Submission on Access to Contraception

2019

Summary

The National Women's Council of Ireland (NWCI) strongly supports a scheme to provide the most effective and appropriate methods of contraception free-of-charge to all women and men who wish to avail of them.

Through this scheme Ireland has the opportunity to be a world leader in properly resourced, comprehensive sexual and reproductive health services, with the benefits of limiting unplanned pregnancies, reducing the need for abortion, stopping the spread of sexual transmitted infections (STIs) and supporting overall reproductive health, including uptake of smears and management of menstrual health conditions.

Currently, significant cost and access barriers exist which prohibit women from using their preferred contraception method. This has resulted in inconsistent use of contraception across the Irish population, low uptake of the most effective long-acting reversible contraception (LARCs) and increasing rates of STIs.

In line with NWCI's *Every Woman model of reproductive healthcare* we recommend that the contraceptive scheme across primary care, family planning clinics, pharmacy and hospitals is designed to:

- **Remove all cost barriers** to women's use of contraception
- **Make contraception accessible to all women**, through increased provider capacity
- **Entitle women to contraception care consultations**, for consideration of medical history, contraindications, a woman's choice of method, and changing lifecycle contraception needs
- Provide women with **information and counselling about all forms of contraception**, including LARCs and copper coil as emergency contraception. LARC fitting made available where it is a woman's preference.
- Resource **reproductive and sexual health promotion** (including STI prevention and care, cervical smear, smoking cessation etc.)

By providing women-centred universal contraception care, women of all ages will be able to choose the most effective contraception methods for their bodies and their life choices; will have access to the most effective forms of contraception, likely increasing uptake of LARCs; and will receive safe, joined-up reproductive healthcare which can reduce STIs and increase smear uptake.

Introduction

The National Women's Council of Ireland (NWCI) advocates for the provision of comprehensive reproductive and sexual health services designed around the lives of women and girls.

Reproductive health affects both women and men, but it is women who carry the highest burden of reproductive ill-health, linked to their biological status, but also because of a wider social and economic disadvantage. It is also primarily women who carry the responsibility for contraception[1]. Continuing high rates of unplanned pregnancy, rising rates of STIs and strong evidence of inconsistent contraception use indicate that we are failing a large proportion of Irish women in achieving their best reproductive health. The development of a comprehensive contraception service will go a long way to improve women's healthcare provision in Ireland.

Women's access to reproductive healthcare is fundamental to women's family and life decisions and essential for women's equality. The development of safe, effective contraception is widely considered to be one of the greatest public health achievements of the 20th century. Contraception enables women and couples to safely space and to limit their pregnancies and reduces unintended pregnancies, unsafe abortions, and maternal morbidity and mortality. These benefits are so significant that universal access to contraception is accepted internationally as essential to human rights.

Access to family planning has been recognised by the United Nations (UN) as a basic human right since 1968 when the Teheran Proclamation stated 'Parents have a basic human right to determine freely and responsibly the number and spacing of their children'.[2] The UN determines that in order to fully realise this right, reproductive health services must be based on the principles of availability, accessibility, acceptability, quality, non-discrimination and informed decision-making.[3] Additionally, the UN Sustainable Development Goals, to which Ireland is a signatory, recognise that good sexual and reproductive health (SRH) is essential to achieving progress in the domains of gender equity and human health.[4]

Access to safe, effective contraception for all women should be a fundamental part of any good healthcare system. Universal provision of the full choice of contraception methods, free at the point of care, is essential to reduce the numbers of unplanned pregnancies and in particular to address the cost and consistency problems that currently hamper effective use. Yet, Ireland continues to lag behind European neighbours in health service provision of contraception. This in part reflects the lack of availability of any form of contraception in the very recent past – prescribing and having contraception of any description was

[1] In this submission contraception is used to describe: barrier methods, short-acting hormonal contraception (e.g. contraceptive pill, patch), long-acting reversible contraception (e.g. contraceptive injection, intra-uterine device), permanent methods (e.g. female sterilisation) and emergency contraception.
[2] Proclamation of Teheran, Article 16 (May, 1968) U.N. Doc. A/CONF. 32/41 at 3 (1968).
[3] United Nations Population Fund (14 May 2018) '*Fifty years ago, it became official: Family planning is a human right*'. https://eeca.unfpa.org/en/news/fifty-years-ago-it-became-official-family-planning-human-right?page=0%2C3.
[4] United Nations (2015) '*Transforming our World: The 2030 Agenda for Sustainable Development*', New York: UN.

illegal until 1980 and emergency contraception was not available without prescription until 2011.[5]

The referendum removing the 8th Amendment from the Constitution represented a turning point in how Irish society responds to women's health. A remarkable mobilisation for women's reproductive health translated into decisions in the ballot box to ensure that our healthcare service can respond to women's reproductive health needs. While a universal, free abortion service has been rolled out (with evident need for further development to ensure consistent, local access for all women across the country), no progress has been made on the Government commitment to provide universal contraception access for all those who require it. This creates a situation in which women are provided with the means to end, but not prevent, unintended pregnancy. Clearly, a comprehensive package of reproductive healthcare must include universal access to both abortion and contraception services.

Free contraception for Ireland – a standard element of public health in many countries – was proposed by the Citizen's Assembly and the Joint Oireachtas Committee on the Eighth Amendment, and the Government pledged to provide it as part of measures to reduce crisis pregnancies. The issue for many women is that while certain types of contraception may be cost-effective in the long-term, they are more costly initially. Further, the provision of universal access to contraception aligns with planned Sláintecare[6] reforms of the Irish health system. In line with Sláintecare's universal package of healthcare, a scheme of universal access to contraception should be provided locally, at the lowest level of complexity and on the basis of need, rather than the ability to pay.

NWCI's work on reproductive health

NWCI is Ireland's leading women's membership organisation, representing over 180 member groups and a growing number of individual members. We work to ensure women's equal access, participation, and recognition in Irish society. One way in which women's equality is realised is through women's control of their reproductive health, which has always been a core area of NWCI's work. In NWCI, we recognise that a woman's reproductive healthcare needs span her lifetime, from relationship education in school to menopause services as she ages. We are closely involved in improving women's access to contraception, increasing maternity entitlements, advocating for affordable, quality childcare and for the ongoing development of women-centred maternity care. In 2018, NWCI was one of the three organisations which formed the Together for Yes civil society campaign to remove the 8th Amendment.

