FSRH The Faculty of Sexual & Reproductive Healthcare

How the Faculty of Sexual and Reproductive Healthcare was born

Dr Lindy Stacey

November 2018

The FSRH would like to thank Dr Lindy Stacey for researching and writing this document – it is fantastic to have the context of the creation of the FSRH captured in one document. We also appreciate the time of our FSRH founders, past and present members for their contributions to the content of this document.

This document forms part of the FSRH's 25th anniversary celebrations during 2018. Find out more by visiting: www.fsrh.org/fsrh25.

How the Faculty of Sexual and Reproductive Health care was born

Today, family planning is part of our daily life and our medical profession, but it has not always been that way. This document explores the journey from the late 19th century, when the modern birth control movement began, to 1993 when the Faculty of Sexual and Reproductive Healthcare became the independent professional body for the specialty.

The 19th century – the modern birth control movement begins

The modern birth control movement developed in the late 19th century in the face of considerable opposition from the church, the state and the medical profession. Controlling fertility was believed to encourage infidelity in women, madness, sterility and moral danger. Separating sexual pleasure from conception was seen as unnatural, and the idea that women should be able to control their bodies was threatening to a male dominated society.

Contraceptive appliances such as caps and condoms were widely available in ‘rubber shops’ and many leaflets and pamphlets providing contraceptive advice circulated freely. These included the Knowlton ‘Fruits of Philosophy’ pamphlet which was published in 1832 and re-printed in 1877 by social reformers Charles Bradlaugh and Annie Besant. They argued it was “...more moral to prevent the conception of children, than, after they are born, to murder them by want of food, air and clothing.”

Bradlaugh and Besant were charged with breaching the Obscene Publications Act of 1857 and found guilty at the Old Bailey, although judgment was set aside on a technicality. The extensive publicity surrounding the trial resulted in increased public interest in contraception and increased sales.

Out of this conflict between the rules of the establishment and the public’s behaviour emerged social reformers, who were prepared to challenge the orthodoxy and campaign for contraception to be available to all who needed it.

Birth control campaigners were concerned about working class women who had less access to contraceptive advice and supplies and were more likely to experience poverty, overcrowding, ill health related to pregnancy and infant mortality. Spacing pregnancies was a way to improve both

maternal and infant health. The campaign was also inspired by early feminist ideas that women should be able to be in control of their reproduction. But conversely, some campaigners saw birth control as a means to control the population and prevent those who were less healthy from reproducing.

The 20th century - and the rise of birth control

At the start of the 20th century medical students were not taught about birth control. Doctors were also largely against using it, as they believed it was associated with prostitution and immorality.

After the First World War, attitudes started to change driven by social disruption, the need to manage venereal disease and poor health of mothers, children and military recruits.

In 1882, the first ever contraceptive clinic opened in Amsterdam. This gave free advice and methods to poor women, including the ‘Dutch cap’ or diaphragm, which was accepted and promoted in Holland.

In 1921, the first clinic in Britain - the Mothers’ Clinic for Constructive Birth Control - was opened by Marie Stopes, a campaigner, biologist and the author of the very controversial book ‘Married Love’. The clinic started in Holloway in London before moving to Whitfield Street in 1925, where it exists today as Marie Stopes UK.

For the first time, qualified clinical staff were available to give contraceptive advice. This signalled the beginning of sexual and reproductive healthcare as a medical specialty rather than a social or commercial activity.

The clinic’s staffing was also ahead of its time. Marie Stopes believed women would respond better to nurses than doctors, so the clinic was run by a qualified midwife who could perform examinations, with a woman doctor for referrals.

The medical profession was not supportive, of either a woman not medically trained commenting on medical matters, or of a clinic being run without a qualified gynaecologist.

Figure 1 Marie Stopes and nurses at the Mother's Clinic, Holloway. Source "Marie Stopes: a biography".

Figure 2 The Mothers' Clinic for Constructive Birth Control, Whitfield Street. Wellcome Images No. L0018436.

