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Ideas that change health and care

Understanding trends in use of abortion services in England: an exploratory briefing

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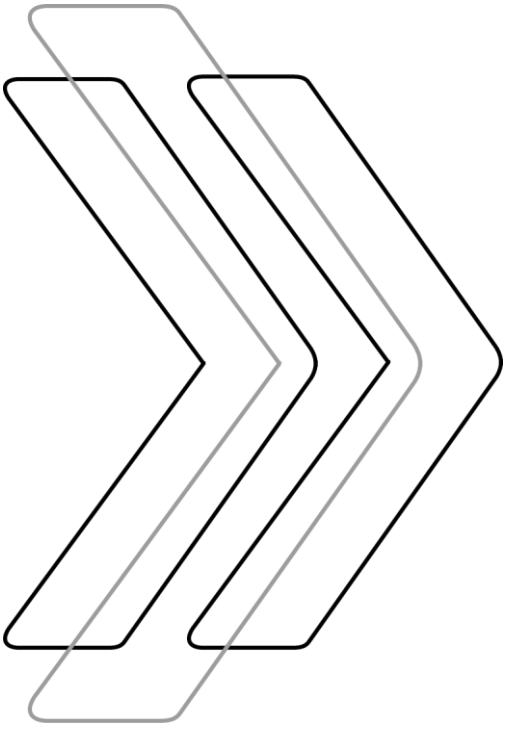

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Contents

Key messages 5

1 Introduction 8

Our approach 9

Structure of this report 10

2 Policy context 12

Legal regime governing abortion services 12

Commissioning and delivery of abortion and contraceptive services 13

Recent national policy related to reproductive health 16

3 How are patterns of abortion use changing in England? 19

Overall trend 19

Age 20

Previous terminations 21

Deprivation 21

Sexual health services 23

Ethnicity 27

4 What factors may be playing a role in trends in use of abortion services? 29

Macro-economic conditions and financial considerations 29

Social attitudes 32

Sexual behaviours 34

Uptake of, and access to, the range of contraceptive methods 36

How health services are organised and delivered in England 38

5 Conclusions and areas for potential further exploration 42

Concluding messages for policymakers 42

Areas for possible further empirical exploration 44

References 47

Appendix 1 60

Acknowledgements 61

Key messages

- Safe, accessible, high-quality abortion services are an integral part of good reproductive health care.
- Abortion numbers, and rates per 1,000 women of reproductive age, are increasing in England and Wales. The proportion of pregnancies that result in termination has also been increasing for a number of years. Within this, abortion rates among younger women (aged 16–24) have been holding steady or falling, while rates among older women (aged 30 plus) have been increasing.
- There is a long-standing association between deprivation and abortion rates, with more deprived areas seeing higher rates of terminations. Our research indicates that between 2015 and 2019, the deprivation gradient in rates of abortion per conception increased, with conceptions in more deprived areas increasingly likely to result in termination.
- Understanding factors that may be influencing trends in abortion is complex, with numerous social phenomena involved. In this report we explore these phenomena in five inter-linked categories: economic considerations, social attitudes, sexual behaviours and lifestyles, use of contraception, and how health services are organised in England.
- Abortion is an issue around which there continues to be ethical and political challenge. Despite evidence suggesting social attitudes in Britain are becoming more accepting, women having terminations report that social stigma is a lived reality.
- Developments in sexual and reproductive lifestyles are an important aspect of understanding abortion trends. Like in many other countries, women in the UK are having fewer children, and having them later in life. Survey evidence from Britain also suggests sexual behaviours are changing in several ways: on average people are having sexual experiences at a younger age, having more sexual partners over their lifetime, cohabiting slightly later in life, and having sex into later life. One effect of these trends is to increase the period of time over which people need to manage the potential of unplanned pregnancy.
- Evidence indicates a range of factors inform pregnancy decisions among women in high-income countries. Particularly important are

economic considerations – both at the individual level and the macro-economic conditions – which can also be affected by national policy decisions. In England and across the UK today, a combination of factors mean large numbers of working-age people, including people in work and in receipt of social security payments, live on low incomes. The UK economy also displays characteristics which have been shown, in other contexts, to have an association with lower total fertility rates, including a relatively flexible labour market and high housing costs.

- The most common method of abortion is changing. Today the bulk of abortions in England – particularly those occurring before 10 weeks gestation – are delivered medically, by taking pills, rather than by surgical procedure. This has beneficial consequences in making abortion less invasive, but also raises questions about how best to offer holistic support to women having terminations, particularly regarding contraception after a termination.
- Effective contraception provision is a key variable in promoting good sexual health and reducing unplanned pregnancies. Today, many expert stakeholders argue that the model of contraceptive provision in England is sub-optimal with planning responsibilities split between local authorities and clinical commissioning groups (CCGs), which is not conducive to holistic, user-friendly services. Recently there have been reductions in public health expenditure which are likely to have affected some people's access to contraceptive services.
- Increasing supply and accessibility of the full spectrum of contraceptive methods is desirable, alongside improving information and support available to women. No method is 100 per cent statistically reliable, though, and there is evidence that preferences change over people's life course. National data illustrate some changes in patterns of utilisation, such as fewer people having permanent methods of contraception. These may reflect changes in users' choices or developments in clinical practice and supply. Deepening understanding of which methods of contraception fit with people's lives, at different stages, could be an important contribution to improving sexual health and maximising the value achieved by public investment in contraceptive services.
- The government has committed to developing a new sexual and reproductive health strategy. This presents opportunities to improve contraceptive services – both by revisiting the planning and delivery models and the overall funding of contraceptive services.

Implementation of the strategy will need to consider how to embed effective local planning arrangements for sexual and reproductive health within the context of statutory integrated care systems (ICSs), which are expected to be operational from April 2022.

- There is a good case for further research to explore the multi-layered interplay of factors influencing trends in abortion use in England. Women with lived experience, and partners, would be important participants in future empirical research.
- Our work points to the array of factors that play a role in the use of abortion services – only some of which are likely to be amenable to policy intervention. For policymakers, the challenge is to differentiate between a complex lattice of influences and prioritise interventions that could make a positive contribution to the overall sexual and reproductive health of the population.

1 Introduction

In 2020, the Department of Health and Social Care commissioned The King's Fund to explore trends in use of abortion in England (*see* box for information on methods of abortion). In light of developments in numbers of abortions being delivered annually, the objectives of the work were to:

- explore in more detail how patterns of abortion use are changing, with a focus on how they are changing across age groups and social groups
- investigate the factors which may be contributing to trends in abortion use, drawing on published research evidence and qualitative insight from expert stakeholders.

The aim was to provide insight that could inform national policy development and identify areas for further empirical research. The scope was purposefully broad – spanning economic, social and attitudinal, behavioural, medical and other factors. Given the numerous relevant factors, it was recognised that this project was unlikely to provide a definitive account of the factors influencing rates of termination.

The King's Fund initiated work in early 2020; when the extent of the Covid-19 pandemic became clear the work was paused for several months on the basis that it would not be reasonable to engage stakeholders during the period of intense operational pressures related to Covid-19. The work was restarted in late 2020 and completed in the first half of 2021.

Methods of abortion

There are two main types of abortion today: medical and surgical (NHS 2017b).

Medical abortion

Medical abortion involves taking two medications – mifepristone and misoprostol – in sequence, usually a day or two apart. The pregnancy is passed through the vagina after both medicines have taken effect. Generally medical terminations do not require anaesthetic. Early medical abortion is defined as a termination at under 10 weeks gestation using medicine, and is the routine method of termination for pregnancies at less than 10 weeks gestation.

Surgical abortion

There are two methods of surgical termination. Vacuum aspiration, used up to 14 weeks gestation, involves a tube being inserted into the womb, through which the pregnancy is removed using suction. Dilatation and evacuation is used between 15 and 24 weeks of pregnancy and involves removing the pregnancy using forceps and suction. Surgical terminations generally involve some form of sedation or anaesthetic.

Terminations are a statistically safe intervention, although there are small risks to women's physical health, including their fertility (NHS 2017a). In 2020, complications were reported at a rate of 1.2 per 1,000 terminations (Department of Health and Social Care 2021b). A range of perspectives have been expressed in the past about an association between terminations and mental health issues. A systematic review of the evidence indicated that having a termination does not increase a woman's risk of mental health problems (National Collaborating Centre for Mental Health and Academy of Medical Royal Colleges 2011).

Our approach

The insight gathering method for this project involved several strands:

- analysis of publicly available datasets relevant to abortion and utilisation of sexual health services (including contraception).
- a rapid review of published research literature relevant to pregnancy decisions, use of contraception, social attitudes and other related

topics. This involved an exploratory search, using The King's Fund database and supplementary searches using snowballing to identify relevant nodes of literature, rather than a systematic search. Research included quantitative and qualitative and mixed methods work.

- a small number of non-attributable discussions with national stakeholders (n=10). This included a mix of policymakers, researchers, representative bodies, commissioners and provider organisations
- a focus group with people who work for organisations that offer support to women accessing or considering accessing termination services (n=7).

All participants were assured anonymity, and that has been maintained throughout. The relatively short timescale for this piece of work meant that involving women with lived experience was not within scope. Alongside this, a number of limitations are worth noting: our evidence scan focused on research published in the English language only; we focused on research conducted in the UK and other high-income countries; and the circumstances during which the research was carried out, during a global pandemic, may have influenced some of the themes emerging.

Structure of this report

This report summarises the themes emerging from our work in the following structure (*see* box for some points regarding terminology and scope).

- Section 2 provides a short overview of the legal regime for abortion and the current policy context for sexual and reproductive health and care.
- Section 3 outlines the key findings of the quantitative analysis.
- Section 4 distils the insights in the published research, and some derived from expert stakeholders, into a discussion of the high-level factors playing a role in abortion trends.
- Section 5 sets out some concluding messages for policymakers and identifies a small number of subject areas where more in-depth empirical research could add value.

Terminology and scope

As the primary users of abortion services and a key user group for contraceptive services, women form the focus of much of the literature and analysis in this area (Brown 2012). In turn, we largely use 'woman' or 'women' in this report. However, two points should be noted.

- Sexual health and wellbeing, including contraceptive needs and options, is not solely the responsibility of women: men have an equal and shared responsibility.
- It is not only cis women who use termination and contraceptive services. For example, trans men and non-binary people might also use these services, and they may have particular needs (Moseson *et al* 2021). While those needs merit dedicated policy attention in England, they were not the focus of this project.

