Fixing the System:
Reducing Women's Reproductive Inequalities

A Report by the APPG on Sexual and Reproductive Health

appg on Sexual and Reproductive Health in the UK

The Faculty of Sexual and Reproductive Healthcare (FSRH) provides the secretariat to the APPG on Sexual and Reproductive Health in the UK, with support from the Royal College of Obstetricians and Gynaecologists, MSI Reproductive Choices, Bayer UK and Organon. Editorial control rests with the APPG alone. This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its Committees.

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1 Foreword by the APPG Officers: Dr Rupa Huq MP, Baroness Barker, Maya Ellis MP and Baroness Sugg

As cross-party Officers of the All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health, we are delighted to introduce this report on the important topic of reducing the reproductive inequalities experienced by too many women across England.

We know that access to high-quality sexual and reproductive healthcare (SRH) is paramount for women and girls to live their lives well.

Women have a fundamental right to take control of pregnancy choices, to choose where and how they wish to access contraception and to do so safely, with autonomy and respect.

However, we also know that many women are currently not able to access the basic health services they need, with almost half of British women experiencing poor sexual and reproductive health.[1]

This has profound consequences for women, communities, and the NHS, including an increase in the number of unplanned pregnancies, a rise in the need for abortion care, and delayed diagnosis of painful reproductive and gynaecological conditions, and cervical cancer. Recent research by the NHS Confederation has demonstrated the detrimental economic impact of this unmet need – absenteeism from work due to heavy and painful periods, endometriosis, fibroids, and ovarian cysts costs the UK economy nearly £11bn every year.[2]

It is also evident that steep disparities exist between different groups of women and that certain groups face significantly poorer outcomes. Shamefully, maternal mortality for Black women is currently almost three times higher than for White women and significant disparities also exist for women of Asian and mixed ethnicity.[3] Recent analysis of gynaecological waiting lists by the Royal College of Obstetricians and Gynaecologists showed a strong correlation between areas of higher deprivation and longer waits for care.[4] In England and Wales, rates of abortion in the most deprived areas are more than double those in the least deprived areas.[5]

This is why we launched this Inquiry; to gain a deeper understanding of the inequalities facing women; the barriers they face accessing essential services; and to advocate for the solutions, with particular

1 BMC Public Health, *Latent class analysis of sexual health markers among men and women participating in a British probability sample survey.*
2 NHS Confederation, *The economic case for investing in women's health services revealed.*
3 MBRRACE-UK, *Saving Lives, Improving Mothers' Care: State of the Nation Report 2020-22.*
4 The Royal College of Obstetricians and Gynaecologists, *Waiting for a way forward.*
5 OHID, Abortion statistics for England and Wales: 2022.

focus on the opportunities presented by this new Government and their explicit commitment to tackling health inequalities.

The strong consensus from the Inquiry was that the current provision of SRH is not working well for women and that the fragmented funding streams for SRH services in England have entrenched existing health inequalities.

Respondents told us that interrupted commissioning pathways place artificial divides between SRH services, creating an unnavigable system. Women are too often bounced between services, waiting months, and attending multiple appointments unnecessarily. Women's care is regularly delayed, or they might not have the finances or time to present at services at all. We heard how this need does not disappear but is shuffled across the health system, leading to chronic conditions going unmanaged and undiagnosed, and resulting in an expensive rise in the use of urgent and emergency care pathways.

Women's Health Hubs are widely seen as an opportunity by respondents to increase access to SRH services for all women by integrating effective care into the local community. Respondents gave fantastic examples of existing Women's Health Hubs across the country successfully beginning to tackle inequalities and long waiting lists. For example, the Women's Health Hub in Tower Hamlets, East London has seen 95% of patients within 48 hours and has 100% positive feedback from patients and GPs.[6]

However, it is clear from this Inquiry that these well-integrated services are currently a 'postcode lottery', and the benefits of this form of community care are not universally experienced by women in England.

This Government made welcome commitments in its Manifesto:

> ***Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS.***[7]

We strongly believe sexual and reproductive health forms a central part of women's health, and we ask the Government to deliver on these promises through tangible concrete action, leadership, and the necessary funding. If the Government wish to fulfil their Manifesto commitment to prioritise women's health, there is huge potential to deliver better patient flow across the system, support prevention agendas, optimise care in the community, and fundamentally secure the better health of 51% of the population.

As Officers of this APPG, we would like to thank all those who have given their time and expertise to this Inquiry. We would like to thank the many organisations who took the time to submit evidence, including the Department of Health and Social Care, MSI Reproductive Choices, the Faculty of Sexual and Reproductive Healthcare, the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners.[8]

We warmly welcome the report's recommendations and very much look forward to working with colleagues across political parties to ensure that all women are able to take full ownership of their wellbeing and are no longer held back by poor reproductive health.

