Maintaining sexual and reproductive health services in the UK during COVID-19

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Received 29 March 2021
Accepted 31 March 2021
Published Online First 20 April 2021

To cite: Mansour D. *BMJ Sex Reprod Health* 2021;**47**:235–237.

INTRODUCTION

No one can deny that the last 12 months have not been easy. The COVID-19 pandemic has brought chaos in the UK to the National Health Service (NHS), devastation to people's lives and a change to our way of life that we would never have thought possible. As I write, more than 120 million people worldwide have tested positive for the virus and more than 2.6 million have sadly died.[1] The positive news is that a number of vaccines are now licensed, and vaccination programmes are rolling out across the globe with G7 countries agreeing to distribute their surplus to low-income countries.[2]

EFFECTS OF THE PANDEMIC ON SRH SERVICES

The four countries of the UK have striven to keep sexual and reproductive health (SRH) services in primary care and the community open, but business is not 'as usual'. Telemedicine and telephone triage/consultations have become the norm. It is no surprise that much less long-acting reversible contraception (LARC) is being fitted and removed in general practice and SRH services as we have struggled with staff sickness, redeployment and strict COVID-19 restrictions. UK prescribing data for 2020 show a 35% drop in the number of implants and a 27% decrease in intrauterine contraceptive devices (IUDs) fitted. Data from 2020 suggest that approximately 121 000 implants were fitted in primary care and 85 000 in community/secondary care compared with 170 000 and 148 000 in 2019. The fitting of copper IUDs and hormonal IUDs fared a little better, with 103 000 fitted in primary care and 153 000 in community/secondary care compared with 140 000 and 209 000 in 2019.[3]

Early in the pandemic it was realised that women with unplanned pregnancies would have great difficulty accessing care. The governments of England, Wales and Scotland gave temporary approval for women to take mifepristone (in addition to misoprostol) at home for medical abortion during the pandemic.[4–6] Several recent UK studies have shown that medical abortion provision delivered by telemedicine away from the clinic/hospital setting is effective, safe and acceptable, leading to shorter waiting times and a lowering of the gestation at which the abortion takes place.[7 8] Many professional bodies including the Faculty of Sexual & Reproductive Healthcare (FSRH) are lobbying the governments of the UK countries to make home use of mifepristone pills a permanent change. We hope this positive step will remain post-pandemic, enabling women to access abortion care in a timely, safe manner without the concerns of unnecessary travel, being away from family and friends, and not having to explain their absence to anyone.

COURSE OF THE PANDEMIC AND FSRH GUIDANCE

In the second half of March 2020, the FSRH Clinical Effectiveness Unit (CEU) set to work interrogating the literature and producing guidance on extending the use of LARCs during the pandemic.[9] This was invaluable when in-person consultations were impossible. We were also being asked about the use of combined hormonal contraception (CHC) in those who contracted COVID-19: should they change to a progestogen-only method owing to the thrombogenic nature of this infection? The CEU were the first to produce guidance that is supported by our international SRH community, namely that those women who are asymptomatic with COVID-19 can continue taking their CHC. For those with symptoms, the severity of the infection and immobility of the users should be assessed, and alternative contraception discussed. In the seriously ill requiring hospitalisation, CHC should be stopped and alternative methods started prior to hospital discharge. There is still uncertainty about

when to restart CHC in this group as venous thromboembolism risk continues for several months following COVID-19 recovery.[10]

Bridging with a progestogen-only pill (POP) was and still is an easy option, with electronic prescribing and pharmacy pickup or delivery available to many or alternatively a 'click and collect' system. We are pleased to see that the Medicines and Healthcare products Regulatory Agency are moving forward with plans to have a desogestrel POP available to buy in pharmacies subject to a positive public consultation.[11]

The FSRH Clinical Standards Committee, together with FSRH Officers and FSRH staff, worked tirelessly to offer guidance on essential SRH service provision and supporting safe practice in the clinical environment. It became clear that much of our work could initially be undertaken by telephone or video call. Where practical procedures were required, limiting both the number of individuals attending and the time that people spent in the surgery/clinic is important, using the largest available room, having good ventilation and appropriate personal protective equipment all help to ensure a safe working environment. Healthcare staff are now being vaccinated, but I think our working practices will not change greatly for the foreseeable future.[12]

FSRH produced a joint statement with the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives to support the immediate provision of contraception post-delivery including LARCs.[13] In 'normal' times women can find it difficult accessing contraception while looking after a newborn, and during the pandemic this has been particularly difficult. A number of UK obstetric units now provide LARC fitting before discharge. The FSRH and RCOG have specially designed training packages for obstetricians and midwives to ensure safe contraceptive provision. Options should be discussed in the antenatal period and, as a minimum requirement, all new mothers should be offered a POP as postpartum bridging contraception until LARCs are fitted by primary or community services.

LOOKING TO THE FUTURE

Who could have predicted the speed of change seen in the NHS during 2020? Hopefully in the next 12 months we will consolidate what works well but also be cognisant of the enormous task s ahead of managing mental health issues in staff and patients as well as the backlog of those awaiting surgery. I have concerns that we have failed young people, as the number of under-18s seeking contraception advice during the pandemic has fallen. We also are aware that vulnerable 'hard-to-reach' groups have found telephone triage a challenge. This must be our focus in the months to come, allowing flexibility to return to SRH and new service models supporting SRH in clinical hubs where patient needs are met, rather than the 'silo' mentality of the past where multiple NHS cost-inefficient attendances were the order of the day.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

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