Irish Family Planning Association

Submission to the Working Group on Access to Contraception, August 2019

Executive Summary

Access to a choice of contraceptive methods is critical to gender equality, to women's ability to plan the number and spacing of any children they choose to have, and to their participation in education, employment and public service, including voluntary work and politics. It is central to the achievement of the right health and it is key to reducing the rate of unintended pregnancy, sexually transmitted infections and ensuring that as far as possible, women and girls have the means to prevent unintended pregnancy and the need for abortion care.

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so. Contraception is intrinsic to such freedom and choice.

The Irish Family Planning Association (IFPA) supports the establishment of a scheme to provide universal access to all methods of contraception without cost to the individual. Such a programme would enable people to choose the contraceptive most appropriate to their needs and preferences and to switch contraceptive method as and when their circumstances change throughout their reproductive lives.

From the time of its inception when the law banned all forms of contraception, the IFPA has worked and advocated for women's and couple's access to the means to avoid the risk of unintended pregnancy and to have access to care in cases of pregnancies that are unintended or become a crisis.

As a provider of abortion care and pregnancy counselling, we are acutely aware that many unintended pregnancies arise from poor or inadequate information and misinformation about reproduction and contraception, due to inadequate local access to services or because cost barriers force women who wish to avoid pregnancy to use unreliable methods or no methods of contraception.

We welcome the establishment of the Department of Health Working Group on Access to Contraception. It is appropriate that this consideration of universal access to contraception is taking place in the year that the international community marks 25 years since the International Conference on Population and Development (ICPD) which introduced the concepts of sexual and reproductive health and reproductive rights. The ICPD Programme of Action underpins the Agenda 2030 and the Sustainable Development Goals (SDGs) of the United Nations, adopted in 2015. The SDGs include targets related to access to universal reproductive health, including family planning, information and education, and to sexual and reproductive health and reproductive rights.

ICPD+25 will culminate in the Nairobi Summit, a major global gathering aimed at renewing and reinvigorating the global commitment to the "full and accelerated" implementation of the ICPD Programme of Action, within the overall context of Agenda 2030 and the SDGs, to ensure that no one is left behind.

In the year following the repeal of the 8th amendment, it would be appropriate to use the opportunity of the Nairobi Summit to show that Ireland takes its commitment to gender equality and to sexual and reproductive rights seriously by removing all costs barriers to access to all forms of contraception.

Recommendations

- Cost must be fully removed as a barrier to accessing all modern methods of contraception. State-funded contraception must include all barrier methods, short-acting hormonal methods, long-acting reversible contraceptives, emergency methods and permanent methods so that individuals can choose the contraceptive that best meets their needs and preferences. Such an approach will also result in considerable cost-saving as women switch to methods that are currently unaffordable as out-of-pocket expenses (although less costly over time).
- Provider training and capacity building must be prioritised so that women can avail of comprehensive contraceptive counselling and can access providers of all methods. Measures must be introduced to ensure that healthcare providers, in particular those who provide abortion care, are adequately trained, resourced and supported to deliver comprehensive contraceptive care and information.
- Access to post-abortion contraception must be a priority and regional disparities in the provision of abortion care should be addressed.
- Specific measures must be introduced to address the contraceptive needs of vulnerable and underserved populations: young people, refugees, asylum-seekers, and migrants, people with disabilities, Travellers and other marginalised groups.
- The relationships and sexuality education curriculum must be revised to ensure young people receive accurate, evidence-based information about contraception and how to access sexual and reproductive health services.
- Proposals to improve access to contraception must be designed to fulfil the essential elements of the right to health: availability, accessibility, acceptability and quality; and that the human rights principles of non-discrimination and informed decision-making are incorporated into government policy on contraception. Women and girls must have access to information and services that provide meaningful choice and can choose the most acceptable and effective method for their circumstances.

- Policy reform in the area of contraception must involve the removal of barriers, including legal restrictions, poor access to information about contraception, regional disparities in the quality and availability of services, gaps in provider training and capacity, stigma and lack of confidentiality.

Format

This submission is structured in line with the Department of Health public consultation questionnaire and provides information on the following topics:

- Important factors informing the development of a scheme to increase access to contraception
- Benefits and challenges of providing such a scheme
- Paying for contraception
- Barriers to contraception
- Ensuring patient safety and high quality care

Note on section 17

In section 17 (Additional Comments), we include a summary table giving an analysis of LARC & SARC cost-effectiveness, comparing the out-of-pocket costs to women of different methods based on 1, 5, and 10 year use of that method.

We also include an overview of contraceptive methods.

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Q.1 About the Irish Family Planning Association

The Irish Family Planning Association (IFPA) submits these remarks on the basis of our 50 years' experience as a provider of contraceptive and other sexual and reproductive health services. Since 1969, the IFPA has worked to promote and protect basic human rights in relation to sexual and reproductive health, relationships and sexuality. The IFPA's vision is for an Irish society where all people can enjoy a fulfilling sex life and can make informed choices in their sexual and reproductive lives; where there is full access to high quality information, education and health services regarding sex, sexuality, conception, contraception, safe abortion and sexually transmitted infections.

The IFPA provides quality reproductive healthcare at its two medical clinics in Dublin and ten counselling centres across Ireland. Our services include non-directive pregnancy counselling, family planning, contraceptive services and early medical abortion. In 2018 the IFPA provided a total of 13,027 appointments, of which 5,162 were contraceptive services.

The IFPA also provides educational services, including medical training and sexuality education. This includes: an annual contraception foundation course for nurses and midwives, which is approved by the Nursing and Midwifery Board of Ireland; peer-to-peer training in long acting reversible contraception training for doctors; and relationships and sexuality education (RSE) workshops in secondary schools.

The IFPA maintains professional relationships with and draws upon the experience and evidence base of international standard-setting bodies, such as the World Health Organisation (WHO), the International Federation of Gynecology and Obstetrics (FIGO) and the Royal College of Obstetricians and Gynaecologists (RCOG). The IFPA is an accredited member association of the International Planned Parenthood Federation (IPPF); and is the Irish collaborating partner of the UN's agency for sexual and reproductive health, UNFPA. The IFPA maintains membership of FIAPAC (the International Federation of Professional Abortion and Contraception Associates), the European Society for Contraception and Reproductive Health and the Irish Association of Sexual and Reproductive Healthcare Providers. The IFPA is the Secretariat to the All Party Oireachtas Interest Group on Sexual and Reproductive Health and Rights.

Q2. Important factors informing the development of a scheme to increase access to contraception

1. Meeting different needs
2. Ensuring equal access to all
3. The cost to individuals
4. How effective each method of contraception is
5. Meeting different preferences
6. The cost to the state

When designing a scheme for contraception access, all of these factors must be taken into account because they are interrelated and interdependent. We set out below the importance of each of these factors and highlight additional factors which should inform the development of any contraceptive scheme.

