health Strategy and the opportunity the strategy presents to adopt a life-course approach to women's health:

***"Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making.***

10 The National Survey of Sexual Attitudes and Lifestyles (Natsal-3).

11 Office for Health Improvement and Disparities. Abortion statistics for England and Wales: 2022

12 Office for Health Improvement and Disparities. Abortion statistics for England and Wales: 2022

13 NHS.uk. Sex and contraception after birth.

14 Boyd EF, Jr, Holmstrom EG. Ovulation following therapeutic abortion. *Am J Obstet Gynecol.* 1972;113:469-473. Lähteenmäki P, Luukkainen T. Return of ovarian function after

abortion. *Clin Endocrinol (Oxf)* 1978; 8: 123-32. Schreiber CA, Sober S, Ratcliffe S, Creinin MD. Ovulation resumption after medical abortion with mifepristone and misoprostol. *Contraception* 2011; 84: 230-3.

15 Boesen HC, Rørbye C, Nørgaard M, Nilas L. Sexual behavior during the first eight weeks after legal termination of pregnancy. *Acta Obstet Gynecol Scand.* 2004 Dec;83(12):1189-92.

16 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. *J Fam Plann Reprod*



**We are encouraged to see examples of local areas providing contraception in maternity settings and encourage local commissioners and providers to consider implementing this service.**<sup>17</sup>

**We also know that there is a significant cost benefit to PPC, which is largely returned to the healthcare service itself.**

In a financial climate where NHS budgets are under pressure to find savings, the cost efficiency of PPC cannot be overstated.

Providing contraceptive counselling and methods at this crucial stage of women's reproductive life ensures that women have timely access to the contraception they want, while they are already in contact with the health system.

As it stands, too many opportunities are missed, to the detriment of women, their families and the health system as a whole.

### The CoSRH Hatfield Vision and our Work to Improve PPC Provision:

Since 2023 we have led a working group of the **CoSRH Hatfield Vision** on post-pregnancy access to contraception; emphasising the importance of collaborative commissioning to make this a reality.

The Hatfield Vision is the CoSRH's blueprint outlining what needs to be achieved to improve the health of 51% of the UK's population and tackle the inequalities that women and girls face across their lifetime.

The Vision sets out goals and actions endorsed by 70 leading organisations in areas such as contraception, abortion,

menopause, menstrual health, cervical screening, and maternal health outcomes in Black women and women of colour.

It is a legacy to the late Jane Hatfield, the first CEO of the Faculty of Sexual and Reproductive Healthcare (now the CoSRH), who worked tirelessly to improve the quality of reproductive healthcare that every woman and girl receives.

Goal 8 of the Hatfield Vision focuses on improving access to PPC:

**"Integrated Care Systems (ICSs) should ensure that all methods of contraception are discussed with women during pregnancy and, where possible, their method of choice should be initiated prior to discharge from maternity services. Rapid follow-up pathways for LARC should be in place when needed."**<sup>22</sup>

A wide range of experts and organisations have come together to work on improving PPC, including researchers, obstetricians, midwives, nurses, and commissioners, all of whom are driven and passionate about improving this pathway, including Dr Ed Mullins, Obstetrician and Clinical Lecturer at Imperial College London; Dr Annette Thwaites, Honorary Research Fellow in Sexual and Reproductive Health at The Institute for Women's Health at University College London; Vicki Pirie, Lead Contraception Midwife in Gloucestershire, and Fiona Gibb, Director of Midwifery at the Royal College of Midwives.

This report is the culmination of the expertise and experiences shared during the meetings of this group since its inception two years ago. It contains invaluable insights from multidisciplinary professionals working tirelessly to research, commission, lead on, and deliver PPC to women across the UK, as well as from women themselves who have accessed this vital service or have faced barriers in doing so.

Health Care 2016;42:93-8.

17 Government UK, Government response to the independent pregnancy loss review: Care and support when baby loss occurs before 24 weeks' gestation.  
18 Government UK, Government response to the independent pregnancy loss review: Care and support when baby loss occurs before 24 weeks' gestation.  
19 Contribution from provider to the report.

20 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93-8.  
21 Government UK, Women's health strategy for England: Fertility, pregnancy, pregnancy loss, and postnatal support.  
22 CoSRH, Hatfield Vision: Two Years in: Progressing our Sector's Consensus Ambitions for Reproductive Health Outcomes (2024).

It is women and their experiences who are central to this report. Their testimonies show us the barriers women still face in accessing contraceptive care during and after pregnancy.

It is for this reason we came together, as Presidents of the CoSRH and RCOG to show how SRH and maternity professionals are united in consensus for this report's ambition and recommendations.

We both warmly welcomed the Government's commitment in its Manifesto:

***"Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS"***<sup>23</sup> as well as the intention to strategically rebuild the NHS so it is fit for future generations.

Specifically, in its 10 Year Plan for the NHS, the Government recognises the longstanding issue of fragmented commissioning and the detrimental impact of this particularly has on women's experiences of health services.

The provision of PPC perfectly exemplifies the consequences of this fragmentation as clinicians and patients are forced to fight siloed arrangements to be able to deliver the essential care regarded as 'common sense' by many.

The Government now has an opportunity to introduce the clarity, accountability and collaboration into PPC provision that is urgently needed. This will be implemented alongside the welcome shifting of services towards preventative, efficient care in the community that will improve outcomes and tackle health inequalities - all goals that are central to PPC provision.

We strongly believe that ensuring access to contraception should be a key priority for this Government, including a focused effort to improve the provision of PPC. The Government's key stated ambitions for the health service, to strategically shift services towards preventative, efficient care in the community that will improve outcomes and tackle health inequalities, are all goals that are central to PPC.

