bpas British Pregnancy Advisory Service

Access to contraception

bpas submission to the APPG on Sexual and Reproductive Health – March 2019

The British Pregnancy Advisory Service (BPAS) is a British reproductive healthcare charity that offers pregnancy counselling, abortion care, miscarriage management, contraception and STI testing to 85,000 women each year via our clinics in England, Wales, and Scotland.

We also advocate for women's reproductive choice and the right to make their own choices about their own bodies and treatments, and have campaigned to reduce the price of emergency contraception in pharmacies to increase its accessibility.

Key Points

- Contraceptive care should be available to women where they want it and at healthcare services women regularly engage with -– not rely on women to know where to present to access contraception beyond basic barrier methods
- Emergency Hormonal Contraception (EHC) should be reclassified to be available for general sale without the requirement of pharmacist involvement
- Provision must be funded not only on the basis of method but also including the clinical time and staff needed to prescribe and/or fit contraception
- A wider range of healthcare professionals should have contraception integrated into their training – enabling them to provide opportunistic care rather than relying on referrals

Contraception in abortion services

Background

bpas offers contraceptive counselling and contraceptive provision to all women we treat. A 2016 study of more than 200,000 women who had an abortion with bpas between 2011 and 2014[1] found that:

- 51% of women received their contraception of choice from bpas;
- 33% received contraceptive counselling from bpas but chose to obtain contraception from their GP or SRH clinic;
- 7% received counselling but already had contraception in place for post-TOP; and
- 8% declined counselling.

Of the women who received their contraceptive of choice from bpas, **51% opted for a LARC** (implant or IUC (hormonal and copper coil)). A further **12% opted for the contraceptive injection**.

Studies included in the Faculty of Sexual and Reproductive Healthcare's (FSRH) 2017 *Contraception After Pregnancy* guideline have found that there is a benefit to uptake and

[1] Aiken ARA, Lohr PA, Aiken CE, Forsyth T, Trussell J. Contraceptive method preferences and provision after termination of pregnancy: a population-based analysis of women obtaining care with the British Pregnancy Advisory Service. BJOG 2016; DOI: 10.1111/1471-0528.14413.

continued usage of LARC when it is provided at the time of abortion rather than with delayed referral back into community services. A study from Sweden and the UK found that for the implant, 0.8% of women who opted for immediate fitting had an unintended pregnancy within 6 months, compared to 3.8% who opted to receive theirs later. Three other studies found that ongoing use of IUCs at 6 months post-abortion was 1.4 times more likely in women who had them fitted immediately versus delaying fitting[2].

Current commissioning

Under current commissioning arrangements, bpas is able to fit most kinds of contraception around the country. However, this is reliant on the understanding of CCG commissioners that contraception should be provided as part of a Termination of Pregnancy (TOP) service.

In recent years we have encountered difficulties with some commissioners who have asserted that they would not fund LARC provision within the TOP service as women are able to access those services in local SRH clinics. There are also a number of areas where less widespread forms of hormonal contraception such as the patch or vaginal rings are not funded by default.

Fitting vs method

As an abortion provider we are funded for method of contraception but not for the staff and clinic time involved in counselling and fitting. This cost can be combined when women receive methods of contraception that can be provided at the same time as treatment, but means that we are unable to run a holistic service.

This is particularly an issue for women undergoing an Early Medical Abortion (EMA) where an IUC cannot be fitted until after they have passed their pregnancy – usually 2-3 days after their clinic appointment. In the 2016 study of bpas clients, while 31% of surgical patients opted for an IUC (fitted at the same times as the abortion procedure), only 5% of medical patients received an IUC.

The current funding arrangements mean that we must discharge women who want an IUC but who have opted for an EMA back into the community and force them to find another local service who can provide them with their contraceptive of choice. Although our nursing staff are keen to run dedicated post-TOP contraceptive clinics, which can include the removal and switching of methods that are found to be unsuitable by clients, the current funding arrangements make this impossible.

Given that 61.5% of all abortion procedures in England and Wales are now EMAs, this has a sizeable impact on the types of contraception abortion providers can offer under current arrangements.

bpas recommends that all TOP contracts should include the provision that CCGs will fund the full range of contraception, including staff time for the fitting and removal of LARC methods, regardless of TOP method.

Non-clinic settings

Offering contraception outside a clinic setting is essential to enabling women to access their contraception of choice. This is particularly true for groups of women who are least likely to

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[2] FSRH Guideline – Contraception After Pregnancy (2017) https://www.fsrh.org/documents/contraception-after-pregnancy-guideline-january-2017/contraception-after-pregnancy-guideline-final27feb.pdf

engage in the wider healthcare system – younger women, women from ethnic minority backgrounds particularly where cultural norms may not include contraception, and women where their engagement is focused on other health and support needs such as post-natally.

