Abortion Review

ISSUE 27 WINTER 2008/9 ISSN 02627299

EMERGENCY CONTRACEPTION: WHAT IT DOES AND DOES NOT DO

By Jennie Bristow, Editor, Abortion Review

An advertisement promoting emergency contraception prescribed for free by **bpas** over the Christmas period provoked international media coverage and divided opinions. The advert, pictured on the back page of this edition of *Abortion Review*, shows a woman locked in a steamy embrace with a man dressed as Father Christmas, under the slogan: 'Santa only comes once a year…but that's all it takes!'

Noting that 'the closure of high street pharmacies, family planning clinics and GP surgeries over the Christmas holidays can pose serious problems for women after contraceptive failure, putting them at risk of unintended pregnancy', **bpas** announced that it would be prescribing emergency hormonal contraception (the 'morning after pill') for women to keep at home in advance of need, free of charge, from 10 clinics across the UK. EC costs around £26 to buy from a high street pharmacy.

Reacting angrily to the advert, Fiona MacRae in the *Daily Mail* asked: 'Is this crude ad really the best way to tackle unwanted pregnancies at Christmas?' 'Critics claim the service's scheme to hand out emergency contraception "gift kits" will fuel promiscuity and the spread of sexually-transmitted infections', wrote MacRae. 'They also question whether it will do anything to cut abortion rates, which have topped 200,000 a year for the first time.' But reactions from readers of the *Daily Mail* were rather more mixed. The 100-plus comments on the *Mail* website were split between those who condemned the advert for promoting irresponsible sex and destroying childish innocence about Santa Claus, and those who commented: 'hilarious', 'brilliant', 'British sense of humour at its best'.

The success of this advertising campaign indicates the gulf that exists between the anti-abortion lobby's attitudes to emergency contraception, and those held by the public at large. Opponents of Emergency Contraception (EC) are motivated by a belief that the methods used to prevent pregnancy *after* sexual intercourse, rather than before, in some way act as an abortifacient. **bpas'** Medical Director Patricia Lohr explains overleaf how EC actually works. But the idea that EC is 'like' an abortion has had a significant impact on the general perception of EC, resulting in high-profile cases in Britain and the United States in which pharmacists exercise a conscientious objection to prescribing the Emergency Contraceptive Pill (ECP), and leading to a public confusion about the difference between ECPs (which contain the drug levonorgestrel) and the 'abortion pill' (which contains the drug mifepristone, and is used to end a confirmed pregnancy of up to 63 days' gestation).

Despite the misinformation generated by opponents of EC, many men and women in the UK are aware that it exists, and are open to making use of it. Many of the respondents to the *Daily Mail* article argued that using EC was a sensible response to having unprotected sex, and that the **bpas** ad was an amusing and effective way to get this point across. Among the public at large, the issues surround EC seem to have little to do with worrying about whether the drug is a method of contraception or abortion: the issues are more to do with remembering to take the drug within 72 hours after sex, and ideally 'the morning after'; and getting affordable access to ECPs.

The reason **bpas** has consistently promoted advance provision of ECPs is to improve this situation. As Ann Furedi, Chief Executive of **bpas**, said of the Christmas ad:

'Sex isn't always planned or prepared for. It's easy to get carried away, which is why we advise women to back up their birth control by keeping the morning after pill at home. You don't wait until you get a headache to buy your pain relief, why wait until you've risked pregnancy to get the morning after pill?'