We sincerely thank all individuals, professionals and organisations who have given their time and expertise to contribute to this report and to the delivery of PPC services across the UK.

We warmly welcome the report's recommendations and very much look forward to working with colleagues in the health sector and policymakers across the country to ensure that all women and their partners are able to access the contraceptive care they need post-pregnancy.

Dr Janet Barter is President of the College of Sexual and Reproductive Healthcare and a Consultant in Sexual and Reproductive Healthcare in East London. After medical training in Sheffield, and time as a GP trainee, she embarked on a career in Obstetrics and Gynaecology, driven by a strong interest in women's health shaped by experiences in the UK and West Africa.



As the specialty of SRH developed she became embedded in the Specialty as a Consultant, Educator and Leader and has worked clinically across the whole sphere of SRH.



Dr Janet Barter

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Prof Ramee Thakar

President,  
The Royal College of Obstetricians and Gynaecologists

<sup>23</sup> The Labour Party, Change Labour Party Manifesto 2024.



# Key Statistics

## IN BRITAIN

around  
**45%**

of pregnancies  
are unplanned  
or ambivalent<sup>24</sup>



FERTILITY RETURNS  
POST-BIRTH WITHIN

**21 DAYS**<sup>25</sup>

**1 IN 8**

parous women conceive and  
continue another pregnancy

**WITHIN A YEAR  
OF A PREVIOUS BIRTH**<sup>26</sup>

ABORTION STATS ARE  
AT A RECORD HIGH, WITH

**17%**

**INCREASE**

IN COMPARISON TO THE  
PREVIOUS YEAR IN 2022<sup>27</sup>



An increasing  
proportion of  
abortions in women  
who already have  
children<sup>28</sup>

**ALMOST  
HALF**

of women  
resumed some  
form of sexual  
activity within

**8 WEEKS**  
of delivery<sup>29</sup>

- ALMOST -  
**1 IN 13**

women presenting for  
an abortion or delivery  
had conceived

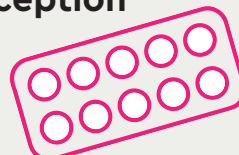
**WITHIN 1 YEAR**  
OF A PREVIOUS BIRTH<sup>30</sup>

Miscarriage is the  
most adverse  
pregnancy outcome

**IN THE UK  
10% TO 15%**

**OF ALL  
PREGNANCIES END  
IN MISCARRIAGE**<sup>31</sup>

**ALMOST** **1/5**  
of women  
are unable to  
access their preferred  
method of postnatal  
contraception<sup>32</sup>



**PROVIDING  
CONTRACEPTION  
SERVICE**

in maternity settings  
has an estimated

**SAVINGS OF  
£32**

to the public sector for  
every £1 invested<sup>33</sup>

24 The National Survey of Sexual Attitudes and Lifestyles (Natsal-3).

25 NHS.uk. Sex and contraception after birth

26 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93-8.

27 Office for Health Improvement and Disparities. Abortion statistics for England and Wales: 2022.

28 Office for Health Improvement and Disparities. Abortion statistics for England and Wales: 2022.

29 Moffat M, Jackowich R, Möller-Christensen C, Sullivan C, Rankin J. Demographic and pregnancy-related predictors of postnatal contraception uptake: A cross-sectional study. BJOG. 2024; 131(10): 1360-1367.

30 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plann Reprod Health Care 2016;42:93-8.

31 Glasier A, Bhattacharya S, Evers H, Gemzell-Danielsson K, Hardman S, Heikinheimo O, La Vecchia C, Somigliana E; Annual Capri Workshop Group. Contraception after pregnancy. Acta Obstet Gynecol Scand. 2019 Nov;98(11):1378-1385. doi: 10.1111/aogs.13627. Epub 2019 May 13. PMID: 31001809.

32 Moffat M, Jackowich R, Möller-Christensen C, Sullivan C, Rankin J. Demographic and pregnancy-related predictors of postnatal contraception uptake: A cross-sectional study. BJOG. 2024; 131(10): 1360-1367.

33 Public Health England. PHE Women's Reproductive Health Programme 2020 to 2021.

# Why is Post-Pregnancy Contraception Important? The Clear Case for Action:

## It's what women want:

*"I had to ask about contraception myself, and then I was told I could have it at the same time as my caesarean."*

*"I wanted to talk about the coil and implant [before birth]."*

*"Obviously, [...] we had, we had to speak about these kind of things. Because, obviously, I dinnae want to be falling pregnant, straight after, [...] And, yeah, it kind of helped me a lot [...] I didn't know that, like, I could get it [the implant] put in straightaway after [...] I thought I had to wait, like, a couple of weeks."*

Guidelines recommend that individuals wait 12-24 months after giving birth before trying to get pregnant again to optimise maternal recovery, reproductive autonomy and improve health outcomes for future pregnancies.<sup>34</sup>

The CoSRH and The National Institute for Health and Care Excellence (NICE) guidance state that service providers should ensure all women have access to the full range of effective contraceptive methods immediately after childbirth and all other pregnancy outcomes such as miscarriage, stillbirth, neonatal death, molar or ectopic pregnancy, or abortion.<sup>35</sup> Additionally, Sands, the UK's leading pregnancy and baby loss charity, guidance advises healthcare professionals to approach these conversations with compassion, empathy and sensitivity, recognising emotional context and individual needs, as outlined in the National Bereavement Care Pathway (NBCP).

However, access to contraception is highly variable to women across the UK. While all women and service users should be able to access contraception from primary care and sexual health services, in reality, women can face huge barriers in doing so, as shown in a recent report from the British Pregnancy Advisory Service (BPAS) which surveyed over 1,000 women aged 18-45 and found that nearly half of women face barriers to accessing contraception.<sup>36</sup>

**Consensus from contributors to this report is that these barriers are often intensified, worsened or exacerbated with a newborn baby.**

The case for improved PPC is clear to providers who see how with a new baby, accessing contraception can be understandably even more difficult to access or prioritise.