Q.3 What are the factors you think might be important?

1. Meeting different needs

Meeting different needs should be a priority. It is imperative for the state to offer a wide variety of contraceptive options, as each woman's medical history and risk factors are unique, so not every contraceptive will work for everyone and the same contraception won't suit every woman throughout her life course. Contraception can have health risks and benefits, and it is important that all methods are available so that each individual can choose the contraceptive that best meets their needs, in consultation with their doctor.

2. Ensuring equal access to all

Ensuring equal access to all should be a guiding principle: this will require a range of interventions to ensure equal access to all in practice, in particular to ensure that marginalised or vulnerable groups are appropriately supported to access information and services. We know from domestic and international evidence that vulnerable groups, such as adolescents, women with disabilities and women from ethnic minorities, experience additional barriers to accessing healthcare, including reproductive healthcare.[1] Therefore in addition to a universal scheme, tailored interventions will also be required to ensure that particular cohorts receive accurate information about all contraceptive methods and are supported to access the method of their choice.

3. Cost to individuals

Long-lasting contraceptives include the implant, the hormonal intrauterine system (IUS) and the intrauterine copper device (IUCD), also known as the copper coil. Long-acting methods can reduce the risk of unintended pregnancy to virtually zero: the IUD, IUS and the implant are over 99 percent effective.

However, many women who have an informed preference for one of the most effective and long-lasting methods are currently impeded by cost barriers. Even though long-acting methods are more cost-effective over the total time that the implant or coil is in place, many women cannot afford them because the payment must be made up-front, resulting in the use of a less effective method. Women have presented to IFPA clinics during this "saving up" time with pregnancies that could have been avoided had they been able to use their chosen more effective method. It is unacceptable that women in this situation make a considered choice to avoid pregnancy, but are prevented from implementing that choice.

4. Effectiveness of methods

Although the oral contraceptive pill and condoms remain the most commonly used methods in Ireland, international research has identified effectiveness as a priority for women when choosing a contraceptive method, underscoring the importance of ensuring individuals receive

clear and accurate information about all contraceptive options, including typical use failure rates.[2]

Long-acting methods, like the IUD, IUS and the implant, are over 99 percent effective at preventing pregnancy once inserted, with less than one percent of women experiencing an unintended pregnancy in the first year of use. The injection is also over 99 percent effective if used perfectly (i.e. always using the injection exactly as instructed, not missing or delaying injections), but has a 6 percent failure rate (unintended pregnancy) with typical use.[3] Conversely, despite being much more commonly used, other contraceptive methods such as the pill, patch, and vaginal ring are much less effective than the longer-acting intrauterine or implant methods, at 9 percent failure rates with typical use.[4] A 2012 study in the New England Journal of Medicine found that individuals using oral contraceptive pills, the transdermal patch, or vaginal ring had a 20 times higher risk of contraceptive failure than those using methods such as coils or implants.[5]

Other popular methods, such as male condoms, have an 18 percent failure rate with typical use, or the withdrawal method which has a 22 percent failure rate with typical use.[6] This means that about 18 out of 100 people who use male condoms as their only contraceptive method, or 9 out of 100 people who use the pill, will experience an unintended pregnancy each year.[7] Fertility awareness methods are even less effective with typical use, with 24 percent failure rates. Individuals who opt for no method of contraception have an 85 percent likelihood of unintended pregnancy over the course of a year.

Women should not be impeded from accessing the most effective methods of contraception (coils and implants) due to cost or other barriers.

5. Meeting different preferences

In 2015, the IFPA carried out an audit of client preferences with regard to contraception. When offered comprehensive counselling and information that empowered women to make the right choice for them, 39% chose a long-acting reversible method.[8] In addition to meeting health needs, meeting different preferences is also very important to any contraception scheme. If an individual is to use a particular method for a significant part of their life, it is crucial that they find this method acceptable; otherwise uptake and continuation will not follow. A 2018 HSE report highlights that inconsistent use of contraception remains a factor in a significant proportion of crisis pregnancies, and it is of particular concern therefore that the same report states that consistent use of contraception appears to be falling in the population.[9] Research suggests that the social determinants of health influence the consistency of contraceptive use: US studies have found that those with fewer resources tend to use contraception inconsistently.[10] Needs may vary throughout the reproductive life-course, and individuals have different desires depending on their personal and family context. Some women discontinue contraceptive use even though they want to avoid pregnancy. Reasons for discontinuation include side effects, myths, contraceptive failure, or the service environment, including service quality and availability of a sufficient choice of methods.[11] World Health Organisation (WHO) research indicates that broadening contraceptive choice can reduce contraceptive discontinuation by 8%.[12]

Long-acting reversible contraceptive methods (LARCs), such as intrauterine devices, intrauterine systems and implants are “fit and forget” methods and thus more convenient than pills, which require daily ingestion to be effective, the patch which requires weekly application

or the ring, which requires monthly replacement. These long-acting methods are also flexible due to their reversible nature: an IUD, IUS, or implant can be removed at any time, restoring fertility or allowing a switch to an alternative method; the injection lasts three months and then can be discontinued or re-administered. An individual's needs and preferences for contraception vary across their reproductive life cycle and are influenced by their personal circumstances. Some individuals may prefer the "fit and forget" method, while others may prefer a shorter-term option like the pill, patch, or ring.

6. Cost to the State

Among younger women, ages 15 to 29, who often have lower rates of contraceptive adherence, studies from Norway and Canada show that over 80 percent of unintended pregnancy costs were due to imperfect contraceptive adherence. These studies also found that cost savings from women switching from a short-acting contraceptive to a long-acting method such as the IUD, IUS, or implant are realised in between 12 and 16 months.[13, 14] A systematic review from Australia which examined 20 international studies on LARC cost-effectiveness in 2019 found that LARCs have lower costs and higher effectiveness than oral contraceptives.[15] Subsidisation of contraceptive services also reduces overall public spending by decreasing the costs associated with unintended pregnancies, such as the cost of abortion care.[16, 17, 18]

Additional factors

Any scheme to increase access to contraception should be designed to fulfil the essential elements of the right to health: availability, accessibility, acceptability and quality. The human rights principles of non-discrimination, informed decision-making, privacy and confidentiality, participation and accountability must also be incorporated into government policy on contraception. These are fundamental to women's autonomy; they also support good uptake and continuation of contraceptive methods.

The extent to which such a scheme could potentially enhance individual wellbeing by supporting people to have satisfying sex lives and experience non-contraceptive benefits such as improved menstrual health, work and family life, should also be taken into account.

