Report of the Working Group on Access to Contraception

October 2019

Table of Contents

1. Executive Summary

The Working Group was established by the Minister in April 2019 to consider the range of policy, regulatory and legislative issues arising in relation to improving access to contraception. This report from the Group draws on the outcome of stakeholder engagement and a review of the research literature to focus on the barriers that exist to accessing contraception and the mechanisms available to overcome those barriers.

The report first briefly reviews the policy and political context and presents an overview of approaches to the provision of contraception and contraceptive services internationally, highlighting the health and human rights perspective in this area. It then considers the current use of contraception methods available in Ireland before focusing on the barriers that may exist with regard to accessing contraception and how they may be alleviated.

It is clear that barriers to accessing contraception do exist for some people, with the most prevalent obstacles identified as lack of local access, cost, embarrassment, inconvenience and lack of knowledge. At the same time, it is evident that contraception use in Ireland is high and stable and difficulty accessing contraception is only a challenge at the margins in overall population terms.

The weight of research evidence and the contributions from stakeholders are persuasive as to the potential beneficial health impacts of providing people, especially women, with the opportunity to choose the most effective and suitable type of contraception for them based on their health and lifestyle needs and preferences. However, what is less clear is the extent to which current funding, legislative and eligibility arrangements may be adversely impacting on this choice.

In particular, the notion that there is a sizable affordability challenge across the population in terms of accessing contraception remains unproven. At the same time, the costs to the State of introducing a free contraception scheme are significant (indicatively in the region of €80m-€100m), and there is a considerable risk that simply making contraception free to the end-user will only displace private expenditure without necessarily modifying behaviour or yielding the level of desired health benefits.

Any policy initiative in this area will, therefore, have to go beyond the question of cost to address issues of accessibility, education and workforce capacity as part of an overall policy on Sexual and Reproductive Health (SRH).

It is questionable as to whether a State-funded contraception scheme represents the optimal use of funds on a purely cost-benefit basis. This reservation should not be dismissed lightly, although there are other considerations that need to be taken into account when formulating policy on contraception. These include the potential for health benefits; the policy context following the enactment of the Health (Regulation of Termination of Pregnancy) Act 2018; and the health and women's rights dimension of contraceptive access. It is these factors that the Group consider may justify policy initiatives in support of improved access to contraception and policy options are suggested accordingly, together with proposed next steps.

2. Introduction

In June 2017, the final report of the Citizens' Assembly on the Eighth Amendment of the Constitution to the Houses of the Oireachtas made a number of ancillary recommendations focused on wider policy areas related to crisis pregnancy and termination of pregnancy. One of these was that

"Improved access to reproductive healthcare services should be available to all women – to include family planning services, contraception, perinatal hospice care and termination of pregnancy if required."

The Citizens' Assembly's ancillary recommendations were taken into account by the Joint Oireachtas Committee on the Eighth Amendment of the Constitution, chaired by Senator Catherine Noone, which was established to consider the Citizens' Assembly's report. The Committee heard from Constitutional, legal, and medical experts, as well as from groups affected by the Eighth Amendment. It noted that

"The issue of contraception and the link between the greater use of contraception and lower pregnancy termination rates featured in the deliberations of the Committee on a frequent basis… The Committee has a particular concern about the cost of contraception and notes that, while it is free for those with a medical card, for those on the cusp of qualifying for a medical card, the costs can be prohibitive."

The Committee went on to recommend:

"…the introduction 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."

In addition, the Committee made recommendations on sex education and other relevant areas.

These concerns and recommendations reflect the fact that unintended or crisis pregnancy remains a public health concern in Ireland, as it does internationally.

Preventing or reducing crisis pregnancy has been a focus of Government policy in Ireland for some time, with the Crisis Pregnancy Agency (now the HSE Sexual Health and Crisis Pregnancy Programme (SHCPP)) established almost 20 years ago in 2001. Recent years have seen a renewed focus on the issue with the deliberations of the Citizens' Assembly and the Joint Committee, as well as the debate during the campaign leading up to the Referendum on the Thirty-sixth Amendment of the Constitution. However, it is important that any policy measures introduced in respect of contraception are not seen solely as a means of reducing the number of crisis pregnancies or the number of terminations. Rather, improved access to contraception should be viewed as having the potential to positively contribute to the health and well-being of women, men and society as a whole.

Reflecting the need for informed policy development in this area, the Minister established a Working Group in April 2019 to consider the range of policy, regulatory and legislative issues arising in relation to improving access to contraception.

The Group's Terms of Reference (ToR) were:

- To conduct a rapid review of national and international literature on contraception and associated issues;
- To specifically examine the extent to which cost is a barrier to accessing reliable methods of contraception in Ireland and to consider whether there are other factors influencing access to contraception that could be addressed;
- To examine mechanisms to address any access issues identified, including financial, legislative, regulatory and contractual issues, as well as any other relevant matters;
- To consult with relevant stakeholders; and
- To make recommendations to the Minister on the optimal policy options and next steps.

This paper represents the outcome of the Group's work. It briefly reviews the policy and political context in this area and presents an overview of policy approaches to the provision of contraception and contraceptive services internationally. It then considers the current use of contraception methods available in Ireland before focusing on the barriers that may exist with regard to accessing contraception. The paper then reflects on how these barriers can be overcome, highlighting implications for health policy and service delivery. It concludes by suggesting some possible policy options and next steps for consideration.

3. Policy and Political Context

Historically, the regulation of fertility and sexual activity has been a controversial subject around the world, and Ireland has certainly been no different in this respect. The availability of contraception and access to contraceptive services was an issue of discord at various times throughout much of the 20th Century, broadly reflecting the conflict between the traditional, religious and moral consensus and the emergence of a more liberal, progressive society and State.

As late as 1979, the introduction of the Family Planning Act was widely, if not universally, interpreted by doctors as only allowing contraception to be prescribed to married couples. Changing social attitudes eventually resulted in contraception becoming fully available in Ireland in 1993. Attitudes and perspectives on reproductive rights have continued to evolve in the intervening years, culminating in the referendum on the Thirty-sixth Amendment of the Constitution in 2018 and subsequent enactment of the Health (Regulation of Termination of Pregnancy) Act 2018.

In relation to Sexual and Reproductive Health (SRH) more generally, the National Sexual Health Strategy (2015-2020) is being implemented to improve sexual health and wellbeing and reduce negative sexual health outcomes. This Strategy, launched on 29th October 2015, represents the first time that a nationally coordinated approach had been developed to address sexual health and wellbeing in Ireland.

Implemented under the Healthy Ireland Framework, the strategy has three overarching goals:

- Everyone in Ireland will receive comprehensive and age-appropriate sexual health education/information and will have access to appropriate prevention and promotion services;
- Equitable, accessible and high-quality sexual health services, which are targeted and tailored to need, will be available to everyone; and
- Robust and high-quality sexual health information will be generated to underpin policy, practice, service planning and strategic monitoring.

Of particular relevance in the context of improved access to contraception is recommendation 4.1 of the Strategy to: "*Provide universal access to sexual health services for all service users and prospective service users".* This recommendation – and the overall principles of the strategy – aligns with the recommendation of the Joint Committee on the Eighth Amendment and with the Ancillary Recommendations of the Citizens Assembly, as well as the international literature on the benefits of contraception.

A mid-term review of the Strategy found that implementation was proceeding well and suggested that it will remain relevant beyond 2020. It is therefore intended that the Strategy will be reviewed and refreshed in the coming months to identify priorities and actions for the post-2020 period.

While acknowledging its benefits for population health and well-being generally, the political and policy discussion around access to contraception is also being framed within the wider context of women's health, particularly in light of the findings from the *Inquiry into the CervicalCheck Screening Programme* by Dr Gabriel Scally, and his recommendation that women's health issues be given more consistent, expert and committed attention within the health system and the Department of Health. As previously highlighted, the issue of contraception is not solely about reducing the number of crisis pregnancies but about providing women with the opportunity to safely and effectively manage their reproductive health and wellbeing.

In this context, and beyond the question of contraception, it should be noted that the Department of Health is convening a Women's Health Taskforce to determine and implement a strengthened, coherent approach to improving Women's Health, including the delivery of the Women's Health Action Plan.

4. International Perspective

It is generally an internationally accepted aim of public health policy to reduce the number of unplanned or crisis pregnancies. Access to contraception enables individuals to safely space and limit their pregnancies while reducing the number of unplanned and crisis pregnancies, while the availability of contraception is also associated with reduced maternal morbidity and mortality and better birth outcomes. Furthermore, barrier methods of contraception can provide protection against sexually transmitted infection and disease, while some methods of hormonal contraception have been associated with proven health benefits, including reduced risk of endometrial and ovarian cancers, among others.

There is variation in policy approaches across the globe reflecting the unique evolution and structures of health systems in different countries. In this context, it is important to recognise that

Ireland is not an outlier in terms of policy on contraception. For example, the European Contraception Atlas for 2019 ranked Ireland twelfth of 46 countries with a rating of 65% for Government policies on access to contraceptive supplies, family planning counselling and the provision of online information on contraception. This is not to say that there is not scope for improvement, but it does indicate that some of the criticisms that Ireland is "failing" in terms of its approach to contraception are somewhat exaggerated.

The provision of contraception and contraceptive services in five OECD countries is summarised below to highlight how approaches vary and are a reflection of the operational structures and systems of the respective health systems. More detailed Country Profiles can be found in Appendix 1.

United Kingdom

Contraception is provided free at the point of access to all in the UK, under the NHS. All forms of contraception are covered including permanent sterilization of both males and females. Contraception can be accessed at specialised clinics, GP surgeries or other services. Prescriptions are required for all hormonal contraceptives (excluding the emergency contraceptive pill which is available over the counter). STI screenings and family planning services are also provided free of charge under the NHS.

Netherlands

In the Netherlands, healthcare is provided under a mandatory insurance scheme which is publicly funded. However, contraception is not covered under the scheme for most people. It is covered for those under the age of 21, but other individuals must meet this cost themselves and will typically purchase complementary voluntary insurance with additional coverage of contraception. Although prescriptions are initially required for contraceptives in the Netherlands, repeat dispensing of oral contraceptives do not require a new prescription. Family planning or contraceptive advice provided by the GP is covered under the public insurance scheme.

