The Faculty of Sexual and Reproductive Healthcare
Submission to Women’s Health Strategy – Call for Evidence

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to submit a response to the consultation ‘Women’s Health Strategy – Call for Evidence’ by the Department of Health and Social Care (DHSC).

FSRH is the largest UK multidisciplinary professional membership organisation representing more than 15,000 members working at the frontline of Sexual and Reproductive Healthcare (SRH) in a range of settings in the community and primary care. Our members are SRH specialists, GPs, nurses, midwives, pharmacists and other healthcare professionals delivering services commissioned by local authorities, Clinical Commissioning Groups, NHS England (NHSE) and Public Health England (PHE).

Our goal is to ensure that high standards in SRH are achieved and maintained through appropriate funding and commissioning to ensure the population can access services which realise our vision for high-quality and holistic SRH across the life course.

As a professional membership organisation whose members deliver women’s reproductive healthcare and preventative services throughout the lifecourse across a range of settings, our response will be focused on the need for a joined up holistic approach to women’s healthcare with a focus on reproductive health and an emphasis on listening to women.

Summary of key points and recommendations

- SRH services in particular have become notoriously fractured in recent years, making them increasingly difficult for women to navigate and access. Many women are struggling to access basic services including contraception and cancer screening because of cuts in funding and a deeply fractured commissioning landscape.
- The APPG SRH, in its Parliamentary Inquiry into Access to Contraception, found that women in England are facing difficulty in accessing contraception, with many being bounced from service to service, which can result in more unplanned pregnancies and increased demand for maternity and abortion care.
- Access to SRH care is highly cost-saving. For every £1 spent on publicly-funded contraceptive services, £9 is saved, most of which is realised in the NHS.
- A lack of overall accountability and ownership in women’s reproductive healthcare has led to variations in access and quality of care. It is unclear in the current system who holds final responsibility for ensuring access and improving health outcomes.
- We believe that there is a need for SRH to be more broadly integrated into women’s healthcare pathways in the NHS. Holistic SRH care means listening to women and integrating care around the needs of the individual, not institutional silos.
- We urge DHSC to consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges (AoMRC), Royal Colleges and Faculties, which calls for women’s reproductive healthcare to be more broadly integrated into women’s health pathways in the NHS.
- The fragmentation of commissioning responsibilities will likely remain until there is one single accountable commissioner for women’s health at national and ICS level, holding accountability for commissioning and outcomes in women’s health. We believe it is also crucial that a SRH lead is represented in ICS Health & Care Partnerships’ Boards.
• At national level, accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women’s reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). Alternatively, we would welcome an expanded remit for the NCD for the Maternity Review and Women’s Health to cover women’s SRH.

• The Women’s Health Strategy and SRH Strategy clearly represent a unique opportunity to tackle the long-standing barriers to the delivery of holistic women’s reproductive health. However, this will only be possible if there is synergy between both strategies.

• We are developing the Hatfield Standards, a tool to inform both Strategies. We urge DHSC to embed the Hatfield Standards in its policy to reform the healthcare system, to ensure that any system change works ultimately to improve the care that women and girls receive.

• We fully support provision of progestogen-only contraceptive pills (POP) in pharmacies. POPs are safe, reliable, easy to use and are an incredibly popular contraceptive method. Reclassification could relieve unnecessary pressures on GPs, who will not need to see patients for repeat prescriptions.

• We would like to see the implementation of the FSRH/RCM/RCOG guidance on contraception after childbirth during COVID-19 beyond the pandemic. After childbirth, effective contraception should be discussed and offered prior to discharge from maternity services.

• Both the RCOG – Better for Women Report¹ and the APPG SRH – Women’s Lives, Women’s Right: Strengthening Access to Contraception Beyond the Pandemic² make excellent recommendations on data and education which we fully support.

• Progress is being made in improving pregnancy outcomes. However, there is much more involved in improving women’s health and wellbeing than focussing exclusively on the pregnant woman and her baby. We need to place women and girls at the centre of our health systems by implementing a lifecourse approach.

• Digital services, remote consultations and telemedicine provide a more convenient form of access to contraceptive care for many people. However, while digital and telemedical services have enhanced access for some marginalised groups, closer examinations of different groups’ needs must be undertaken. The resumption of face-to-face care, including walk-in clinics, will be crucial to ensuring continued access to care.

