Advisory Group on Contraception (AGC)
Women's Health Strategy: Call for Evidence Submission

Introduction

Thank you for inviting submissions to inform the development of the Government's Women's Health Strategy. This submission from the Advisory Group on Contraception (AGC) focuses on the importance of full and open access to contraception and holistic women's reproductive health services,[1] for all women at all times and places over their life course, and suggests the changes needed to ensure this.

At the core of this response is the fundamental right of access to a full range of contraceptive options, and the right for women to choose their reproductive path. However, AGC members are increasingly concerned about the impact of year-on-year public health budget cuts combined with a fragmented commissioning and provider landscape on women's ability to access the contraception they need.

In particular, AGC members are concerned about the challenges in accessing contraception faced by women who are disadvantaged and underrepresented but who are most vulnerable to unplanned pregnancies – such as sex workers, refugees and asylum seekers, and victims of domestic violence.

This AGC submission highlights the challenges these women face throughout, whilst also highlighting the wider issues affecting women's ability to access the proper education, information, advice and contraception itself across a life course, from menstruation to menopause. It focuses on the core themes identified in the call for evidence that are most relevant for access to contraception.

Summary of recommendations

The Women's Health Strategy, together with the upcoming Sexual and Reproductive Health Strategy, provides an opportune moment to ensure tangible changes and improvements for women's reproductive health. The AGC encourages cross-ministerial working on the two strategies to ensure a joined up, holistic approach towards reproductive health. As part of this, the AGC recommends:

1. ***Integrated Care Systems (ICSs) take a leading role in ensuring a mixed model of contraception provision*** to ensure a blend of 'mass' services with targeted outreach and opportunistic care, taking into account the various settings through which contraception should be available
2. ***Listening mechanisms are embedded at an ICS level to capture women's experiences and views*** to inform a mixed model of provision
3. ***A reproductive health lead is appointed at system (ICS) and national (NHS England) levels*** to hold accountability for commissioning and outcomes in women's reproductive health
4. ***Teachers receive proper training to provide relationship and sex education (RSE)*** with local authorities working to ensure access to training, evidence-based resources and support

[1] The AGC recognises that access to contraception is essential for everyone who can become pregnant, no matter how they identify, and therefore supports and advocates for the right to access contraception for trans, non-binary and intersex people that need it. It is essential that there is an understanding of intersectionality to help minimise inequalities in care and the provision of essential service. We use the word women for simplicity but also in recognition that the majority of those requiring access to contraception identify as women.

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5. ***A dedicated amount of time is set aside for RSE each school year*** and added to national guidance to ensure that this time is protected
6. ***Ofsted reviews the quality of RSE and standard of its teaching*** and publishes reports every two-to-three years in order to keep a spotlight on its provision
7. ***ICSs take responsibility for updating and increasing signposting across their local populations*** including online and in person, through GP surgeries, Sexual and Reproductive Health (SRH) clinics and wider touchpoints such as maternity and abortion services
8. ***More is done to 'make every contact count'***, encouraging joined-up working with other public health services, including services for refugees, asylum seekers, addiction and domestic abuse
9. ***ICSs oversee workforce planning and training for contraception – including fitting and removal of long-acting reversible contraception (LARC) – in their area,*** covering an assessment of networked provision across SRH clinics, general practice, and secondary care – including maternity settings – and abortion clinics to ensure a mixed model of provision
10. ***The Government undertakes a national assessment of funding required to deliver high-quality full and open access to contraception across the life course*** including the costs of workforce training and planning across SRH clinics, GP practices and other settings
11. ***The Government leads a review of where and how digital services can support access to contraception*** as part of the Sexual and Reproductive Health Strategy
12. ***HM Treasury sets out a multi-year, ring-fenced spending settlement for public health services, including contraception,*** to reverse the public health cuts of 2015-2020 and support recovery and reinvestment in the sector

Background to the Advisory Group on Contraception

The Advisory Group on Contraception is an expert advisory group made up of leading clinicians and advocacy groups who have come together to discuss and make recommendations on policy concerning the contraceptive needs of women of all ages in England. Information on AGC members and activity can be found at www.theagc.org.uk.

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Core theme 1 – Women's Voices

Access to contraception is a basic fundamental right for all women. Contraception empowers women to take control of if and when they choose to become pregnant and protect themselves from the human and financial costs of an unplanned pregnancy. In Public Health England's 'What do women say' report on reproductive health, 'not getting pregnant' is identified as women's greatest reproductive concern,[2] and yet in reality almost half of pregnancies are estimated to be unplanned.[3] For some women an unexpected pregnancy may be a joyful event, but for other women it will be both unplanned and unwanted.