2 Policy context

Legal regime governing abortion services

All abortions in England must comply with the legal framework governing access to terminations. The Abortion Act 1967, which came into effect in 1968, and was subsequently amended by the Human Fertilisation and Embryology Act 1990, sets the bulk of this regime.

The 1967 Act specifies seven grounds on which abortions can be legally obtained (*see* Appendix 1). The great majority of legal abortions – 98 per cent in 2019 – are obtained under ground 'C' which stipulates that a pregnancy has not exceeded its 24th week and that continuing with the pregnancy would present a risk to the physical or mental health of the woman, greater than if the pregnancy were terminated (Department of Health and Social Care 2021a).

In all cases, two registered medical practitioners must certify, in good faith, that a termination is justified under one of the Act's grounds (with exceptions for emergency situations). The Act specifies that abortions must be carried out in an NHS hospital or at a place approved by the Secretary of State for Health and Social Care. The Act affords the Secretary of State the power to approve a class of place, which specifies places where medical abortions can take place (*see* box below). Registered medical practitioners delivering abortion services are required to notify the Chief Medical Officer of all terminations within 14 days. Any abortions carried out in ways which do not comply with the Act's requirements are illegal.

The Abortion Act set the legal regime for most of the UK, but Northern Ireland remained outside the Act and has historically maintained more restrictive rules governing access to abortion services (British Medical Association 2020). There is an ongoing academic and policy debate about the merits of the existing legal framework in England (eg, Dyer 2017; Sheldon 2016). Although these debates about the legal framework are important context when seeking to understand trends in termination numbers, the pros and cons of legal reform were not in scope for this work. This project is focused on England.

Changes to rules around location of early medical abortion

Before 2018, women having a medical termination attended a clinic or hospital to take both medicines. In 2018, an approval was put in place for abortions up to 10 weeks gestation, which allowed women to visit a clinic to take the first medicine, and then, if they chose, to take the second tablet and pass the pregnancy at home.

In March 2020, the Department of Health and Social Care introduced a temporary approval allowing women having an early medical abortion to take both medicines at home up to 10 weeks gestation, after consultation with a clinician (Department of Health and Social Care 2020b). This was intended to ensure abortion services could continue safely and reduce the risk of Covid-19 transmission. The dispensation is scheduled to last until the day on which the temporary provisions of the Coronavirus Act 2020 expire, or the end of the two-year period from the approval being made, whichever is earlier. In Autumn 2020 the Department of Health and Social Care launched a consultation on whether to make this measure permanent (Department of Health and Social Care 2020a). At the time of publication, in autumn 2021, the results of that consultation were not in the public domain.

Commissioning and delivery of abortion and contraceptive services

Since the Abortion Act came into force in 1968 termination services have been publicly funded by the NHS. Today, the bulk of pregnancy termination services are commissioned by CCGs, with CCGs contracting with NHS trusts or foundations trust and with non-statutory providers, such as the British Pregnancy Advisory Service (BPAS) and MSI Reproductive Choices, to deliver these services. Over recent years, the proportion of terminations delivered by non-statutory providers holding an NHS contract has grown – reaching 74 per cent in England and Wales in 2019 (Department of Health and Social Care 2021a). Each year, a small number of terminations are also privately funded.

Through its changes to public health commissioning, the Health and Social Care Act 2012 re-shaped the planning of sexual health services, including contraception. It introduced a tripartite division of responsibility among local authorities, CCGs and NHS England for planning sexual, reproductive and HIV services. Responsibility for commissioning contraception (of which there are

many types – *see* box below) was divided into three main areas (Public Health England 2017).

- CCGs commission permanent methods of contraception, ie sterilisation and vasectomy services, contraceptives that are used for non-contraceptive purposes, and contraception accessed as part of abortion care.
- Local authorities commission the bulk of contraceptive services such as those provided at dedicated sexual health services and long-acting reversible contraceptives in general practice.
- NHS England funds some contraceptives including those provided by GPs as an additional service under the national contract.

This model of planning has placed a premium on collaboration at a local level: requiring different planners and service providers to work together to ensure services are joined up and meet the needs of users. There is evidence suggesting some places have achieved this and developed ways of working that add up to more than the sum of their parts (Local Government Association 2019).

Analysis of the 2013 public health reforms by The King's Fund found that they were based on a solid logic, namely, that local government is well placed to plan public health services (Buck 2020). However, notwithstanding some examples of promising local approaches, one effect of this parallel model of planning responsibilities has been to create some operational challenges in the delivery of sexual health services and holistic contraceptive services (All Party Parliamentary Group on Sexual and Reproductive Health in the UK 2020; Health and Social Care Select Committee 2019; Baylis *et al* 2017).

Following a commitment in *The NHS Long Term Plan*, the Department of Health and Social Care conducted a review exploring whether NHS commissioners should play a larger role in planning public health services, including sexual health services (NHS England and NHS Improvement 2019 p 33). The review concluded local authorities would retain lead responsibility but that further work was needed to support deeper local collaboration between planning organisations (Department of Health and Social Care 2019).

Main types of contraception

Barrier methods

Barrier methods prevent pregnancy through putting a barrier between a sperm and an egg. They are widely used and depend to some extent on users to deploy them effectively. As such, their statistical effectiveness can depend on user error. Examples include condoms and diaphragms.

Hormonal contraceptives

Hormonal methods prevent pregnancy through modulating, or stopping, ovulation. Like barrier methods, they involve some user control. When used correctly, they are highly reliable. Examples include the combined pill and the progesterone-only pill.

Long-acting reversible contraception

Long-acting reversible contraceptives are fitted, and removed, by a health care professional and are one of the most effective forms of contraception. Once fitted, users do not have control over their operation. Examples include contraceptive implants and intrauterine devices.

Emergency contraception

If taken or fitted within the required timeframe, emergency contraceptives can prevent pregnancy after unprotected intercourse or if another method of contraception fails. Methods include intrauterine devices and emergency contraceptive pills, which operate through similar mechanisms to other hormonal contraceptives.

Permanent methods

Permanent methods of contraception require a health care intervention (usually surgery) and are not easily reversible. Methods are female sterilisation or male vasectomy, both of which are high statistically effective at preventing pregnancy. Both carry small risks of complications.

Natural methods

Natural contraception (sometimes known as fertility awareness) involves tracking fertility signals to understand when a woman might get pregnant. While it can be effective, it depends on user decisions and it does not protect against sexually transmitted infections. Some people use technologies, like smart phone apps, to track fertility signals.

Sources: All Party Parliamentary Group on Sexual and Reproductive Health in the UK 2020; NICE 2019; NHS 2017c

Recent national policy related to reproductive health

For more than two decades there has been concerted focus on reducing conception rates among young women (often defined as those aged 18 and under) in England. Launched in 1999, the Teenage Pregnancy Strategy established dedicated capacity in central government and channelled funding to local government to support delivery (Hadley *et al* 2016). Cited as an example of a highly successful multi-faceted policy intervention, subsequent years have seen sustained falls in the national rate of teenage conceptions – more than halving between 2000 and 2018 (Skinner and Marino 2016; Wellings *et al* 2016). Analysis has, however, raised questions about the extent to which these reductions should be attributed to the strategy (Baxter *et al* 2021).

The teenage pregnancy strategy was succeeded by the *Teenage pregnancy prevention framework*, produced by Public Health England (Public Health England 2018a). This document aimed to support local areas to assess and improve their service offer to support young people with reproductive health needs. It included 10 key factors for effective local strategy, including relationships and sex education in schools and colleges, targeted contraception schemes aimed at young people.

The most recent whole-population national strategic document for sexual health in England was the *Framework for sexual health improvement in England* published in 2013 (Department of Health 2013). The framework focused on a number of objectives spanning broad sexual health and wellbeing, and included an objective to reduce unintended pregnancies among women of all reproductive ages, and a focused goal of reducing the rate of conceptions among under 16s and under 18s.

The Health and Social Care Act 2012 coincided with a period of tight public spending as the coalition government and subsequent Conservative administrations sought to reduce the deficit in annual public expenditure – largely through reductions in day-to-day spending (rather than tax increases). Local government was a key site of this fiscal adjustment, with grant funding from central to local government falling around 77 per cent per person

between 2009/10 and 2019/20 (Harris *et al* 2019). While councils were able to offset some of this by generating more income through increasing council tax and drawing on reserves (Atkins 2020), the overall effect was a prolonged period of tough financial choices for councils. Alongside this, the public health grant – funding allocated to local authorities from central government to support services such as children's services, smoking cessation, sexual health services and drug and alcohol services – saw reductions: in 2019/20 the public health grant was worth around 15 per cent less than in 2013/14 (The King's Fund 2021).

These financial pressures combined with continued demand in some service areas, eg, adult and children's social care, meant local authorities had to make difficult choices to balance their budgets (as they are legally required to). Between 2013/14 and 2017/18, for example, 88 per cent of local authorities reduced their expenditure on sexual health services. Within that, upstream prevention services often bore the brunt of funding reductions (Robertson 2018). During this period of fiscal consolidation, there were also changes to social security policy that affected people of working age with children (*see* box below).

Recently, there have been signs that cost and demand pressures are having an impact on services and people's health. Despite ongoing progress in some areas like HIV and teenage pregnancy, over the past few years there have been increases in diagnoses of some sexually transmitted infections such as gonorrhoea and chlamydia (The Nuffield Trust 2021). These trends take place within a context in which sexually transmitted infections particularly affect certain parts of the country, eg London, and certain demographic groups like young people and some ethnic minority communities (Terrence Higgins Trust and British Association for Sexual Health and HIV 2020).

Over the past couple of years, the government has committed to a number of national policy initiatives, which will contribute to shaping the population's sexual and reproductive health, and the associated services.

- In summer 2019, the government published a green paper on prevention setting out broad areas of action to support the aspiration of increasing healthy life expectancy by five years by 2035 while also reducing the gap between the most and least deprived (Cabinet Office and Department of Health and Social Care 2019). A response to this green paper is yet to be published.