NWCI advocates for reproductive healthcare services which are based on best medical practice and which reflect the lived experiences of women. We engage with the issue of contraception from a broad perspective, reflecting the diversity of experiences women face and the different decisions women make about reproduction and family formation.

[5] Molloy GJ, Sweeney L, Byrne M, *et al.* (2015) 'Prescription contraception use: a cross-sectional population study of psychosocial determinants'. *BMJ Open* https://bmjopen.bmj.com/content/5/8/e007794

[6] Department of Health (2018) *Sláintecare Implementation Strategy* https://health.gov.ie/wp-content/uploads/2018/08/Sl%C3%A1intecare-Implementation-Strategy-FINAL.pdf.

Our comments on the proposed contraception scheme are grounded in NWCI's *Every Woman*[7] model for reproductive healthcare for women and girls.

In 2017, NWCI launched our *Every Woman* model for quality, universal reproductive healthcare for women and girls. The model recognises that women have a life-long need for reproductive healthcare services across six priority areas, which should be available through the health system:

1. Relationship and sexual health education
2. **Affordable and accessible contraception**
3. Sexual and reproductive health services
4. Comprehensive pregnancy care, including fertility treatment
5. Reproductive cancer care
6. Menopause services

Every Woman further describes key principles which should underpin the provision of all reproductive healthcare services:

- Services should be private, with confidentiality between the doctor and patient protected
- Services should be accessible through public funding
- Services should be comprehensive
- Services should be of high quality, complying with best medical practice and standards
- Services should be adequately funded to ensure timely access

[7] NWCI (2017) '*Every Woman – affordable, accessible healthcare options for women and girls in Ireland*' https://www.nwci.ie/images/uploads/EveryWoman_Repro_Health_Model_-_Nov_2017.pdf

In examining the current contraception proposal, NWCI has considered how provision could be designed in a way which upholds *Every Woman's* model of reproductive healthcare.

Submission structure

As a membership organisation, NWCI has a unique role in communicating the health concerns of women in Ireland through ongoing consultation with our membership base and other organisations. This submission is grounded in the experiences and expertise shared with us by our member groups working to support women to access reproductive health services and to provide such services directly to women.

This submission is framed around section 2 of Department of Health's consultation questionnaire and is divided into the following sections:

1. Benefits of providing a scheme as described above
2. Challenges of providing a scheme as described above
3. Paying for contraception
4. Barriers to accessing contraception in Ireland
5. Responsibility for delivering contraception
6. Benefits of investing in contraception
7. Conclusion

1. Benefits of providing the scheme (Consultation Q2, 4)

Q2 Important factors that will inform the development of a scheme to increase access to contraception.

Most important factors:

1. Ensuring equal access to all
2. Cost to individuals
3. How effective each method is
4. Meeting different needs

Benefits

By granting women control over their sexuality, fertility and reproduction, contraception plays a pivotal role in the health and well-being of women. The benefits of universal access to free and effective contraception are significant and span improved health to greater opportunity for economic independence and participation in society.

While the majority of sexually active people in Ireland use contraception, evidence indicates that use is inconsistent and that discontinuation due to cost is prevalent. Free contraception would enable women to access the most suitable form of contraception for their body and life. Removing the cost barriers would greatly support increased use of LARCs, which are the most effective and cost-efficient form of contraception.

Contraception is essential to safeguarding women's health and improving maternal health outcomes. Use of contraception reduces unintended pregnancies among women who face increased health risks such as older women,[8] adolescents,[9] and women with HIV.[10] Preventing unintended pregnancies also reduces the demand for abortion, including unsafe abortion. Many contraceptive methods can have benefits unrelated to pregnancy, such as management of menstrual-related disorders.[11]

Remove cost barriers to contraception use

Cost is clearly a barrier to contraception use in Ireland. In the 2010 Irish Contraception and Crisis Pregnancy Study (ICCP-2010)[12], 9% of women who had used the contraceptive pill, patch or ring during the previous year reported that at some time they had not been able to refill their prescription because they could not afford it. Of those adults who reported a difficulty accessing contraception in the ICCP-2010, 24% said cost was a barrier to accessing contraception.

Removing cost as a barrier would enable more consistent use; decrease discontinuation; and improve use among women with fewer resources. Research demonstrates that those with fewer resources often use contraception inconsistently[13] or don't use the most effective method of contraception because they cannot afford it[14]. Providing contraception free-of-charge would therefore increase access to the most effective forms of contraception in addition to increasing prevalence and consistency of use.

It is also clear that cost is currently impacting on women's *method* of contraception. Irish research[15] found that LARC use may predominate in those with lowest incomes who qualify for free LARC on their medical card and in those with higher incomes, where the initial device and fitting cost is not a barrier. Those without medical card, or high income, predominate in use of contraceptive pill which is significantly less expensive in the short term (less than €20 per month).

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[8] WHO (2019) Evidence Brief on Contraception. https://apps.who.int/iris/bitstream/handle/10665/112319/WHO_RHR_14.07_eng.pdf?ua=1

[9] Jacqueline D, Vanessa W, Akinrinola B, Lori A. (2016) '*Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents*,' New York: Guttmacher Institute https://www.guttmacher.org/report/adding-it-meetingcontraceptive-needs-of-adolescents.

[10] WHO (2019) Evidence Brief on Contraception.

[11] Megan L. Kavanaugh and Ragnar Anderson (2013) *'Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers'* 13 New York: Guttmacher Institute http://www.guttmacher.org/pubs/health-benefits.pdf.

[12] McBride, O., Morgan, K., McGee, H. (2012) *Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-2010). A Survey of the General Population.* HSE Crisis Pregnancy Programme. https://www.hse.ie/eng/services/publications/corporate/iccp2010.pdf Thereafter ICCP-2010.

[13] Jennifer J. Frost and Jacqueline E. Darrock (2004) '*Factors Associated with Contraceptive Choice and Inconsistent Method Use*' United States: Guttmacher Institute https://www.guttmacher.org/journals/psrh/2008/factors-associated-contraceptive-choice-and-inconsistent-method-use-united.