Providing a range of contraception at alternative sites mean that provision reaches out to women rather than waiting for them to either be able to present elsewhere.

Sources of contraception

Only 6% of women between the ages of 13 and 54 had at least one contact with an SRH service in 2017/18 – 70% of which were for non-contraceptive purposes. Women who already use LARC methods of contraception and who are between the ages of 18 and 24 are disproportionately represented in these figures. Proportions accessing these services also vary significantly between LA areas – with 17% of women accessing this care in Liverpool and St Helens and only 1% accessing care in Darlington, Barnsley, Wakefield, and Cumbria[3].

PHE data indicated that sizeable proportion of women are unhappy with how they currently access contraception[4]. Around 20% of women accessing IUDs/IUSs/implants from SRH clinics or GPs would have preferred to access elsewhere – a figure skewed towards SRH clinics where women may be expressing a desire to access care at their GP surgery which has experienced cuts to services.

More notably, about half of the 80% of women currently accessing the pill via a GP wanted to get it elsewhere – rising to about 2/3rds of women accessing the pill via SRH clinics. This proportion was uniform across all age groups.

Finally, 28% of women who were not using contraception and were at risk of unplanned pregnancy wanted to access care either online or via a pharmacy.

A recent study conducted by LSE also round there was a significant appetite among women for accessing their contraception in pharmacy settings.[5]

Telephone counselling

A 2018 paper of bpas clients who had opted to undergo contraceptive counselling examined the impact of offering counselling in a different form[6]. 31% of clients opted for telephone counselling, with this group more likely to be non-white and much more likely to report difficult obtaining contraception in the past (40% compared to 3% for the face-to-face group). A greater proportion using telephone counselling ended up receiving a LARC as their contraceptive of choice (54% compared to 43%).

Telephone counselling is thus an effective means of reaching women who may otherwise struggle to access contraception in traditional settings, but current contracts (including TOP contracts) do not provide for the funding of staff to run this service. Payment instead is based on treatment and provision figures, which means that establishing new services outside the existing infrastructure is not cost-effective.

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[3] SRHAD Report 2017 – 2018 https://files.digital.nhs.uk/3A/1D0442/srh-serv-eng-17-18-rep.pdf

[4] What do women say? – Reproductive Health is a Public Health Issue (2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731891/What_do_women_say_reproductive_health_is_a_public_health_issue.pdf

[5] http://www.lse.ac.uk/business-and-consultancy/consulting/assets/documents/Improving-Access-to-Contraception.pdf

[6] Lohr PA, Aiken ARA, Forsyth T*, et al*. Telephone or integrated contraception counselling before abortion: impact on method choice and receipt. *BMJ Sex Reprod Health* 2018;**44:**114-121

Pharmacy provision

Pharmacies are ideally placed to provide a wider array of contraception than they are currently able to. Pharmacists are qualified medical professionals who in recent years have become increasingly involved in primary care – from providing prescription drug reviews, to Patient Group Directions to provide immunisation and travel vaccinations, to dedicated clinics on topics like smoking cessation. Pharmacies already routinely provide Emergency Hormonal Contraception both via PGD and as an Over the Counter medication.

In Lambeth, Southwark, and Lewisham commissioning area, specialised pharmacies are from April 2019 being commissioned to provide emergency contraception, contraceptive counselling, and ongoing contraception without the need for referral (or referral to SRH services for eg. IUCD fitting). This means, for instance, that women would be able to attend a pharmacy for their first prescription of oral contraceptives.

The pilot of this scheme began in 2009 in limited scale and reported success in encouraging young women (about half of whom had never taken oral contraception before) to start using oral contraception. The indication is that this type of provision therefore engages with women who are not in contact with other parts of the health service and may have, otherwise, been at risk of unplanned pregnancy.

BPAS recommends that Local Authorities are encouraged to commission pharmacies via PGD to provide contraception. All pharmacists could provide oral contraceptives, or at a minimum, POP. More specialised pharmacists and pharmacies could be trained to provide contraceptive counselling and other methods up to and including the injection and the implant.

Emergency Hormonal Contraception

Emergency Hormonal Contraception (EHC) is provided from branches of healthcare including SRH clinics, GP surgeries, and pharmacies. It is currently licensed as a 'P' – meaning that it is kept behind the counter in pharmacies but can be bought without prescription (in the case of EHC, after a discussion with the pharmacist that is not clinically necessary).

In the past ten years, there has been a 32% fall in the monitored provision of EHC via SRH clinics, and a 44% fall in provision from GP surgeries and under PGD. This does not denote a decline in the use of EHC as women are now able to buy the medication over the counter in a way that is not captured in this data.