- A women's health strategy is being developed. While rightly far broader than reproductive and sexual health, they are important components of women's health. The government consulted on the women's health strategy in Spring 2021 (Department of Health and Social Care 2021c).
- An updated sexual and reproductive health strategy (Department of Health and Social Care 2019) is planned for 2021. At the time of writing, the strategy had not been published.

These programmes of work represent an opportunity to reassess the approach to promoting good sexual and reproductive health, address some of the weaknesses in today's service design, and chart a new course.

Changes to social security payments for working-age people with children

In 2015, the government announced a 'two-child limit' in tax credits and Universal Credit, the key welfare support programmes for people of working age. The policy meant that for families in receipt of these payments which had two children, they would not generally receive additional financial support – currently worth around £2,800 per year – if they had additional children (with some limited exceptions) (Kennedy 2018). The changes came into effect in April 2017, and it was subsequently confirmed that the change would apply only to third children born after that date (Waters 2019). Child benefit, a separate payment for people caring for a child, continues to be available to all children (subject to some eligibility rules).

3 How are patterns of abortion use changing in England?

In this section, we explore publicly available datasets to understand how abortion use is changing across groups, and any associated changes in how people are accessing sexual health services (*see* box for details on methodology).

Methodology

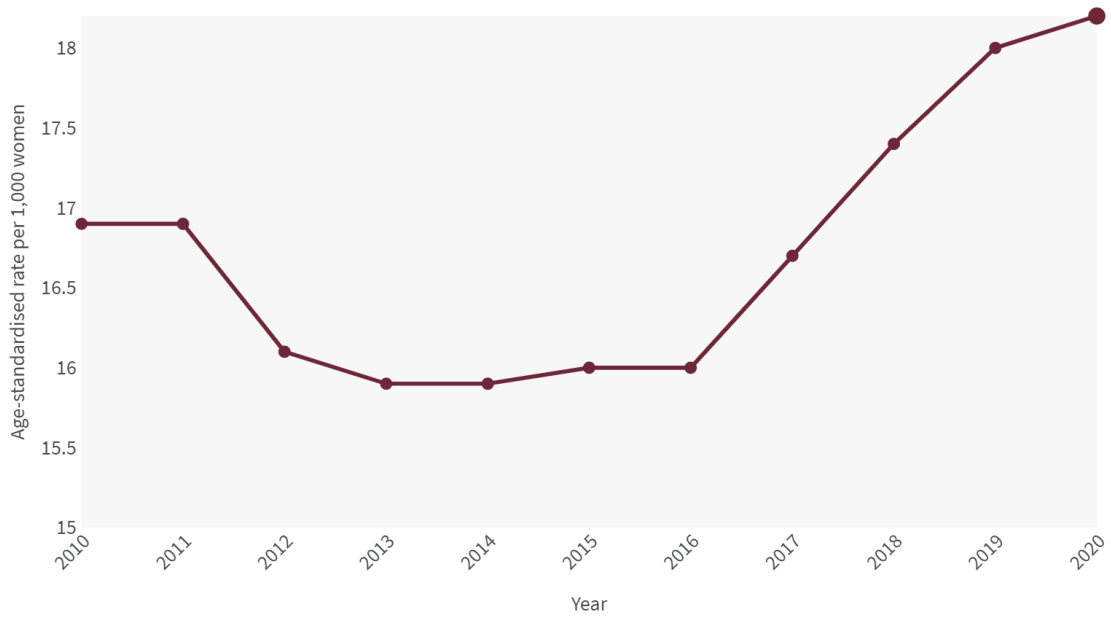
The following analysis draws from the Abortion Statistics, England and Wales and Statistics on Sexual and Reproductive Health Services (Contraception) datasets, with analysis at the national level presented across the longest time period available (from 2011 to 2020 for the statistics on abortion and 2008/09 to 2018/19 for sexual health services).

We have also compiled data at the upper tier local authority level for 2015 and 2019 to allow comparison with other local level statistics, such as deprivation indices and demographic data. This local-level analysis was performed for English local authorities only, though the national data used will cover England and Wales in the abortion statistics and England only in the sexual health services data.

Overall trend

There has been a significant shift in the pattern of abortion rates among women in England and Wales. This can partly be understood in the context of work by Wellings *et al* (2016) highlighting a reduction in conceptions among women under 18 years of age between 2000 and 2013. As we can see in Figure 1, the period 2012 to 2016 saw a steady abortion rate among women at around 16 procedures per 1,000 women. Since 2017 however, age-standardised abortion rates have risen, climbing to 18.2 per 1,000 women aged 15–44 living in England and Wales in 2020, the highest rate since the Abortion Act was introduced in 1968 (Department of Health and Social Care 2021b).

Figure 1 Age-standardised rate of abortion per 1,000 women resident in England and Wales aged 15–44 , 2010–20



Source: Department for Health and Social Care, 2021

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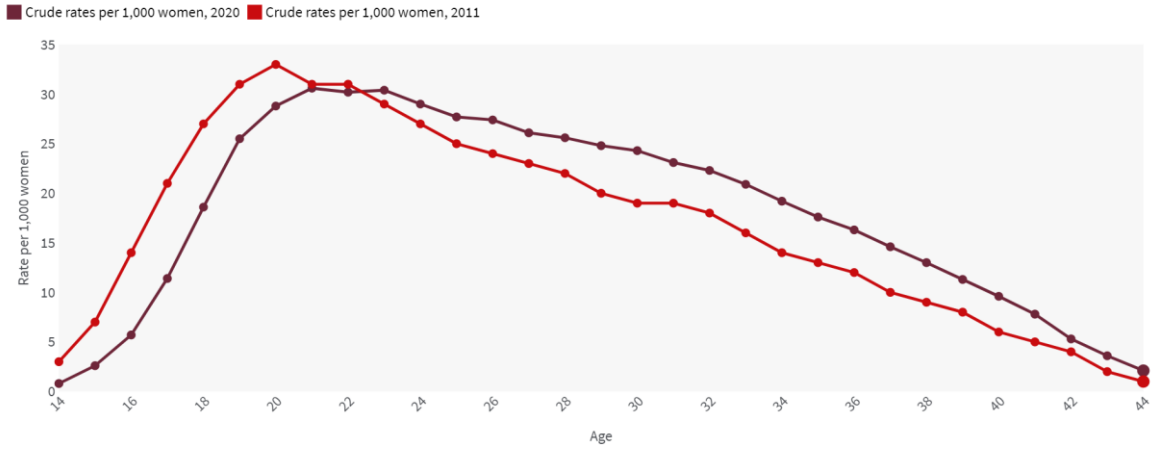
We were asked to explore the data on abortions in England compared to a range of factors that could help to explain some of the overall shifts in the pattern of abortion we've seen over the last 10 years. We present those findings in this section.

Age

The majority of procedures are still provided to women in the 20–34 age group, with women in these age groups accounting for 71 per cent of procedures in 2020. The largest increase in the number of abortions by age group has been among women 30 and older, with the rate per 1,000 women 30–34 rising from 16.5 in 2010 to 21.9 in 2020 (*see* Figure 2). The number of abortions and rate per 1,000 women under 20 has continued to fall over time.

Figure 2 Abortion rate per 1,000 women by single year of age, England and Wales, 2011 and 2020



Source: Department for Health and Social Care, 2021

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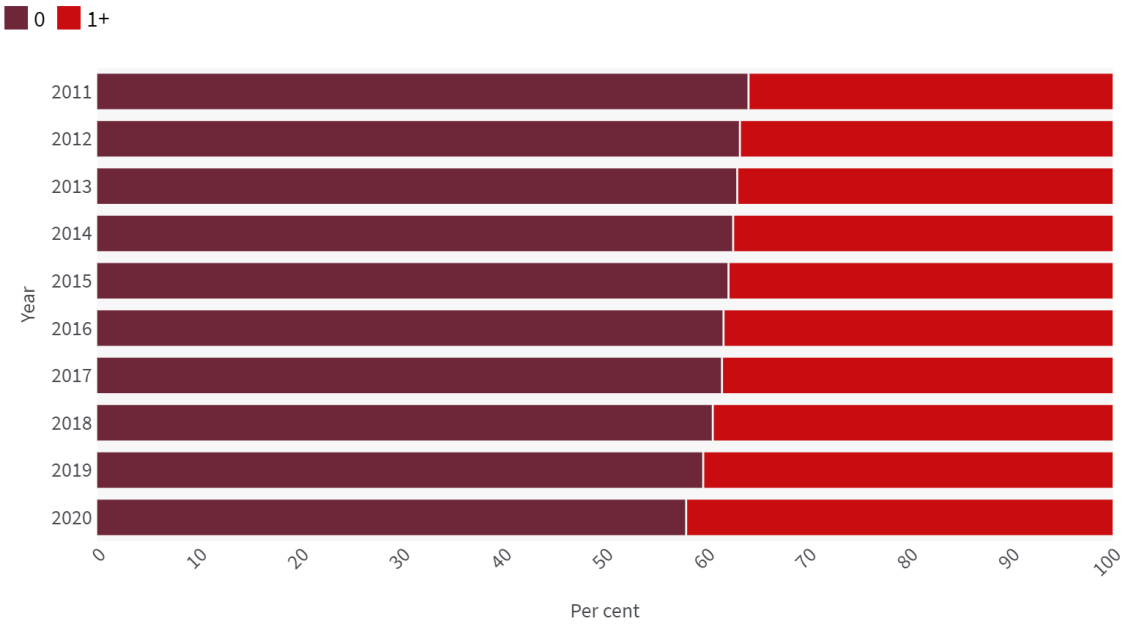
Previous terminations

The proportion of abortions being provided to women who have previously used abortion services has been increasing in recent years, with 42 per cent of all abortion procedures in 2020 being provided to women who have previously had at least one abortion, up from 36 per cent in 2011, as shown in Figure 3.

Deprivation

There is a clear relationship in the data between deprivation and the rate of abortion at a geographic level – as the rate of deprivation in an area increases, the abortion rate in that area also rises. Over recent years, this relationship seems to have become stronger, with the increase in the rate of abortion rising more sharply with deprivation in recent data as shown in Figure 4.

