English HIV and Sexual Health Commissioners Group

AGC Advisory Group on Contraception

Breaking barriers

Inequalities in access to contraception in England

August 2024

Foreword

James Woolgar
Chair, English HIV and Sexual Health Commissioners' Group (EHSHCG)

The launch of the first Women's Health Strategy for England – informed by a call for evidence completed by almost 100,000 women – has sparked a welcome, and much-needed interest in reversing the long-standing neglect of women's health needs. Moreover, the recent launch of a national Women's Reproductive Health Survey should provide indispensable information to support the design of reproductive health services.

However, in considering how to design services that effectively meet the needs of local communities, there must be a concerted effort to reach those 'easier to ignore' marginalised communities, ensuring we do not inadvertently further deepen disparities between women.

While challenging for all women, the current fragmentation in women's health services pose particular problems for marginalised communities including homeless women, refugees and women in contact with the criminal justice system, who can face additional barriers accessing the care they need.

The EHSHCG has therefore been delighted to partner with the AGC on this survey – and resulting report – examining the particular barriers to accessing contraception experienced by some of the most marginalised women in our society. Thanks to our network of commissioners across the country, we have been able to uncover the experiences of women whose needs are too-often forgotten or ignored, and understand what they want from their reproductive health services. While we cannot claim to have solved the evidence gap between marginalised women and the broader population, we do believe that every additional voice heard can make a tangible difference to service design – and in turn, help many more women to access the care they need. We hope that this report is just the first step in an ongoing journey, and we look forward to continuing to play our part.

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Executive summary

The AGC has championed the right of every woman in England to access comprehensive reproductive health services for over ten years, underpinned by her right to choose the right method for her, from the setting that is most accessible and acceptable. Our research and commentary has focused on the impact of funding cuts and system fragmentation on contraceptive provision, and we have long argued that while challenges in contraceptive provision, from fragmentation to under-funding, are detrimental for all women, it is the most marginalised women in society who experience the most damaging consequences. Yet, opportunities for women to communicate how their experiences of contraceptive care might be improved have historically been lacking. The views of marginalised women– whether advertently or inadvertently – have been particularly muted.

As a first step in filling this evidence gap, we conducted quantitative and qualitative research to better understand the experiences of women from marginalised communities, and crucially, explore how these differ to the experiences of women who do not identify as marginalised. Our research comprised of:

- A survey open to all women living in England and requiring contraception, completed by 1,068 respondents, conducted in partnership with the English HIV & Sexual Health Commissioners Group
- Informal, semi-structured interviews with four women who identified as being marginalised, representing groups including migrant women without English as a first language, women living in temporary or sheltered accommodation, women with physical disabilities, women with mental health conditions, and victims of sexual violence and/or sexual assault

Our research spanned a range of themes, including preferences around contraceptive method and access setting, ease of access to contraceptive services, and experiences of contraceptive provision. Across these areas, our findings consistently tell us that the current system is all too often impeding women's right to choose. For example, fragmentation between services, and limited appointment availability, are restricting women's access to their preferred care setting. Limited means for information and education around contraceptive methods are disempowering many women from making an informed choice, or forcing them to seek information elsewhere, increasing the risk of encountering harmful misinformation.

In many cases, our findings expose concerning inequalities in women's access to, and experiences of, contraceptive care. Women with physical disabilities were the most likely to report access to contraception being difficult or very difficult; Gypsy, Roma and Traveller communities and women living in temporary or sheltered accommodation reported significantly lower than average awareness of different contraceptive methods; and marginalised women overall were much more likely to report difficulties making an appointment with their GP. Sometimes, the gap was much less stark. Only 30% of marginalised women, and 25% of "non-marginalised", had all contraceptive options discussed with them before making a decision about the right method for them. This is in direct contrast to NICE guidelines, and shows we are not serving women well enough across the board.

Set against this, there is best practice out there. In their qualitative feedback, many women – including from the most marginalised communities, such as sex workers – told us that specific clinics or healthcare professionals had gone to great lengths to provide high-quality, non-judgemental care. For the broader population, new models of care such as the "LARCathon" provide innovative means to deliver contraceptive provision that better fits around women's lives. As more and more Women's Health Hubs are established across England, we see a clear opportunity to replicate and adapt this good practice.

While the majority of survey respondents did report finding it easy to access contraception, this headline figure masks a significant number of women having to access contraception from a service that wasn't their preference, experiencing long waits for care, or being told by their healthcare professional to use a particular method without robust counselling. It is not good enough to simply have the basics in place, and consider it job done. Our findings make clear the range of preferences expressed by different women, and while we know that services across primary and specialist care are highly stretched, it is critically important that systems take steps to make a range of access options freely available, supporting every woman's right to choose.

Introduction

For over ten years, the AGC has made it its mission to ensure that every woman* in England has comprehensive and open access to reproductive healthcare at all stages of the life course, no matter their background, postcode, or personal circumstances. At the heart of this, our founding belief is that 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.

This right to access contraception should be underpinned by the right for a woman to choose: the best method of contraception for her, as well as where and how she accesses contraceptive services. Yet, our analysis has repeatedly shown that the policy and commissioning landscape for contraceptive provision all too often undermines these rights:

- Deeply fragmented commissioning arrangements for contraception – in which commissioning responsibilities are divided between local authorities, NHS Integrated Care Boards (ICBs) and NHS England – mean that care is often disjointed and pathways are difficult to navigate
- Contraceptive provision was hit particularly hard by central Government funding cuts to the public health grant. Between 2015/16 and 2020/21, there was a 42% real terms reduction in local authority contraceptive spend across England, with a particularly sharp drop in 2020/21 during the height of COVID-19[1]
- In 2018, 61% of local authorities in the quartile with the highest social deprivation reported having recently cut or frozen sexual and reproductive health (SRH) budgets, with 89% planning to further freeze or cut budgets[2]

The personal impact is far-reaching

In 2018, 8 million women of reproductive age were living in an area where SRH spend had been cut

The AGC has long been concerned that the repercussions of these cuts are most keenly felt by those 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. However, to date, the true picture of access to contraception by marginalised communities is blurred by an absence of research at a granular level into the barriers that these individual groups face in accessing their contraception of choice.

While this report aims to take the first step in addressing this gap, we know there is more work to do. Women living in the most deprived areas of England are more than twice as likely to have abortions than women living in the least deprived areas,[3] and 12% of the women who died during or up to a year after pregnancy in the UK in 2019-21 were at severe and multiple disadvantage (three or more of: substance abuse, domestic abuse, abuse in childhood, arrival in UK within last five years, refugee or asylum seeker, mental health diagnosis, female genital mutilation, and known learning difficulties).[4] A planned pregnancy is a healthier pregnancy,[5] and it is now incumbent on us all to ensure that the most marginalised women in our society have an equal opportunity to take full ownership of their pregnancy choices.

* 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.

Support for the AGC is provided by Bayer plc, Organon and Pfizer, who fund AGC meetings, activities and the AGC secretariat, delivered by Incisive Health. Sponsor organisations have no influence or input in the selection or content of AGC projects or communications. Members of the AGC receive no payment from Bayer plc, Organon and Pfizer for their involvement in the group, except to cover appropriate travel costs for attending meetings.

Methodology

In our research, we sought to focus in particular on uncovering the experiences of the most marginalised groups, who are often underserved by health and care services – particularly with regard to their sexual and reproductive health. Our priority communities were:

- Members of the Gypsy, Roma and Traveller communities
- Sex workers
- Migrant women who do not have English as a first language
- Women living in temporary or sheltered accommodation
- Women with mental health conditions
- Women with physical disabilities
- Women with learning disabilities
- Victims of sexual violence and/or sexual assault

Throughout the report, we have referred to those who do not identify as being a part of any of these priority communities as "non-marginalised" for brevity. However, this does not mean that these women do not face any other form of marginalisation.

We used quantitative and qualitative methods to undertake this research, through an online survey and semi-structured interviews. These are outlined in further detail below.

The extent and reach of our research were limited by the resources available for this project and our findings are unlikely to provide a comprehensive picture of the experiences of any one community. For example, we were unable to fund translation of the survey questions into different languages and were unable to capture the views of many women from the Gypsy, Roma and Traveller communities. However, we hope that this is a first step in a longer-term process to build contraceptive services informed by the needs and views of people from every community.

It is also worth noting that this survey was undertaken prior to the launch of the Pharmacy First scheme in January 2024, which enables patients to access oral contraception at the pharmacy without visiting a GP.[6]

Survey

Hosted on SurveyMonkey, the survey was open to everyone living in England and requiring contraception. The decision was made to open the survey up to all women to gather as many views as possible and support analysis of the particular challenges experienced by underserved communities.

The survey was live between Wednesday 4 October and Thursday 30 November 2023. It was publicised via social media and outreach from AGC member organisations. The survey gathered basic demographic data such as age, ethnicity, and location, before asking a range of questions about respondents' awareness and preferences around different contraceptive methods, options for accessing contraception, and their experiences of contraceptive care. Survey questions were developed in full consultation with AGC member organisations. While the survey was completed anonymously, participants were given the option of providing contact details if they were happy to speak with the AGC in further detail about their experiences. All survey participants took part voluntarily.

To encourage and facilitate participation by the marginalised communities listed above, the AGC partnered with the English HIV and Sexual Health Commissioners Group (EHSHCG) to disseminate the survey. The survey was disseminated across the current commissioner networks. Subsequently, local providers were invited to support and publicise the survey and reach the intended audiences. The AGC understand that not all areas have clinical outreach team capacity and so, where possible, the survey was promoted within specialist sexual health services and online via websites and social media run by local providers. We are grateful to the EHSHCG and all providers for their vital support with this project, without which it would not have been possible.

The AGC would also like express our gratitude to Birth Companions and the Clinks Women's Network, who kindly supported dissemination of the survey to the communities that they work with.

1,068 respondents participated in the survey. A breakdown of respondents by key demographics is available on page 6.

Semi-structured interviews

To supplement our survey findings, we conducted four informal, semi-structured interviews with women from marginalised groups, who had put themselves forward when completing the online survey.

- **Anon E:** a Portuguese migrant who moved to the UK ten years ago, without English as a first language
- **Marie:** who lives in temporary accommodation in East London
- **Tsungi:** a migrant woman from Zimbabwe, who also has a physical disability
- **Anon W:** a migrant woman who moved to the UK when she was 8 years old, without English as a first language, and who has a mental health condition associated with domestic violence

These interviews sought to understand these women's experiences in greater depth and have informed the analysis included in this report. All participants took part in the interviews voluntarily and were sent an information and consent form prior to speaking to the AGC. Interviews took place virtually, via Zoom. While interviews were not recorded, the AGC took a confidential note of each discussion. Interviewees' names were not attached to these notes, except when interviewees had expressed a preference to be referred to by their (real or fictional) first name in the final case study.

