BPAS
British Pregnancy Advisory Service

Contraception Re-Imagined:

The Unfinished Revolution

Contents

Contents (Contd)

Acknowledgements

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Finally, and most of all, we express our deepest appreciation to the women and people who responded to our contraception survey, sharing with us their personal experiences and hopes for the future. Our hope is that by amplifying their voices, together we will generate the changes we all want to see and bring about a contraceptive future that meets the needs of all.

Foreword - by Caroline Criado Perez

"We deserve better choices"

When it comes to contraception, we tend to think we're spoilt for choice. You've got your patch, your coil, your ring, your injection, your various formulations of the pill and mini pill: what more could we possibly want?

This impression of choice is, however, an illusion; if your choice doesn't, for whatever reason, include hormones, you will find you've run out of choices pretty quickly. The only choice you're generally making is how you want your hormones served up.

In the sixty years since the pill first ushered in the sexual revolution, there has been remarkably little contraceptive innovation, and young women today are still relying on the same basic science to prevent pregnancy as their mothers. It's hard to think of another field of medicine that has remained similarly stagnant over this time period.

But there is some good news. A non-hormonal method of fertility control is already being tested in clinical trials, and this pill, or "contragestive" could be taken weekly, monthly, or simply on demand after unprotected sex and a missed period. BPAS's survey indicates that women are enthusiastic about this too: 72% of respondents said they would be open to using such a pill. The only issue is that even if this pill is found to be safe and effective, our Victorian abortion laws might make approval tricky.

If you're reading this report, chances are that you're a believer in a woman's right to choose. You believe in a woman's right to choose if and when she wants to have a baby. And you believe in her right to choose how she controls her fertility.

But belief in a woman's right to choose only takes us so far. Because unless there are actually good options for her to choose from, well: that's no choice at all. And yet this is where, according to the findings of this report, we find ourselves.

One in seven respondents said that they were dissatisfied with their contraception's side effects. Eighty-four per cent of them have changed their method of contraception at some point, with the average woman changing her method twice.

Meanwhile, 49% of respondents faced barriers in accessing their contraception of choice. They either couldn't get an appointment with a healthcare provider, had a partner or family member blocking access, had to wait too long for insertion or found it too expensive.

By identifying these gaps in contraceptive provision this report represents an important first step to closing them. Now, we must act on its findings. Women (and men) deserve better. We deserve better laws. We deserve better contraception. We deserve better choices.

Caroline Criado Perez is a best-selling and award-winning writer, broadcaster, speaker and feminist campaigner. Her #1 Sunday Times best-seller, INVISIBLE WOMEN: Exposing Data Bias in a World Designed for Men (Chatto & Windus, Abrams, 2019), highlights the systematic biases behind the data and assumptions impacting our everyday lives.

Executive Summary – By Heidi Stewart, Chief Executive of the British Pregnancy Advisory Service (BPAS)

Hormonal contraception has been, and remains, revolutionary for women. It has given women unprecedented control over their fertility, empowering them to choose whether and when to have children. It has enabled women to regulate their menstrual cycles, alleviate negative period symptoms, manage conditions like endometriosis and reduce the risk of endometrial and ovarian cancers. All of this – and more – is to be celebrated.

But there are problems too. Women are increasingly vocal about the side effects of hormonal contraception, with many asking why non-hormonal options are so limited, and why the innovation of the last 60 years has focused primarily on changing the delivery mechanism of the same set of hormones. Others are wondering why, in an age of gender equality, women still bear primary responsibility for pregnancy prevention. Millions are turning to fertility awareness apps, with FemTech filling the gap left by slow progress in contraceptive innovation.

Meanwhile, many of those women who do still want hormonal contraception cannot access the contraception they want, when they need it. Barriers to access stem, in large part, from contraceptive provision being hit particularly hard by central government funding cuts to the public health grant: Between 2015/16 and 2020/21, there was a 42% drop in local authority contraceptive spend across England.[1] Over 1/3 of local authorities have reduced, or plan to reduce, the number of sites commissioned to deliver contraceptive services since 2015.[2] The consequent costs to women, and to society, cannot be overstated. Aside from the human toll, the economic argument for investment in contraceptive services is compelling: Over 10 years, there is a £9.00 saving for every £1 invested in publicly provided contraception.[3] If the government wants to cut spending, investing in contraception is the way to go.

Our hope at BPAS is that this report will kickstart a long-overdue national conversation about contraception. About what is working, and what is not. About what needs urgent attention and investment, and what needs longer-term exploration and regulatory reform. We want to celebrate the revolutionary change that has empowered women, while acknowledging that the contraceptive revolution is not finished.

We at BPAS also want to push boundaries – as we have done since we were founded in 1968, on the day the Abortion Act came into force. BPAS (then the Birmingham Pregnancy Advisory Service) knew women needed a service to provide safe, legal and accessible abortion care. We were, and we are, the service that has women's backs. And now we are pushing boundaries even further. Imagine a future where women are in full control of their contraception. Where they can take a non-hormonal pill once a week, once a month, or after unprotected sex. That pill exists. It's called a contragestive. And it will revolutionise the future of contraception.

Women deserve better than what is on offer now. They deserve improved access to the contraception they want, when they need it. They deserve up-to-date and independent information about their contraceptive options – whether from healthcare professionals or online sources – to enable them to make fully informed decisions about what is right for them. And – most importantly – women deserve more options that give them the fertility control they want without the side effects they do not want. I invite you to join us in this conversation.