Figure 3 Percentage of abortion service use by number of previous pregnancies ending in abortion, England and Wales



Source: Department for Health and Social Care, 2021

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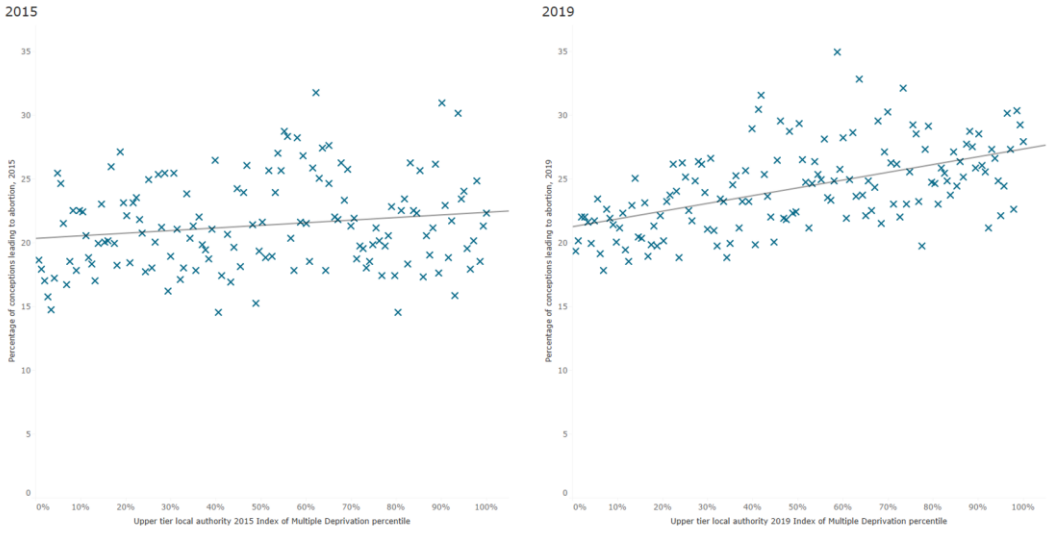
Figure 4: Abortion rate per conception compared to deprivation by upper tier local authority in England, 2015 and 2019



Sources: Department of Health and Social Care 2016 and 2021a; Office for National Statistics 2016 and 2020b; Ministry of Housing, Communities & Local Government 2015 and 2019

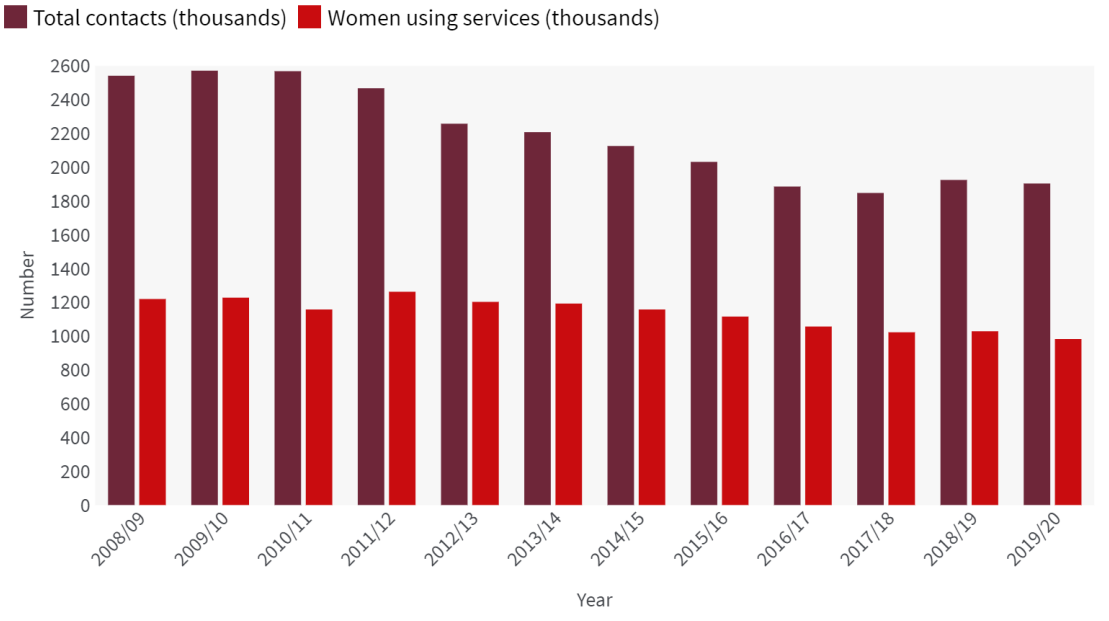
In the above charts, each point of data is an upper-tier local authority, plotted against its deprivation percentile and the percentage of conceptions which led to abortion in 2015 and 2019 respectively in each area.

Across both time periods we can see that as the level of deprivation in an area increases, so does the rate of conceptions leading to an abortion. In 2019 there was a pronounced change in the relationship, with the increase in the rate of abortions per conception rising faster per index of multiple deprivation percentile in 2019 compared to 2015 (though some of this change may be related to changes within the index of multiple deprivation scores).

Sexual health services

There has been a reduction in the number of contacts with sexual health services of almost 25 per cent in England over the past 10 years (these are services provided by the NHS's dedicated sexual and reproductive health services, and so excludes provision of services at GP practices and pharmacies), falling from 2,542,000 in 2008/09 to 1,904,000 in 2019/20 (*see* Figure 5). There has also been a 19 per cent decrease in the number of

Figure 5 Total contacts with sexual health services in England, 2008/09 and 2019/20



Source: NHS Digital

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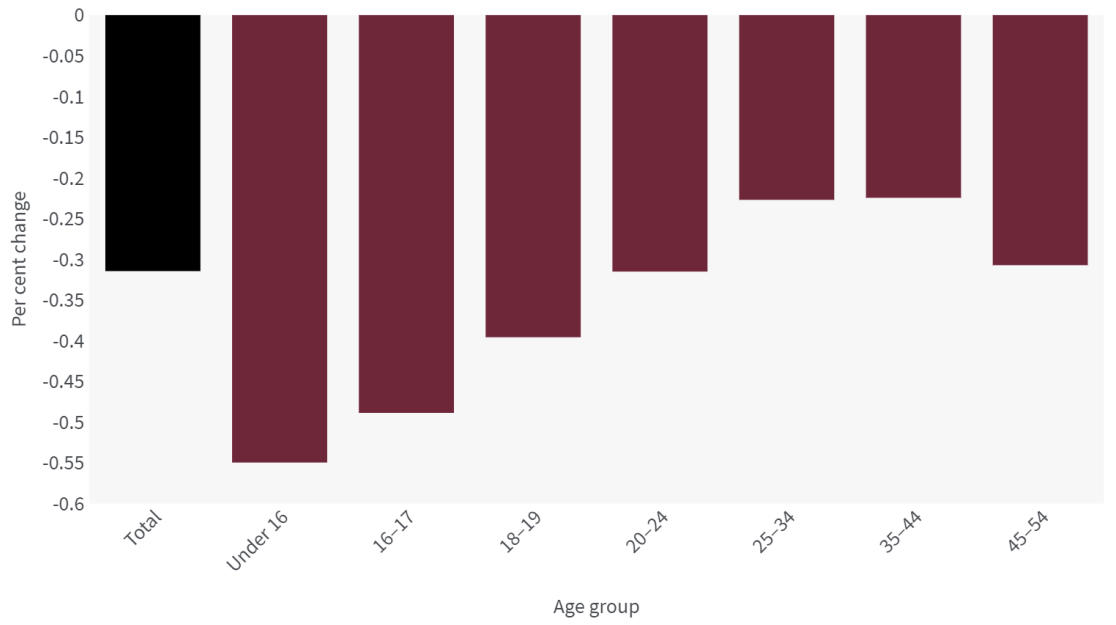
women accessing these services over the same time period, falling from 1,220,000 contacts made by women in 2008/09 to 983,000 in 2019/20.

Within this trend, the number of contacts with women aged 18 and under has fallen faster than other age groups since 2014/15, as shown in Figure 6.

Figure 6 Change in total number of contacts with sexual health services by women in England between 2014/15 and 2019/20



Source: NHS Digital

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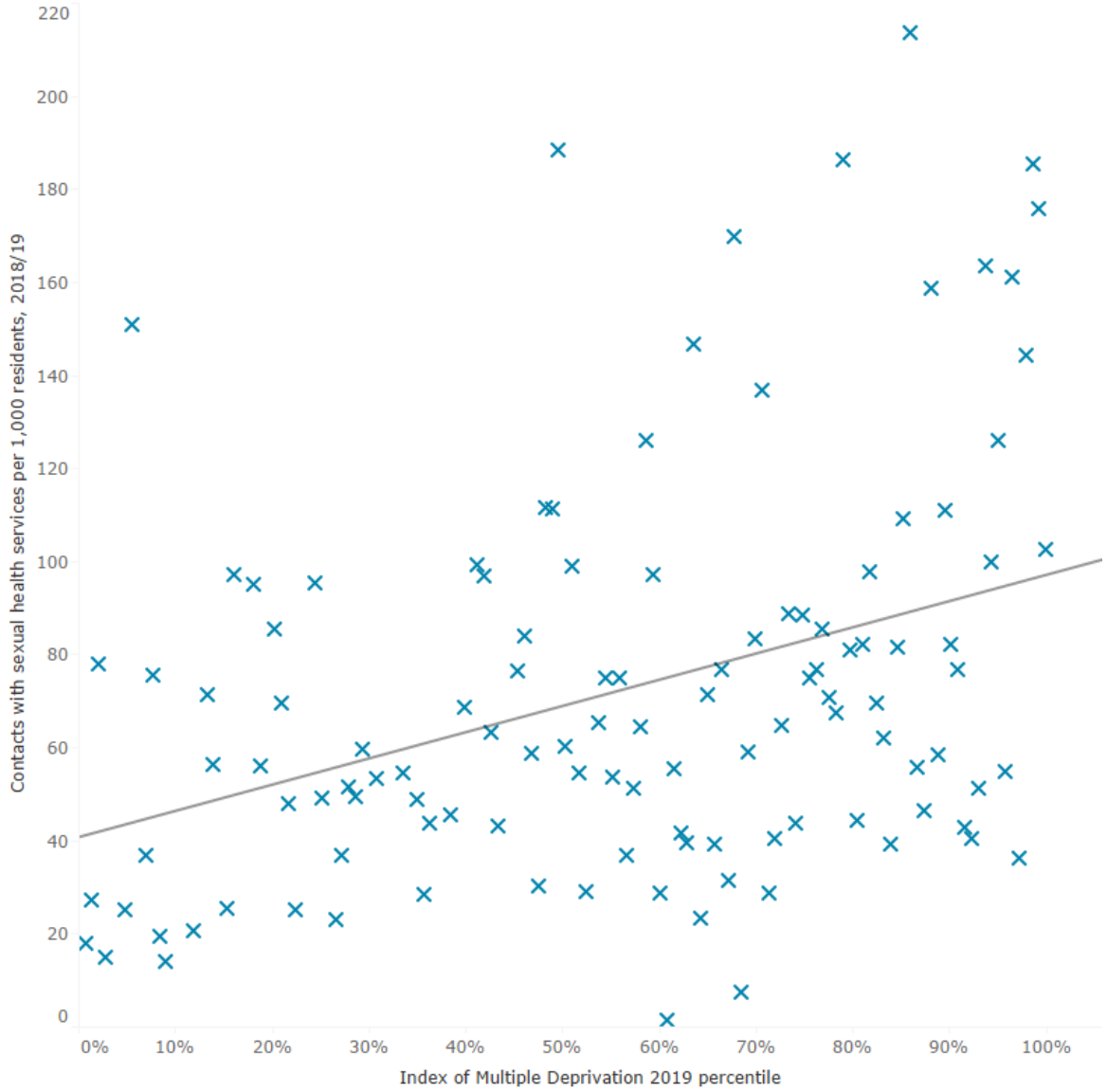
Similar to the pattern of abortion service use, the uptake of sexual health services in an area seems to increase with the level of deprivation in that area, as shown in Figure 7.