In the section on barriers below, we provide more information on key issues which must be addressed as part of any reforms to contraception access. Briefly, additional factors to include in the development of any scheme are: local access to services; legal barriers to young people's access to services; access to information and comprehensive sexuality education; healthcare provider training and education; and the social determinants of health.

Q.4 Benefits of providing a scheme to increase access to contraception

There are a range of benefits for both individuals and the state of providing universal access to all methods of contraception and by removing all associated access barriers:

- Enable informed decision-making
- Improve sexual wellbeing
- Improve physical and mental wellbeing and quality of life

- Improve public health
- Broader societal benefits

Enable informed decision-making

A universal access scheme would enable informed decision-making and remove the barriers to accessing the contraceptive method best suited to the individuals' needs and preferences. It would allow individuals and couples to plan the number and spacing of any children they may wish to have in line with their education, work and other life plans.

The UK's National Institute for Health and Care Excellence (NICE) guidelines state that women seeking contraception should be given information about and offered a choice of all methods, including long-acting methods. And women should be provided with the form of contraception that is most acceptable to them, unless contraindicated.[19]

There is much evidence for the effectiveness of comprehensive information in supporting meaningful choice in relation to contraceptive methods. The Contraceptive CHOICE Project in the US—a large prospective cohort study of 10,000 women aged 14-45 years who wanted to avoid pregnancy for at least one year—provided education about reversible contraception and long-acting reversible options, and offered all methods of contraception at no cost. When access, cost, and information barriers were removed, seven out of 10 young women chose a LARC (IUD, IUS, or implant) over other contraceptive options. CHOICE participants, including those who received LARCs, the pill, the patch, or the ring, had 4 to 5 times lower rates of teenage pregnancy, births, and abortions, as compared to sexually active teens in their age range.[20]

Improve sexual wellbeing

Ensuring women can control their fertility supports them to live healthy sexual and reproductive lives. A universal access scheme would improve sexual wellbeing by enabling individuals to enjoy a satisfying sex life through removing fear and anxiety related to unintended pregnancy.[21] Such a benefit would contribute to the realisation of the vision set out in the National Sexual Health Strategy that "everyone in Ireland experiences positive sexual health and wellbeing". [22]

Improve physical and mental wellbeing and quality of life

Each woman's medical history and risk factors are unique and not every contraceptive will work for everyone and the same contraception will not suit every woman throughout her life course. For example, the commonly prescribed combined oral contraceptive pill ("the pill") is not recommended for women who are obese, smokers over age 35, or with migraines, due to risk of blood clots or stroke. Ensuring informed choice and equitable access to all forms of contraception, therefore, is critical to women's wellbeing and quality of life.

Women may also experience improved wellbeing and quality of life through non-contraceptive benefits of access to contraception, which can be used to treat disorders such as acne, polycystic ovary syndrome and endometriosis.[23,24] Contraception reduces the risk of developing certain reproductive cancers and can be used to treat menstruation-related symptoms and disorders, such as heavy menstrual bleeding, irregular menstrual cycles.

Menstruation can have a physical, mental, and financial toll for women. Women may suffer from heavy bleeding, cramping, or other period symptoms which impede their quality of life

and may cause them to miss work or school. In addition to covering most contraceptive costs, women also bear the costs of period products, such as tampons and pads, which can be a costly, but essential, expense.[25] The reduced or lack of bleeding and cramping with the hormonal IUS can also lead to a more productive and comfortable lifestyle, without the need to miss work or important events due to heavy cramping/bleeding.[26]

The hormonal IUS has been shown to reduce menstrual bleeding, with the Mirena being most effective, reducing bleeding by up to 92 percent. Conversely, the copper IUD may increase bleeding and period symptoms, but some women prefer it since it does not contain any hormones and can last up to 10 years.[27]

Studies have also shown that long-acting reversible contraceptives (LARCs) in particular are highly acceptable to women as a quality method of contraception: LARCs have high satisfaction rates and higher continuation rates than other contraceptive methods for adult women.[28]

A universal access scheme is therefore in line with the government's vision for a Healthy Ireland wherein "everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility".[29] Advancing the health and wellbeing of women and girls is also a key objective of the National Women's Strategy.[30]

Improve public health

Universal access to contraception would improve public health through a reduction in the number of unintended pregnancies and sexually transmitted infections (STIs), the associated anxiety and stress these events may cause to the individual as well as the costs to the State of associated health services, including STI screening and treatment, pregnancy counselling, abortion care and maternity care.

Broader societal benefits

Irish society will benefit through the empowerment of women to participate more fully in public life, including in their communities and in local and national politics. Early and subsequent pregnancies due to an inability to afford or otherwise access contraception can trap individuals in poverty, limiting their ability to engage with education and the labour market, thereby restricting them from reaching their full potential. There is an opportunity cost to both the individual and to society of cutting off the education and work force potential of a cohort of young women who could otherwise make a valuable contribution to Irish society.

Q.5 Challenges of provision of universal access to contraception

The development and rollout of any healthcare intervention is by its nature complex and presents challenges. And addressing availability of contraception alone is not sufficient to ensure uptake of the most effective methods. The challenges we identify relate principally to the removal of existing barriers in order to:

- Ensure equitable access to quality contraceptive information and services across the country;

- Reach marginalised or vulnerable groups, including adolescents, asylum-seeking and undocumented women, sex workers, Travellers, women in prison, women with disabilities, migrant women, women living in poverty and homelessness and members of the LGBTI+ community;
- Ensure healthcare providers are appropriately resourced and supported to deliver the service;
- Ensure policy and services are youth-friendly, including through the removal of legal barriers.

All these challenges can be addressed if the scheme is designed and delivered in a manner that meets human rights standards. Proposals to improve access to contraception should be designed to fulfil the essential elements of the right to health: availability, accessibility, acceptability and quality. The human rights principles of non-discrimination, informed decision-making, privacy and confidentiality, participation and accountability must also be incorporated into government policy on contraception. These are fundamental to women's autonomy; they also support good uptake and continuation of contraceptive methods.

Qs. 6 – 8 Paying for contraception

The IFPA supports a scheme which would remove cost as a barrier to accessing contraceptive services and supplies for all individuals who wish to avail of contraception. This includes: barrier methods (male and female condoms; diaphragm); short-acting hormonal methods (contraceptive pill, vaginal ring, contraceptive patch); long-acting reversible contraceptives (copper coil, hormonal coil, implant, contraceptive injection); emergency methods (emergency contraceptive pill, copper coil); and permanent methods (vasectomy, tubal occlusion).