Heidi Stewart, Chief Executive Officer, BPAS

[1] *Breaking barriers: Inequalities in access to contraception in England (theagc.org.uk)*

[2] *SLH0025 - Evidence on Sexual Health (parliament.uk)* and *'Cuts, Closures and Contraception: An audit of local contraceptive services in England' (theagc.org.uk)*

[3] *Contraception: Return on Investment (ROI) report (publishing.service.gov.uk)*

Headlines from BPAS' recent survey of women's contraceptive experiences and attitudes[4]

Women and people needing contraception are overwhelmingly enthusiastic about contragestives – non-hormonal alternatives to existing contraception that could be taken regularly once a week or month, or on demand when needed, and work to either prevent implantation or to end an early pregnancy:

- 72% of respondents said they would be open to taking a non-hormonal pill regularly or only if necessary to control their fertility
- Only 14% of respondents said the way it operated (i.e. to prevent implantation or to end an early pregnancy) would be one of the most important factors influencing their decision to take a non-hormonal pill

Women are overwhelmingly supportive of their male sexual partners using long-acting reversible contraceptives (pills, gel or injections), and trust them to do so reliably:

- 76% of respondents said they were open to their male sexual partner using a long-acting reversible method of male contraception if it were available
- 81% of respondents said they would not use an additional method of contraception

Oral contraception is less popular, and a significant proportion have used fertility awareness methods:

- 21% of respondents currently use oral contraception, compared to 44% who said they had used it previously
- 10% have used fertility awareness methods, with 1 in 20 using fertility awareness methods currently, including 4% using apps, with the highest proportion of app users aged 26-35 years
- Nearly a third of respondents (28%) have no main method of contraception

Almost half (49%) of respondents are encountering challenges in accessing their preferred method of contraception:

- The most common reported barriers were not being able to get an appointment with a healthcare provider (12%), partners or family members preventing access (12%), too expensive (11%) and waiting too long for insertion (9%)

Respondents showed significant dissatisfaction with their contraception's side effects:

- 1 in 7 respondents are dissatisfied with their contraception's side effects
- Higher dissatisfaction rates were observed in those aged 26-35 years

Women are trying lots of different contraceptive options:

- 84% of respondents have changed their method of contraception at some point
- On average, respondents had changed their contraception twice
- The main reason for changing was to avoid negative side effects

[4] BPAS commissioned independent polling company Censuswide to conduct a survey of 1,000 women aged 18-45 across the U.K. The survey was open to women and those who identify as transmen, non-binary or agender.

Calls to Action

Together, we can empower women and people needing contraception to take back control. But, to do so, we are calling on decision-makers, policymakers, regulators, pharmaceutical companies, research bodies, and healthcare professionals to make the following changes urgently. These calls to action call for improvements in access to existing options and, crucially, aim to broaden the future choices available to women. They focus on investing in novel forms of fertility control, tackling waiting times for long-acting reversible contraception, and improving current contraceptive choices.

To invest in the future of fertility control, we call on the following:

1. **The Department of Health and Social Care to allocate greater funding to contraceptive innovation** and work with other departments, public health agencies and research councils to accelerate innovation.
2. **All those involved in contraceptive innovation to ensure greater user involvement**, at all stages of the design and development process.
3. **Research bodies and pharmaceutical companies to invest in the introduction of contragestive fertility control in the UK.**
4. **Parliamentarians to remove any barriers in existing law that would inhibit clinical trials around, or the introduction of, contragestives.**
5. **The Medicines and Healthcare products Regulatory Agency (MHRA) to review mifepristone licensing to facilitate the introduction of contragestives.**
6. **Research bodies, pharmaceutical companies and the MHRA to accelerate access to long-acting reversible male contraception** (pill, gel, and injection) to share the contraceptive burden of responsibility more fairly.

To tackle waiting times for long-acting reversible contraception (LARC), we call on the following:

7. **UK Health Security Agency (UKHSA), NHSE, local authorities and Integrated Care Systems (ICSs) to identify and publish the data on waiting times, nationally and locally, on insertions and removals of LARCs** (coils, implants, and injections), as well as on seeing GPs for oral contraceptive pill prescriptions (initial and renewals).
8. **NHSE, local authorities and ICSs to reduce waiting times for accessing contraception**, especially LARCs, to avoid unintended pregnancies. Specifically, we call for the production of local plans to reduce waiting times for access to contraception to nationally-agreed levels. These plans should include more appointments, adequate staffing and an expansion of contraception locations.
9. **NHSE to centralise data on contraceptive prescribing and use** to enable stakeholders to easily identify patterns, problems, and backlogs.

To improve current contraceptive choices, we call on the following:

10. **The MHRA to reclassify emergency contraception to a General Sales Label** (GSL) so that it is easily accessible from a wider range of outlets.
11. **NHSE, local authorities, Integrated Care Systems (ICSs) and others responsible for commissioning contraception should consider procuring male condoms** to be available on prescription for free to men and women of all ages across all parts of England..
12. **FemTech, social media influencers, clinicians, and those in the sexual and reproductive health community to take a lead in combatting contraceptive misinformation on social media** by producing accurate and engaging content on contraception across media and social media channels.

Glossary of Key Terms

APPGSRH – All Party Parliamentary Group on Sexual and Reproductive Health

BPAS – British Pregnancy Advisory Service

CHC – Combined Hormonal Contraception, which usually encompasses pills, patches and rings

COCP – Combined Oral Contraceptive Pill, which is often abbreviated to the 'Pill'

DHSC – The Department of Health and Social Care

EHC – Emergency Hormonal Contraception

EMA – Early Medical Abortion

FABM – Fertility Awareness-Based Method

FOI – Freedom of Information

FPA – Family Planning Association

FRSH – Faculty of Sexual and Reproductive Healthcare

IUD – Intrauterine Device

IUS – Intrauterine System

LARC – Long-Acting Reversible Contraception

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

OC – Oral Contraception

PCS – Pharmacy Contraception Service

The Pill – Combined Hormonal Contraceptive Pill

POP – Progesterone-only pill (sometimes called the 'mini-pill')

SAE – Serious Adverse Event

SRH Services – Sexual and Reproductive Health Services

SRHAD – Sexual and Reproductive Health Activity Data Set

UKHSA – UK Health Security Agency

Timeline of Contraceptive Changes in the UK[5]

1915: The London Rubber Company (now Durex) was launched to sell condoms

1921: Marie Stopes opened the first birth control clinic in the UK

1930: The Church of England ruled that birth control could be used by married couples.