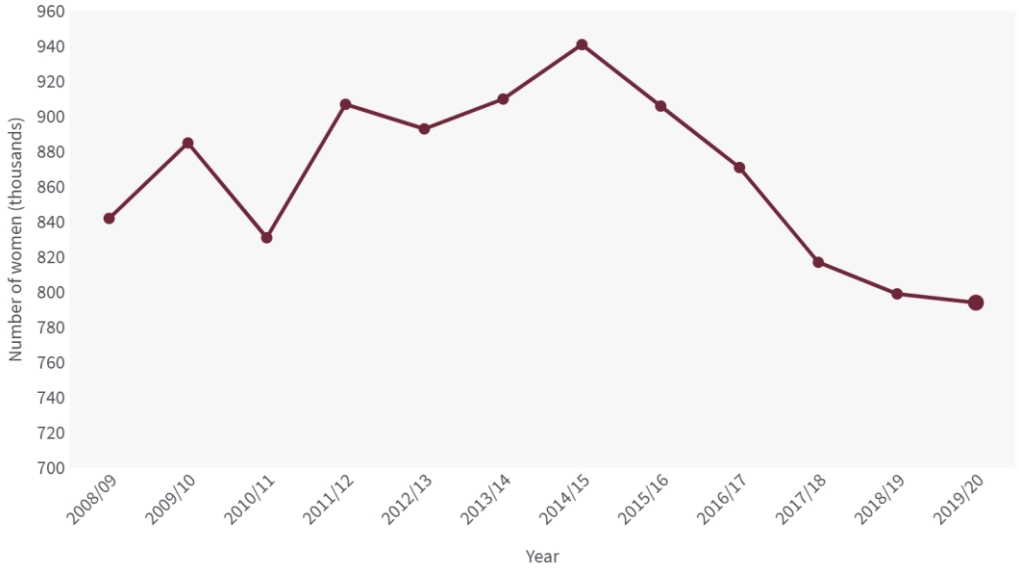
Figure 7: Total contacts with sexual health services by Upper Tier Local Authority in England, 2018/19



Sources: NHS Digital 2019; Ministry of Housing, Communities & Local Government 2019

The number of women accessing contraceptive services has fallen in recent years, from a peak of 941,169 in 2014/15 to 794,669 in 2019/20, a 15 per cent fall, as shown in Figure 8.

Figure 8 Number of women accessing contraceptive services, England, 2008/09 to 2019/20

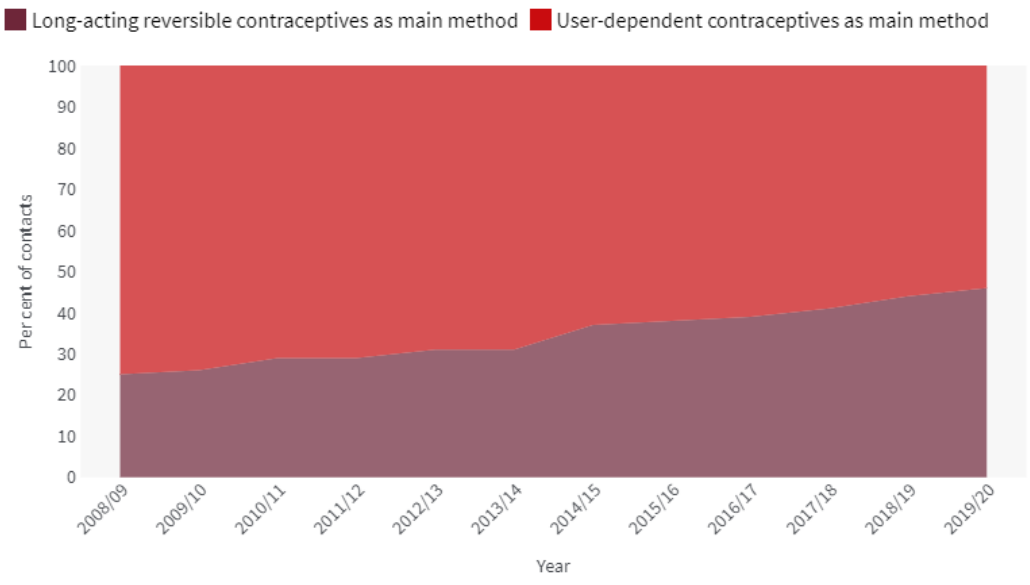


Source: NHS Digital

The King's Fund

However, the number of women accessing long-acting reversible contraceptive devices increased over the last 10 years, with the proportion of contacts relating to the provision of long-acting reversible contraceptives rising from 25 per cent in 2008/09 to 46 per cent in 2019/20, as shown in Figure 9.

Figure 9 Changes in contraceptive provision use by women, 2008/09 to 2019/20

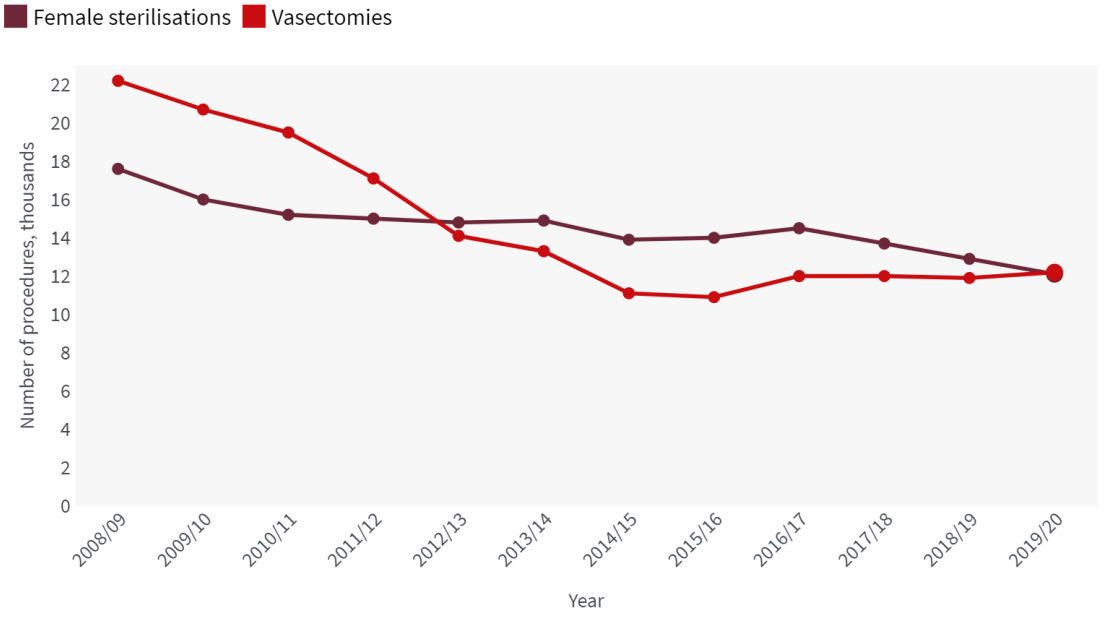


Source: NHS Digital

The King's Fund

The number of people accessing permanent contraceptive procedures has decreased since 2008/09, with the number of female sterilisation procedures falling by 31 per cent, from 17,600 procedures in 2008/09 to 12,100 in 2019/20, as shown in Figure 10. The number of vasectomies fell by 45 per cent, from 22,200 in 2008/09 to 12,200 in 2019/20, as shown in Figure 10.

Figure 10 Female sterilisation and vasectomy procedures in England, 2008/09 to 2019/20



Source: NHS Digital

The King's Fund

Ethnicity

The use of abortion services among different ethnic groups varies significantly. The White British group still accounts for the majority of procedures in 2019. When new figures for the population of England by ethnicity are published as part of the 2021 Census, it will be important for analysis to be conducted on changes to the rate of abortion service use within ethnic groups. Without this data, we cannot comment on changes within ethnic groups with confidence.

Summary

- There are clear increases in the pattern of abortion use towards older women (the 30 plus age group), and women in more deprived areas.

- Fewer women are accessing sexual health services, with contacts more commonly taking place in more deprived areas. Fewer women are undergoing permanent contraceptive procedures, though more are using long-acting reversible devices.

4 What factors may be playing a role in trends in use of abortion services?

There are a number of complexities to consider when attempting to delineate factors that affect trends in abortion use. While acknowledging this, here we draw on published empirical research and some expert stakeholder insights to outline what can be said – at a high level – about factors influencing abortion trends.

The empirical research we draw on varies in methodology – from large surveys through to small qualitative studies and statistical work. Research participants span service users and health professionals. We largely restricted the evidence included to high-income countries in Europe, North America and Australasia (on the basis that the legal framework is more likely to be similar and some contextual social considerations may be different in middle- and low-income countries). Consequently, only some of the empirical research cited below was conducted in the UK.