1) Fragmented Women’s Reproductive Healthcare - impact on Women

Current fragmentation in the way our healthcare services are designed and delivered means that many women are struggling to access basic services including contraception and cancer screening. The consequences of this are shown in debilitating indicators:

• Almost half of British women experience poor sexual and reproductive health³

• Around 45% pregnancies in Britain are unplanned or ambivalent⁴.

¹ https://www.rcog.org.uk/better-for-women
• Abortions among women in older age groups have been steadily rising. Rates to women over 30 have been increasing over the last 10 years\(^5\). Abortion rates in 2019 were the highest on record, suggesting widespread unmet need for contraception.

• Prescriptions of long-acting reversible contraception (LARC), the most effective methods to prevent unplanned pregnancies\(^6\), dispensed in the community have fallen by 8% since 2013 when commissioning responsibilities changed.

• More than a quarter of GPs responding to a survey by the Royal College of General Practitioners (RCGP) disagreed that patients who need LARC are always able to access it\(^7\).

• Late diagnosis of cervical cancer adversely impacts on survival rates. Cervical screening coverage for women aged 25 to 64 is now at 72.2%, significantly below the 80% national target\(^8\).

1.1) Impacts of COVID-19 on Women’s Health

Provisional statistics on contraceptive provision in community SRH services covering April to September 2020 show a steep fall in access to emergency contraception and LARCs compared to the same period in 2019:

• 37% fall in contraception-related contacts with SRH services
• Overall contacts including for other SRH care have fallen by 35%
• Uptake of LARC has fallen to 43%, down from 46%
• 53% fall in emergency contraceptive items

To improve these outcomes, we believe there is a need for SRH to be more broadly integrated into women’s healthcare pathways in the NHS. Holistic SRH care means listening to women and integrating care around the needs of the individual, not institutional silos, with people able to get holistic advice and support across the breadth of SRH.

2) The Current Challenges: Funding and Commissioning of Women’s Reproductive Healthcare Services

2.1) Funding

Local Authorities receive an annual ring-fenced grant to fund their public health functions. In addition to their SRH responsibilities, this includes competing responsibilities in relation to children’s health services, substance misuse services, smoking cessation, obesity prevention and physical activity. In recent years the public health grant has faced a series of significant cuts. Analysis by the Health Foundation estimates that these cuts were equivalent to £700 million in real terms between 2014/15 and 2019/2020. Cuts to the wider public health grant have affected SRH budgets. Evidence presented to the All Party Parliamentary Group for Sexual and Reproductive Healthcare’s (APPGSRH) Inquiry – Women’s Lives, Women’s Rights: Strengthening Access to Contraception Beyond the Pandemic\(^9\) suggests that SRH budgets were cut by £81.2 million (12%) between 2015 and 2017/18. During the same period, it is estimated that contraceptive budgets were cut by £25.9 million (13%).

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\(^6\) LARCS are the intrauterine device (IUD), the intrauterine system (IUS, a hormonal IUD), the contraceptive implant and the contraceptive injection.

\(^7\) RCGP 2017. *Time to Act*


The Inquiry heard that although Directors of Public Health have taken action to mitigate the significant impact of cuts through innovation and modernisation, some Local Authorities are now reaching the limit of available efficiencies. The Inquiry heard that in some areas routine oral contraception is not being provided in SRH contraceptive services to people over 25 years old. In other locations free emergency contraception from pharmacies is unavailable for those over 25, 21 or 17 or is not commissioned at all. In other areas, access to services is restricted by a patient’s address.

In practical terms, cuts have led to service closures, reduced opening hours, reduced service provision and cuts to staff numbers. Almost half of councils have reduced the number of sites delivering contraceptive services in at least one year since 2015, whilst 13% of councils have reduced the number of sites over multiple years.\(^{10}\)

SRH contraceptive services are being commissioned with a reduced service offer. This can lead to reduced access to different methods of contraception or discrepancies based on age, or residency. Cuts to Local Authorities funding also increase pressure on other services as women are redirected.