Raising the profile of EC, and improving access issues, are extremely important for giving women the ability to prevent unintended pregnancy after their contraception has failed, or after they have failed to use contraception. But it is also important for family planning professionals to keep a sense of perspective about the extent to which EC can prevent unintended pregnancy. In a presentation to the **bpas** conference in June 2008, Kate Guthrie, Clinical Director of Hull and East Riding Sexual Healthcare Partnership, opened a frank discussion about the fact that EC use is now known not to have an impact on abortion rates, and the reasons why that might be. Guthrie's paper can be read in full on *Abortion Review Online*, here:

http://www.abortionreview.org/images/uploads/AR_SpecialEdition_2.pdf

The fact that EC has no proven impact on abortion rate is an important point both for family planning professionals, and for the anti-abortion lobby. A favourite argument put forward by the anti-abortion lobby is that increased availability of EC will encourage promiscuity – presumably as a result of women choosing to have sex and access EC, rather than abstaining from sex altogether.

Inside this issue:

Abortion Review, a quarterly update on issues relating to abortion is produced as an educational service by bpas. Editor: Jennie Bristow. Subscription enquiries to the marketing department - Email: abortionreview@bpas.org Published by bpas, 20 Timothys Bridge Road, Stratford Enterprise Park, Stratford-Upon-Avon, Warwickshire CV37 9BF, United Kingdom. www.bpas.org

Many women do not routinely use EC following unprotected sex

Commenting on the **bpas** ad, Anthony Ozimic, political secretary of the anti-abortion campaign SPUC, said:

'It is....a despicable ploy which threatens unborn children, promotes promiscuity, undermines public health and insults the child-centred meaning of Christmas. The offensive sexual innuendo linked to Santa Claus is evidence of **bpas'** morally bankrupt status.'

Rather than promoting what some may view as irresponsible behaviour, EC should be viewed as a responsible intervention when a woman has had unprotected sex. However, despite improved access, many women do not routinely use EC following unprotected sex, even if they have been prescribed the morning-after pill in advance. Indeed, as Guthrie notes, one of the reasons for the lack of impact on the abortion rate from EC is 'insufficient use'. This means that the family planning movement does need to take care not to overstate the public health benefits of Emergency Contraception.

However, on an individual level, EC provides women with a vitally important back-up. In that respect, all measures that improve access, helping those women who want to use it to use it in time, are a positive and progressive development. For all those in the *Daily Mail* and anti-abortion lobby who objected to **bpas'** 'offensive sexual innuendo linked to Santa Claus', there will have been many more women who have benefited from the ability to prevent an unintended pregnancy, and welcomed the opportunity to laugh in recognition of a simple fact of modern life: that sometimes, contraception is an after-thought, and it is not just the thought that counts.

Emergency insertion of a copper IUD reduces the risk of pregnancy by more than 99%

CLINICAL UPDATE

By Patricia Lohr, Medical Director, bpas

In her Q&A column for Abortion Review, **bpas'** Medical Director examines developments and discussions in abortion provision. This edition:

Emergency contraception

Q) What is emergency contraception?

Emergency contraception (EC) is birth control that is used to prevent pregnancy after unprotected vaginal intercourse. There are many indications for EC including lack of contraceptive use, contraceptive failure or failure to use a back-up method, for example when more than 2 weeks have passed from a woman's last contraceptive injection. (1)

Q) What are the methods of emergency contraception?

There are two methods: emergency contraceptive pills (ECPs), and insertion of a copper T intrauterine device (IUD or 'the coil'). Two types of ECPs are available, those containing the estrogen ethinyl estradiol and progestin, and progestin-only pills.

Q) How does emergency contraception work?

Most, if not all, of the effectiveness of combined ECPs and those containing only the progestin levonorgestrel can be attributed to inhibition of or delay in ovulation. (2) Levonorgestrel-containing ECPs also have been shown to interfere with corpus luteum function. These mechanisms explain how ECPs work prior to ovulation. There is limited evidence regarding the way in which ECPs may prevent pregnancy after ovulation. Possible mechanisms of action include thickening of the cervical mucus which impedes sperm transport or function, alteration of fallopian tube transport of sperm, egg, or fertilised ovum, or impairment of endometrial receptivity to implantation. (3)

The copper IUD creates an inflammatory reaction throughout the upper genital tract and copper ions are noxious to sperm which inhibits their ability to fertilise the ovum. (4) Post-fertilisation effects, such as damage to or destruction of the fertilised ovum before implantation, may occur; however, there is limited evidence to support this mechanism. (4, 5)

Q) How effective is EC at preventing pregnancy?