The same year, another clinic, the Walworth Women's Welfare Centre, was set up in London, and an affiliated clinic in North Kensington opened in 1924. The first centre outside London was in Wolverhampton in May 1925.

Putting pressure on the government

By 1930, five birth control societies were pressuring the government to enable local authorities to spend money on birth control as part of the Maternity and Child Welfare Clinics.

This led to a 1931 memorandum from the Ministry of Health which said:

> "It is not the function of the Centres to give advice in regard to birth control…the government consider that, in cases where there are medical grounds for giving advice on contraceptive methods to married women in attendance at the Centres, it may be given, but that such advice should be limited to cases where further pregnancy would be detrimental to health."

At the same time, The National Birth Control Council (NBCC) was founded, to coordinate the work of the clinics and persuade local authorities to cooperate.

The memorandum was seen as a breakthrough by the NBCC, despite its obscure wording – but the NBCC and its new secretary Margaret Pyke produced and publicised its own explanation.

Although this caused considerable disapproval, it did its job - by forcing the Ministry of Health to clarify and circulate its guidance.

The Family Planning Association was born

In 1939 NBCC member societies merged into the Family Planning Association (FPA), but Marie Stopes, a woman of very strong opinions and who resisted other influences on her project continued to run her clinic independently.

The new organisation's role was 'to advocate and promote the facilities for scientific contraception so that married people may space or limit their families and thus mitigate the evils of ill health and

poverty'. The FPA also established women's health centres, to provide treatment and advice for minor gynaecological ailments and marriage difficulties and give contraceptive advice.

Figure 3 Prorace cervical cap England 1915 - 1925. Science Museum, London

Figure 4 Rubber condoms in original carton with instructions, United. Science Museum, London

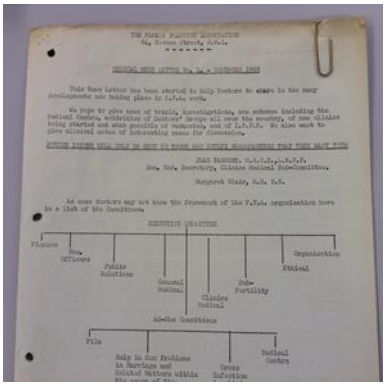
The FPA was originally organised as branches, and later autonomous federations which raised their own funds, campaigned locally and employed staff to run the clinics. Because medical students were not trained in the subject, training clinics were set up early on. The association also provided information via publications and medical conferences.

Pressure on local authorities

In 1948, after the National Health Service (NHS) had formed, local authorities took over the maternity and child welfare centres. Provision of contraceptive advice to married women on medical grounds was still discretionary. Some authorities paid for this service from the FPA, others provided premises for clinics to be run, and many did not provide a service.

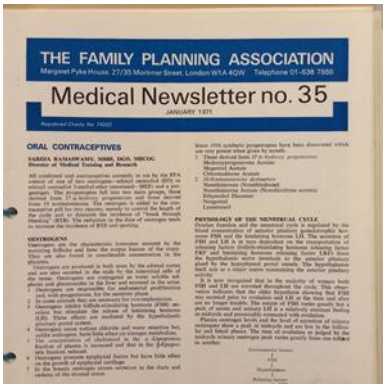
The FPA actively campaigned for the local authorities to fulfil their responsibilities, but ultimately wanted contraception to be provided by the NHS. Women who did not meet local authority criteria for contraceptive advice could attend an FPA clinic for a small consultation fee and would also pay for supplies.

Clinics continued to expand, and by 1955 there were 11 federations. In 1958, the FPA began producing a medical newsletter to provide up to date information to the clinicians.



1968

1958



1971

Figure 5 How the FPA Medical Newsletter evolved

Contraceptives were changing

In 1960, caps and diaphragms were the most commonly issued contraceptives in FPA clinics, but this was about to change, and fast. Hormonal contraceptives were already available in the USA whilst they were being tested in Britain.

The oral contraceptive pill became available in the UK in 1961. To support this massive change in the contraceptive landscape, the FPA set up a Medical Advisory Council in 1960, set standards for pill prescribing and arranged training for its medical officers.