6 Submission to APPG on SRH inquiry.

7 Labour Party, *Change*, Labour Party Manifesto, 2024.

8 A full list of contributors can be found in Appendix A and B.

Dr Rupa Huq MP
Chair

Baroness Barker
Co-Chair

Maya Ellis MP
Vice-Chair

Baroness Sugg
Vice-Chair

Top Recommendations

1. The Government should reaffirm their welcome commitment to women's health and set out detail on how they will meet their Manifesto promise to 'never again neglect women's health' and to 'prioritise it as they reform the NHS'. This should include:
    a. National prioritisation of women's health agenda at the system level, including a dedicated focus on women's sexual and reproductive health.
    b. Continuation of the 10-year Women's Health Strategy for England, and the roles of Women's Health Ambassador for England and the National Clinical Director for Women's Health in England.
    c. Further detail on how they will reduce gynaecology waiting lists through the elective reform plan, close the maternal mortality gap and meet the NHS' ambition to eliminate cervical cancer by 2040.
2. The Government should consider providing additional support and oversight for the growing network of Women's Health Hubs across England. This should include publishing regular guidance and instructions on sharing existing best practice to support their implementation and ensure women can access essential services, no matter where they live.
3. The Government's upcoming National Cancer Plan must include proposals to improve gynaecological cancer care and outcomes, and specifics on how they will meet the NHS' ambition to eliminate cervical cancer by 2040.

2 Introduction

The All-Party Parliamentary Group on Sexual and Reproductive Health in the UK (APPG on SRH) exists to promote awareness and understanding of a range of issues relating to sexual and reproductive health across the life-course – from menstruation to menopause and beyond. These issues are fundamental to women's physical, psychological and social wellbeing, and to women being able to live their lives to the fullest. The Group brings together parliamentarians, medical professionals, and sector advocates to discuss how policy and legislative change can best support the needs of girls and women.

In the UK, women are becoming sexually active earlier and having children later in comparison to previous generations. With a desire to have fewer children, the majority of women now spend several decades of their reproductive life trying to prevent pregnancy. **Since women make up 51% of the population, women's reproductive health and the provision of contraception must be an important priority for any Government.**

Despite this, women's reproductive health has been historically overlooked by policy makers and **recent statistics suggest that only 2% of medical research funding is spent on pregnancy, childbirth, and female reproductive health**, leaving stark gaps in evidence about female-specific health.[9]

There are also acute variations of women's access to local reproductive health services due to the fragmented way the system is designed and delivered. In the thirteen years since the passage of the 2012 Health and Social Care Act, when the full responsibility of contraception in England was removed from the NHS, the APPG on SRH has seen the detrimental impact of separating these funding streams for SRH services and how this fragmentation has entrenched existing health inequalities.

The division of responsibilities for SRH is complex and split between local authorities, NHS England, and Integrated Care Boards (ICBs). ICBs are NHS organisations responsible for planning services for their local population, and there are 42 across England.

There is a clear consensus among those working in SRH that the system in England is not fit-for-purpose. The APPG on SRH has repeatedly heard that there are gaps in the delivery of SRH services, creating disjointed care for women. For example, in many areas, women are not able to access their long-acting reversible contraception (LARC) fitting and cervical smear tests in one healthcare setting, meaning they must undergo multiple invasive examinations in different settings.

This is an issue of inequality as many women do not have the means or finances to travel longer distances or for multiple appointments, often have caring or childcare responsibilities, nor the ability to take repeated time off work.

Pressure is also increased on primary care where patients repeatedly attend for the same gynaecological issue while they wait for a further appointment. For example, although **endometriosis is common and affects 1 in 10 women, with debilitating symptoms including pelvic pain and painful periods, diagnosis for endometriosis takes 8-12 years on average**.[10]

9 Imperial College London, *How can medical sciences better serve women?*

10 British Journal of General Practice, *Management of endometriosis in general practice.*

There are also significant and preventable health inequalities disproportionately affecting certain groups of women. According to Nuffield Department of Women's and Reproductive Health, **Black women are 50% less likely to get an endometriosis diagnosis than white women**, despite experiencing the condition at the same rate.[11] **Thousands of women have been let down by our health system with at least 630,000 on gynaecological waiting lists** – a number which has doubled since 2020.[12]

Over recent years, we have seen a move towards policies which seek to enable greater integration of health services. For example, we strongly welcomed the publication of the *Women's Health Strategy* in 2022, and the plans to expand Women's Health Hubs which provide women with a one-stop point of access to integrated healthcare services in their community.

This Government made welcome commitments in its Manifesto:

Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS.[13]

They also pledged to tackle health inequalities as they rebuild an NHS fit for the future and will do so through three key shifts – focusing on prevention, moving care into communities, and making use of technology.[14]

It is in this context of these new Government commitments that the APPG on SRH launches this report: to outline the impact of a fragmented, disjointed healthcare service for women's reproductive health and, importantly, what solutions are needed to tackle reproductive health inequalities and ensure all women can access the essential services they need.

This report is based on the APPG on SRH's comprehensive Inquiry which was launched in November 2023. The APPG has since conducted several evidence sessions in Parliament, a series of interviews with expert respondents, and opened a call for written evidence to gather insights from different voices across the sector with specialist knowledge on women's reproductive health.

A note on language:

We acknowledge that it is not only people who identify as women or girls who access women's health and reproductive services. The terms 'woman' and 'women's health' are used for brevity. We welcomed responses from all individuals who identify as female and non-binary individuals assigned female at birth who require access to SRH services.

11 Nuffield Department of Women's and Reproductive Health, *Endometriosis: Black women continue to receive poorer care for the condition.*

12 BBC News, *Gynaecology waiting lists double, leaving women in pain.*

13 Labour Party, *Change*, Labour Party Manifesto, 2024.

14 Labour Party, *Change*, Labour Party Manifesto, 2024.

3 Key Findings

3a SRH services are failing to provide women with the care they need

Interviewees throughout this Inquiry shared their serious concerns that, at present, reproductive health services are not set up to provide accessible or effective care to women. Commissioning structures were highlighted as playing the most significant role in this. The 2012 Health and Social Care Act removed the full responsibility of contraception provision in England from the NHS and divided responsibilities between local authorities, NHS England and Clinical Commissioning Groups (since subsumed into Integrated Care Systems (ICSs)).

