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All Party Parliamentary Group on Sexual and Reproductive Health in the UK

Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic

Contents

The Faculty of Sexual and Reproductive Healthcare (FRSH) provides the secretariat to the APPG on Sexual and Reproductive Health in the UK, with support from the Royal College of Obstetricians and Gynaecologists, Marie Stopes UK, and Bayer Healthcare. Editorial control rests with the APPG alone.

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This report has been formally endorsed by the Faculty of Sexual and Reproductive Healthcare, the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners.

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Foreword

Access to contraception is a human right. The ability to decide whether and when to have children is fundamental to the physical, psychological and social wellbeing of women. This is reflected in the UN Sustainable Development Goals, where universal access to contraception and other sexual and reproductive healthcare underpins Goal 3 of Good Health and Wellbeing.

Since the passage of the 2012 Health and Social Care Act, the All-Party Parliamentary Group on Sexual and Reproductive Health (APPGSRH) has heard evidence of women being unable to access contraception in a way that meets their needs, and as a result being unable to fully control their reproductive lives. This Inquiry was launched in response to these concerns, and re-launched to understand the impact of the Covid-19 pandemic on women's access to contraception in the spring and summer of 2020.

We were grateful to receive over 70 written and oral evidence submissions from organisations in the public, private and voluntary sectors including the Minister for Women's Health, the Department of Health and Social Care, Public Health England, the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare and the Royal College of General Practitioners.

During the Inquiry we heard of problems associated with funding, commissioning and workforce resulting in women having to travel unacceptably long distances or wait for far too long to access contraception. Despite the best efforts of many practitioners, the Covid-19 pandemic highlighted these existing problems and further restricted access to contraception for many women. Many services face severe long-term challenges as a result of the pandemic.

We also heard of systems that artificially separate women's contraceptive needs from their other reproductive health needs, which can result in them being bounced from service to service or being required to undergo multiple examinations when only one is clinically necessary. Examples relating to cervical screening or the provision of contraception to treat medical conditions, such as heavy menstrual bleeding (menorrhagia) provide particularly stark illustrations of these failures.

The restoration of services after the Covid-19 pandemic, along with the repurposing of the functions of Public Health England, provides a unique opportunity for national and local government to reshape contraceptive services according to the needs of women themselves and to make more efficient use of NHS resources. This report sets out our findings and recommendations, which aim to ensure services are in place to enable women to fulfil their reproductive choices and look after their reproductive health. Collaboration between the Department of Health and Social Care and NHS England, working closely with the relevant teams in the future arrangement of Public Health England, will be paramount to meeting these goals, and addressing the structural barriers put in the paths of women.

We hope that you will find this report of value, and we especially hope it will prove useful to those with the important task of rebuilding services following the pandemic.

Dame Diana Johnson DBE MP

Chair, All Party Parliamentary Group on Sexual and Reproductive Health in the UK

Introduction

The All Party Parliamentary Group on Sexual and Reproductive Health (APPGSRH) is a cross-party group of Peers and MPs established to facilitate discussions between Parliamentarians and stakeholders on sexual and reproductive health issues.

In recent years the APPGSRH has become increasingly concerned that cuts to budgets, fragmented commissioning and workforce issues were affecting women's ability to access contraception in a way that meets their holistic sexual and reproductive health needs. The APPGSRH launched an Inquiry in February 2019 to assess the extent of these issues, and if necessary, to make recommendations to policy makers. Although the Inquiry was launched with the intention of publishing within a year, this was not possible due to a general election being called in November 2019.

By June 2020, the Covid-19 pandemic had drastically altered the landscape of contraception care, changing access pathways and often limiting patient choice over what form of contraceptive care to access. In response to these circumstances, the APPG decided to reopen the Inquiry to examine the impact of the pandemic on access to contraception, and to highlight constructive changes to preserve in the coming months when rebuilding services.

The Inquiry was supported by an expert panel consisting of:

- Baroness Barker, Co-Chair, APPG for Sexual and Reproductive Health
- Dame Diana Johnson DBE MP, Co-Chair, APPG for Sexual and Reproductive Health
- Baroness Tonge, Chair, APPG for Population, Development and Reproductive Health
- Paula Sherriff, former MP and Chair, APPG for Women's Health
- Alison Hadley, Director of Teenage Pregnancy Knowledge Exchange, University of Bedfordshire
- Dr Connie Smith, Former Consultant in Contraception and Reproductive Health Care
- Dr Anne Connolly, Chair of Primary Care Women's Health Forum and GP

The APPG issued a call for written evidence from individuals and organisations involved in the sexual health and reproductive healthcare sector. The panel was extremely grateful to receive 35 submissions of written evidence in its 2019 submissions window and 25 submissions of written evidence in its 2020 submission window. The panel also wishes to thank those witnesses who participated in the oral evidence sessions in 2019.

A list of organisations who gave evidence can be found in Appendix 1. The full terms of reference for the Inquiry can be found in Appendix 2.

A note on language

We acknowledge that not only individuals who identify as women require access to contraceptive care, and that services must be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth. The terms 'woman' and 'women's health' are used for brevity, on the understanding that trans men and non-binary individuals assigned female at birth also require access to these services.

The report focusses on contraception and reproductive health for those with a female reproductive system. Access to male contraceptives, such as male condoms and vasectomy, although an important contribution to women's reproductive health, are not the focus of this report.

Background and current situation

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, rather than from dedicated sexual and reproductive health (SRH) clinics. Young people and marginalised groups are most likely to access contraception from clinics.

What are the main methods of contraception?

There are fifteen common methods of modern contraception (see Appendix 3) which provide women with a choice of short term, long-acting reversible and permanent methods of contraception to best suit their needs. In addition to the 15 methods of contraception outlined, emergency contraception, which incorporates both the emergency contraceptive pill and the intrauterine device (IUD) is a crucial part of full contraceptive choice.

Some methods of contraception such as the IUD can also be used to treat symptoms of certain conditions including menorrhagia (heavy menstrual bleeding).

Types of contraception

- **Long-Acting Reversible Contraception (LARC)** – Contraceptive methods that require administration less than once per cycle or month, including **Intrauterine Devices (IUDs)** and subdermal implants.
- **Emergency contraception** – Contraception used after sexual intercourse to prevent pregnancy. Two main types of emergency contraception exist:
  - Emergency contraceptive pill protects against pregnancy for 3-5 days after intercourse, depending on the medication.
  - IUD fitting prevents pregnancy for up to 5 days after intercourse, and provides contraception thereafter for up to 10 years.
- **Oral contraception** – Contraception that can be taken orally, such as the Progestogen-Only Pill (POP) and the combined hormonal contraceptive.
- **Permanent methods** – Surgical procedures which cause permanent sterilisation.
- **User-dependent methods** – Methods of contraception that rely on the user ingesting or administering them, such as oral contraception, condoms and the contraceptive patch.

For a full glossary of terms used, please see the Appendix.

Why is access to contraception so important?

The ability to choose when and whether to become pregnant has a direct impact on a woman's mental and physical health. Globally, women's control over when to have children and how many children to have 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.[1] Contraception provision also has major economic and public health benefits: Public Health England estimates that for every £1 spent on contraception there is a £9 saving for the public sector.[2]

In the UK, women are becoming sexually active earlier and having children later in comparison with previous generations. Taken together with women's desire to have fewer children, this means that the majority of women are trying to prevent pregnancy for most of their 30 years of reproductive life. Since women make up 51% of the UK population, providing equitable access to contraception is a major challenge, and an important priority, in terms of service provision.

Numerous studies have shown that an increased use of contraception can lead to a decrease in the number of unintended pregnancies. Whilst the majority of unintended pregnancies in the

UK have positive outcomes, women who have unintended pregnancies are more likely to present later for antenatal care, which can lead to obstetric complications, and are more likely to experience postnatal depression. Babies born in such circumstances are more likely to experience low birth weight, mental health issues and poor health outcomes. Babies born to women under 20, the age group at highest risk of unintended pregnancy, also have higher rates of stillbirths and significantly higher rates of infant mortality and low birth weight.

Who is responsible for ensuring access to contraception?

Responsibility for sexual and reproductive (SRH) healthcare services is split across three bodies.

1. Local Authorities are mandated to "*commission contraceptive advice and a broad range of contraceptive methods*".[3] This is primarily delivered in specialist SRH services, which are increasingly integrated as SRH services to test and treat for sexually transmitted infections (STIs). It is also delivered within pharmacies, schools and in services for young people. Many Local Authorities also commission some General Practices to deliver Long Acting Reversible Contraception (LARC), which are not user-dependent.
2. The General Medical Services (GMS) contract between General Practices and NHS England requires General Practice to provide basic (i.e. user dependent) methods of contraception.
3. Clinical Commissioning Groups (CCGS) are responsible for commissioning permanent methods of contraception (i.e. vasectomy and sterilisation) as well as access to contraception in abortion services.

Clinical Commissioning Groups	NHS England	Local Authorities
› Abortion services (and contraception in abortion pathways) › Gynaecology, including any use of contraception for non-contraceptive purposes, e.g. heavy menstrual bleeding › Permanent contraception i.e. vasectomy and sterilisation › Non-sexual-health elements of psychosexual health services	› Basic contraception under the GP contract › HIV treatment and care › STI testing and treatment under GP contract › Cervical screening › HPV programme › Sexual assault referral centres	› Contraception delivered in specialist services › LARCs in GPs › STI testing and treatment › chlamydia screening › HIV testing and prevention › Sexual health aspects of psychosexual counselling › Services for young people › Services in schools › Services in pharmacies

What do the statistics say?

Contraception access and uptake

13% of sexually active women who are not planning a pregnancy reported not using any source of contraceptive supplies within the last year.[4] The majority (around two thirds) of women using contraception obtain it from their GP, who are the main providers of LARC. This Inquiry heard that the number of prescriptions for LARC, which is the most effective form of contraception, dropped by 11% in General Practice between 2014 and 2016.[5]

Around a quarter of women obtain contraception from specialist SRH services.[6] Although contraception-related attendances in specialist services dropped by 13% between 2014/15 and 2017/18, LARC prescriptions have remained relatively stable.[7] In total this has led to a 3% decline in the number of overall LARC prescriptions across GPs and SRH clinics.[8]

Data on inequalities in access and provision exists, but is incomplete. The Sexual and Reproductive Health Activity Data Set (SRHAD) provides key measures from SRH services by Index of Multiple Deprivation (IMD), but is not recorded in General Practice, where the majority of women access contraception.

Unintended pregnancies

Data from the National Survey of Sexual Attitudes and Lifestyles (NATSAL) shows that 45% of pregnancies and one third of births in England are unplanned or associated with feelings of ambivalence.[9] This suggests a serious unmet need for contraception. At present abortion rates and teenage conception data are used as proxy to understand access to contraception. Whilst statistics show significant improvements, they also indicate geographical and demographic inequalities.

Teenage pregnancies

In England 16.7 per 1,000 women under 18 became pregnant in 2019. This is almost a 60% decrease compared with 2007.[10] Despite significant improvements, inequalities are apparent: there is, for example, a seven-fold difference in teenage pregnancy rates between Local Authorities and 60% of Local Authorities have at least one ward with a rate significantly higher than the England average. Among under-18s, 53% of conceptions end in abortion; this rises to over 60% in under 16s.[11]

Despite a decline in the overall teenage pregnancy rate over the last decade, England remains the country with the highest rate in Western Europe. This, together with persistent inequalities within England, illustrates the need for further progress.

Abortion rates

Abortion rates have been rising incrementally over the last 10 years, with rates in 2019 the highest since the Abortion Act 1967. Abortion rates are highest amongst 20-24 year olds, however rates in under 25s have declined in the last ten years, and have halved among under-18s since 2007. In contrast, there have been increases in rates of abortion in women over 30, suggesting a rise in unplanned conceptions among this cohort of women.

Inequalities exist by ethnicity and 8% of abortions occur in women self-reporting as black, who represent just 3% of the general population. Though data do not monitor variations by ethnicity in the uptake of contraception, this strongly suggests an unmet need for contraception among black communities. There is also inequality by deprivation. The rate among the most deprived populations is 26.1 per 1000 women, more than double the rate of 12.0 in the least deprived populations.

In 2019, 40% of women receiving abortion care had had one or more previous abortions, a proportion that has increased steadily from 34% in 2009. This indicates a longstanding unmet need for contraception, which is worsening in some areas of the population.

While it is positive that so many women can access abortion services when they do not wish to continue a pregnancy, abortion is also a more expensive and less preferable option in comparison to contraception for most women.

Overview of findings

Whilst most women are able to access some form of contraception, this Inquiry 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 this Inquiry heard that people from deprived or marginalised groups are particularly affected.[12]

Funding cuts have resulted in reduced Local Authority funded provision of contraception. This not only increases demand on remaining services but increases pressure on General Practice as women are redirected. It also limits the amount of support specialist services can provide to primary care, including providing training opportunities and opportunities for referral of women with complex problems.

