# Models of integration to increase equity & access to contraception & abortion care

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# Expand service delivery beyond existing models & range of providers

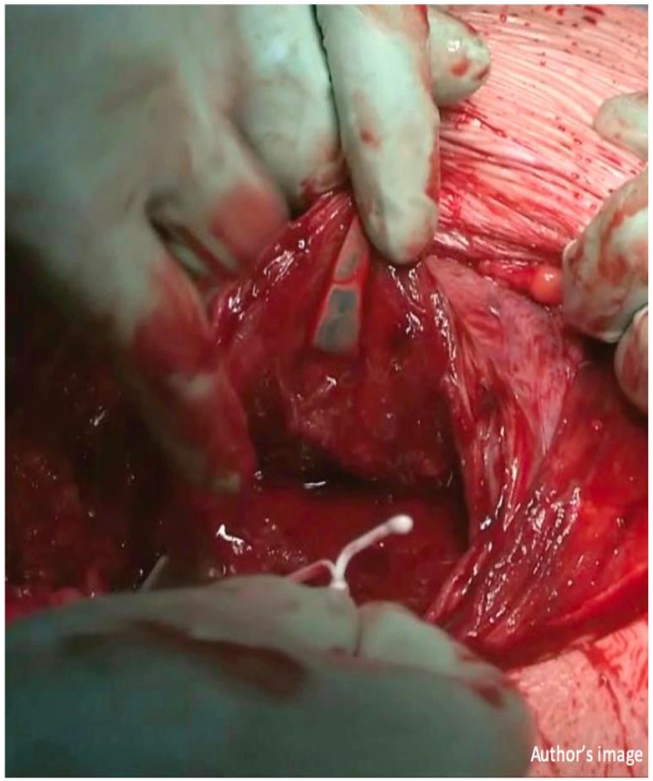
- Contraception from maternity setting
- Contraception from pharmacy setting
- Abortion from community setting

# Improving access postpartum


- Fertility & sexual activity resume quickly
- Recovery childbirth & looking after a baby
- Extra visits barrier to access (LARC)
- Unintended pregnancy common

# Antenatal contraceptive counselling by midwives & contraception after delivery

- Antenatal time to consider options
- LARC demand high (43%)
- Provision challenging
- Obstetrician IUC at c/section
- Midwife implant & IUC at vaginal birth
- Holistic care for women




- FIGO > 36 000 PPIUC
- Safe, low complications

*Cameron et al BJOG 2017*
*Heller et al Acta Obstet Gynecol Scand 2017*
*Makins et al IJOG 2018*

# Pharmacy & contraception

- EC main access pharmacy
- Studies not showed impact EC on abortion
- Efficacy, not used every UPSI
- Further UPSI x 2-3  risk preg
- Start effective ongoing contraception

‘Bridging’ supply of  POP from pharmacy ?

# ‘Bridging’ POP after EC

- ‘Pilot’ N= 168 women, pharmacies (n=12)
- Standard (n=54), POP 1 month (n=56), Rapid access SRH (n=58)
- Follow up at 6-8 wks
- Intervention groups higher % effective method

  POP 56% vs 16% standard (p=0.001)

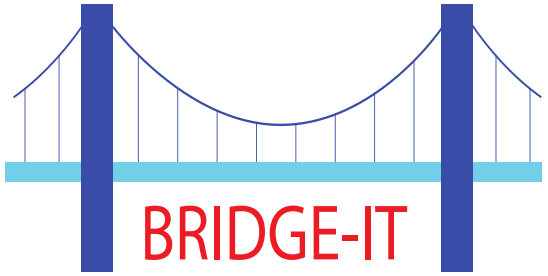
  Rapid access 52% vs 16% standard (p=0.01)

  Simple strategy to prevent more unintended pregnancies?

*Michie et al Contra 2014*

# Bridge-It

- Pragmatic cluster randomised cohort cross-over study
- N = 639 women EC pharmacy (LNG)
- Standard care vs combination intervention
- 3 months POP plus rapid access




NIHR HTA funded

- Contraceptive use at 4 months
- Abortion at 12 months

# Pharmacy provision of injectable

- Survey **1:3** consider injectable if could get from pharmacy
- Access, convenience
- Pilot (N=50) DMPA- SC repeat injections over 1 yr
- Women mixed experiences
- Pharmacists enthusiastic but availability issue
- Feasible only if large pool of trained pharmacists

*Heller et al Int J Pharm Practice 2016*
*Heller et al Eur J Contra Reprod Health Care 2017*

# Should contraception be available from pharmacist ?

- Survey UK SRH providers ( N=174)
- Pharmacy medicine **P** or General sale **GS** ?
- POP (59% **P** vs 21% **GS**) COC (40% **P** vs 12%**GS**)
- Injectable or implant given by pharmacist?
- 63% support injectable , 60% not implant
- Competency, capacity, training & support

*Boog et al BMJ SRH 2019*

# Shift hospital to community SRH

# Contraception after abortion

- Most women seek abortion used method low effectiveness or inconsistent
- Choose IUC or implant X16 less risk another abortion
- Hospital junior medical staff with limited contraceptive expertise


More effective contraception uptake if care from community SRH setting ?

*Heikinheimo et al Contra 2008*
*Cameron et al BJOG 2012*
*Rose and Lawton Am J Obstet Gynecol 2012*

# Shift hospital to SRH setting

- Abortion assessment & early medical abortion
- N > 1300 women
- Same high safety and clinical outcomes EMA
- Higher LARC uptake at SRH ( 48% vs 23%)
- Same high satisfaction with care

*Cameron et al JFPRHC 2016*

*Purcell et al Contra 2016*

- Women want range of providers inc. GP, midwife, nurse

*Smith et al BMJ SRH 2019*

*Dawson, Bateson et al BMC HSR 2016*

# Telemedicine access for EMA

- SR (n=13) studies
- Safe, effective, liked by women & providers
- Clinical outcomes similar as in person visit
- Evac rates higher in restricted settings
- Service delivery model for more legal settings ?


*Endler et al BJOG 2019*

# Conclusions

- Equity and access to contraception and abortion
- Expand service delivery beyond existing models & range of providers
- Obstetrician, Gynaecologist, GP, SRH, Midwife, nurse, pharmacist, women
- Fewer unintended pregnancies

& better outcomes for women and babies