**"PPC is an essential aspect to empower women who are often under significant pressures to support a newborn and or other children."**

York and North Yorkshire PPC service

**"PPC is important to us, because contraception is important to us, and the health of women and their families now and moving forwards is important to us. I find it frustrating that we are able to do many, many complex things for women and their babies without even thinking about it, but we are unable to easily provide one of the most basic forms of healthcare, one that has very valuable benefits to women and their families."**

South Tees PPC service

## PPC Can Help Tackle Health Inequalities:

**The Government has made clear that reducing health inequalities is at the heart of its vision for the future of the NHS.** Several contributors to this report outlined how PPC has successfully reduced health inequalities in their local area by facilitating access to essential services and engaging with typically 'easy to ignore' groups.

By flexibly providing contraception to women post-pregnancy in circumstances that suited them, they are improving women's outcomes, particularly those who may find it harder to access SRH services:

<sup>34</sup> World Health Organization. Birth spacing: A policy brief, 2005; College of Sexual and Reproductive Healthcare. Contraception after pregnancy: Guideline, January 2017; National Institute for Health and Care Excellence. Quality statement 4: Contraception after childbirth, 2016.

<sup>35</sup> College of Sexual and Reproductive Healthcare. Contraception after pregnancy: Guideline, January 2017; National Institute for Health and Care Excellence. Quality statement 4: Contraception after childbirth, 2016; UK Parliament. CDP-2025-0038: Women's Health.

<sup>36</sup> British Pregnancy Advisory Service, Contraception Re-Imagined: The Unfinished Revolution, March 2025.

**"In one instance, a 15-year-old planned to have an implant fitted postnatally but was too distressed on the ward due to a transfer to a mother-and-baby foster placement. A follow-up home visit enabled timely contraception."**

**"Another woman with learning difficulties was supported over multiple appointments using simplified resources, while a mother with mental health challenges accessed a virtual consultation and felt empowered by the process."**

Quotes from Gloucestershire PPC service

**"By embedding contraception provision into routine maternity care, the service ensures women are supported with timely, effective options that align with their needs and circumstances, ultimately promoting reproductive autonomy and reducing health inequalities across Greater Manchester."**

Greater Manchester  
PPC service

**"Women from Black and ethnic minority backgrounds and lower socioeconomic groups are at greater risk of physical and psychiatric conditions of pregnancy when compared to white British women. Without appropriate education about risk factors, such as obesity and smoking, as well as effective and robust mechanisms for follow-up beyond the traditional postpartum period of 6 weeks, these inequalities are reinforced."**

Commissioner, Bedfordshire, Luton and Milton Keynes ICB

Contributors agreed that providing PPC helps to address wider public health inequalities and improve health outcomes for mothers in the most deprived areas while they are already in contact with health service.

This echoes academic research into PPC:

**"Our [research] results also highlight the potential for contraception provision on the postnatal ward to reduce inequalities in access to contraceptive services as 10% of our sample had never used any contraception."**

Thwaites A, Logan L, Nardone A et al.'s study.<sup>37</sup>

Importantly, echoing existing research, contributors were keen to stress that a universal approach to providing PPC was essential to tackling inequalities. Only by ensuring that all pregnant people and their partners, regardless of their background or circumstances, receive an offer of contraception can a service can address the needs of all vulnerable populations and reduce disparities.<sup>38</sup>

### PPC Can Provide Huge Cost-Benefits to the NHS:

A strong argument in favour of improving the provision of PPC is its huge potential for cost-saving benefits to the NHS and wider health system.

The cost of training and initial contraceptive supply is offset by public health and financial savings including on:

- Reduced rates of unplanned and high-risk pregnancies
- Decreased demand on primary care, abortion and maternity services
- Prevention of complications associated with short birth intervals

37 Thwaites A, Logan L, Nardone A, et al. Immediate postnatal contraception: What women know and think BMJ Sex Reprod Health 2019;45:111-117.

38 Heller R, Cameron S, Briggs R, et al. Postpartum contraception: a missed opportunity to prevent unintended pregnancy and short inter-pregnancy intervals. J Fam Plan Reprod Health Care 2016;42:93-8.

# Government analysis of the return of investment of contraception found that it could lead to savings of £32 over a 10 year period for the system as a whole, for every additional £1 invested.<sup>39</sup>

In relation to post-pregnancy contraception in particular, the cost savings are stark:

**"Over 10 years, based on an estimated 64% uptake of postnatal contraception on maternity wards, total cost savings to the NHS and wider system would amount to £150 million, comprising £59 million for the NHS, £9 million for local authorities, and £82 million for other government departments."<sup>40</sup>**

These estimated savings compare highly favourably with other public health interventions such as childhood vaccinations or HIV Prevention (PrEP) which have been implemented.<sup>41</sup>

**This is critically important in the current financial context and the significant reductions facing Integrated Care Board (ICB) budgets.**

Importantly, in areas such as York and North Yorkshire, contributors for this report set out how improving PPC provision allowed them to optimise efficiency of their resources, and become more operationally cost-effective:

**"Allowing new mums the access to a safe and inexpensive contraception in their own home at a time when they were juggling a new baby [...] the POP [progestogen-only pill] six-month supply cost was £2.62 this is a cost-effective bridging method which allowed women an opportunity to consider their next contraception plan without having to rush a decision."**

York and North Yorkshire PPC service

Many contributors noted how providing contraception at this point, when women are already in contact with the health system, is resource efficient and eases pressure on other services in primary or community care where women would have had to make additional appointments to access contraception – which then become avoidable and unnecessary.