Having a contraceptive method available that required medical supervision altered the nature of the clinics and encouraged the medical establishment to become interested. Until now, they had not considered contraception to be part of their responsibilities.

Contraceptive use had evolved. Previously a rather dubious choice made by individual women and men and provided by social reformers and commercial organisations via clinics run by mainly nurses and volunteers, it had changed into a medical service requiring specialist training.

A major reorganisation

These drastic changes were difficult to manage in an organisation divided into federations, that had little clinical leadership and was heavily reliant on volunteers.

A review into family planning took place – and led to the Lafitte report ‘Family Planning in the Sixties' which was produced in 1963.

The review recommended that the organisation should continue to campaign for the NHS to take over clinical services eventually. But it acknowledged a major reorganisation would be required to allow the FPA to influence the medical profession and the authorities and provide a model of clinical services.

Structurally, the 11 federations were reorganised into 50 to 60 new branches, with a National Council, a Scientific Advisory Council for professional matters, and a National Executive including doctors’ and

nurses' committees. The finances would be rationalised and centralised, and a Medical Director appointed to enhance the status of the organisation. The report also included a survey of clinic staff, including nearly 500 doctors (most of whom were women and worked part-time), over 600 nurses, and 3210 support staff, of which only 210 were paid, the rest were volunteers.

The recommendations were accepted by the AGM in 1964. This was despite reservations from some of the federations about giving up their local autonomy - the vote was reported to the members as 'a graceful and calm act of suicide…we fell on our sword in the Roman manner'.

The association was moving away from its 'Women's Institute' approach that relied strongly on volunteers to become a more professional organisation. It now was aiming to become 'a model service, professional in purpose, but still infused by the voluntary spirit'.

By 1967, the restructuring was nearly complete, with increased emphasis on training and professionalism.

The marriage dilemma

Unmarried women seeking contraceptive advice posed a dilemma for the FPA, an organisation which aimed for social reform but also respectability.

In 1952 clinic guidelines extended eligibility to women about to be married, with various requirements for proof, but the position of single women continued to be divisive. The first services for unmarried women were not provided by the FPA but were run by Helen Brook initially in the still independent Marie Stopes clinic, and from 1964 in the Brook Advisory Centres, set up specifically for young unmarried people.

The FPA's dilemma for unmarried women would be solved in 1967.

1967, a year of legislation

1967 marked a huge change in laws about sexuality, reflecting changing public attitudes and the problems people were experiencing from legal restrictions.

The Abortion Act

First, the Abortion Act was passed despite considerable opposition, and laid down circumstances where abortion could be performed legally by registered medical practitioners.

Public health was a key driver of the Act, especially maternal mortality and morbidity as a result of illegal abortion.

This was coupled with the feminist idea of women having autonomy over their own bodies, and a desire to give some guidance to gynaecologists, who were regularly confronted with abortion requests and complication.

Although amended since, this Act is still in place today, and a bill pushing for complete decriminalisation is currently passing through Parliament.

The Sexual Offences Act

The same year, the strongly contested Sexual Offences Act addressed male homosexuality and decriminalised homosexual acts between two men aged 21 or over in private.

This Act marked the start of a significant shift in public opinion and legislation which led to complete parity between homosexual and heterosexual behaviours in 2000.

The Family Planning Act

1967 also saw the NHS' (Family Planning Act) passed which enabled local health authorities in England and Wales to give contraceptive advice, supplies and appliances as part of the NHS, at the discretion of the authority. This included provision for the unmarried, solving the dilemma previously faced by the FPA.

In contrast to the others, this Act met very little opposition - even the Times newspaper commented: ‘Rarely can social reform have had such a loving reception’.

Although they could provide services, the local authorities were not obliged to do so, which meant the service provided by different authorities was inconsistent. Most users still needed to pay for supplies.

Time to upskill clinical staff

By 1971, the FPA had developed an agency scheme, which offered local authorities a service package. Services were provided to the unmarried, and women under the age of 16 could be seen and given contraception with parental consent.