The effectiveness of EC at reducing the risk of pregnancy is estimated by comparing the number of observed pregnancies in a cohort of treated women to the expected number of pregnancies if women were untreated (based on published probabilities of pregnancy by cycle day). This differs from determinations of effectiveness of other medications, where outcomes would be compared to a placebo; an intervention considered unethical in studies of EC. Calculating risk reduction by this method cannot account for many variables that may impact upon the effectiveness of EC such as the accuracy of the reported cycle day, timing and frequency of coitus, and fecundity of the study population. Although published estimates of effectiveness have been drawn into question (6, 7), good evidence exists that using EC after unprotected intercourse is better than not using it. One of the greatest challenges to EC effectiveness is the failure to use EC after unprotected intercourse.

Studies of the levonorgestrel-only ECPs demonstrate a range in the reduction of the risk of pregnancy from 59-94%. (3) This regimen can be used up to 120 hours after unprotected intercourse (8); however its effectiveness diminishes over time. (9) Combined data from two randomised trials comparing levonorgestrel-only regimens and ECPs containing ethinyl estradiol and levonorgestrel (10) showed that the chance of pregnancy among women who received the progestin-only regimen was about half that among those who received the combined regimen (relative risk of pregnancy 0.51, 95% CI 0.31-0.83).

Emergency insertion of a copper IUD up to 5 days after unprotected intercourse is substantially more effective than use of ECPs, reducing the risk of pregnancy by more than 99%. (11)

Q) What regimen of emergency contraceptive pills is used in the UK?

Two dedicated ECP products are available in the UK, Levonelle® One Step and Levonelle® 1500. Both formulations contain 1.5 mg levonorgestrel to be taken orally in a single dose.

Q) How has the regimen changed from the past?

The original hormonal EC regimen (the 'Yuzpe method'), consisted of 200 mcg ethinyl estradiol and 1.0 mg levonorgestrel. (12) Half the dose was taken within 72 hours of unprotected intercourse, and the other half 12 hours later. This regimen, or a progestin-only regimen which is associated with fewer gastrointestinal side effects, can be reproduced using daily oral contraceptive pills. The website **http://ec.princeton.edu/index.html** has a useful database of proper dosages using pills available in a variety of countries.

Older levonorgestrel-only products included two tablets of 0.75 mg to be taken 12 hours apart. A single dose of 1.5 mg of levonorgestrel has been shown to be as effective (8), leading to the currently available products containing one tablet. As mentioned, this regimen can be used up to 120 hours after unprotected intercourse (8); however extension of the timing of use beyond 72 hours is not licensed in the UK.

Q) What developments are being made to improve ECPs?

The progesterone receptor modulator CDB-2914 has been studied for use as EC and found to be at least as effective as levonorgestrel. (13) However, unlike levonorgestrel ECPs, the effectiveness of CDB-2914 did not appear to diminish when initiated greater than 48 hours after unprotected intercourse. This attribute may be advantageous when there are barriers to accessing EC promptly.

Cyclooxygenase-2 (cox-2) inhibition has been shown to prevent ovulation in animal studies (14, 15) and to delay ovulation in

humans. (16) A pilot study of the addition of a cox-2 inhibitor, meloxicam, to levonorgestrel ECPs suggests that it has the potential to improve contraceptive efficacy by significantly increasing the proportion of cycles without follicular rupture. (17)

Q) How can EC be accessed in the UK?

Emergency contraceptive pills and the copper IUD are available through general practices that provide contraceptive services, family planning and young person's services like Brook, sexual health clinics and some genitourinary medicine (GUM) clinics. (18)

Free ECPs are available from most NHS walk-in centres in England, some pharmacies, most NHS minor injuries units, and some hospital accident and emergency departments.