1961: Birth control pills could be prescribed on the NHS for married women.

1967: After passing of NHS Family Planning Act, birth control pills became available for single women.

1976: Copper IUDs shown to be highly effective when used as emergency contraception.

1984: The first oral emergency contraception (known as the morning after pill) was launched in the UK.

1995: A health scare over thrombosis caused women to stop taking the Pill.

2001: The morning after pill became available to buy over the counter in pharmacies.

2005: British Pregnancy Advisory Service (BPAS) started to provide contraceptive services to abortion care patients.

2013: Fertility tracking app Natural Cycles was launched.

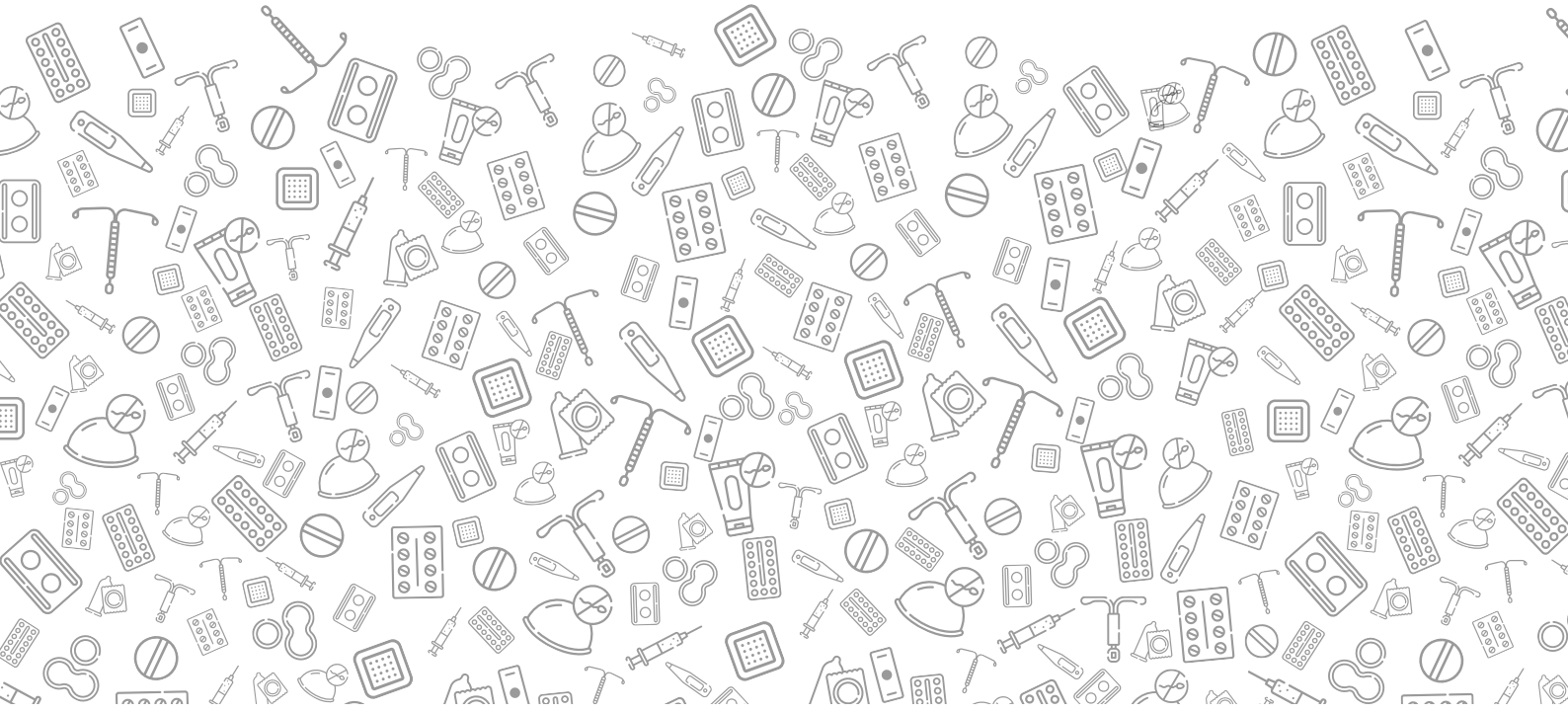
2015: The morning after pill was licensed for under-16s.

2018: Natural Cycles was granted medical approval to be used as contraception in the European Union, and then by the Food and Drug Administration (FDA) in the US.

2021: The progesterone-only mini pill became available to buy over the counter from pharmacies.

2022: BPAS started a mobile clinic service to fit IUDs and implants to support local SRH services.

2023: NHS England started commissioning Community Pharmacy England to enable pharmacists to provide oral contraception for women.



[5] *Adapted from A brief history of birth control: a timeline of contraception (cosmopolitan.com)*

Introduction

Hormonal contraception has been, and remains, revolutionary for women. Indeed, it was perhaps one of the most significant medical advances of the twentieth century. It has given women and people needing contraception unprecedented control over their fertility, bodies, and lives. It played a leading role in the postwar emergence of the women's liberation movement as well as enabling greater sexual freedom for women. Before its advent, women had tried to prevent pregnancy and limit their family size by a range of natural and artificial methods, some effective, some deadly.

When the combined hormonal contraceptive pill (or the Pill) was licensed in the UK in 1961, it enabled women to take unprecedented and unparalleled control of whether and when to have a baby. At first, only married women benefited from its transformative power. But from 1974, all women, married and unmarried alike, were able to use the Pill to prevent pregnancy, decide when to start their families, space their pregnancies, and cease childbearing.