At the same the time, fewer training opportunities as well as a lack of incentives for General Practices to offer LARC means staff may not have the qualifications to fit LARC. This can result in long waits and delays, women not being able to access the full range methods of contraception or women being unnecessarily redirected to specialist services, leaving them at risk of unintended pregnancy during the delay.

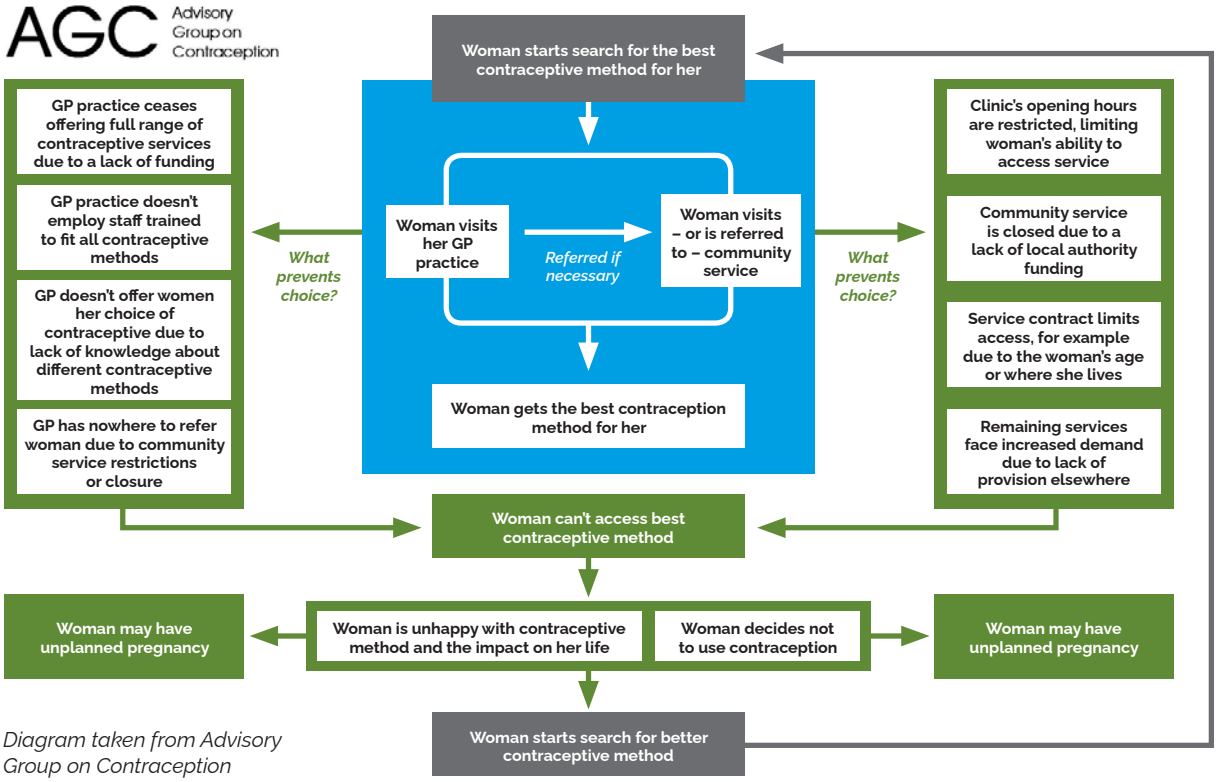


Diagram taken from Advisory Group on Contraception

This Inquiry heard that contraception is just one facet of good reproductive health over a woman's life course. However, organisational silos within women's health created by issues relating to funding, workforce and compounded by fragmented commissioning and inadequate lines of accountability hinder women from receiving the best possible care.

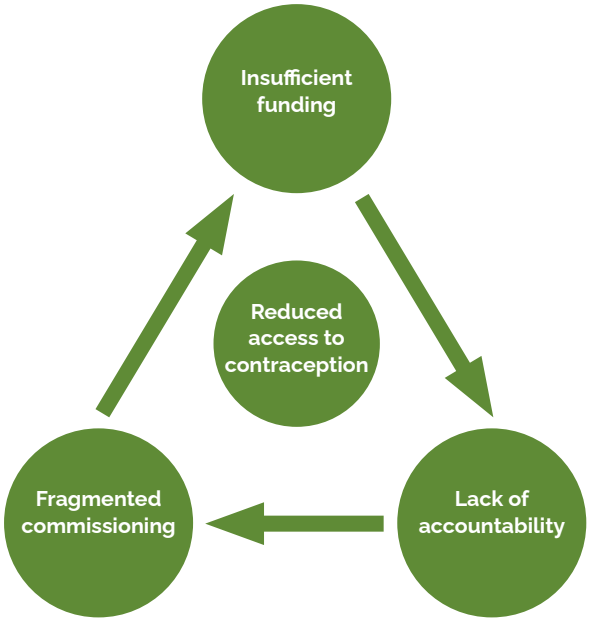
As well as improvements regarding the issues outlined above, there are opportunities to improve access by making use of technology, better utilising opportunities that exist in pharmacy and post pregnancy settings and ensuring girls and women have appropriate education and information to enable effective and empowered decision making.

Funding

This Inquiry heard evidence that a combination of insufficient funding, fragmented commissioning and a lack of accountability is reducing access to contraception and causing gaps in care pathways, which leaves women's health disjointed and piecemeal.

Funding arrangements

Local Authorities receive an annual ring-fenced grant from the Department of Health and Social Care to fund their public health functions. In addition to their SRH responsibilities, this includes responsibilities in relation to children's health services, substance misuse services, smoking cessation, obesity prevention and physical activity.



Funding cuts

In recent years the public health grant has faced a series of significant cuts. Analysis by the Health Foundation estimates that these cuts will have been equivalent to £700 million in real terms between 2014/15 and 2019/2020.[13]

Cuts to the wider public health grant have affected Sexual and Reproductive Health (SRH) budgets. Evidence presented to this Inquiry 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%).[14]

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.[15]

Impact of cuts on service provision

In practical terms cuts have led to service closures, reduced opening hours, reduced service provision and cuts to staff numbers. This Inquiry heard that:

- 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.[16]
- 11% of councils reduced the number of contracts with GPs to fit LARC in 2018/19.[17]
- 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.

> This 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.

Cuts to Local Authorities funding also increase pressure on other services as women are redirected. Evidence from a 2017 RCGP survey found that 41% of GPs in England reported an increased number of appointments for contraceptive advice.[18]

Despite this, General Practices are not being adequately funded to provide LARC, which disincentivises provision. This Inquiry heard that practices in Hampshire were paid £80 for the provision of LARC. This covers staff time for the consultation, fitting, follow-up and removal of LARC, as well as funding for the necessary chaperone.[19] Evaluation in another area suggested that the true cost was nearer to £140.

Impact on women

Reduced service provision inevitably impacts women. This Inquiry heard reports of long waiting times to access contraception and anecdotally heard of women becoming pregnant whilst on waiting lists.

This Inquiry also heard report of women travelling unacceptable distances to access health care.

> *'People are travelling from London to access sexual healthcare from us as they have friends or relatives here and it is easier for them to come for a long weekend to Devon and have their needs met whilst here rather than find a service in London. One woman advised me she was unable to get her IUC changed in London as she was over 25 and therefore could not attend a sexual health service and her GP did not offer IUC fitting.* – Dr Jane Bush, Clinical lead, Exeter

Comments offered to a survey conducted by researchers from the UCL Institute for Women's Health provide an example of common concerns relating to access and choice.

> *"I wanted the coil but I found it difficult to find someone to fit it in London."*
>
> *"I find it very difficult to find a clinic that's accessible, and has appointments out of office hours. My injection was late because I couldn't get an appointment anywhere in time."*
>
> *"Got my (first) implant out November. It wasn't until March that I was able to successfully get the (second) implant inserted."*
>
> Quotes taken from responses to a survey by UCL Institute for Women's Health

Impact on marginalised groups

further and to less convenient locations. This disproportionately affects groups without the means or finances to travel further or those who struggle to navigate the increasingly complex system. For example, this Inquiry heard of sharp reductions in cervical screening among South Asian women when a service was relocated.

Furthermore, disadvantaged and young people are more likely to attend specialist services, whilst Black, Asian and Minority Ethnic (BAME) individuals are less likely than their white counterparts to attend their GP for contraception. They are therefore more likely to be affected when specialist SRH services struggle to meet demand.

> *'I have tried to go to the clinic repeatedly and waited for hours. If you work a minimum wage job or shift work then you really can't do that.'* – Respondent, Decolonising Contraception survey

The Inquiry acknowledges the limited usefulness of the 'BAME' terminology when discussing the needs of Black, Asian and other ethnic minority people with regards to contraception. The Inquiry heard that, while Black, Asian and other ethnic minority people are certainly more likely to encounter significant barriers while accessing contraception, the needs of this group are not homogenous and should not be treated as such by policy makers. The Inquiry welcomes the suggestion from Decolonising Contraception that improving access for marginalised groups requires an examination of the way in which women's identity and life circumstances, as well as other socio-economic, educational, cultural and historical factors, affect their ability to access contraceptive care.

Specialised clinics for young people are also particularly vulnerable, as cost savings promote moves towards all age integrated services, which may deter young people from seeking early advice and have safeguarding implications.

Impact on staff

This Inquiry also learnt of the wider impact of cuts on staff retention (chapter 6). Continual service re-organisation causes uncertainty and affects staff morale. The awareness of further cuts means staff vacancies are frozen and acts as a disincentive for investment and innovation.

Case study: The impact of funding cuts on services for young people

Brook provides specialist young people's services. Its service users are often vulnerable and are more likely to have safeguarding issues than older people attending integrated services. As a result, consultations can take longer.

This Inquiry heard that as budgets are squeezed, specialist provision for young people's sexual health (which is assumed to be more expensive) is often cut. This may involve reduced opening hours, the defunding of roles, the reduction in the age range catered for, or the total closure of services.

Evidence presented to this Inquiry suggests that in areas where specialist young people services have been decommissioned, the reporting of safeguarding concerns in local all age services does not increase in line with expectations. It is not clear whether this is because all age services have a higher safeguarding threshold or because vulnerable young people are not accessing these services.

There is insufficient evidence on whether vulnerable young people are still being protected when specialist young people's services are closed, integrated or moved*.

**Brook and the Open University conducted an FOI last year, and found that over 90% of LAs reported that they couldn't provide any data about contraception provision in GP clinics. Furthermore, 89% of LAs said that they could not identify their spend on young people's sexual health and contraceptive services.*

Commissioning structures and accountability

Commissioning structures

The 1974 NHS Reorganisation Act made contraception free at the point of access for all contraception users, notwithstanding age or marital status. The 2012 Health and Social Care Act removed the full responsibility of contraception provision in England from the NHS. The division of responsibilities for sexual and reproductive health is complex and responsibility is split between Local Authorities, NHS England and CCGs.

This has resulted in services that are shaped by the source, availability and amount of funding available, rather than by women's needs. The arrangements also mean that although contraception is funded by Local Authorities, many of the short-term economic benefits of preventing unintended pregnancy are felt in the NHS. In the context of significant cuts, this can inhibit the prioritisation of spending.

This Inquiry heard that this divide has led to the fragmented delivery of women's healthcare. Artificial divisions drawn between contraception and reproductive health have led to a disjoint in women's health, which can result in women being bounced from service to service, being required to undergo multiple consultations and occasionally multiple intimate examinations when only one is clinically necessary, and women having to wait weeks, or even months, to access appropriate services.

Example 1: Women who attend a specialist service for contraception or an STI screen may not be offered a cervical screen, even if one is due. This is not because the physician does not have the skills to perform the test, but because cervical screening is commissioned by NHS England and it is not a commissioning requirement for Local Authorities.

As a result the service may be contractually unable to perform the cervical screen and the individual will have to undergo a separate intimate examination. This happens in the context of a 20-year low in the uptake of cervical screening.

"Every day I come across patients for whom I am fitting a coil and I am not able do a cervical smear, because my area is not commissioned to perform smear tests" – Dr Asha Kasliwal, President, FSRH

Example 2: An intrauterine system can be used to treat heavy menstrual bleeding. Under current commissioning arrangements, devices for therapeutic indications, rather than contraceptive purposes, are the responsibility of CCGs.

This means that, unless specific arrangements are in place, patients are unable to access this treatment in community or primary care settings and instead need to be referred to see a gynaecologist. This is despite the much higher cost associated with secondary care treatment and the additional inconvenience to the patient who may have to attend three appointments as opposed to one.