New Zealand

Most forms of contraception are available either partially or fully subsidised in New Zealand. The subsidy will vary depending on the brand or device in question. Methods that have at least one fully subsidised option are: male condoms, copper IUDs, implants, combined oral contraceptive pills, progestogen-only pills, injections and emergency contraceptive pills, although prescription charges will still apply for some methods. Lower cost or free contraception is also available from Family Planning Clinics, which are partially State-funded. A prescription is required for first-time use of hormonal contraceptives, excluding the emergency contraceptive pill. However, women who have previously been prescribed an oral contraceptive pill can then access contraceptive pills over the counter, i.e. they do not need to obtain a new prescription.

Australia

Australians who enrol in the publicly funded Medicare scheme are entitled to some free or subsidised healthcare services, such as GP visits. Those enrolled in Medicare can also access subsidised prescription medicine on the Pharmaceutical Benefits Scheme, which covers some forms of the following hormonal contraception: combined oral contraceptive pill, progestogen-only pill, contraceptive implant, hormonal IUD, and contraceptive injection. A prescription is required for all hormonal contraceptive methods and the IUD (excluding the emergency contraceptive pill which is available over the counter).

Canada

In Canada, there is a publicly funded healthcare system called Medicare. However instead of a single national plan, each province/territory has its own public insurance plan with variations in cover. Contraception cover depends on the province/territorial plan. Some health plans cover the cost of prescription birth control, but typically provincial health insurance plans do not cover drugs and devices. As such, many Canadians require supplemental insurance schemes or pay out of pocket for contraception. Although prescriptions are required for hormonal contraceptives in Canada, in some provinces, pharmacists can prescribe short acting hormonal contraception directly.

4.2 Global Policy - Health and Human Rights Perspective

At a global level, access to contraception is now considered as a key component of the human right to health and has been affirmed as such by both the United Nations (UN) and organisations such as the World Health Organization (WHO) on numerous occasions.

UNFPA, the UN sexual and reproductive health agency, maintains that every individual has the right to make their own choices about their sexual and reproductive health and views access to safe, voluntary family planning as a human right. To maintain sexual and reproductive health, UNFPA states that people need access to accurate information and to a safe, effective and affordable contraception method of their choice. UNFPA also says that people must be informed and empowered to protect themselves from sexually transmitted infections and highlights the fact that, when they decide to have children, women must have access to services that can support them during pregnancy and promote safe delivery and healthy baby. The UNFPA's goal is universal access to sexual and reproductive health and rights, including family planning.

The WHO also acknowledges the importance of access to contraception, describing it as essential to securing the well-being and autonomy of women, while supporting the health and development of communities. The WHO has stated that it is important that family planning is widely available and easily accessible through midwives and other trained health workers to anyone who is sexually active, including adolescents.

It is also important to acknowledge that from a rights perspective, contraception can be thought of as a gendered financial burden, with the vast majority of costs associated with contraceptive services borne by women. Indeed, although much of this paper will be concerned with economic and health benefits and costs, it is a legitimate approach to set such considerations aside and for the State to provide contraception on purely rights-based or equality grounds, accepting any costs that may subsequently arise.

5. Contraception in Ireland

As the Irish Contraception and Crisis Pregnancy Study 2010 (ICCP-10) highlighted consistent use of contraception is the most effective way to reduce the risk of experiencing an unwanted pregnancy or acquiring a sexually transmitted infection. Having a clear picture of contraception use and factors that influence people's decisions to use contraception is essential to inform policy aimed at improving sexual health and reducing crisis pregnancy.

The ICCP-10 found that 94% of people aged 18-45 years who were having sex but not actively trying to conceive had used some method of contraception to avoid pregnancy in the previous year. Furthermore, 78% of respondents (84% of women and 72% of men) reported that they always used a form of contraception each time they had sex. This suggests that contraception use in Ireland is relatively high and stable. Male condoms are the most commonly used form of contraception in Ireland while the contraceptive pill is the most common form of contraception used by women. Appendix 2 provides further information on the use of different contraceptive methods in Ireland.

Despite the high level of contraception use, it remains the case that 6% of respondents who were having sex but not actively trying to conceive had not used any method of contraception during the previous year. This is in line with international norms but remains a concern as is the finding from ICCP-2010 that 22% of respondents had not used contraception every time they had sex during the previous year. More recent data from the Healthy Ireland Survey 2015 showed that almost one-half (47%) of respondents did not use any form of contraception when they last had sex, while that survey also found that 17% of those having sex outside of a steady relationship did not use contraception.

It is noteworthy that the proportion of sexually active respondents not using contraception but not trying to conceive increased with age, while married couples were 63% less likely to have used contraception compared with single people. ICCP-10 suggested that this was because of a relatively high level of ambivalence towards pregnancy among the older age groups surveyed.

The effectiveness of different methods of contraception is an important factor to bear in mind when considering contraceptive use. The table below highlights the effectiveness of long-acting reversible contraception (LARC) compared to other contraceptive methods, especially in terms of typical as opposed to perfect use.

Table 1: Effectiveness of Contraception - Typical vs Perfect Use[1]

	Typical Use %	*Perfect Use %*
Natural Family Planning	**76**	**99**
Female Condom	**79**	**95**
Diaphragms & Caps (used with spermicide)	**71 - 88**	**92 - 96**
Male Condom	**82**	**98**
Contraceptive Patch	**91**	**99**
Vaginal Ring	**91**	**99**
Combined Contraceptive Pill	**91**	**99**
Progesterone-Only Pill	**91**	**99**
Contraceptive Injection	**94**	**99**
Contraceptive Implant	**99**	**99**

[1] NHS Contraception Guide https://www.nhs.uk/conditions/contraception/how-effective-contraception/

	Typical Use %	*Perfect Use %*
Intrauterine System	**99**	**99**
Intrauterine Device	**99**	**99**
Female Sterilisation	**99.5**	**99.5**
Vasectomy	**99.9**	**99.9**

Indeed, a consistent theme to emerge in stakeholder consultation was around the efficacy of LARC and the need for LARCs to be included in any new contraception scheme. This is also reflected in research with, for example, a study from Finland suggesting a link between an increase in LARC utilisation and a fall in the number of terminations and a study from Norway suggesting that a 5% increase in LARC use resulted in a 30% reduction in typical use method failure rates as a cause of unintended pregnancy.

5.1 Regulation of Access to Contraception

Condoms are available without restriction in Ireland from a variety of commercial sources, including pharmacies, supermarkets and vending machines. Other forms of contraception, including hormonal contraceptives and LARCs, require a prescription from a registered medical professional under the Medicinal Products (Prescription and Control of Supply) Regulations 2003.

The Regulations define several different classifications ("Schedules") relating to the supply of medicines to the Irish market. The First Schedule (S1) lists all medicines subject to prescription control; this is further subdivided into three classes (S1A, S1B, S1C) which have implications for the way a prescription should be written and dispensed.

Under these regulations, all forms of LARC (the contraceptive injection, implant, intrauterine system (IUS) and intrauterine device (IUD)) are classified as S1A medicines and are thus restricted to medical prescription which may not be repeated, unless specifically stated by the prescriber. In other words, a new prescription is required from a registered medical professional to obtain a new product.

Oral contraceptives fall under a different schedule (S1B) which allows for a prescription to be repeated for up to six months from the date of issue, unless the prescriber specifically limits the number of repeats or the amount to be dispensed.

5.2 Eligibility for Contraceptive Services

Eligibility for access to contraceptive products is currently governed by the same eligibility framework as applies more broadly in the Irish healthcare system. Under this framework, any person regardless of nationality, who is accepted by the Health Service Executive (HSE) as being ordinarily resident in Ireland has eligibility to health services. A person is deemed ordinarily resident if they are living in Ireland and have lived here, or intend to live here, for at least one year.

There are two types of eligibility for people who are ordinarily resident:

- Full eligibility for medical cardholders; and
- Limited eligibility for people who do not have a medical card.

Approximately one-third of the population hold a medical card, and these individuals can access contraception, including LARCs, free of charge except for a €2 per item prescription charge levied at the pharmacy. Condoms and the copper coil are not covered under the General Medical Services (GMS) scheme.

A further 10% of the population have GP visit cards which provide free access to a doctor, including consultations on contraceptive need which effectively removes the clinical cost associated with contraception, although it does not defray product costs. For those not in possession of either a medical card or GP visit card, contraception is an out-of-pocket expense although the Drug Payment Scheme (DPS) covers in full the cost of prescribed medication in excess of €124 a month for an individual or family which can serve to limit out-of-pocket expenditure.

5.3 Crisis Pregnancy in Ireland

As noted earlier, crisis pregnancy has long been a focus of Government policy in this country, with the Crisis Pregnancy Agency (Establishment) Order, 2001 defining crisis pregnancy as "…a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her."

Crisis pregnancies are those that involve a personal crisis or emotional trauma and, as such include the experiences of women for whom a planned pregnancy may develop into a crisis over time due to a change in circumstances. The ICCP-10 found that 35% of women and 21% of men surveyed reported experiencing a crisis pregnancy at some point and that around 13% of all pregnancies could be considered as a crisis pregnancy.

Young adults aged between 18 and 25 are the main "at-risk" group for experiencing a crisis pregnancy, with the average age for experiencing such a pregnancy being 24 for women and 23 for men. Furthermore, young people who have sex before the age of 17 are 70% more likely to experience a crisis pregnancy and three times more likely to have a termination in later life. However, it should also be noted that an increase in older married women reporting crisis pregnancy has been identified between 2003 and 2010.

Overall, the characteristics of crisis pregnancy in Ireland mirror the wider international picture: socio-economic status and higher educational attainment improve women's ability to access information and services and to exert control over their sexual and reproductive lives.

Although contraceptive failure is a factor in the prevalence of crisis pregnancy, the ICCP-10 found that almost one-half of women who reported experiencing a crisis pregnancy were not using contraception at the time of the conception of their most recent or only crisis pregnancy. Of these, 47% said that they did not believe that they were at risk of becoming pregnant at the time, highlighting knowledge gaps within the general population relating to fertility. Other reasons for not using contraception were that sex was not planned, individuals were "taking a chance" or that alcohol or other drugs were used.

It must be emphasised that most crisis pregnancies are resolved through the birth of a baby with up to 75% of woman and 66% of men choosing to parent as a result of a crisis pregnancy. According to the ICCP-10, 32% of men and 24% of women reported that their most recent crisis pregnancy had ended in termination of pregnancy (at a time when the procedure was not readily accessible in Ireland).

6. Accessing Contraception and Contraceptive Services in Ireland

In the ICCCP-10 study, 12% of respondents reported they had experienced some level of difficulty in accessing contraception at some point in their lifetimes. Of these, 75% reported access was sometimes difficult, 16% quite difficult and 8% very difficult. This means that in terms of the total cohort, just under 3% or 67 of 2,360 respondents reported that access to contraception was quite or very difficult.