Alongside this unprecedented fertility control, hormonal contraception – which over the last 60 years has evolved to include hormonal coils, injections, implants, patches, and rings – has had a range of other positive side effects. It has enabled some women to regulate their menstrual cycles, reducing the frequency and intensity of their periods, as well as associated pain and bleeding, and in some cases stopping their periods altogether. It has also enabled some women to better manage conditions like endometriosis, while reducing the risk of endometrial and ovarian cancers.

Hormonal contraception has always had its critics. For conservatives, the sexual revolution facilitated by the advent of the Pill was a travesty that promoted female promiscuity at the expense of the traditional family. For feminists though, the more serious problem was that hormonal contraception was sometimes used to try to limit the fertility of certain groups within the global north, and to control population growth in the global south. Intolerance and racism drove some to repurpose birth control for the individual into a tool of population control for the state. Such practices have cast a long, dark shadow that lives on today.[6]

Today, other concerns and criticisms are present. Women are increasingly vocal about the unpleasant, even intolerable, side effects of hormonal contraception. These can include mood swings, depression, anxiety and weight gain, among others.[7] Many are asking why non-hormonal options are so limited, and why the innovation of the last 60 years has focused primarily on changing the delivery mechanism of the same set of hormones, rather than creating a new generation of non-hormonal alternatives with fewer side effects.

More fundamentally, in an age that strives for gender equality, men and women alike are asking why women should bear the primary responsibility for pregnancy prevention, given they are only fertile for a few days each month, whereas most men are fertile every day of the year. Why has innovation in male contraception been so slow, and when will long-acting reversible forms of male contraception finally come to market and into people's bedrooms?

[6] *These concerns are now coming into discussions about contraception and the climate emergency. See, for example:* *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10444000/* *and* *https://blogs.bmj.com/bmjsrh/2019/10/16/climate-change-and-contraception/*

[7] *Side effects and risks of hormonal contraception - NHS (www.nhs.uk)*

Disagreements about whether current contraception offers true choice are captured nicely by the divergence between the UK's official position and that of gender researcher and campaigner Caroline Criado Perez. The Department of Health and Social Care claims "a number of metrics demonstrate a sustained picture of improved choice of contraceptive method when compared to the previous year."[8] By contrast, Perez believes it's a myth that modern women have a dizzying array of contraceptive choices. She states, "What we have, with the various forms of pills, patches, implants and coils, is simply a wide range of delivery mechanisms for the same basic method: hormones."[9] She explains, "If you can't or don't want to use hormones as contraception for whatever reason, the only options available to you are the copper coil, which can cause heavier more painful periods, and condoms."[10]

Growing dissatisfaction with side-effects from hormonal contraception and the limited range of non-hormonal contraceptive options appear to be leading more and more women to turn to Natural Family Planning methods, often called fertility awareness-based methods (FABM). These range from the rhythm method to sympto-thermal monitoring of basal body temperature and cervical mucus.[11] Sometimes these approaches are combined with digital fertility awareness apps that gather users' data and algorithmically predict fertile/unsafe unprotected sex days and infertile days when, they claim, the risk of pregnancy with unprotected sex is akin to the Pill with typical use. In this sense, FemTech is filling the void left by others' failure to invest in contraceptive innovation – with all the regulatory and data risks that shift entails – while at the same time seeming to empower women to take charge of their own fertility, free from hormones.

As attitudes to contraception shift – with more women choosing alternatives to hormonal contraception – the time has come to kickstart a national conversation that pushes forward this unfinished contraceptive revolution. This report aims to be that conversation starter.

First, it outlines the latest trends in contraceptive use over the past five years, combining data from publicly available datasets with our recent survey, conducted by independent polling company Censuswide, on the contraceptive experiences of 1,000 women – and those who identify as transmen, non-binary or agender - aged 18-45 years from across the U.K. This data includes information about past contraceptive experiences, the reasons respondents have changed methods over the years, their current main method of contraception, how easy they found accessing it and how satisfied they are with it.

Second, perhaps more importantly, our survey assesses respondents' appetite for future innovations, in particular their desire for their sexual partners to use new male long-acting reversible contraceptives (like the gels and injections currently in development), and their willingness to use a new method of fertility control for women, a contragestive, that takes the form of a non-hormonal pill that could be take regularly once per week or month, or as needed after unprotected sex and a missed period. Finally, this report makes several calls to action to urgently improve access to existing contraception while pushing for quicker advances to take forward this unfinished contraceptive revolution in ways that give women what they want, when they need it.

[8] *Reproductive health profiles: statistical commentary - GOV.UK (www.gov.uk)*

[9] *Why do we still know so little about the pill? (thetimes.co.uk)*

[10] *Caroline Criado Perez, Invisible Women Newsletter, "Evidence Free Handwaving," 8th April 2024.*

[11] *See here for an overview of the range of methods and their effectiveness: Fertility awareness-based methods for pregnancy prevention | The BMJ*

The Data on Contraceptive Behaviour and Attitudes

Challenges with the Existing Data

First, a disclaimer: It is challenging to get a full and reliable picture of the latest trends in contraceptive use. Not all the data is gathered and published publicly, such as data about contraception distributed by pharmacists and maternity services. The data that is published often exists in separate places. For example, the Sexual and Reproductive Health Activity Data Set (SRHAD), which consists of anonymised patient-level data covering contraception prescribing at specialist Sexual and Reproductive Health (SRH) services, is submitted and published on an annual basis in one place,[12] whereas the public health data provided by Fingertips,[13] which is managed by the Office for Health Improvement and Disparities (OHID),[14] is published in another.