We divide the discussion of the available evidence into five subsections:

- macro-economic conditions and financial considerations
- social attitudes
- sexual behaviours
- uptake of, and access to, the range of contraceptive methods
- how health services are organised and delivered in England.

Macro-economic conditions and financial considerations

Empirical research evidence makes clear that economic considerations show a relationship with fertility and pregnancy decisions in at least two respects: at the macro level and the individual level.

Macro level

There is a body of research illustrating an association between macro-economic trends and fertility in high-income countries. In short, macro-economic trends are positively correlated with aggregate fertility, meaning that economic recessions presage – or occur simultaneously with – temporary reductions in total fertility rates (often described as a 'procyclical' relationship). This effect has been observed across numerous European countries over the last 30 years (Bellido and Marcén 2019; Sobotka *et al* 2010) and in the US over a similar time period (Buckles *et al* 2018).

Some work has explored related questions about the micro-economic indicators associated with fertility. For example, some work has explored an association between housing costs and fertility. Analysis in the US between 1940 and 2000 suggested a link between housing costs – as measured by rent per room – and fertility; in particular it suggested higher housing costs were negatively correlated with fertility rates (Simon and Tamura 2009). Later research in the UK found a similar trend – with fertility rates falling among homeowners as housing costs increased between the 1990s and the 2000s (Berrington *et al* 2019). Interestingly, however, the research did not observe the same effect among families living in private rented accommodation.

The role of other factors has also been explored. For example, research in Italy has explored the connection between perceived economic uncertainty and fertility trends and found an association (Comolli and Vignoli 2021). Analysis in France, alternatively, focused on the impact of changes to labour market regulations. Where these had the effect of increasing job insecurity for under 50s, this was found to be materially associated with reduced fertility (Clark and Lepinteur 2020).

Individual level

There is an extensive body of evidence illustrating that for women making pregnancy decisions – across a range of countries – their personal financial situation is an important consideration that influences their pregnancy decisions. A 1998 review of published research found socioeconomic concerns – particularly direct or indirect costs of having a child – to be the second most commonly cited reason for seeking an abortion (Bankole *et al* 1998). Similarly, a more recent review drawing on work in 14 countries – ranging across high- and low-income – found that socioeconomic concerns were *the*

most commonly reason cited by women seeking a termination (Chae *et al* 2017).

Similar findings have been reported from research conducted solely in high-income countries. For example, a large survey study in the USA in the early 2000s found that nearly three quarters of respondents identified not being able to afford a child as a reason for seeking a termination (Finer *et al* 2005). More recently, the Turnaway Study, a US-wide project exploring the social and economic consequences of having a termination (or being denied one), found financial reasons to be the most commonly cited reason among women accessing services (Biggs *et al* 2013). A smaller study conducted in the North East of England also found that financial worries was the most commonly cited reason women gave for seeking a termination (Wokoma *et al* 2014).

These findings reveal how economic developments in England might have shaped the circumstances of people who are accessing termination services. At the macro level, it seems likely that some key trends in recent years – both developments in the labour market, and national policy choices around welfare policy – have contributed to an environment where socio-economic concerns are more prevalent among people of working age.

The total proportion of the UK population living in relative poverty (after housing costs) – ie, those with income below 60 per cent of the median household income adjusted for family size and composition – has been largely stable over the past 15 years at around 22 per cent (Joseph Rowntree Foundation 2021). Within that, however, the distribution of incomes has changed. Over the 15 years to 2019, incomes among pensioners grew relatively strongly, with national policy choices around the state pension playing a key role, while average wages among the working age grew slowly by historical standards (Corlett *et al* 2019). The effect has been to reduce poverty among older people while becoming more likely among working age groups; by 2017/18 working households made up 58 per cent of those below the official poverty line – defined as net income below 60 per cent of the 2010/11 median (Bourquin *et al* 2019).

Alongside this, policy choices around working age welfare policy have had material financial consequences for less well-off households. Despite improvements in the job market, changes to benefits – including freezes to some benefits and tax credits – saw low-income households (the bottom two deciles) experience a five-year stagnation in their real incomes between 2013/14 and 2018/19 (Bourquin *et al* 2020). Moreover, assuming no further

policy changes, the two-child limit to tax credits and Universal Credit will mean a reduction in state support of slightly less than £3,000 a year for low-income families with three children (Waters 2019). A recent survey with women making pregnancy decisions has pointed to the financial implications of these changes as a factor in some women's decisions (British Pregnancy Advisory Service 2020).

Social attitudes

Globally, women (and families) are having fewer children. Between 1990 and 2019, the global fertility rate fell from 3.2 to 2.5 live births per woman (Department of Economic and Social Affairs 2020). Downwards trends in fertility rates are present in all major continents, although are occurring later and at a slower pace in sub-Saharan Africa. In Europe, total fertility rates are the lowest of any continent (The ESHRE Capri Workshop Group 2010).

The UK has mirrored, indeed led, some of these trends. In England and Wales, the total fertility rate (ie, number of children per woman) fell substantially between the mid-1960s and the mid-1970s – from 2.9 in 1964 to around 1.7 in 1977. During this period a number of significant developments occurred, including the extension of access to contraception within the NHS and the Abortion Act coming into effect. Since then, the total fertility rate has fluctuated between 1.6 and just below 2.0 – consistently below the population replace rate of around 2.1 children per woman (Office for National Statistics 2020a).

Attitudes towards abortion

Polling is conducted fairly regularly in Britain to explore public sentiment about abortion, sometimes connected with a proposed change to legislation or rules. Assessing changes in prevailing attitudes via these sporadic pieces of polling evidence can be unreliable because they are often sponsored by interested pressure groups and comparability can be an issue. Nevertheless, an assessment of a range of polling evidence identifies a gradual trend over the past 50 years towards people in Britain being more accepting of abortions, with only very few people being opposed in all circumstances (Clements and Field 2018).

Alongside, the British Social Attitudes (BSA) survey can offer a window on how the views of the British population are changing, based on a robust social scientific method. The BSA uses a representative sample and has recurred regularly over more than 30 years. BSA survey data shows that since the

early 1980s there have been consistently high levels of support – at or around 90 per cent – for abortion in cases where a woman's health is endangered. Additionally, it showed that the percentage of people supporting abortion in situations where a woman or couple cannot afford a child has increased from around 51 per cent in 2005 to 65 per cent in 2016 (Attar Taylor 2017). It has also found that in 2016, 70 per cent of people felt abortion should be allowed in situations where a woman does not wish to have a child, up from 60 per cent in 2005.

This gradual change in attitudes at the population level does not, however, show that socio-cultural norms have changed entirely. Research evidence makes clear that through a number of mechanisms, some women undergoing a pregnancy termination in high-income countries, including England, experience social stigma (Purcell *et al* 2020). For example, recent work has highlighted that national newspapers in the UK frame coverage of abortion in predominantly negative language (Purcell *et al* 2014). Additionally, empirical work shows that for some women in Britain the lived experience of terminating a pregnancy continues to be characterised by internalised stigma (Hoggart 2017).

Furthermore, the broad picture of changing public attitudes does not necessarily translate at the level of smaller population groups, where a range of dynamics may be present. However, among Catholics in Britain, traditionally a group with relatively conservative views about abortion, there is evidence that attitudes on social or moral issues are becoming more liberal (Attar Taylor 2017), and becoming more diverse within the community of practising Catholics (Clements and Bullivant 2021). Our evidence search did not find comparable evidence on other faith groups.

Recently questions have been raised about whether sex-selective abortions were taking place in the UK. In 2014 the Department of Health (as it then was) issued guidance spelling out that abortion solely on the basis of sex of a foetus does not satisfy any of the legal grounds in the Abortion Act 1967 (Department of Health 2014). Subsequent research did not produce categorical evidence that sex selective abortion is taking place at scale in the UK (Caird *et al* 2015). Research continues in this area (University of Reading undated) and there is ongoing debate about the best ways to understand the scale of the phenomenon (Dubuc and Sivia 2018).

Sexual behaviours

Much like social attitudes, understanding changes in sexual behaviours at the population level is fraught with methodological challenges given the cultural preference for privacy regarding sexual matters. Notwithstanding this, the UK has a long-running survey programme, the National Surveys of Sexual Attitudes and Lifestyles (Natsal), that sheds some light on sexual behaviours in Great Britain through a nationally representative survey design. There were three waves of data-gathering as part of Natsal between 1991 and 2012; a fourth wave is scheduled to take place in 2021 (having been delayed by the Covid-19 pandemic). This resource provides an invaluable window onto developments in sexual behaviour.

In relation to trends in abortion, evidence from Natsal points to a number of relevant trends.

- Over the past 30 years there has been a gradual reduction in the median age at first sexual encounter – reaching 16 in the 2012 survey (Lewis *et al* 2017). This behavioural trend has also been seen in research exploring the characteristics of women who have more than one termination (*see* box below).
- There has been a slightly increase in the median age at which people cohabit with an intimate partner, and have a first child (Mercer *et al* 2013; Chao *et al* 2020).
- There has been a diversification in people's sexual experiences with increases in the median numbers of sexual partners over the life course, the continuation of sex into later life, eg, 50 years of age and above (although with diminishing frequency) (Mercer *et al* 2013).
- Conversely, there has been a reported reduction in frequency of sex among people aged 16 to 44, which may be partly accounted for by fewer people being married or cohabiting (Wellings *et al* 2019).
- There is a correlation between household structure and some sexual behaviours. In particular, younger people (aged 16–24) who live alone or with non-relatives were more likely to report having more sexual partners and more likely to report unsafe sex (Curtis *et al* 2018).
- Some research has pointed to variations in sexual behaviour across ethnic groups that may affect risk profiles. For example, analysis has found that, when compared with White British women, a smaller proportion of women of some groups, eg, women of Black African

heritage and those of mixed ethnicity, reported a number of markers of good sexual health at the time of their first sexual experience, eg, contraceptive use (Wayal *et al* 2017). Adjusting for explanatory factors, such as socioeconomic status, explained only some of these differences.

Overall, data from Natsal and other sources paint a picture of a population experiencing ongoing changes in sexual preferences and behaviours which raise a number of questions for how policy can best promote good sexual and reproductive health. Specifically related to abortion trends, Natsal's data highlights that people are spending a longer period of time managing the possibility of pregnancy and first cohabiting slightly later in life. These trends raise questions about whether developments in sexual lifestyles are informing investment and service design choices relating to contraceptive services.