Literature review: what research is already out there?

From cancer care to contraception, women have been historically left out of conversations on their own health, highlighted by the recent *Department for Health and Social Care (DHSC) Women's Health – 'Let's Talk About It'* survey revealing that 84% of respondents felt they were not listened to by healthcare professionals.[7] This is even more concerning when we look at marginalised groups of women, whose voices are rarely heard and are the least likely to be empowered to speak up on their healthcare experiences.[8] This invisibility is heightened by a lack of relevant data and the fact that women, especially women from marginalised backgrounds, are underrepresented in clinical trials and research.[9]

To support the development of this report, the AGC has reviewed existing research that has explored:

- Access to contraception for marginalised groups
- Relevant research investigating marginalised groups without a specific emphasis on contraception

What was evident from reviewing existing surveys and research into marginalised women's access to contraception is the current lack of a single survey or piece of research that covered a wide range of marginalised groups of women in one place. Moreover, it is clear that data on inequalities in access and provision to contraception exists but is incomplete.

Marginalised groups of women

Their voices are rarely heard and are the least likely to be empowered to speak up on their healthcare experiences

Research exploring access to contraception for marginalised groups

A small but thorough body of research has looked at specific marginalised groups' reasons for choosing certain types of contraception, preferred methods of contraception, access to contraception, barriers to access and their experience and personal stories with contraception:[10]

- Of this research, a substantial portion focuses on the experiences of women with both physical and learning disabilities accessing contraception,[11,12] as well as for migrant, refugee, or asylum-seeking women without English as a first language.[13]
- Research dedicated to access to contraception by sex workers and women in temporary or sheltered accomodation does exist but is limited compared to research on women with disabilities and migrant, refugee, or asylum-seeking women without English as a first language.[14]
- Existing research on women in contact with the criminal justice system within the UK, especially specific to England, is scarce. Most research for this marginalised group is focused within the US.
- Existing research on Gypsy Roma and Traveller women largely ignores access to contraception, focusing instead on the response to the pandemic, its impact on this community, and their views towards vaccination.[15,16]

Consistently within this research, it was noted that funding and budget cuts often have the most detrimental effect on marginalised women and the specific sexual and reproductive services they may use.[17,18]

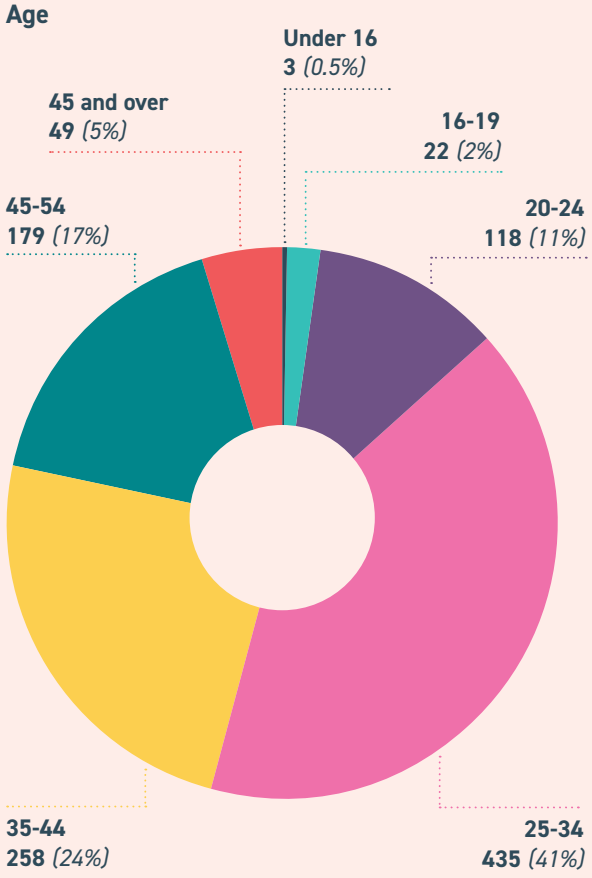
Breakdown of survey respondents

Total: 1068 respondents

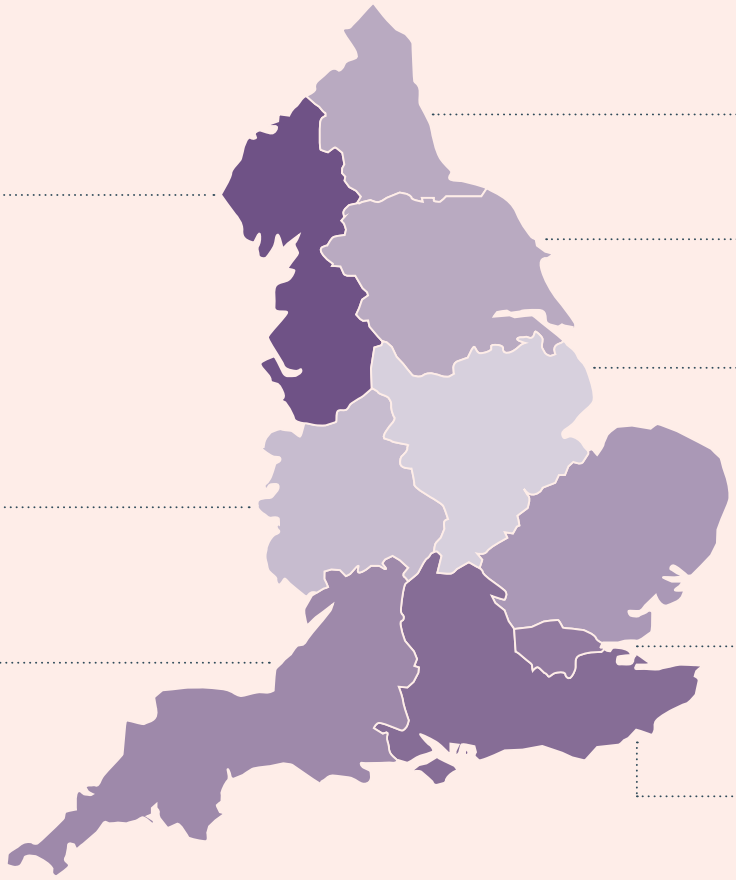
Marginalised groups
30% of respondents considered themselves to be part of one of the marginalised groups:

6	Members of the Gypsy, Roma, Traveller communities *(0.5%)*
52	Migrant women who do not have English as a first language *(5%)*
8	Sex workers *(1%)*
8	Women living in temporary or sheltered accommodation *(1%)*
9	Women in contact with the criminal justice system *(1%)*
28	Women with learning disabilities *(2.5%)*
209	Women with mental health conditions *(20%)*
40	Women with physical disabilities *(4%)*
71	Victims of sexual assault and/or violence *(8%)*

Age



Region



North West
693 *(66%)*

North East
27 *(2.5%)*

Yorkshire and the Humber
27 *(2.5%)*

East Midlands
11 *(1%)*

West Midlands
20 *(2%)*

East of England
36 *(3.5%)*

South West
49 *(5%)*

London
73 *(6%)*

South East
109 *(10%)*

None of the above
13 *(1%)*

Gender

18 respondents do not identify as the same sex they were registered at birth (1.5%), and 10 preferred not to say (1%)

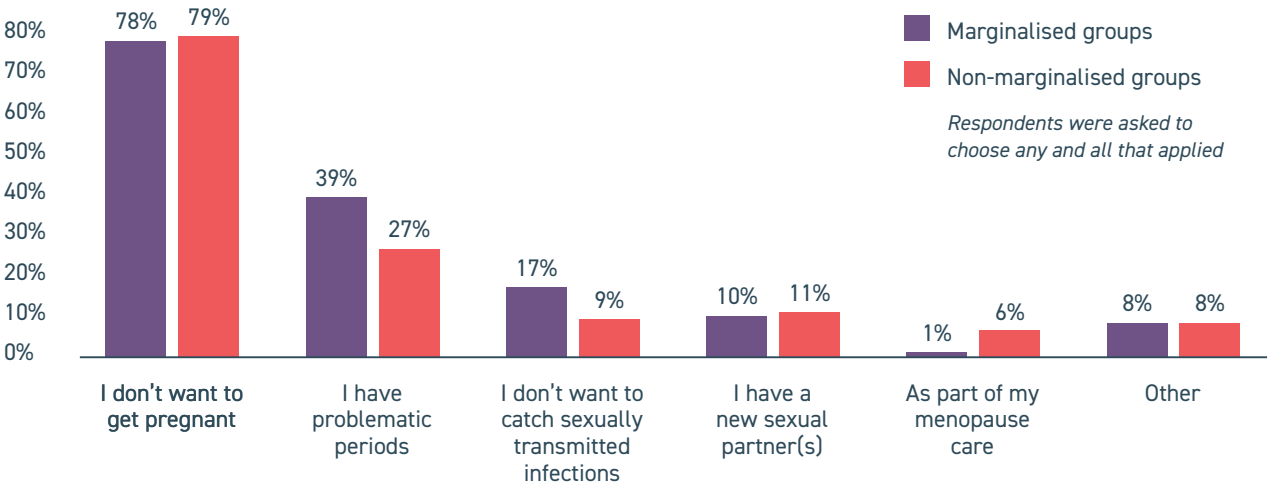
Ethnicity

74% of respondents were white British, broadly in line with wider population demographics.

784	**White British**
18	**White Irish**
83	**Other White background**
18	**White and Black Caribbean**
13	**White and Black African**
9	**White and Asian**
14	**Other Mixed Background**
17	**Indian**
11	**Pakistani**
6	**Bangladeshi**
18	**Other Asian Background**
11	**Caribbean**
28	**African**
2	**Other Black Background**
10	**Chinese**
6	**Latin American**
5	**Other**
5	**Prefer not to say**

Reason for accessing contraception

Why did you want to access a method of contraception?



Findings

Nearly 80% of both marginalised and non-marginalised women are accessing contraception to avoid unwanted or unplanned pregnancy. However, of note, nearly 40% of marginalised women and just under 30% of non-marginalised cite problematic periods as their reason for using contraception. Using contraception for problematic periods is particularly high in women with mental health conditions (42%), learning disabilities (55%) and physical disabilities (58%).

Looking more closely at marginalised groups, the use of contraception to avoid catching STIs is much more common with 17% citing it as a reason, in comparison to only 9% of non-marginalised women. It is also worth noting that sex workers' primary reasons for accessing contraception differed from the wider group, with the priorities being to avoid pregnancy (86%), avoid catching STIs (57%), and due to new sexual partner(s) (28%).