It is crucial to note that PPC also provides valuable non-contraceptive uses to many women. For example, it can support the management of menstrual disorders or heavy menstrual bleeding, as acknowledged in the Women's Health Strategy:

**"Contraception also has an important wider role in women's lives – for example, managing symptoms of menstrual problems, gynaecological conditions and perimenopause. Through management of gynaecological conditions, contraception also supports women and girls to reach their full potential in education or the workplace."<sup>42</sup>**

The better management of such conditions through PPC would undoubtedly help ease pressure on other primary and community services in the health service. This is particularly welcome as absenteeism from work due to heavy and painful periods, endometriosis, fibroids and ovarian cysts costs the UK economy nearly £11 billion every year.<sup>43</sup> Improving PPC access may help reduce health-related work absences and deliver savings in both healthcare costs and lost productivity.

## Improved PPC Provision Can Empower Women and Improve Their Health Literacy:

Contributors were in consensus that in addition to reducing pressure on other healthcare services across contraception, sexual health and women's health, PPC educates and empowers women and their partners to make informed decisions about their families – improving health literacy and maternal and child health outcomes:

**"Better public awareness of these issues would also help women make an informed choice as to when to have their next pregnancy and whether to access immediate post-natal contraception."**

Dr Georgina Forbes, Specialist Doctor in SRH and the CoSRH Wales Committee Chair

## PPC is a Global Maternal Health Priority:

This domestic progress echoes a growing global consensus from countries such as Australia and the US that PPC is not only a matter of women's autonomy but a key strategic tool to address reproductive health inequalities. The UK has an opportunity to become a world leader in providing PPC, tackling reproductive health inequalities while also bringing financial savings to the NHS.

<sup>39</sup> Public Health England. PHE Women's Reproductive Health Programme 2020 to 2021. Cost effectiveness analysis has also demonstrated that immediate contraception provision at the time of a medical abortion is more cost-effective than delayed provision.

<sup>40</sup> Public Health England, Extending Public Health England's contraception return on investment tool, maternity and primary care settings.

<sup>41</sup> Ong KJ, Desai S, Field N, Desai M, Nardone A, van Hoek AJ, Gill ON. Economic evaluation

of HIV pre-exposure prophylaxis among men-who-have-sex-with-men in England in 2016. *Euro Surveill.* 2017 Oct;22(42):17-00192.

<sup>42</sup> Government UK. Women's health strategy for England: Fertility, pregnancy, pregnancy loss, and postnatal support.

<sup>43</sup> NHS Confederation. Women's health economics, 2024.

# The Postcode Lottery of PPC and Commissioning Barriers across England

Across England, the provision of PPC is a postcode lottery and highly determined by chance of living in an area where dedicated and passionate local healthcare professionals have succeeded in overcoming systemic barriers.

Most significantly these barriers include problematic commissioning structures, unsustainable funding arrangements, and often others within a local health system seeing PPC as a 'nice to have,' a 'luxury' or not a priority.

- The format and length of contraceptive counselling received by the women
- When the counselling and provision was provided throughout the maternity journey
- What contraception methods were available to women and how they could access them
- How consistently could this be provided to women within an area or service itself

Findings from a **Greater Manchester** patient satisfaction survey demonstrate the inconsistency of PPC provision even within a specific geographic area:

**49%** of women reported that contraception was never discussed with them in the antenatal period prior to the piloting of the service.

**54%** of women would like to start contraception before leaving hospital, or within 4 weeks of birth.

**53%** of women reported that contraception was discussed with them on the postnatal ward before the piloting of the service.

Additionally, the fragility of an existing PPC services was apparent in many service provider's contributions to the report:

**"The removal of one of these clinicians [on the PPC service] would likely cause the collapse and loss of any contraception currently being provided."**

Georgina Forbes, Specialist Doctor in SRH and the CoSRH Wales Committee Chair

**"Access remains limited and inconsistent. It is also reliant on the goodwill of all involved and subject to change at any time."**

Norfolk and Waveney PPC service

Even within established PPC services, the provision of certain contraceptive methods was inconsistent, for example at The Royal London Hospital:

**"The subdermal implant can theoretically be offered at all sites, depending on the availability of trained staff on any one day. Provision varies across sites."**

Royal London Hospital, Barts NHS Foundation Trust PPC service

This lack of standardised provision is despite a pregnant women frequently coming into contact with health services during their pregnancy journey, providing ample opportunity to consider PPC:

Overall, contributions from providers to this report made clear the regional variability and lack of a standardised PPC offer to women. They called for a 'Once for England' approach – seen elsewhere in the UK in Wales and Scotland, where collaboration and a standardised approach improves efficiency, consistency, and quality of care.<sup>44</sup>

In some areas of England, the provision of PPC is practically non-existent. Even in areas where there is some PPC provision or an established PPC service, significant variation exists between them as to:

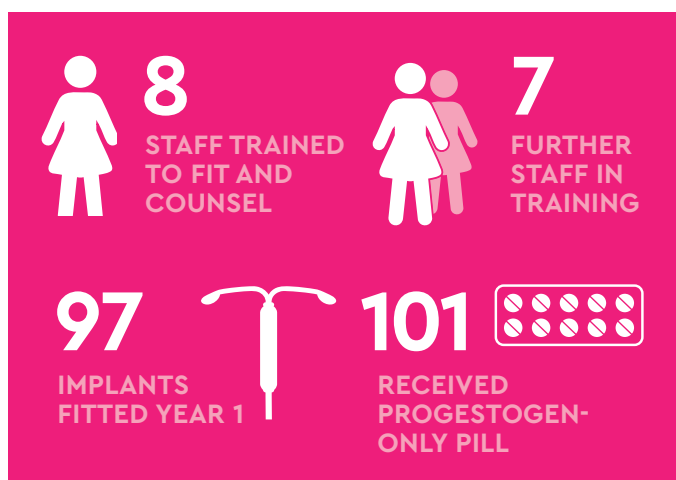
<sup>44</sup> 'Once for Scotland' Workforce Policies Programme