Women who have more than one termination

In 2020, 42 per cent of women having an abortion in England and Wales had previously had one or more terminations. This proportion has been increasing over the past decade, up from 34 per cent in 2010 (Department of Health and Social Care 2021b). Research has offered some findings about women who access more than one termination, and the circumstances of their lives.

- In Britain, women having more than one termination have been found to be more likely to have lower levels of educational qualifications, live in rented accommodation, have engaged in sexual experiences at an earlier age, and were more likely to be from a Black ethnic group (Stone and Ingham 2011).
- Research in Grampian, Scotland, found women accessing more than one termination were more likely to have had a termination at less than 20 years of age, and belong to a deprived quintile of the population (as measured by the Scottish index of multiple deprivation) (McCall *et al* 2016).
- A comparative study in Scotland found that women who had more than one termination within a two year period were often experiencing socio-economic disadvantage and pointed to an association with intimate partner violence as well (Purcell *et al* 2017).

Research has also highlighted some of the limitations of characterising cases based on 'repeat abortion' status: women's reproductive histories can be varied and a binary distinction based on whether they have had one or more

abortions is unable to reflect this; moreover, discourses that narrowly focus on 'repeat abortion' risk compounding stigma (Hoggart *et al* 2017).

Uptake of, and access to, the range of contraceptive methods

As the data explored in Section 3 illustrates, how people in England access contraceptive services is changing over time, with apparent reductions in use of permanent methods and increases in use of long-acting reversible contraceptives. In this sub-section, we explore what the published empirical evidence can add to the analysis and draw in some expert stakeholder insight.

There are a number of contraceptive methods available today, and different routes to accessing them in England, including GP surgeries, sexual health clinics, community pharmacies and retail outlets. The evidence is clear that users make a range of choices about which methods of contraception to use, and where to access contraception.

Globally, the most common methods of contraception are male condoms and female sterilisation. In Europe, alternatively, the use of the pill and male condoms is higher than in other regions of the globe (UN Department of Economic and Social Affairs 2019). In Britain, a recent estimate suggested that the most common methods of contraception are the female pill (combined oral contraceptive or the progestogen-only pill) and barrier methods, with around a quarter of women aged 16–49 using one or both of these methods (Gill and Taylor 2017). A similar proportion of the female population were estimated to not be routinely using any contraceptive method, either because of trying to conceive or for other reasons.

Within these headline figures, evidence from Natsal points to a number of behavioural patterns in how contraception use varies among the population.

- Choice of contraceptive method varies by age group and based on some other characteristics such as relationship status. For example, younger women are more likely to report using hormonal and barrier methods (Firman *et al* 2018).
- Use of contraception has been reported to vary across ethnic groups, with rates of utilisation lower among women from South Asian groups and Black African and Black Caribbean women when compared with White British women – which was not fully accounted for by other factors such as deprivation and education (Saxena *et al* 2006). More

recently, rates of use of emergency contraception has been reported to be higher among Black Caribbean women, when compared with White British women, and lower among women of South Asian ethnicity (Wayal *et al* 2017).

- The decline in sterilisation and vasectomies over time shown in national data is also found in reductions in the numbers of Natsal respondents reporting taking up permanent methods of contraception (French *et al* 2020).
- Over the first decade of the century there were increases in the proportion of women reporting using emergency contraception, yet the scale of uptake remains relatively low in comparison with estimates of unintended pregnancies (Black *et al* 2016). Research has suggested that, despite improvements in access, practical barriers to accessing emergency contraception may play a role in this (Glasier *et al* 2021). Other work has pointed to social stigma as an ongoing barrier to uptake of emergency contraception (Eastham *et al* 2020).

Analysis of Natsal waves two and three, which occurred between 1999 and 2010, pointed to some changes in the uptake of long-acting reversible contraception. In particular, it found that uptake had increased most markedly among younger women, aged under 25. The authors concluded that concerted efforts during the 2000s to increase use of long-acting reversible contraception had a real-world impact (French *et al* 2020). This builds on research exploring the impact of a dedicated reimbursement scheme for general practitioners to provide advice to women about long-acting reversible contraceptive methods, which highlighted that between 2004/05 and 2013/14 crude uptake rates of these methods increased by nearly a third (Ma *et al* 2020).

More recently, however, expert stakeholders have been expressing concern about access to long-acting reversible contraceptives in England. In 2020, the All-Party Parliamentary Group on Sexual and Reproductive Health highlighted testimony suggesting that funding issues and skills shortages are making it more difficult for women to access long-acting reversible contraceptives in general practice (All Party Parliamentary Group on Sexual and Reproductive Health in the UK 2020). Some recent research involving service users and health care professionals similarly contended that access to long-acting reversible contraceptive provision is variable and some women are finding it difficult to access this method (British Pregnancy Advisory Service *et al* 2021).

How health services are organised and delivered in England

Developments in numbers of women accessing termination services occur within the context of changes to how abortion and wider health services are organised and delivered in England. In turn, services are shaped by a number of factors, including developments in national policy, changes in technology and the ongoing evolution of clinical practice. All of these factors potentially contribute on the supply side to changes in how abortion services are used.

Changing modality of abortion

In the early decades after the passage of the Abortion Act 1967, terminations were provided surgically. This determined some aspects of how services would be delivered, and was reflected in the legal requirements that abortions be delivered in NHS hospital premises or a registered non-statutory provider. Over the past 30 years, however, medical abortions have emerged and become mainstream in the UK.

Today, the shift to medical abortions in England and Wales has become widespread: in 2020, 85 per cent of abortions were delivered medically, up from less than 50 per cent in 2010 (Department of Health and Social Care 2021b). The upward trajectory suggests the share of abortions that must be conducted surgically for clinical reasons may fall further in the coming years. Although the shares of each modality vary across countries, many other high-income countries, such as those in northern Europe, are seeing substantial shifts from surgical to medical abortions (Popinchalk and Sedgh 2019).

The service implications of the shift from surgical to medical abortion are material. Women having a medical termination do not need to experience an invasive procedure and anaesthesia (and avoid associated risks); additionally, since 2018 women in England undergoing early medical abortion up to 10 weeks gestation have had the option to take the second pill while at home rather than in a clinic (promoting privacy and avoiding the risk of terminating while travelling back from a clinic). Importantly, however, the provision of post-termination contraception is changed by the shift to medical terminations. During a surgical termination it is possible to fit some long-term contraceptive devices as part of the procedure (if a woman chooses). Conversely, with a medical abortion, a separate process may be required to facilitate that, which introduces potential for delay and attrition.

Developments in attitudes and practice among clinicians

There is some evidence to suggest that the practice of health professionals is changing, particularly those working in primary care, in terms of how they support and advise women considering a termination. Abortion providers in England operate self-referral routes so women are not required to consult a GP to access abortion care, but some women choose to consult a GP.

The Abortion Act includes provision that allows doctors to not participate in abortion care if they have a conscientious objection. In these cases, doctors are required to explain to a patient if they have a conscientious objection and facilitate the patient consulting with another medical professional if they wish to (British Medical Association 2020 p.11).

It is clear that over time GPs' interpretation of their role in supporting women making pregnancy decisions, has been subject to some variation. Historical research has pointed to testimony from health professionals, and service users, highlighting that in the years following the 1968 legislation GPs took varying approaches when consulting women making pregnancy decisions: some prioritised women's wishes including where they expressed a choice for a termination; others felt an imperative to interrogate the rationale and circumstances of women seeking an abortion (O'Neill 2019). Moreover, some doctors in those decades are described as actively dissuading women from terminating a pregnancy based on their personal moral beliefs.

Recent attitudinal research suggests GP attitudes, like the general population, are changing. Studies conducted in the past 20 years have found attitudes among health professionals, both practising GPs and medical students, are shifting towards empowering women through supporting them to take decisions about pregnancies (although those studies also found substantial proportions of health professionals who choose not to be personally involved in delivering abortion care) (Gleeson *et al* 2008; Francome and Freeman 2000).

Notwithstanding this, recent research has found that some women seeking to access termination services have interactions with health professionals that they experience as stigmatising or which introduce barriers to accessing timely care. For example, a study in north east England from the early 2000s found 15 per cent of participating women had to arrange a second GP consultation with a practitioner who was willing to refer them for a termination (Finnie *et al* 2006). A more recent study in Scotland – focused on

women living in rural communities – found women experienced the attitudes of some GPs as a barrier to timely termination care (Heller *et al* 2016).

Overall, the balance of practice among GPs appears to be shifting towards empowering women to make pregnancy decisions and facilitating them accessing timely termination care when that is their preference. This reflects broader changes in the social dynamics between users of health services and health professionals. However, the extent to which this was true in the past is open to question, and a picture also emerges of some variation in practice indicating that some women may continue to experience obstacles in their pathway of care.

Commissioning arrangements for sexual and reproductive health

Since 2013, the planning of sexual health services has been based on structures introduced by the Health and Social Care Act 2012. Since then, finding approaches to optimise this arrangement at the local level has been a recurring issue.

While robust real-world evidence is relatively limited (and claims of attribution need to be treated with caution), a range of expert stakeholder groups have expressed concerns that division of planning responsibilities for sexual health care is leading to operational issues – for both staff and service users. For instance, the Health and Social Care Select Committee, when it explored sexual health services in 2019, concluded that division of responsibilities remained a 'significant obstacle to effective commissioning' (Health and Social Care Select Committee 2019 p.14) The All-Party Parliamentary Group for Sexual and Reproductive Health has noted that the multi-sided responsibility for contraceptive services extends to the national level where responsibility has been shared between the Department of Health and Social Care, Public Health England (and in the future the Office for Health Promotion) and NHS England (All Party Parliamentary Group on Sexual and Reproductive Health in the UK 2020).

Stakeholders engaged for this work highlighted a number of issues, which they saw as stemming from commissioning arrangements which may be affecting the quality of services available to people and potentially, therefore, playing a role in the number of people accessing termination services.

- CCGs have lead responsibility for commissioning abortion services. In practice, though, abortion services account for a relatively small proportion of CCGs' annual spend. Consequently, it can be difficult for

CCGs to mobilise leadership resource to proactively shape and improve abortion services (including their provision of post-termination contraception).