Evidence from a 2017 survey by the Royal College of General Practitioners (RCGP) found that 41% of GPs in England, where local authorities had responsibility for commissioning LARC in their practices, reported an increased number of appointments for contraceptive advice. Despite this, General Practices are not being adequately funded to provide LARC, which disincentivises provision. More than 10% of councils reduced the number of contracts with GPs to fit LARC in 2018/19.\(^{11}\)

2.3) Impact on women

Reduced service provision inevitably impacts women. The APPG SRH, in its Parliamentary Inquiry into Access to Contraception, found that women in England are facing difficulty in accessing contraception, with many being bounced from service to service, which can result in more unplanned pregnancies and increased demand for maternity and abortion care.

The APPG SRH Inquiry heard reports of long waiting times to access contraception and anecdotally heard of women becoming pregnant whilst on waiting lists. The Inquiry also heard report of women travelling unacceptable distances to access health care.

2.4) Commissioning

The current commissioning arrangements for women’s health cause significant barriers for many women and girls trying to access basic preventative healthcare. Women’s health has suffered the most from the reorganisation of NHS services that ensued with the implementation of the Health & Social Care Act in 2013. Where once women could have all their reproductive health needs met in one place and one go, women are now subjected to disjointed, non-holistic, disintegrated care.

A review of SRH commissioning by Public Health England (PHE) and the Association of Directors of Public Health (ADPH) has found that fragmented commissioning is threatening access to contraception and other services, indicating that “LARC and cervical cytology might suffer”\(^{12}\).

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\(^{12}\) PHE 2017. *Sexual Health, Reproductive Health and HIV. A Review of Commissioning*
A lack of overall accountability and ownership in women’s reproductive healthcare has led to variations in access and quality of care. It is unclear in the current system who holds final responsibility for ensuring access and improving health outcomes. The APPG SRH Inquiry gathered evidence of a significant lack of local and national accountability for ensuring access and improved women’s reproductive health outcomes.13

We urge DHSC to consider the joint position on integrated Sexual and Reproductive Healthcare commissioning by the Academy of Medical Royal Colleges (AoMRC), Royal Colleges and Faculties, which calls for women’s reproductive healthcare to be more broadly integrated into women’s health pathways in the NHS. Similar recommendations have also been made by the APPG SRH in their inquiry.

The below table14 illustrates clearly why by-design the current system has inherent faults across SRH, whereby there is not a single body vested in ensuring the holistic needs of women are being met15. To underline how this fractured system does not meet the needs of women, we have highlighted the split in women’s reproductive health commissioning responsibilities with a ✓.

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>Clinical Commissioning Groups (CCGs)</th>
<th>NHS England</th>
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<tbody>
<tr>
<td>✓ Contraception and advice on unplanned pregnancies in SRH services</td>
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<tr>
<td>✓ LARCs in primary care</td>
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<td>✓ STI testing and treatment in SRH services and primary care: partner notification</td>
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<td>✓ HIV testing and partner notification</td>
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<td>✓ Sexual health specialist services incl. young people’s services, outreach and promotion</td>
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<td>✓ Support for teenage parents</td>
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<td>✓ Chlamydia Screening</td>
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<tr>
<td>✓ Sexual health aspects of psychosexual counseling</td>
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<tr>
<td>✓ Abortion services, incl. contraception, STI &amp; HIV testing in abortion pathway</td>
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<tr>
<td>✓ Contraception for gynaecological purposes</td>
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<td>✓ Female sterilisation</td>
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<td>✓ Male sterilisation</td>
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<tr>
<td>✓ Non-sexual health aspects of psychosexual health services</td>
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<td>✓ HIV testing when clinically indicated in CCG-commissioned services</td>
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<td>✓ Contraception under GP contract</td>
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<td>✓ Cervical screening</td>
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<tr>
<td>✓ Specialist foetal medicine services, incl. late termination of pregnancy for foetal anomaly between 18 and 24 gestational weeks</td>
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<tr>
<td>✓ HIV treatment</td>
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<tr>
<td>✓ STI &amp; HIV testing and STI treatment in general practice when clinically indicated / requested by patient</td>
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<tr>
<td>✓ HIV testing when clinically indicated in NHS-commissioned services</td>
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<tr>
<td>✓ HPV immunisation</td>
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<tr>
<td>✓ Sexual assault referral centres (SARCs)</td>
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<tr>
<td>✓ Sexual health in secure and detained settings</td>
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<tr>
<td>✓ NHS Infectious Diseases in Pregnancy Screening</td>
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Although many of the downstream benefits of preventing unplanned pregnancy are felt in the NHS (costs to maternity services, abortion pathways etc), it has been particularly difficult to engage Local Authorities to prioritise commissioning for benefits which are realised under NHS auspices, not least at a time where the public health budgets of Local Authorities have been severely cut. Conversely, there are policy decisions being undertaken through the NHS, which demonstrate a lack of holistic planning, not least the example of contraception having no clear workstream pathway under the NHS’s Maternity Transformation Programme.