40% of marginalised women are accessing contraception due to problematic periods

57% of those who do not identify as the same sex that they were registered at with birth cite avoiding catching STIs as their reason for accessing contraception

Analysis

These findings demonstrate the active role of contraception across a huge range of health issues and priorities, and the importance of contraceptive providers recognising each individual's unique priorities, circumstances, and preferences – and taking steps to ensure the full range of contraceptive options is available (or signposted to). This in turn makes clear the importance of comprehensive contraceptive counselling to assess the best and most appropriate contraceptive provision for each individual's needs and priorities. This is especially true for women from marginalised groups who may have more complex requirements or require additional support to choose the best methods for their needs.

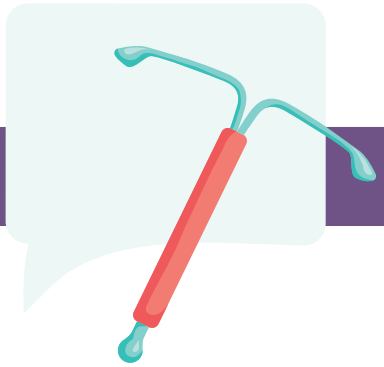
Other reasons for access:

Anaemia
Endometriosis
Acne and other hormonal issues
PCOS
Mental health
Migraine
As an antiandrogen
To avoid periods
Herpes infection

Interview highlight – Tsungi

Tsungi suffered from polycystic ovary syndrome (PCOS) and endured heavy menstrual bleeding (HMB) for over six years, impacting her daily life, university, and work. Having had negative experiences at GPs in the past – with her concerns about weight gain dismissed and her HMB side-lined – Tsungi eventually visited her local sexual health clinic having researched the benefits of the intrauterine system (IUS) for HMB. Here she had a much more positive experience and appreciated the doctor's honesty about the potential side effects. The doctor addressed her fears and agreed that the coil was the best course of action.

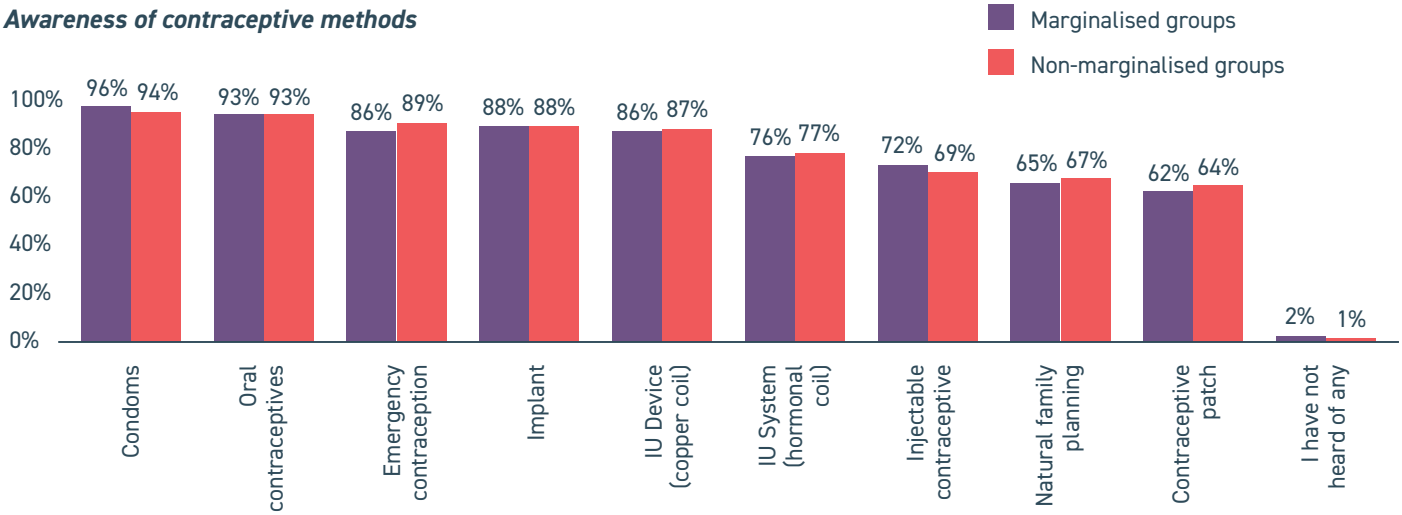
"The doctor at the sexual health clinic genuinely took the time to explain to me why she also thought the IUS was best for me... it has changed my life"



Choosing a method of contraception

Findings

Awareness of contraceptive methods



Awareness of different methods of contraception was found to be relatively high overall; however, there were significant differences between each of the marginalised groups. Overall, the majority of marginalised groups appeared to have a lower awareness than the non-marginalised women – in particular, Gypsy, Roma or Traveller communities and women living in temporary or sheltered accommodation.

50% of women from Gypsy, Roma or Traveller communities had not heard of any listed methods

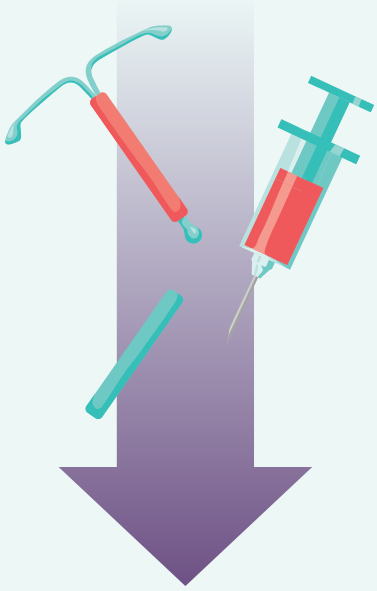
However, women who identified as having mental health conditions, physical disabilities or as victims of sexual assault and/or violence reported significantly greater awareness than was seen overall. Notably, the women in these three groups also reported higher instances of having a healthcare professional discuss *all* contraception options with them before making a decision on which method they chose.

Current methods of use

Overall use of contraception is higher across the marginalised groups than across non-marginalised. Only 18% of marginalised women were not using any contraception, whereas 25% of non-marginalised women reported not using any contraception, with 49% of those noting that they have not been on any contraception for over five years.

Use of LARC (including injectables) was much higher in marginalised women (33%) than in non-marginalised respondents (18%). Particularly high levels of LARC usage were seen in sex workers, women living in temporary accommodation, women in touch with the criminal justice system, victims of sexual assault and/or violence, and women with physical disabilities.

LARC usage, including injectables



75% Women living in temporary or sheltered accommodation

56% Women in touch with the criminal justice system

50% Sex workers

39% Victims of sexual assault and/or violence

36% Women with physical disabilities

32% ***All marginalised groups***

32% Women with mental health conditions

26% Women with learning disabilities

22% Migrant women who do not have English as a first language

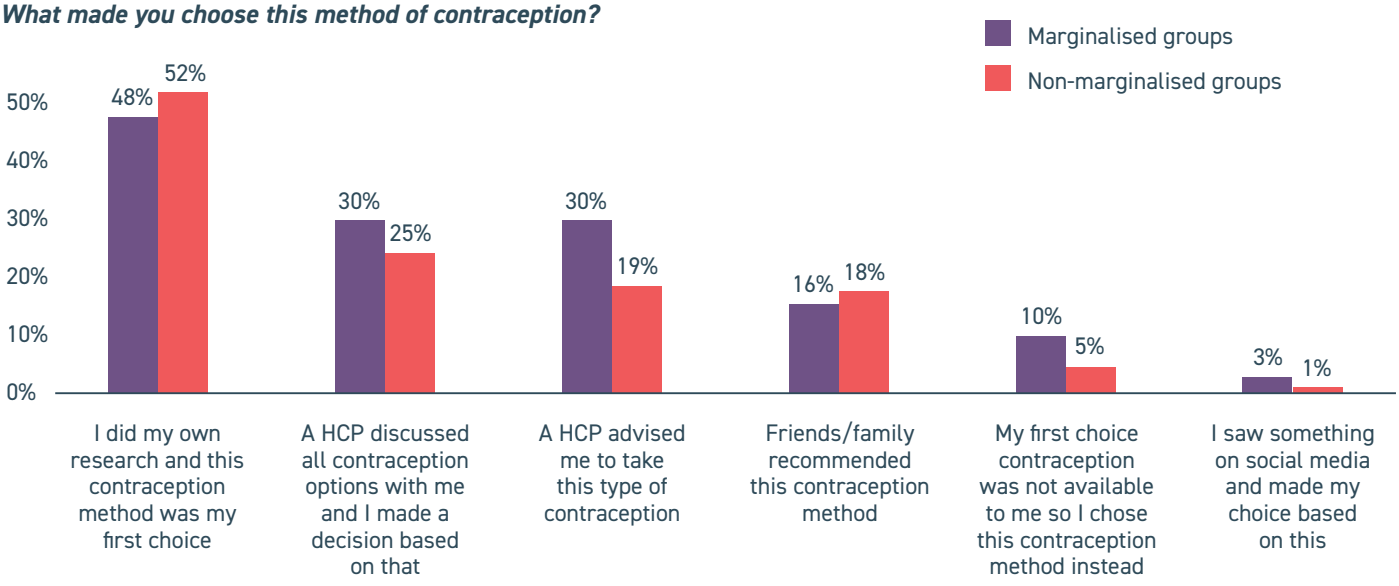
18% ***Non-marginalised***

0% Gypsy, Roma, and Traveller communities

Looking at individual forms of LARC, it is clear that the IUS is the most commonly used form (14% of respondents)* with injectables the least common (1%).* Notably however, injectables were used considerably more by women living in temporary housing or sheltered accommodation (13%).

* It is worth noting that within individual responses to the survey, some used IUS (or hormonal coil) and intrauterine device (IUD, or copper coil) interchangeably, which could have skewed this figure.

What made you choose this method of contraception?



Reason for using that method

Around half of all respondents across all groups based their decision on contraceptive method on their own research. This research was very often cited as being based on concerns around hormones and their impact on the body and mind.

NICE guidance states that women asking for contraception from contraceptive services should be *"given information about, and offered a choice of, all methods including long-acting reversible contraception".*[19] Despite this, only 30% of marginalised women had all contraceptive options discussed with them before making a decision, which is only slightly higher than the 25% of non-marginalised women who experienced this level of counselling. Of all respondents who had a healthcare professional discuss all contraceptive options with them ahead of making a decision, 41% now are on a form of LARC. This increases to 48% in marginalised women.

"I have struggled to find contraception that matches my needs, despite this I have never had a complete discussion with a healthcare provider on what would suit me best, it has solely relied on me trying different forms of contraception"

25-34, White British, North West,
Woman with mental health condition

"The healthcare professional put [an oral contraceptive] on the desk and said "this will sort you out" after going to discuss period cramps, and other period symptoms including sickness/nausea"

25-34, White Irish, North East

A much higher percentage of **marginalised women (30% vs 19% of non-marginalised) reported being told by their healthcare professional to use a particular method, without full discussion of all options** – restricting their ability to make an informed choice from the full range of methods. Of those marginalised women who were told to use a particular method, 41% of them are using a form of LARC, which is slightly more than the 37% of non-marginalised women.