To promote consistent standards in clinics, the FPA produced a clinic handbook, which contained medical information and information about the FPA’s organisation. This included doctors’ and nurses’ groups and representation on the national councils, and the roles and grades of clinical staff, the NHS (Family Planning Act) and how it should be applied. Professional support for clinical staff was improved and a career structure for doctors and nurses was created.

A move to free family planning – and a new provider

In 1973 the NHS Reorganisation Act was passed under a Conservative government. It included a clause providing free family planning services but continued the prescription charge for supplies unless people were exempt.

In early 1974 Labour won the election and announced that the service would be totally free. The DHSS sent guidance to all health and local authorities in May 1974, and a joint working party between the FPA and the Department of Health and Social Security (DHSS) facilitated the transfer of clinics, domiciliary services and staff.

This removal of fees was applied to FPA clinics immediately, but it took longer for the DHSS to negotiate with the GPs. In February 1975, service payments were agreed, although GPs had the right to refuse to provide contraception for any individual patient.

By January 1976 about 90% of GPs had registered to provide contraceptive services, but only a few had had any training.

The end of an era, and a new one begins at the FPA

The FPA had run an effective campaign.

It had negotiated at a local and national level and had led public discussions.

Ultimately it had achieved the aim of a free contraceptive service provided by the NHS. It had developed a major medical service, the last one to be provided outside the NHS.

The FPA had also paved the way for a specialty with professional support for clinical staff via local and national clinical groups, teaching and training, career development and publications.

By the end of 1976, the clinical services were in the hands of the NHS, except for a few research clinics.

The FPA became much smaller and changed focus to become a campaigning organisation, providing public information about methods and services, education, and monitoring standards. In the 1980s it became the mainstay of clear and evidence-based information for users and professionals about contraceptive methods, and an advocate and monitor for clinical services which were at risk of cuts and closures.

Hard times for the NHS

The transfer of the clinics to the NHS was not without risk. There were national financial problems as a result of the oil crisis, industrial unrest and inflation. After the extensive NHS reorganisation of 1974, the family planning clinics, along with other community services such as child and school health services and community nursing, were transferred to the 90 new area health authorities.

The new structure of the NHS was found to be complex with too many tiers, so in 1982 the NHS was restructured - this time, areas were abolished and replaced with 192 district health authorities.

Service provision continued to vary widely throughout the country during the 1980s, and management arrangements were highly complex. There was no consistency about responsibility for family planning services.

Training and qualifications

The FPA had provided qualifications for both doctors and nurses working in the clinics since its inception, training them about the medical aspects of contraception, and the attitudes and aims of the organisation. There was a joint doctors' and nurses' committee on training, and by 1968 they held a joint conference for instructing doctors and nurses and a yearly programme of refresher seminars.

In 1976, the regional health authorities, which had been formed during the 1974 reorganisation took over the responsibility of training clinical staff.

To prepare for this, the Royal College of Obstetrics and Gynaecology (RCOG) set up a Family Planning Subcommittee in 1971 with the Royal College of General Practice (RCGP) and the FPA. This became the Joint Committee on Contraception (JCC) in 1973. It was joined by the Faculty of Community Medicine and later by the National Association of Family Planning Doctors (NAFPD).

The group's role was to recognise theoretical and practical training programmes and issue certificates in basic contraception and instructing. The qualification was the first postgraduate medical qualification in the UK to require re-certification every five years by providing evidence of updates.

The training scope went far beyond contraception and included other aspects of sexual health such as well women care, screening, the management of sexual problems, the management of planned and unplanned pregnancy and legal and ethical issues. The JCC was an important upholder of clinical standards by training doctors but had no professional or academic status.

Continuing the FPA's legacy

One of the FPA's legacies was professional support for doctors and nurses. A new organisation called the National Association of Family Planning Doctors, or NAFPD, sprang into life in 1974 to continue this legacy.