[2] Public Health England, What do women say? Reproductive health is a public issue, 2018. Accessed here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731891/What_do_women_say_reproductive_health_is_a_public_health_issue.pdf

[3] Royal College of Obstetricians and Gynaecologists, Better for women report, December 2019. Accessed here: https://www.rcog.org.uk/globalassets/documents/news/campaigns-and-opinions/better-for-women/better-for-women-full-report.pdf

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This right to access contraception should be underpinned by the right for a woman to choose; choose the best method of contraception for her, as well as where and how she accesses contraceptive services. For many women, there are sensitivities and sometimes stigma surrounding which services they are comfortable using. For some, this is around attending a Sexual and Reproductive Health (SRH) clinic, but for others it is around visiting their family doctor for contraceptive purposes.[4] In recent years, there have been growing gaps in the health and care system that obstruct this right to choose where they go for contraception, and as a consequence leave a system that does not always listen to women's voices or respond to their needs.

The current gaps in the health and care system, which are inhibiting women's contraceptive choices, result from two issues: first, a fragmented commissioning and provider landscape and second, budget cuts.

Fragmented commissioning and provider landscape

Since the implementation of the Health and Social Care Act 2012, commissioning of contraception has been split across three different responsible bodies, with funding coming from three different routes:

a. **Local authorities** commission contraception delivered in community clinics, integrated sexual health provision and some GP practices, including specialist care and LARC provision – funded by the public health grant
b. **NHS England** leads the commissioning of basic contraceptive services under the GP contract, including user-dependent methods – funded through the GMS contract
c. **Clinical Commissioning Groups (CCGs)** commission contraception for gynaecological purposes – funded through NHS CCG allocations

This fragmented commissioning landscape has resulted in a fragmented provider landscape, each commissioned in a different way, with different incentives to deliver isolated aspects of care, rather than supporting women with their reproductive health needs in a holistic, accountable and joined-up way.

A further implication of this fragmented landscape is a lack of comparable data on where and how women are accessing care, what that care looks like, and how women feel about their experiences of accessing care. This is evidenced through a recent AGC FOI audit of 145 local authorities, which showed that only 38 (26%) collect data on the number of complaints received in general practice, and 86 (59%) collect data on the number of complaints received in SRH services.[5] Without this data, there are gaps in our understanding of women's experiences of contraceptive services.

Budget cuts

In 2018, Public Health England published a study which found that for every £1 invested in publicly-funded contraception, £9 is saved in public sector costs (around a third of which is healthcare costs) over the course of 10 years.[6] Yet, since the 6.2% in-year budget cut in 2015,[7] the public health grant has been hit by annual

[4] AGC, At tipping point: an audit of cuts to contraceptive services and their consequences for women, November 2018. Accessed here http://theagc.org.uk/wp-content/uploads/2018/11/At_tipping_point_AGC_Nov_18.pdf
[5] AGC, Shining a light on access to contraception in England: an overview of 2019-2020 data. Accessed here: http://theagc.org.uk/wp-content/uploads/2020/09/AGC-2019-2020-data-deck_September-2020.pdf
[6] Public Health England, Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England, August 2018. Accessed here: https://www.gov.uk/government/publications/contraceptive-services-estimating-the-return-on-investment
[7] BMJ, "Deeply disappointing" public health cuts will increase demand on NHS, says expert, November 2015. Accessed here: https://www.bmj.com/content/351/bmj.h6035

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real-terms cuts of 3.9% each year to 2020.[8] Whilst the 2020 Budget saw the public health grant rise with inflation for the first time in five years, it is nowhere near the levels of investment required to reverse the damage of year-on-year cuts. Indeed, frontline services in England have experienced a **20% cut in real terms** and **12% cut in actual budget** for contraception since the 2015 public health cuts.[9]

Over the same period, AGC research has reported that **26% of local authorities** in England reduced the number of sites commissioned to deliver contraception in 2018/19 – up from 9% of local authorities that had reduced sites in 2015/16. The reasons for changes to local services vary, with local authorities citing **funding and workforce pressures**, **service quality issues** and **pressures on primary care** as contributing factors.[10]