[14] Adam Sonfield (2011) '*The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing*' Guttmacher Institute https://www.guttmacher.org/gpr/2011/03/case-insurance-coverage-contraceptive-services-and-supplies-without-cost-sharing.

[15] Molloy GJ, Sweeney L, Byrne M, *et al.* (2015) 'Prescription contraception use: a cross-sectional population study of psychosocial determinants'. *BMJ Open,* 5:e007794. doi: 10.1136/bmjopen-2015-007794.

Further, anecdotal evidence suggests a rise in women using online GP services (less costly than in-person GP visits) to obtain contraceptive prescriptions. Online consultations may raise safety concerns as they do not allow for direct blood pressure, BMI and other measurement by the prescribing GP.

Provide for women's choice of contraception method

Imperative to reforms in the availability and accessibility of contraception is the provision of the most effective and appropriate method of contraception, having regard to the personal circumstances, wishes and needs of the individual woman. It is important that the method a woman uses aligns with both her medical history and with her lifestyle and reasons for contraception use (such as avoidance of pregnancy or family spacing).

The World Health Organisation (WHO) advises that inclusion of the full range of contraceptive methods is critical to meeting the unmet need for contraception.[16] As every woman's contraceptive needs, medical history and risk factors are unique and may vary throughout her life, not every form of contraception will work for every woman and the same form of contraception is unlikely to be suitable for a woman throughout her entire life course. For example, one of the most commonly prescribed contraceptives, the combined oral contraceptive pill, is unsuitable for many women such as those who experience migraines or smokers over the age of 35 due to the risk of blood clots.[17] Many women who discontinue contraceptive use do so due to unhappiness with their current method of contraception and lack of access to alternative, more suitable, methods.[18] The WHO therefore finds that broadening contraceptive choice can reduce contraceptive discontinuation by 8%.[19] Finally, a scheme of provision of contraception must include provision of long-acting reversible contraceptives (LARCs) (discussed further below).

Increase use of most effective form of contraception - LARCs

A major benefit of a universal scheme would be to ensure all women, regardless of resources, can access LARCs where that is their preference. International clinical guidance is that all women requiring contraception should be both informed of and offered a choice of all methods, including LARC.[20],[21],

Current Irish contraceptive use does not track with the most effective methods – the ICCP-2010 found that while 43% of women used a contraceptive pill and 62% of respondents

[16] WHO (2018) *Evidence Brief on Expanding Contraceptive Choice* WHO/RHR/17.14 Rev.1.
[17] IFPA, Factsheet on The Combined Pill, https://www.ifpa.ie/factsheets/combined-pill/
[18] Castle, S. and Askew, I. (2015) '*Contraceptive discontinuation: Reasons, challenges and solutions*' FP2020 and Population Council. http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/12/FP2020_ContraceptiveDiscontinuation_SinglePage_Final_12.08.15.pdf
[19] WHO (2018) *Evidence Brief on Expanding Contraceptive Choice* WHO/RHR/17.14 Rev.1.
[20] NICE Guideline (2005) 'Long-acting reversible contraception'. Updated 2019. https://www.nice.org.uk/guidance/cg30/resources/longacting-reversible-contraception-pdf-975379839685
[21] American College of Obstetricians and Gynecologists (2018) Committee on Adolescent Healthcare, Committee Opinion No. 735 https://www.acog.org/-/media/Committee-Opinions/Committee-on-Adolescent-Health-Care/co735.pdf?dmc=1&ts=20180424T1549579166.

used condoms as contraception, only 8% of women used contraceptive ring, patch, injections or implanted capsules and 11% used LARCs (intra-uterine devices or intrauterine systems).[22]

The evidence is clear that where suitable for a woman, LARCs are the most effective form of contraception. When used perfectly short-acting methods provide effective contraception, but their failure rate in real-life usage scenarios makes them less than ideal. As 'fit and forget' methods, which eliminate the potential for user error, LARCs are widely recognised as having the highest efficacy rates in preventing unintended pregnancy.[23] LARCs are also more cost effective and have been shown to reduce pregnancy and abortion rates. The Contraceptive CHOICE Project, one of the largest prospective cohort studies of women in the US, reported that non-LARC users were more than 22 times as likely to experience an unintended pregnancy compared to their LARC counterparts.[24]

When LARCs are available, they will often be women's preferred method. Dublin Well Woman has reported a growing demand amongst women in Ireland for LARC[25] and when the IFPA undertook an in-depth analysis of client preferences in 2015, 39% chose LARCs.[26] Despite this, uptake of LARCs in Ireland overall is relatively low and short-term contraception – predominantly the contraceptive pill – is most regularly used by women in Ireland.

The significant initial cost of LARC insertion at €350-plus (includes charge for the first €144 of the device cost, GP's consultation fee and prescription, a subsequent visit to have the device fitted, and a third visit for a check-up after six weeks) poses the primary barrier to access. However, LARCs are cost-effective in the long term when compared to shorter-acting methods owing to their fixed, one-off cost which need not be repeated for between 3 and 10 years.

In the large-scale US Contraception CHOICE project where women were provided with information on all contraception methods and where contraception was available at no cost, 75% of women enrolled chose a LARC.[27] Further, a recent study reported that when public funding was made available for LARC in Finland there was a 2.2-fold increase in uptake.[28]

Reduce number of abortions

While no form of contraception is 100% effective and abortion services will always be necessary, access to contraception can significantly reduce the number of unplanned

[22] ICCP-2010.
[23] ICCP-2010.
[24] McNicholas, C. *et al.* (2014) 'The Contraceptive CHOICE Project Round Up: what we did and what we *learned', Clin Obstet Gynecol*, 57(4): 635–643. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4216614/pdf/nihms624012.pdf.
[25] Dublin Well Woman (2018) Annual Report 2017 https://wellwomancentre.ie/well-woman-centre-annual-report-2017/.
[26] IFPA Press Release (26 April 2018) 'Government plan for free contraception must focus on long-acting reversible methods'. https://www.ifpa.ie/government-plan-for-free-contraception-must-focus-on-long-acting-reversible-methods/; IFPA *Annual Report 2015* https://www.ifpa.ie/sites/default/files/2015_ifpa_financial_statments.pdf
[27] McNicholas, C. *et al.* (2014) 'The Contraceptive CHOICE Project Round Up: what we did and what we *learned', Clin Obstet Gynecol*, 57(4): 635–643.
[28] Gyllenberg F, Juselius M, Gissler M, *et al.* (2018) *'Long-Acting Reversible Contraception Free-of-charge, Method Initiation, and Abortion Rates in Finland', Am J Public Health,* 108: 538-543.

