PRACTICAL MEDICAL ETHICS

OVER-THE-COUNTER ORAL CONTRACEPTION

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Since the development of the first synthetic progesterone in 1951 and the commercial introduction of the oral contraceptive pill (OCP) to the UK in 1961 there have been numerous attempts to extend its reach. A particular target has always been young women who over time have become sexually active at a progressively younger age. Approximately one in three young people now have sexual intercourse before 16 years [1]. Concern around the increasing rates of teenage pregnancy ensured that the provision of oral contraception to teenage women was a key component of the 1999 Teenage Pregnancy Strategy [2].

The use of oral contraception in young women substantially increased in the first decade of the 21st century in the UK. Current figures from the Omnibus Survey [3,4], the most reliable source of information on UK population contraceptive use which is carried out every five years by the Office of National Statistics on behalf of the Department of Health, show that use of the OCP in 16-19 year olds rose from 24% to 54% from 2002/03 to 2008/09.

However, teenage women are not good at taking the pill. Discontinuation rates 12 months after initiation are between 65% and 70%, with 45 – 50% of discontinuation occurring in the first six months from method-related failure [5]. This contributes to a quoted failure rate of the pill of 16% for women under the age of 20 years compared with failure rates of 8% in married women aged 30 years and older in the first year of use [6,7]. Contraceptive failure brings with it the risk of pregnancy, the majority of teenage pregnancies being unplanned [8], and its attendant risk of abortion.

The impact of the Teenage Pregnancy Strategy on reducing pregnancy rates in young women up until 2009 was modest. The conception rate for under-18s fell by 13.3% against the government-set target of 50% by the ten year point in 2010 [9] with most of this fall occurring in the first two years of the strategy before the main spending came into place [10]. However, the abiding legacy of the Teenage Pregnancy Strategy has been the year-on-year increase in the numbers of teenage abortions [9] peaking in 2009, and the sustained rise in the rates of new diagnoses of sexually transmitted infections [11]. The conception rate to teenage mothers has decreased since 2009, probably due to the increased use of long-acting reversible contraception (LARC). But many forms of LARC are abortifacient [12]. This when taken into consideration with the increasing use of emergency contraception (EC) which works in part after fertilisation [13], makes it certain that rates of abortion, whether recorded in government statistics or not, will continue to be very high in teenage women.

A project providing over-the-counter oral contraception was recently conducted as a pilot study in Lambeth and Southwark, two inner-city boroughs in south London [14]. This follows on from the over-the-counter availability of EC which was launched nationally in the UK in 2001 and previous pilots of over the counter pill provision in Manchester and the Isle of Wight in 2010. Lambeth and Southwark have the highest levels of teenage pregnancy in the UK and have particularly high levels of abortion in teenage girls at 60% and 66% respectively. The pilot aimed to increase access to oral contraception for the target group of 16 to 30 year old women, to contribute to reducing the numbers of unintended pregnancies and to reduce use of EC as a main method of contraception for many women. The funding of £263,000 came from NHS London most of which was spent on training costs of £4,000 per pharmacist who received an MSc on completion.

Five pharmacies were involved in the pilot and 741 consultations carried out. The majority of consultations (43%) were for women between 20 and 24 years with 22% being for women under 19 years. Recruitment was through pharmacies where women presenting for EC were offered a consultation to help them consider regular use of the OCP. Approximately 70% of consultations ended in the

prescription of oral contraception, 46% of which were to first time users. There were low levels of repeat prescriptions with only 32% of users returning for further supplies within the two year study period, the majority of others returning to condom and EC use.

Emergency contraception prescriptions were reduced in only one pharmacy (the one with the highest rate of OCP prescription) but not across all participating pharmacies and not across the two participating boroughs. The report claimed a 10% increase in new users of OCP prescriptions within the target group but admitted that most increased use was probably through redistribution of clients from other services. No clients were persuaded to start on LARC. The impact on pregnancy rates was not given. The average pharmacy consultation took twenty minutes and was given a nominal costing of £20.

There are many deficiencies of this pilot: the majority of women continued high risk condom and EC use; the aimed-at increased access to OCP in the target group was marginal and, most tellingly, there is lack of outcome data on pregnancy rates. The latter is a serious omission given it was a primary end point of the study. If there was serious intent to reduce pregnancy rates why did publication of results occur before its impact could be quantified? In spite of these significant limitations the report calls for its extension to young women between 13 and 16 years (mirroring the Manchester and Isle of Wight schemes [15]), as well as its extension to sixty other pharmacies in Lambeth and Southwark and, eventually, to a national roll-out.

Conceptually, the recent Department of Health public health policy statement *Healthy Lives, Healthy People [16]* promotes over-the-counter oral contraception as a more creative and cheaper way to provide a contraception service than the traditional GP or family planning route. There are undoubted risks in this approach, not least being the lack of awareness of and time taken to explore a woman's full medical history in a pharmacy. The fact that the pilot fails to adequately address the researchers' aims means that the call for its extension is not evidence-based and suggests that this pilot is just another in a long line of costly, poorly researched and enthusiastically promoted schemes, among which are enhanced sex education programmes[17], over-the-counter EC availability [18] and, in all likelihood, condom distribution schemes, that have failed to reduce teenage pregnancy rates while serving only to induct young women into sexual activity.

During the pilot the free availability of oral contraception was advertised in participating pharmacies which 80% of users noticed and felt was effective. Such a degree of exposure sadly means that a target group of vulnerable young women who do not have the capacity to be compliant with oral contraceptive use are being offered another apparent short term safety net which in the long term will increase their risks [19]. Young women deserve more compassionate care than this ill-thought out, expensive and poorly administered scheme and the taxpayer deserves more prudent use of public funds.

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