As a society, we do not ask people to self-finance or co-pay for important preventive care, such as childhood vaccines or cervical cancer screening, because we do not want them to delay accessing the service. Contraception is a public health intervention for which widespread uptake is important to reduce unintended pregnancies and STIs, therefore the removal of cost barriers is key – otherwise, people will delay accessing services due to other factors. Contraception is costly, and LARCs in particular incur a high out-of-pocket cost. When people defer accessing modern methods of contraception because of the burden of other expenses, such as mortgage payments, school costs etc., the gaps in contraceptive use can increase the risk of unintended pregnancy and STIs.

Provision of the full range of methods, including long acting reversible contraceptives costs less than the provision of short-acting methods alone. And evidence suggests that the overall cost to the state will fall year on year as women and girls switch to more reliable and cost-effective methods. If reforms to contraception access remove cost barriers to short-acting methods only, or only removes cost from methods that can be provided over-the-counter, the state risks incentivising women towards contraceptive methods that are less effective at preventing unintended pregnancy, and reducing the likelihood of women switching from less to more reliable methods. In other words, the state would be defeating the purpose of the policy and doing so at a higher cost than if all methods were included.

Cost comparison of long acting and short acting methods

Long acting reversible methods are not only more effective in preventing unintended pregnancy, they are more cost-effective over the typical 3 to 5 years of use. It is beyond the scope of this submission to calculate the total cost of universal coverage of contraception to the state. However, a comparison of the out-of-pocket costs to individuals of various forms of contraception offers an indication analysis of the relative costs of different approaches to state coverage. (See Table p.22: Analysis of LARC & SARC cost-effectiveness: out-of-pocket costs to women of different methods based on 1, 5, and 10 year use.)

Condoms can cost €69 over 12 months. A year's use of the pill, including two GP visits, can cost €191. The ring and patch each cost around €350 per year, including GP visits and insertion costs. Including consultation, insertion and the device itself, the hormonal IUS costs between €67 per year and €149, depending on the system. The implant's cost averages at €110 per year, while the cost of the copper coil spread averages at €49 per year over 5 years (and just €24.50 over 10 years).

The annual cost of the IUD, IUS and implant, therefore, averaged over 5 years, range from €49 to €150 per year, lower than any of the shorter-term contraceptive options or the injection. The only contraceptives with costs equivalent to the LARC options are the male condom and diaphragm, but with failure rates between 12 to 18 percent with typical use, these barrier methods are not as cost-effective for unintended pregnancy prevention.

The findings of this cost comparison are echoed in international studies. A white paper on contraception access published by the European Parliamentary Forum for Sexual & Reproductive Rights, which emphasises that "with budgetary constraints, LARCs are not only the most effective contraceptive option, but also the most cost-effective for the health system."[31] The UK National Institute for Health and Care Excellence (NICE) guidelines state that all currently available LARC methods (intrauterine devices, intrauterine systems, injectable contraceptives and implants) are more cost-effective than the combined oral contraceptive pill, even at one year of use. And amongst the long-acting methods, the guidance confirms that IUDs, IUSs and implants are more cost-effective than injectable contraceptives.[32]

Qs. 9 – 10 Barriers to accessing contraception

While all modern methods of contraception are currently available in Ireland, there are numerous barriers that may impede access and uptake. The main barriers, outlined below, include:

- Barriers related to social determinants of health
- Cost to women of contraceptive services and supplies
- Access to services
- Provider training and capacity
- Legal inconsistencies in relation to youth access
- Misinformation and lack of comprehensive sexuality and contraception information.

Of the respondents in the 2010 Irish Contraception and Crisis Pregnancy Study (ICCP-2010),[33] 11 percent experienced difficulty accessing contraception, and more women and men reported experiencing some level of difficulty accessing contraception (15% and 9% respectively) than in ICCP-2003 (4% of women and 6% of men). These findings illustrate that the barriers to accessing contraception have increased over time in Ireland. And, the burden of contraception access mainly falls to women, who most acutely deal with the consequences of unintended pregnancy, the barriers to contraception access are higher for Irish women than men.[34]

According to ICCP-2010, approximately one-third of women and one-fifth of men with experience of pregnancy reported a crisis pregnancy:

- Young adults aged 18 to 25 years and those who have first sex before the age of 17 years are most at risk.
- Half of self-reported crisis pregnancies are associated with contraceptive failure.
- Half of self-reported crisis pregnancies are associated with non-use of contraception.
- Half of those failing to use contraception were unaware of the risk of pregnancy at that time.[35]

1. Barriers related to social determinants of health

Barriers to contraception access may be magnified for those from marginalised or underserved populations. Inequities in sexual and reproductive health stem not just from gaps in healthcare services, but from the social determinants of health. The societal conditions in which people are born into, live, work, and grow old profoundly influence health outcomes.[36] As the United Nations Population Fund (UNFPA) asserts, "sexual and reproductive health inequalities are deeply affected by income inequality, the quality and reach of health systems, laws and policies, social and cultural norms, and people's exposure to sexuality education."[37]

Policy considerations

Social determinants, such as political systems, government policies, gender inequalities, and social norms, can limit the choices that individuals have to meet their sexual and reproductive health needs.[38] And, inequitable access to contraception often mirrors the social inequalities and power imbalances present within a society.[39] Therefore, policymakers must consider the wide range of social determinants when looking at potential solutions to improve contraceptive access in Ireland.

2. Cost to women of accessing contraception

Cost is a major barrier to contraceptive access in Ireland. About one-third of people living in Ireland can access medical care and receive prescription drugs, including contraceptives (with the exception of the copper IUD and condoms), via the medical card scheme (GMS). An additional 10% have GP visit cards meaning they do not have to pay for doctor visits but must still cover the cost of contraceptive supplies. For the rest of the population, contraceptive services and supplies are an out-of-pocket expense which can be costly. Of those who reported experiencing difficulty accessing contraception in the 2010 Irish Contraception and Crisis Pregnancy Study (ICCP-2010), 24 percent of adults cited cost as a main barrier to contraceptive access. This is an increase from 17 percent who cited cost barriers in ICCP-2003. According to ICCP-2010, condoms and the oral contraceptive pill are the most commonly used contraceptives in Ireland, with 62% and 43% usage rates respectively. While available in pharmacies, condoms are not covered under medical or GP visit cards and cost

can be a barrier to young people and those with lower incomes; for example 1 in 10 young men surveyed by ICCP-2010 reported that cost had prevented them from using condoms.[40] And, condoms are much less effective at preventing unintended pregnancy in comparison to both long- and short-acting methods.