pregnancies.[29] The ICCP-2010 found an increase in the number of crisis pregnancies in Ireland compared to the previous study in 2003, with 1 in 3 women and 1 in 5 men with experience of pregnancy reporting having had experienced a crisis pregnancy. Almost half of the women who had experienced crisis pregnancy reported non-use of contraception as cause of pregnancy, with contraception failure among the other causes.[30]

Following the introduction of abortion services in 2019, Ireland is currently providing a reproductive health service which is not fully integrated and coherent; abortion care is free but many women must pay for contraception. Current providers of termination of pregnancy in primary care indicate that many women they are caring for had condom or pill failures, or were not using contraception. It is also the case that the abortion aftercare appointments would be an ideal moment to provide women who desire it with free contraception. Indeed, because so many women report having used a contraceptive method at the time of an unintended pregnancy, women seeking abortion may be particularly motivated to initiate a LARC method at the time of procedure.[31]

Stop the spread of sexually transmitted infections (STIs)

Some forms of contraceptives – and use of condoms in particular - has the additional public health benefit of reducing transmission of STIs such as HIV. This is of particular importance in the context of a steadily increasing rate of STI notifications, including HIV, in Ireland in the past 20 years.[32]

2. Challenges of providing a scheme as described above (Q5)

Providing access to the full range of contraceptives free-of-charge for all women would present a number of initial challenges. But as stated above, this service has been developed in many other high, middle and low-income countries, is consistent with human rights standards, is in line with the Government's Sláintecare reforms[33] to develop universal healthcare, and delivers on Government commitments during the referendum on the 8th amendment to provide contraception care.

The contraception service will require resourcing of providers within primary care, family planning clinics, pharmacies, hospitals and of the HSE Sexual Health and Crisis Pregnancy Programme (SHCPP), which develops information for patients and research on contraception use in Ireland. Resources will also be required to ensure providers receive the appropriate and necessary training, particularly if they are being asked to provide methods of contraception which they had not previously been providing, for example GPs

[29] Guttmacher Institute (2019) Factsheet on '*Unintended Pregnancy in in the United States'* https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states
[30] ICCP-2010.
[31] McNicholas, C. *et al.* (2014) 'The Contraceptive CHOICE Project Round Up: what we did and what we learned'. *Clin Obstet Gynecol.* 57(4): 635–643.
[32] Health Protection Surveillance Centre, '*Sexually Transmitted Infections (STIs) in Ireland,*' 2016. 2017, HPSC: Dublin.
[33] Department of Health (2018) *Sláintecare Implementation Strategy*.

not currently trained in LARC fitting. Training must be provided for reproductive health service providers in order to ensure that service provision is both culturally sensitive and non-heteronormative. The benefits of making these investments are addressed in Section 7 below.

Another challenge will be ensuring that the scheme includes and meets the needs of more marginalised groups of women. It has been widely accepted that the women who are most severely impacted by reproductive health policies are those who have fewer resources and means to navigate systemic barriers. Initial indications are that women with low incomes, women with disabilities and women in direct provision are disproportionately impacted by the restrictions of our current abortion service (due to multiple appointments, need to travel to providers, etc.). It is critical that the State is aware of and targets the unique needs of marginalised groups of women in the design of the contraception scheme and learns from these issues (see Section 4 below for barriers experienced by specific groups of women).

3. Paying for contraception (Q6, 7, 8)

NWCI strongly agrees that all forms of contraception should be provided free-of-charge to all residents in Ireland (i.e. no GP or product cost would arise). The scheme must also be available for residents without PPSN (such as undocumented migrants and some members of the Roma Community).

4. Barriers to accessing contraception in Ireland (Q9, 10)

Cost of contraception

If contraception is too expensive or not easily accessible, women will not be able to use it consistently. Of those adults who reported a difficulty accessing contraception as part of the ICCP-2010, 24% said cost was a barrier to accessing contraception.[34]

While approximately one third of people in Ireland can access contraception free-of-charge via the medical card scheme, neither condoms nor the copper IUD are included (although free condoms can be accessed via certain locations and organisations through the HSE national condom distribution service[35]). The cost of condoms in Ireland, which are used both to avoid unplanned pregnancy and to stop the spread of STIs, is among the highest in Europe.[36]

It is clear that women in the very midst of their reproductive years are finding it difficult to pay the cost of contraception. In many cases, women who have very significant

[34] ICCP-2010.
[35] For details see: https://www.sexualwellbeing.ie/for-professionals/national-condom-distribution-service/national-condom-distribution-overview/.
[36] ICCP-2010

overheads and squeezed income may consider contraception – and particularly the upfront cost for LARC[37] – beyond their means. This includes young women in their late teens or early 20's who may be students, or working in low income jobs facing high rents, or women in their late 20's and early 30's with young children who are paying the high cost of childcare and housing. Our members report that many migrant women say cost presents a large barrier to accessing contraception here. These women are often working in low pay jobs – just above the threshold for medical card – and cannot afford to pay privately for healthcare services.

For those who do not have access to a medical card, cost has huge impact on contraceptive decision-making. As discussed above, LARCs involve significant and often prohibitive upfront costs. The oral contraceptive pill can be purchased from as little as €3 per month but requires frequent GP appointments – at €50/€60 each – for repeat prescription. 12% of women without medical cards surveyed as part of the ICCP-2010 failed to refill their contraceptive prescription. 18% of adults surveyed reported the cost of a GP appointment as being a frequent barrier to seeking medical attention.[38]

Primary Care Capacity

Lack of capacity within primary care can create barriers to women seeking to use LARC. Many LARC methods must be fitted at a certain point in a woman's menstrual cycle and women report that it can at times be difficult for over-burdened GP and family planning clinics to accommodate an appointment that coincides with a specific day of her cycle. This may particularly be the case for medical card holders, many of whom are experiencing increased waiting times for appointments and cannot pay to go privately for an available appointment outside their medical card appointed-GP.