The ICCP data also highlighted that the issue of access was more pronounced among females, with almost twice as many women (15%) as men (9%) reporting difficulty in accessing contraception. Younger people (18-25 years) were more likely to say that they had experienced difficulty in accessing contraception.

The main barriers to accessing contraception reported in 2010 were lack of local access, cost, embarrassment, inconvenience and lack of knowledge about where to access contraceptive services as detailed in the table below.

Table 2: Reasons Given for Difficulty in Accessing Contraception

	% of total respondents	*% of respondents reporting difficulty in accessing contraception*
Cannot access contraceptive services in locality	**4.7**	**42**
Cannot afford contraceptive services	**3**	**24**
Embarrassment	**3**	**23**
Inconvenience	**1.2**	**13**
Do not know where to access contraceptive services	**0.8**	**7**

A database search and review of reference lists for published research literature conducted on behalf of the Working Group found that the barriers identified in 2010 continue to be relevant today. This research exercise also identified additional barriers relating to the prescription status of some contraceptives; the capacity of GPs to provide certain services; and the perceived risks associated with the use of particular contraceptives. Access issues for vulnerable groups also emerged as an important theme from the review.

Individuals may of course experience more than one barrier to accessing services. This is an important factor when considering the issue of cost as it implies that simply making contraception

free to all may not achieve the desired health outcomes – a free service is of little use if there is no local access to the service or if an individual is not informed about the options that are available to them.

It is also important to recognise that these barriers are not independent of one another but are rather interrelated. For example, embarrassment may be more of a barrier when the only local access to contraceptive services is via a male GP or a practitioner who is known among family members.

7. Cost as a Barrier to Contraception

The cost of contraception varies according to the particular form of contraception being used and the requirement for clinical consultation and/or procedure as detailed in the table below.

As can be seen in Table 3, a packet of 12 condoms would cost around €13, while the cost of the oral contraceptive pill is between €5-€14 per pack plus an average cost of around €50 for a GP consultation and prescription (twice yearly). There is further variation in the costs of different types of LARC, but broadly these devices would cost in the region of €250-€350, including the cost of fitting and consultation. The contraceptive injection costs around €70-80 and lasts for three months, with subsequent injections priced at €65-€70 including consultation.

As previously noted, these costs are covered for those with a medical card, while those with a GP visit card will save a considerable amount of clinical costs, for example, they will not have to pay the costs arising from two GP visits to secure a year's supply of oral contraception.

The ICCP-10 found that 3% of all respondents identified cost as a barrier to accessing contraception while just under one-quarter of those who had experienced difficulty accessing contraception identified cost as an issue. During its deliberations, the Working Group noted that the emphasis on cost by some stakeholders appeared to be based, at least in part, on a misreading of the available data, and it should be clarified that it is not the case that 24% of all respondents reported cost as a barrier to contraception. This is an important point as it highlights the marginal nature of cost as a barrier, suggesting affordability concerns may not be prevalent among the wider population.

Indeed, the variance between the ICCP-10 data and emphasis placed on cost by stakeholders is striking. On one level, this reflects a concern for the more vulnerable or less wealthy in society. Stakeholders frequently noted that cost was more likely to be an issue for specific cohorts including young people, those on low incomes or the working poor (who may still be just above GMS threshold) and other vulnerable groups such as the homeless. The possibility that this emphasis reflects changes in economic circumstances over the past decade cannot be dismissed. It may be the case that there are now more people "Just About Managing" or people in other vulnerable groups with the result that the cost of contraception is now problematic for more people in a way it has not been heretofore. Further study and more current data are required to gain greater clarity on this point.

Table 3: Cost Comparison of Contraception Methods

Method	Clinical/Consultation Cost[2]	Cost per Unit[3]	Units per year	One Year Cost	Five Year Cost	Average Annual Cost (5 Year)	Ten Year cost	Average Annual Cost (10 year)
Male condom	n/a	€1.25	55[4]	€69	€344	€69	€688	€69
Female condom	n/a	€5	55[3]	€275	€1375	€275	€2750	€275
Diaphragm	€100 initial; €50 follow-up (every 2yrs)	€55[5]	1	€155	€475	€95	€850	€85
Oral contraceptive	€50 (every 6 months)	€7	13	€191	€955	€191	€1910	€191
Vaginal ring	€50 (every 6 months)	€20	13	€360	€1800	€360	€3600	€360
Transdermal patch	€50 (every 6 months)	€19	13	€347	€1735	€347	€3470	€347
IUS (hormonal: Mirena or Kyleena – effective for 5 years	€210 (consultation & insertion); €290 (removal & re-insertion)	€124	1	€334	€334	€67	€748	€75
(IUS) (hormonal: Jaydess – effective for 3 years)	€210 (consultation & insertion); €290 (removal & re-insertion)	€124	1	€334	€748	€150	€1576	€158
IUD (non-hormonal: copper – effective for 10 years)	€220 (consultation & insertion)	€25	1	€245	€245	€49	€245	€25
IUD (non-hormonal: copper – effective for 5 years)	€220 (consultation & insertion)	€25	1	€245	€245	€49	€490	€49
Implant (hormonal: Implanon – effective for 3 years)	€160 (consultation & insertion); €150 (removal & re-insertion)	€124	1	€284	€558	€112	€1106	€111
Intramuscular injection (DMPA)	(quarterly visit included in unit cost)	€70	4	€280	€1400	€280	€2800	€280

[2] Based on average taken from nine clinics across Ireland

[3] Based on average pharmacy cost and maximum payment under the Drug Payment Scheme

[4] Based on average sexual frequency of adults in the U.S.

[5] Includes diaphragm and spermicide/contraceptive gel costs

It may also be the case that the stakeholder focus on cost reflects the fact that women are likely to be more disadvantaged in this respect. The more reliable forms of contraception that require clinical consultation (and are thus more expensive) are used by women, while at the same time, evidence suggests that women are more likely to have lower earnings than men.

At another level, the emphasis on cost seems to reflect a desire to change behavioural patterns in terms of contraceptive usage. The interaction between contraceptive usage and cost is complex and should not be framed only in simple binary terms as whether an individual can or cannot afford contraception. Rather, the question must also be whether cost factors may be influencing decision-making around the type of contraception used or how effectively or consistently a particular method of contraception is being used.

For example, the ICCP-10 study highlighted how cost considerations could lead to behaviours that increase the risk of crisis pregnancies, finding that;

- 5% of respondents who had used condoms during the previous year indicated that they had had sex on at least one occasion during the year without using condoms because of cost factors; and
- 12% of women without a medical card had not filled their prescription for contraception because they could not afford it.

The research review reinforced these findings, with, for example, a study by Barlassina[6] finding that 18.8% of oral contraception users without a medical card had missed taking the pill because they could not afford the prescription. Clearly, crisis pregnancies can occur in scenarios where a woman can, in general terms, afford the costs associated with oral contraception but may nonetheless delay renewing a prescription, even for a few days, because, for example, she needs to wait for payday.

The vast majority of stakeholders also suggested that women were opting for other, less effective forms of contraception because of the upfront cost of LARCs. This is in line with the ICCP-10 finding that 27% of women who had considered using LARCs reported that cost factors had prevented them from choosing these products as their method of contraception. At the same time, there is evidence of an increase in uptake of LARC in recent years despite any concerns about cost.

The focus on cost then is not, in most cases, simply about whether it is a barrier to contraception per se. Rather it is a matter of whether cost may be preventing people, but particularly women, from accessing the most effective form of contraception or whether cost may be responsible for undermining optimum use of the preferred contraceptive method. A further consideration is whether the cost barrier relates more to the product itself or the clinical costs associated with obtaining the product. For LARC, it may be both, but the cost of the product is certainly more significant than other forms of contraception, whereas for oral contraceptives, the main cost is very much clinical.

There is also a wider issue around the cost of medical care preventing individuals from seeking medical treatment beyond contraceptive services. The ICCP-10 found that 18% of respondents without a medical card found the cost of a GP consultation to be a frequent barrier to them seeking medical attention. This question was not specifically concerned with access to contraceptive services, and it is unfortunate that again there appears to be some misinterpretation of this finding in some of the discussion around contraceptive access. Nonetheless, it does seem reasonable to

[6] Barlassina L. Views and attitudes of oral contraceptive users towards their availability without a prescription in the Republic of Ireland. Pharmacy Practice. 2015 Apr.

infer that concerns about medical expenses, in general, may be having at least some adverse impact on individuals' access to contraception.

8. Other Barriers to Contraception

8.1 Access to Services

The most frequently cited barrier to contraception in ICCP-10 was accessing services in the locality, identified by 42% of those who had experienced difficulties accessing contraception or almost 5% of total respondents.

This is a somewhat surprising finding given the wide commercial availability of condoms and the fact that there are around 2,500 GPs who hold a GMS contract and numerous community pharmacists across the country. Certainly, it would seem that geographical access is not a challenge in the same way as it may be in the United States, Canada or New Zealand, and it is noteworthy that there were no statistically significant differences between respondents living in urban or rural areas in the Irish context.

It would, therefore, seem that "access" encapsulates a number of scenarios beyond geography, ranging from lack of access to any service whatsoever in a given area to extended waiting times for service to lack of service at convenient times such as evenings or weekends.

8.2 Embarrassment & Stigma

Again, the research review conducted on behalf of the Working Group mirrored the findings of ICCP-10 (and indeed ICCP-2003) in highlighting the fact that embarrassment continues to be a barrier to contraception despite the significant attitude shifts in society.

Almost one-quarter of those who reported difficulty accessing contraception in ICCP-10 cited embarrassment as a factor, while research highlighted how young women have reported being afraid to reveal they are sexually active; embarrassed to be seen at a family planning clinic; or worried about confidentiality breaches. Embarrassment has also been reported in relation to talking to GPs, pharmacists and clinic staff about contraception and with regard to purchasing condoms, as well as asking partners to wear them and using them.

The research literature concords with ICCP-10 that younger adults are more likely to cite embarrassment as a reason for having difficulty in obtaining contraception as compared to older individuals. It also appears, somewhat counter-intuitively, that stigma is more of a factor among younger adults, with younger people, especially younger men, more likely than their older counterparts to hold a negative opinion about women carrying condoms as a precautionary measure in the event of an unanticipated sexual encounter.