These multiple data sources reflect the various service providers of contraception, and the fragmented commissioning system.[15] In England, contraception is available from General practitioners (GPs), pharmacists, and a range of retail settings for condoms.[16] Contraception is also provided by SRH services, which include family planning services, community contraception clinics, integrated Genitourinary Medicine (GUM) clinics, and young people's services (such as Brook advisory centres). These provide a range of services including, but not exclusively, contraception provision and advice.[17] BPAS also provides contraception to patients previously provided with abortion care.[18]

The problem, then, is that "there is no single dataset which captures all methods of contraception across all services which provide contraception."[19]

Caution also needs to be taken when interpreting the data. Some data shows the numbers of women prescribed a particular method of contraception from a specific source (such as from either GPs or SRH services as in the Fingertips data), whereas other data (such as SRHAD) shows the number of prescriptions from SRH services.[20] So, the metric is different. In some cases, specifically prescriptions for user-dependent methods like the Pill, there may also be a gap between what is given to the woman and what she uses, either at all or as her main method of contraception. In that sense, these datasets only capture what healthcare professionals give to women, and not the fuller picture of women's contraceptive choices and behaviour.

Finally, these datasets do not track women's experiences of using their contraception or their attitudes towards it. For that we have three National Surveys of Sexual Attitudes and Lifestyles (or Natsal) surveys. These are among the largest surveys of sexual behaviour in the world and have taken place every 10 years since 1990. They use a probability sampling method to randomly select people from across Britain to take part, which means that the results are broadly representative of the general population. So far, over 45,000 people have taken part in Natsal surveys, and the consistent methodology and repetition of the surveys have made it possible to look at differences in sexual behaviours over time.[21]

[12] Sexual and Reproductive Health Activity Data Set (SRHAD) collection - NHS England Digital

[13] Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)

[14] *Fingertips combines the SRHAD data with NHS Business Services Authority ePACT2 prescribing data (based on GP practice level contraception data) and Office for National Statistics mid-year population estimates.*

[15] appg-full-report-4.pdf (fSRH services.org)

[16] Reproductive health profiles: statistical commentary - GOV.UK (www.gov.uk)

[17] Sexual and Reproductive Health Services (Contraception) - NHS England Digital

[18] Contraception | BPAS

[19] Reproductive health profiles: statistical commentary - GOV.UK (www.gov.uk)

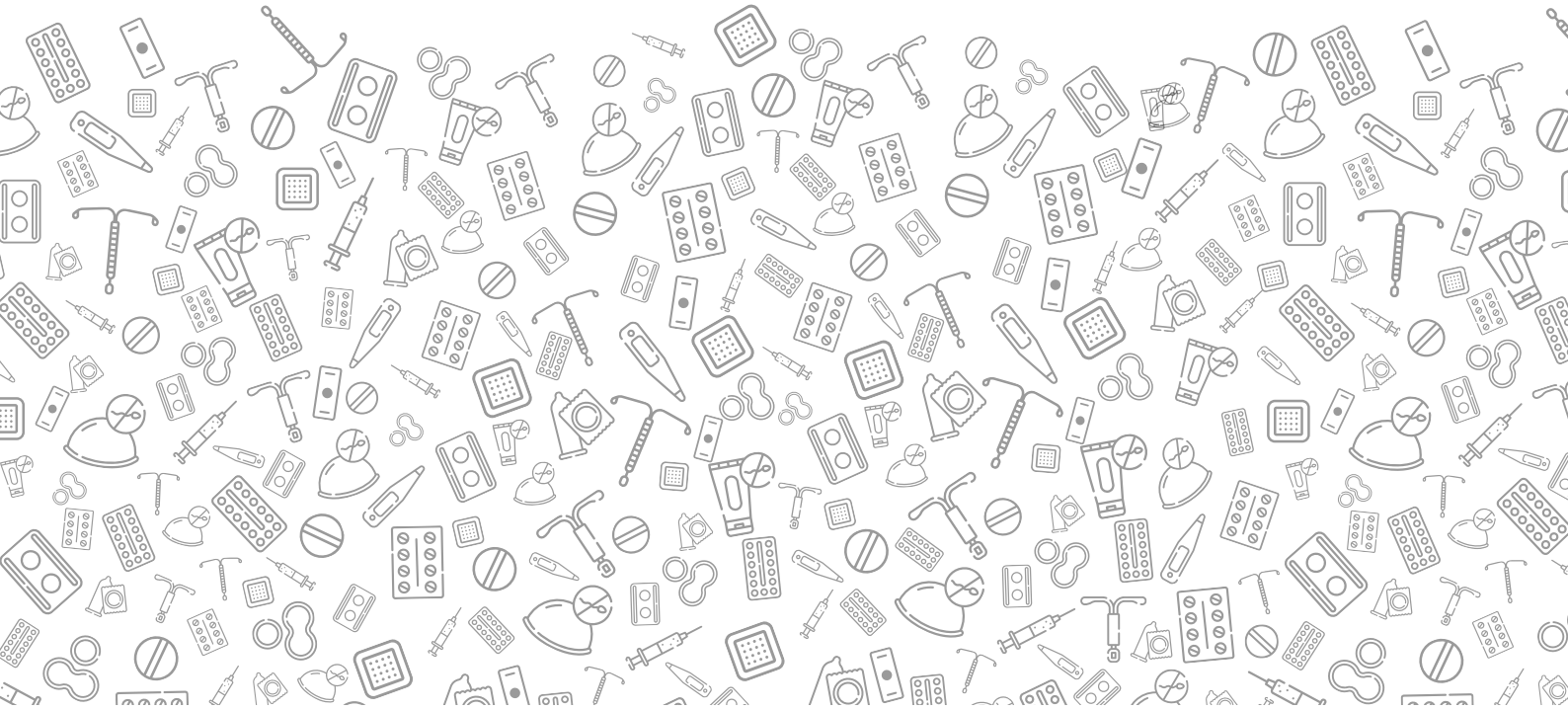
[20] Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital

[21] About – NATSAL

There are some useful findings about contraceptive use from previous Natsal surveys. For example, one study that compared the responses between Natsal-2 (conducted in 1999-2001) and Natsal-3 (conducted in 2010-12) found that "The condom and oral contraceptive pill remain the most commonly used methods" and "a decline in sterilisation use was compensated by an increase in long-acting reversible contraceptive (LARC) use", which was particularly evident among under-25s compared with women aged 40–44 years.[22] Yet, as the study authors conclude, "Whether this trajectory is maintained given changing sociodemographic characteristics and more recent financial cuts to sexual health service provision will warrant investigation."[23]