According to a 2015 study, LARC usage may predominate in those with lowest incomes who do qualify for GMS and those with higher incomes in, where the initial higher cost is not a barrier.[41] Compared with users of LARCs, users of the pill were significantly younger, less likely to be married, less likely to be in receipt of GMS and were more likely to report difficulty both in affording and in accessing contraception/services in their locality. Users of LARCS were significantly older, more likely to be married, less likely to have third level education and more likely to be in receipt of GMS. Injections or subdermal contraceptive implants users were more likely to be significantly younger, more likely to be unmarried and more likely to be in receipt of GMS.

A 2019 study highlighted that barriers to the relatively low uptake of LARCs in Australia has been associated with factors including the lack of suitable training for LARC insertion and the high upfront costs of LARCs compared with the oral contraceptive pill, which is subsidised by the Australian government.[42]

While LARCs are highly-effective and can last years before needing to be replaced, the initial cost outlay for a coil or an implant is particularly onerous. The device alone can cost upwards of €125. Combined with the fee for the initial consultation with a doctor and the subsequent appointment to insert the device, a woman may be faced with an outlay of several hundred euro if she does not have a medical card or GP visit card. Among those using contraception, LARC usage in Ireland has risen to 11 percent as of 2010 (latest year data is available). LARC usage amongst young people (aged 18 to 25) is lower still, at only 4 percent.[43] More up-to-date data on sexual and reproductive health in Ireland is needed.

Policy considerations

Despite the high initial cost for the device, the projected five-year and ten-year costs to the individual woman of three main LARCs – the IUD, IUS, and implant – are lower than any of the shorter-term contraceptive options or the injection. And at an effectiveness rate of greater than 99 percent, each long-acting option is much more effective than the pill, patch, ring, or injections at preventing unintended pregnancy.

The only contraceptives with costs equivalent to the LARC options are the male condom and diaphragm, but with failure rates between 12 to 18 percent with typical use, these barrier methods are not as cost-effective for unintended pregnancy prevention. Condoms remain a vital component of overall sexual and reproductive healthcare as a public health measure to support STI prevention.

In addition to the cost of the contraceptives themselves, the price of a GP or family planning consultation can be a barrier to contraceptive access, with non-medical holders paying out-of-pocket costs to see a provider for prescription refills or fitting a long-acting contraceptive. In ICCP-2010, 18 percent of adults cited the cost of a GP consultation as a frequent barrier to seeking care. And, 27 percent of Irish women reported that the high cost of LARCs, including the consultation/insertion fee, prevented them from choosing a long-acting method.[44]

Government reimbursement schemes must extend to all persons of reproductive age and ensure that the most effective contraceptives – and the provider fees to obtain them – are adequately covered.

It is critical that women who have made a considered decision to use a long-acting reversible method are not forced to continue a less effective or unreliable method for a few more months until they have saved the money for their chosen method. Nor should they be actively incentivised by state coverage of only a limited range of methods to opt for one of the less effective methods.

3. Access to services

In addition to cost, individuals can encounter other barriers when trying to access contraceptive care, such as regional disparities in the quality and availability of services, stigma and lack of confidentiality.[45] The low level of provision of abortion care in a number of counties is of concern: if women have to travel to another county or one of the major cities to access abortion care, they are less likely to return to avail of post-abortion contraception, without provision of which, women may remain vulnerable to further unintended pregnancy.

According to the ICCP-2010, of the 11 percent of Irish people who noted difficulty in accessing contraception, lack of access to contraceptive services in their locality was the top reason for 42 percent of respondents, followed by cost (24 percent), embarrassment or stigma (23 percent), and lack of information on where to access services (7 percent). In terms of access to contraceptives by locality, there was no significant difference for those living in rural or urban areas, meaning that access barriers can occur anywhere. Stigma and embarrassment in accessing contraception was more common among young adults in Ireland than older adults. The issues of local access and stigma may be compounding factors, as someone with access to only specific contraceptive services in their area (e.g. a family General Practitioner) may feel embarrassed about accessing these services due to privacy or confidentiality concerns.[46] These findings echoed earlier results from the 2008 Irish Study of Sexual Health and Relationships Sub-Report 2: Sexual Health Challenges and Related Service Provision.[47]

Policy considerations

The IFPA knows from our services that marginalised groups face additional barriers to those identified above. For example, we know that some women and couples living in direct provision who wish to limit their family size, often in the interests of the wellbeing of their children, have been unable to do so. Having access to contraceptive methods at a location and time that meets the needs of women is vital to minimising the risks and consequences of unintended pregnancies. It is crucial that women living in direct provision have a choice of healthcare provider, including access to a female healthcare provider. For some women, receiving sexual and reproductive healthcare from a man will be culturally inappropriate and may deter women from seeking care. Women may be reluctant to express problems, ask questions or consent to physical examinations such as insertion of a coil with a male healthcare provider.

Healthcare providers, including pharmacies, are entitled under law to refuse to provide contraceptive care in their practice on the basis of conscience, i.e. personal beliefs. There is no publically available register of objectors. In addition, public availability of permanent methods of contraception (i.e. tubal occlusion and vasectomy) is poor, due to both the religious

ethos of some hospitals and the low priority the procedure is afforded compared with urgent care cases.

4. Provider training and education

Providers need practical training on how to effectively deliver contraceptive counselling, LARCs need to be readily available in the clinic setting, and contraception must be affordable for patients. There is currently no resourcing for LARC training in Ireland and this limits the amount of providers willing and able to provide the full range of contraceptive services.

While contraception training is provided in hospital settings, GP training is quite unstructured. Currently, GPs and trainee GPs can obtain education and training on LARC placement, removal, and care from other GPs who are registered LARC trainers. However, these doctors do not receive reimbursement for delivering this training, although they must pay a fee to register as a LARC trainer. Once trained, a GP working in a centre where few women present for LARC fittings will find it difficult to acquire and maintain LARC skills in practice. Some GP practices have established referral pathways to experienced providers of LARCs, but others do not, meaning that access to LARCs is patchy and inconsistent across the country.[48]

The above issues are compounded by the fact that sexual and reproductive health is not recognised as a speciality on the Medical Register. On a very practical level, this means it is not possible for non-LARC providers to look up specialist sexual and reproductive healthcare providers on the register and establish referral pathways accordingly. The absence of speciality recognition means sexual and reproductive health has no recognised and resourced training programme and can also mean that it is afforded a lower status than other areas of healthcare.

Policy considerations

Sexual and reproductive healthcare should be given recognition as a speciality on the Medical Register. Healthcare providers need specialised and ongoing education to incorporate sexual and reproductive health services, including contraception, into their practices. There are many considerations to take into account when counselling an individual on their contraceptive options and helping them choose the best method based on their medical history, needs, and preferences. Providers should be trained on all currently available contraception methods in Ireland, so that they can effectively counsel patients and either provide or refer them to the contraceptive care that they need.