The current system also creates challenges for accountability in commissioning. Though healthcare services still have a duty to facilitate women's access to contraception, it is unclear in the current system who holds final responsibility for this access, especially when the fragmentation of services means that many women fall through the cracks.

Lack of accountability

This Inquiry heard of a significant lack of local and national accountability for ensuring services are delivering full and open access to contraception in line with the regulations of the 1974 NHS Reorganisation Act.

Split commissioning means that there is no central oversight of the full range of contraceptive and gynaecological services being delivered. This means that holistic healthcare for women is not easily delivered.

At a local level Local Authorities are accountable to their electorate. The Inquiry heard there are difficulties in holding Local Authorities to account. This is exacerbated by a lack of interest in women's health services and the stigmatisation of women's reproductive health. This stigma is exemplified by results from PHE 2018 reproductive health survey, which found that although 31% of women experience severe reproductive health problems, under half of these seek help.[20]

At a national level, leadership is split across DHSC, PHE and NHS England. This fragmentation is exemplified by the split in

ministerial remits at DHSC, which sees one minister responsible for public health and primary care, and another responsible for women's health and maternity care. Since the recent announcement that PHE will be scrapped and a new National Institute for Health Protection established, it is at present unclear which body will assume PHE's responsibilities around contraception. This Inquiry has heard that there is an urgent need to implement a population needs-based approach to contraceptive provision with clearly defined roles and responsibilities at a national and regional level.

Opportunities to improve service provision

It is clear to the APPG SRH that the disjunctures between services are preventing women's health needs from being sufficiently met.

Some respondents to this Inquiry, including the Royal College of Obstetricians and Gynaecologists, the Faculty of Sexual and Reproductive Healthcare (FSRH) and the Royal College of General Practitioners have called for a single accountable commissioner, who sits within the NHS, to be responsible for commissioning sexual health services. This view has also been endorsed by the Academy of Medical Royal Colleges.[21]

Following the publication of the NHS Long Term Plan, in 2019 the Government undertook a review to consider whether there was a stronger role for the NHS to play in the commissioning of sexual health services. In June 2019 the Health and Social Care Committee published a report on sexual health,[22] which called for strengthened collaboration rather than a single accountable commissioner, and the Government confirmed that sexual health would remain the responsibility of both Local Government and the NHS.[23] This report also concluded that the fragmentation in funding for LARCs has contributed to unacceptable variation around the country, and found an ongoing risk that the defunding of Local Authorities will continue, meaning women's access to LARC will likely continue to decline.

It is clear that greater collaboration is needed between local government, CCGs and NHS England to ensure that women's reproductive and contraceptive needs are met. The Government's 2019 review recommended closer and more joined up working between commissioning bodies. It is also important that co-commissioned services are held accountable locally.

In 2017, PHE and the ADPH published a review of commissioning highlighting issues and proposing recommendations. The review found limited collaboration between CCGs and Local Authorities. Pooled budgets, for example, provide an opportunity for different commissioners to work together. Despite this over 80% of Local Authorities respondents reported no pooled budgets between local councils and CCGs to address sexual health, reproductive health and/or HIV needs of the local population.[24] Although collaboration between Local Authorities and CCGs is at present limited, this Inquiry heard some welcome examples of new service models which facilitate joined up working.

Primary Care Networks

Contributors to this report also highlighted opportunities for the integration of women's health within the developing Primary Care Networks (PCNs).

Primary Care Networks consist of GP practices, community services, pharmacy, the voluntary sector and social care. This network will work together to provide a wider array of Primary Care services involving a wider set of staff roles than might be feasible in individual practice, to a patient population of 30-50,000 people. This would allow women to be transferred more swiftly between care providers when their own GP or clinic does not offer their preferred choice of contraceptive care.

Whilst PCNs will decide their own objectives based on local need, this Inquiry heard opportunities for the development of women's health hubs, within the PCN. They will ultimately be expected to deliver on a set of seven national service specifications, including to tackle inequalities, by 2021.

Case Study: Hampshire – Women's Health Hub

The North Hampshire GP Alliance currently holds a contract on behalf of all the practices in North Hampshire for fitting LARC. There is also an agreement with the local CCG to fit the IUS as a treatment for heavy menstrual bleeding. All practices can therefore fit intrauterine contraception regardless of indication. However, not all have the capacity, numbers of fits or resources to maintain their qualifications. In order to ensure sustainability of fitting in General Practice, the practices within the Alliance use inter practice referrals.

As an extension of this, three GP practices within the PCN have merged to develop an enhanced women's health. The new hub is seeking to concentrate the expertise for all contraception and women's health, taking more care out of hospitals and into the community.

Conclusion

At present there is a lack of accountability and oversight for the delivery of holistic sexual and reproductive health care at local and national level and gaps exist in the delivery of women's health services. This Inquiry recognises the need for collaboration between different commissioners and service providers in order to integrate care around the needs of individual women.

The pending reorganisation of Public Health England, which was announced during the drafting stages of this report, presents an opportunity to re-evaluate current commissioning arrangements around contraception provision. Though plans to reorganise the functions of PHE were not known at the time of submissions made to this Inquiry, evidence highlighted both the need for more effective, integrated commissioning and for SRH care to be more broadly integrated into women's healthcare pathways. This Inquiry also recognises opportunities for collaboration within Primary Care Networks.

Workforce and training

A well trained and consistent supply of staff is fundamental to the delivery of good sexual health services and the provision of the full range of contraception.

The sexual health workforce is diverse and contraception is provided across a range of settings. This includes in:

- specialist SRH services
- General Practice
- community gynaecology
- abortion and maternity services
- pharmacy settings

Many respondents to this Inquiry noted concerns relating to recruitment, retention and training of the SRH workforce, as well as opportunities to make better use of the existing staff in maternity, abortion and pharmacy settings.

Recruitment and retention

Recruitment and retention are issues across the NHS. Respondents to this Inquiry raised significant concerns about the future workforce and its impact on the delivery of services.

Community Sexual and Reproductive Health (CSRH) consultants were raised as a specific example. CSRH Consultants provide leadership, governance and clinical support for complex cases. This Inquiry heard that although only a small number of CSRH Consultants are required and a single consultant can lead service provision for at least 125,000 people, the workforce is in a succession crisis. One third of CSRH Consultant vacancies in England were left unfilled in 2018, and Health Education England estimates that one third of the current CSRH Consultant workforce could retire within the next five years. Moreover, a small number of consultant posts unevenly spread across England leaves whole areas without any SRH leadership to support delivery of care to the population. The predicted output of the current training program falls well short of filling this gap.

CSRH training is a popular specialist training program, and shortfalls are not due to a lack of demand. Rather, not enough funded training posts are available. Posts in this specialty are 50% funded by Health Education England (HEE) and 50% by local authorities. Given the successive cuts, it is often impossible for local authorities and services to match the HEE funding.

This Inquiry also heard that concerns about workplace culture, poor work-life balance and service instability were negatively impacting many different workstreams. The Obstetrics and Gynaecology training program,[25] for example, has an attrition rate of 30% and despite increased numbers of GP trainees, shortages are apparent because staff are not choosing to work at the end of their training or retiring early.[26] This inevitably has an impact on what can be delivered.

> *"Nurses, who have lots of skills, can move about and that's what they do… They are not leaving because they don't like the service, they are leaving because they don't know whether their job will be there in 12 months… Until issues of stability are addressed it is like rearranging the deckchairs on the Titanic. As quick as we can train nurses, they are going out of the back door."* – Dr Claire Dewsnap, BASHH

Given these concerns, the APPG welcomes the establishment of the NHS People Plan, which focuses on improving culture and a better work-life balance. However, the success of such initiatives, as well as the ability of employers to provide stable and attractive work environments in which staff are sufficiently trained will depend on an uplift in funding. Central investment in workforce education and training has dropped from 5% of health spending in 2006/7 to 3% in 2018/19.[27]

Training

CSRH consultants are responsible for training and supporting the nursing and primary care workforce and witnesses raised concerns about the knock-on effect of an insufficient specialist workforce on the wider sector, particularly given that the majority of people access contraception though primary care and specialist services are increasingly nurse led.

> *"Because we don't have enough specialists, we are not able to train GPs and others who are the workforce doing the majority of Level 1 and Level 2 work."* – Dr Asha Kasliwal, President, FSRH

This Inquiry heard evidence that reduced capacity in specialist services can lead to long waits and limited access to training, in both primary care and among specialist nurses.

Furthermore, whilst there is an expectation that providers who are delivering SRH services will support the development of new and existing staff, this Inquiry heard that is not always happening. Local Authorities do not have to stipulate or fund continued professional development (CPD). As a result, nurses and doctors have to self-fund training.

General Practice

Whilst all practices are required to provide basic (i.e. user-dependent) contraception as part of their core contract, the provision of LARC is an "opt-in" enhanced service, which means not all General Practices provide it. This has led to issues with funding for services and training which have meant that GPs are increasingly less likely to offer LARC services.

> *"We now have a waiting list for healthcare professionals requesting clinical training for intrauterine and subdermal techniques."* – Dr Frances Fuller, Royal Cornwall Hospitals Trust

In order to fit LARC, GPs and practice nurses are required to undertake specific training. This Inquiry heard a number of factors, in addition to those caused by limited capacity in specialist services, were leading to reduced uptake of training.

The reasons cited for this were complex. This Inquiry heard that currently there is no coherent system for the ongoing training of GPs or practice nurses, and that the closure of some clinics has led to reduced opportunities for LARC training.

> *"I feel the closure of the [Sexual and Reproductive Health] Clinics has led to a lack of training facilities to train coil fitters. These clinics also offered evening appointments for young women working full time […] They offered a fantastic sexual health service, including cervical screening, STD screening and contraception at places and times that suited women - this has now all been lost and I fear we have a skill timebomb about to happen as my generation of LARC fitters retire."* – Respondent, Primary Care Women's Health Forum Survey

General Practices are often not fully reimbursed to cover the cost of fitting a LARC. In the absence of long-term guarantees that the practice will continue to be commissioned to provide LARC and in the context of the many competing priorities and growing pressure on GPs, this Inquiry heard that some practices are reluctant to fund training. This is exacerbated by reduced competition for jobs, meaning clinicians are now less likely to self-fund training in order to make themselves more employable. Following the Covid-19 pandemic, there are concerns that the cost of reinstating LARC services will prove a deterrent for many GP surgeries who may decide it is not economically viable to provide these services.

Concerns were also raised about the future workforce. In areas of low demand, or in places which are decommissioned to provide LARC, staff are unable to maintain qualifications to fit LARCs. This Inquiry recognises opportunities for the development of women's health hubs within PCNs, enabling practices to work in partnership and in doing so allowing practices to continue to provide LARC within local areas.

Specialist nurses

At present there are no national standards for nurse education in SRH. This means that there is an inconsistent approach to training and nurses access training through a variety of resources, including through FSRH, Higher Educational Institutes (HEIs), or local universities.

Whilst many nurses do access high quality training, others struggle to access training due to insufficient funding and problems associated with backfill. This system results in place-based discrepancies in standards of care around contraception provision.

Maternity and abortion settings

The provision of contraceptive counselling and methods is a key part of holistic post-pregnancy healthcare. NICE guidelines stipulate that "*women should be offered a choice of all contraceptive methods within seven days of delivery*".[28] In abortion settings the guidelines state, "*Commissioners and providers should ensure that the full range of reversible contraceptive options is available for women*".[29]

However, this Inquiry found that provision of post-partum contraception is patchy, particularly in postnatal settings, where provision is rare. This is despite the fact that provision of contraception is an integral part of best practice and midwives and nurses are well placed to provide this support. This Inquiry heard, that at present, training and support is lacking.

> *A qualitative study of midwives' experiences and views of giving postpartum contraceptive advice, published in 2014, found that while all discussed the return of fertility, most found it a job of lesser importance which they felt inadequately trained for.* – BPAS written evidence

Abortion care providers are often also responsible for providing contraceptive care for their women, thus helping women to control their fertility in order to reduce further unintended pregnancies. Women receiving abortion care are offered quick access to wide range of contraceptive options, subject to availability in the abortion care clinic. There are strong levels of uptake, with BPAS data showing that 51% of women received their contraception of choice from BPAS.[30]

However, variations in contracts with CCGs impinge upon what care abortion settings can sustainably provide. Submissions to this Inquiry from abortion care providers reported experiencing difficulties with commissioners who have asserted that they would not fund LARC provision within abortion services as women are able to access those services in local SRH clinics. This is another example of fragmented healthcare structures creating unnecessary barriers to holistic, women-centred healthcare.