The impact of this on women is that care pathways are often disjointed and difficult to navigate. **Artificial divisions are drawn between contraception, sexual and reproductive health which means women can be bounced from service-to-service**; may be required to undergo multiple consultations and occasionally multiple intimate examinations when only one is clinically necessary; and women having to wait weeks, or even months, to access appropriate services. This delays the delivery of essential care and builds frustration towards the system from both patients and clinicians:

> *"Something went very wrong in 2012 when the commissioning was fragmented, and we lost that connection. Something goes really wrong when we lose communication between systems.*
>
> *Women aren't, none of us as human beings are, just a sort of black and white, 'oh no well I'm coming to you about my leg today but therefore my gynae problem doesn't exist...' Somebody who's having heavy menstrual bleeding, it is going to be relevant to their menopause Hormonal Replacement Therapy, even though they might be going to one doctor one day over contraception – it all overlaps."*
>
> Dr Stephanie Cook,
> Clinical Lead for Women's Health Hubs in Liverpool

> *"[Patients] attend their GP practice for contraception or a gynaecological need and are then signposted to different services e.g. sexual health clinic for their IUD fitting, while being referred to gynaecology for their pain symptoms, and booked in with the practice nurse for a smear test. This is very disjointed and confusing for the patient, not to mention expensive for the NHS with multiple unnecessary appointments."*
>
> Doctor who submitted evidence to the APPG Inquiry

i. Fragmented services entrench women's inequalities

Multiple interviewees expressed how these fragmented and disjointed services deepen and compound inequalities between women, with certain groups facing disproportionate additional barriers to accessing care.

For example, Dr Stephanie Cook, Clinical Lead for Women's Health Hubs in Liverpool, and James Woolgar, Chair of the English HIV and Sexual Health Commissioners Group, discussed how the system navigation is very difficult within reproductive healthcare for all women. However, women from higher socio-economic backgrounds are often able to navigate the system more easily than those from under-served communities, who more often have caring responsibilities, are without the finances to travel to multiple appointments, have language barriers or have learning difficulties.

> *"I think navigating health is more complex than it's ever been. If you're a bright, intelligent person, it's difficult. If you are struggling, you may have a learning difficulty, you may have little access to money, you have problems with accessing because you just can't explain and communicate well, it must be a nightmare communicating how to get to the right service at the right time. I think it's the hardest thing people have to cope with."*
>
> **James Woolgar, SRH, HIV and Women's Health Commissioning Lead at Liverpool City Council and Chair of the English HIV & Sexual Health Commissioners Group**

Interviewees also shared that systemic biases, and cultural and religious beliefs present specific challenges for women trying to access vital services. For example, there are reports of women being denied access to emergency contraception, or being dissuaded from doing so, because of family or community ties to pharmacists who hold specific religious beliefs about sex before marriage and pregnancy termination.

Simphiwe Sesane, Contraception and Sexual Health Nurse Consultant at MSI Reproductive Choices and Equality, Diversity and Inclusion Advocate, also highlighted that systemic racism within healthcare has contributed towards feelings of mistrust for many Black women in relation to healthcare services. **Misdiagnosis, gaps in understanding of the difference in experiences and prevalence of gynaecological conditions, and the lack of ethnicity reporting have led to disparities in care and outcomes**. These issues, compounded by fragmented commissioning, result in multiple appointments for a single service, which can have a disproportionate impact on women affected by racism, who are less likely to seek further services due to their negative experiences.

ii. The impact of cuts to women's reproductive health

The APPG also heard that funding cuts have had a detrimental impact on women's access to SRH, including restricted opening hours, reduced service provision and cuts to staff numbers.

Year-on-year real term reductions in the Public Health Grant funding have impacted women's access to vital sexual and reproductive healthcare services at a local level. Commissioners have been forced to make difficult decisions, often resulting in an inability to deliver a full range of services due to continuing pressures on budgets.

The Health Foundation analysis found that the cuts to the Public Health Grant have resulted in real terms spending on

contraception falling by 29% between 2015/16 and 2022/23[15] and NHS England data shows that only fewer than half of the specialist clinics offering sexual health services in 2015-16 were still doing so in 2021-22.[16] Additionally, these real terms per person cuts to the Public Health Grant have tended to be greater in more deprived areas, compounding existing health inequalities. For example, in Blackpool, ranked as the most deprived upper tier local authority in England, the cut to the Public Health Grant has been one of the largest – at £30 in real terms per person since 2015/16.[17]

Primary care colleagues discussed that, where cuts are made to the public health-funded elements of SRH provision, the need for this service does not disappear but instead the impact of this reduction and the associated cost is often felt in other parts of the healthcare system paid for by different commissioners.

For example, local authority-driven reductions in specialist SRH services in the community increase the workload on GPs and other core contraceptive providers.

This has a direct impact on women, who, as previously mentioned, have to navigate this disjointed system, often while waiting longer or travelling unacceptable distances to access healthcare. It disproportionately affects women who do not have the means or finances to travel further, who may be forced to delay or even withdraw from these services. Again, this need for care does not disappear but is shuffled across the health system, leading to chronic conditions going unmanaged, later diagnosis of conditions, and an expensive rise in the use of urgent and emergency care pathways.