Analysis

The higher use of LARC in marginalised women who responded to the survey could demonstrate that efforts are being made to ensure those more vulnerable women have the access they need to effective methods of contraception. However, the link between greater uptake of LARC with those who were told by their healthcare professional to use a particular method could indicate that in some cases women – and in particular marginalised women for whom this was more common – are being pressured into using LARC. A recent report from BPAS showed 44% of women using LARC felt pressure to accept these methods,[20] noting concerns that LARC methods were being positioned as 'superior' to all other methods by healthcare professionals.

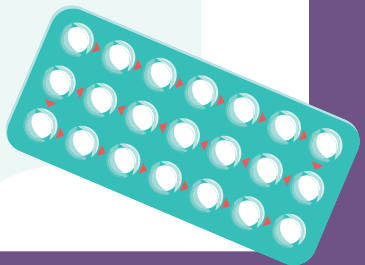
Whether women are feeling pressure to choose LARC over other forms of contraception or are making an independent choice, **it is clear from the comments and our one-to-one interviews that women – and in particular those in marginalised groups with specific needs and/or preferences – are too often not being listened to by their healthcare professional.** For example, in her interview Tsungi noted that she had had concerns about weight gain, especially in light of her PCOS and physical disability, that were dismissed as unimportant by her GP. These findings are concerning and show the importance of providing thorough, considered and unbiased counselling that is based on the individual needs and preferences of the woman, and that ensures informed choices and active patient decision making.

Separately, the high rate of women making a decision on their method of contraception through their own research demonstrates the importance of easily accessible, accurate information and signposting. Whilst these results saw only a small number of respondents noting that they based their decision on something they had seen on social media, this does not account for those who saw something on social media that sparked their own research; it is therefore likely the findings are not indicative of the true influence of social media and wider online misinformation. We know from other research that social media is a huge influence on women – especially young women – with influencers found to create and share inaccurate and potentially harmful content on the use of hormonal contraception and promoting 'natural' methods without substantiated evidence.[21] This type of misinformation has a huge and significant reach, with a recent Brook survey on young people in Manchester finding that 47% primarily get their information about contraception from social media and online.[22] The scale and potential impact of this issue is something that needs further research and to be addressed nationally.

Interview highlight – Tsungi

As a Zimbabwean, Tsungi noted the popularity of using social media communities to share healthcare experiences. It was through these communities that she heard negative attitudes and myths around contraception that put her off for years.

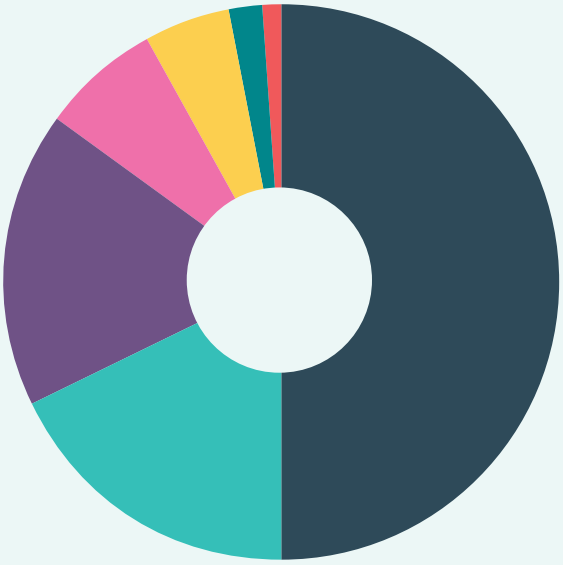
"If I didn't work in sexual health now, I might have continued thinking negatively towards contraception and listened to the myths and online stories"



Provider of contraception

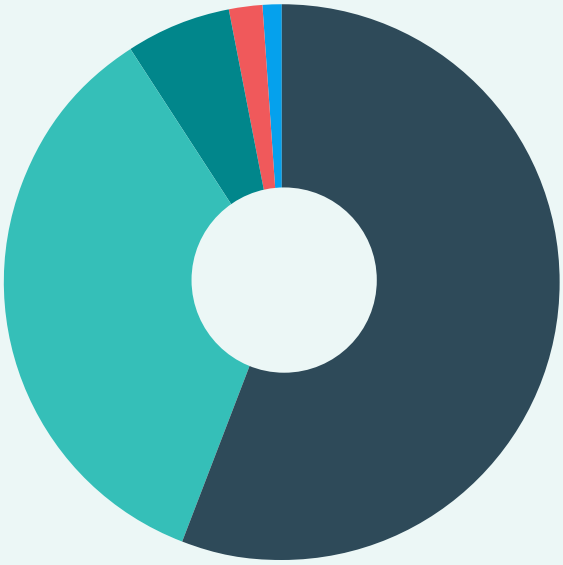
Findings

Provider



- **50%** GP
- **18%** Contraception and sexual health service in local area
- **17%** Bought in shops
- **7%** Bought online
- **5%** Pharmacy
- **2%** Contraception and sexual health services outside local area
- **1%** Abortion services
- **0%** Specialist outreach service
- **0%** Postnatal services

LARC provision



- **56%** GP
- **35%** Contraception and sexual health service in local area
- **6%** Contraception and sexual health services outside local area
- **2%** Abortion services
- **1%** Specialist outreach service

Where have women accessed their contraception?

Around **50% of all women access their contraception at the GP** – which was similar between marginalised and non-marginalised respondents – with others most likely to use a local contraception or sexual health service or to purchase in a shop. Almost zero respondents accessed contraception at post-natal services and only 1% at abortion services.

Crucially, **90% of those who went to the GP to access contraception noted that this was their preference.** For those who said they would have preferred a different setting, 69% said they would have preferred to go directly to a pharmacy, and 38% to a contraception and sexual health service in their local area.

Of the 17% of women who accessed their contraception from a local contraception and sexual health service (which goes up to 34% of those currently using a form of LARC), only 67% noted that it was their preferred place. For those who said they would have preferred a different setting, 92% said they would have preferred to access through the GP.

Interview highlight – Anon E

Anon E struggled to have conversations about her post-pregnancy contraceptive choices with either maternity services or her GP. She was told to call a sexual health clinic to have a coil fitted, but had not previously been aware that sexual health clinics were an option for accessing contraception, and received little information about where or how to access such a clinic. She ended up waiting three months after giving birth to have her coil fitted.

Whilst the survey finds overwhelming preference across the board for accessing contraception through the GP, a more mixed picture is seen when we take a deeper dive into our individual marginalised groups, who sometimes reported greater need for provision elsewhere:

- **Migrant women** for whom English was not their first language had a higher-than-average use of pharmacy (16% vs 5% overall), which could be linked to the reduced chance of migrant women being registered with a GP, as well as the possibility of experiencing language barriers when engaging with GPs and at contraception and sexual health clinics.[23,24]
- **Sex workers** are more likely to use a contraception and sexual health service, with 43% using a local service and 14% using one outside their local area, compared with 17% and 2% respectively across all respondents. Some respondents told us this was due to negative attitudes experienced in other settings such as GPs.
- Those living in **temporary or sheltered accommodation** also had a higher-than-average use of contraception and sexual health services outside their local area (17% vs 2%), which could be linked to moving between local areas as these women move between shelter/housing.
- 44% of women in touch with the **criminal justice system** had accessed contraception through a contraception and sexual health service, which could be linked to problems with registration with a GP following release from prison.[25]

Interview highlight – Marie

Marie – who lives in temporary accommodation - has found it difficult to access a GP since her relocation. Unsure about her future location, she faces a dilemma – whether to register at a new GP in Ilford or maintain her registration in Hackney. She fears losing her place at her old GP in Hackney and remains registered there, despite the distance of 8.5 miles from Ilford. The uncertainty of future relocations makes choosing a local GP challenging for Marie.

Of all those who accessed contraception and sexual health services outside their local area, 46% tried to access their local services but were unable to receive support. When asked why, the top three responses were:

35% *I made contact with my local provider but the* ***waitlist was too long*** *so I went elsewhere*

26% *I made contact with my local provider but they* ***didn't have any appointment times to suit me***

22% *I tried making contact with my local provider but* ***could not get through to make an appointment***

Interview highlight – Anon W

The first sexual health clinic Anon tried when seeking post-natal contraception did not answer their phones, leading her to look for an appointment in two alternative boroughs. The first of these alternative sexual health clinics did not have availability for an initial telephone consultation for another six weeks – when she missed the call, she was not able to call back and was asked to wait another six weeks to reschedule. Anon then tried a second alternative borough, where she was able to have her new coil fitted.

Use of contraception or sexual health services outside of their local area was highest in those living in temporary or sheltered accommodation (17%) and sex workers (14%). For sex workers, this was often due to not feeling comfortable talking to a GP and preferring a provider they knew or had been advised by friends or others in their line of work.

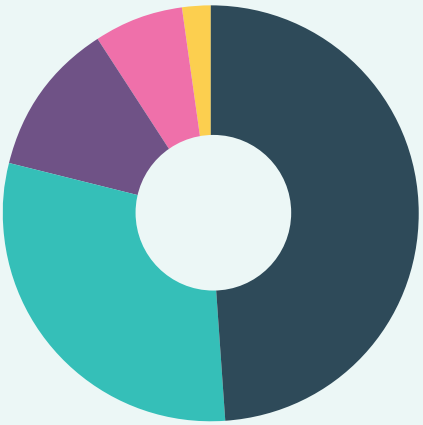
Finally, of all of our marginalised groups, access through specialist outreach services was only notably seen in women who are in touch with the criminal justice system (11%) and women with learning disabilities (4%).

"Now that I'm a queer sex worker, I still manage my sexual health in Central London because I have greater confidence that they will meet my needs. This is despite having moved even further away than when I first started going there. I knew from their website that they would be affirming and I saw other [sex workers] recommend it online so I felt it made sense to stay there and not move to somewhere closer. They offer a wider variety of services that consistently meet my needs, even if I often have to wait significant periods to get an appointment. And I have an online GP that does not offer sexual health services"

Age 20-24, African, London, sex worker, victim of sexual assault and/or violence, with learning and physical disabilities

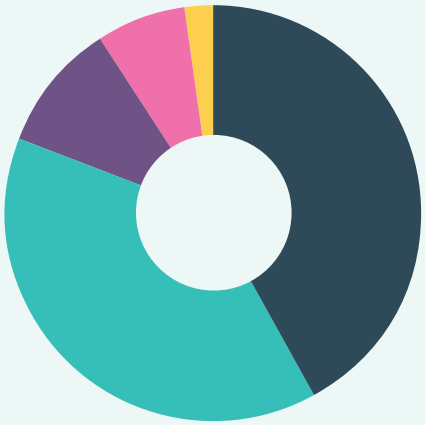
How satisfied were women with their experience of contraceptive provision?