13 RCOG 2019. Better for women
This does not make economic sense – access to SRH care is highly cost-saving. PHE estimates that for every £1 spent on publicly funded contraceptive services, £9 is saved, most of which is realised in the NHS\(^\text{16}\).

3) Solutions

We believe the fragmentation of commissioning responsibilities will likely remain until there is one single accountable commissioner for women’s health at national and Integrated Care System (ICS) levels, holding accountability for commissioning and outcomes in women’s health. There is consensus across the medical and non-medical healthcare professions that the commissioning and accountability landscape is not fit-for-purpose, with calls for integrated holistic commissioning of women’s reproductive healthcare.

3.1) Leadership and Accountability at National Level

At national level, accountability could be enhanced with the appointment of a National Clinical Director (NCD) for women’s reproductive health or a National Specialty Adviser in Community Sexual and Reproductive Healthcare (CSRH). Alternatively, we would welcome an expanded remit for the NCD for the Maternity Review and Women’s Health to cover women’s Sexual and Reproductive Health.

3.2) Leadership and Accountability in Integrated Care Systems (ICS)

As ICSs develop and are given statutory footing, we believe merging CCGs into ICSs might prove helpful to undo some of the commissioning barriers. However, the question of how the commissioning responsibilities of ICSs and those that stay with NHSE will work and interrelate in practice still remains.

To ensure clear lines of accountability, we would strongly welcome the appointment of a women’s health lead at the ICS NHS Body Board or equivalent structure. We believe it is also crucial that a Sexual and Reproductive Healthcare lead is represented in Health & Care Partnerships’ Boards.

3.3) National Strategies: Women’s Health and SRH

The Women’s Health Strategy and SRH Strategy clearly represent a unique opportunity to tackle the long-standing barriers to the delivery of holistic women’s reproductive health. However, this will only be possible if there is synergy between both strategies.

In May 2021 correspondence addressed to FSRH, AoMRC and Colleges and Faculties, the Minister Nadine Dorries stated that policy officials are working closely together to ensure coherence between the two strategies. We welcome the reassurance as well as the Minister’s willingness to work with us and take part in a women’s reproductive health roundtable. The roundtable will be an important vehicle to ensure both strategies work towards improving women’s reproductive health outcomes holistically.

3.4) The Hatfield Standards

The current policy environment presents an important opportunity to set out a clear vision for
good women’s reproductive healthcare, including access to contraception. The system
reforms and upcoming strategies must align and interrelate in order to benefit women’s
reproductive health and to ensure that women’s contraceptive needs are met.

To that end, we are developing the Hatfield Standards, a tool focusing on nine key areas
representing the highest potential for delivering improved outcomes at the individual and
population level. The Standards are being developed in consultation with DHSC civil servants
and key stakeholders such as Brook, the Advisory Group on Contraception and the Primary
Care Women’s Health Forum (PCWHF). We urge DHSC to embed the Hatfield Standards in
its policy to reform the healthcare system, to ensure that any system change works ultimately
to improve the care that women and girls receive.

The concept is supported by Dr Matthew Jolly, National Clinical Director for the Maternity
Review & Women’s Health; Dr Ed Mullins, leading postpartum contraception specialist, clinical
advisor to the CMO; and Alison Hadley - Director of the Teenage Pregnancy Knowledge
Exchange.

4) The Right to Contraception

There is a long-established history of free, open-access sexual health services in England.
Women have been able to access contraception free of charge since 1974 when changes
outlined in the NHS Reorganisation Act were implemented. Currently, the majority of women
in England access contraception from General Practice. Young people and marginalised
groups are most likely to access contraception from community SRH clinics.