Rebecca Curtayne, External Affairs Manager at Healthwatch, stated that many women will go to their GP as a first port of call for SRH issues. She argued that unless the wider pressures in primary care are addressed, including the increased workload following COVID-19, women will continue to struggle to access essential services.

iii. A postcode lottery of LARC provision

Dr Michael Mulholland, Honorary Secretary and Women's Health Lead at the Royal College of General Practitioners, outlined how current circumstances are preventing GPs from delivering a service which enables women's choice of contraception, especially when considering the poor reimbursement for contraception provision, such as LARC.

LARC methods are highly effective forms of contraception, yet **women across England face a postcode lottery in being able to access it** from GPs due to commissioning arrangements making it unviable for them to provide it. This was echoed by several professionals who spoke to the APPG during this Inquiry:

> *"In many areas primary care is unable to fit LARC for gynaecological reasons, because the reimbursement... is in place for contraceptive reasons only. This leads to an increased burden on secondary care and long waiting times (up to 18 months in some areas) for patients."*
>
> **Submission to the Inquiry by a healthcare professional.**

15 The Health Foundation, *Investing in the Public Health Grant*.

16 NHS Digital, *Sexual and Reproductive Health Activity Data sets, 2016 (October) and 2022 (September)*. Data tables 20 and 20c.

17 The Health Foundation, *Investing in the Public Health Grant*.

> *"The other group that are currently disadvantaged are the peri/ menopausal women who require a Mirena [intrauterine device] insertion for Hormone Replacement Therapy. Sexual health clinics often refuse to fit them if not solely for contraception and with the new extended licence for contraception (8 years) and only 5 years for endometrial protection many women are struggling to find a service that will change their Mirena in a timely fashion."*
>
> **Submission to the Inquiry by a healthcare professional.**

> *"We are trained and resourced to provide LARC, but we are not commissioned by NHS ICBs to provide contraception for reasons beyond pregnancy management. This creates an artificial distinction which does not reflect the interconnected and nuanced factors behind reproductive healthcare decisions."*
>
> **Submission to the Inquiry by a healthcare professional.**

The provision of LARC is also restricted by financial disincentives. Dr Mulholland told our Inquiry that 89% of LARC fitters report that the fee paid for LARC fitting for contraceptive purposes does not cover the cost of providing the service.

The Government's own analysis illustrates the significant return on investment that could be harnessed through improved provision of LARC: every £1 invested in the provision of LARC in primary care saves £48 in healthcare and non-healthcare costs over 10 years.[18] This return on investment is currently underutilised, and its provision relies on advocates at the local level of the healthcare system.

Dr Julie Oliver, Chair of the Primary Care Women's Health Forum, remarked that:

"It only takes one women's health-focused GP to make a big difference."

For example, in Liverpool, through direct efforts to break down barriers between different parts of the commissioning system locally, there has been a 150% uplift in LARC activity across the city compared to pre-pandemic levels.[19] However, women who are not treated by these advocates are too often left without access.

iv. The fragility of the SRH workforce

Nearly all interviewees raised that services currently rely on a huge amount of goodwill from professionals to deliver vital care outside of agreed funds and working hours, with this being an unsustainable approach which results in outcome variation.

> *"What has to be realised, by Government and health leaders, is that there is a lot of skills and goodwill out there in primary care. If not for that goodwill, the situation would be much, much worse. I am constantly amazed with what I hear about GPs going the extra mile for women. For example, I hear of colleagues providing menopause advice and guidance for their fellow GPs in their locality in their own time. Hubs can build on this goodwill and formalise an offer."*
>
> **Ewa Craven, General Practitioner, Menopause Specialist and Trainer, Clinical Lead for Women's Health for Lancashire & South Cumbria**

18 Public Health England, *Extending Public Health England's contraception return on investment tool.*

19 Pulse Magazine, *Why we set up women's health hubs in Liverpool.*

Respondents emphasised the need for a well-trained, properly equipped, and diverse multidisciplinary workforce and called for the Government to ensure that Community Sexual and Reproductive Health training posts are fully funded and rolled out immediately, with the support of the Faculty of Sexual and Reproductive Healthcare, to address workforce supply gaps.

v. The importance of national leadership on women's reproductive health

Interviewees highlighted their concerns that the 2012 Health and Care Act had created challenges when it came to identifying responsibility, accountability and transparency in the system and a historic lack of national leadership around women's health.

As such, interviewees were positive with regards to the Women's Health Strategy and the appointments of Dame Lesley Regan as the Women's Health Ambassador for England and Dr Sue Mann, the first-ever National Clinical Director for Women's Health for England, to drive forward this policy agenda at a national level. As James Woolgar, Chair of the English HIV & Sexual Health Commissioners Group stated:

> ***"We have a Women's Health Strategy for a reason. We're talking about 51% of the population."***

In her role of Women's Health Ambassador for England Dame Lesley Regan has been a vocal proponent for the women's health agenda, using her expertise and extensive background in gynaecology to drive it forward and advocate for policy changes needed. For example, when giving testimony to this Inquiry in Parliament, Dame Lesley Regan provided welcome updates on the progress of the Women's Health Strategy and Women's Health Hubs at a national level and highlighted opportunities for further advancement. This included the importance of outreach initiatives targeting specific groups of women to tackle health inequalities and the crucial need for collaboration to demonstrate that it is "everyone's business to wrap services around the individual" receiving care.