Capacity issues further arise because not all GPs are trained to fit and remove LARCs. While training has increased since 2008[39], there are insufficient LARC trainers to meet demand and resources are necessary to increase capacity.

Increasing pharmacists' role in the dispensing of contraception and provision of information and guidance could decrease burden on GPs but would require increased training capacity and changes in regulation.

Local access

An additional barrier faced by individuals when trying to access contraceptive care is lack of adequate services in their local area. Of the 11% of the respondents to the ICCP-2010 who noted difficulty in accessing contraception, 42% reported lack of access to

[37] While there is partial reimbursement for cost of hormonal LARC device through the Primary Care Reimbursement Service (PCRS), the scheme does not cover costs associated with the insertion or removal of the device.
[38] ICCP-2010
[39] ICGP and HSE (2018) '*Sexual Health Services in Ireland: A Survey of General Practice*' https://www.sexualwellbeing.ie/for-professionals/research/research-reports/survey-of-general-practice_january2018.pdf

contraceptive services in their locality.[40] Importantly, local access was reported as a barrier in urban as well as rural areas. The ICCP-2010 also uncovered significant regional disparities in the quality and availability of services. Family planning clinics are not evenly distributed across the country, with the majority in urban centres.

We know that not all GP practices provide for LARCs and it is likely that there is uneven coverage across the country. A HSE/ICGP survey[41] found that seven in ten GP respondents reported LARC insertion was provided in their practice, with 83% of those accepting referrals from other GPs who do not offer this service. However, private patients are more likely than medical card patients to be accepted for such referrals. However, as recognised by the authors, the findings of the survey are likely to overestimate the actual level of contraception provision in primary care. This is due to both to the low response rate of 17% (insufficient to accurately document current provision by GPs across the country) and a level of selection bias, whereby those who responded are likely to have participated in the survey because they have a particular interest in delivering contraception and STI services.

The roll-out of contraception services must ensure access in all areas of the country and particularly in disadvantaged communities where primary care capacity is often lower than in more affluent areas.

Treatment for young people

Ambiguity surrounds the legal status of prescribing contraception to people under the age of 16. This has the potential to present an additional barrier to young women seeking to access contraception. The HSE National Consent Policy[42] states that a person over the age of 16 can give consent to medical treatment. However, the policy also notes that sexual activity under the age of 17 may constitute a criminal offence. Unfortunately, as we have seen in other areas of women's reproductive care, the existence of legal ambiguities can lead medical professionals to decline to provide care for fear of prosecution.

Barriers experienced by specific groups of women

When we examine women's reproductive health, we must address the health inequities which exist between groups of the women, for example between Traveller and settled women and between women living in deprived and affluent areas. Domestic violence disempowers women from all sections of society and can be a barrier to women accessing contraception. It is vital that contraception provision accommodates the needs of all women, particularly those who experience the worst health outcomes and/or least access to health services, including:

[40] ICCP-2010.
[41] ICGP and HSE (2018) '*Sexual Health Services in Ireland: A Survey of General Practice*'.
[42] HSE National Consent Policy QPSD-D-026-1.V.1. Section 10, page 60; Supplementary document to the HSE National Consent Policy, '*Consent: A guide for young people*' (QPSD-GL-055-1. V.1).

- **Women with disabilities** who face additional barriers such as physical inaccessibility of services, societal attitudes that deny their sexual and reproductive agency and a hesitancy among service providers to provide adequate information and services.[43]
- **Members of the LGBTQI+ community**. When examining the needs of the LGBTQI+ community in relation to the contraception scheme, attention must be paid to the diversity of members within the community who can become pregnant, including trans, non-binary, intersex and bisexual individuals. Services should support trans, non-binary and intersex people, who often are the least likely to access contraception and simultaneously unlikely to seek reproductive services if it would place them in a position to be mistreated, discriminated against and misgendered by healthcare professionals.[44] Transgender women and men may encounter discrimination in accessing services, a lack of clinical knowledge of their health needs among providers and a lack of access to relevant health information. There may be also be reluctance among transgender people to access sexual and reproductive healthcare due to discomfort with the physical exam, lack of access to a medical provider they are comfortable with and/or fear of discrimination or refusal of care.[45]
- **Homeless women** who are particularly impacted by cost and local access barriers and are often unable to prioritise health – particularly reproductive health - due to competing demands.[46]

Below, we highlight barriers accessing contraception experienced by migrant women, Traveller women, young women and women in prostitution.

Migrant women

We know from our members that migrant women experience particular barriers to accessing contraception. Many migrant women in Ireland are in low income jobs and are unable to afford private healthcare. They are often particularly vulnerable to the cost barriers presented by expensive GP appointments and LARC fitting. It is therefore common for migrant women to access contraception services such as the pill – or even LARCs – while visiting their home countries.[47] These women will not receive any necessary follow-up care. Additionally, for women living in direct provision (often in isolated locations), the challenges of accessing a pharmacy or GP can be unsurmountable. In some cases it may be beneficial for contraceptive care providers to visit direct provision centres to ensure women's needs are met.

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[43] Grant, S (2017) '*Sexual and reproductive healthcare issues facing women with disabilities'* http://frontline-ireland.com/sexual-reproductive-healthcare-issues-facing-women-disabilities/

[44] Klein, D. *et al.* (2018) 'Providing quality family planning services to LGBTQIA individuals: a systematic review'. *Contraception,* 97, 378-91.

[45] J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, M. Keisling, (2011) *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. National Center for Transgender Equality and the National Gay and Lesbian Task force. https://transequality.org/sites/default/files/docs/resources/NTDS_Exec_Summary.pdf

[46] Kennedy, S. *et al.* (2014) '*A Qualitative Study of Pregnancy Intention and the Use of Contraception among Homeless Women with Children'. Journal Health Care Poor Underserved*, 25(2): 757-770 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4232303/.