During 2017, BPAS ran a campaign to reduce the price of EHC which, despite being available as a generic for a couple of pounds, was being sold by most pharmacies for £25 or more. That campaign resulted in many pharmacies providing levonorgestrel (generic Levonelle) for around £15. Although progress, this is still around three times as much as the price for the same drug in France. Ulipristal acetate, another type of EHC, is not available in generic and continues to cost around £30 per dose.

Clinical position

According to the World Health Organisation, there are no clinical contraindications to the use of levonorgesterol (LNG-EC), no notable side-effects, and it can be used by all women. LNG-EC

can be used more than once in the same cycle and it cannot disrupt or harm a developing pregnancy. It poses no risk to future fertility.[7]

It provides effective protection against unwanted pregnancy, which can pose a significant risk to a woman's health and wellbeing. LNG-EC is significantly safer than many pharmaceutical products which are available to buy straight off the shelf.

The role of pharmacists

The current method of provision requires that women who present to a pharmacy looking to buy EHC speak to the pharmacist. A bpas mystery shopper study from 2018 found that in half of cases, a woman needed to ask at least 2 people before help could be offered. In only 6/23 cases did pharmacists inform the shopper that ulipristal acetate (EllaOne) was the more effective method of EHC.

Most notably, no pharmacy offered information about ongoing methods of contraception or STI testing, and where such help could be obtained, and no pharmacy informed the shopper that the IUD was the most effective method of emergency contraception or where it could be found.

Improving provision

In other countries women are allowed to buy LNG-EC directly from the shelf and ask for further information only if they need it. In the UK this has been resisted on the basis that the consultation provides an important opportunity to provide further information on other methods of contraception, STI testing, and answer other sexual health questions.

For clarity, bpas believes this information should be optional and provided at the woman's request, in the same way that anybody buying medications in a pharmacy can seek advice without it being mandated. However our mystery shop makes clear that this information is in any event not being provided.

One in six pregnancies is unplanned. Bpas does not believe EC is a silver bullet for these; however it remains a significantly underused resource. **We would like to see LNG-EC reclassified as a General Sales List product so it can be sold straight from the shelves of pharmacies without the need for a consultation, unless women request to speak to the pharmacist.**

This is also what women would prefer. Polling by bpas finds the majority of women would prefer the consultation to be optional (64% v 29%) and would prefer to be able to pick the product up directly from the shelf (58% v 35%). We believe that the failure to remove obstacles in the way of women's access to EC can deny individual women the opportunity to avoid a pregnancy she has not planned and which can place her health and wellbeing at risk.

Workforce and training

Although the bulk of the frontline bpas workforce are nurse or midwife practitioners, bpas staff are not generally part of the specialised contraceptive workforce. Because contraceptive counselling and LARC fitting are not compulsory aspects of nurse and midwife training, it is therefore unusual for us to hire a member of staff we do not need to train to provide contraceptive services.

We are currently working with the Faculty of Sexual and Reproductive Healthcare (FSRH) to

[7] https://www.who.int/news-room/fact-sheets/detail/emergency-contraception

train frontline nursing and midwifery staff to provide LARC including both implant and IUS/IUD. This is especially important given the number of women who opt for an Early Medical Abortion which means they generally are not treated face-to-face by a doctor.

Postpartum contraception

This lack of core training is also an issue in other aspects of healthcare which are primarily nurse- or midwife-led such as postpartum services. A qualitative study of midwives' experiences and views of giving postpartum contraceptive advice, published in 2014, found that while all discussed the return of fertility, most found it a job of lesser importance which they felt inadequately trained for. In this study, no midwife made a firm contraceptive plan with women, the only plan being that they should see another healthcare professional to obtain further information and advice.

Anecdotally, many women report contraceptive counselling being part of the 6-week postpartum check with the midwife, but that subsequent accessing of their chosen contraception has no firm pathways to care. Moreover, fertility can return within a month of childbirth. A bpas survey found a quarter of new mothers (23%) start having sex again by 6 weeks after having a baby, and therefore will need access to contraception before the 6-week postnatal check. Less than a quarter of mothers said they found it "easy" to get their chosen contraceptive. There are several effective contraceptive methods which can be used while exclusively or partially breastfeeding, including the mini-pill, coil and implant and emergency contraception (the Levonelle morning-after-pill). However knowledge about the safety of these methods is poor, with most mothers believing only condoms can safely be used.[8]

Bpas believe that contraceptive counselling, provision, and LARC fitting should be a core part of the nursing and midwifery curriculums to enable a wider range of services to not only counsel women on contraception but provide them with their chosen method.

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[8] https://www.bpas.org/media/1187/sex-and-contraception-after-childbirth.pdf