These cuts have contributed to a number of challenges now facing the sustainability of the range of contraceptive services, notably women's access to **LARC in primary care**. With service closures and public health budget cuts, increasing pressure is falling on primary care. This is compounded by two key issues: first, the variation in LARC fitting fees, which often do not cover the costs of delivering the service, training new staff and maintaining qualifications;[11] and second, a shortage of trained fitters in general practice.[12] These challenges have coincided with an overall decline in LARC fittings in recent years, with LARC prescriptions (excluding injectables) dispensed in the community **falling by 5%** between 2013 and 2019.[13]

The consequences of a fragmented system are worse for vulnerable and marginalised women – including sex workers, refugees and asylum seekers, and victims of sexual violence – whose voices are not always heard as they should be. Many of these women are not registered with a GP and, whilst some targeted services do exist for these women, 17% (26) of local authorities responding to the AGC's FOI audit in 2019 confirmed they do not commission any community outreach sites to deliver contraceptive services.[14] Any reduction in targeted outreach services makes it harder for these women to access vital contraception.

Recommendations

To ensure that the system works for women, listening and responding to their voices and choices, the AGC recommends:

1. ***Integrated Care Systems (ICSs) take a leading role in ensuring a mixed model of contraception provision***. A mixed model of contraception provision is vital in ensuring a blend of 'mass' services with targeted outreach and opportunistic care, taking into account the various settings through which contraception should be available. This could include the formation of 'women's health hubs' within primary care, that build on the provision of local authority-funded contraception with other reproductive services (such as cervical screening, psychosexual services, menopause treatment etc) and work with 'spokes' across primary, community and secondary care services to ensure breadth and depth of access.

[8] HM Treasury, Spending Review and Autumn Statement 2015, November 2015. Accessed here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/479749/52229_Blue_Book_PU1865_Web_Accessible.pdf

[9] Ministry of Housing, Communities and Local Government, Local authority revenue expenditure and financing: outturn data from 2015 to 2016 and 2019 to 2020. Accessed here: https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing

[10] AGC, Shining a light on access to contraception in England: an overview of 2019-2020 data. Accessed here: http://theagc.org.uk/wp-content/uploads/2020/09/AGC-2019-2020-data-deck_September-2020.pdf

[11] Royal College of General Practitioners, Sexual and Reproductive Health: Time to Act, 2017 Accessed here: https://www.rcgp.org.uk/-/media/Files/Policy/Media/8895-RCGP-Sexual-Health-online.ashx?la=en

[12] Royal College of General Practitioners, Sexual and Reproductive Health: Time to Act, 2017. Accessed here: https://www.rcgp.org.uk/-/media/Files/Policy/Media/8895-RCGP-Sexual-Health-online.ashx?la=en

[13] NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2019/20. Accessed here: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2019-20

[14] AGC, Shining a light on access to contraception in England: an overview of 2019-2020 data. Accessed here: http://theagc.org.uk/wp-content/uploads/2020/09/AGC-2019-2020-data-deck_September-2020.pdf

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This approach would require the coming together of both commissioners and providers across their patch, and should be overseen by an accountable lead for women's health at the ICS level.

2. ***Listening mechanisms are embedded at an ICS level to capture women's experiences and views.*** To inform this mixed model of provision, listening mechanisms to capture women's experiences of care and their views on how services can best meet their needs must be put in place. We recommend that responsibility for this also sits at ICS level and is overseen by the same accountable lead for women's health.

3. ***A reproductive health lead is appointed at system (ICS) and national (NHS England) levels to hold accountability for commissioning and outcomes in women's reproductive health.*** At national level, this could be a reproductive health director or specialist advisor within NHS England, and at system level an accountable lead should be appointed to each ICS Health & Care Partnerships' Board.

Core theme 2 – Information and education on women's health

Information and education on women's health are vital across the life course. Our response therefore breaks this down into two sections: education in schools; and information and signposting beyond schools.

Education in schools

Evidence-based education is crucial for empowering people to take control of their sexual and reproductive health, including understanding their right to access the best method of contraception for them. High-quality relationships and sex education (RSE) can protect women and girls from unplanned pregnancies, and the associated personal, social and financial costs. At a time when sexual health services, in line with other local authority and NHS services, face financial pressures, now more than ever we need to get this right. AGC members therefore welcome the introduction of mandatory RSE in secondary school and relationship education in primary schools. However, it is vital that this education is delivered in a robust and structured way.