Research[7] has also highlighted that parents can feel uncomfortable and lack confidence when talking about relationships, sexuality and contraception with their children. This is problematic as

[7] Ackers et al "Family Discussions About Contraception and Family Planning: A Qualitative Exploration of Black Parent and Adolescent Perspectives" Perspectives on Sexual and Reproductive Health, September 2010.

families are the primary social context in which children's sexual socialisation begins and if communication around safe sex is limited or awkward, this can further feelings of embarrassment and discomfort around contraceptive access and lead to younger users feeling the need to hide their contraception use from parents and other older adults.

8.3 Inconvenience

The concept of inconvenience as a barrier to contraception is two-fold. On the one hand, inconvenience can relate to the limitations of service, with young women highlighting the lack of availability of contraception services out of school or work hours[8] or more generally the need to visit a GP to access oral contraception because of its prescription status.

The second aspect of inconvenience is a function of the use of the product, with various sources in the research review noting that adherence to the oral contraceptive pill is troublesome with Irish users needing improved knowledge of correct use instructions or often forgetting to take their pill.[6,9] Other research has referenced the perceived inconvenience of using condoms.

8.4 Misinformation and Lack of Information

The ICCP-10 showed that lack of knowledge about where to access contraceptive services was one of the top five barriers to accessing contraception while also highlighting some deficiencies in knowledge about contraception and fertility. For example, some 68% of respondents thought that taking a break from long-term use of the contraceptive pill was a good idea despite the literature showing that there is no medical need to refrain from using the contraceptive pill for long periods.

Again, the review of more recent research suggests that little has changed in this regard and that a lack of knowledge or lack of access to accurate information remains a barrier to contraception use in Ireland (and indeed across Europe). The cross-European TANCO study of 2018, which included Irish respondents, found that self-reported knowledge of intrauterine contraception was significantly lower than for oral contraceptives while research in Ireland found misconceptions about side effects or negative health outcomes of LARCs to be common and influential in terms of contraceptive decision making[10].

Numerous studies have found that hormonal contraception, in general, is hampered by misinformation around safety and its impact on fertility. Stakeholders also highlighted the prevalence of these myths as a factor that continues to impact contraception use and choice.

8.5 Capacity of Healthcare Providers

An issue highlighted through the research review and by many stakeholders was the possible lack of capacity to deliver contraceptive services among medical practitioners, especially in terms of the insertion and removal of LARC. This can effectively be considered a supply-side constraint on access to contraception.

[8] Kavanagh R, Lawless JM. Young Women's Understanding of their Sexual Health Needs.
[9] Molloy GJ et al. Adherence to the Oral Contraceptive Pill: a cross-sectional survey of modifiable behavioural determinants. BMC Public Health. 2012 Dec.
[10] Daly MD. Long-Acting Reversible Contraception: Giving Women Knowledge and Options. Nurs Gen Prac, May 2014.

In the hospital sector, obstetricians and gynaecologists receive training in all methods of contraception and there was a suggestion that GP education and training was more unstructured and reliant on individuals pursuing a particular interest. In two different studies[11] [12], GPs reported a lack of the appropriate skills or training required for LARC insertion procedures, while even those who were trained in LARC services felt they had become deskilled by not carrying out the procedure regularly enough.

At the same time, the Group heard that there was considerable interest among GPs in further developing their expertise in sexual and reproductive health, while inter-practice referral is an established means of ensuring a client can, for example, access a GP with training in LARC insertion.

Some stakeholders identified an inconsistent approach to the establishment of referral pathways with the consequence that access to LARC can be patchy and inconsistent across the country. Others suggested that there are poor financial incentives for GPs to provide LARC services to their patients given that, from a clinical perspective, these products are more labour intensive and time-consuming than other contraceptive methods.

9. Overcoming Barriers to Contraception: Policy Considerations & Challenges

9.1 Cost of Contraception and the Introduction of a State Scheme

There was considerable support for the introduction of a universal, fully funded State scheme for contraception among stakeholders.

The task of estimating the potential cost to the State of such a scheme is not straightforward given the lack of financial data available. The Working Group was reliant on costing information received from HSE PCRS and data provided by industry stakeholders[13] as part of the consultation exercise. It should be stressed that there is no single dataset of contraception costs that is available for analysis. From the public sector viewpoint, PCRS data is the best source for estimating drug costs but this data relates only to prescription contraception dispensed by pharmacies under the community drug schemes and does not capture items dispensed where the prescription has been paid for privately by the patient or patient representative. Industry sources have access to additional market data, but this too has limitations and is likely to be commercially sensitive.

Given these caveats and given the capacity constraints facing the Working Group, the estimate below should be considered as offering indicative costings rather than as a definitive budget impact analysis.

[11] Sweeney LA et al. A qualitative study of prescription contraception use: the perspectives of users, general practitioners and pharmacists. PloS one. Dec 2015.

[12] Health Service Executive (HSE). Sexual Health Services in Ireland: A Survey of General Practice. 2018.

[13] A Budget Impact Analysis prepared by Bayer should be acknowledged as particularly helpful.

Based on CSO data, there were estimated to be just over 1 million women aged 16-44[14] living in Ireland in 2018. In the same year, PCRS has confirmed that some 243,757 women aged 16-44 had medical cards and were eligible for both free clinical care and free contraception (other than a per item pharmacy prescription charge) while a further 34,287 women in this age group qualified for free GP treatment through a GP visit card. Subtracting those already eligible for GMS services, this would mean an additional 765,843 women would be eligible for free contraceptive services with 731,556 of those newly eligible for both the clinical and pharmacy costs associated with contraception.

PCRS data indicate that 124,379 clients availed of contraceptive drugs and special services through the GMS scheme in 2018 at a cost of around €11.45m. Deducting the special services payments from this figure, the pharmacy cost of delivering this service emerges as approximately €9.66m at an average of €77.66 per person (ingredient cost plus dispensing fees).

Based on these figures, an estimate of the cost of providing the current GMS contraceptive service on a universal basis to those aged 16-44 is summarised in Table 4.

Table 4: Estimated Cost of Providing GMS Contraceptive Service for 16-44-year-olds

Uptake	Pharmacy & Product Costs (€ m)	Indicative Average Clinical Cost (€m)	Additional Cost (€ m)	GMS Cost (€m)	Total Cost (€ m)
100%	59.48	87.50	**146.98**	9.66	**156.64**
75%	44.61	65.63	**110.24**	9.66	**119.89**
60%	35.69	52.50	**88.19**	9.66	**97.85**
50%	29.74	43.75	**73.49**	9.66	**83.15**

It should be pointed out that a budget impact analysis conducted by Bayer concluded that an additional 468,635 clients availing of contraception services under such a scheme would be associated with additional pharmacy and product costs of €27.21m. This would compare to the estimate of €35.69m at 60% uptake in the table above. Bayer employed a different methodology and used different datasets so the figures are not directly comparable, but this difference does raise the possibility that the extrapolation from GMS data above may be overestimating pharmacy and product costs on a whole population basis.

In terms of clinical costs, these will be dependent on the outcome of consultation with practitioners and cannot be derived from GMS capitation payments. In order to provide a quantum of the potential cost, an indicative figure based on an average of a range of costs per client from €50 to €120 (two consultations per annum) is shown above. It is worth once again noting that some stakeholders suggested that the financial incentives for the provision of LARCs were insufficient, thus implying that the "ask" in this regard may be at the upper end of the cost range. At the same time, there is an element of double payment in the approach suggested above as GPs would retain their capitation payments, and it is clear that such issues can only be resolved through consultation and more detailed consideration of the practical design of any scheme.

There are clearly a number of uncertainties in terms of costing given its dependence on uptake rates and annual clinical cost per patient. The ICCP-10 would suggest that at any point in time 75% of heterosexual individuals have been sexually active in the previous year, are not pregnant and are not trying to conceive. The 75% uptake level can, therefore, be considered as a ceiling

[14] Cohort chosen for consistency with age range of respondents in the ICCP-10 survey.

on costs for this population cohort and one which is highly unlikely to be reached, with uptake most likely to be between 50% and 60%.

On balance, based on GMS data, the most likely cost range for the introduction of a State-funded contraception scheme for 16-44-year-olds will be between €85m and €105m. There would however be savings with regard to current expenditure on DPS Contraception Drugs and Special Items of Service under the GMS of around €5m under such a scheme, so the actual likely budgetary impact is most likely to be between €80m and €100m per annum at current prices.

It is important to emphasise that these estimates do not include the cost of providing free condoms (currently estimated at around €50k for 2019) nor do they include ancillary costs associated with public information campaigns, specific interventions for marginalised groups or any costs associated with additional training or recruitment. The above estimate is also based on the mix of contraceptive methods currently available under the GMS scheme and is therefore subject to change. For example, any increase in LARC uptake will be associated with an increase in costs in the short-term given its relatively high up-front costs, although this is likely to be marginal and should be offset in the longer term given the cost-effectiveness of such products.

These figures are also based on providing eligibility to those aged 16-44. This closely mirrors the age range of respondents in the ICCP-10 survey for purposes of consistency. However, there will be additional demand for contraception from those aged over 44 and including women aged between 45-54, under a universal scheme will increase overall costs, possibly by as much as €20m depending on uptake rates.

Irrespective of the various caveats and uncertainties, it is clear that the provision of free contraception entails significant costs for the State, particularly given concerns about overall health expenditure and the myriad of other service requests being made of the Department and the health system more generally. At the same time, these numbers can be looked at in the context of the overall health budget and then they do not appear as significant as the cost of this contraception service would be unlikely to account for much more than 0.6% of overall current health spend. It is also the case that the cost of a scheme can be reduced by modifying how it is delivered and, as discussed below, a lengthening of prescription periods to improve accessibility and tackle inconvenience will also have the benefit of lowering clinical costs associated with contraception.

An economic rationale for a universal contraception programme has been advanced on the grounds that it has the potential to reduce the future burden of costs associated with unplanned or crisis pregnancies (including terminations). Some research referenced in the British context suggests access to contraception can generate benefits in the order of ten times the amount spent. However, aspects of these projections are questionable and can go far beyond health-related costs to include education and social protection savings arising from the “non-existence” of an individual. Other studies are more health-focused but can include estimates of savings arising from all family planning services including STI prevention and cervical cancer screening which are not directly comparable to savings that may arise through an expansion of contraception services in the Irish context.