- Ensuring the planning arrangements function effectively relies in part on stakeholders in local authorities and CCGs collaborating closely and aligning decisions. While some places have made this work, in others where relationships are more nascent or there are challenges, it has been more difficult.
- The fiscal choices of governments over the last decade has seen the public health grant reduced in real terms and local authorities having to take tough financial choices. This has fed through into the accessibility of sexual health services in some places.

Overall, while acknowledging limitations of the evidence base in this area, the range of expert testimony suggests there is an issue with planning structures for sexual health services. In short, rather than commissioning structures supporting integrated services, local leaders have needed to find innovative ways to work around the planning structures to develop holistic sexual and reproductive care.

There is a good case for further work in this area, particularly in light of the changes to NHS commissioning structures presaged by the new Health and Care Bill 2021. Since 2016, there has been a process of CCGs collaborating across larger geographies, working under joint leadership arrangements, and latterly, merging to create new commissioning organisations (Wenzel and Robertson 2019). Looking ahead, the Bill indicates that ICSs will become statutory organisations, subsuming the responsibilities of CCGs and some functions that previously sat with NHS England (McKenna 2021). These changes are intended to take effect from April 2022, depending on the progress of the legislation through parliament.

5 Conclusions and areas for potential further exploration

This project does not offer a definitive account of the precise combination of factors which are influencing abortion trends in England. Instead, it has sought to illuminate the breadth of factors that are at play. Mindful of these limitations, in this section we first offer some conclusions for policymakers, and then identify areas where more in-depth empirical research could support policy development around sexual and reproductive health.

Concluding messages for policymakers

- **Understanding trends in abortion use involves looking across a spectrum of factors – including the circumstances in which people live.** The evidence we reviewed suggests that numerous factors influence fertility trends and play a role in women's (and partners') pregnancy decisions. These include, but are not limited to, personal financial considerations (including social security payments), housing costs and security, employment security, social attitudes, and supply and uptake of contraception. Moreover, some macro-economic trends have been shown to be correlated with fertility trends in high-income countries. Recognising the breadth of relevant factors can help to contextualise trends in abortion use and points to the need to think holistically about the drivers of good reproductive health and wellbeing.
- **Variations in abortion rates across deprivation deciles, which appear to have increased in recent years, merit further attention from policymakers.** Developing high-quality models of support, incorporating contraceptive services, in geographical areas with higher levels of deprivation should be a priority for new strategic approaches to sexual and reproductive health. More broadly, the evidence reviewed suggests that good reproductive health is intrinsically linked to the ambient conditions of people's lives, including financial circumstances. This reinforces the case for policymakers to consider the health impacts of the choices made in other areas of domestic public policy. In particular, there are valid questions to be

explored about the full impacts of national decisions around working-age welfare policy.

- **Survey evidence suggests sexual behaviours and lifestyles in the UK are changing, with a growing period of people's lives spent sexually active.** This is due to people having their first sexual experiences at a younger age and having sex into later life. There is also evidence that women are cohabiting with a partner slightly later in life. Alongside the international trends towards women, on average, having fewer children, these domestic trends increase the period of time over which people need to manage the possibility of pregnancy, and highlight the need to think about the stages of life at which women need to be able to access contraceptive choices. More up-to-date insight on sexual behaviours in Britain will be provided by the latest wave of the Natsal survey.
- **Contraception includes a continuum of methods with different pros and cons for users – and evidence suggests that women make different choices at certain stages of their life course.** Evidence suggests that contraceptive utilisation varies across age brackets and groups. Additionally, at national level there appear to be changes in the method of contraception women are opting to use which may reflect changes in users' preferences or changes in women's ability to access their preferred methods. Deepening our collective understanding of these developments on the demand side – including women's preferences and priorities – could help in supporting sexual and reproductive health. Men also have a shared responsibility for contraception and unplanned pregnancies, and their role ought to be considered in any sexual and reproductive health policy.
- **Contraception services – how they are funded, planned and delivered – would benefit from renewed policy attention.** Recent years have been a difficult period for contraceptive services. A combination of the commissioning model introduced by the Health and Social Care Act 2012 and a period of tight funding settlements has seen real service pressures emerge (alongside changing population health needs and preferences). While there is some evidence that progress continues to be made in young people's contraceptive services, overall, it is likely that some people have found it difficult to access their preferred methods of contraception. Given it has been decided that local authorities will continue to play a key role in public health services, and the planned establishment of statutory integrated care

boards, there is a need for policy development to support the optimisation of local planning arrangements, and to ensure adequate funding is made available to allow a full range of contraceptive methods to be accessible across age groups.

- **The most common modality of abortion is changing, which raises questions about models of effective holistic support for women accessing terminations.** Today the majority of women have a medical rather than surgical termination (particularly at less than 10 weeks gestation). In some respects this is beneficial for women, eg, in reducing the need for an invasive procedure, but it raises questions about how to provide effective support for women and, in particular, effective models of contraceptive support after a termination.
- **Only some of the factors influencing abortion use are likely to be amenable to policy intervention, and consequently policymakers need to ensure the selection of policy measures is informed by an understanding of the array of relevant factors.** Some factors which are contributing to trends in abortion utilisation, eg, international trends towards having fewer children, arguably represents a success for gender equality and female empowerment. There is a risk that a discourse that focuses on headline abortion trends obscures this wider context and the opportunities it presents to promote good sexual and reproductive health throughout women's lives.
- **Abortion care should be viewed as part of a broader continuum of services focused on meeting people's sexual and reproductive health needs as well as possible.** The government is devoting more policy attention to promoting good sexual health through its commitment to develop a new national strategy (the first of its kind for many years), and is developing a dedicated women's health strategy. These initiatives represent opportunities to think holistically about the funding and services which are needed to best promote good sexual and reproductive health across the life course. Abortion care should be in scope for these programmes of work, and emphasis should be afforded to how best to support women who access abortion services.

Areas for possible further empirical exploration

Exploring trends in abortion use touches on numerous social phenomena. Our work has pointed to several of these but has not investigated them in detail. Some of these would benefit from further exploration. Based on this project,

we identify three areas which would repay additional focused empirical research.

The relationship between macro- and micro-economic conditions and abortion use in the UK

There is a substantial body of research exploring the relationship between macro-economic conditions and fertility trends. Much of this work has focused on high-income countries and, as such, there is a basis to think it is relevant to the UK. However, there is ongoing academic debate about the micro-economic mechanisms, which best shed light on some of these associations. For example, some work focuses on the predictive power of unemployment rates; others have focused on GDP performance; and others have focused on indicators like housing costs and security of tenure. Alongside this, there is an established link between deprivation and abortion rates with more deprived places seeing higher rates of abortion.

This presents an opportunity to extend and deepen the analysis to understand how these trends apply in the UK (and specifically England). In particular, analysis could help to explore how a range of micro-economic factors – unemployment rates, under-employment rates, prevalence of low-security work, average wages, housing costs – correlated to abortion rates across the UK and variations between regions. Understanding in greater depth the impact of recent changes to working-age welfare policy would also be a valuable contribution. This work could help to better understand the association between ambient economic conditions and changes in fertility and illuminate the implications of decisions in other areas of domestic policy.

Developments in contraceptive preferences and choices across groups and the life course

There are a range of contraceptive methods available today, each of which vary in their use cases, statistical reliability and possible side effects. There has been some research exploring how use of contraceptive methods varies across age groups, often with a focus on understanding preferences among certain groups, eg, younger people. Public Health England has engaged women in work to understand some of their experiences of reproductive health issues (Public Health England 2018b). The latest tranche of the Natsal survey (wave 4) will help in providing more up-to-date insight into how contraceptive utilisation is developing across age groups.

Building on this, there is an opportunity to deepen this analysis by exploring users' preferences regarding contraceptive methods, and the sources of information and support they access, via empirical work. It could be insightful to explore how preferences vary between groups, and if preferences about contraceptive method change over someone's life. The factors that shape these decision-making processes would also be insightful; for example, is control over contraception particularly important at certain stages of people's lives? Relatedly, the sources of information which women (and men) consider reliable, meaningful and readily accessible at different stages of their lives may be useful to explore. Better understanding of these user perspectives, drawing on engagement with people with lived experience, could help to ensure local resource allocation choices, and service design approaches, respond to people's real contraceptive needs and preferences.

Understanding commissioning approaches for sexual and reproductive health

Planning responsibilities for sexual health services in England are determined by the Health and Social Care Act 2012. Making the Act's tripartite division of planning responsibilities work has been a recurring issue in recent years. Following the recent review by the Department of Health and Social Care, local authorities will retain lead responsibility for planning public health services (reflecting their central role in influencing the wider determinants of health). Alongside, NHS commissioning structures are set to be reorganised over the coming year as ICSs are established as statutory budget holders for health services by April 2022 (if the enabling legislation is delayed it is likely CCGs will continue to merge, or collaborate horizontally, to span system footprints).

Within this context, there is an opportunity to better understand how joined-up planning across health and public health services can be implemented at a local level. This includes building on pre-existing work to understand the range of models being used to plan sexual and reproductive health, and other questions to support the development of durable approaches. For example, there are questions about how local geographies understand needs, allocate resources between different services (including across contraceptive options) and how they assess service performance within the context of sexual and reproductive health. Developing insights about effective planning approaches that genuinely leverage the combined power of health and public health functions to meet needs effectively would be a powerful contribution to inform local planning arrangements.

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Appendix 1

The Abortion Act 1967 laid down seven legal grounds for abortion. Two medical practitioners must certify, in good faith, that a case satisfies one of these seven requirements for an abortion to be legally provided. The grounds are as follows.

a) Continuing the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
b) The termination is necessary to prevent serious permanent injury to the physical or mental health of the pregnant woman.
c) The pregnancy has not exceeded its 24th week and continuing the pregnancy would involve risk of injury to the physical or mental health of the woman, greater than if the pregnancy were terminated.
d) The pregnancy has not exceeded its 24th week and continuing the pregnancy would involve risk of injury to the physical or mental health of any children of the family or pregnant woman, greater than if the pregnancy were terminated.
e) There is substantial risk that if the child were born it would suffer from physical or mental abnormalities to be seriously handicapped.
f) To save the life of the pregnant woman.
g) To prevent grave permanent injury to the physical or mental health of the pregnant woman.

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