Across the country, there are several examples of impressive progress which has been made to establish comprehensive PPC offers to women locally:

For example, in Gloucestershire:

***"The [PPC] pilot revealed that 68% of pregnancies among the target population (women with vulnerabilities) were unplanned. Results [from this pilot] demonstrated that 90% of women discussed contraception with their midwife, 89% made a contraception plan antenatally, and 76% received their preferred method prior to discharge... Over 94.7% women received contraceptive counselling post-birth."***

In Liverpool, data from the first year of their PPC service showed:



In Bedfordshire:

***"One of our trusts has operationalised the pathways, and contraception is now available to mothers attending this unit for maternity care. All mothers are offered a fitting during the time of caesarean section. To date we know 80 IUDs have been inserted post-caesarean section."***

This is due to the dedication, skills and commitment of local healthcare professionals who have overcome significant barriers and won the 'hearts and minds' of colleagues to establish services for local women.<sup>45</sup>

For example, in Bradford and Craven:

***"We learned that change takes more than clinical protocols; it takes cultural transformation. When the Progesterone Only Pill (POP) was delivered by pharmacy to the Birth Centre, it was returned by the staff, stating they do not dispense this medicine."***

In addition to regional variation in PPC services, what was also evident from the contributions to the report was how many now successful PPC services had struggled to set up services initially, facing bureaucracy and operational barriers. For example, in South Tees:

<sup>45</sup> These professionals include Vicki Pirie, Lead Contraception Midwife in Gloucestershire, James Woolgar, Chair of English HIV and Sexual Health Commissioners' Group (EHSCHG), Gillian Matthews, Specialist Midwife in London and Frances Lamb, Consultant Obstetrician in South Tees.

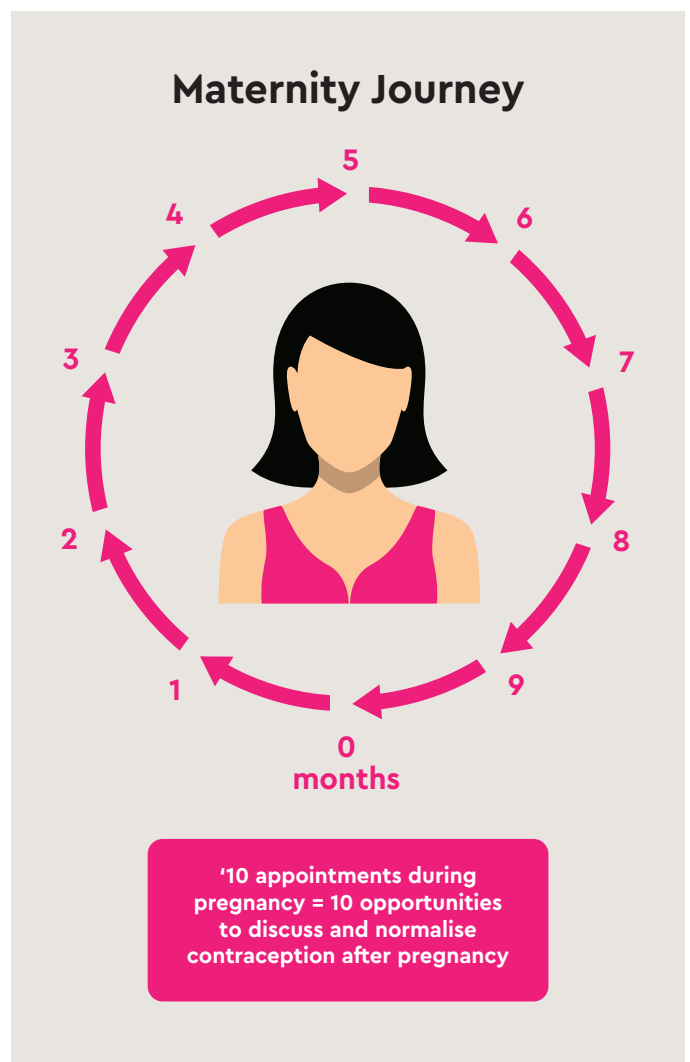
***"The initial set up of the service was very difficult and it is equally difficult to maintain and expand it. It took us over a year of negotiations with Sexual Health and our finance department to get the funding for coils and implants in place."***

### The 6-week Postpartum Check with a GP

Moreover, many contributors outlined how the inconsistency and absence of PPC provision antenatally and in the immediate postnatal period means that currently avoidable pressure was being placed on GPs at the 6-week postpartum check.

Echoing this, an online survey of UK mothers reported that for over half of the respondents, the 6-week GP postpartum visit was the first time contraception was properly discussed.<sup>46</sup>