Nonetheless, it is broadly accepted that the provision of effective contraception should bring about some reduction in costs associated with unplanned or crisis pregnancies. The previously referenced Henry et al. study from Norway revealed a 2.34% reduction in costs associated with unplanned pregnancy among those in the 15-24 age bracket following a 5% increase in LARC uptake, while an analysis provided to the Working Group suggested potential savings of almost €11m in crisis pregnancy costs with a 5% increase in LARC usage.

It is important to acknowledge that any potential for long-term savings does not eliminate the opportunity cost associated with providing a free contraception service. The argument that spending more now will generate future savings and benefits is made frequently in respect of health spending and would apply, for example, to the provision of early intervention services or

more community services. Moreover, the benefits of any particular programme or initiative does not mean that it is affordable within current financial constraints. The fact is that a judgement has to be made about where best to direct scarce resources to ensure the maximum value is achieved in terms of both public health and economic benefits.

There is a further complication in determining whether a universal contraception service represents value for money as it may simply displace or substitute for private expenditure. Although the removal of cost may have benefit at the individual level, public health or economic benefits will not be realised if patterns of contraceptive use at the national level do not change or if typical failure rates for certain contraceptives do not improve due to the enabling of more consistent or correct use. From a health or economic benefits perspective, the focus should be on designing a behavioural intervention to enable people, especially women, to either access and use contraception more consistently or, alternatively, to move from using less effective to more effective methods.

The fact is that 25% of women aged 16-44 hold a medical card and so already have free access to most contraceptive services, while it must be assumed that a significant portion of those paying privately for their contraception are reasonably informed and content with the option that they have chosen. Therefore, much of any new State expenditure will simply displace private spending with no associated health gain. This means that there will always be some doubt as to whether a State-funded contraception scheme represents the optimal use of funds on a purely cost-benefit basis.

The GMS data are instructive in that 14% of women availing of contraception through the scheme opt for LARCs, which suggests that cost is not the sole determining factor in contraceptive choice. The experience of the United Kingdom is also interesting as despite the availability of free contraceptive services since the 1970s, one in two pregnancies are still classified as unplanned, there remains a relatively low uptake of LARC at 17% and recent data suggest an increase in the number of terminations. There is a considerable risk that simply making contraception free to the user represents an ineffective and inefficient use of resources as it may not deliver the behavioural change and subsequent positive health outcomes that are intended. The removal of cost as a barrier to accessing contraception may not therefore be sufficient to improve SRH.

Targeted Interventions

In order to reduce the costs to the State, an alternative option is to introduce a more targeted eligibility scheme for contraceptive services. It appears evident that young people are more likely to find cost to be a barrier to contraception than older individuals and there is evidence to suggest that younger people are also more at risk of a crisis pregnancy. As such, a scheme targeting 17 - 24-year olds would reduce costs and may represent more value for money by targeting those most in need (alongside existing supports for GMS clients). Based on a population in this cohort of around 240,000 (2016) and an uptake of 60%, the cost of providing such a targeted contraceptive scheme would be in the region of €18-€22m before taking into account any savings generated through avoiding crisis pregnancies.

Other options may be to provide free contraceptive services to particular cohorts of individuals such as those who currently hold a GP visit card or those below a defined income. Any such targeted interventions would entail additional administrative costs and complexity as well as the potential for “hard cases” to arise; nonetheless such options may be worthy of more detailed exploration given ongoing resource constraints.

Any decision to make contraception freely available will require the development of a specific eligibility scheme underpinned by legislation that amends the Health Act 1970. This may take some time to draft and bring through the Oireachtas and will require the provision of the necessary

resources at Departmental level. As indicated, there will also need to be engagement with healthcare professionals to agree to the pricing of the model of care for the provision of contraceptive services and counselling. It should be recalled that one of the features that seem to emerge from the review of international approaches is that access to contraception is managed within the same broad eligibility framework as other health services. The notion of establishing a separate framework for contraception would seem to be unusual and less than optimal from an administrative or legal perspective.

Other Options for Easing Cost Barriers

Aside from the introduction of a new eligibility scheme to provide for State-funded contraception, there are other options to help mitigate cost barriers to accessing contraception. One option is to further expand the National Condom Distribution Service (NCDS) which was established in 2015 and distributes free condoms to those working directly with population groups who may be at increased risk of negative sexual health outcomes. The NCDS facilitates statutory agencies and bodies as well as NGOs to promote condom usage and help prevent unplanned pregnancies and sexually transmitted infections (STIs).

In 2018, figures indicate that 409,319 condoms and 287,565 lubricant sachets were delivered through NCDS to individuals and groups who may be at an increased risk of negative sexual health outcomes. The SHCPP is already working to further develop the NCDS, including the national launch of a dispenser service across third-level colleges and universities.

It may also be possible to revisit the VAT rate on condoms which is currently 13.5% although this is a matter for the Minister for Finance, and the Working Group is aware that the Minister for Health has already written to him on this matter.

Costs can also be offset further by changing or reducing the level of GP oversight currently involved in the provision of contraceptive services, thus removing clinical costs for both the individual and the State. For example, if the prescription for oral contraceptives were provided for a period of 12 months rather than requiring a new prescription after six-months, savings in the region of €12m could be achieved. This proposal is considered in more detail below under the heading of accessibility.

9.2 Accessibility

It is clear from the research literature and both the ICCP-03 and ICCP-10 studies that providing better access to local contraceptive services is essential to helping people to optimise their sexual and reproductive health.

One option is to enhance the supports offered through community pharmacists. This would not only increase convenient access to services to those who find existing service offerings unsatisfactory but would also ease pressure on GPs, allowing them to focus more on improving those services that they are uniquely capable of offering.

One proposal is for pharmacists to be allowed to supply contraceptives including oral contraceptives and implants without any requirement for the individual woman to have been previously prescribed a contraceptive. In such a scenario, pharmacists would be required to undertake additional training and would only be able to prescribe according to strict criteria and formal assessment. Women would have a consultation and BP/BMI check with their pharmacist

every six months, and pharmacists would refer clients to a GP or other provider in circumstances where a LARC might represent the most suitable contraceptive option. This latter idea is welcome but would appear to risk creating a new "inconvenience" barrier to LARC and "bridging" measures would be required to ensure that an individual is not left without any contraception.

This proposal builds on the experience of pharmacists in providing emergency hormonal contraception and is premised on the fact that oral contraceptive pills, including both COCs and POPs, are widely used, safe and effective methods of birth control. There is precedent internationally for such an approach with a 2015 review[15] of contraceptive services across 147 countries finding that oral contraceptive pills were legally available in 35 countries over the counter; informally available in 56 countries; and available on a "behind the counter" basis following eligibility screening by trained pharmacy staff in a further 11 countries.

The Lancet has twice recommended non-prescription availability for oral contraception, while pharmacist prescribing and supply of OCPs is also now permitted in California and other US states. The approach has also been tested in the UK via locally established Patient Group Direction in which pharmacists are allowed to prescribe prescription items in circumstances agreed by the doctors responsible for their design (but only after appropriate training for pharmacists). Furthermore, the WHO has recently recommended that over-the-counter oral contraceptive pills should be made available without a prescription to those using such pills.

Nonetheless, the provision of contraception through pharmacy services raises questions about patient safety with a risk that pharmacists will prescribe without sufficient knowledge of the woman's medical and family history. Contraindications and side-effects of oral contraception may be rare, but they do occur, and this must be of paramount concern. This risk could be mitigated – as highlighted in the recent WHO paper on self-care and SRHR[16] – by the use of simple self-screening tools to complement eligibility screening and by pharmacist consultation.

There is however a more general healthcare issue to be considered. By reducing the level of interaction with a health professional to one purely focused on contraception, women may lose the wider health benefits that can be associated with more regular visits to their GP, as such consultations offer an opportunity for other, non-sexual health concerns to be raised and addressed. The risk to continuity of care is also a concern, while the proposal clearly runs counter to the long-established practice of ensuring a distance between those who prescribe and those who dispense drugs.

Medical supervision of access to hormonal contraception can, when viewed negatively, be associated with increased costs, reduced accessibility and restricted development of informed self-care. The counter view in this context is that medical management of patients allows for education, counselling and helps to ensure that the patient correctly avails of the contraceptive method most suitable for them, including guiding individuals in choosing an alternative contraceptive option should they require them. Closer medical supervision also facilitates detection and management of potential side effects, such as thrombo-embolic episodes or the potential increased breast cancer risk that research has indicated may be associated with long-term use of hormonal contraception.[17]

In order to balance these competing priorities and promote improved access to contraception, it is recommended that the initial focus should be on introducing longer prescribing lengths for oral contraception. There is general agreement among stakeholders that current dispensing practices

[15] Grossman D. Over the Counter Access to Oral Contraceptives. Obstet Gyn Clin N Am. 2015
[16] WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health & Rights
[17] White ND, Pharmacy Review, May-June 2018

for oral contraception could be lengthened to 12 months as recommended under Medical Eligibility Criteria guidelines published in the UK. A consultation with a pharmacist at six-months for prescription renewal would help ensure patient safety. This extension of script length would also have the additional benefit of reducing an element of clinical cost from the contraception scheme.

It should be noted that the Group is not opposed in principle to the concept of pharmacist prescribing of contraception. However, it is clear that there are differences in opinion among expert stakeholders, while the Group is also mindful that there is a wider context regarding the role of pharmacists in the health system, including prescribing by hospital pharmacists. Given the many important issues that would need to be decided prior to the implementation of pharmacist prescribing, and given the potential implications for patient care, the Group considers that a more detailed examination of the issue is required.

Other Options for Easing Accessibility Barriers

An expanded role for community pharmacists is not the only option available to improve the accessibility and convenience of contraceptive services. A focus on "making every contact count" in relation to contraception would improve accessibility, particularly in relation to antenatal, postnatal and post-termination care.

Antenatal and Postnatal Care

Pregnancy and the interval after delivery is an extremely important time for counselling women regarding contraceptive options. Indeed, the Royal College of Obstetricians and Gynaecologists recommends that "*Contraception should preferably be discussed with all women while they are still pregnant since this allows them to choose immediate postpartum contraception without the need to make a hurried choice."*

From an accessibility perspective, the fact that a woman will already be engaging with the health services when she is pregnant represents an opportunity to provide contraceptive services and information and to emphasise the importance of choosing the most effective method that is acceptable to the woman. It is acknowledged that a combination of work pressures and focus on early discharge may limit the scope for contraception counselling in the hospital setting, but it would certainly be regrettable if opportunities to engage with women, especially those who may be vulnerable and may not otherwise present to health services, were being missed.