Provider education and the knowledge and willingness to provide contraceptive counselling are integral for increasing contraceptive access, but a systematic approach that addresses cost, east of access, and both patient and provider knowledge gaps is essential for improving contraceptive uptake and reducing unintended pregnancies. A study of US contraceptive care delivery found that the introduction of contraceptive counselling to usual care was not nearly as effective for lowering unintended pregnancy rates as when the contraceptive care included healthcare provider training and immediate availability and cost support for LARCs, in addition to contraceptive counselling. Participants in this “Contraceptive CHOICE” model of care had a 40 percent lower risk of unintended pregnancy within the year, as compared to individuals receiving just contraceptive counselling.[49]

5. Legal inconsistencies in relation to youth access

The National Consent Policy states that it is only in “exceptional circumstances” that a young person under 16 will be able to consent to medical treatment, including contraceptive care, without the involvement of their parents.[50] In 2016, the HSE and Tusla published a report about the sexual health and sexuality education needs of young people in care.[51] A major concern expressed by service providers working with these young people was the absence of clear local and national guidelines about how to approach both sexuality education and the delivery of sexual healthcare, such as providing contraception, to those under the age of 17. They expressed uncertainty about the legal situation and argued that it caused problems with respect to trust and confidentiality.

The IFPA is aware of cases where young people are refused sexual health treatment by medical professionals. We are also aware that other young people choose to avoid sexual health services altogether, and risk unintended pregnancies and STIs, rather than consult with their parents on contraception and sexual health services. Those young people who do avail of sexual health services do so under threat of being reported to their parents or the Gardaí. Doctors who provide sexual health services do so in a legal vacuum risking legal action by parents or guardians.

Policy considerations

Rather than being "exceptional" for a young person to be sexually active and not want to inform their parents, it is the IFPA's experience that a young person taking responsibility for their own sexual health is a relatively frequent occurrence. Lack of clarity on this point could result in unnecessary barriers to young people accessing sexual health services.

The ambiguity in the law relating to young people and access to contraception may sway a doctor in the direction of not providing contraceptive services to young women under the age of sexual consent for fear of prosecution**.** Or, doctors violating principles of confidentiality, may contact the parents of the young person against their express wishes. Young people may be deterred from attending a doctor for contraception because of fear of the doctor reporting consensual sexual relationships between young people under 17 to the Gardaí as a potential criminal act.

6. Misinformation and lack of comprehensive sexuality and contraception information

The availability of quality, evidence-based information about contraception and how to access contraceptive services is key to supporting informed decision-making. Domestic research with vulnerable cohorts indicates deficiencies in information accessibility. For example, vulnerable young people who participated in the 2016 HSE/Tusla study identified lack of knowledge as a key reason underlying the failure to use contraception or to use it effectively.[52] And research with ethnic minority women found that lack of knowledge about existing sexual and reproductive health services was a key barrier to accessing care - the women consulted for the study felt that the Irish health care system does not fully meet their needs, either because they do not know about the services available or how to access them.[53]

A survey of over 4,000 women as part of the Contraceptive CHOICE Project - one of the largest assessments of women's prior knowledge of contraceptive effectiveness in the United States - found significant knowledge gaps regarding the efficacy of different methods.[54] Most participants overestimated the effectiveness of the oral contraceptive pill, the contraceptive patch, the ring, contraceptive injection and condoms. Another study of 1,665 women in the

United States found a similar information gap about the efficacy of contraceptive options, as well as misinformation about the health risks of long-acting methods. Between 11 to 36 percent of respondents noted concerns of infection, infertility, and cancer from using intrauterine contraception (i.e. IUS, IUS), which are unfounded.[55]

The 2010 Irish Contraception and Crisis Pregnancy Study also revealed disparities in contraceptive information by age group. Older women (aged 35-45 years) were much more likely to have considered using a LARC than both groups of younger women (aged 18-25 and 26-35), despite that long-acting options like the implant or IUD are perfectly suitable for young people, and even recommended due to their high efficacy rates.[56] There are also pervasive myths that it may be harder to fit an IUD or IUS for a young woman who has never given birth, leading providers to not recommend LARCs for young adults. However, the American College of Obstetricians and Gynecologists (ACOG) describes LARCs as "first-line" options for all women and adolescents on the basis of their "top-tier effectiveness, high rates of satisfaction and continuation, and no need for daily adherence."[57]

Policy considerations

It is imperative that people have access to quality, evidence-based information about the full range of contraceptive methods in order to protect themselves from unintended pregnancy and STIs. Research has identified effectiveness as a priority for women when choosing a contraceptive method,[58] underscoring the importance of ensuring individuals receive clear and accurate information about all contraceptive options, including typical use failure rates and true health risks. Yet myths about contraception are wide-spread.

At present, there is no requirement on schools to provide comprehensive information on the full range of contraceptive methods.[59] Integrating contraceptive information into sexuality education is important for dispelling myths, addressing medical concerns, and equipping individuals with the knowledge necessary for family planning and sexual well-being throughout the life course. Addressing contraception in an evidence-informed manner will reassure young people of their efficacy, address concerns related to side effects, and ultimately empower them to pick a method that works best for them as an individual.

Qs. 11 – 12 Access to condoms

Access to condoms has improved significantly in recent decades, and recent initiatives such as the establishment of the National Condom Distribution Service in 2015 are very welcome. Condoms should be widely accessible to all individuals as a public health intervention to reduce the transmission of sexually transmitted infections, including HIV. Cost should not be an impediment to condom use, but awareness-raising is also key to improving accessibility. In the IFPA's experience, stigma about carrying condoms persists; particularly amongst younger women, some of whom who express fears of being labelled promiscuous by their peers. Stigma-busting publicity campaigns could be a useful way of promoting condom access. Condoms can also function as a stopgap method of contraception. In some circumstances, such as for those in long-term relationships where an unintended pregnancy would not represent a crisis, condoms may be the couple's method of choice, but they should never be

the only contraceptive method available to individuals/couples and their limitations as a means of preventing unintended pregnancy should be acknowledged – male and female condoms have typical use failure rates of 18% and 21% respectively.

Qs. 13 – 16 Ensuring patient safety and high quality care

Reform of contraception access focused on making the oral contraceptive pill and/or condoms available without cost over the counter in pharmacies without removing costs from LARC methods would have perverse and concerning consequences. Such a scheme would incentivise women to opt for a contraceptive that is less effective at preventing unintended pregnancy than long-acting reversible methods, such as coils and implants. Any proposals to expand access to contraception must include the removal of cost barriers to long-acting methods and women must be offered a choice of contraceptive method.