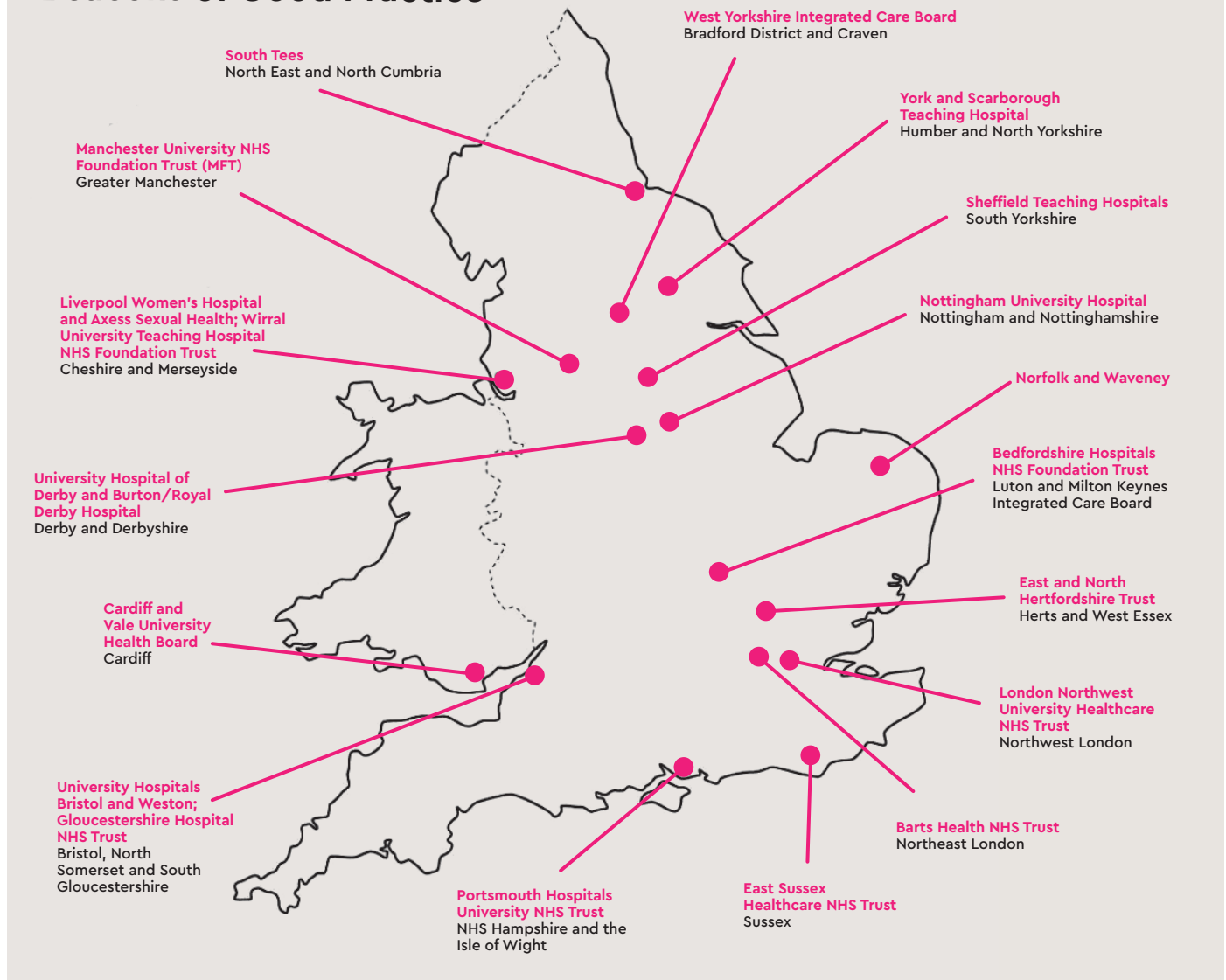
Indeed, GPs have long reported the pressures and competing priorities of the postnatal visit, as well as the need for additional appointments to provide LARC.<sup>47</sup>



<sup>46</sup> BPAS, Mumsnet/BPAS survey shows gaps in contraception care for new mums – unclear advice to breastfeeding women raises risk of unplanned pregnancy (2012).

<sup>47</sup> Lunniss H, Cameron S, Chen ZE. Views of general practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: a qualitative study. J Fam Plann Reprod Health Care 2016; 42:99-106.

## Beacons of Good Practice



Depending on the GP practice, either 10 or 20 minutes were allocated for this consultation, which was the only dedicated time to discuss all aspects of the mother's health in the postpartum period and would not easily facilitate comprehensive personalised contraceptive counselling, which may be needed.<sup>48</sup>

Additionally, there are concerns that women do not always attend this check-up:

***"Our trouble is not all women come for their 6-week check. We're in a deprived area and many forget all about coming."***<sup>49</sup>

Research has shown that only 50% of women who plan to initiate LARC postnatally do not attend a follow-up appointment to have this fitted after birth.<sup>50</sup> This raises valid arguments that discussions about PPC should be had antenatally, earlier in the maternity journey, when women are already in contact with services to avoid 'missing' the opportunity for women to receive comprehensive contraceptive counselling:

***"I can certainly think of one or two quite young women who have got pregnant very quickly after having the first baby, and you wonder whether you might in some cases miss it."***<sup>51</sup>

With improved PPC throughout the pregnancy journey, particularly antenatally, when women are already in contact with health services, contributors stated they believed this could ease pressure on primary care services such as GPs and potentially prevent unintended pregnancies.

Our contributors also told us that best practice of PPC utilised healthcare professionals in the community, including health visitors, midwives, to facilitate access to this service post-pregnancy:

***"Where our health visitors identify the need for vulnerable mothers to access post-natal contraception, we defined a fast-track"***

48 Lunniss H, Cameron S, Chen ZE. Views of general practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: a qualitative study. *J Fam Plann Reprod Health Care* 2016; 42:99-106.

49 Lunniss H, Cameron S, Chen ZE. Views of general practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: a qualitative study. *J Fam Plann Reprod Health Care* 2016; 42:99-106.

50 Lunniss H, Cameron S, Chen ZE. Views of general practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: a qualitative study. *J Fam Plann Reprod Health Care* 2016; 42:99-106.

51 Lunniss H, Cameron S, Chen ZE. Views of general practitioners on providing contraceptive advice and long-acting reversible contraception at the 6-week postnatal visit: a qualitative study. *J Fam Plann Reprod Health Care* 2016; 42:99-106.