Recommendations

To ensure that RSE and relationships education is delivered in a robust and structured way, the AGC recommends:

4. ***Teachers receive proper training to provide this education.*** We recognise the workload and pressure that teachers face already; however, it is important that they receive the training and support to deliver high-quality, evidence-based RSE. Local authorities should work with schools and healthcare professionals to ensure teachers have access to training, evidence-based resources and support.

5. ***A dedicated amount of time is set aside for RSE each school year.*** An assessment should be made of the amount of time that should be dedicated towards RSE in each year group per school year and added to national guidance to ensure that this time is protected.

6. ***Ofsted reviews the quality of RSE and standard of its teaching.*** Ofsted should publish reports every two-to-three years on the quality of RSE, in order to keep a spotlight on its provision. The above two recommendations should be taken into account, on training and dedicated time, to ensure consistent, high-quality RSE is being received by all students across the country.

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Information and signposting beyond schools

Changes to local services as a result of funding cuts and fragmented landscape, outlined under Theme 1, are making it increasingly and unnecessarily difficult for women to know where to find advice and support with contraception, particularly when familiar local services have closed.

Information about local services is not easy to find on the NHS website and our members have found that, when local information does exist, it is often out-of-date. It should be 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. Yet there is currently no online directory or up-to-date resource to support women in their search for appropriate contraceptive care. This is particularly important as digital services continue to expand, offering more opportunities to provide information and advice remotely, but with the risk that face-to-face counselling opportunities are being missed.

A running theme throughout this submission is the disproportionate effect of current women's reproductive health services on vulnerable and marginalised women, and inadequate signposting is no exception. A lack of understanding for how and where to access contraceptive advice and services is greater for many vulnerable women who (for example) may not be registered with a GP or have access to internet services. An AGC survey in collaboration with two local community groups in 2018 indicated that not having access to information, and thus not having a full understanding of contraceptive options and how to access them, has resulted in some vulnerable women being intimidated by the complex care pathway or not using contraception at all.[15]

Recommendations

To support life-long education and access to information on contraception, the AGC recommends:

7. ***ICSs take responsibility for updating and increasing signposting across their local populations.*** The monitoring of adequate and effective signposting and information on contraception should become an ICS level responsibility. Where information is lacking or incorrect, it must be updated and made accessible both online and in person, through GP surgeries, SRH clinics and wider touchpoints such as maternity and abortion services. Information available should include evidence-based patient leaflets on the full range of contraceptive options and, if services are not available on-site, signposting towards where – and how – women can access them in their local area.

8. ***More is done to 'make every contact count'.*** As well as including information and signposting, more should be done to encourage joined-up working with other public health services, including services for refugees, asylum seekers, addiction and domestic abuse, to make sure that every contact counts to empower women about their contraceptive choices. The designated ICS lead for women's health should seek ways to capitalise on the range of services that can be harnessed to educate and inform women, particularly those impacted by health inequalities, about contraception and good reproductive health.

Core Theme 3 – Women's health across a life course

As a group, we want to highlight the importance of reproductive healthcare across the life course, from menstruation to menopause and beyond. This includes access to contraception at different places and at

[15] AGC, At tipping point: an audit of cuts to contraceptive services and their consequences for women, November 2018. Accessed here http://theagc.org.uk/wp-content/uploads/2018/11/At_tipping_point_AGC_Nov_18.pdf

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different points of life, including through fundamental reproductive health services such as abortion and maternity services.

Whilst access to contraception for young people is widely acknowledged as important, particularly in light of the successful efforts to bring down the teenage pregnancy rate, with a decrease of 60% between 1993 and 2018,[16] the provision of these services to women at other stages of life is often overlooked. The latest ONS figures show that between 2011 and 2018 there was a steady decline (8%) in conceptions for women aged 15-44;[17] however there has also been a continued increase in the number of abortions. Figures for England and Wales in 2019 show that there has been an increase in abortion rates for all ages 25 and above, with the largest increase in the 30-34 group, from 15.7 per 1,000 in 2009 to 20.9 in 2019.[18] Whilst these figures are not a direct output of contraceptive services, in the absence of other outcomes or experience data, they may be indicative of provision, suggesting that women aged 25 and above may not have full access to the contraceptive services they require, at the time that they require them.

A major challenge for access to contraception at different times and places in women's lives can be the fragmented commission and provider landscape, outlined under Theme 1. In particular, ramifications exist for joined-up care with other reproductive health services that are commissioned differently, notably maternity care. These challenges include questions over who pays for staff training, as well as how provision of post-natal contraception (for example) fits into the patient pathway for women who have just given birth.