> *"When an appointment for LARC fitting post-abortion is offered, clients often say "It's ok – I'll go to see my GP" – not knowing that their GP might not be trained to fit the IUC, or that their local [SRH] Clinic has a massive waiting list."* – Julia Hogan, CaSH Nurse Specialist, Marie Stopes UK

Pharmacy

Community pharmacies are central to local health and wellbeing and many already provide emergency hormonal contraception (EHC). However, there are clear opportunities to make better use of this workforce. This would not only reduce pressure on GPs and be more convenient for women, but it would provide an opportunity to engage with people who are not accessing contraception in other settings. Witnesses noted examples of pharmacists in some areas providing oral contraceptive pills and in other places having been trained to provide injectable LARC.

Data and monitoring

Current data collection around contraception provision makes it difficult to assess and monitor contraception uptake across all settings, and does not extend to recording provision by ethnicity, socioeconomic status or other demographic factors. Without clearer data it is not possible to assess access or to efficiently plan and commission services to meet the needs of women. Currently it is only possible to use data to get a picture of LARC provision rather than of the full range of contraceptive methods. Even with LARC the data is fragmented and incomplete.

In relation to recording access to contraception concerns were also raised about:

- the failure to collect data from across all settings which provide contraception, particularly primary care
- the inability of existing data sets to record outcomes or women's experiences in accessing contraception
- the masking of inequities in provision within current data collection systems

What data is currently collected from 'specialist' sexual and reproductive health services?

There are two main datasets relating to sexual and reproductive health.

1. **Sexual and Reproductive Health Activity Data Set (SRHAD):** NHS Digital coordinates data from local authority commissioned SRH services, pertaining to provision of contraception. SRHAD is now only reported annually.
2. **Genitourinary Medicine Clinic Activity Dataset (GUMCAD):** PHE co-ordinates the GUMCAD dataset. It is a mandatory surveillance system for STIs and collects data on STI tests, diagnoses and services from all commissioned sexual health services in England.

A number of concerns were raised with regards to the SRHAD and GUMCAD datasets. Primarily overlaps between the GUMCAD and SRHAD datasets were identified. The services using these reporting systems may report to one or both data collection systems confusing their interpretation. Neither dataset currently collects information about contraceptive provision in an adequate way.

Inadequate data collection across a range of settings

Fittings of LARC for contraception and for gynaecological purposes (e.g. to treat heavy menstrual bleeding) are reported separately to Local Authorities and CCGs respectively. These datasets are not collated or reported nationally or regionally, meaning that it is not possible to gain a complete overview of LARC provision by GPs. Meanwhile, data on LARCs prescribed in community SRH clinics is collated and reported in the SRHAD dataset.

Data around the prescription of LARCs by GPs are collected by the NHS Business Services Authority and reported regularly by NHS Digital. This data does not include any devices purchased directly by the practices and will include some devices that are not successfully fitted. Non-LARC contraceptive prescriptions are also collected but in a form that renders the data unhelpful for analysis. NHS Business Services Authority (NHSBA) data does not allow any identification of demographics.

Given that the majority of contraception is provided in General Practice, this Inquiry heard serious concerns around a lack of understanding about uptake and access to contraception in primary care settings. Without accurate data it is difficult to assess who is accessing contraception, what their needs are, and whether the fall in contraceptive attendances at sexual health services has been offset by increasing attendances in General Practices.

> Research undertaken by Brook and FPA found that most areas cannot identify how many contacts young people have with specialist SRH clinics or GPs for contraception. Without this information, it is impossible to assess whether services meet the needs of young people or even whether young people are accessing services – this is particularly concerning in the context of funding cuts, which has led to the decommissioning of specialised young people's services.

Furthermore, whilst contraception provided in abortion settings is recorded by the provider, it is not collected or monitored centrally. There are also serious concerns about access to contraception in maternity settings. Contraception is rarely provided in maternity settings, and when it is it not recorded in a form accessible for wider analysis. Overall this fragmented and mixed picture leaves a considerable gap in the understanding of what is being delivered, where it is being delivered and to whom.

Inadequate data about outcomes or experiences in accessing contraception

Outcomes

At present abortion rates and under-18 conception data are used as proxy to understand access to contraception. This Inquiry heard that the complex reasons behind abortion renders this data an insufficient measure, whilst the use of teenage pregnancy data, although very accurate, masks inequalities. Furthermore, around one third of births in England are unplanned or associated with feelings of uncertainty and these proxies do not take into account the clear unmet contraceptive needs of women who continue with an unintended pregnancy.

The best outcome measure to assess access to contraception would consider unintended pregnancy, taking into account both pregnancies that end in abortion and in maternities. This Inquiry heard that the London Measure of Unplanned Pregnancy (LMUP) provides a more accurate understanding of pregnancies and pregnancy intentions, and recommends the LMUP is adopted as an indicator within the Public Health Outcomes Framework. For this to happen, abortion and maternity services should adopt LMUP as a primary data standard and routinely collect and share this data.

Experiences

Evidence presented to this Inquiry suggests that women are experiencing increasing difficulties in accessing contraceptive services and the full range of contraceptive methods. Long waits, difficulties in accessing services because of reduced opening hours, limited choices in terms of methods of contraception available, a lack of information and problems having LARC removed have all been reported. Restrictions on access to contraceptive care during the Covid-19 pandemic are examined separately in the final section of this report.

> *"GP did not offer the services to get implant fitted."*
>
> *"My health visitor wants me on the coil, but it wasn't available."*
>
> *"Very difficult to find an appointment to have implant replaced due to GPs no longer offering this service."*
>
> *"As when I first started the pill I wasn't told about the different types of pills and how they work."*
>
> Quotes taken from responses to a survey by UCL Institute for Women's Health

At present it is difficult to assess the extent of these issues, because no dataset includes data relating to women's experiences.

This Inquiry is pleased that some actions have already been taken to support the understanding of contraceptive provision. Given that access to LARC is a useful proxy to consider the availability of all contraception, the inclusion of an indicator within the Public Health Outcomes Framework (PHOF) to record total prescribed LARC per 1000 women and girls aged 15-44, is, for example, welcome. It provides Local Authorities with a valuable instrument to benchmark their progress in improving access to contraception.

The APPG urges the Department of Health and Social Care to commit to continuing the review of data planned as part of PHE's Reproductive Health Action Plan. This Inquiry heard that the review will include an assessment of what data currently exists, what we need to know and what new data points are needed to better assess access, outcomes and women's experiences. The Inquiry additionally recommends that the Department of Health and Social Care consider including data on waiting times for contraception, as well as provision of contraceptive counselling and information.

Inadequate data to enable understanding of inequalities

Witnesses to this Inquiry also raised concerns that existing data collection masks inequalities in access to contraception by ethnicity, geography, sexual orientation and gender identity.

BAME people

As detailed in other areas of this report, Black, Asian and other Minority Ethnic women may face a range of additional obstacles in accessing contraception, and access contraception differently than white women. For example, BAME individuals are less likely to attend General Practice for contraception.[31] Abortion data from 2018 indicates that black women are more likely than white or Asian women to require more than one abortion, suggesting a high unmet need for contraception among this group.[32]

Despite this, data considering uptake of contraception by ethnicity is not collected. To improve understanding of the contraceptive needs of BAME people, the Inquiry recommends that ethnicity is recorded and considered alongside contraceptive provision. This should include data which is sufficiently specific to account for the diversity of cultural experiences.

Sexual orientation and gender identity

Current understanding of access to contraception in LGBT+ communities is limited. US data shows higher rates of unplanned pregnancy among lesbian and bisexual adolescents than heterosexual teens.[33] Furthermore, evidence from the LGBT Foundation's survey of women who have sex with women found that 35% of those who have sex with men and women never use barrier methods or contraception if required and that LBT+ people are less confident negotiating contraception than their heterosexual peers.[34]

It is particularly important that any services providing contraception consider gender identity, including trans status, and sexual orientation so that they can give the correct advice and support to individuals.

Data considering uptake of contraception by sexuality or trans status is not collected. To improve understanding of the reproductive needs of this group, this Inquiry recommends that sexual orientation and gender identity, including trans status, is recorded and considered alongside contraceptive provision.

Geography

This Inquiry also heard that existing datasets mask geographical variations in access to contraception likely to be related to the distribution of the skilled workforce. Whilst SRHAD data is available by location, the absence of available geographical data in General Practice, where the majority of people access contraception, makes it extremely difficult to assess variations across the country, which anecdotal evidence suggests are apparent.

Additional inequality measures

Consideration should be given to the collection of demographic data for women attending services to allow understanding of any effects of age and deprivation on access to services.

Improving access to contraception

This Inquiry has identified a number of structural issues that inhibit access to contraception. However, several areas currently offer opportunities to improve access.

Improving access to contraception following pregnancy

Maternity settings

Maternity services are ideally placed to support women to make an informed choice about contraception. Fertility can return quickly after childbirth and NICE recommends that women should be offered a choice of all contraceptive methods within seven days of delivery.[35]

Despite this, this Inquiry heard that contraceptive provision in maternity settings is patchy at best and non-existent at worst. Whilst some areas are commissioned to provide contraception, others are only able to provide it at specific times and many are not commissioned to provide it all

> *"In our area postnatal contraception is commissioned, but only between 9-5. The vast majority of women who deliver out of hours aren't going to wait to around for it."* – Dr Claire Dewsnap, BASHH

> *"A lady who has delivered a baby in September was unable to receive a coil until May, because a lack of proper pathways."* – Dr Asha Kasliwal, President, FSRH

Whilst provision of contraception in maternity settings makes sense for all women, this Inquiry also heard that it carries significant social and economic benefits for especially marginalised groups.

The Minister for Women's Health drew attention to the development of Maternity Outreach Clinics in her response to this Inquiry. The integration of maternity, reproductive health and psychological therapy for women experiencing mental health difficulties related to maternity experiences through these clinics is extremely welcome. However, these clinics will not cater for women who do not experience mental health difficulties related to maternity experiences or women who have mental health issues unrelated to pregnancy.

Case study: Benefits of providing postnatal contraception to marginalised groups

Since 2013 SHRINE have delivered a weekly consultant-led SRH clinic on the premises of two specialised addiction services, visited various homeless hostels as well as the postnatal ward at St. Thomas' Hospital.

Before the intervention (2009-2012), 32 opioid-dependent women were looked after on the postnatal ward. During the first 4 years of the intervention (from 2013 to 2016) this fell to 17 women.

Providing effective and timely postpartum contraception prevents rapid repeat unintended pregnancies, associated adverse maternal and perinatal morbidity and delivers cost efficiencies; while empowering women to realise their right to plan and space their pregnancies for the best outcomes. This achieves the best results for patients and generates savings for health and reduces social care costs of a child in care exceeding £36,000 per year per child. SHRINE's interventions alone resulted in cost savings for the Local Authorities of at least £465,000 in care for looked-after children and £110,000 for the Family Drugs and Alcohol Court.

It is disappointing that the National Maternity Review does not have a contraception workstream. Post pregnancy is an ideal opportunity to engage with women. This Inquiry recommends that immediate postpartum contraception is made available in all maternity settings as part of service restoration after the first wave of the pandemic.

Abortion settings

The offer of a range of contraceptive methods following abortion is important to prevent further unintended pregnancies. This Inquiry heard that, in general, there are clear pathways for the provision of contraception and access is relatively good. A survey of women who had an abortion at a BPAS clinic, for example, found that 91% of women who obtained contraception from BPAS received their chosen method of contraception.[36]

However, variations are apparent. This Inquiry heard that some areas do not commission the

contraceptive patch or contraceptive ring, whilst others have asserted that they would not fund LARC because women are able to access those services in local SRH clinics, in other cases funding is inadequate.[37]

> *"We found that some clinical commissioning does not adequately fund contraception as an integral part of post-abortion care. Indeed, several years ago, we took a stance against continuing an abortion care contract which did not include post-abortion contraception."* – Marie Stopes International evidence

Providers also raised wider concerns regarding funding. At present abortion providers are funded for the method of contraception provided, but not for the clinic or staff members' time for counselling or fitting the device.

This cost can be combined when women receive methods of contraception that can be provided at the same time as the abortion.

However, intrauterine contraception cannot be provided at the same time as Medical Abortions, which in 2019 accounted for 73% of all abortion procedures in England and Wales.[38] Under current funding arrangements women must find an alternate service within the community to provide the intrauterine contraception or the provider must cover the consultation and fittings cost, which is clearly not sustainable in the long term.

This Inquiry recommends that all abortion contracts include the provision of the full range of contraception. This must include staff time for the fitting and removal of LARC methods, regardless of abortion method.

Improving access to contraception in pharmacy settings

Community pharmacies are one of the most frequented healthcare settings in the UK. They are often open in the evenings and weekend and are centrally located. This Inquiry heard that over 99% of people living in areas of highest deprivation are within a 20-minute walk of a community pharmacy, and as such they have an important role to play in improving health and tackling health inequalities.