*pathway via our local sexual and reproductive health services. This was important for supporting our vulnerable mothers."*

Commissioner, Bedfordshire, Luton and Milton Keynes ICB

As the Government continues to shift healthcare away from GPs and Emergency Departments into the community and neighbourhood models of care, as outlined in the 10 Year Health Plan, PPC models such as those quoted in this report provide excellent examples of integrating care in the community, and how to prevent avoidable pressure on primary care services and reduce health inequalities.

### The Existing Barriers Caused by Commissioning Arrangements

There was unanimity among contributors that the current commissioning arrangements pose a significant barrier to making this a reality and can often paralyse clinical enthusiasm to offer PPC more routinely.

The 2012 Health and Social Care Act transferred the full responsibility for contraception provision in England from the NHS to local authorities, NHS England, and Clinical Commissioning Groups (which have since been subsumed into Integrated Care Systems (ICSs)). Table 1 sets out these commissioning splits:

**Table 1: Commissioning of SRH Services in England\***

Local Authorities	Integrated Care Boards (ICBs)	NHS England
<ul style="list-style-type: none"> <li>✓ Comprehensive Sexual Health Services, incl. most contraceptive services and all prescribing costs, excluding contraception provided by GPs.</li> <li>✓ LARC provision in primary care (GP) incl. Implants and IUDs/IUSs (for contraception purposes only)</li> <li>✓ Sexual health specialist services incl. youth sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies</li> <li>✓ Support for teenage parents</li> <li>✓ STI testing and treatment, chlamydia screening and HIV testing; partner notification</li> <li>✓ HIV pre-exposure prophylaxis (PrEP) provision (activity, not drug costs)</li> <li>✓ Sexual health aspects of psychosexual counselling</li> </ul>	<ul style="list-style-type: none"> <li>✓ Maternity services</li> <li>✓ Gynaecology services (incl. contraception for non-contraceptive purposes)</li> <li>✓ Abortion services, incl. contraception, STI &amp; HIV testing in abortion pathway</li> <li>✓ Female &amp; male sterilisation (vasectomy)</li> <li>✓ Non-sexual health aspects of psychosexual health services</li> <li>✓ HIV/STI testing and STI treatment - if clinically indicated or at the request of a patient.</li> <li>✓ Adult specialist services for people living with HIV</li> </ul>	<ul style="list-style-type: none"> <li>✓ Contraception under GP contract</li> <li>✓ Pharmacy contraception scheme</li> <li>✓ Cervical screening</li> <li>✓ HPV immunisation</li> <li>✓ Specialist fetal medicine services, incl. late termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks</li> <li>✓ NHS Infectious Disease in Pregnancy Screening</li> <li>✓ HIV testing when clinically indicated in NHSE-commissioned services &amp; treatment</li> <li>✓ Sexual assault referral centres</li> <li>✓ Sexual health elements of prison health services</li> <li>✓ PrEP medication costs</li> </ul>
<p><b>Source:</b> Making it work; Health and Social Care Act 2012; Care Act 2014; Health and Care Act 2022; Commissioning local HIV sexual and reproductive health services</p>		

Commissioning bodies share budgets and contractual mechanisms to reduce fragmentation and improve outcomes to facilitate simple solutions where capacity, priority, timing and relationships enable this to happen.

\* The Government has announced that by 2025 NHSE will be brought into the DHSC so future commissioning arrangements are unclear.

For example, in Hertfordshire:

***"This lack of clarity and the absence of collaborative commissioning creates inconsistencies in delivery and inequities in provision between Trusts in different areas of the country."***

Local authorities responding to the English HIV and Sexual Health Commissioners' Group survey on PPC echoed this challenge when asked about the obstacles for providing PPC:

***"Lack of clarity over whose responsibility it is in a very difficult funding climate."***

***"Lack of national guidance about commissioning responsibilities."***

***"The commissioning responsibilities for maternity and contraception being separate doesn't help."***

The Government's 10 Year Health Plan rightly acknowledges the particular challenges women face in navigating the health system and the ongoing fragmentation of women's health services.

Indeed, the current system does little to support the reality of women's lives, leaving them to try to manage their reproductive and post-reproductive health across siloed, disjointed services.

The Government's stated intention to increase integration, collaboration, and clarity across the NHS presents an opportunity to fix the fragmented commissioning structures surrounding women's health and contraception, while empowering ICBs to plan and deliver the services women need across the life course, including PPC.

### **What is Needed to Deliver Better PPC? The View of Local Authorities**

*"More clearly defined commissioning responsibility with clear funding and accountability to support."*

*"First, national policy and commissioning structures must evolve to reflect the reality that contraception is a core component of postnatal care."*

*"Promote consistent commissioning guidance nationally: standardise expectations across Integrated Care Boards to avoid regional variation."*

**With the merging of NHSE and the DHSC and the Government's welcome stated focus on integration, accountability and clarity in the health system, comes an ideal opportunity to fix the fragmented commissioning structure around women's health and contraception:**

- a. The DHSC should ensure that each ICB has a named individual who is formally accountable for the joined-up commissioning of contraception and women's health services, including post-pregnancy contraception, always in collaboration with local authority partners. This role should carry clear responsibility and authority to coordinate service delivery. This accountability is essential to empower ICBs to plan and deliver the services women need.
- b. The DHSC should support and promote best practice of co-commissioning of PPC services, for example, creating a national forum to share examples amongst ICBs.