Additionally, NHS England made a welcome ambition in 2023 to eliminate cervical cancer by 2040.[20] Respondents were clear that this commitment must be accompanied by national leadership and oversight to drive and track progress – especially as **cervical screening uptake currently falls below the 80% national target, with only 68.8% of eligible individuals adequately screened in 2023-24, meaning more than five million women are not up to date with their routine check-ups**.[21] As the Government continues to develop their national cancer plan, gynaecological cancers including cervical cancer should be included as a priority. The Government should also learn from best practice elsewhere, for example on the effective prevention of cervical cancer in Scotland.[22]

Overall there was a consensus amongst respondents that all parts of the system must work together effectively. Simphiwe Sesane, Contraception and Sexual Health Nurse Consultant at MSI Reproductive Choices and Equality, Diversity and Inclusion Advocate, described it as being like a "jigsaw puzzle" which needs to be joined up to ensure women are able to access care in a way that meets their needs.

20 NHSE, NHS sets ambition to eliminate cervical cancer by 2040.

21 NHSE, NHS makes fresh uptake appeal as five million women not up to date with cervical screening.

22 Public Health Scotland, No cervical cancer cases detected in vaccinated women following HPV immunisation.

3b Delivering women's reproductive healthcare in the community

The Government has made clear its ongoing commitment to shift health services into the community, away from under-pressure primary and secondary care services, such as A&E and GPs.

i. Standardising pharmacies' provision of contraception

Respondents outlined how in recent years community pharmacies have played an increasing role in women's health leveraged to provide an additional source of support, access to care and signposting across the wider health system.

Community pharmacies are often located conveniently on high streets, in shopping centres and at transport hubs. The extensive network and the availability of walk-in appointments provides women with options to choose when and where to access essential healthcare. This may include visiting a local pharmacy with a known pharmacist or seeking anonymity by attending a previously unfrequented setting.

Furthermore, many pharmacies have long opening hours, including on the weekend and in the evenings. As a result, they are often more accessible than other healthcare settings, which is especially important for time sensitive medication, such as emergency hormonal contraception (EHC).

Respondents noted that pharmacies were one of the main routes of access to EHC but cautioned that, as it stands, there is significant variation of access to free EHC and no standard offer to women – whilst EHC services are commissioned by an estimated 90% of local authorities, only 48% of community pharmacies are included in such schemes.[23] Respondents highlighted that there are varying restrictions on usage in different areas, including differences in lower and upper age limits, and differences in access based on a patient's home address. **In effect, this means that two women, in the same area, could face an entirely different level of care depending on their age, address or which pharmacy they choose to visit, creating a postcode lottery of access**.

Furthermore, in 2023, NHS England announced plans to enable women across England to get the contraceptive pill at their local pharmacy without GP consultation, which represents another welcome option for women to access healthcare locally.

Respondents were keen to emphasise that the Government must ensure this service is accompanied by appropriate counselling and advice, and calls for them to monitor its accessibility to all women in the local community, particularly as there are growing reports of pharmacy closures, financial pressures and pharmacies opting not to provide this essential service.[24]

ii. The untapped potential of Women's Health Hubs

Respondents to the Inquiry agreed that Women's Health Hubs provide an ideal opportunity to help realise the Government's ambition of moving care into the community for many women.

Women's Health Hubs Women's bring together healthcare professionals and

23 National Pharmacy Association, *Emergency Hormonal Contraception Statement*.

24 inews, *Pharmacists could stop serving patients across UK this month in NHS funding row*.

existing services in a local community to provide integrated women's health services, centred on meeting women's varying needs across the life-course.

> *"The women can be seen in a timely fashion for the majority of their women's health needs while freeing up hospital appointments for women who require surgery or more complex care."*
>
> **Submission to the APPG inquiry by professional working in a Women's Health Hub**

> *"We are able to see women for all their gynaecological/sexual health needs in one place. I was able to see a patient for smear/Transvaginal ultrasound/pipelle biopsy/Mirena [intrauterine device] insertion/menopausal care... This has very high patient satisfaction rates."*
>
> **Submission to the APPG inquiry by professional working in a Women's Health Hub**

They outlined several strengths to the model of Women's Health Hubs:

Dr Aamena Salar, a GP based in Birmingham, described Women's Health Hubs as providing a safe and accessible space for healthcare, located within the community, with flexible appointment availability and a one-stop service with diagnostic capabilities and integrated pathways with secondary care:

The needs of women – who often juggle multiple roles, including caregiving – are universal, and time constraints are a common challenge. Women's Health Hubs provide solutions in the form of choice and personalised care.

Dr Aziza Sesay, a GP and Health Content Creator, said that Women's Health Hubs also do not have the negative reputation that sexual health clinics often have, in that many patients are reluctant to visit, fearing they will be seen by others and associated with negative stigma or stereotypes.

Interviewees also raised the importance of Women's Health Hubs linking up with other support services to ensure that women's needs were met holistically, for example with domestic violence or housing services, as well as working with outreach groups who may have better links with certain groups of under-served women.