In recent years pharmacists have become increasingly involved in primary care, from the provision of immunisations and travel vaccinations, to the delivery of Emergency Hormonal Contraception (EHC). However, the Inquiry heard that they are significant opportunities to improve access to contraceptives in pharmacy settings; this would both be convenient for women and reduce the burden on GP and specialist providers.

Oral hormonal contraception

Despite extensive research demonstrating the clinical safety of oral contraceptive pills Progestogen-Only Pills (POP), women in England currently require a prescription from a doctor to access contraception and "maintenance prescriptions", whereby women must return periodically to replenish their supply of contraception, placing a significant burden on GPs and specialist services. One third of contraceptive appointments in GPs[39] and almost half in specialist services are to maintain existing contraception.[40]

This Inquiry heard that there is a significant opportunity to expand the role of community pharmacists in supplying POP. Independent Prescribers or Patient Group Directions (which permit pharmacists to prescribe Prescription Only Medicines in circumstances agreed by the doctor) are already being used in some areas. They remove the need for women to visit a GP or clinic to obtain ongoing contraception, and in some areas, including Lambeth, Southwark and Lewisham, allow women to attend a pharmacy for their first prescription of POP.

Such initiatives are not only beneficial for women and alternate service providers, but evidence shows that they can encourage the use of contraception and a result may help reduce unintended pregnancies.[41] This heard that an enhanced use of pharmacy Independent Prescribers or PGDs may be appropriate to increase access to contraception.

We also heard a compelling case to change the classification of POP to make POP available over the counter, making it easier for women to access. This would bring the UK in line with many other parts of the world where POP is already available without a prescription.

> *"The data is quite clear, you have far greater risk of high blood pressure or a thrombosis if you become pregnant unexpectedly, than if you are taking the progestogen-only pill (POP).*
>
> *[In comparison] Viagra was sold over the counter, within a year of being licensed. The Pill has been licenced for over sixty years and yet we still don't trust women to take it."* – Professor Dame Lesley Regan, former President, RCOG

As such this Inquiry recommends the reclassification of the POP to make it available over the counter without a prescription as a Pharmacy Medicine.

Improving access to Emergency Hormonal Contraception (EHC)

EHC is available in GPs and in SRH services, and is also available for purchase in community pharmacies. It is classified as a Pharmacy Medicine (P) which means it can be bought without a prescription under a pharmacist's supervision. Community pharmacies are now the main route of access for emergency hormonal contraception

This Inquiry heard that levonorgestrel (LNG-EC), one of two emergency contraception methods, is extremely safe. It has no clinical contraindications and it can be used by all women. In many countries, women are able to buy LNG-EC directly over the counter without pharmacist supervision. This would necessitate LNG-EC being reclassified from a Pharmacy Medicine to a General Sales Medicine.

Regardless of the classification, the cost of EHC is prohibitive for many. Whilst some areas commission free contraception, it is not available free of charge in as many as half of services.[42] Where EHC is available free of charge, this Inquiry heard of significant variations in access, with some areas imposing upper age limits above which women have to pay, whilst other areas specify by postcode. This not only perpetuates place and age-based inequalities, but can cause significant issues in university towns and transportation hubs.

Given the current discrepancies in provision, the establishment of a single national commissioning specification for EHC services to ensure women experience consistent care across the country would be beneficial.

Improving access through technology

This Inquiry heard that possibilities to expand access to contraception through technology are being explored by PHE and DHSC.[43] Opportunities are diverse and include the booking of appointments, contraceptive counselling as well as the completion of online consultations to enable postal delivery of oral contraceptives. The Covid-19 pandemic has accelerated shifts towards use of these remote services during the spring of 2020, with remote consultations for SRH care rising from 18% before the pandemic to 89% currently. These changes are explored in more detail in the Covid-19 chapter.

Evidence relating to online testing for STIs demonstrates that online users may be less complex and lower risk, which could free up to time for more challenging cases. In the context of significant funding cuts, this is a welcome development for many services.

However, concerns have also been raised about the impact of online services on marginalised and under-served groups. Those without private internet access, for example, may find themselves further marginalised as appointments become scarce. The needs of the estimated 9 million adults who are functionally illiterate and the 4.1% of the population who have no computer experience whatsoever, need to be taken into account.[44] This issue is examined in more detail in the Covid-19 section of this report.

Education and information

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 life course approach, meeting the needs of all people, regardless of age.

Relationships and sex education (RSE)

School based RSE plays a crucial role in improving the sexual health and wellbeing of young people as well as improving uptake of contraception. Numerous respondents to this Inquiry provided evidence, including that from The National Survey of Sexual Attitudes and Lifestyles (NATSAL) to highlight this.

> *"The evidence is clear that children and young people who receive comprehensive, high quality RSE are more likely to delay the first time they have sex, have consensual relationships, be aware of and report abuse, use contraception when they start a sexual relationship and be less likely to be pregnant by 18 or contract an STI." (ADPH)*

From 1 September 2020 Relationships, Sex and Health Education (RSHE) becomes statutory in all schools: relationships education in primary, relationships and sex education in secondary and health education, which includes puberty, in both. Due to the Covid-19 pandemic the Department of Education has indicated that schools will be allowed a phased approach to implementation but will be expected to deliver the full curriculum by the Summer 2021.

Despite improvements in the provision of RSE, this Inquiry heard evidence that young people often lack knowledge about contraception and how to access it. A focus group carried out in May 2019 in a maintained school in an area where the local authority was engaged and the school was delivering RSE found that young people lacked basic knowledge as well as an understanding of their rights to confidentiality.

> *"[Young people] Didn't know about rights to confidentially, couldn't name very many forms of contraception and didn't know where they could access contraception."* – Lisa Hallgarten, Brook

Similar concerns were raised by witnesses throughout this Inquiry and it is apparent a knowledge gaps exists, despite statutory guidance.

> *"Understanding how to access clinics and the rights to confidentiality is a key barrier to young people's access to contraception."* – Dr Stephanie Lamb, GP in South London and Founder of The Well Centre

In relation to contraception, the updated RSE guidance states that pupils should know:

- the facts about reproductive health, including fertility;
- the facts about the full range of contraceptive choices, efficacy and options available;
- how to get further advice, including how and where to access confidential SRH advice and treatment.

Whilst the guidance is clear, efficacy will rely on high quality implementation. This will depend on:

- teachers having the skills, confidence and knowledge to deliver RSE effectively;
- teachers having access to evidence based and medically accurate information and resources;
- schools being held to account for the delivery of RSE in adherence with the guidance;
- schools allocating sufficient time to RSE within the curriculum.

Whilst there are areas of excellent practice, research from the Sex Education Forum (SEF) suggests that many teachers are not confident in delivering RSE, particularly components relating to contraception and sexual health.[45]

As highlighted by UNESCO, teachers responsible for the delivery of RSE require specific training. This will require funding. The government has, to date, committed £6 million to support schools as they implement the guidance.

However, it has not clarified how this will be distributed across the 24,000+ schools in England, what the money it will be spent on, or how impact will be measured.

Of those surveyed by SEF to explore the preparedness of teachers ahead of the implementation of statutory RSE:

- less than half rated the RSE in their school as high quality or very high quality
- less than half reporting having had adequate training
- 99% would find it helpful to have guidance on meeting the needs of children with SEND
- 70% would like guidance on choosing and using reliable resources for RSE
- Teachers reported feeling least confident about teaching contraception, pregnancy options, STIs and accessing SH services

The RSE guidance provides a framework for teaching and allows schools a significant degree of flexibility. Evidence from the Sex Education Forum suggests that teachers would find supplementary guidance for selecting resources and for meeting the needs of SEND pupils helpful.

It is crucial that young people are provided with evidence-based information on contraception. DHSC and DfE should ensure teachers have access to reliable and evidence-based information on contraception.

As well as adequate teacher training and the use of reliable materials, schools should be held to account for the implementation of RSE in line with the guidance. The Inquiry recommends that RSE is included in routine OFSTED inspections from 2020. Inspectors must be sufficiently trained to ensure they understand the key components of RSE, prior to inspections.

The establishment of OFSTED subject reports for RSE would also provide a more in depth understanding of RSE lessons, which will prove useful when the guidance is due to be reviewed in 2023.

Post-education information

The Inquiry heard that the availability of free, evidence-based information on contraception is limited. PHE currently funds a digital platform to provide information regarding sexual and reproductive health. Despite this, evidence presented to this Inquiry suggests that many women above school age lack adequate knowledge.

43% of women do not know that the IUS, IUD and implant can be removed at any time by a trained healthcare professional and that their fertility will return to normal once removed – Bayer evidence submission

A small qualitative study conducted in Luton by the University of Bedfordshire explored the knowledge, attitude and behaviour towards contraception among young people aged 16-25 from six different ethnic minority backgrounds. The study found inconsistent knowledge as well as misinformation regarding different contraception and perceived barriers to accessing local contraceptive services.

However, there is limited evidence regarding people's knowledge, or lack of it, at a national level. If the government is to address understanding relating to contraception, they first need to understand the gap. As such, the body replacing PHE should incorporate questions on knowledge about contraception in future reproductive health surveys.

"Lack of knowledge about the availability of contraceptive services in Luton was discussed as a barrier to accessing contraception by the majority of participants regardless of gender and ethnicity." – University of Bedfordshire evidence submission

A mystery shopping study, carried out in Lancashire, for example, found inadequate materials for people with low literacy skills. The group lobbied for easy read information for over two years before the provider took action. Supported Loving evidence submission

This Inquiry also heard concerns regarding inequalities in access to information. People without access to the internet, for example, struggle to access digital platforms, whilst the needs of people with low literacy skills and those for whom English is not a first language are not always met. As such this Inquiry recommends that DHSC should conduct a review to identify and address the information needs of marginalised groups.

Contraception during the Covid-19 pandemic

Overview: the impact of the Covid-19 pandemic on access to contraception

The Covid-19 pandemic has vividly highlighted the critical importance of access to contraception in women's everyday lives.

The changes to contraceptive provision necessitated by the Covid-19 pandemic have occurred against a backdrop of pre-existing challenges including funding cuts and fragmented commissioning structures detailed in previous sections of this report. In many ways, these issues have been compounded by the pandemic. However, the pandemic has also opened up new opportunities for more comprehensive provision of contraception in the future.

How Covid-19 has changed contraceptive services

The social distancing measures introduced in March 2020 necessitated a major rollback of face-to-face contraceptive services, as the SRH sector deprioritised all but essential services to limit the risk of infection. The diversion of many SRH sector staff to the 'front line' to treat Covid-19 patients has further impacted contraceptive provision, as this has caused many services to run at reduced capacity, particularly during the first months of the pandemic.

In many areas, even essential care provision, such as access to oral contraception and emergency LARC fittings and removals, has been affected. Member surveys conducted by BASHH and the FSRH indicate that a significant proportion of healthcare settings ceased or limited provision of essential services at some point during the early months of the pandemic, whereas surveys of contraceptive users indicate that many have found it more difficult to access contraception during these months.

Though the data collected do not include this, it is likely that marginalised groups will be the most adversely affected by these changes, and that the unmet need for contraception in these groups, as well as in the population as a whole, is greater than it was prior to the pandemic.

Telemedicine and remote consultations

The introduction of telemedicine services, whereby women can be triaged, assessed and even treated without the need to physically attend a healthcare setting, has shown great potential for the future streamlining of services. The availability of remote consultations and postal and electronic prescriptions for routine appointments has improved access and convenience for many. This applies particularly to women living in rural areas and women facing childcare or financial constraints which may preclude travel to a healthcare setting. As services begin to normalise after the pandemic, it will be important to ensure all modalities of consultation, including face-to-face care, can continue.

Fragility of services in primary care

The pandemic has exposed some of the weaknesses of the current commissioning structure for contraceptive care, demonstrating the need for a more integrated system capable of greater flexibility in times of extreme demand. The Inquiry has heard that the fragility of service provision in some primary care services means that contraceptive provision within those services will take time to recover, and may struggle to recover at all. This indicates an urgent need to re-evaluate commissioning structures, and to mitigate against the financial and practical disincentive for the resumption of services such as LARC, which are vital to women's wellbeing but are often unattractive and unprofitable to service providers, especially in General Practice.

At the time of this report's publication, the ongoing restoration of services is also an opportunity to reshape them, integrating positive aspects of the digital and triage services that have been put in place over the last few months. However, the Inquiry has heard valid concerns over the long-term impact on services and specifically LARC provision, which need to be urgently addressed in the restoration of services.

As we emerge from the pandemic, the implementation of PCNs, the strengthening

of digital service provision and the restoration of outreach services will be especially important as a solution to the fragmented commissioning of contraceptive care.

Service restrictions during the pandemic

The social distancing measures introduced in March 2020 necessitated unprecedented restrictions on contraceptive services. This was due to a combination of factors including the need to balance benefits of care with the risk of infection to both patients and healthcare professionals, and the diversion of staff in the SRH sector to other areas of the NHS. Where services continue, many have moved to a digital and telephone-first approach to assess client need for face-to-face consultations.