Contraception and sexual health



49%	Very satisfied
30%	Satisfied
12%	Neither satisfied nor dissatisfied
7%	Dissatisfied
2%	Very dissatisfied

GP



42%	Very satisfied
39%	Satisfied
10%	Neither satisfied nor dissatisfied
7%	Dissatisfied
2%	Very dissatisfied

"[I had] difficulty with getting my GP to listen to me and understand my contraceptive needs"

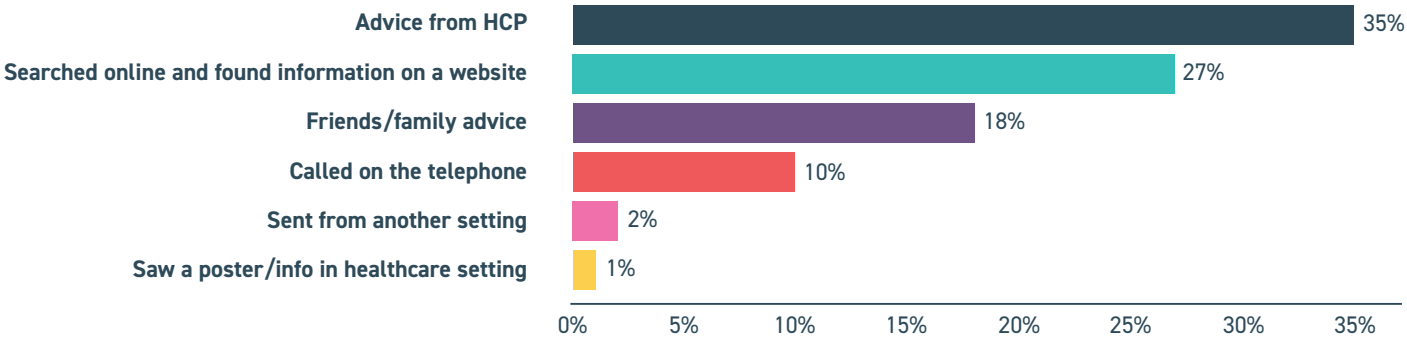
Age 20-24, White British, South East, victim of sexual assault and/or violence with mental health condition and learning disabilities

While satisfaction levels were relatively high across GP and contraception and sexual health services, satisfaction was slightly higher with those who accessed support through a contraception or sexual health service. Whilst the satisfaction levels were much aligned across the marginalised groups, there was particularly low satisfaction of provision through the GP for women with learning disabilities and victims of sexual assault and/or violence, with 33% and 24% respectively noting they were either dissatisfied or very dissatisfied with their experience of accessing contraception through the GP.

Interview highlight – Tsungi

Tsungi waited around 3 weeks for her initial appointment and a month for the procedure, to account for her menstrual cycle. Despite an early dislodging requiring a coil change, the sexual health clinic provided quick and tailored assistance for her HMB. Accommodating her physical disability, the clinic ensured accessibility, a chaperone, and all clinicians she came into contact with asked her about her needs. In contrast, Tsungi faced challenges at the GP's office, repeatedly reminding them of her need for a ground floor room due to her wheelchair.

How did women find out where to go?

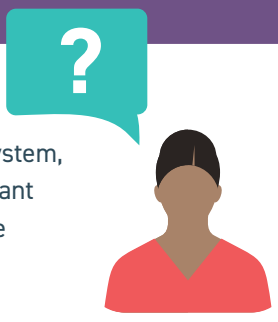


A high proportion of women found out where to access contraception as a result of advice from a healthcare professional (35% of all respondents). Further insights from responses show that this is often linked to women enquiring at the GP and either being told to book a further appointment there, or being told where else they can go to get an appointment.

Importantly, and similar to the findings on why women are using their method of contraception, a high percentage (27%) did their own research to work out where they could go to access contraception. This was even higher in some of our marginalised groups, including for women with mental health conditions (31%), those in touch with the criminal justice system (33%), sex workers (50%) and migrant women for whom English is not their first language (36%).

Of particular note, **only 1% of respondents saw a poster or information in another healthcare setting with information on where to go to access contraception.**

Interview highlight – Anon E



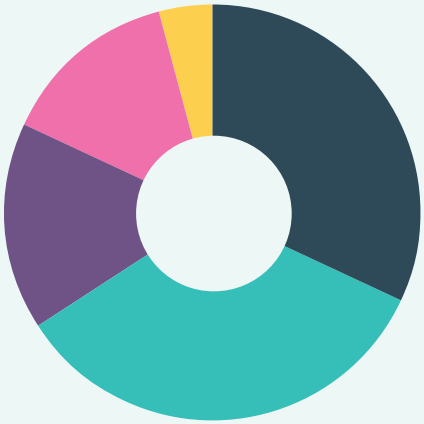
Anon now works in sexual health services, and feels more confident navigating a complex system, but is concerned about how difficult this will be for other migrant women. Women from migrant communities may lack a support network of other women they can ask for help, and struggle to negotiate factors including a different system to their own country, language barriers, and a lack of financial means to travel to appointments.

How comfortable do women feel accessing contraception via pharmacy?

Community pharmacy is taking on an increasing role in pharmacy provision, following the launch – and expansion in January 2024 – of the NHS Pharmacy Contraception Service. To inform the delivery of these new services, we wanted to understand how perceptions of pharmacy provision might vary between different groups.

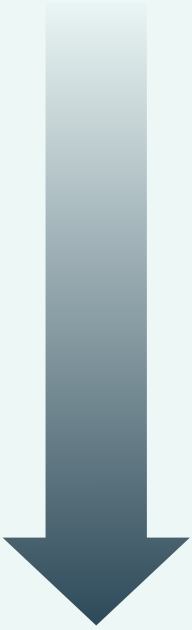
65% of all respondents reported either being comfortable or very comfortable with discussing their contraceptive needs with their local pharmacy if that service became available. Whilst this number was slightly lower in our marginalised groups overall, with only 60% feeling comfortable or very comfortable, there was considerable variation between each group, ranging from 50% of sex workers to 78% of those in touch with the criminal justice system.

How comfortable would you feel accessing contraception via pharmacy if that option was available?



- **32%** Very comfortable
- **34%** Comfortable
- **16%** Neither comfortable nor uncomfortable
- **14%** Uncomfortable
- **4%** Very uncomfortable

Comfort levels in marginalised groups



- **78%** In touch with criminal justice system
- **75%** Temporary/sheltered accommodation
- **64%** Learning disabilities
- **61%** Physical disabilities
- **53%** Migrant women, for whom English is not their first language
- **50%** Victims of sexual assault and/or violence
- **50%** Sex workers

Interview highlight – Anon W

Anon – as a migrant woman – had a bad experience with accessing contraception at a pharmacy where she was questioned on her right to access healthcare in the UK and incorrectly charged for her contraceptive prescription.

Analysis

Whilst there is a clear and overwhelming use and preference for access to contraception through the GP, overall, the findings demonstrate variation in provider actually used, and in preferences between each of the marginalised groups. This reinforces the importance of meaningful choice for where women access their contraception, including being able to choose services outside their local area, should this better meet their needs – as reported in particular by sex workers and respondents who do not identify as the same sex registered at birth. Of course, in an ideal scenario, contraception and sexual health services that understand and cater for specific needs of marginalised groups would be accessible in every area.

In reality, funding cuts to contraception and sexual health services in recent years are impacting women's abilities to make this choice. Marginalised women – who were found in the survey to rely more heavily on contraception and sexual health services – are being disproportionately impacted by these cuts.

The lower satisfaction rate for those who did access contraception through the GP, coupled with the number of women whose preference was to access at the GP but were unable to do so, reflects a broader landscape of primary care access challenges. Our findings are also in line with growing concerns about the viability of contraception provision – particularly relating to LARC

– in general practice. A recent report by the Primary Care Women's Health Forum – *On the brink* – suggests that primary care provision of LARC is not only unchanged since 2020 (and the COVID-19 pandemic) but likely actually in decline as a result of lack of remuneration for LARC fittings and access to training for healthcare professionals.[26] As noted in the DHSC *'Let's talk about it'* report, the concern here is the simultaneous decline in GP provision and availability of contraception and sexual health clinics, which could not only impact women's ability to choose where they access contraception, but also if they access it at all.

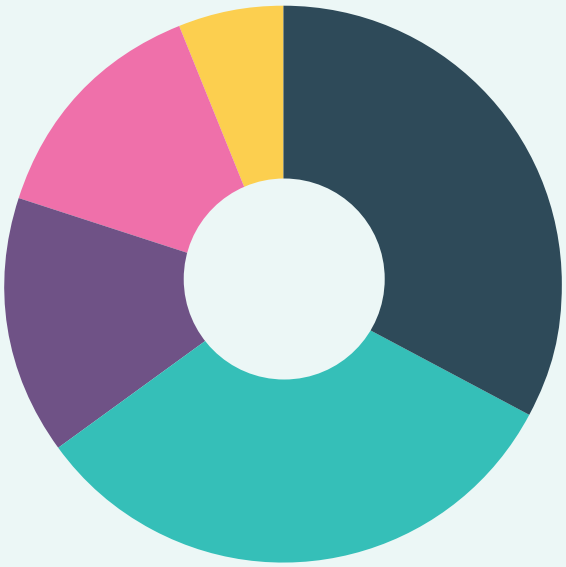
Findings on the number of women who do their own research on where to access contraception, again points to the importance of clear, accessible and accurate information online and on social media for women to use, that specifically addresses the needs and circumstances of different groups of women and signposts them to the most relevant service for them. Beyond this, there is also a need for improved signposting in other health settings. The 1% who reported signposted materials being readily available is starkly low and highlights a clear missed opportunity for improved signposting across healthcare services, and the wider system, in particular for our marginalised groups.

To ensure that all opportunities and touch points that these women go through are capitalised on, the development of contraceptive information and signposting should consider the potential of a Making Every Contact Count (MECC) approach, equipping all practitioners supporting marginalised women to direct them towards contraceptive care. More broadly, the principle of "health in all policies", leveraging settings such as probation offices, A&E, education settings and social services, can ensure systems are working in tandem to better serve women on reproductive health.