Moreover, the Natsal studies are now out of date. Due to the COVID-19 pandemic, Natsal-4 has been delayed, with the last full Natsal survey, Natsal-3, conducted 12-14 years ago.[24] That data may not reflect current, post-pandemic preferences and patterns. Though the surveys span a wide variety of behaviours and attitudes towards sex, the contraception questions in Natsal-3 were limited to which contraception method was used in the last 12 months,[25] whether respondents used these methods on different occasions or in combination on the same occasion, the source of their contraception, and from where respondents would prefer to access contraception.[26] Absent from the last survey were questions about the respondents' degree of satisfaction with their current contraception or barriers they may have faced accessing contraception.

As a result of these limitations with the existing data, we at BPAS decided to gather our own fresh data, focused on women's current contraceptive use and appetite for future options.



[22] *Changes in the prevalence and profile of users of contraception in Britain 2000–2010: evidence from two National Surveys of Sexual Attitudes and Lifestyles | BMJ Sexual & Reproductive Health*

[23] *Ibid.*

[24] *Please note, two Natsal surveys were conducted online during the COVID-19 pandemic in 2020 and 2021, but these focused on the impact of the pandemic on sexual attitudes and lifestyles, identifying trends that were likely unique to that particular historical moment. See "National Survey of Sexual Attitudes and Lifestyles COVID-19 Study, 2020-2021" via UK Data Service › Study*

[25] *See Table 56 here: Report template long (natsal.ac.uk)*

[26] *See copy of Natsal-3 interview questionnaire here: Natsal 3 Questionnaire (ukdataservice.ac.uk)*

BPAS Survey Methodology

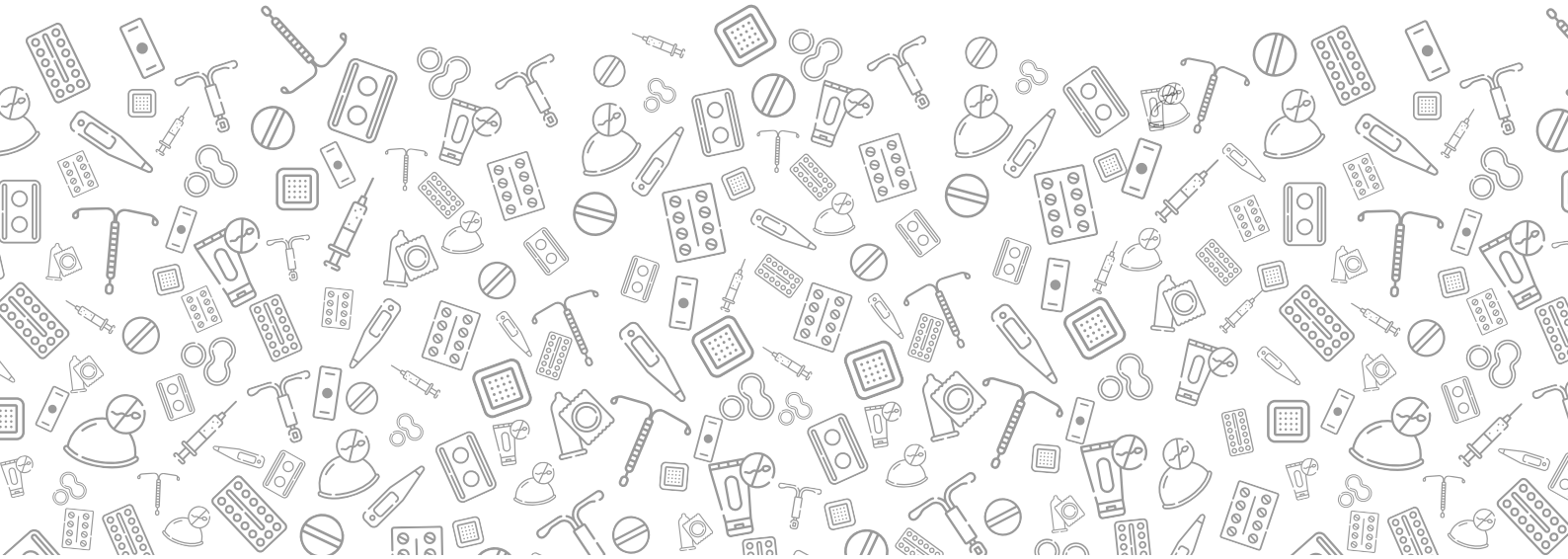
BPAS commissioned independent polling company Censuswide to conduct a survey of 1,000 women aged 18-45 years[27] in the UK The survey was conducted in July 2024 and consisted of nine questions. The questions spanned women's past and present contraceptive experiences, and future preferences, to capture both changes in individual women's choices and test their appetite for contraceptive innovations.

The first questions focused on respondents' current main method of contraception, their level of satisfaction with it, whether they encountered any barriers accessing it, the methods they have used previously and why they changed methods. The later questions asked respondents whether they would use male contraception with different types of sexual partners (i.e. only in a long-term relationship or with any sexual partner, including casual sexual partners and one-night stands), and whether they would use a new method of fertility control – known as a contragestive – in the form of a non-hormonal pill taken either regularly once per week or month, or on-demand if they had unprotected sex and missed their period. The survey then invited respondents to rank which factors would influence their decision to use this new method of fertility control, such as its effectiveness, safety, dosage, and mode of operation. Finally, the survey provided a free text box for respondents to share their reflections on their contraceptive experiences, with a steer to share further views on male contraception and this new method of fertility control for women. See Appendix 1 for survey questions.