Clinic closures and reduced access to care

Temporary clinic closures have been extensive, with many of the clinics that have remained open operating at a fraction of their normal capacity:

- A member survey conducted by BASHH found that 54% of clinics had closed at some time since the beginning of the pandemic.
- In early April 2020, 65% of respondents to the same survey reported having less than 20% capacity for face-to-face contraception provision.[47]
- A patient-facing survey conducted by the Advisory Group on Contraception (AGC) found that 42% of respondents' GPs or SRH clinics had closed during the pandemic.[48]

The closure of services and restriction on many types of contraceptive care have, in many cases, compounded difficulties faced by women in accessing care. The AGC survey found that 40% of respondents who used contraception had found it more difficult to access contraception during the pandemic, compared to 19% who said it was easier. Meanwhile, a study on the effects of Covid-19 on pregnancy and birth outcomes found that women in their first trimester of pregnancy in June (i.e. who had become pregnant during the pandemic) reported significantly higher difficulty in accessing contraception than women in their second and third trimesters.[49]

Many women are unsure where and how to access services and advice, particularly when their familiar local services have closed.

Multiple submissions to this Inquiry outlined the need for an online contraceptive care directory. This would make it easier for women to find out where their local services are and which are able to offer access to the full range of contraception, including LARC. Such a directory would help women to quickly access their preferred type of contraception and better navigate the postcode lottery of commissioning structures without the need for multiple appointments and consultations.

> *"[There is] Minimal access to advice or appointments for problems to current contraception"* – respondent to AGC survey

Reduced options for care

Between late March and June 2020, a significantly reduced range of contraceptive options were available to women. While contraception was recognised from the outset as an essential service to be maintained, the vast majority of contraceptive care providers found it necessary to limit contraceptive methods whose provision requires a face-to-face element. In practice, this meant that:

- Routine fittings of LARCs were predominantly suspended, with women often offered oral contraception as a 'bridging method' until such time as they could access their preferred method of contraception;
- 12% of services ended or limited LARC fittings for emergency contraception;
- 39% of services ended or limited provision for LARC complications;
- 23% of services ended or limited provision of oral contraception, and with anecdotal reports of women being told by GPs to 'use condoms' rather than being offered alternative oral contraception.[50]

Though some restrictions on contraceptive access were necessary and were implemented in order to minimise the risk of infection for women as well as for NHS staff, the resultant disruption to the sexual and reproductive health of some women, especially those from marginalised groups, should not be overlooked.

As England emerges from lockdown, it is expected that services will begin to normalise and to widen the scope of their care provision to include non-essential services. However, SRH organisations expect that this is likely to coincide with a spike in demand for contraception in addition to the lengthy backlogs which have accumulated over he lockdown period.

LARC fittings

The Inquiry has heard that LARC fittings have been most severely impacted by restrictions on contraceptive services. FSRH guidance issued at the beginning of the pandemic recommended that non-urgent LARC fittings be postponed due to the pandemic, and that some types of routine LARC removals or replacements can be safely postponed for up to a year when clinically appropriate.

However, despite guidance specifying that provision should continue where capacity exists for emergency LARC fittings, fittings for people from marginalised groups, and emergency removals, many services have suspended LARC provision completely.

> *"[I have] issues with my coil and I can't get to the clinic to get it out"* – respondent to AGC survey

The FSRH members' survey found that 54% of SRH service providers have ended or limited the provision of emergency LARC and 39% have ended or limited provision for LARC complications. Of these, 55% of service providers were not confident that women would be able to access these services elsewhere. It should also be noted that women who use LARC for other indications such as heavy menstrual bleeding have been forced to wait longer for treatment.

> *"I felt I am being left in pain"* – respondent to AGC survey

The impact of the pandemic on women's access to LARC services is particularly concerning, since it limits choice to user-dependent forms of contraception which may not be as well-suited to their needs. Prior to the pandemic, the closure of specialist clinics put pressure on GPs to provide LARC services. However, a combination of fragmented commissioning structures, reduced funding, and a lack of financial incentives for GPs to provide LARC has also led to a reduction in the availability of LARCs in General Practice, leading to reduced overall provision and long waiting times for women.

Provision of LARC during restoration of services

A significant increase in women requiring LARC care, and a substantial backlog, is anticipated once services resume. However, there is concern that the cost of reinstating LARC services will prove prohibitive to many GPs. A failure to recommission LARC services following the pandemic would mean losing the skilled Primary Care workforce, which was already facing a succession crisis prior to the pandemic, and placing greater pressure on stretched specialised clinics to pick up excess demand. This would lead to reduced availability of LARC and ultimately further erosion of women's choice of contraceptive methods.

Emergency contraception (oral and LARC)

Similarly, despite guidance classifying emergency fittings of the intrauterine device for emergency contraception as essential care, only one third of services have been able to offer this care. Anecdotal evidence suggests that some women struggled to access oral emergency contraception in the early stages of the pandemic, when pharmacies were busy and clinics had not implemented clear guidelines.

Post-Partum Contraception

Post-partum contraception, which is mentioned earlier in this report as a neglected aspect of contraception provision in the UK, has become more crucial now that other pathways to contraceptive care have become more challenging. The Inquiry has heard that some postnatal wards have attempted to increase provision of post-partum contraception in response to restricted access in the community and from GP services, but this provision is still patchy.

'Prior to 'lockdown' measures I had been trying to convince senior staff members in the obstetric team to improve LARC provision on the postnatal wards. Suddenly, all the support I was told could not be provided has appeared and the fitting of LARCs seems to have doubled overnight.' – Gynaecology Registrar

Post-abortion contraception

Abortion care providers have continued to offer post-abortion contraception to women during the pandemic. Following the temporary authorisation of home use of both mifepristone and misoprostol medications to begin an early medical abortion (EMA) before 10 weeks' gestation, it is estimated that around 70% of abortion care women are now accessing abortion from home.[51]

For these women, social distancing measures have meant that women accessing EMA at home (i.e. those with no face-to-face contact with a healthcare provider) cannot access LARC. Instead, new contraception users are offered POP, where suitable, as a default bridging method. Those who require face-to-face abortion care are still eligible for LARC fittings.

While the continued provision of post-abortion contraception to all women accessing services is cause for optimism, the Inquiry has heard that lack of access to LARC may be having consequences for the reproductive health of some women. LARC uptake is high as a post-abortion option, with 51% of women who accessed contraception directly from BPAS in 2019 choosing a LARC method.[52] Marie Stopes UK's Medical Director, who separately leads the NHS abortion service in Cornwall from a large acute Trust, reports that their service has treated four patients who have required more than one abortion during lockdown as they could not access effective contraception. This suggests that the wider lack of access to LARC is likely to have led to unintended pregnancies for many women for whom oral contraception is not an effective form of birth control.

The Inquiry also heard that there have been some supply chain issues, including temporary delays to deliveries, due to the current high demand for POP.

SRH sector response to the Covid-19 pandemic

Developing digital services and telemedicine in response to the pandemic

The use of digital services and telemedicine has been expanded rapidly to uphold contraceptive services during the pandemic. In the weeks following the social distancing order, there was a 74% increase in remote consultations in specialist SRH services and a 69% increase in General Practice.[53] This is an example of the rapid positive changes in service provision precipitated by the pandemic.

The majority of women are now being asked to first contact their healthcare provider by phone or email, whereupon they may be offered a remote consultation or referred to triage prior to accessing a consultation. Women with a need for essential face-to-face care, or marginalised women, will then be offered an in-person appointment.[54]

Feedback on telemedicine from women and healthcare professionals has been overwhelmingly positive. Remote consultations provide a more convenient form of access to contraceptive care for many people, women in rural areas or those who struggle to travel to healthcare settings due to childcare responsibilities, disability, or financial constraints. The Inquiry heard that remote consultations may remove the stigma of visiting an SRH clinic, which can act as an obstacle to access for some marginalised groups.[55] Healthcare providers report that remote consultations and the use of telemedicine can relieve pressure on them and reduce waiting times for women.

Postal prescriptions

Some women can get prescriptions of their oral contraception posted to them or collect from their local pharmacy, removing the need to attend their GP or clinic at all.

> *"Prescription was issued to chemist quicker than normal; so quick and easy"* – respondent to AGC survey

Impact of telephone and digital services on marginalised groups

This Inquiry heard that the introduction of telephone and digital services offers significant opportunities to improve access to contraception for marginalised groups who might typically face barriers to care.

The online contraception provider SH24 noted several benefits of internet provision for vulnerable groups. For women for whom English is not their first language, online services may be easier to access than services which require face to face interaction, with the assistance of online translation services. Furthermore, for women from cultures where contraception is stigmatised, or for those who may find traditionally gendered services a barrier to access, the discreet nature of online services and their increased prominence in the SRH service landscape as a result of the pandemic may also offer a more acceptable route to accessing contraception.[56]

The Inquiry heard some concerns that the lack of available face-to-face consultations risks not picking up safeguarding issues such as domestic violence and abuse (DVA), coercive relationships and sexual exploitation. There are also concerns that young people may not disclose pregnancy or STI risks, for fear of being reported for breaking social distancing rules.

Evidence submitted to the Inquiry also suggested that there are some marginalised groups whose needs are better accommodated by face-to-face services. In particular, women with restricted access to telephone or internet and women with low literacy would be at risk of further marginalisation if face-to-face services and walk-in clinics do not resume.[57] In addition, women with language barriers may find telephone services particularly difficult to access.[58] However, other organisations report being able to conduct effective safeguarding measures via phone or telephone, and have robust systems in place to follow up with women who may be at risk.

The Inquiry has received consistent feedback from contributors that future models for contraceptive care must include both telemedical and face-to-face services, in order to ensure that the needs of all women are met. Maintaining use of digital consultations for routine appointments will also protect face-to-face time for more women from marginalised groups.

Impact of commissioning structures on access to services

As noted in previous sections of this report, current commissioning structures create a siloed approach whereby women face barriers to accessing integrated healthcare. The pandemic has exacerbated the pressure on this already compromised system, with the additional hurdles posed by remote access, limited consultation capacity and severely reduced face-to-face access making access to contraception difficult and even unnavigable for many women during the period.

The effects of the pandemic have demonstrated the need for a more integrated commissioning system which can provide holistic, woman-centred care. The Inquiry heard from multiple organisations that the implementation of PCNs, which would enable more swift referrals between primary care and clinics, and offer a solution to women's healthcare delivery by the development and expansion of women's health hubs delivering SRH and community gynaecology services. Existing women's health hubs have also reduced their service provision as a result of the pandemic, but are in an advantageous position to recover quickly.

> *"Commissioning arrangements should not limit the service provision that can be provided by the contraception services. There shouldn't be a cap on providing services to women who reside in your own borough."* – London borough evidence submission

Impact of commissioning on digital and remote service provision

Despite the success of digital and telemedical care in many areas, provision is fragmented, with individual CCGs, GPs or clinics creating their own systems, which are often based on rudimentary digital or telemedical systems which were in place prior to the pandemic. Accordingly, data suggest that current digital and telemedical provisions vary hugely across the country, resulting in a postcode lottery and inequitable access and outcomes.

> *"Sexual health service advised contact GP, GP said I need to use the NHS app, the app was really painful and kept asking me about Covid-19 symptoms when I literally just wanted contraception."* – Respondent, Decolonising Contraception survey

The Inquiry recommends the development of a dedicated digital contraceptive service which will protect contraceptive provision in the event of another 'lockdown', even out inequalities in remote access to contraception, and streamline care pathways for women.

Workforce

The pandemic has weakened workforce capacity in both GPs and SRH clinics, with 32% of staff at specialist services and 8% of GPs being redeployed during Covid-19.[59] This is severely limiting capacity in SRH clinics, whilst competing demands on GPs' time may cause them to deprioritise contraceptive services.

The Inquiry heard several concerns in relation to SRH staff wellbeing in the aftermath of the pandemic, which may have a knock-on effect on the effective provision of contraception:

- Access to Personal Protective Equipment (PPE) has varied across service providers during the outbreak, though it is unclear how much this has hampered, or could hamper, contraceptive provision.
- There are ongoing concerns about the safety of BAME members of their workforce, as well as other members of staff with underlying health conditions who may be nervous or unwilling to return to offering regular face-to-face services.
- There are valid long-term concerns about an already overstretched SRH workforce, which is likely to face the challenge of lengthy care backlogs as services emerge from the pandemic. Staff may feel exhausted and deskilled following redeployment to the NHS 'front line'.
- The pandemic has led to significant disruption for workforce education and training, with many important modules and courses postponed or moved online. This risks jeopardising staff development opportunities and placing further strain on the workforce, especially in respect of certification for LARC fittings.