Rebecca Curtayne, External Affairs Manager at Healthwatch, shared an example of a local practice which had sought to understand certain cultural-related barriers to cervical screening. The practice adopted an approach where drop-in clinics were set up in various culturally relevant locations to offer information on screening and, working with faith groups in the community, focused on encouraging Indian and Pakistani women's attendance.

iii. The importance of Women's Health Champions

Respondents also spoke of the power of the network of Women's Health Champions at ICS level - made up of senior leadership in each ICS – who are able to advocate for improvements in women's health locally, and coordinate to share best practice. As Dr Janet Barter, President of the Faculty of Sexual and Reproductive Healthcare (FSRH) added, that the Champions must also "ask difficult questions and drive this agenda forward."

iv. Relieving pressure on the NHS

An "undeniable" benefit of Women's Health Hubs, highlighted by Geeta Kumar, Vice-President of the Royal College of Obstetricians and Gynaecology, is that they relieve pressure on secondary care, allowing women to avoid unnecessary and expensive referrals to hospital settings.

This was supported by respondents and demonstrated by the following testimony from a healthcare professional working in a Women's Health Hub:

We have found that 35% of gynaecology referrals can be kept in primary care with advice and guidance and increased support for GPs. 35% can be seen in a Women's Health Hub for a one-stop clinic where they have their needs met and are then discharged back to the GP, with very low follow up rates (1:9 vs 1:1 in gynaecology) and about 30% still require gynaecology appointments in a hospital. This means that a significant proportion of women currently sitting on gynaecology waiting lists could be seen in a Women's Health Hub, managed adequately and discharged back to the community. This would be cost saving for the NHS but more than that would massively improve a huge number of women's lives.

Similarly in Birmingham, Dr Salar outlined how the Hub has achieved a 7.1% onward referral rate to secondary care in 2024 which enables women to access support quickly, offering up to 1,000 appointments per month.

If replicated across other hubs, the Women's Health Hub model could bring vast financial savings to the NHS. This approach has already been delivered elsewhere including across London, Liverpool and Manchester, resulting in wider system benefits.

The Government's own analysis has demonstrated that the benefits of implementing Women's Health Hubs outweighs the costs due to the increased access and improved experience for patients and the high return on investment for contraceptives.[25]

The Government's analysis has also identified that if 50% of LARC procedures for gynaecology were provided in Women's Health Hubs, it would provide a saving of £1.8m, reduce further pressures and costs on secondary care gynaecology services, and cut gynaecological waiting lists – a key priority for this Government.[26]

25 Department of Health and Social Care, *Women's health hubs: cost benefit analysis.*
26 Department of Health and Social Care, *Women's health hubs: cost benefit analysis.*

v. The need for national oversight and support for Women's Health Hubs

However, a number of respondents raised that there is still work to be done for Women's Health Hubs to fulfil their potential, and further leadership, support and funding is needed by this Government to make this a reality.

Women's Health Hubs are intended to be developed in accordance with local need, determined using local public health population data alongside gynaecology referral data. However, it is important that this does not come at the cost of a nationally driven and coordinated approach.

Government data suggests that implementation has not kept pace with national ambitions, with 3 of 42 ICBs not having a Women's Health Hub open as of December 2024, and crucially many in that statistic in the preliminary stages of being established or in operational infancy.[27] It will be some time before women in every part of England are covered by an operational Women's Health Hub, and in some areas – such as rural communities – this model may be less effective or feasible.

Respondents were keen to emphasise that sufficient national leadership and oversight must be retained to monitor progress and record performance, particularly imperative in light of the Government's decision to remove the target for each ICB region to have a Women's Health Hub in NHS Operational Planning Guidance for 2025/6.

Without such a commitment, at a national level there are concerns from the sector that Women's Health Hubs are now left without a mandate for their creation, ongoing development and without further funding to remain open.[28] Further direction and support for this model from Government would be welcome to ensure the potential of Women's Health Hubs is realised locally across the country.

vi. The future of Women's Health Hub funding

A number of participants also raised concerns relating to the funding of Hubs, saying the £25 million funding announced in March 2023 – which was to be shared equally across ICSs – will not be sufficient for extra staff, infrastructure and longer-term delivery of adequate care.

Concerns were also shared in relation to reports that this funding was being used by ICBs to help deliver other cost-savings in other areas – sending a dangerous message that the provision of reproductive healthcare is a 'nice to have' rather than essential to 51% of the population.

The two-year initial funding allocation to Women's Health Hubs ends in March 2025, and respondents were in consensus that the Government should communicate on future funding arrangements or else Women's Health Hubs are likely to face reductions of hours or closure as their vital work may not be considered a local priority.

27 UK Parliament, *Health Services: Women, Question for Department of Health and Social Care UIN 10149*, October 2024.

28 RCOG, RCOG responds to the NHS Operational Planning Guidance.

3c The clear need to communicate with women about their reproductive health

The strong consensus from this Inquiry was that there is a deficit in women's health literacy and that provision of SRH will not be effective until women are better informed and educated about their own health and made aware of the full range of services that are available to them locally.

i. The important preventive role of RSE

Support for better accurate and informative Relationships and Sex Education (RSE) was emphasised repeatedly by respondents throughout the Inquiry.