The officers were seasoned campaigners from the FPA, and the original president was Sir Stanley Clayton, who was also the president of the RCOG. This cemented the connections between the two organisations, and in 1977 the offices moved from the FPA to the RCOG. In December 1976 Dame Josephine Barnes became president.

The objects of the NAFPD included promoting family planning and sexual medicine, exchanging information through conferences and publications, promoting research, and promoting high standards of training and practice.

Figure 6 Dr Kay Reid (right), first chairman of NAFPD with Dr Barbara Law, subsequent Chairman.

The Association launched a quarterly publication called the Journal of Family Planning Doctors, (renamed the British Journal of Family Planning in 1977) which was the mouthpiece of NAFPD. Both endeavours were sponsored by Wyeth.


THE JOURNAL OF
FAMILY PLANNING DOCTORS

Use-effectiveness of the condom in a selected family planning clinic population in the United Kingdom

Contrasting views of use and provision of family planning services

Figure 7 Journal Vol 1, April 1975


The British Journal of Family Planning

Pelvic inflammatory disease and IUCDs

Figure 8 Journal Vol 4, July 1978

Figure 9 Wyeth advert – Journal of Family Planning Doctors, 1976

The chairman, Dr Kathleen Reid, wrote the leading article, and in the second issue she commented on the position of family planning in relation to the Royal Colleges. She wrote:

"In other branches of medicine standards and guidelines for clinical practice are produced by the appropriate professional bodies and Royal Colleges. Family planning is not covered and cannot be, by these, since it has developed this century independently of other branches. It overlaps with several but is not totally enclosed by any of them."

From the beginning NAFPD was concerned with the position of the doctors and the status of the specialty. Another message from Dr Reid in the second issue of the journal described the problems with the clinic doctors' employment transfer and administrative efficiency. She wrote:

> "Progress towards an improved service to patients from doctors and others working in friendly liaison with each other is hampered, to put it mildly…of course we know that the whole of the NHS is having a very trying time and the Family Planning Services are but a fragment thereof."

After the transfer FPA doctors were given clinical medical officer (CMO) or senior clinical medical officer (SCMO) positions in Community Trusts, and those working in hospital family planning clinics were clinical or medical assistants.

Most clinic doctors worked part-time, and had other jobs in general practice, public health or a hospital. This meant they brought a wealth of experience to the specialty, but it was not consistent with mainstream postgraduate training.

Dr Joyce Neill wrote about the past and the future of working in the field:

> "We all know what a family planning doctor was. Depending on the point of view, she was a dedicated pioneer, opening and working in clinics for the good of humanity, alternatively she was a tiresome sort of battle-axe inventing this cult of which she was a self-appointed priestess…I would like to see, within consultancy units, some sort of metamorphosed family planning doctor of consultant state."

Northern Ireland

Dr Neill was chair of the Northern Ireland FPA (NIFPA), which was founded in 1965. Establishing a family planning service in Northern Ireland took considerably longer than the rest of the UK for social, religious and political reasons. The 1967 Abortion Act was never extended to Northern Ireland and attempts to do so in 1984 and 2000 met with strenuous cross-community opposition. Clinical family planning services were integrated into the NHS in the early 1970s.

Professional support locally

Professional support for doctors included up-to-date medical information, so NAFPD set up a Scientific Advisory Council. Initially there was some overlap with the FPA but eventually joint meetings were established. The possibility of a Faculty of Family Planning had been proposed by members of the council of the RCOG in 1974 as a development of the JCC and was discussed at a NAFPD council meeting in August 1976, but it wasn't taken forward at this time.

An important part NAFPD's work was through the local groups that had arisen from the FPA branches. These were self-funding, and groups organised local meetings to provide clinical updates for doctors, and sometimes nurses. The groups were an important professional support to clinicians,

who were often working in isolated situations. They became affiliated to NAFPD, and each group could send two representatives to the annual affiliated groups meeting.

Having some nurses present at affiliated groups became a way for doctors and nurses to communicate about the specialty. Joint meetings and responsibilities had been lost after the FPA handover, because doctors and nurses were the responsibility of different hierarchies in the area health authorities.