Understanding the factors behind the variation in how comfortable our marginalised groups are with access through pharmacy merits additional research. The lower comfort levels reported by migrant women without English as a first language, victims of sexual assault and/or violence and sex workers may relate to stigmatisation of women's situations, and perceived lack of privacy in pharmacy settings. A mystery shopper study by the British Pregnancy Advisory Service (BPAS) could go some way to validating these attitudes, finding that only 50% of pharmacies visited offered a private room for an emergency contraception consultation. To optimise roll-out of the NHS Pharmacy Contraception Service, NHS England and pharmacy providers may wish to highlight safeguarding and privacy protocols that have been put in place as part of awareness campaigns on the service.

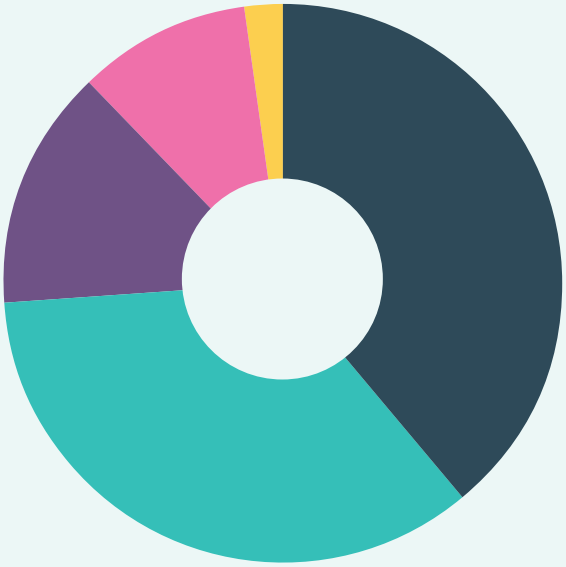
Ease of access

Marginalised groups



- **33%** Very easy
- **32%** Easy
- **15%** Neither easy nor difficult
- **14%** Difficult
- **6%** Very difficult

Non-marginalised groups

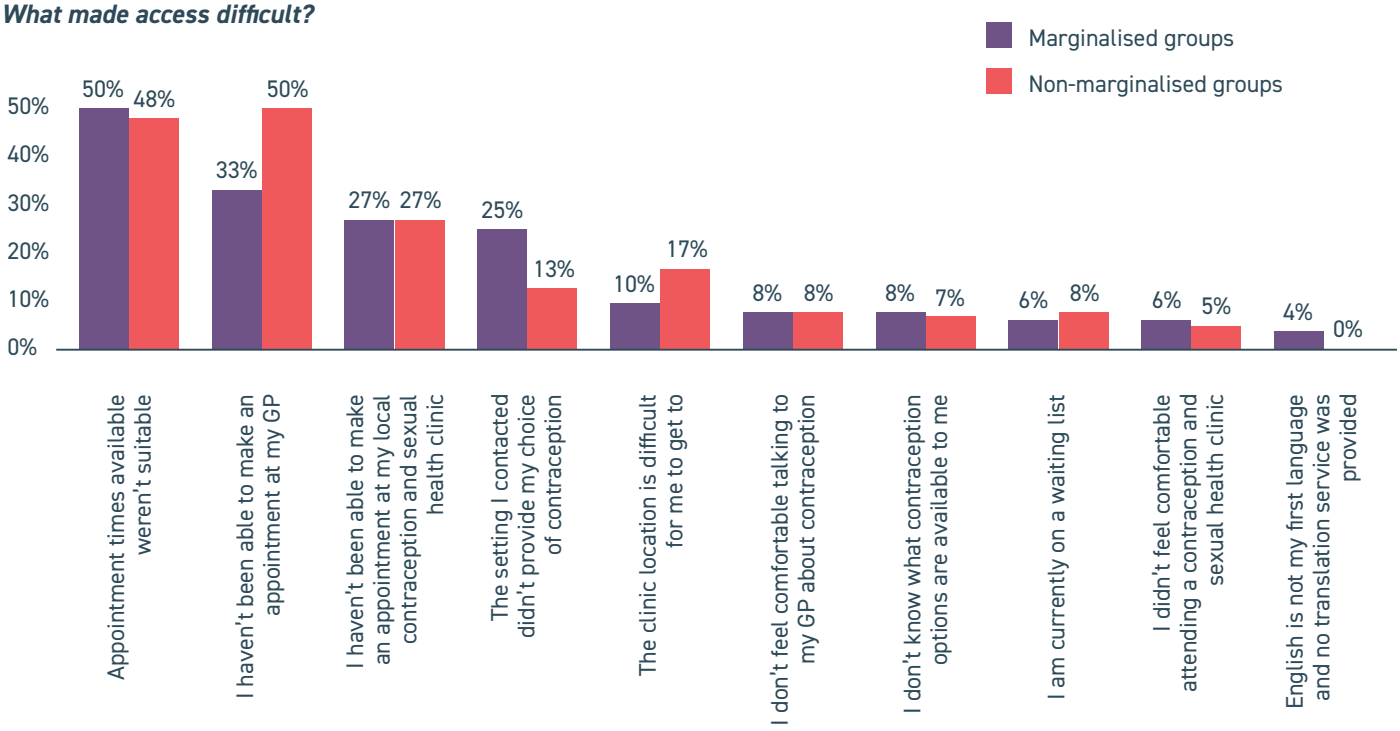


- **39%** Very easy
- **35%** Easy
- **14%** Neither easy nor difficult
- **10%** Difficult
- **2%** Very difficult

Findings

Overall, findings on the ease of access are positive, with the majority of all survey respondents either reporting to have found contraception very easy or easy to access. Whilst this was also the case with **our marginalised groups of women, 20% did report access to be either difficult or very difficult,** compared to just 12% of non-marginalised. The group reporting access being the most difficult was women with physical disabilities, with 23% reporting access as difficult or very difficult.

What made access difficult?



Those who reported finding it difficult or very difficult were asked what made it difficult for them to access. In response, **exactly half of those in marginalised groups noted that the available appointment times were not suitable for them.** Other highly rated barriers for these women included:

- Being unable to make an appointment at either the GP or local contraception and sexual health clinic
- The contacted setting not providing their choice of contraception

These top barriers were similar for non-marginalised respondents, though difficulties in making an appointment at the GP were much more prominent with these women (50% citing this barrier, compared with just 33% of marginalised women).

Marginalised women were also more likely to report feeling uncomfortable talking to their GP about contraception, or attending a contraception and sexual health clinic.

"There is no specialist service in my area: no specific clinic for trans people (like LCinicQ, which I have been to in London and is excellent), and no clinic for gay/MSM (which I have previously been to in Edinburgh, who were able to address all my sexual health needs as they had an understanding that gay trans men have the same risks as gay cis men, which non-specialist clinics often do not)"

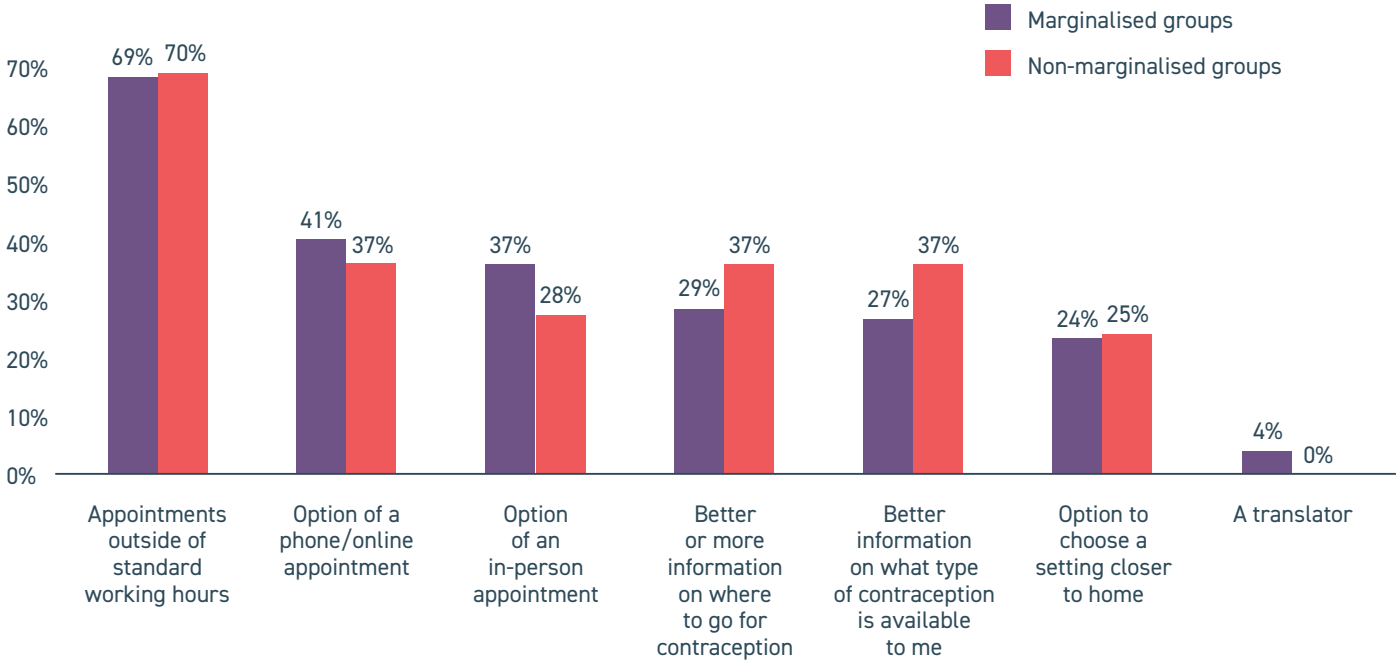
Age 20-24, White British, East of England, with mental health condition and who does not identify with their gender assigned at birth

"The only way to make appointments at my local sexual health clinic is via telephone call and the waiting times to get through are astronomical – hours! Which can negatively impact your working day"

Age 25-34, White British, North East, Victim of sexual assault and/or violence

How can ease of access be improved?

Those who reported finding it difficult or very difficult to access contraception were also asked what would make it easier to access contraception.



The overwhelming majority (70%) of both marginalised and non-marginalised women noted that appointment times outside of normal hours would make accessing contraception easier.

Accessibility of appointments was the next priority for our marginalised women, with:

- 41% suggesting the option of a phone/online appointment would improve ease
- 37% suggesting the option of in-person appointments

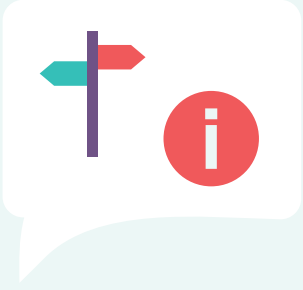
Phone/online appointments were top suggestions in particular for:

- Those with physical disabilities (87%)
- Sex workers (100%)
- Migrant women for whom English is not their first language (56%)

Conversely, the option of an in-person appointment was more popular among victims of sexual assault and/or violence (50%), who may have a preference for additional counselling and support.