[47] HSE Crisis Pregnancy Programme (2014) '*Research with Young Migrant Women on Sex, Fertility and Motherhood*' https://www.sexualwellbeing.ie/for-professionals/research/research-summaries/research-with-young-migrant-women-2014.pdf

Language barriers may also impede migrant women's decisions about contraceptive methods. In the absence of patient information in their native language, misconceptions about the side effects, or the effectiveness of certain types of contraception may occur. There is almost no availability of interpretation services in primary care. As a result, women will sometimes bring a friend or her children to provide interpretation. This may be particularly inappropriate when she is discussing her reproductive health. Disseminating information leaflets in a variety of different languages which explain how to access and use the various methods of contraception would go a long way towards addressing this barrier. Migrant women also report that they can find it difficult to navigate the Irish health system, which does not operate in a similar way to their home country. And they may be unfamiliar with terms, such as 'crisis pregnancy', which are learned tacitly over time by growing up in the local community.

Migrant women, or women from different ethnic minority backgrounds, may also face unique cultural barriers to accessing contraception. Women of certain cultures that do not approve of contraception may fear repercussions from their partners, families or communities if their use of contraception is discovered.[48] Lack of choice of healthcare provider may also present a barrier to some migrant women for whom it would be culturally inappropriate to receive reproductive healthcare from a man. Training is required for healthcare professionals to ensure they can provide a culturally appropriate contraception service. It is also vital that providers respect a woman's decision if she chooses not to take up contraceptive services, so that women do not feel there is any attempt to control their reproductive rights, instead emphasising services are available where it is her choice.

Undocumented migrants and those seeking asylum often experience very poor access to health services.[49] Exclusion from health services means that undocumented women face delayed access to screening, treatment and care, limited access to contraception and heightened levels of discrimination and gender-based violence, all of which damages women's health and perpetuates health inequities.[50] Undocumented migrant woman often report they are afraid to access GP care as they are concerned about being asked for a PPSN. It is vital that the future scheme provides care to undocumented women who are particularly disadvantaged in their access to healthcare services.

Traveller and Roma women

Traveller and Roma women face stark health inequities due to structural inequalities and failure to address the social determinants of health, including poor accommodation conditions, poverty, illiteracy and discrimination.[51] Language is a particular barrier for

[48] HSE Sexual Health and Crisis Pregnancy Programme (2018) '*Sexual Health in Ireland: What Do We Know?*' https://www.sexualwellbeing.ie/for-professionals/research/research-reports/sexual-health-in-ireland_june2018.pdf

[49] AkiDwa, Dorus Luimni and HSE (2017) '*Migrant Women's Awareness, Experiences and Perceptions of Health Services in Limerick'* http://dorasluimni.org/wp-content/uploads/2017/07/healthmapping.pdf.

[50] WHO (2016) *Migrant women's health issues: addressing barriers to access health care for migrant women with irregular status.* http://www.euro.who.int/__data/assets/pdf_file/0017/330092/6-Migrant-womens-health-issues-irregular-status.pdf?ua=1.

[51] All Ireland Traveller Health Study Team (2010) *Our Geels, All Ireland Traveller Health Study*. UCD https://www.paveepoint.ie/wp-content/uploads/2013/10/AITHS-Summary-of-Findings.pdf; Pavee Point Traveller and Roma Centre & Department of Justice and Equality (2018) *Roma in Ireland – A National Needs Assessment*.https://www.paveepoint.ie/wp-content/uploads/2015/04/RNA-PDF.pdf

Roma women given the lack of translation/interpretation services in health services. Roma women have limited access to public healthcare - 31.5% of Roma women do not have a GP; 44.6% do not have a medical card. Travellers report lower levels of trust in healthcare professionals at 41%, compared to 82% for the general population.[52]

Our members highlight particular barriers for Traveller women accessing contraception services. These include difficulties accessing health services due to location of sites and lack of public transport; lack of targeted health programmes – such as STI screening - for Traveller women; and the cost of contraceptive care, particularly in a community with a very high unemployment rate. There is a lack of culturally aware patient information and health service providers for Traveller and Roma women. Traveller women also report difficulty obtaining a GP. In general, Traveller women do not speak openly about sexual health. They may fear discrimination on the part of service providers and may be negatively impacted by societal expectations about the agency and sexual activity of Traveller women. Educational discrimination against Traveller children may mean that members of the community receive less sexual health education.

Working closely and alongside Traveller and Roma organisations to develop and disseminate culturally appropriate resources and health education awareness is crucial. Research has shown that 40% of Travellers and more than 70% of Roma felt discriminated against in accessing healthcare services. 83% of Travellers have reported getting their health information and advice from Primary Healthcare for Traveller Projects.[53] Training and resourcing a network of Roma Primary Healthcare projects, modelled on the Primary Healthcare for Traveller Projects, could increase Roma women's access to contraception.

Young women

For many young women the thought of going to their local GP to acquire a contraception prescription is intimidating, or embarrassing. Young people are usually not in a financial position to pay the fee for a GP visit, or to actually pay for the method of contraception on their own, with many relying on parents for financial support. This can become a large barrier as many young women are not comfortable sharing details of their sexual activity with their parents, which can lead to a sense of shame and consequently a lack of contraception altogether, or the use of condoms only.

A significant barrier to young women seeking to access contraception is the lack of education around sex and contraception in secondary schools. An Irish Second-Level Students' Union survey of its members on the quality of sex education for second level

[52] Pavee Point and the National Traveller Women's Forum (2017) 'Irish Traveller & Roma Women Joint Shadow Report – A Response To Ireland's Consolidated Sixth And Seventh Periodic Report To The Un Committee On The Elimination Of Discrimination Against Women.' http://www.paveepoint.ie/wp-content/uploads/2015/04/Pavee-Point-NTWF-2017-Joint-Shadow-Report-to-CEDAW-Committee-19012017.pdf

[53] All Ireland Traveller Health Study Team (2010) *Our Geels, All Ireland Traveller Health Study*. UCD https://www.paveepoint.ie/wp-content/uploads/2013/10/AITHS-Summary-of-Findings.pdf; Pavee Point Traveller and Roma Centre & Department of Justice and Equality (2018) *Roma in Ireland – A National Needs Assessment*. https://www.paveepoint.ie/wp-content/uploads/2015/04/RNA-PDF.pdf

students[54] found that a high proportion of respondents (28%) received no information about contraception in school; of those students who did receive contraception education 78% reported they were not taught about how to use the different methods of contraception. Contraception education is essential to support healthy sexual relationships, to lower the rate of teenage pregnancies and STI rates (see Section 8 below).