In striving to overcome these challenges, the system could look to replicate the successful efforts within abortion services to ensure the availability of contraception, which has resulted in every abortion contract in the country, as well as the licensing of all independent clinics, requiring contraception to be available. However, there does still exist an issue for abortion services, like GP practices, around a lack of funding for fitting LARC once a patient has received an Early Medical Abortion, which accounts for around 80% of all abortions.[19] Currently, abortion contracts are to provide a comprehensive abortion service, which does not take into account the additional costs of providing a coil fitting service subsequent to EMA provision.

The recent reduction in standalone youth and community outreach services for vulnerable groups gives further cause for concern. Data from the AGC FOI audit of local authorities in 2019 showed that:[20]

- Only 52% of local authorities currently commission "standalone" services for under 25s
- 17% confirmed that they do not commission any community outreach sites to deliver contraception
- 6% stopped commissioning standalone services or reduced the number of services available between 2017/18 and 2018/19, with a further 4% planning to do so in 2019/20

[16] ONS, Conceptions in England and Wales, 2019. Accessed here: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018

[17] ONS, Conceptions in England and Wales, 2019. Accessed here: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2018

[18] GOV.UK, Abortion Statistics for England and Wales 2019. Accessed here: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019

[19] Gov.UK, Abortion statistics for England and Wales during the COVID-19 pandemic, March 2021. Accessed here: https://www.gov.uk/government/statistics/abortion-statistics-during-the-coronavirus-pandemic-january-to-june-2020/abortion-statistics-for-england-and-wales-during-the-covid-19-pandemic

[20] AGC, Shining a light on access to contraception in England: an overview of 2019-2020 data. Accessed here: http://theagc.org.uk/wp-content/uploads/2020/09/AGC-2019-2020-data-deck_September-2020.pdf

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The reduction in outreach services, combined with a reduction in women's reproductive services more generally, is contributing to the overall decline in access and contraceptive options for women across the different places and stages of their lives, but especially for the most vulnerable and disadvantaged groups.

Recommendations
In order to ensure provision of contraception for all age groups, in all settings, the AGC recommends:

9. ***ICSs oversee workforce planning and training for contraception in their area***. This should include an assessment of networked provision across SRH clinics, general practice, secondary care – including maternity settings – and abortion clinics, to ensure a mixed model of provision.

10. ***The Government undertakes an assessment of funding required to deliver high-quality full and open access to contraception across the life course.*** This should include the costs of workforce training and planning across SRH clinics, GP practices, pharmacies and other settings, including the training of midwives for post-natal contraceptive care. Based on this assessment, a long-term funding settlement should be set out to invest in contraception services over the next 5-10 years.

Core Theme 6 – Impact of COVID-19 on women's health

As with most health and care services, contraceptive services were significantly reduced during the COVID-19 pandemic. The extent of these reductions can be seen by the most recent SHRAD data, covering April to September 2020 which demonstrates:[21]

- **A 37% fall in contraception-related contacts with SRH services** compared to April – September 2019; this is a fall of 249,927 contacts (overall contacts including for non-contraception reasons fell by 35%)
- **Uptake of LARC has fallen to 43%**, down from 46% in 2019/20 (including injectables), based on main method used by those presenting at SRH services
- **A 53% fall in emergency contraceptive items provided by SRH services** compared to the same time period in 2019; this is a fall of 21,766 items

This reduction in services has created further challenges for women's ability to access their preferred method of contraception. A snapshot AGC public survey taken during the first lockdown in 2020 saw 38% of respondents noticing additional challenges in accessing contraception as a result of GP and SRH service closures during the pandemic.[22] Moreover, the British Pregnancy Advisory Service (BPAS), an AGC member, has noted that a large proportion of women reported being told by medical professionals to 'use condoms' when asking about a repeat contraceptive pill (or other form of contraception) prescription during this time.

During the pandemic, there were competing demands for staff both in SRH clinics and GP practice. AGC member the Faculty of Sexual and Reproductive Healthcare (FSRH) found that 32% of staff in SRH services were redeployed during the first peak.[23] Whilst GPs only had 8% of staff redeployed, they experienced rapidly increasing competing demands on their time and had to adapt to new ways of working, which have

[21] NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2019/20. Accessed here: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2019-20
[22] AGC, Shining a light on access to contraception in England: an overview of 2019-2020 data. Accessed here: http://theagc.org.uk/wp-content/uploads/2020/09/AGC-2019-2020-data-deck_September-2020.pdf
[23] Faculty of Sexual and Reproductive Healthcare COVID-19 rolling members survey results, 2020. Accessed here: https://www.fsrh.org/news/fsrh-covid-19-members-survey-interim-results-07-may-2020/