The third priority for marginalised women is for better information, both on where to go for contraception and on what type of contraception is available. Information was noted as a higher priority in non-marginalised women, with:

- 37% suggesting better information on where to go for contraception
- 38% for better information on what types of contraception are available

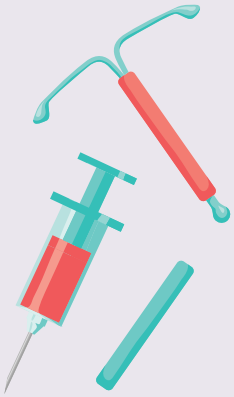


Case study

'LARCathon' in Bedfordshire

iCaSH Bedfordshire had a significant LARC waiting list due to the increased demand since the COVID-19 pandemic. Bedford Borough Council therefore commissioned BPAS to help reduce the waiting list with a mobile clinic that delivers a number of all-day (usually on a Saturday) 'LARCathons' that deliver approximately 40 LARC device fittings in one clinic.

These public health funded additional initiatives are separate from the main SRH contract. Not only do they help reduce LARC waiting lists but they also provide appointment times outside of normal working days/hours.



Deep dive into different marginalised groups

Migrant women who do not have English as a first language – 20% found access difficult or very difficult due to:

1. Appointment times available weren't suitable (71%)
2. Unable to make an appointment at the GP and/or sexual health clinic (57% & 43%)
3. English is not my first language and no translation was provided (29%)

Priority solutions for this group:

67% Appointments outside of normal hours

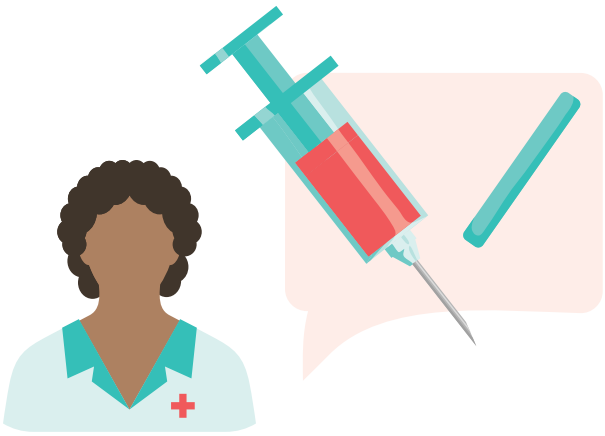
44% Information on what type of contraception is available

56% Option of phone/online

11% Option to have a translator

Interview highlight – Tsungi

Tsungi highlighted the vagueness and the lack of ethnic minority representation in NHS information. Her experience working in sexual health services has enhanced her understanding of the system, prompting her call for outreach services to be in place, especially for migrant women, to better educate women on accessing necessary contraception and sexual health services.



Women with learning disabilities – 18% found access difficult or very difficult due to:

1. The setting I contacted didn't provide my choice of contraception (50%)
2. Don't know the contraception options available to them (25%)
3. Unable to make an appointment at the GP (25%)

Priority solutions for this group:

Appointments outside of normal hours

Information on what type of contraception is available

Better and more understanding communication with healthcare professionals

Women in contact with the criminal justice system – 11% found access difficult or very difficult due to:

1. Primary issue was that appointment times weren't suitable

Priority solutions for this group:

Appointments outside of normal hours

Option of phone/online

Sex workers – 17% found access difficult or very difficult due to:

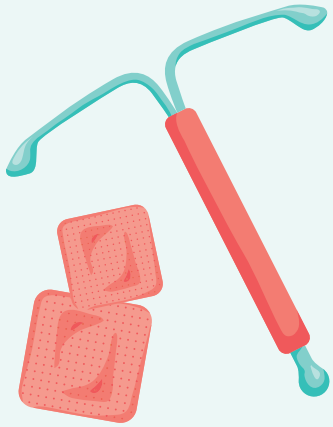
1. Primary issue was that appointment times weren't suitable

Priority solutions for this group:

Appointments outside of normal hours

Option of phone/online

Option to choose a setting closer to home



"Previously I used my GP surgery for IUD and condoms but they were very old fashioned in their views, for example they were surprised I would want condoms as well as an IUD as they assumed as an older lady I would only have one partner and therefore STIs weren't an issue"

55 or over, White British, Sex worker, mental health conditions, physical disabilities

Women with mental health conditions – 18% found access difficult or very difficult due to:

1. Appointment times weren't suitable (48%)
2. Unable to make an appointment at the GP (32%) or contraception/sexual health service (23%)
3. The setting contacted didn't offer their choice of contraception (29%)

Priority solutions for this group:

Appointments outside of normal hours

Option of phone/online

Better information on where to go for contraception

"They denied my contraception because I'm too fat, despite telling them I've been using it for several years and I regularly do tests and it has been prescribed by my doctor in my country. So, as I can't have prescription here through the GP, I have to buy it in my country"

Age 25-34, Other white background, North West, Woman with mental health condition

"Having a sexual health clinic that was easy to get in touch with and book appointments with, and has specialist clinic sessions for LGBT people"

Age 20-24, White British, East of England, does not identify with the same sex as registered at birth, and has mental health conditions

Women living in temporary or sheltered accommodation – 20% found access difficult or very difficult due to:

1. Primary issue was being unable make an appointment at local contraception and sexual health clinic

No solutions suggested by survey respondents

Women with physical disabilities – 23% found access difficult or very difficult due to:

1. Appointment times weren't suitable (71%)
2. The clinic location is difficult to get to (43%)
3. Unable to make appointment at local contraception and sexual health clinic (29%)

For women with physical disabilities, reports of unsuitable appointment times were considerably higher than the average for all marginalised groups (50%). Additionally, accessibility of the clinic location was also reported as a greater barrier than across the board.

Option of phone/online

Appointments outside of normal hours

Information on what type of contraception is available

"I have become too unwell with chronic fatigue syndrome to make and attend multiple appointments and the GP surgery won't discuss it via email"

Age 35-44, White Irish,
Woman with mental health conditions and physical disabilities

Victims of sexual assault and/or violence – 22% found access difficult or very difficult due to:

1. Appointment times not suitable (58%)
2. Unable to make a GP appointment (42%)
3. Unable to book a contraception and sexual health clinic appointment (25%)

Priority solutions for this group:

Appointments outside of normal hours

Option of phone/online

Option of in person appointment

Analysis

Overall, our findings show that accessibility issues are a higher concern for marginalised women than for non-marginalised groups. However, accessibility concerns and needs vary between these marginalised groups. For example, we observed differing preferences for phone/online vs in-person appointments, while some women were looking for appointments outside of normal hours and others preferring appointments closer to home. This demonstrates the necessity for providing choice of *how* contraception is provided, as well as where and what type – with swift and equitable access to in-person appointments maintained against a growing trend towards telemedicine.

For those women who do prefer digital options, it is important that this is underpinned by robust counselling and information provision to bolster reproductive health literacy.

Through some of the comments highlighted above, it is also clear that a large barrier to marginalised women accessing contraception is stigma in healthcare settings – reported in particular by sex workers, members of the LGBTQ+ community, and those with physical disabilities. This either led to them failing to get the contraception they wanted, or in some cases failing to access any contraception at all. It is therefore vital that healthcare professionals in all settings are encouraged to have unbiased discussions with women, that make them feel at ease and empowered to make informed decisions about their sexual and reproductive health. Research by Dr Rebecca Mawson has pointed to the impact that the unequal power balance between healthcare professionals and marginalised women can have on the patient experience, noting that "the more significant the health belief gap between patient and professional, the less likely the health need would be recognised. Making assumptions or judgements about a patient could lead to missed opportunities." [27]

The need for more information on what types of contraception are available, and from where, was a key concern across all respondents, and a current gap for marginalised communities in particular.

This reinforces the importance of improved signposting, information and counselling on contraception for *all* women, tailored and translated as required to make them as accessible and relevant as possible for different communities.

Feeding back on wait times and experiences

Findings

The final section of the survey looked at how long women are waiting for contraception after first contact with the service, and whether those who did have a longer wait made a complaint.

Everyone:	All	vs	LARC
Less than 24 hours	29%		7%
1-2 days	15%		7%
3-6 days	16%		13%
1-3 weeks	24%		43%
4-8 weeks	9%		19%
More than 8 weeks	7%		13%
LARC access:	**Marginalised**	**vs**	**Non-marginalised**
Less than 24 hours	9%		6%
1-2 days	7%		7%
3-6 days	16%		11%
1-3 weeks	42%		42%
4-8 weeks	12%		22%
More than 8 weeks	14%		12%

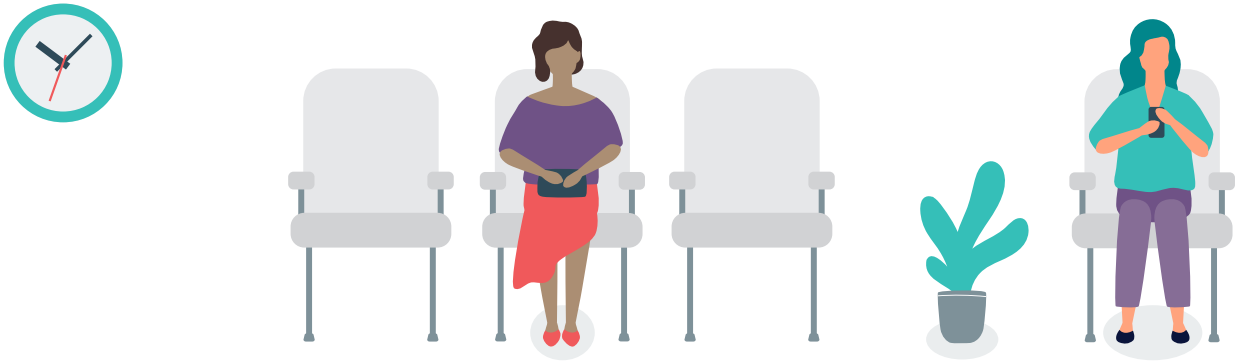
Time to access

The overall picture of wait times is positive, with 84% of all respondents waiting less than three weeks for their method of contraception after first contact, with the highest percentage (29%) accessing in less than 24 hours.

Though positive to see, this finding likely reflects the speed of access for the high number of those who use condoms as their primary method of contraception. It is therefore also helpful to consider length of time to access for LARC specifically, which was significantly longer across the board with **32% of LARC users reporting a wait of four weeks or more from first contact to receiving the contraception.** The majority (43%) waited one to three weeks.