The need for this is evident in a world where misinformation is growing. **A Sex Education Forum poll suggests nearly half of students aged 16 and 17 in England learned nothing at all or not enough at school on power imbalances in relationships, porn, and how to access local sexual health services**. The same poll suggested that 30% of young people turned to social media as their main source of information about sexual orientation and gender identity, ahead of school.[29]

Dr Aziza Sesay, GP and Health Content Creator emphasised the need for more accurate information and early education on SRH. She advocates for using a "spiral approach" to education, where concepts are taught progressively and at appropriate stages. She spoke of the importance of teaching children the correct terms for anatomy, avoiding euphemisms and negative connotations, and the benefits of involving parents in this process.

ii. Access to accurate information on SRH throughout the life-course

Many respondents stated that accurate information on SRH must go beyond school age and be accessible to all throughout the life-course. This is important as patients often experience insufficient counselling and advice by professionals and there is an absence of accessible information on contraceptive options and where to access care. **A recent Advisory Group of Contraception (AGC) survey found fewer than 30% of women received counselling on the full range of contraceptive methods**, as recommended by NICE and this has profound consequences for marginalised women already navigating a knowledge gap.[30]

Respondents also raised how the rise of misinformation about contraception may lead to women making choices about their contraceptive method or choosing not to use contraception based on inaccurate information from social media or the internet. For example, **one social media influencer has claimed that the pill is "this generation's cigarettes."**[31]

There were strong calls from respondents for better public health campaigns and public education to improve knowledge and understanding of the breadth of SRH including fertility, menstruation, contraception and pregnancy options, and to remove stigma from the range of SRH topics.

29 Sex Education Forum, Young people's RSE poll 2024.

30 The Advisory Group on Contraception, *Breaking barriers: inequalities in access to contraception in England.*

31 Eleanor Hayward, the Times, *Tiktok Misinformation Turns Women Away from Contraceptive Pill.*

Interviewees spoke to the importance of improved communication about the services available to enable them to have confidence in accessing the right care. Simphiwe Sesane, Contraception and Sexual Health Nurse Consultant at MSI Reproductive Choices and Equality, Diversity and Inclusion Advocate remarked that this is in alignment with the ambitions of the Women's Heath Strategy, one of which is to ensure "all women across all demographic groups have access to high-quality health information and know their health care options and where to seek support."

iii. How we can ensure information is accessible to all women

Respondents were in consensus that it is important that information is made accessible in a range of formats to suit women's different needs.

Interviewees supported the continued use of more traditional communication methods, such as posters in GP surgeries, adverts on buses and in public toilets. A number of interviewees also raised the need to consider how information can be tailored for specific audiences via different channels, including making effective use of existing organisations who already have links with particular groups of women.

Examples of such organisations include Black Beetle Health, Black Nurses & Midwives UK, Love Sex Life and Prepster. The Menopause Charity have also delivered sessions in various worshiping places, enabling them to share information with women who may not present to the GP or SRH services.

Rebecca Curtayne, External Affairs Manager at Healthwatch, highlighted the possible opportunity to engage with local Healthwatch organisations (there are 153, in every local authority area of England), many of whom have links with relevant community organisations. These community organisations are trusted by different sections of the community and may be able to host talks or facilitate focus groups and possibly offer informal translation with non-English speakers.

Brook's *Contraception: What Works For You?* tool and the FSRH's *Contraception Choices* website were also suggested as helpful resources to help support better access to accurate information.

It was suggested that any local efforts would ideally be supported by a national campaign on the importance of high-quality contraceptive care, with James Woolgar, Chair of the English HIV and Sexual Health Commissioners Group, noting that such a campaign would be welcome alongside national public awareness efforts seen in other areas (reducing STIs, for example).

4. APPG Conclusion and Recommendations

This inquiry has demonstrated that women's reproductive health has been neglected for far too long. The fragmented, disjointed nature of current SRH services has only deepened the inequalities that women across England continue to face.

Despite the dedication and tireless efforts of professionals and advocates within the NHS, Department of Health and Social Care, local authorities, and Parliament, too many women still struggle to access the SRH care they need – whether it be through primary, secondary, or community services. As a result, women are often left to endure debilitating pain without adequate support, guidance, or help.

With the Government's Manifesto commitment:

Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS.[32]

The Government now faces an opportunity to make this commitment a reality and deliver for 51% of the population through action, leadership, and support for the women's health agenda, and crucially women's reproductive health.

Recommendations

National Level Recommendations:

1. The Government should reaffirm their welcome commitment to women's health and set out detail on how they will meet their Manifesto promise to 'never again neglect women's health' and to 'prioritise it as they reform the NHS'.

   This should include:

   a. National prioritisation of women's health agenda at the system level, including a dedicated focus on women's sexual and reproductive health.

   b. Continuation of the 10-year Women's Health Strategy for England, and the roles of Women's Health Ambassador for England and the National Clinical Director for Women's Health in England.

   c. Further detail on how they will reduce gynaecology waiting lists through the elective reform plan, close the maternal mortality gap and meet the NHS' ambition to eliminate cervical cancer by 2040.

2. The Government should consider providing additional support and oversight for the growing network of Women's Health Hubs across England.

   This should include publishing regular guidance and instructions on sharing existing best practice to support their implementation and ensure women can access essential services, no matter where they live.

3. The Government's upcoming National Cancer Plan must include proposals to

32 Labour Party, *Change*, Labour Party Manifesto, 2024.

improve gynaecological cancer care and outcomes, and specifics on how they will meet the NHS' ambition to eliminate cervical cancer by 2040.

4. The Government should evaluate the need to introduce an integrated commissioning model for SRH, with one body maintaining oversight and holding accountability for all commissioning of women's reproductive healthcare.

5. The Government should instruct ICS Women's Health Champions to undertake regular reviews of local reproductive health provision and pathways, to understand gaps in women's access to contraceptive and abortion provision, including LARC provision across indications.