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resulted in women being offered limited time slots to discuss contraception options and seek advice with their GP.[24]

As highlighted throughout this submission, services changes disproportionately affect vulnerable and disadvantaged women, which has been exacerbated through the pandemic. Data from the British Association for Sexual Health and HIV (BASHH) showed that one in five sites were unable to offer care to the most vulnerable populations with the greatest need.[25]

Locking in positive changes

Whilst the pandemic has been an extremely challenging time, there have been some positive changes in women's reproductive health. In particular, the rise in digital appointments and telephone triaging, which has been seen across many service pathways, is a welcome innovation. FSRH data from 2020 showed that following the start of the pandemic there was a 74% rise in online consultations in specialist SRH services and a 69% increase in general practice,[26] and NHS Digital data suggests that 44% of SRH service contacts were non-face to face between April and September 2020, compared to 3% in 2019/20. This digital rise has potential benefits, including increased accessibility, streamlined services and the removal of the stigma attached to attending SRH clinics for some women. As these changes are embedded into women's reproductive health service pathways; however, it is important to be mindful of widespread accessibility and to ensure that both face-to-face and digital contacts continue, not least since some forms of contraception require in-person consultations to fit and remove. More work needs to be done to assess where and how digital services fit in the pathway, including how they will be funded within the system.

As a group, the AGC supports the temporary MHRA approval for both early medical abortion (EMA) pills to be taken at home following telephone/e-consultations, and supports the permanent availability of this service. We also support the proposed provision of progestogen-only contraceptive pills in pharmacies, which will help expand access to contraception.

These innovations are essential developments for women's sexual and reproductive health. However, more must be done in order for women to have the best access to reproductive healthcare and contraceptive services as we build back from the pandemic. Whilst the latest PHE data suggests services are slowly returning to pre-pandemic levels, following an 85% reduction in GP prescribed LARC in May 2020,[27] the data do not reflect the ongoing backlog of patients that services are facing. Whilst we recognise competing NHS recovery priorities, the importance of full and proper funding for public health services, including putting contraceptive services on a sustainable footing for the long-term, cannot be overlooked as a crucial part of the recovery plan.

Recommendations

In addition to the permanent approval of telemedicine EMA and the reclassification of progestogen-only pills, the AGC recommends:

11. ***The Government leads review of where and how digital services can support access to contraception.*** As part of the Sexual and Reproductive Health Strategy, there should be a review of the role of digital

[24] Faculty of Sexual and Reproductive Healthcare COVID-19 rolling members survey results, 2020. Accessed here: https://www.fsrh.org/news/fsrh-covid-19-members-survey-interim-results-07-may-2020/

[25] British Association for Sexual Health and HIV: Clinical Thermometer survey, 2020

[26] Faculty of Sexual and Reproductive Healthcare COVID-19 rolling members survey results, 2020. Accessed here: https://www.fsrh.org/news/fsrh-covid-19-members-survey-interim-results-07-may-2020/

[27] Public Health England, Wider Impacts of COVID-19 on Health (WICH) monitoring tool. Accessed here: https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/#

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services in supporting access to contraception. It is vital that digital services are harnessed to improve information, signposting and access to contraception; however, digital is just one access point out of a whole range and therefore must be part of a broader mixed model of provision.

12. ***HM Treasury sets out a multi-year spending settlement for public health services.*** Following an assessment of the funding required to deliver high-quality, full and open access contraception services, the Government must commit to reverse the public health cuts of 2015-2020 and set out a long-term, ringfenced funding settlement for public health, including contraception, that will support recovery and reinvestment in the sector.

Conclusion

Whilst the COVID-19 pandemic has brought about new challenges for women's reproductive health, including contraceptive services, we hope this submission demonstrates the reality of the pre-pandemic system where women's voices and contraceptive needs were already often overlooked.

The combination of the Women's Health Strategy and the upcoming Sexual and Reproductive Health Strategy provide a landmark opportunity for women's reproductive healthcare, and in particular contraceptive services. It is vital that these strategies align with each other and harness the changes to ICSs and the transformation of the public health system to ensure women's contraceptive needs are fully met, no matter their age, their personal situation or where they live.

If you have any questions on the issues raised in this submission or would be interested in meeting with AGC members, please get in touch via AGC@incisivehealth.com.

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