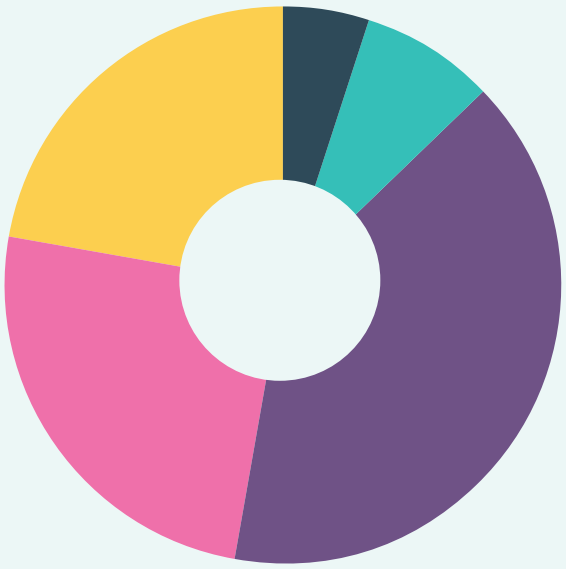
Looking at access between our marginalised and non-marginalised groups, the results suggest that wait time for contraception is shorter for those in marginalised groups, including for LARC. 32% of marginalised women using LARC waited under a week for their contraception, compared with only 24% of non-marginalised women. Time to access was particularly good for those living in temporary or sheltered accommodation and those in contact with the criminal justice system, with 75% and 60% (respectively) reporting having accessed LARC in under a week. Conversely, longer waits were seen for migrant women without English as their first language and those with learning disabilities, with 40% and 43% (respectively) reporting access to LARC taking longer than four weeks.

Those who waited four weeks or more were asked if they made a complaint about the wait, and if not, why not. Of these women, only 2% noted that they had made a complaint. The only marginalised group where any respondent reported making a complaint was those with learning disabilities, where 14% did report doing so.



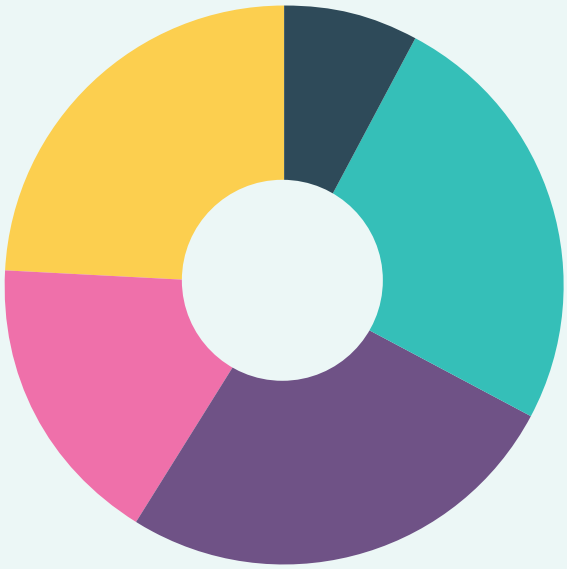
Why did you not make a complaint?

Marginalised groups



- **5%** Contraception is not a priority for me, so I was not concerned about the wait time
- **8%** I was happy to wait as I felt the wait time was not significant, so it was not appropriate for me to make a complaint
- **40%** I was unhappy with the wait time but making a complaint is not something I would usually do
- **25%** I was not sure who to make a complaint to
- **22%** Other

Non-marginalised groups



- **8%** Contraception is not a priority for me, so I was not concerned about the wait time
- **25%** I was happy to wait as I felt the wait time was not significant, so it was not appropriate for me to make a complaint
- **26%** I was unhappy with the wait time but making a complaint is not something I would usually do
- **17%** I was not sure who to make a complaint to
- **24%** Other

Looking at the reasons why those who had waited over four weeks had not complained, the findings demonstrate significant differences between marginalised and non-marginalised women.

Most significant is the proportion of marginalised women (40%) who were unhappy with the wait but noted that they wouldn't usually complain, compared with non-marginalised (26%). For some marginalised groups, this rationale was considerably more common, including for sex workers (100%), victims of sexual assault and/or violence (67%) and those in temporary/sheltered accommodation and those with learning disabilities (50% of both groups). A number of women also commented that they had not complained as they believe NHS services are under strain.

Also of note is that only 8% of marginalised women felt that the wait time was not significant, compared with 25% of non-marginalised women. Given the survey found that marginalised women actually had less wait time, this gap between the two could indicate the difference in urgency when it comes to these women trying to access contraception, as a result of their particular circumstances. Amplifying this point, no victims of sexual assault and/or violence, sex workers or women in touch with the criminal justice system reported being happy to wait for four weeks or more, which likely reflects their more urgent circumstantial needs for contraception.

Finally, a significant proportion (25%) of marginalised women reported that they did not complain because they were unsure who to make a complaint to. Migrant women without English as a first language and those with physical disabilities were even more likely to report this (43% of each group). Though not as high, a still significant 17% of non-marginalised women also reported that they were unsure who to complain to.

"I knew the service was under strain so I didn't want to add pressure by making a complaint"

"I knew the GP is doing their best"

"I trust that the services go as quick as they can on the resources they have"

When asked about accessing contraception next time they need it, only 66% of marginalised women felt confident that they would be able to. This was lower than non-marginalised women, 76% of whom reported feeling confident. When asked who they would complain to if they were unable to access, 59% of marginalised women (and 48% of non-marginalised) noted that they would be unsure of who to complain to.

Analysis

The proportion of marginalised women reporting that while they were unhappy with the wait, complaining is not something they would usually do, indicates a greater feeling of unease with raising their concerns and/or a lack of faith that a complaint would be listened to. This makes apparent the need for greater empowerment of marginalised women, ensuring women feel comfortable sharing their experiences, and advocating for themselves when care has not been optimal. In order for their voices to be heard by this system, there must be clear processes and procedures in place for registering and responding to complaints. Our findings suggest that currently signposting for how and where to complain and/or feedback is inadequate and needs improving.

Women's attitudes around "not normally complaining" or holding back as they know the NHS is under strain was reported beyond our marginalised groups, and reflects patient perceptions across the health service. This was exacerbated over the COVID-19 pandemic as a result of messaging around "protecting the NHS", which in 2020 saw four in ten people being too concerned about being a burden on the NHS to seek help from their GP.[28] However, no matter what the strains are on the system, it is still vital that women – and in particular marginalised women – have their voices heard, and that services are continuously working to ensure they are meeting women's needs. Avenues for proactively understanding women's experiences – whether positive or negative – therefore must be facilitated and promoted to ensure all women are able to help shape their local services, without feeling a burden to the system.

Conclusion

Since its inception, the AGC has championed the importance of choice in contraception: choice of the method of contraception as well as how and where it is accessed. These survey results demonstrate that the importance of this choice is more vital than ever, and yet the ability to make these choices is still too often being restricted. These restrictions take many forms, from cuts to contraception and sexual health services and a lack of clear signposting of options, to biased counselling and women feeling that their voices are not being heard.

Though there are limitations with our findings, what is stark is the diversity in needs, preferences, and experiences depending on the different circumstances of women, especially when we consider those in marginalised groups who can be more vulnerable and easier to ignore. For the women in these groups in particular, choice is vital to ensure that they feel able and comfortable to access the contraception that they need and is their fundamental right to access. Despite this, the results show that women in our marginalised groups often did not have the ability to choose: either as a result of not being presented with comprehensive information on all methods, being pressured into a particular method, or feeling they had to access their contraception through a provider that did not accommodate their needs.

Analysing the survey results, it is clear that choice alone is not enough: instead, we must champion *informed* choice. In order for women to be able to choose what method they use and where they access it, they need to know what forms of contraception are available, how they work, the possible side effects and what is best suited to them, as well as where they can go to access their choice. Empowering *all* women with the information to enable them to make a decision on the right contraception for them is vital, especially given the high proportion of women that this survey has found to be basing decisions on their own research.

In an era dominated by the internet, it is essential that we ensure women have easy access to accurate, clear and engaging information, both from the health and care system and online, to counter the risk of misinformation online and on social media.

This theme of ensuring informed choice for all women must be central to the development and improvement of all contraceptive services. By prioritising informed choice and considering how to empower women – in particular, marginalised women – we can ensure that contraceptive provision delivers for *all* women. The recommendations set out below could enable such provision.

Recommendations

Equipping women with the information and resources necessary to make informed choices:

- The NHS website and NHS App should be updated to include easily accessible, accurate and engaging information on contraception, including the full range of methods, that is inclusive of all backgrounds and circumstances, and clearly signposts women on how to access contraception
- The Department of Health and Social Care should work with other government departments – including the Ministry of Justice, Ministry of Housing, Communities and Local Government and Department for Education – to ensure the opportunity to reach the vulnerable and marginalised women that pass through settings covered by these departments is leveraged. Legacy Public Health England's MECC evaluation guide could support this cross-functional working[29]
- The Department of Health and Social Care and NHS England should commission a national 'myth-busting' campaign – including on all social media channels – on hormones and contraception to support all women to make informed choices on their contraception
- NHS England and pharmacy providers should highlight safeguarding and privacy protocols that have been put in place as part of awareness campaigns on pharmacy provision of contraception
- Integrated Care Boards and local authority commissioners should work with providers to improve local signposting – both digital and physical – to ensure that they make every contact count in order for their population to have the resources and information necessary
- Integrated Care Boards and local authorities should commission specialist outreach teams for marginalised groups to not only provide access to contraception, but provide information, education and counselling on contraceptive options

Ensuring contraceptive provision that caters for all women, regardless of background or circumstance:

- NHS England should update available workforce training, in consultation with the Faculty of Sexual and Reproductive Healthcare, to ensure that:
  - The sexual and reproductive health workforce is supported to deliver comprehensive and unbiased contraceptive counselling based on the individual, that allows patient-led decision making
  - All primary health care givers are aware of the uses and benefits of contraception – beyond avoiding pregnancy
- Integrated Care Boards should work to establish Women's Health Hubs across their jurisdiction, ensuring accessible and adequately funded primary provision of contraception, including LARC, is available for all women. Each Women's Health Hub should look to ensure all needs and preferences are accounted for through:
  - Specialist outreach teams to reach marginalised groups to provide contraceptive counselling and provision
  - Out of hours "booster"/LARCathon events that cater for women who are unable to attend appointments during working hours and to help reduce waiting lists
  - Ensuring contraceptive counselling and provision is available in maternity and abortion settings
  - The choice of phone, virtual or in-person consultations where possible to accommodate different needs and preferences
  - The ability to choose the location for an appointment to ensure it is as convenient as possible for women

Evolving contraceptive provision by listening to women's voices:

- Integrated Care Boards and local authority commissioners should work with providers to implement well-signposted, clear and easy to use avenues for feedback that empower and encourage women – especially marginalised women – to share their experiences
- The Department of Health and Social Care should consider ways to ensure that future national surveys on women's reproductive healthcare adequately capture the experiences of vulnerable and marginalised women, for example, through enlisting the support of community champions

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