The IFPA's perspective is that there is a role for doctors, nurses and pharmacists to work collaboratively as part of a universal access scheme. It is important that women receive accurate and comprehensive information about all methods of contraception, irrespective of where they access services. And regardless of the service delivery point, it is imperative that all providers must be willing to engage in initial training, participate in continuous professional development, develop and abide by protocols, conduct tick list consultations and keep good records. Record-keeping is crucial to allow for service audits which will ensure quality of care and patient safety. Clear protocols are essential to ensuring that women who present at pharmacies are provided with comprehensive information about LARCs and offered referral pathways to services that can provide LARCs.

Provision of short-acting hormonal contraceptives

There are numerous, complex issues to consider with respect to the provision of short-acting hormonal contraception. While these products are appropriate for nurse prescription and pharmacy dispensing, nurses and pharmacists would need to be apprised of the literature on the medical implications of pill prescribing, due to the health risks of mis-prescribing, in order to safely prescribe and provide contraception. In addition to initial training, staff would need to engage in continuous professional development, including training updates for specific medications. Service delivery would need to be governed by clear protocols which ensured consultations are recorded, all health risks have been assessed and informed consent is obtained. There must be a mechanism for reviewing a woman's contraceptive method at appropriate intervals so she can be supported to switch contraceptive methods (including to a long-acting method) as her needs and preferences may change throughout her reproductive life. Special procedures and protocols would need to be in place for the provision of care to minors and other complex cases, including appropriate referral pathways. Such a service must also be subject to audit.

Provision of long-acting reversible contraceptives

There is no publicly available information on the number and geographic dispersal of LARC trainers and providers.[60] The IFPA knows from our services that some women travel long

distances to access long-acting methods, but the specific access issues in their local area are unclear. Any expansion in the number of LARC providers should be aimed at enhancing local access.

To improve LARC accessibility, the IFPA would support a system that enabled providers to stock these contraceptives in their clinics. Currently, LARC providers can only stock the copper coil and women must fill their prescription for a hormonal coil or implant at a pharmacy and return to the clinic for insertion. This is because only pharmacies can operate the Drug Payment Scheme. If the provider could stock a full range of devices, the woman would not need to make her final choice of method until the day of the fitting. This would allow for flexibility to use the most appropriate device on the day and save both time and money for women, providers and the state.

With respect to the provision of the contraceptive injection (which lasts for 12 weeks), this is not generally designed to be a long-term method. The contraception injection potentially affects bone density, and is not as reversible as other LARCs because you cannot remove it once injected – it gradually wears off. While nurses and pharmacists could be trained to give repeat injections after a woman's initial consultation and 3-month review with a doctor, the issues highlighted above in relation to short-acting hormonal methods also arise and would need to be comprehensively addressed if access were to be expanded in this manner.

Q.17 Additional comments

- Access to a choice of contraceptive methods is critical to gender equality, to women's ability to plan the number and spacing of any children they choose to have, and to their participation in education, employment and public service, including voluntary work and politics. It is central to the achievement of the right health and it is key to reducing the rate of unintended pregnancy, sexually transmitted infections and ensuring that as far as possible, women and girls have the means to prevent unintended pregnancy and the need for abortion care.
- The availability of and knowledge about a range of methods is essential. A woman's medical history and circumstances will dictate which method is most suitable. Not every contraceptive will work for everyone and the same contraceptive won't suit most women throughout their life course.
- The hormonal coil, copper coil and contraceptive implant are long-acting methods of contraception that are the most effective at preventing unintended pregnancy, with a failure rate of less than 1%. The contraceptive injection (6% failure rate) along with short-acting methods (oral contraceptive pill, vaginal ring, patch) and barrier methods (male and female condoms, diaphragm) are less effective at preventing unintended pregnancy due to the risk of user error. The pill, ring and patch all have a typical use failure rate of 9%; and the failure rates for barrier methods are 18% (male condoms); 21% (female condoms); and 12% (diaphragm).
- No woman should need abortion care because of contraceptive failure. Nor should any woman have to choose a less effective contraceptive method because of cost. Ensuring equitable access to long-acting reversible methods is absolutely critical to reducing the

risk of unintended pregnancy and thereby reducing women's need for abortion services: these methods are significantly more effective than short-acting methods.

- Removing cost as a barrier to access to the full range of modern contraceptive methods is critical to the success of any policy aimed at reducing unintended pregnancy.
- When provided with appropriate information to make an informed decision about a contraceptive method, women are more likely to opt for the most effective methods. Uneven availability of information, specialist counselling and providers of long acting reversible methods is a significant barrier to uptake.
- Provision of the full range of methods, including long acting reversible contraceptives, costs less than the provision of short-acting methods alone. And evidence suggests that the overall cost to the state will fall year on year as women and girls switch to more reliable and cost-effective methods. If reforms to contraception access remove cost barriers to short-acting methods only, or only removes cost from methods that can be provided over-the-counter, the state risks incentivising women towards contraceptive methods that are less effective at preventing unintended pregnancy, and reducing the likelihood of women switching from less to more reliable methods. In other words, the state would be defeating the purpose of the policy and doing so at a higher cost than if all methods were included.
- Addressing availability of contraception is not sufficient to ensure uptake of the most effective methods. Lack of knowledge among women about the full range and effectiveness of contraceptive methods is a barrier to informed decision-making, reforms of contraception policy will be most effective if they are supported by reforms in sexuality education to address this knowledge gap.
- To be effective, policies in relation to access to contraception must address inequities in access to healthcare. The human rights principles of non-discrimination, informed decision-making, privacy and confidentiality, participation and accountability must be incorporated into government policy on contraception. Proposals to improve access to contraception should be designed to fulfil the essential elements of the right to health: availability, accessibility, acceptability and quality. These are fundamental to women's autonomy; they also support good uptake and continuation of contraceptive methods.