Impact on marginalised groups

The closure and restructuring of services during the pandemic are likely to have had the most adverse impact on the most marginalised communities. Young people under 25, BAME women and those from socially disadvantaged backgrounds are all more likely to have abortions than other populations, suggesting that there is already an unmet need for contraception among these groups.[60] The Inquiry has heard that some marginalised groups are also more likely to access care via walk-in services, which have been disproportionately affected due to the requirement for social distancing within clinics.

Additionally, service providers have faced challenges communicating changed models of service provision with hard-to-reach service users and those who are not digitally literate. There are also concerns around other groups who may be delaying access to contraception for fear of infecting or being infected by others.

> *"I worry that many vulnerable groups will have had reduced access, either because they do not know services remain open, or because they are not allowed out to visit the service, or do not have the privacy to contact services if others in the house may be listening"* – Respondent, FSRH members' survey

The provision of dedicated outreach services for marginalised groups has, as much of contraceptive provision, varied significantly between services, creating a postcode lottery for women across England. This Inquiry received evidence submissions from six separate NHS Trusts and Local Authorities, some of which had continued programmes for marginalised groups virtually unchanged, some of which had switched to remote services and some of which had suspended services entirely due to a lack of workforce capacity. Overall, data suggest that 1 in 5 services has ended or severely limited outreach services for marginalised people during the pandemic, with only 31% of healthcare professionals confident that women from marginalised groups could access contraception and other SRH care during this time.[61] These challenges occur against a backdrop of reductions in dedicated service capacity for marginalised groups, with many clinics having limited or curtailed outreach services prior to the pandemic due to budget cuts.

Young people

Due to the nature of their circumstances, lockdown has been especially detrimental for younger people's access to contraception. Outreach services for schools and colleges and other young people's services such as walk-in clinics have been temporarily suspended. The Inquiry heard from multiple organisations that the numbers of young people contacting, and being seen by, clinics have dropped disproportionately.

The young people's sexual health charity Brook reports that young people often feel unable to leave the family home to attend appointments, or have moved away from their familiar clinic (e.g. in their university town or city) and now face additional barriers in accessing care. Where postal delivery is available, young people may also feel unable to receive contraception in their family home.

> *"The young people we see are usually very reluctant to attend their own GPs for contraception and feel that a drop-in service is most appropriate as they can attend without their parents/carers knowing."* – Respondent to FSRH members' survey

BAME people[1]

Multiple factors have caused black people, Asian people and people of other ethnic minorities to face increased barriers to accessing contraception prior to the pandemic. The Inquiry heard that these inequalities are likely to have been exacerbated by the pandemic. The closure of many walk-in clinics, which BAME people are disproportionately likely to access, has led to concerns that there is a rising unmet need for contraception in BAME communities.

In addition to this, BAME people are over-represented in the most serious cases of Covid-19. There are concerns that this can manifest in greater anxiety from BAME communities about accessing healthcare services due to the perceived risk.

[1] As stated earlier in the report, the Inquiry recognises the limitations of the BAME categorisation.

> *"We are particularly aware of the reduction in the number of women attending our services from the BAME community. There is a possibility that changes to our services may have a negative effect on this population."* – Central London Community Healthcare Trust submission

An informal online survey conducted by Decolonising Contraception in June 2020 found that most respondents from marginalised communities experienced difficulty in accessing contraception during the pandemic.

> *'My contraception request was rejected by my GP surgery. They did not inform me so I went to collect my prescription (including asthma pumps) and found out on arrival at the pharmacy. I contacted the GP and they advised that they rejected it (without informing me) because I should have one month's supply left according to their records. […] I have an underlying health condition and had to make multiple trips to the pharmacy during the official gov lockdown. This could have been avoided.'* – Respondent to Decolonising Contraception survey

The PHE report on disparities in the risk and outcomes of Covid-19, published in June 2020, has led to significant confusion around next steps from the Government to address the disparities experienced by BAME communities, due to a lack of recommendations for measures to tackle health inequalities during the pandemic.[62] The Inquiry calls for a clear commitment from the DHSC, or from the body which takes on PHE's responsibility for provision of contraception, on how it intends to progress with this work, along with a timeframe.

Telephone access and Data poverty

While telemedicine and the use of telephone or video consultations may have reduced obstacles to access for some marginalised groups, there is concern that they may have compounded access issues for other groups. Clinics who have limited all triage to telephone or video consultation admit that this will effectively remove access for those without adequate access to internet or telephone.[63]

Challenges and opportunities around safeguarding

Changes to services have provided both challenges and opportunities for existing safeguarding practices. The success of telemedical abortion services, following a regulatory change to abortion care allowing the home use of mifepristone and telemedicine for early medical abortion, has shown how women from marginalised groups can be effectively screened for safeguarding via a telephone or video consultation.

Where domestic violence and abuse (DVA) is an issue, women may find it easier to access healthcare confidentially from home rather than risk drawing attention to their actions by leaving the house to attend a healthcare setting. Some healthcare professionals have reported that women are more forthcoming during a phone consultation than a face-to-face consultation.

However, some healthcare professionals have reported that they have difficulty detecting non-verbal cues via telephone or video consultation. Safeguarding via telemedicine also relies on the ability of the patient to have an open discussion with their healthcare provider from their own home or another remote setting. For younger women who are living with their family or a victim of DVA living with their abuser, this may create considerable barriers to accessing care.

As noted earlier in the report, there is a need for better understanding of the impact of telemedicine and digital services on all populations, especially marginalised groups. Additional training and workforce support will be paramount in delivering high quality care through telemedicine.

Conclusions and recommendations:

Contraception is a human right and an essential part of healthcare for many women in England. Where access is limited, there is a ripple effect on the health and social wellbeing of women.

The pandemic has changed the face of contraception in England more rapidly than any policy change could have done. This Inquiry considers that the benefits of digital services, remote consultations and telemedicine are clear, and hopes that these developments are here to stay. These services offer opportunities to make access to contraceptive care more straightforward and convenient for women with routine appointments, and to remove barriers to care for some of the most marginalised groups, such as women at risk of DVA. However, they must complement, rather than replace, face-to-face services which are still crucial to maintain for many women, and further training should be offered to strengthen remote safeguarding processes.

The pandemic has also brought health inequalities in the UK between white people and people of black, Asian or other ethnic minority into sharp focus.[64] While much of this has centred on health outcomes for Covid-19 patients, disparities in access to contraceptive care must not be overlooked.

The pandemic has stress-tested pathways for contraceptive care in England. In particular, it has shown the need for greater service integration to ensure women have access to a full range of contraceptive options, and greater visibility and awareness of women's needs as they access care. The restoration of services following the pandemic is an opportunity to rebuild services in a way that better meets the contraception needs of women, particularly the more marginalised.

Recommendations

These recommendations are intended to inform the forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care and ensure equitable access to high quality contraceptive care for all women, and provide guidance to the Department on maintaining and improving the important contraception workflows which have hitherto been the remit of Public Health England.

The reorganisation of Public Health England presents an opportunity for a broader review of SRH commissioning responsibilities for contraceptive provision. In light of this, the recommendations reflect five overarching ambitions for the future of contraceptive provision in England:

- **To create accountability in co-commissioning of SRH provision, including primary care, to meet population contraceptive need**
- **To tackle the unmet need for contraceptive care within women's reproductive healthcare, identifying and addressing the needs of underserved groups**
- **To secure sustainable, long-term funding for contraception as a key cost-effective public health intervention**
- **To maximise the potential of statutory Relationships, Sex and Health Education (RHSE) to equip young people with an understanding of fertility and contraception, and support easy access to services**
- **To use learnings from the Covid-19 pandemic response to improve provision of SRH care, delivering accessible care via a collaborative approach using new and innovative means of delivery**

Maintaining access to a number of different service providers is essential to allowing women choice of contraception provision. As such, the recommendations set out measures to be adopted across all different service providers, including:

- primary care,
- specialist clinics,
- pharmacy,
- abortion and maternity settings, and
- the voluntary sector.

1. Funding

1.1 The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should recognise and address the reduction in contraception funding across all areas of service provision, and the consequent impact on the most marginalised groups.

1.2 The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should calculate and set out necessary levels of contraceptive funding to meet both national and local population need. Accountability arrangements need to be in place to ensure local spending on contraception reflects population need.

1.3 All abortion contracts should include provision of the full range of post-abortion contraceptive methods. This should include the training of staff and staff time for the fitting and training of LARC methods, regardless of abortion method, whether medical or surgical.

1.4 Funding arrangements should be in place for routine post-partum contraception in all maternity settings.

2. Commissioning structures and accountability

2.1 The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should incorporate all aspects of women's sexual and reproductive health needs and recognise the changing needs of women throughout their lives. This will provide a consistent, joined up vision around which providers can work to ensure that population contraceptive needs are met.

2.2 Co-commissioning should be mandated to ensure that all women can access the full range of contraception via clear, streamlined and well-publicised pathways until the Department of Health and Social Care's engagement on future options for PHE, which presents an opportunity for a broader review of SRH commissioning responsibilities. In the context of the current review of PHE responsibilities, the Department should consider introducing an integrated commissioning model for SRH, with one body maintaining oversight and holding accountability for all commissioning decisions.

2.3 The use of incentivised payment systems such as CQUIN and QOF should be considered to encourage universal provision of all methods of contraception across all providers.

2.4 New service models, such as Primary Care Networks (PCNs), should prioritise examining how they can ensure women have good access to high quality care for their contraceptive, reproductive, gynaecological and sexual health needs. As part of this, PCNs should engage with colleagues within the voluntary, pharmacy and community sector to maximise reach according to local population need. PCNs should also prioritise optimisation of training opportunities.

2.5 NHS England should appoint a National Speciality Advisor for Sexual and Reproductive Healthcare to support the work of the National Clinical Director for Maternity and Women's Health and to drive improvement in the quality of contraceptive provision across the system of reproductive health commissioning.

3. Workforce and training

3.1 Health Education England and the Department of Health and Social Care should collaborate to develop a workforce needs analysis and strategy based on population need for the future delivery of SRH services. They should plan and publish analysis of appropriate current and future skill mix and training needs of specialist and generalist contraceptive providers. Local areas should conduct workforce capacity assessment based on their population need.

3.2 The Community SRH training programme should be expanded and funded to enable leadership for all local areas to meet specialist and Primary Care contraceptive workforce needs with a recommended specialist capacity of 1:125,000 population. This should include dedicated provision for LARC training.

3.3 The quality and breadth of contraception provision should be improved by the introduction of national standards for specialist contraception training for nursing, and ensuring that basic contraception is a core part of nursing, midwifery and health visitor curricula.

4. Data and monitoring

4.1 Consideration should be given to the system-wide collection of demographic data on gender, age, socio-economic status, ethnicity and sexual orientation. This should include fit-for-purpose ethnicity data which is sufficiently specific to account for the diversity of cultural experiences. Inequalities in access and outcomes should be routinely monitored at national and local level.

4.2 DHSC should evaluate current data collection processes (GUMCAD, SHRAD and routinely entered GP SNOMED data) to assess and optimise usefulness and coverage and to examine ways to develop a population lens on use of contraception. Measures should be taken to explore how to unite different data sets to enable a comprehensive view of population contraceptive provision.

4.3 A survey capturing women's experiences of contraceptive provision, including whether or not they are able to access their preferred method of contraception, should be developed for national and local use. The survey should extend to women with an unmet need for contraception and should be used to monitor quality of access and choice over time.

4.4 To provide a better outcome indicator f or all ages, the London Measure of Unplanned Pregnancy should be adopted as primary data standard, collected at front line by maternity, early pregnancy and abortion services. The data should subsequently be utilised as part of the Public Health Outcomes Framework.

5. Improving access to contraception

5.1 The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should prioritise the need for local streamlined women-centred contraceptive service provision for underserved populations, who are less likely to have frequent and easy access to contraceptive services.

5.2 The forthcoming national Sexual and Reproductive Health Strategy from the Department of Health and Social Care should consider how best to integrate SRH care into existing women's healthcare pathways in the NHS. Integrating care around the needs of individual women would improve access by removing the institutional silos which create obstacles for women seeking care.

5.3 Local authorities should embrace the introduction of evidence-based technologies to improve access to contraceptive provision. They should also assess the impact of technology on marginalised groups.

5.4 The Department of Health and Social Care should consider the development of a national digital contraception service. At a minimum, commissioners should ensure there is a dedicated digital contraceptive offer to widen access, and to preserve access if face to face services are suspended. Commissioners should identify digitally excluded groups and ensure they are reached through outreach and other means.

5.5 The full range of immediate post pregnancy contraception should be made available in abortion, maternity and early pregnancy settings.

5.6 The role of pharmacy Independent Prescribers and of Patient Group Directions (PGDs) should be maximised for a wider range of prescription-only contraceptives to increase access to these methods of contraception.