Revamping nurse qualifications and training

The professional situation for nurses on leaving the FPA was similar to that of doctors. They required a new form of certification which was initially provided by the NHS Joint Board of Clinical

Nursing Studies (JBCNS) 900 course, which became the recognised family planning training for nurses. In the 1980s, this changed to the English Nursing Board (ENB) Course 900 Certificate of Competence.

Although the Royal College of Nursing provided support for some nurses, in 1 979 only around ten percent of family planning nurses belonged to it because they worked part time and could not afford the subscription.

The National Association of Family Planning Nurses (NAFPN) was formed that year, sponsored by Wyeth. It provided recognition for nurses working in family planning and it produced a bi-annual newsletter to keep them updated. When the Faculty was formed, nurses were able to become associate members, but full membership for nurses was not achieved until 2014.

Figure 10 NAFPN Newsletter August 1985

Treating young people

In the 1980s contraceptive services experienced another storm in the guise of the Gillick case. Mrs Victoria Gillick challenged West Norfolk and Wisbech Health Authority to prevent under 16s from being given contraception without parental consent.

The initial case was dismissed, but this was reversed on appeal, putting clinicians in a very difficult situation. Within a year the Law Lords ruled in favour of the original judgement, and the Fraser Guidelines, a pragmatic set of criteria that could be used in clinical situations, was issued. The Brook Advisory Centres were a major source of advice and support for clinical staff during this period.

Changes for general practice

The 1988 white paper 'Promoting Better Health' included family planning as part of the health promotion aspect of general practice. This resulted in a further threat to local health authority clinics, which could be seen to be duplicating GP services.

In 1989 Dr Michael Cox wrote an article for the British Journal of Family Planning to explain the history and captured feelings at the time:

> "The clinic service was painstakingly built up over many years by the FPA which depended on the devoted work of many doctors, nurses and others, many of whom were not paid. From 1974 nearly all the clinics were…willingly handed over because the FPA confidently believed that the NHS would carry on the good work and would build on the foundation which the FPA had established. The FPA and their workers in 1000 clinics trusted the NHS. Is that trust now being betrayed?"

The frustrations of working in family planning during this time created an impetus for a more influential body to represent the specialty.

Influencing the career structure

Although a significant proportion of family planning was done in general practice, specialist services were needed for people with complex medical problems, for specific groups, to improve accessibility and for training. These services were often led by senior clinical medical officers, who were experienced clinically and often in management positions but they did not have consultant status or need to be a member of a Royal College.

An RCOG committee on Medical Gynaecology was set up to explore options, and in 1983 reported:

> "There is … room for development of a specialist grade, particularly for the part time doctor practicing medical gynaecology, ultrasonography and family planning."

The JCC could provide basic training but was not in a position to develop higher training. The appointment of consultants in Family Planning, which started in the 1970s with those trained in gynaecology or general practice, demonstrated the need for senior clinicians, who had professional support and clinical autonomy.

Stepping stones to forming a Faculty

By 1987 another proposal from the NAFPD council about forming a Faculty was accepted by the RCOG and a steering group was set up, to include the RCGP. The standing orders of the Faculty of Family Planning were drafted and agreed, based on those of the Faculty of Community

Medicine. There was discussion about how the board would be elected, by members or by the Royal Colleges, and also about the autonomy of the Faculty and the influence of the parent bodies.

In March 1991 the RCGP decided to withdraw because the College did not believe an additional qualification should be required by holders of the MRCGP to provide family planning services.

The negotiations for a joint faculty came to an abrupt end but there was still enthusiasm from both NAFPD and the RCOG for pursuing a single college faculty, and the articles were adapted for this

purpose, including adding Reproductive Health Care to the title. By 1992 plans were shared with NAFPD members.

The Faculty was born

In March 1993 the Faculty came into formal existence. NAFPD was wound up at an extraordinary meeting in May that year, in an echo of the vote to end the federations of the FPA in 1965. The assets of the company were transferred to the Faculty, with donations to Brook, the FPA, the Institute of Psychosexual Medicine, NAFPN and Terence Higgins Trust. Members needed to join the new organisation individually.