Table: Analysis of LARC & SARC cost-effectiveness: out-of-pocket costs to women of different methods based on 1, 5, and 10 year use

Method	Typical use failure rate†	Physician Services Cost[a]	Cost per unit[b]	Units per year	1-year cost	5-year cost	Average annual cost (5 yr)	10-year cost	Av annual cost (10 yr)
Barrier Methods									
Male condom	**18%**	n/a	€1.25	55[c]	€69	€344	€69	€688	€69
Female condom[d]	**21%**	n/a	€5	55[c]	€275	€1375	€275	€2750	€275
Diaphragm	**12%**	€100 initial; €50 follow-up (every 2yrs)	€55[e]	1	€155	€475	€95	€850	€85
Short-acting, reversible contraceptives									
Oral contraceptive	**9%**	€50 (every 6 months)	€7	13	€191	€955	€191	€1910	€191
Vaginal ring	**9%**	€50 (every 6 months)	€20	13	€360	€1800	€360	€3600	€360
Transdermal patch	**9%**	€50 (every 6 months)	€19	13	€347	€1735	€347	€3470	€347
Long-acting, reversible contraceptives (LARCs)[f]									
Intrauterine system (IUS) (hormonal: Mirena or Kyleena – effective for 5 years)	**0.2%**	€210 (consultation & insertion); €290 (removal & re-insertion)	€124	1	€334	€334	€67	€748	€75
Intrauterine system (IUS) (hormonal: Jaydess – effective for 3 years)	**0.4%**	€210 (consultation & insertion); €290 (removal & re-insertion)	€124	1	€334	€748	€150	€1576	€158
Intrauterine device (IUD) (non-hormonal: copper – effective for 10 years)	**0.8%**	€220 (consultation & insertion)	€25	1	€245	€245	€49	€245	€25
Intrauterine device (IUD) (non-hormonal: copper – effective for 5 years)	**0.8%**	€220 (consultation & insertion)	€25	1	€245	€245	€49	€490	€49
Implant (hormonal: Implanon – effective for 3 years)	**0.05%**	€160 (consultation & insertion); €150 (removal & re-insertion)	€124	1	€284	€558	€112	€1106	€111
Intramuscular injection (depomedroxyprogesterone acetate – DMPA)	**6%**	(quarterly visit incld in unit cost)	€70	4	€280	€1400	€280	€2800	€280

† Based on typical couples who start using any method (though not necessarily for the first time) and experience an unintended pregnancy within the first year (if they do not stop use for any other reason). Failure rates from: Trussell J (2011), Contraceptive failure in the United States. *Contraception 83(5)*; 397-404.
a) Cost estimates based on average taken from 9 clinics across Ireland (Dublin, Bray, Limerick, Cork, Galway, Tralee, Sligo, Midlands).
b) Unit cost based on average pharmacy cost (for barrier methods and short-acting methods). IUS and implant costs are based on the maximum monthly payment amount of €124 under the Drugs Payment Scheme.
c) Based on the average sexual frequency of American adults (54 times/year), as of 2017 study. Varies by age group.
d) Female condoms are not widely available.
e) Annual diaphragm unit cost includes diaphragm (€40) and must be used with spermicide/contraceptive gel (€15).
f) Estimated IUD and IUS costs do not include STD and pregnancy testing, which is generally mandatory before having an intrauterine device/system placed.

Overview of contraceptive methods

There are numerous contraceptive options available, differing in form, cost, effectiveness, and ease of access. Methods of contraception include barrier methods, short- and long-acting contraceptives, permanent methods, emergency contraception, and fertility awareness methods.

1) Barrier methods: This type of contraception blocks the sperm from getting into the womb.

- **Male condom:** Made from very thin, natural latex rubber and fits over an erect penis. A new condom must be used each time. Condoms also prevent the spread of sexually transmitted infections (STIs) and HIV/AIDS.
- **Female condom**: A tube made of very thin polyurethane plastic. It is closed at one end, and designed to form a loose lining to a woman's vagina with two flexible rings, one at each end, to keep it in place. A new condom must be used each time. Condoms also prevent the spread of STIs and HIV/AIDS.
- **Diaphragm:** A small, flexible silicone cup that stays in the vagina during sex. It is taken out after sex and cleaned for future use. Must be initially fitted by a healthcare provider, and needs to be used with a contraceptive gel to inactivate any sperm that are present. Do not protect against STIs and HIV/AIDS.

2) Short-acting, hormonal contraceptives: Hormonal contraception works by changing the natural, monthly hormonal cycle and do not prevent STIs and HIV/AIDS.

- **Contraceptive pill:** A daily pill which contains two hormones, oestrogen and progesterone (combined pill), or there is also a progesterone-only pill.
- **Vaginal ring:** The vaginal ring sits inside the vagina for three weeks at a time. It is then taken out for one week to have a period as normal.
- **Patch:** A new patch is applied onto the skin every week for three weeks. On the fourth week no patch is applied, to allow for a period.

3) Long-acting, reversible contraceptives (LARCs): Highly-effective, long-lasting contraceptives that can last anywhere from three months to ten years, depending on type chosen. These contraceptives do not prevent STIs and HIV/AIDS.

- **Hormonal IUS**: The intrauterine system (IUS) is also known as the hormonal coil. It stays in the womb and works for three to five years (dependent on model chosen).
- **Copper IUD (hormone-free):** The intrauterine copper device (IUCD) is also known as the copper coil. It stays in the womb and is effective for five to ten years (dependent on model chosen).
- **Implant:** The implant is a small rod placed under the skin in the arm. It gradually releases hormones and works for up to three years.
- **Injection:** An injection of hormones given in the gluteal muscle. It is effective for up to three months.

4) Permanent methods: For those who feel their families are complete or know that they never want to have children, permanent methods (sterilisation) are one option to consider. A vasectomy is a minor procedure with local anaesthetic that can be completed on an outpatient

basis, at clinics like the IFPA. Tubal occlusion involves an operation and must be done in a hospital setting.

- **Vasectomy (male sterilisation):** A vasectomy is where the tube connecting each testicle (where sperm are made) to the penis is blocked or cut.
- **Tubal occlusion (female sterilisation):** A tubal occlusion is where the tube connecting each ovary (where eggs are made) to the womb is blocked or cut.

5) Emergency contraception: Emergency contraception is a safe, effective and responsible method of preventing pregnancy when regular contraception has failed, no contraception was used, and/or in the case of sexual assault. Emergency contraception can be used up to five days after unprotected sex.

- **Emergency contraceptive pill (ECP) – progesterone (3-day) and ulipristal (5-day):** Both methods of the ECP work by preventing or delaying ovulation, thereby preventing fertilisation. **Copper IUD:** Works as a method of emergency contraception as it may stop an egg being fertilised or implanted in the uterus (womb), and also functions as a long-acting, reversible contraceptive. A trained doctor fits an IUD in the uterus (womb) up to 5 days after unprotected sex. [61]

6) Fertility awareness methods: Also known as “natural family planning” or “the rhythm method, fertility awareness methods involve tracking ovulation and are most often used to aid conception. Alternatively, fertility awareness methods can be used for pregnancy prevention, but are much less reliable than modern methods. There are numerous methods, but the most effective is the symptothermal method, which involves tracking body temperature, cervical mucus, and the menstrual cycle. Days near ovulation are the most fertile days, so couples can choose to abstain from sex or use another contraceptive method on those days where pregnancy is a greater risk.[62]

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