- c. Local Women's Health Champions and the Women's Health Ambassador/National Clinical Director for Women's Health should maintain national oversight of commissioning decisions to ensure the needs of women are met throughout the life course.
- d. Merging NHSE and DHSC also brings an opportunity to bring together and merge the expertise of the women's health and reproductive health policy teams which currently sit separately. This will help to enable joined-up policy around the holistic needs of women across the life course.
- e. Moving NHSE into the DHSC also brings an opportunity to bring together and merge the expertise of the women's health and reproductive health teams which currently sit separately. This will help to enable joined-up policy around the holistic needs of women across the life course.

**At a minimum, providers of PPC are desperate for the Government to make clear the responsibility for PPC in the maternity pathway to avoid PPC continuing to be seen as a luxury by too many and causing the entrenchment of health inequalities.**

### **The Impact of Commissioning Arrangements on Funding**

Contributors were also in strong consensus that PPC commissioning structures across England resulted in highly unsustainable funding arrangements, and this presents an immense obstacle to delivering the service for women in their local area.

With no detail or clear accountability as to who is responsible for the commissioning of maternity contraception, funding, sustainability and staff training cost remain unclear and variable by area:

***"[PPC] doesn't actually sit anywhere in terms of commissioning responsibility, so you're often working with willing leads in areas, forging your own local direction and clarity around who should pay for what. This undoubtedly leads to variable offers at local level. Consistency is key."***

**James Woolgar, Chair of the ESHCG**

Vast amounts of time and resource is spent by healthcare professionals organising, negotiating and securing funds for this service across multiple funding pots – an avoidable waste of clinical time in a pressurised health system.

For example, in Portsmouth the PPC service is funded by various existing services:

- Maternity covers the cost of POP and injectable training and provision
- Obstetrics fit IUCDs at C-section within their provision of care
- Public health covers the cost of the IUCDs and condoms in maternity settings
- Public health fund the integrated sexual health service who provide the follow up of IUCDs at elective c-section following 4 weeks post fit

- All other provision is 'business as usual', including the outreach within the integrated sexual health service
- Public health lead on overview of the programme and reducing inequalities through equitable opportunities.

In Bradford Teaching Hospitals Foundation Trust (BTHFT):

***"To date, provision of contraception and training has relied on ad hoc funding."***

This makes the PPC service highly exposed to cuts or withdrawal of funding as responsibility for its provision is so unclear.

For example, in Derbyshire the service is no longer able to provide any form of PPC service due to withdrawal of public health grant funding, something they find "really concerning".

Additionally, in South Tees, the £30 fit fee the PPC service received from the local sexual health service had been planned to contribute towards training the next cohort of staff delivering the PPC. However, it was subsumed into the local ICB budget as PPC is not a mandatory requirement and was therefore not deemed a local priority.

Often these healthcare professionals had spent a huge amount of time and effort to secure sustainable funding but instead found arrangements siloed and challenging:

***"There is currently no funding from maternity for this service and no funding for maternity staff time or training to provide contraception."***

Particularly in a climate where ICB budgets are being reduced substantially, contributors were highly concerned about the future of PPC services.

***"We have been trying to get this established for years but ICB colleagues are not able to commit to funding or even jointly funding this."***

Local authority responding to ESHCG's survey

Overall, with no one clear part of the health system responsible for providing PPC, commissioning, provision and funding is highly precarious. Contributors were in absolute consensus that this was the most significant obstacle to the provision of PPC, and urged for a 'Once for England' approach to standardise services through national guidance and clarification to support their strategic plans locally.



# Conclusion

The provision of PPC has been an overlooked area of policy nationally – reflecting the historic neglect of women's health by successive generations of policymakers.

This Government has promised to bring this to an end and prioritise women as they reform and rebuild the NHS. The 10 Year Health Plan reiterated this commitment and recognised the particular difficulty women have faced with the NHS fragmentation in the past, leaving essential care siloed, disjointed and un navigable for patients.

Some areas across the UK are offering and delivering invaluable PPC services to women; despite the lack of clarity, transparency or accountability in the system, and the absence of robust national direction. However, these services face significant barriers to maintaining sustainable funding and resources in a climate of financial reductions, cuts and closures.

In producing this influencing report, providers have expressed how their service may be at risk of closure without support and investment. This would leave women without an essential, efficient, and important service.

PPC provision is too often seen as a luxury, and in reality, its provision is more likely non-existent. Too many women are

without access to services which can inform, empower, and provide them with the reproductive freedom they need to live their life to the fullest when they need it most.

However, the improvements needed require support, guidance, and commitment at a national level.

The Government now has an opportunity to ensure that PPC provision is not simply a postcode lottery, dependent on local goodwill and the sheer determination of individuals but is embedded in all local health systems.

We know that post-pregnancy contraception offers financial savings with returns of around £32 per £1 invested.<sup>52</sup>

For providers and women alike, it is common sense to improve PPC provision and eliminate the PPC deserts that currently exist, to improve women's reproductive autonomy, reduce unplanned pregnancies, and facilitate efficient service delivery in local communities.

We have developed recommendations aimed at Government, the NHS, ICBs and other policymakers to ensure that women wherever they are can receive this essential service, considered a lifeline by so many.

**Women's voices have been clear in their support for PPC and the crucial care it provides to them.**

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<sup>52</sup> Public Health England. PHE Women's Reproductive Health Programme 2020 to 2021.

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English HIV and Sexual Health Commissioners Group

Gloucestershire Maternity Contraception Project

Hertfordshire County Council

Manchester City Council

Saint Mary's Hospital Managed Clinical Services

Salford City Council

Sands Charity UK

Trafford Council

University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

Wirral Community Health & Care NHS Foundation Trust

Women's Voices public engagement group, Sheffield

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**“It is very difficult to understand why postnatal contraception is not prioritised across the UK, and instead left to a small group of motivated staff to try to establish a service.”**

PPC Provider

**“I've seen how it empowers women – we're offering something practical and important at exactly the right time.”**

PPC Provider

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