The six-week check-up after birth is now generally a community-based service, but it still offers an excellent opportunity to overcome accessibility barriers and engage with women on contraception. This consultation is offered without charge as part of the Maternity and Infant Care scheme which makes it particularly concerning that there is some anecdotal evidence that pressures of time or reduced GP availability mean that not all women are availing of the service. Any new contraception scheme must ensure that the opportunities for engagement that already exist are fully utilised.

Termination Services and Contraception

The focus of discussion around contraception and termination is understandably mostly around the potential role of improved access to contraception in preventing the need for termination in the first instance. However, the Joint Committee on the Eighth Amendment heard from a number of medical experts, both international and domestic, who highlighted the importance of offering post-termination contraception as part of an overall termination care package.

During engagement with the Joint Committee, Dr. Abigail Aiken reported that approximately 92% to 95% of women who used the termination services of the British Pregnancy Advisory Service, left the clinic with a contraceptive method, while Professor Sabaratnam Arulkumaran noted that many women in France, Italy and Turkey will accept a long-acting reversible contraceptive at post-termination counselling. Furthermore, WHO recommends that women commence hormonal contraception at the time of surgical termination or at the point at which abortifacients are administered, while there is also research evidence suggesting that post-termination is an optimal entry point for contraception commencement.

For these reasons, post-termination counselling on contraception is included in the Model of Care for termination of pregnancy services. In the General Practice setting, funding is provided for three GP visits, the last of which is to be provided post-termination. GPs are contracted to provide advice on contraception as part of the service. This approach has the potential to be very effective since access barriers are removed as the woman is already engaging with health services and it may be especially useful in terms of helping more vulnerable individuals to access contraception services.

Other Options

Obviously, system-wide improvements such as increased GP numbers, extended service hours and expanded community services would make services more accessible, while online health information can also play a role in an appropriately regulated environment.

On a very practical level, the accessibility of LARCs would be improved if the individual did not have to purchase the product from a pharmacist and then return to the clinic or GP practice to have it fitted.

9.3 Education and Information

The related issues of lack of information, misinformation and embarrassment can only be tackled via improved health education and information. Indeed, the importance of education cannot be overstated in any scheme to improve access to contraception. At the Joint Committee hearings, the IFPA stated that *"First, one needs good quality education and awareness programmes so that women are aware of contraceptive methods and where to access them. Second, one must remove the financial barrier."* Many of the successful interventions around contraceptive services reported in the research literature are also dependent on education and counselling for the improved outcomes that they report, including the CHOICE study in the United States.

The Joint Committee also recognised the importance of education for SRH in its ancillary recommendations, calling for *"…. a thorough review of sexual health and relationship education, including the areas of contraception and consent, in primary and post-primary schools, colleges, youth clubs and other organisations involved in education and interactions with young people."*

These concerns were echoed in the recent report by the Joint Committee on Education and Skills which found that the Relationships and Sexuality Education taught in Irish schools was outdated and in need of an overhaul and urged improvements to be made to the curriculum to provide young people with the skills they need, particularly in the areas of consent and contraception, as part of a wide-ranging programme of reform. The National Council for Curriculum and Assessment is currently reviewing the programme on behalf of the Department of Education.

It is to be hoped that such initiatives will close knowledge gaps around the use and efficacy of contraceptive methods as well as countering some of the myths that exist around health risks and/or the appropriate use of different contraceptive methods. The aim must be to support informed decision-making and help to overcome embarrassment and remove stigma by "normalising" such discussions.

Although improved school-based education is essential, there is a need to ensure that individuals of all ages (including those who may have dropped out of school) have access to the quality, evidence-based information they need to make informed decisions around their contraceptive choices. This suggests a need for information resources to be visible and available in key health sites such as GP practices, Primary Care Centres, maternity hospitals, pharmacists and so on while there is also scope for broader campaigns, potentially under the Healthy Ireland banner and through such initiatives such as Healthy Ireland at your Library.

Of particular importance in this regard would be building on the efforts of the Union of Students in Ireland and individual Student Unions around the country to promote contraceptive services and access to contraception. Beyond this, healthcare professionals – whether nurses, GPs or pharmacists – must be able and willing to provide individually-tailored counselling and advice on the best contraceptive options.

9.4 Workforce and Professional Capacity

The accessibility and effectiveness of contraception services are also dependent on there being a sufficient number of healthcare providers who incorporate sexual and reproductive health services, including contraception, into their practice.

As noted earlier in the paper, concerns do exist about the lack of the appropriate skills or training among GPs in respect of LARC insertion. Efforts have been made to address this skills gap in recent years, with the Irish College of General Practitioners (ICGP) and the SHCPP developing and continuing to deliver an education and training programme for GPs on LARC methods. Moreover, an e-learning module on LARC was developed in 2016 for GPs and practice nurses, and there are now over 1,000 GPs who hold LARC certification.

The vast majority of the population can access the contraceptive services they require through GP services and through clinics like that operating from Holles Street and from facilities such as the Well Woman Centre and Irish Family Planning Association. However, there may be scope for both raising awareness of services and enabling practitioners to develop their skills further by promoting more integration between the hospital and community sector and seeking to develop local centres or sites of expertise in contraception and other SRH services.

There would also seem to be scope for utilising the skills of practice nurses and indeed the skills of the nursing profession more widely so as to ensure that the health system can deliver a comprehensive SRH service. This would seem to be particularly important given the acknowledged pressures currently facing the GP sector in terms of numbers of serving GPs and the demands on their services.

It should also be noted that there are a number of Sexual Health Clinics around the country as detailed in the *Sexual Health Services in Ireland* report (HSE, 2018). These clinics are a mix of public, private and non-governmental organisations and are based in primary, community and hospital settings. The report identified 50 sexual health service providers, almost half of which provided contraception beyond condoms. However, the report did note that very few of the 23

public clinics provided wider contraceptive services, and there would seem to be merit in examining whether these clinics have a role to play in improving access to contraceptive services.

Any changes in approaches to service delivery will require appropriate resourcing and should be based on the principles of consultation and cooperation across the health sector.

10. Marginalised and Vulnerable Groups

Specific issues around access to contraception exist for vulnerable or under-served populations and for those who may be socially and/or economically disadvantaged, including asylum seekers, young people in care, those with an intellectual disability, members of the Travelling and Roma communities, other ethnic minorities and people who are experiencing homelessness. It will also be important to ensure that people who identify as trans or non-binary are not excluded under the eligibility criteria of any scheme, while there is also a particular need to ensure that women in controlling relationships or at risk of sexual coercion and abuse can access the contraceptive services they need.

Policies and interventions will have to be designed and implemented in a manner that is inclusive, culturally appropriate, and specific to the needs of different groups in order to ensure equitable access. These challenges are not specific to the provision of contraception services, and the principle of making every contact count will be important to ensure that contraceptive needs can be considered whenever women in these groups come into contact with the health services. It will also be necessary to work with community and representative groups to promote awareness of and access to contraceptive services and to identify mechanisms for integrating sexual health care, as far as possible, into existing social inclusion initiatives.

In relation to contraception, a further issue exists given potential legal inconsistencies in relation to the provision of contraceptive services to those under the age of 17. The age of consent to sexual activity in Ireland is 17, and it may be a criminal offence to have sex with a person under 17 years of age. It will, therefore, be important that any contraception scheme is designed to ensure that it does not trespass on the issue of consent or affect any enactment or rule of law relating to consent to medical treatment. In sum, it will be essential that the operation of any contraceptive services should accord with the HSE's National Consent Policy[18].

11. Conclusion and Policy Options

The research review and engagement with stakeholders conducted over the past number of months have highlighted the fact that the policy issues arising around improved access to contraception are complex and multi-faceted. Given this complexity, the lack of recent data regarding contraceptive usage, crisis pregnancies and termination in Ireland presents a challenge for informed policy development.

[18] https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-hse-v1-3-june-2019.pdf

It is clear that barriers to accessing contraception do exist and that those barriers identified in ICCP-10 are likely to still be the most prevalent - local access, cost, embarrassment, inconvenience and lack of knowledge. At the same time, contraception use in Ireland is high and stable and difficulty accessing contraception is only a challenge at the margins in overall population terms. There are a number of policy levers available to Government if it wishes to remove or alleviate the impact of these barriers. These include State funding, changes to the prescription status of oral contraceptives, workforce training and capacity building and education initiatives.

The challenges associated with expanding access to contraception are a microcosm of the wider challenges facing the health service around Government funding, eligibility, integrated care, primary care staffing and workforce capacity and so on. It is therefore important to continue to make progress towards the vision outlined by Sláintecare of a more integrated health system, providing care on the basis of need, and not ability to pay and where there is a meaningful and significant expansion of community-based care.

Even looking at access to contraception in isolation, the key to improving access is still to adopt a systemic approach that targets the often-interrelated barriers in a coherent and strategic manner. In this respect, the Group cautions against the view that simply making contraception free to the user will have the desired impact in terms of reducing the number of crisis pregnancies or promoting the uptake of more effective contraceptive methods. There is a very real risk that, as a standalone measure, removing the cost barrier will simply displace private expenditure (including that of wealthier individuals) and thus will represent an ineffective use of scarce resources. Similarly, a focus solely on accessibility (for example by only targeting dispensing practices) is not recommended from a health and effectiveness viewpoint given the impact that this is likely to have on incentives to use oral contraception rather than LARCs.

It is essential that alongside any efforts to reduce the cost burden or increase accessibility, resources are devoted to developing educational and informational campaigns and boosting the capacity of healthcare professionals, be that through training and certification, additional recruitment or new models of care. It will be necessary to engage and work with the different healthcare professions to ensure successful implementation of policy to expand access to contraceptive access.

The weight of research evidence and the contributions from stakeholders are persuasive as to the potential beneficial health impacts of providing women with the opportunity to choose the most effective and suitable type of contraception for them based on their health and lifestyle needs and preferences. However, what is less clear is the extent to which current funding, regulatory or eligibility arrangements may be adversely impacting on this choice. Moreover, the pervasiveness of any affordability challenge is open to debate. Certainly, given the displacement of existing private expenditure, there will always be some doubt as to whether a State-funded contraception scheme represents the optimal use of funds on a purely cost-benefit basis and in terms of opportunities foregone.

Nonetheless, even a relatively marginal improvement in access and contraceptive use will have some health advantages at a population level in terms of avoiding some of the negative consequences of crisis pregnancy, while at an individual level, some women will undoubtedly be spared the risks and emotional difficulties of a crisis pregnancy. There is also merit in having consistent policy and, in many ways, it can be argued that precedent has been set in this area with the introduction of a universal termination of pregnancy service. It is certainly difficult to justify different approaches to the availability of termination and contraceptive services, as both are intended to protect women's health, maximise choice and seek to ensure, as far as possible, that every child can be born into a situation with the necessary material and emotional supports.