5.7 Progestogen-Only Pills should be reclassified as pharmacy medicines (made available over the counter without a prescription) to widen access while maintaining public funding for this contraception.

5.8 A single national commissioning specification for Emergency Hormonal Contraception services should be established to ensure patients experience consistent ease of access across the country.

5.9 Guidance should be offered on the improvement of pharmacy settings to make it easier for women to access contraception. This may include:

- More privacy for women to discuss needs;
- Making information about contraception more visible in pharmacies.

5.10 DHSC should publish the revised You're Welcome standards for young people friendly health services to provide clear criteria for local commissioning of accessible SRH services and outreach work.

6. Information and education

6.1 The forthcoming Sexual Health, Reproductive Health and HIV Strategy should ensure all women have access to a national source of up-to-date, woman-centred information on the methods of contraception and how to access them. This digital resource should be well-publicised to women via search engine optimisation.

6.2 The forthcoming Sexual Health, Reproductive Health and HIV Strategy should ensure assessment of population level understanding of contraception, by incorporating questions on knowledge on contraception in future reproductive health surveys. Additional research should be conducted to assess the specific information needs of underserved groups, with action taken to address identified needs.

7.Education settings

7.1 The Department for Education should provide information about the teacher training strategy for the implementation of statutory Relationships, Sex and Health Education (RSHE), including how many schools have completed training, quality assurance of providers, and funding for effective delivery. A set of teacher competencies for RSE should be developed, drawn from international evidence, to help ensure the quality and impact of training programmes.

7.2 The Department for Education and the Department of Health and Social Care should ensure teachers are able to access a national source of medically accurate, up to date and evidence-based information on contraception.

7.3 Local authorities should support schools to fulfil their statutory duty to ensure students know how and where to access confidential sexual and reproductive health advice and treatment, by providing up to date information about local SRH services. The requirement to liaise with schools and publicise services should be within specialist SRH clinics service contracts.

7.4 The delivery of RSE within RSHE should be included in routine OFSTED inspections from 2020. Inspectors should be sufficiently trained to ensure they understand the key components of RSE, prior to inspections. The OFSTED subject reports for RSE should be re-established to provide a more in-depth understanding of the quality of RSE provision. The findings should be used to inform the three-year review of the statutory guidance.

7.5 Considering the higher rates of sexual activity among older teenagers, information about contraception and service access should be continued in sixth form and further education colleges and university settings.

Appendix 1

Organisation who provided written evidence

- Advisory Group on Contraception (AGC)
- Association of Director of Public Health South East
- British Association of Sexual Health and HIV (BASHH)
- Bayer
- British Medical Association (BMA)
- BPAS
- Brook
- Company Chemists' Association
- Central London Community Healthcare Trust
- Croydon Sexual Health Services
- David Taylor
- Decolonising Contraception
- East Sussex Public Health team
- English HIV and Sexual Health Commissioning Group (EHSHCG), Association of Director of Public Health (ADPH), Local Government Association (LGA)
- Exeter and Devon
- FPA
- Faculty of Sexual and Reproductive Healthcare (FSRH)
- Healthwatch
- Imperial College London
- Jackie Doyle Price MP, Minister for Women's Health
- Dr Kathy French
- King's College Hospital NHS Foundation Trust
- Lambeth, Southwark & Lewisham Council
- Leeds Community Healthcare NHS Trust
- LGBT Foundation
- Marie Stopes International
- National AIDS Trust
- Oxfordshire County Council
- Primary Care Women's Health Forum
- Public Health England (PHE)
- Rosehill Clinic
- Royal College of General Practice (RCGP)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal Cornwall Hospital Trust
- SHRINE
- SH24
- Supported Loving
- The Circle Room
- Umbrella
- UCL Institute for Women
- University of Bedfordshire
- University of Sussex Centre for Cultures of Reproduction, Technologies and Health
- Waltham Forest, East London and Redbridge

Witnesses who provided oral evidence

- Dr Amanda Britton, GP
- Andrea Duncan, Sexual Health Programme Manager, DHSC
- Dr Asha Kasliwal, President, FSRH
- Dr Claire Dewsnap, Consultant Physician in Sexual Health and HIV, BASHH
- Professor Jim McManus, Vice President, ADPH
- Jonathon Holmes, Senior Policy Analyst, Healthwatch
- Dr Kathy French, Independent nurse advisor
- Professor Dame Lesley Regan, President, RCOG
- Lisa Hallgarten, Head of Policy, Brook
- Malcolm Harrison, Chief Executive, Company Chemists' Association
- Dr Marian Davis, Chair of Adolescent Health Group, RCGP
- Dr Matthew Jolly, National Clinical Director: Maternity & Women's Health, NHS England
- Oliver Mann, Account Manager, Incisive Health
- Rachael Clarke, Public Affairs and Advocacy Manager, BPAS
- Robert Carroll, Chair, ESHHCG
- Rosie Mughal, Account Director, Incisive Health
- Dr Rudiger Pittrof, SRHINE
- Professor Simon Gregory, Deputy Medical Director, Health Education England
- Dr Stephanie Lamb, GP, The Well Centre
- Dr Sue Mann, Medical Expert in Reproductive Health, PHE
- Dr Usha Kumar, SHRINE

Appendix 2

Terms of reference 2019

The All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health invites short written submissions from interested organisations and individuals, regarding access to contraception in England.

The APPG on Sexual and Reproductive Health believes that access to the full range of contraceptives, as well as comprehensive information and advice regarding an individual's choices is a fundamental right for all people.

It is now almost six years since contraception services were made the responsibility of local authorities.

Since then, concerns regarding fragmented commissioning, a lack of accountability and cuts to the public health budget have been repeatedly raised. The APPG is concerned that it is becoming increasingly difficult for individuals to access the full range of contraceptive methods (including long acting reversible contraception, hormonal contraception, barriers methods and emergency contraception), in a timely manner which takes account their holistic sexual and reproductive health needs.

Members are looking for written evidence that address all areas concerning access to contraception in England, but are particularly interested in;

- Evidence and trends relating to:
  - Estimating and commissioning to meet population need for contraception.
  - Demand for contraceptive methods.
  - Ease in accessing contraceptive methods (including locations of clinics, opening hours of clinics, the variety of methods available, waiting times, etc.)
  - Role of General Practice as key provider of contraception – measurement of access and method used, in particular relating to LARC.
  - Variation of costs of the different forms of contraception and the impact this has on Health Care Professionals (HCPs) prescribing the different forms of contraception.
  - Variation in incentive schemes and the impact this has on HCPs prescribing different forms of contraception.
  - Inequalities in access by, for example region, ethnicity, disability, age, sexuality, gender.
  - Lack of access to contraception for particular groups with additional vulnerabilities, for example, mental ill health, drug/alcohol dependence, migrant/asylum seeking women.
  - Access to contraception and rates of unintended pregnancies.
  - Availability of post-pregnancy contraception including in postnatal services.
  - Access to contraception through non-clinic based services, for example in pharmacies, educational settings, the workplace or online.
- The links between relationships and sex education (RSE) in school and other information provision for women, and access to contraception.
- The impact of funding arrangements on access to holistic sexual and reproductive health, and recommendations on how funding challenges can be overcome.
- The impact of current commissioning arrangements on access to holistic sexual and reproductive health, and recommendations on how commissioning challenges can be overcome.
- Example of good models, in all settings, which are improving or facilitating access to contraception.
- Evidence relating to the quality and availability of data regarding access to contraception and contraceptive outcomes, and how or if this could/should be improved.
- Evidence regarding issues affecting the specialist and non-specialist workforce delivering sexual and reproductive healthcare in all settings, including skill set, quality and numbers to reflect current and future population need.
- Recommendations for work which could be taken by bodies including, DHSC, NHS England, Public Health England, Health Education England, CCGS, local authorities and others to improve access and standards of care and reduce variations.

Terms of reference 2020

Members of the Cross-Party Group on Sexual and Reproductive Health, formerly the APPG on Sexual and Reproductive Health, are looking for written evidence that addresses all areas concerning **access to contraception in England during the Covid-19 pandemic**.

Members are particularly interested in the following areas:

- The **impact of changes to services** brought about by the pandemic on access to contraception, and **availability of appropriate services**.
- The **extent to which people are able to easily access contraceptive methods** in a way that takes account of their holistic sexual and reproductive health needs, while complying broadly with social distancing measures.
- The **impact of current commissioning structures**, be it positive or negative, on facilitating appropriate and quick access to contraception during the pandemic.
- The **effectiveness of the remote consultation systems** employed by many contraception providers in response to the pandemic, and any implications, be they positive or negative, for women' access to care in the short or long term.
- **Inequalities in accessing contraception** by, for example, region, ethnicity, disability, age, sexuality, gender, mental ill health, drug or alcohol dependence, and amongst migrant or asylum seeking women.
- Impact of any inequalities on **vulnerable populations**.
- Examples of good practice, in all settings, which are **improving or facilitating access to contraception during the pandemic**.
- Potential **challenges or obstacles to the restoration of contraception services**, including workforce, implications for social distancing, increases in demand or backlogs and supply chain.
- Recommendations for work which could be taken by bodies including DHSC, NHS England, Public Health England, Health Education England, CCGS, local authorities and others **to overcome challenges and improve access and standards of care** during the next stages of the pandemic.

Appendix 3

Methods of contraception

Long Acting Reversible contraception (LARC)		
The contraceptive implant	The contraceptive implant is inserted under the skin on the upper arm. It releases the hormone progestogen which stops ovulation, thickens cervical mucus to prevent sperm reaching an egg, and thins the lining of the uterus (womb) to prevent a fertilised egg implanting	• LARC methods are fitted by a health care professional and depending on the type, are effective for between 4 months and 10 years. • With efficacy rates of over 99% long-acting reversible contraception or LARC is one of the most effective forms of contraception. • LARC does not depend on a user remembering to take it or using it correctly. • LARC methods do not prevent against Sexually Transmitted Infections. • Some methods of LARC, for example the IUS, can be used to treat gynaecological disorders.
The contraceptive injection	The injection also works by releasing progestogen.	
The intrauterine system (IUS)	The IUS is a small T-shaped plastic device, which is inserted into the uterus. It works by releasing progestogen.	
The intrauterine device (IUD)	The IUD is a small plastic and copper device which is inserted into the uterus. It works by stopping a sperm reaching an egg, and may also stop a fertilised egg implanting in the uterus.	
Barrier methods of contraception		
Male condom	Male condoms are put on the penis and prevent a sperm from entering the vagina.	• Barrier methods of contraception prevent a sperm reaching an egg. • If used as the instructions indicate they are between 92% and 98% effective. • However, barrier methods depend on correct use. With typical use, male condoms are around 82% effective, female condoms are 79% effective and diaphragms and caps are 72% effective. • Male and female condoms can help prevent against STIs.
Female condom	Female condoms prevent sperm from entering the vagina	
Cap	Caps and diaphragms are flexible device which are put into the vagina to cover the cervix, prevents a sperm entering the uterus. It must be used with spermicide.	
Diaphragm		
Short-term hormonal methods of contraception		
Combined Pill (COC)	COC contains oestrogen and progestogen. It stops ovulation, thickens cervical mucus to prevent sperm reaching an egg and thins the lining of the uterus (womb) to prevent a fertilised egg implanting.	• Short term hormonal contraceptive is around 99% effective when used perfectly. • However, these methods depends on being used correctly. With typical use they are around 91% effective. • Short term hormonal contraception does not protect against STIs. • Some methods such as POP, can be used to treat conditions such as heavy menstrual bleeding.
Contraceptive patch	A small patch stuck on the skin. It works in the same way as the combined pill.	
Contraceptive ring	A small, flexible plastic ring is put into the vagina. It works is the same way as the combine pill.	
Progesterone only pill (POP)	POP contains the hormone progestogen, which thickens cervical mucus to prevent sperm reaching an egg.	
Permanent methods of contraception		
Female sterilisation	The fallopian tubes are cut or blocked, preventing an egg and sperm meeting.	• These are permanent methods of contraception which are difficult to reverse and only suitable for people who are sure they don't want children in the future.
Male sterilisation	The tubes that carry sperm from the testicles to the penis are cut, sealed or tied.	
Fertility awareness		
Fertility awareness	This technique must be learnt. It relies on a person monitoring different fertility signals to identify when they are most likely to get pregnant and avoiding sex at these times.	• The fertility awareness method is up to 99% effective if used perfectly. With typical use it is around 76% effective.

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All Party Parliamentary Group on Sexual and Reproductive Health in the UK

Chair: Dame Diana Johnson DBE MP, House of Commons, London, SW1A 0AA
Administration: FSRH, 10-18 Union Street, London, SE1 1SZ
Tel: 020 3794 5310 | Email: appg@fsrh.org