Many young people report a sense of shame or embarrassment when purchasing contraception due to a fear of judgement or disapproval. A free-of-charge contraception service could facilitate a more open conversation about the sexual health of young people. This is crucial to raise awareness amongst young people about the importance of using contraception, not only to prevent pregnancy but to prevent the spread of STIs.

Women in prostitution

The sexual and reproductive health issues for women in prostitution are numerous and widely documented internationally, including STIs, vaginal infections, unintended pregnancies, cervical cancer, hepatitis, rape, and HIV infection[55]. Many women are unaware of current contraceptive services, or are not in a position to access or use them. A universal contraception scheme has the potential to provide some harm reduction for women in prostitution. In particular, increased geographical spread of free contraception across the country would enhance access to contraception for many women in isolated situations. A key challenge will be to reach out to the most vulnerable and isolated women in prostitution who are often denied access to reproductive and sexual health supports, for example, women held in brothels and under varying degrees of emotional, coercive and physical control of pimps, traffickers and other third-party organisers. The contraception scheme should include training for contraception providers in identifying and supporting those affected by prostitution and trafficking and specialised referral pathways for women to access more holistic supports and exit programmes.

5. Increased access to condoms is needed in Ireland (Q11, 12)

Condoms are vital for the prevention of STI and should always be recommended alongside more effective forms of contraception. Universal contraception provision could facilitate expansion of the National Condom Distribution Service[56] into primary care, pharmacy and other relevant locations.

[54] ISSU (2018) 'Submission to the Joint Oireachtas Committee on Education and Skills' https://www.oireachtas.ie/en/debates/debate/joint_committee_on_education_and_skills/2018-05-01/3/

[55] See Farley, M. (2004) '"Bad for the Body, Bad for the Heart": Prostitution Harms Women Even if Legalized or Decriminalised'. *Violence Against Women,* 10(10): 1087-1125; O'Connor, M. and Pillinger, J. (2009) *Globalisation, Sex Trafficking and Prostitution - the Experiences of Migrant Women in Ireland*. Immigrant Council of Ireland, Women's Health Project HSE and Ruhama. http://emn.ie/files/p_201211231126542009_Trafficking_Report_ICI.pdf

[56] For details see: https://www.sexualwellbeing.ie/for-professionals/national-condom-distribution-service/national-condom-distribution-overview/.

6. Who should be responsible for delivering contraception and ensuring patient safety and a high quality of care in relation to contraception? (Q13, 14, 15, 16)

NWCI approaches all questions about the provision and access to contraception from the viewpoint of the best overall outcome for women. It is paramount – irrespective of the setting in which it is delivered – that contraceptive care is designed to accommodate the needs of individual women and is of high quality.

In coming late to universal provision of contraception, Ireland now has the opportunity to be a world leader in properly resourced comprehensive sexual health service, reducing the number of abortions that are needed, stopping the spread of STIs, increasing uptake of smears and increasing opportunities for reproductive health promotion.

The best outcome for women can be achieved by providing contraception in all appropriate locations – family planning clinics, primary care, hospitals and pharmacies – in line with clinical guidance. The scheme should be flexible to be able to respond to changing clinical best practice. Crucially, the provision of contraceptive care – spread as it will likely be across a number of locations – must work to ensure that Irish women's patterns of contraceptive use into the future reflect international guidance, and in particular increased LARC uptake. In practice, a large proportion of those attending for contraception consultations will be healthy young women who are unlikely to have regular interaction with primary care. In such cases their attendance for contraception provides an opportunity to raise and deal with other reproductive and sexual health matters and to provide STI screening for at-risk groups. This would have significant health gain for the woman but would also reduce costs to the health system for future disease.

Ensuring the free contraception scheme is available in hospital settings would optimise women's reproductive healthcare experiences. Hospital visits, particularly for gynaecology and obstetrics, can be used for opportunistic contraception consultations. Hospitals also have a crucial window of opportunity during the post-partum or post-abortion period to provide women with contraception consultations and to fit LARCs where desired. This is particularly beneficial for women from marginalised groups who may have limited contact with primary care services.

In considering all the options for provision (primary care, family planning clinics, pharmacy, etc.) it is vital that the overall approach and service provided to each woman achieves the following:

- All **cost barriers removed**
- **Greater accessibility of contraception**, through increased provider capacity
- **Safe care**, including contraception consultations enabling consideration of medical history, contraindications, woman's choice of method, reason for contraception use, etc.

- **Contraception consultations providing information and counselling** about all forms of contraception, including LARCs and copper coil as emergency contraception.
- **Access to LARC fitting where it is a woman's preference**.
- **Reproductive and sexual health promotion** (including STIs, cervical smear, smoking cessation etc.)

Women's privacy must be maintained in all locations. For example, pharmacists providing care under the scheme should have and make use of a consultation room for contraception discussions, checks and care.

In its operation we anticipate that a contraception consultation in primary care/family planning clinic would follow a Pro Forma consultation approach which would enable providers to check cervical smear status, undertake urine tests for STIs, STI swaps, menstrual health etc. as appropriate in each case.

In line with similar services, consultations in primary care and family planning clinics could be reimbursed via the Special Treatment Claim system via a new contraception consultation code, with equivalent reimbursement for pharmacy. Eventually, contraception should be included in the new GP contract and in the Sláintecare universal package of care.

7. Benefits of investing in contraception (Q17)

Q17 How important do you think it is to invest in the development of a scheme "for the provision of the most effective method of contraception, free-of-charge and having regard to personal circumstances, to all people who wish to avail of them within the State

NWCI believes that investment in such a scheme is of extremely high importance.

Benefits of contraception for women are addressed in section 1 above. This section focuses on the cost benefits of universal contraception provision to the health system.