The ability to choose when and whether to become pregnant has a direct impact on a woman’s
mental and physical health and plays a crucial role in improving maternal health, reducing
infant mortality and reducing poverty, as women are better able to participate in economic life.
Equitable access to contraception is seen as fundamental to achieving the Sustainable
Development Goals by 2030, and in 2012 the United Nations declared contraception a
human right. Concomitantly, the 2012 Health and Social Care Act (HSCA) had two key
objectives, to improve care for patients and ‘facilitate’ choice. It has been unsuccessful in both
these respects and has resulted in more fragmentation of services.

Whilst most women are able to access some form of contraception, the recent Inquiry by the
APPG SRH heard that choice of both method and location of provision is being eroded. PHE
estimates that one third of women cannot access contraception from their preferred
setting and the Inquiry heard that people from deprived or marginalised groups are particularly
affected. As a result, their human right to access contraception is not being realised.

The following are recommendations on how the system can best facilitate women’s right to
contraception across different settings.

4.1) Progestogen-Only Pill (POP) in pharmacies

We fully support provision of progestogen-only pills (POP) in pharmacies. POPs are safe,
reliable, easy to use and are an incredibly popular contraceptive method. Availability over the
counter in pharmacies will make it easier for women to access essential contraception to avoid
unplanned pregnancies beyond COVID-19. Reclassification could relieve unnecessary
pressures on GPs, who will not need to see patients for repeat prescriptions.
Pharmacies already play an important role in the provision of contraception and are a convenient, expert source of help and advice. Reclassification would increase access to an effective method of contraception and enable women to make an informed choice about their needs after discussion with a pharmacist and is supported by the Royal Pharmaceutical Society (RPS) and RCOG\(^\text{17}\).

There is strong evidence to support the provision of progestogen-only pills in pharmacies. The well-designed recent study “Use of effective contraception following provision of the progestogen-only pill for women presenting to community pharmacies for emergency contraception (Bridge-It)\(^\text{18}\): a pragmatic cluster-randomised crossover trial” by Cameron, et al 2020 reported that individuals receiving levonorgestrel emergency contraception from a pharmacy are more likely to be using effective contraception four months later if they also receive a three-month supply of progestogen-only pills.

Over 600 individuals took part in the study and were randomised into either the control or intervention groups. At four months, subjects in the intervention group were 20% more likely to be using effective contraception than those in the control group, and significantly less likely to have required further emergency contraception.

The Bridge-It study indicates that provision of a 3-month bridging supply of a desogestrel POP by a pharmacist when an individual presents to the pharmacy requesting oral emergency contraception could increase their future use of effective contraception. In the UK, most oral emergency contraception is provided in pharmacies.

### 4.2) Contraception in maternity settings

Together with RCOG and RCM, we have released ‘Guidance on the provision of contraception by maternity services after childbirth during the COVID-19 pandemic’. It is not only during the pandemic that postnatal contraception should be offered, and we would like to see the implementation of our guidance in maternity settings. However, this will only be possible within a more joined up holistic SRH system. We recommend:

- Information about contraception after childbirth should be offered in the antenatal period to support informed decision-making and facilitate provision of contraception by maternity services.
- After childbirth, effective contraception should be discussed and offered prior to discharge from maternity services.
- Maternity services with staff trained in postpartum insertion of intrauterine contraception and the implant should offer insertion of a LARC device to all medically eligible women prior to discharge from maternity services.
- If women cannot be provided with their preferred method of contraception prior to discharge from maternity services, they should be offered effective bridging contraception and information about accessing local contraceptive services.
- Protocols for timely offer and provision of contraception should be put in place to prevent delay in discharge from maternity services.

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\(^{18}\) [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31785-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31785-2/fulltext)
5) Information and Education on Women’s Health

Getting the funding, commissioning, workforce and data right and making it easier for people to access the support they need in a range of settings is essential to improving access to contraception. However, the ability to make informed choices is underpinned by education and information. Whilst school provides an ideal opportunity for young people to learn about sex, relationships, contraception and pregnancy, the provision of information must take a lifecourse approach, meeting the needs of all people, regardless of age.