6. The Government should ensure that future national surveys on women's reproductive healthcare specifically capture the experiences of marginalised women comprehensively, for example by enlisting the support of community champions.

7. The Government should restore the Public Health Grant to pre-2015/16 levels, incrementally if required, to ensure contraceptive provision is put on a sustainable footing.

   This is of critical importance for areas where Women's Health Hubs have not been established or are in their operational infancy.

8. Guidance should be offered on the improvement of pharmacy settings to make it easier for women to access contraception. This may include more privacy for women to discuss needs or making information about contraception more visible in pharmacies.

9. The Government should guarantee free, funded and accessible emergency contraception for all who need it by establishing a single national commissioning specification for Emergency Hormonal Contraception services to ensure patients experience consistent ease of access across the country.

10. The Government should increase access to Long-Acting Reversible Contraceptives and non-reversible contraception by evaluating its current provision across each ICB, so that all women have equal access to the full range of contraceptive methods regardless of their postcode.

11. The Government should implement sequential progression of health literacy in Relationships and Sex Education at school, to help address stigma around SRH from an early age, address misinformation and enable people to make informed and accurate decisions about their sexual and reproductive health.

12. The Office for Health Improvement and Health Disparities should work with national professional bodies such as the FSRH to ensure everyone can access a national source of up-to-date, woman-centred information on the methods of contraception and how to access them, as well as about how to find local services throughout the life-course.

    This should include 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. This digital resource should be well publicised to women via search engine optimisation.

13. The Government should ensure that Community Sexual and Reproductive Health training posts (medical Consultants who provide local specialist care and leadership) are fully funded, with one new fully funded Specialty training post per NHS England Workforce, Training and Education (WTE) region for the next three years, to provide local leadership, training and governance to the SRH workforce and services.

Local and Regional Level Recommendations:

1. Each ICB should work with their Women's Health Champion and relevant women's health organisations in their area to develop a Strategy on women's reproductive health for their population.

   The Strategy should include clear pathways to enable effective working with other parts of the wider health system, such as domestic violence and housing services.

2. ICCs, local authorities and NHS England should agree local joint plans for SRH, with the aim of maximising choice and creating the best outcomes for patients, according to assessed local need.

   This should include conducting a workforce capacity assessment and developing a Strategy based on their population need for the future delivery of SRH services.

3. ICB commissioners, local authorities and NHS England should consider establishing specialist outreach teams to reach marginalised groups to provide contraceptive counselling and provision, or out of hours events that cater for women who are unable to attend appointments during working hours to help reduce waiting lists.

4. ICB commissioners, local authorities and NHS England should ensure that methods of contraception are discussed with women during pregnancy or abortion care and their method of choice should be initiated prior to discharge from services.

5. ICB commissioners, local authorities and NHS England should offer choice of phone, virtual or in-person consultations where possible to accommodate different needs and preferences.

6. ICBs should set guidance with KPIs for Women's Health Hubs to evaluate how their services are performing and helping to improve reproductive health inequalities locally.

7. All ICSs should set up a website detailing the local SRH services and appointments available.

   This should include working with Women's Health Hubs and local community organisations representing different groups of women, to ensure information is accessible, relevant and culturally sensitive.

8. Local authorities should support schools to fulfil their statutory duty to ensure students know how and where to access confidential sexual and reproductive health advice and treatment, by providing up to date information about local SRH services.

   These strengthened links between schools and SRH services through RSHE, will help to reduce absenteeism in schools and unnecessary pressure on the NHS.

Appendix A

With thanks to the individuals and organisations who submitted written evidence to the APPG's inquiry:

Bart's NHS Health Trust

Bayer

BPAS

Brook

Company Chemists' Association

Dr Aziza Sesay

Dr Rebecca Mawson

Dr Sylvia Kama-Kieghe

iCaSH, Cambridgeshire Community Services NHS Trust

MSI UK

Organon

Primary Care Women's Health Forum

Public Health and Communities Directorate, Suffolk County Council

Royal College of Obstetricians and Gynaecologists

The Advisory Group on Contraception

The Motherhood Group

Appendix B

With thanks to those who gave oral evidence to the APPG's inquiry:

Dr Janet Barter, Consultant in SRH at Bart's Health NHS Trust and President of the Faculty of Sexual and Reproductive Healthcare

Dr Stephanie Cook, GP and Clinical lead, Cheshire and Merseyside Women's Health Hub

Dr Ewa Craven, Lancashire and South Cumbria ICB Clinical Lead for Women Health

Rebecca Curtayne, External Affairs Manager, Healthwatch England

Geeta Kumar, Vice President for Clinical Quality at the RCOG and Clinical Lead for Women's Services at Betsi Cadwaladr University Health Board

Dr Michael Mulholland, GP and Honorary Secretary at the Royal College of General Practitioners

Dr Julie Oliver, GP and Chair of the Primary Care Women's Health Forum

Dr Aamena Salar, GP and Clinical Lead for Modality Community Gynaecology Clinic

Simphiwe Sesane Medical Educator/ Sexual and Reproductive Health Nurse Consultant and Equality, Diversity and Inclusion Advocate at MSI UK

Dr Aziza Sesay, GP and Health Content Creator

James Woolgar, Sexual and Reproductive Health and HIV Commissioning Lead in Liverpool and Chair of English HIV and Sexual Health Commissioners Group

on Sexual and Reproductive Health in the UK

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