The WHO determines family planning to be one of the most cost-effective investments a country can make in its future.[57] Investing in publicly-funded, universal access to the most effective contraceptive methods can realise significant cost savings over time. Primarily, improving access to contraception leads to a reduction in public spending associated with unplanned pregnancies.[58]

Access to contraception is fundamental to securing the autonomy and empowerment of women and girls. When women are in control over whether and when to have children, they are empowered to develop their education and career; their earning capacity is

[57] WHO (2019) Evidence Brief on Contraception.
[58] Guttmacher Institute (2019) Factsheet on '*Unintended Pregnancy in in the United States*'

increased; and they enjoy greater domestic equality and autonomy.[59] Enabling teenage girls to avoid unintended pregnancy is particularly impactful as they would otherwise be highly likely to leave education with all of the associated long-term implications.[60] Reproductive autonomy through access to contraception strengthens women's economic independence and enables them to break intergenerational cycles of poverty and inequality.

The cost of preventing unintended pregnancy through providing free, universal access to contraception is much lower than the cost of providing care for an unplanned pregnancy.[61] In particular, a reduction in the number of unintended pregnancies would lead directly to a reduction in demand for abortions. Given that they are highly-effective and can last for years without needing to be replaced, LARCs represent the most cost-effective investment for the health system. Research from the European Parliamentary Forum on Population and Development[62] found that for every euro the public sector spends on LARCs, six euro is saved in unintended pregnancy costs.

In addition to the savings associated with reducing unintended pregnancies, investing in contraception also reduces the need for public expenditure on healthcare generally. For example, in some cases contraception can be used to treat menstrual health conditions which the State would otherwise incur cost in managing. Attendance at contraception consultations supports opportunistic health promotion and screening and enables increased medical surveillance of women during their reproductive years, ensuring chronic illnesses are picked up earlier.

8. Conclusion (Q18)

In addition to the above, there a number of other factors which must be taken into account when developing a scheme of universal access to contraception.

Provision of fact-based, objective relationship and sexual health education

Investment in access to contraception must be accompanied by a thorough review and update of relationship and sexual health education (RSE). In order to empower women and girls to control their sexual and reproductive lives – including the prevention of unintended pregnancy and STIs – we must provide them with a comprehensive and fit-for-purpose education on their sexual and reproductive health. This need was recognised by both the Citizen's Assembly and the Joint Committee on the Eighth Amendment which

[59] United Nations Population Fund (UNFPA) (2014) '*Population and Poverty'*, New York: UNFPA http://www.unfpa.org/resources/population-andpoverty.
[60] UNFPA (2014) Population and poverty. http://www.unfpa.org/resources/population-andpoverty
[61] Guttmacher Institute (2018) '*Adding It Up: Investing in Contraception and Maternal and Newborn Health in Ethiopia'* https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-ethiopia
[62] European Parliamentary Forum on Population & Development (2018) '*Limited Access: Europe's Contraception Deficit'* Contraception Atlas https://www.contraceptioninfo.eu/sites/contraceptioninfo.eu/files/786209755_epf_contraception-in-europe_white-paper_cc03_002.pdf.

recommended the provision of impartial and evidence-based RSE independent of school ethos.[63]

RSE must be designed around the realities of girls' and boys' lives and inclusive of the full range of gender identities and sexualities. All young people should receive age-appropriate, comprehensive RSE based on scientific, accurate information. In particular, RSE should provide a space for challenging assumptions and building greater understanding around the issue of consent. Crucially, the scope, content and quality of RSE must be standardised and therefore independent of the ethos of individual schools. To do this, we must support teacher training so that educators feel comfortable teaching RSE and speaking with students about relationships and sex. We must also ensure that RSE is provided to young people who are outside the classroom, including to migrant and out-of-school children.

Increasing patient awareness and understanding of contraception

In addition to improving understanding around relationships and sexuality among young people, it is imperative that greater societal awareness and understanding of contraception is fostered. A recent Irish study found that GPs and pharmacists often assume a far greater level of understanding on the part of contraception users than is actually the case.[64] A key finding of this study was that service providers need to improve effective communication with their patients to ensure that they fully understand the implications of, as well as how to use, their chosen contraceptive method.

In order to address this need, service providers, and pharmacists in particular, must be provided with the necessary training (including cultural awareness training) to effectively communicate with their patients. Increased funding should also be provided to the HSE SHCPP to enable the further development and promotion of resources for women to support them in choosing and adhering to the most appropriate method of contraception for their needs.[65] Dissemination of these resources to the broadest possible audience must be prioritised and, in particular, developing and disseminating resources in languages other than English.

Investment in research

As reproductive healthcare develops in Ireland, policymakers must invest in an ongoing research programme focusing on contraceptive use in Ireland. Building on previous ICCP studies (2003 and 2010), this research would gather up-to-date data on sexual and reproductive health, track any barriers to care and support ongoing improvements of information and services. If health inequities in access to contraception are identified, research into effective strategies for reducing these inequities should be undertaken.

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[63] Report of the Joint Oireachtas Committee on the Eighth Amendment 2017 (December 2017) https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_the_eighth_amendment_of_the_constitution/reports/2017/2017-12-20_report-of-the-joint-committee-on-the-eighth-amendment-of-the-constitution_en.pdf.

[64] Sweeney L-A, Molloy GJ, Byrne M, Murphy AW, Morgan K, Hughes CM, *et al.* (2015) *'A Qualitative Study of Prescription Contraception Use: The Perspectives of Users, General Practitioners and Pharmacists.'* PLoS ONE 10(12): e0144074 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0144074.

[65] For example, see https://www.sexualwellbeing.ie/sexual-health/contraception/talking-about-contraception/talking-to-your-gp-or-doctor/your-contraceptive-choices.pdf

In order to ensure that the most effective, safe and appropriate contraceptive methods are being provided, ongoing clinical research into new and alternative methods must be funded.[66] In particular, efforts to develop male controlled contraceptive technologies must be prioritised in order to balance the contraceptive burden.

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[66] UNFPA (2018) '*Making Reproductive Rights and Sexual and Reproductive Health a reality for all*' https://www.unfpa.org/resources/making-reproductive-rights-and-sexual-and-reproductive-health-reality-all