They can also be purchased from most pharmacies without a prescription (age restrictions may apply), and independent healthcare providers like **bpas**.

References

1. Stewart F, Trussell J, Van Look PFA. Emergency Contraception. In Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology*, 18th edition. New York: Contraceptive Technology Communications, 2004.
2. Croxatto HB, Devoto L, Durand M, et al. Mechanism of action of hormonal preparations used for emergency contraception: a review of the literature. *Contraception*. 2001;63:111-121.
3. Trussell J, Raymond EG. Emergency contraception: *A last chance to prevent unintended pregnancy*. Available at: http://ec.princeton.edu/questions/ec-review.pdf, Accessed 15 December 2008.
4. Ortiz ME, Croxatto HB. Copper-T intrauterine device and levonorgestrel intrauterine system: biological bases of their mechanism of action. *Contraception*. 2007;75:S16-30.
5. Stanford JB, Mikolajczyk RT. Mechanisms of action of intrauterine devices: update and estimation of postfertilization effects. *American Journal of Obstetrics and Gynecology*. 2002;187:1699–708.
6. Stirling A, Glasier A. Estimating the efficacy of emergency contraception—how reliable are the data? *Contraception*. 2002;66:19–22.
7. Westley E, Bigrigg A, Webb A, et al. Risk of pregnancy and external validity in clinical trials of emergency contraception. *Journal of Family Planning and Reproductive Health Care*. 2006;32:165-9.
8. von Hertzen H, Piaggio G, Ding J, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial. *Lancet*. 2002; 360: 1803–10.
9. Trussell J, Cleland K. Levonorgestrel for emergency contraception. Expert Review, *Obstetrics and Gynecology*. 2007;2:565–576.
10. Raymond E, Taylor D, Trussell J, et al. Minimum effectiveness of the levonorgestrel regimen of emergency contraception. *Contraception*. 2004;69:79–81.
11. Cheng L, Gülmezoglu AM, Piaggio GGP, et al. Interventions for emergency contraception. Cochrane *Database of Systematic Reviews* 2008, Issue 2. Art. No.: CD001324. DOI:10.1002/14651858.CD001324.pub3.
12. Ellertson C. History and efficacy of emergency contraception: beyond Coca-Cola. *Family Planning Perspectives*. 1996;28:44-8.
13. Creinin MD, Schlaff W, Archer DF, et al. Progesterone receptor modulator for emergency contraception: a randomized controlled trial. *Obstetrics and Gynecology*. 2006;108:1089–1097.
14. Salhab AS, Gharaibeh MN, Shomaf MS and Amro BI.Meloxicam inhibits rabbit ovulation. *Contraception* 2001;63:229–233.
15. Duffy D and Stouffer R. Follicular administration of a cyclooxygenase inhibitor can prevent oocyte release without alteration of normal luteal function in rhesus monkeys. *Human Reproduction*. 2002;11:2825–2831.
16. Pall M, Fridén BE and Brännstron M. Induction of delayed follicular rupture in the human by the selective cox-2 inhibitor rofecoxib: a randomized double-blind. *Human Reproduction*. 2001;16:1323–1328.
17. Massai MR, Forcelledo ML, Brache V, et al. Does meloxicam increase the incidence of anovulation induced by single administration of levonorgestrel in emergency contraception? A pilot study. *Human Reproduction*. 2007;22: 434–439.
18. fpa. Your guide to emergency contraception. Accessed 18 December 2008. **http://www.fpa.org.uk/information/leaflets/documents_and_pdfs/detail cfm?contentID=141**

BPAS CHIEF EXECUTIVE APPOINTED TO GOVERNMENT ADVISORY COMMITTEE

Ann Furedi has been appointed Contraception and Abortion Care specialist advisor to the Independent Advisory Group on Sexual Health and HIV. This group exists to monitor progress and advise government on implementation of sexual health and HIV strategy. It is chaired by Baroness Joyce Gould.