It is this combination of policy context, potential health benefits and awareness of the human and women's rights perspective that has led the Working Group to conclude that policy initiatives in support of improved access to contraception may be justified and warrant further exploration, despite reservations that would seem to exist from an economic perspective. Indeed, this approach explicitly reflects the Public Spending Code (PSC) which acknowledges that all relevant factors – both economic and social – should be taken into account when arriving at policy decisions on investment programmes or individual projects. It must also be remembered that the PSC is explicit that the Government or Minister, under the delegated sanction arrangements set down by the Minister for Public Expenditure & Reform, retain the authority to approve projects independent of the detailed application of the Code.

The Group has identified three different approaches to expanding access to contraception as detailed below.

Option A
The introduction of a universal, State-funded contraception scheme covering those items now available under the GMS as well as the copper coil. The costs associated with such a scheme are dependent upon a number of factors such as uptake and agreed clinical costs, but any budgetary planning would most probably need to set aside in the order of €80 - €100m per annum.

Option B
The expansion of the GMS scheme as it relates to LARC to all women. Such an initiative would cover the consultation and insertions costs associated with LARC and would cost in the region of €30-€40m per annum depending on uptake rates. Such a scheme could be justified as the evidence indicates that LARCs are the most effective form of contraception yet are also associated with upfront clinical and product costs that may be a factor in discouraging their use. However, the targeting of specific contraceptive solutions in this manner cuts across the rights arguments advanced earlier and was opposed by most stakeholders who wish to retain individual choice, especially in recognition of the fact that women will have different contraceptive needs and preferences at different stages in their life.

Option C
The introduction of a State-funded contraception scheme targeting particular cohorts of the population, with an initial focus on younger women, for example, those aged 17-24. Such a scheme could possibly cost around €18-€22m and is based on the premise that the evidence suggests that younger age groups are most at risk for crisis pregnancy and are more likely to find cost a barrier to contraception. This approach is likely to be the most effective in cost-benefit terms, as not only are the costs themselves reduced, but through targeting those most in need, the benefits obtained should be relatively higher. The main drawback to this option is clearly that it does not address any cost barrier that may exist for older women and is likely to attract criticism on those grounds while it may also be administratively and legally more complex. Of course, rather than being seen as a standalone measure, the provision of free contraception to younger women could be seen as the first stage of a phased, long-term approach to steadily improve access to contraception to all.

Any of these options, if undertaken, should be supported by a range of complementary initiatives as a narrow focus on cost and affordability is highly unlikely to deliver the intended outcomes in terms of a reduction in crisis pregnancy. These would include an expansion of the National Condom Distribution Service and measures to improve accessibility by enabling oral contraceptives to be available on a 12-month prescription basis with pharmacist consultation at six-month renewal. The importance of Making Every Contact Count, especially in relation to post-

partum and termination of pregnancy care, should not be underestimated in terms of improving accessibility and should continue to be promoted among service providers.

Moreover, there must be a focus on improved health education and information to address the related issues of lack of information, misinformation and embarrassment. The development of the new Relationships & Sexuality Education curriculum is a matter for the Department of Education to advance in the first instance, but the Department of Health should support and contribute this initiative, as appropriate, to ensure that its impact is maximised. In addition, the Department should work with the HSE to begin to scope the requirements for a communications initiative which, among other things, should highlight the effectiveness of LARCs and seek to dispel some of the myths around the use of different contraceptive methods.

It should be emphasised that the measures above are not dependent on the introduction of a funded contraceptive scheme and should help support improved access even if the issue of cost continued to be addressed through the GMS scheme as is currently the case.

Next Steps

From an administrative perspective, the introduction of a scheme for free contraception is inevitably a cross-cutting issue, but there is still a need for clear ownership (and resourcing) of this policy area within the Department. The Group notes the clear linkages between contraception and the National Sexual Health Strategy (and SRH services more generally) as well as with the Women's Health Action Plan. It is important that the issue of contraception can be appraised alongside other Departmental objectives and priorities as this will bring greater focus and transparency to policy and budgetary decisions.

The work of the Group has indicated that a policy intervention may be justified to promote access to contraception and has identified potential costs, benefits and risks that would require further appraisal under the PSC. In respect of Option A, the introduction of a universal contraception scheme, it would be expected that a full cost-benefit analysis would ordinarily be conducted given the level of ongoing expenditure proposed. The demands in respect of Options B and C would perhaps be less onerous, although both would still require further detailed appraisal to ensure affordability within funding constraints and appropriate prioritisation relative to competing proposals.

More recent data on SRH, crisis pregnancy and contraception use in Ireland would also help inform further policy appraisal and development. The Group welcomes the fact that SHCPP is currently undertaking preparations to conduct a general population survey on the knowledge, attitudes and behaviours of sexual health and wellbeing and crisis pregnancy in Ireland. The Group understands that a scoping study will commence in 2019 with a view to commissioning the survey by Q2 2020. It would be helpful if findings from this exercise could inform the design of a new scheme, although clearly there are timing issues in this regard.

More generally, it is important that relevant datasets required to measure progress and monitor the impact of innovations in SRH are collected and utilised, including data relating to the provision of termination of pregnancy services under the Health (Regulation of Termination of Pregnancy) Act 2018, when it becomes available.

The Department will also need to consider how best to proceed in terms of amending legislation to both expand eligibility to contraceptive services beyond GMS clients and to modify the schedule for oral contraceptives. Alongside this detailed appraisal and legislative work, the model of care

underpinning an expanded contraceptive service provision will need to be considered to ensure that services are accessible and that the necessary expertise and capacity exists to provide a quality and safe service to those who access it.

There is no single, easy way to deliver a step-change in contraceptive access and support. The focus of the proposed actions is therefore on advancing policy on contraceptive access in a way that acknowledges the reality of finite budgets and competing health demands and that reflects the importance of adopting a coherent policy approach that goes beyond issues of cost to also consider public understanding and knowledge, workforce capacity, legislation and wider policy initiatives in respect of women's health and sexual health more generally.

Appendix 1 – Country Profiles

1. United Kingdom

Available forms of Contraception	Contraception Funding (and Eligibility)	Access or Dispensing Protocol	Related Services
Barrier methods: • Male condoms • Female condoms • Diaphragm • Cap Oral contraceptive pills: • Combined pill • Progestogen-only pill • Emergency contraceptive pill Other short-term contraceptives: • Contraceptive patch • Vaginal ring LARCs: • Intrauterine device • Intrauterine system (hormonal) • Contraceptive implant • Contraceptive injection Permanent Methods: • Female sterilization • Male sterilization	Contraception is free at the point of access to all in the UK under the National Health Service (NHS). This includes GP services and insertion procedures. Family planning services are free even for those not ordinarily resident in the UK.	All forms of contraception are available for free at: • contraception clinics • sexual health or GUM (genitourinary medicine) clinics • some GP surgeries • some young people's services. A prescription/ procedure from a medical professional is required for all hormonal methods and the IUD, excluding emergency contraception which is available OTC. The c-card scheme also offers free condoms to those aged between 13-25. <u>Over-the-counter</u> Condoms can also be easily purchased in settings such as community pharmacies or via vending machines and/or the internet. The emergency contraceptive pill can be purchased in pharmacies and other organisations.	Sex and relationship education (SRE) is compulsory from age 11 onwards in the UK national curriculum. This programme covers types of contraception, effectiveness, and how they are accessed. STI screenings and family planning advice services are also provided for free by the NHS.

2. Netherlands

Available forms of Contraception	Contraception Funding (and Eligibility)	Access or Dispensing Protocol	Related Services
Barrier methods: • Male condoms • Female condoms • Diaphragm • Cap Oral contraceptive pills: • Combined pill • Progestogen-only pill • Emergency contraceptive pill Other short-term contraceptives: • Contraceptive patch • Vaginal ring LARCs: • Intrauterine device • Intrauterine system (hormonal) • Contraceptive implant • Contraceptive injection Permanent Methods: • Female sterilization • Male sterilization.	Every person who lives or works in the Netherlands is legally obliged to take out standard health insurance. The statutory insurance scheme covers healthcare - e.g. GP visits, hospital treatment and prescription medication - but contraception is only covered until the age of 21. This excludes condoms. Individuals aged 21+ must meet the cost of contraception themselves, e.g. will typically purchase complementary voluntary insurance with additional coverage of contraception. Hormonal contraception may also be covered under public healthcare insurance in other circumstances such as if it is used to treat a certain complaint/ condition.	A prescription/ procedure is required for hormonal contraceptives and the IUD, excluding the emergency contraceptive pill, which is available OTC. However, repeat dispensing of oral contraceptive pills do not require a new prescription. <u>Over-the-counter</u> Condoms are available to purchase in pharmacies, shops and vending machines. The emergency contraceptive pill is available over the counter from pharmacies, hospitals, family planning clinics, on-line and in drug stores.	Family planning or contraception advice provided by a GP is covered under the public insurance scheme. Sexual education is compulsory for primary and lower secondary education and special education. This programme is called Long Live Love and covers safe sex and contraception.

3. New Zealand

Available forms of Contraception	Contraception Funding (and Eligibility)	Access or Dispensing Protocol	Related Services
Barrier methods: • Male condoms • Female condoms Oral contraceptive pills: • Combined pill • Progestogen-only pill • Emergency contraceptive pill LARCs: • Intrauterine device • Intrauterine system (hormonal) • Contraceptive implant • Contraceptive injection Permanent Methods: • Female sterilization • Male sterilization	Most forms of contraception are available either partially or fully subsidized in New Zealand. The subsidy varies for different brands/ devices. Methods that have at least one fully subsidized option are: male condoms, copper IUDs, implants, combined oral contraceptive pills, progestogen-only pills, injections and emergency contraceptive pills, though prescription charges will still apply for some methods. Subsidized medications are available to citizens, permanent residents or holders of a work permit for more than two consecutive years, i.e. the same eligibility criteria for publicly funded healthcare. GP visits are subsidised by the government if you are enrolled in a specific GP practice. The amount you pay will depend on if you hold a Community Services Card. Holders will receive healthcare and prescriptions at a lower cost. Lower cost or free contraception is also available from Family Planning Clinics - which are partially State-funded - appointments for under 22s are free.	IUDs and implants can be inserted at the GP or at Family Planning Clinics by a medical professional. A prescription is required for first-time use of hormonal contraceptives, excluding the emergency contraceptive pill. Women who have previously been prescribed an oral contraceptive pill can access subsequent contraceptive pills over the counter, i.e. they do not need to obtain a new prescription provided they meet the eligibility criteria. <u>Over-the-counter</u> Emergency contraceptive pills can be accessed under prescription through a GP, or a family planning clinic or can be purchased directly from pharmacies. Condoms are available to purchase from retail shops, pharmacies, family planning clinics and online or from vending machines. Condoms can also be accessed on prescription at reduced prices.	Sex education is compulsory in schools from Year 1 to Year 13 as per the National Curriculum. Sex education includes information on contraception. Free STIs screenings are available at Family Planning clinics for those under 22.