A foundation board representing a mix of geographical and professional positions was elected by the three parent organisations. The first chair was Dr David Bromham, an active member of NAFPD who played a key role in setting up the Faculty.

The foundation of the Faculty continued the development of the specialty of sexual and reproductive Health (SRH). The need for contraceptive services had driven much of the campaigning and legislation, but more holistic care was understood and promoted by the FPA in its original objectives to provide help for gynaecological problems and marriage difficulties, and in the scope of the JCC and NAFPD which included a wide range of related issues in their remits.

The Faculty came into existence through a period of challenge and change. Challenge to the establishment through the decades and significant changes in legislation, public opinion and contraceptive methods.

A pivotal role in patient care

This document has shown the long journey to establishing the Faculty of Sexual and Reproductive Healthcare. Now the Faculty exists to maintain and develop standards of care and training, encourage improvements in quality and provide a voice for professionals involved in SRH.

These underpin the main purpose of the organisation, to ensure that that patients are safely and properly cared for.

Useful books and articles

The Fight for Family Planning: The Development of Family Planning Services in Britain 1921-74
Audrey Leathard
The Macmillan Press 1980

Faculty of Family Planning and Reproductive Health care of the Royal College of Obstetricians and Gynaecologists
David Bromham
British Journal of Family Planning July 1992 18 (2) 33-34

Faculty of Family Planning
Geofffrey Chamberlain
British Journal of Obstetrics and Gynaecology June 1993, Vol.100, p507

NAFPD prepared for the end
Jeanette Cayley
British Journal of Family Planning July 1993, 19 (2) 177

NAFPD revisited
Josephine Barnes
British Journal of Family Planning April 1995, 21 (1) 3-4

The Faculty of Sexual and Reproductive Healthcare; 20th anniversary
Christopher Wilkinson and Diana Halfnight.
Journal of Family Planning and Reproductive Health Care April 2013, 39 (2) 78-70

Series: Twenty-Five years ago: Then and Now

Training for Reproductive Health: Beyond Apprenticeship
Lindsay Edouard
Journal of Family Planning and Reproductive Health Care Oct 2002, 28 (4) 210

The Politics of Contraception: Policies Lost and Gained
Lindsay Edouard
Journal of Family Planning and Reproductive Health Care Oct 2009, 35 (4) 257-259

Sexual Health: the Cinderella of Reproductive Health Services
Lindsay Edouard
Journal of Family Planning and Reproductive Health Care Oct 2013, 39 (4) 297-299

Reproductive Health at the Crossroads
Lindsay Edouard
Journal of Family Planning and Reproductive Health Care Oct 2015, 41 (4) 303-305

Resources for Service Provision: Policies and Politics
Lindsay Edouard
Journal of Family Planning and Reproductive Health Care Oct 2017, 43 (4) 339-341

About the FSRH

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the largest UK professional membership organisation working in the field of sexual and reproductive health (SRH). We support healthcare professionals to deliver high quality healthcare including access to contraception. We provide our 15,000 doctor and nurse members with NICE-accredited evidence-based clinical guidance, including the UKMEC, the gold standard in safe contraceptive prescription, as well as clinical and service standards.

The FSRH provides a range of qualifications and training courses in SRH, and we oversee the Community Sexual and Reproductive Healthcare (CSRH) Specialty Training Programme to train consultant leaders in this field. We deliver SRH focused conferences and events, provide members with clinical advice and publish BMJ Sexual & Reproductive Health – a leading international journal. As a Faculty of the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK, we work in close partnership with the College but are independently governed.

The FSRH provides an important voice for UK SRH professionals. We believe it is a human right for women and men to have access to the full range of contraceptive methods and SRH services throughout their lives. To help to achieve this we also work to influence policy and public opinion working with national and local governments, politicians, commissioners, policy makers, the media and patient groups. Our goal is to promote and maintain high standards of professional practice in SRH to realising our vision of holistic SRH care for all.

www.fsrh.org