Ann Furedi will take this opportunity to try to increase the Government's understanding of the reasons for unplanned, unwanted pregnancy and the role that abortion plays in allowing women to manage their fertility. Furedi has argued that if women are to play a full part in public life they must be able to decide if and when they have children. Contraception fails and sometimes people fail to use it effectively. Abortion is an essential back-up.

On being appointed to the Independent Advisory Group on Sexual Health and HIV, Ann Furedi said:

'I am delighted to be given a seat at the table to share my knowledge and experience of reproductive health care and the role that not-for-profit independent sexual health organisations can play. Abortion is an accepted part of reproductive health care. It is a normal, if unfortunate, experience for more than 200,000 women in Britain each year. It is important for the provision of abortion services to be seen as legitimate as STI and contraceptive services. I hope my appointment will help to end any remaining stigma.'

Ann Furedi has worked in reproductive healthcare for many years, being employed by the Family Planning Association, Birth Control Trust, and the Human Fertilisation and Embryology Authority (HFEA), the UK's fertility treatment regulator, before being appointed as **bpas** Chief Executive in 2003. Ann Furedi championed the introduction of the non-invasive early medical abortion 'pill' method (used under 9 weeks) in the UK, which experts credit for making abortions take place, on average, much earlier in the UK. In 2007, an unprecedented 70% of all abortions in England and Wales took place below 9 weeks. She has also vociferously opposed attempts to reduce the gestational time limit. **bpas** specialises in the provision of abortions after 16 weeks' gestation.

Under Ann Furedi's direction, **bpas** has come to provide around a quarter of all abortions in England and Wales. More than 90% are carried out under contract to the National Health Service.

THE ROLE OF NURSES IN ABORTION SERVICES

By Lisa Maith, parliamentary officer of the Royal College of Nursing

The role of nurses in abortion services has developed in response to a number of internal and external drivers. The political drive to reorganise the NHS, while modernising and developing the role of health professionals within it, provides an ideal backdrop for professional and service development.

The Royal College of Nursing has recently published guidance for its nursing members working in abortion services. As a result of changes in practice and the advancing role of nurses in providing abortion services, nurses from the RCN's Termination of Pregnancy Network considered it appropriate to further revise the guidance, which was last reviewed in 1997.

Since the late 1960s, the authorisation and provision of abortion has been the legal responsibility of a registered medical practitioner and the strict requirements are set out in the Abortion Act 1967. The role of the nurse was historically to provide general nursing care. However, recent advances in abortion methods, particularly medical abortion (abortion stimulated by drugs rather than surgical removal), have led to the development of innovative nursing roles and a more holistic provision of nursing care. Nurses are now planning, leading and managing a significant proportion of care for women undergoing medical abortion, under the guidance of a registered medical practitioner.

In the past year there has been a considerable amount of attention on the role of nurses in abortion care. The Human Fertilisation and Embryology (HFE) Bill and a Commons Select Committee inquiry both provided the opportunity to discuss abortion care at the highest levels and this generated debate amongst the media and public.

Ahead of the HFE Bill entering Parliament, the Commons Science and Technology Committee launched an inquiry into scientific developments relating to the Abortion Act 1967. The RCN consulted members who work in abortion services to inform its submission to the Committee in August 2007. The inquiry was completely focused on scientific developments and did not look at ethical or moral arguments. While the RCN acknowledges and respects those nurses who have a conscientious objection to providing abortion care, the organisation is committed to providing support to those nurses who do work in abortion to provide safe and quality care. We therefore thought it was important to submit evidence to this inquiry.

Following this consultation it was clear that those RCN members who worked in this clinical field felt the law on abortion required modernisation. These members saw both the requirement for two doctors to agree that a woman can have an abortion and the law that prohibits nurses and midwives from performing early surgical abortions as outdated. Both these views were adopted by the Committee in its final report.