4. Australia

Available forms of Contraception	Contraception Funding (and Eligibility)	Access or Dispensing Protocol	Related Services
Barrier methods: • Male condoms • Female condoms • Diaphragm Oral contraceptive pills: • Combined pill • Progestogen-only pill • Emergency contraceptive pill Other short-term contraceptives: • Vaginal ring LARCs: • Intrauterine device • Intrauterine system (hormonal) • Contraceptive implant • Contraceptive injection Permanent Methods: • Female sterilization • Male sterilization	The publicly funded Medicare system covers, reimburses or subsidizes some healthcare services e.g. GP visits for those enrolled (eligibility for Medicare is based on citizenship and residency status). If enrolled in Medicare prescription medicine is also subsidized under the Pharmaceutical Benefits Scheme (PBS). Some contraceptives are included in the PBS, including some types of combined hormonal contraceptive pills. Other contraceptives with at least one type on the PBS: • Progestogen only pill • Implant • Hormonal IUD • Injection Additional discounts are available under the PBS for those with concession cards e.g. a low-income healthcare card. Some other contraceptive procedures (insertion of implants and IUDs by GPs only) are partially covered under Medicare	A prescription is required for hormonal contraceptives and the IUD, excluding the emergency contraceptive pill. <u>Over-the-counter</u> The emergency contraceptive pill is available for purchase at pharmacies. Male condoms can be purchased in supermarkets, pharmacies/chemists and petrol stations. Some clinics, youth services and community health services provide condoms for free. Female condoms can be purchased at family planning clinics, sex shops, some pharmacies/chemists, and online. Diaphragms can be purchased at pharmacies/chemists, family planning clinics and online.	Relationship and sexuality education is included in the curriculum from Foundation to Year 10. Contraception is covered in this programme. Free STI screening is also available for Medicare cardholders.

5. Canada

Available forms of Contraception	Contraception Funding (and Eligibility)	Access or Dispensing Protocol	Related Services
Barrier methods: • Male condoms • Female condoms • Diaphragm • Cap • Sponges Oral contraceptive pills: • Combined pill • Progestogen-only pill • Emergency contraceptive pill Other short-term contraceptives: • Contraceptive patch • Vaginal ring LARCs: • Intrauterine device • Intrauterine system (hormonal) • Contraceptive injection Permanent Methods: • Female sterilization • Male sterilization	There is a publicly funded healthcare system called Medicare in Canada, but each province/territory has its own public insurance plan with variations in cover. Eligibility for Medicare is based on citizenship or residency status. Cover of contraception depends on the province/territorial plan, some health plans cover the cost of prescription birth control, but typically provincial plans don't cover most drugs and devices. Many require supplemental insurance schemes or pay out of pocket for contraception. Some school-based services, government-run youth clinics, and non-profit organizations provide prescriptions, and low-cost or no-cost contraceptives for youth in Canada. Provincial/territorial health care plans cover the cost for women who are economically disadvantaged, receiving social welfare benefits, or both. Indigenous populations are covered under the federal Non-Insured Health Benefits program. Again, however, not all plans cover all contraceptive methods. In particular, condoms, the copper IUD, the vaginal ring and the contraceptive patch are variably covered.	Prescriptions/ procedures by a medical professional are required for hormonal contraceptives (excluding the emergency contraceptive pill), the IUD, and for fitting a diaphragm/cap. However, pharmacists also have the ability to prescribe in some Canadian territories. For example, pharmacists in Saskatchewan can prescribe hormonal contraception (oral, transdermal patch or vaginal ring) to most healthy women. Pharmacists in Quebec can also prescribe short-acting hormonal contraception. <u>Over-the-counter</u> Condoms, sponges, spermicides and emergency contraception are available to purchase in drugstores.	Sex education varies across Canadian provinces. Some school-based services, government-run youth clinics, and non-profit organizations provide free contraception counselling for youth. STI screening services are free across Canada.

Appendix 2 – Contraceptive Use in Ireland

1. Barrier Methods

Male condoms are the most commonly used form of contraception in Ireland. ICCP-10 found that 62% of people (aged 18-45) used condoms to avoid pregnancy during the previous year, while more recent findings from the Healthy Ireland 2016 survey indicated that 25% of respondents report the use of condoms at last sex. Younger adults are more likely to report using condoms than older adults, reflecting the fact that condoms are often used during first and early-stage sexual relationships and that they are readily available in commercial stores, online or via vending machines.

Widely available, relatively low cost and offering protection against STIs, the male condom has a number of advantages as a contraceptive method, especially if supported by emergency contraception services. Nonetheless, these advantages tend to be offset by the fact they are associated with a high failure rate given that they are very user-dependent.

There is very little recorded uptake of female condoms in Ireland. Use of diaphragms and cervical caps is also low with less than 1% of the population reporting use in the previous year according to ICCP-10.

2. Short-Acting Hormonal Contraception

Short-acting hormonal contraception is available in many forms - the contraceptive pill (combined pill or progestogen-only pill), the contraceptive patch and the vaginal ring. A prescription is required for most hormonal methods of contraception.

These hormonal methods are commonly used by women in Ireland, particularly the contraceptive pill. ICCP 2010 found that 51% of respondents (18–45) or their partners had used hormonal methods during the previous year to prevent pregnancy. The combined oral contraceptives (COCs), which consist of a combination of oestrogen and progesterone and the progesterone-only pill (POP) were the most commonly used. Data from the HSE's Primary Care Reimbursement Service (PCRS) confirms the popularity of oral contraceptives. This shows that contraceptive pills were the most commonly prescribed contraceptives among GMS clients, accounting for 74% of all prescribed contraceptives recorded by the PCRS in 2013.

This level of uptake reflects the overall safety, convenience and general effectiveness of oral hormonal contraception. Indeed, the oral contraceptive can be considered as one of the safest and most well-studied medicines available, and it has the added benefit of offering women a sense of control - it is taken on a daily basis but is quickly reversible as, once stopped, a woman's' hormone levels quickly return to normal.

Nonetheless, contraindications do exist for both COCs and POPs while evidence also suggests the efficacy of the pill, in reality, is likely to be closer to 90% as individuals may not adhere to daily pill-taking regimens or may suffer some gastric upset that can undermine the pill's effectiveness. Moreover, it is the most vulnerable individuals who may have more chaotic lifestyles who are most at risk of inconsistent use. Such concerns are reinforced by high early discontinuation rates, with one Swedish study finding that approximately 30% of women who begin to take COCs needed to change product or turn to another means of contraception within 6-12 months.

3. Long-Acting Reversible Contraception

The drawbacks associated with condoms and oral hormonal contraception has resulted in a greater focus on supporting the wider use of LARCs such as IUDs, IUSs and implants. There are high efficacy rates associated with these methods in terms of averting unplanned or crisis pregnancy, with the failure rate for either the copper or other IUDs less than 1 per cent. This difference is not dependent on the failure rate of the product itself, but rather reflects imperfect use which is not an issue with LARCs as they have the advantage of not being user-dependent once fitted.

The most recent general population data available suggests that uptake of LARC in Ireland is at a low level, but increasing across all age groups, with an increase in the proportion of women (aged 18-45) using the coil, the IUD or the IUS from 5.7% in 2003 to 10.9% in 2010. This trend of increasing usage of LARCs has been noted in the Dublin Well Woman Centre's Annual Report 2018 and in their submission to the Working Group. The Well Woman Centre reported that many women presenting for an initial consultation were increasingly aware of the benefits of LARCs with the numbers fitted per annum by the centre rising from around 850 to almost 1,350 between 2005 and 2018 (including IUS, IUD and implant).

The widespread use of LARCs is dependent on the availability of a skilled medical practitioner to insert a device into a woman's uterus or arm while, as with any drug, LARCS can and do (on occasion) have unwanted effects including a low possibility of problems such a pelvic infection, abdominal pain after insertion or irregular/heavy bleeding. It is also the case that some individuals may not wish to use a LARC because they have concerns about the insertion procedure or have a fear of injections or because they believe that they will wish to conceive within a given timeframe if not immediately.

4. Emergency Contraception

Emergency contraception can be used to avoid an unplanned pregnancy after sex without contraception or if contraception has failed. Emergency hormonal contraception comes in the form of an oral pill and can be taken up to five days after unprotected sex, while a copper IUD can be fitted by a trained medical practitioner up to five days after unprotected intercourse and can serve as a primary method of contraception thereafter.

The ICCP-2010 found that emergency contraception use is low among the population at 4%, with young adults more likely to report using such contraception than older adults. It is noteworthy that EHC is available directly from community pharmacists in line with World Health Organisation recommendation that EHC should be as freely available as possible. Indeed, some observers believe that EHC should be more widely used, suggesting that women be allowed to obtain supplies in advance, for use as and when they judge appropriate, although this view did not emerge from the consultation undertaken by the Working Group.

5. Sterilisation

Sterilisation methods include tubal ligation or sterilisation implants for women and vasectomy for males. Female sterilisation is an invasive procedure requiring hospital admission, although it is often performed on request at the time of caesarean section where the family is complete. HIPE data from 2015 suggest approximately 450 such procedures were conducted.

Vasectomy is offered by a range of providers in various settings, and is considered[19] a quick and simple procedure, usually only taking 15-30 minutes, that can be performed at a GP surgery, in hospital as a day-patient appointment, or in a private clinic. Data from the HSE would suggest around 1,000 male sterilisation procedures were carried out in the public health system in 2015.

In their submission to the Working Group, the Institute of Obstetricians and Gynaecologists noted that access to both male and female sterilisation can involve delays due to long waiting lists, although the option of sterilisation was generally not otherwise raised by stakeholders.

[19] https://www.hse.ie/eng/health/az/v/vasectomy/