The survey was open to women and those who identify as transmen, non-binary or agender.[28] 1,002 people responded to our survey. Of them, 988 were, or identified as, women, while 8 were non-binary, 5 were transmale, and 1 was agender. The sample also included nationally representative quotas on age, region, and race/ethnicity. It also included at least 100 respondents in each income bracket, which were designed to match ONS household income bands.

In the overview of contraceptive trends that follows, we have endeavoured to build as full a picture as possible of the current contraceptive situation and future preferences using both SRHAD and OHID datasets, alongside the results of our own survey.

Please note that the most recent SRHAD data from 2023-24 - published as this report went to press - shows similar trends to the previous year's data, with only slight variations for a few methods of contraception.[29]



[27] *The study population is women of child-bearing age, aged 18 to 45 years old. Although women aged over 45 are often still fertile and need contraception, women aged 18 to 45 represent the majority of conceptions in England.*

[28] *Men and transfemales were excluded since they would not need contraception to prevent their own pregnancy.*

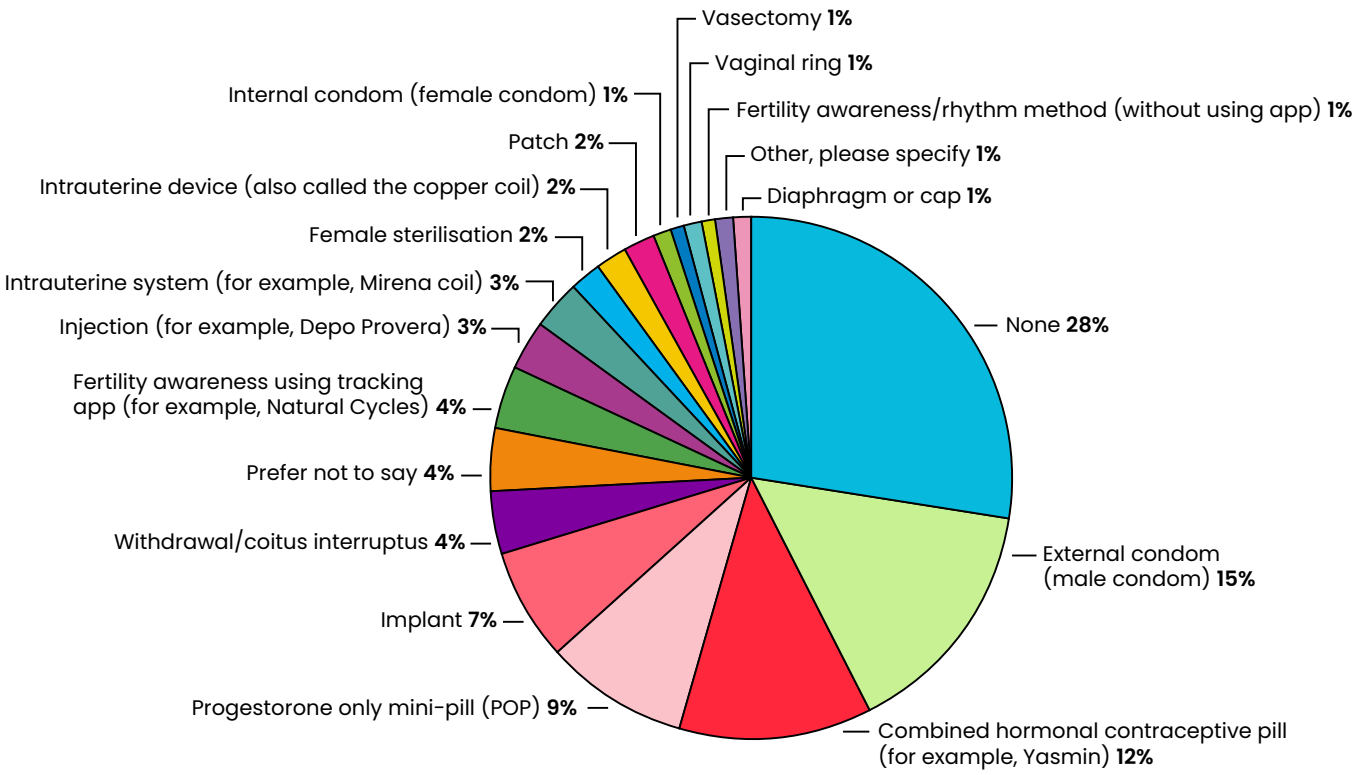
[29] *Sexual and Reproductive Health Services, England (Contraception), 2023-24*

Current Trends in Contraceptive Use

Are women turning away from the Pill?

Our survey showed that while 44 per cent of respondents have previously used oral contraception in their lifetime, only 21 per cent of women are now using oral contraception as their current main method. That includes 12 per cent of respondents who are using the combined hormonal contraception pill (COCP) and 9 per cent who are using the progesterone-only mini-pill (POP), as can be seen in Figure 1 below:

Figure 1: Respondents' current main methods of contraception, by type[30]



That percentage gap between ever use and current use in our survey is similar to the drops in the percentages of women using oral contraceptives shown in the SRHAD data over the last decade. As Table 1 below shows, 27 per cent of women used oral contraceptives in 2022-23. But the proportion has nearly halved in almost 10 years from a high of 48 per cent who used that method in 2013-14.[31]

[30] *Source: BPAS survey conducted by Censuswide, July 2024.*

[31] *Source: Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

"Hormonal pill isn't for me as I am concerned about mental health issues and other side effects."

"I have fears about most of the contraceptive pills as regards [to] the side effects."

"I wish I had been told about the side effects in more detail when I was put on them."

"I find that the hormones with the pill can be all over the place making my emotions and mood variable. I find myself quite anxious as well."

"The pill made me fat and depressed and caused inflammation [sic], when I stopped using the pill all those things went away."

"I have mostly used the tablets or injections the past few years. I have stopped using these products due to struggling with hormones and depression while taking contraception."