Despite the law on abortion remaining unchanged following the passage of the Bill (after abortion amendments were not debated at Report stage, following a procedural motion), the nursing profession remains committed to developing more responsive, patient-centred services. Opportunities for nurses, in conjunction with medical colleagues, to take a far more proactive role in developing abortion services across England, Scotland and Wales have been created as a result of the European Working Time Directive. In addition, the increasing number of doctors 'opting out' of providing abortion services has resulted in gaps in service provision, which has led to further opportunities for enhanced development of nursing roles in providing medical termination of pregnancy.

The current climate of change in health care provides an ideal opportunity for clinical leaders to shape the way abortion services are provided in the future. The development of a designated resource to achieve this (for example, consultant nurse, clinical nurse specialist and nurse practitioner roles) has been successful in shaping local, regional and national nursing practice in caring for women undergoing abortion. All nurses have an opportunity to lead from a clinical perspective and can be empowered to influence change in service provision and practice development, ensuring improved services for women undergoing abortion within the legal framework.

The RCN remains committed to helping those members who work in abortion care. There have been considerable developments for nurses working in this field since the Abortion Act 1967. We hope our new guidance will provide accurate and up-to-date clinical and legal information while also empowering nurses that work in abortion care to develop their roles and promote best practice.

Abortion care: RCN guidance for nurses, midwives and specialist community public health nurses can be downloaded for free at:
http://www.rcn.org.uk/__data/assets/pdf_file/0008/194282/003270.pdf

BPAS MEDICAL AND NURSING CONFERENCE DISCUSSES FETAL TISSUE DONATION, STI SCREENING, AND IMPROVING CONTRACEPTION

By Abigail Fitzgibbon, bpas press and public policy officer

The **bpas** Nurse and Doctor Forum in London on 12 December 2008 brought together doctors and nurses from across London and the South of England. **bpas** developed this approach to give its clinical staff the opportunity to learn together, and to give both doctors and nurses the chance to hear the latest news and research in sexual and reproductive health. A similar event was run in Birmingham for doctors and nurses from Northern and Central regions.

Clinical updates on post-abortion ultrasound, Implanon insertion and removal, and pain medication, were followed by a number of presentations from experts in the field. Professor Naomi Pfeffer, Professor of Social and Historical Studies of Health at London Metropolitan University, discussed abortion, fetal tissue and medical research. Dr Martyn Walling, General Practitioner and Fellow of the Royal College of GPs, discussed Long Acting Reversible Contraceptives (LARCs). An expert panel discussed the relationship between abortion services and screening for HIV and Chlamydia.

Abortion and fetal tissue donation

Naomi Pfeffer raised issues around fetal tissue and the potential for tissue from aborted fetuses to be used in stem cell research.

Professor Pfeffer discussed issues around approaching women having an abortion about donating fetal material for medical research. She also took the opportunity to outline the findings of her qualitative research which explores women's views about donating fetal tissue. Many began with the view that donation could be a positive outcome of their unintended pregnancy and abortion. One concern which her research raised was that, as stated by the Polkinghorne guidelines, women are not allowed to know in detail what the tissue they donate would be used for. According to Pfeffer, some women felt that this would be important in their decision whether to donate, as they felt a 'duty of care' to the fetus.

Guidance in this area was last updated when the Polkinghorne guidelines were published in 1989. The Department of Health recognised the need to update this guidance in 2004 but as yet there have been no moves to update it. Professor Pfeffer called for a full review, public discussion and regulatory guidance in order to address the concerns clinicians feel about asking women having an abortion about fetal tissue donation, and assist researchers who need such tissue in order to carry out medical research.