- Knowledge and understanding of different contraceptive methods are fundamental to ensuring women can make an informed choice. Evidence to the APPG SRH Inquiry suggested significant gaps, but currently there is no national measure to assess women’s knowledge and monitor improvements.

- Current data on access to contraception is inadequate. Current data only covers LARC provision rather than the full range of contraceptive methods in General Practice and the annual publication of SRH service contraceptive activity is inadequate. Without these data it is not possible to assess access to contraception or to efficiently plan and commission services to meet the needs of women.

- More accurate data are needed to understand inequalities in access to contraception. Collecting data considering uptake of contraception by ethnicity and socioeconomic group, as well as sexuality and gender identity, would enable a better understanding of issues affecting these groups, for example the higher rates of unwanted pregnancy among lesbian and bisexual adolescents.

Both the RCOG – Better for Women Report\(^{19}\) and the APPG SRH – Women’s Lives, Women’s Right: Strengthening Access to Contraception Beyond the Pandemic\(^{20}\) make excellent recommendations on data and education which we fully support.

6) Women’s Health Across the Lifecourse

During every woman’s life, there are opportunities to help her improve her physical and mental health and wellbeing. Women have predictable long-term reproductive healthcare needs and more frequent interactions with health services than men.

It is important to acknowledge the progress that is being made in improving pregnancy outcomes. Political leaders, policy makers, clinicians and other stakeholders have shown a commitment and determination to improve standards in maternity care and safety across the UK. However, there is so much more involved in improving women’s health and wellbeing than focussing exclusively on the pregnant woman and her baby. Indeed, sustainable improvements in maternity care will never be achieved until we recognise, tackle, and resolve all of the determinants of health and wellbeing throughout women’s lives and place girls and women at the centre of our health systems.

While women number 51% of the population they represent a much higher proportion of the primary carers in society and exert a strong influence on the health behaviours of their families and local communities. Adopting a lifecourse approach provides an insight into the impact of the many biological, behavioural, and social determinants of health and wellbeing. Not only do events occurring at each stage of an individual woman’s life have an impact on the quality of the next stage, but there is clear evidence of a strong intergenerational transmission of

\(^{19}\) https://www.rcog.org.uk/better-for-women

health behaviours and outcomes. Most importantly, a lifecourse perspective offers us the potential for early intervention to reduce the risk of certain diseases from developing.

In contrast to sporadic episodes, women have reproductive and sexual health needs that unfold across their lifecourse. The majority of women want to enjoy healthy sexual relationships and have control of their fertility in order to decide if, when and how often they want to become pregnant. This requires timely and accurate SRH education and access to effective contraception. The trend towards earlier sexual activity and deferred childbearing means that most women in the UK now require reliable reversible contraception for up to three decades.

We know that the physiological demands of pregnancy can be viewed as an early stress test. For many women pregnancy can identify an increase in their risk of future chronic diseases such as diabetes, heart disease and mental health conditions. A growing number of older women are now seeking assisted conception as their fertility declines with age and nearly one in five women will remain childless, either through choice or circumstance. There is an inevitability that women will become menopausal and require help with management of chronic conditions and the onset of frailty in their later years.

We need to use this wealth of knowledge and data collected throughout women’s lives by healthcare professionals to develop improved services for women that avoid wasted resources and deliver better outcomes. This is neither rocket science nor blue-sky aspiration. It can be achieved by placing women and their predictable needs at the centre of our service planning and taking some simple practical steps to harness existing resources and use them more efficiently.

7) Access for marginalised groups

During the COVID-19 pandemic, services have reported a drop in the number of young and Black, Asian, and Minority Ethnic (BAME) people requesting care, leading to concerns that these marginalised groups may have been particularly affected by restrictions in access to care.

Digital services, remote consultations and telemedicine provide a more convenient form of access to contraceptive care for many people, including women in rural areas or those who struggle to travel to healthcare settings due to childcare responsibilities, disability, or financial constraints. They also help to alleviate stigma which, in some communities, may be associated with visiting a clinic.

However, while digital and telemedical services have enhanced access for some marginalised groups, closer examinations of different groups’ needs in relation to digital and telemedical care must be undertaken. The resumption of face-to-face care, including walk-in clinics, will be crucial to ensuring continued access to care for all women.

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