STI screening

Ruth Lowbury, Executive Director of the Medical Foundation for AIDS and Sexual Health (MedFASH) joined Dr Mary Macintosh, Director of the National Chlamydia Screening Programme, in arguing the case for abortion services to increase STI screening. Ms Lowbury focused on HIV testing. She noted that because of the improvements made to anti-retroviral therapy, many people with

Naomi Pfeffer discussed the potential for tissue from aborted fetuses to be used in stem cell research

HIV can have a very good prognosis but that one of the greatest barriers to improving care is delayed diagnosis of HIV infection. She also emphasised that although a pre-test discussion is needed before testing, specialist pre-test counselling is not required which makes HIV testing more feasible in the non-GUM setting . According to figures she quoted from London studies, there appears to be a higher prevalence of HIV infection in women terminating their pregnancies compared with those giving birth. Since 1998, HIV testing has been universally recommended in antenatal care (resulting in a mother-to-child transmission rate of below 2%). MedFASH is arguing for an increase in HIV testing across wider healthcare settings, as 25% of people living with HIV are not aware of their infection and late diagnosis is the biggest factor in HIV-related morbidity and mortality.

Dr Macintosh explained that in order to reduce Chlamydia prevalence, 30-50% of the target population (15 – 24 year olds) needs to be screened. Currently most Primary Care Trusts (PCTs) are a long way off reaching this target and inclusion of Chlamydia screening in abortion services could help address this deficit. Abortion services currently account for 3-4% of screening and see many women in the target age group for screening.

Dr Simon Barton, Clinical Director of HIV/Sexual Health at the Chelsea and Westminster Hospital, closed the session by addressing various practical concerns that doctors and nurses may have about HIV and Chlamydia screening. The point was made by delegates that, as an organisation which provides most of its services on behalf of the NHS and funded by PCTs, **bpas** is limited in what it can do with regard to screening as a PCT must be willing to fund testing. Dr Barton suggested that one option would be to encourage PCTs who are reluctant to offer HIV testing by including it in agreements as standard, and if they are unwilling to fund this when commissioning services, for staff to flag it up with the Independent Advisory Group on Sexual Health and HIV.

Long Acting Reversible Contraceptives (LARCs)

PCTs are blocking access to LARCs because of the cost implications of funding these methods of contraception, Dr Martyn Walling told the conference. LARCs are far more reliable than 'traditional' methods such as the contraceptive Pill, and are ultimately cost-saving. However, local health trusts are reluctant to give women choice in this area because of the higher initial cost. This is contrary to guidance from the National Institute of Clinical Excellence (NICE) and is contributing to the unplanned pregnancy rate in the UK, he argued.

Dr Walling argued that GPs are not able to offer women the best chance to prevent unintended pregnancies because PCT funding rations the full choice of contraception, so women do not have the option of selecting the most suitable method for their lifestyle. However, he did note that the Department of Health's additional investment into LARCs, announced in the summer of 2008, was a positive sign, and that the new funding would increase LARC use and improve the options available to GPs and therefore patients.

Dr Walling also reported on the pending availablility of a new method to the UK, the contraceptive vaginal ring (NuvaRing®). The device is like an oral contraceptive pill in ring form. But is easier to use as it is inserted in the vagina where it remains, providing continuous contraceptive cover for 3 weeks, and can last up to 35 days. Dr Walling noted that there was an issue in the first trial of NuvaRing® with irregular bleeding: however the method is no different from and perhaps better than the Pill in this area. He felt this method would be effective and popular once the benefits were 'sold' to women.

Example of recent campaign. Please contact marketing@bpas.org for more details.

Santa only comes once a year...
...but that's all it takes!

In the heat of the moment it's easy to get carried away with the festive spirit.

The condom splits. You forget to take your pill. You have unprotected sex.
Whatever the reason, bpas can help.

This Christmas we are giving away FREE contraception kits, so you can be prepared by having your emergency contraception in advance of needing it.

Ask at reception or at your consultation.

For more information call **08457 30 40 30** or email **help@santacomes.org** - **www.santacomes.org**

Available while stocks last, through December 2008

bpas

Pick up a FREE emergency contraception kit here

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