Table 1: Females using Sexual and Reproductive Health Services for contraception, by main method of contraception, England, 2012/13 to 2022/23[32]

Main method in use	2012-13	2013-14	2014-15[2]	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Total with a method in use (thousands)	**892.6**	**909.6**	**941.2**	**905.8**	**870.7**	**817.0**	**798.5**	**748.2**	**479.2**	**456.9**	**472.8**
LARCs total 3	**272.6**	**285.3**	**346.1**	**347.7**	**341.9**	**336.0**	**351.9**	**343.0**	**220.2**	**256.6**	**259.9**
IU device	37.2	38.5	54.2	52.9	54.2	56.6	60.9	60.5	41.3	48.4	47.9
IU system	41.7	45.5	67.7	70.6	72.2	74.9	83.4	83.8	57.9	72.0	74.9
Implant	109.7	119.0	138.9	140.0	134.6	129.8	136.6	133.2	88.1	104.2	103.8
Injectable contraceptive	84.0	82.3	85.3	84.2	80.8	74.8	71.0	65.5	32.9	32.0	33.2
User dependent total	**620.1**	**624.3**	**595.1**	**558.1**	**528.8**	**481.0**	**446.6**	**405.2**	**259.0**	**200.3**	**212.9**
Oral contraceptives	420.6	432.6	426.8	405.4	384.7	341.7	311.1	282.3	188.5	125.3	126.4
Male condom	179.2	167.9	141.2	126.9	118.1	110.6	109.6	96.8	52.9	56.4	64.4
Contraceptive patch	11.0	11.9	13.8	14.0	13.9	13.0	12.9	13.5	8.1	8.2	10.4
Natural family planning	4.5	6.7	7.7	6.3	6.5	6.9	7.9	8.5	7.4	7.7	8.8
Other methods 4	4.8	5.3	5.7	5.5	5.7	8.7	5.0	4.1	2.2	2.7	2.9
Total (percentages)	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
LARCs total 3	**31**	**31**	**37**	**38**	**39**	**41**	**44**	**46**	**46**	**56**	**55**
IU device	4	4	6	6	6	7	8	8	9	11	10
IU system	5	5	7	8	8	9	10	11	12	16	16
Implant	12	13	15	15	15	16	17	18	18	23	22
Injectable contraceptive	9	9	9	9	9	9	9	9	7	7	7
User dependent total	**69**	**69**	**63**	**62**	**61**	**59**	**56**	**54**	**54**	**44**	**45**
Oral contraceptives	47	48	45	45	44	42	39	38	39	27	27
Male condom	20	18	15	14	14	14	14	13	11	12	14
Contraceptive patch	1	1	1	2	2	2	2	2	2	2	2
Natural family planning	1	1	1	1	1	1	1	1	2	2	2
Other methods 4	1	1	1	1	1	1	1	1	0	1	1

The declining trend in the number of women using hormonal contraceptive pills is consistent across both public health datasets. As the two graphs below show, the latest public health data from Fingertips shows a significant decrease in the number of women being prescribed short acting combined hormonal contraception (CHC), which includes the combined pill, as well as contraceptive patch and vaginal ring, by both GPs and SRH services.[33] The number of women being prescribed CHC by both GPs and SRH services shows an overall drop from a combined high of 2.27 million women in 2016 to 1.4 million in 2022.[34]

[32] *Source:* *Statistics on Sexual and Reproductive Health Services (Contraception) - 2022/23*

[33] *Source:* *Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)*

[34] *See here* *Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)* *and here* *Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk).*

Figure 2: Women prescribed short acting combined hormonal contraception in GP practices: rate per 1,000[35]

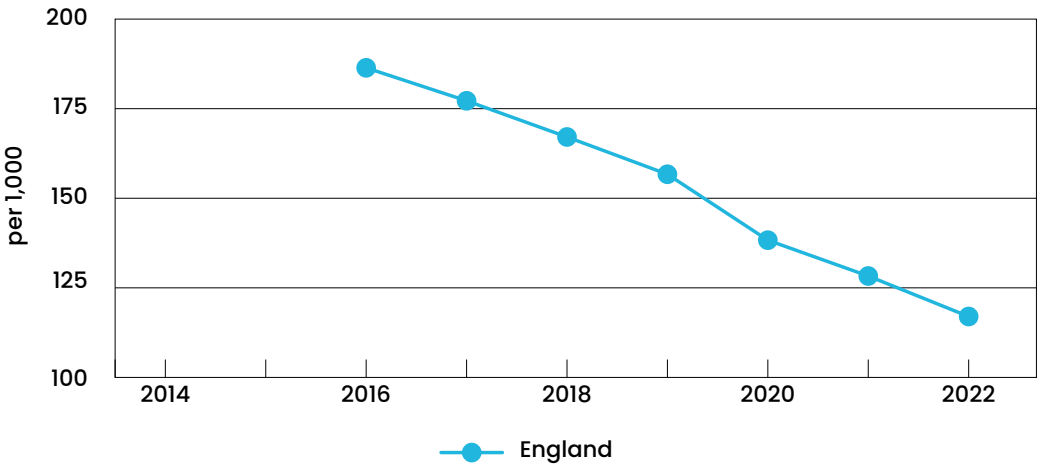


Table 2

Recent trend: ↓ Decreasing

Period	England				
		Count	Value	95% Lower CI	95% Upper CI
2016	●	2,017,711	186.4	186.1	186.6
2017	●	1,918,797	177.2	177.0	177.5
2018	●	1,815,295	167.1	166.9	167.4
2019	●	1,710,616	156.7	156.4	156.9
2020	●	1,512,279	138.3	138.1	138.5
2021	●	1,410,919	128.3	128.1	128.5
2022	●	1,301,145	117.0	116.8	117.2

Source: OHID, based on NHS Business Services Authority and Office for National Statistics data

[35] Source: Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

Figure 3: Women prescribed short acting combined hormonal contraception at SRH services: rate per 1,000[36]

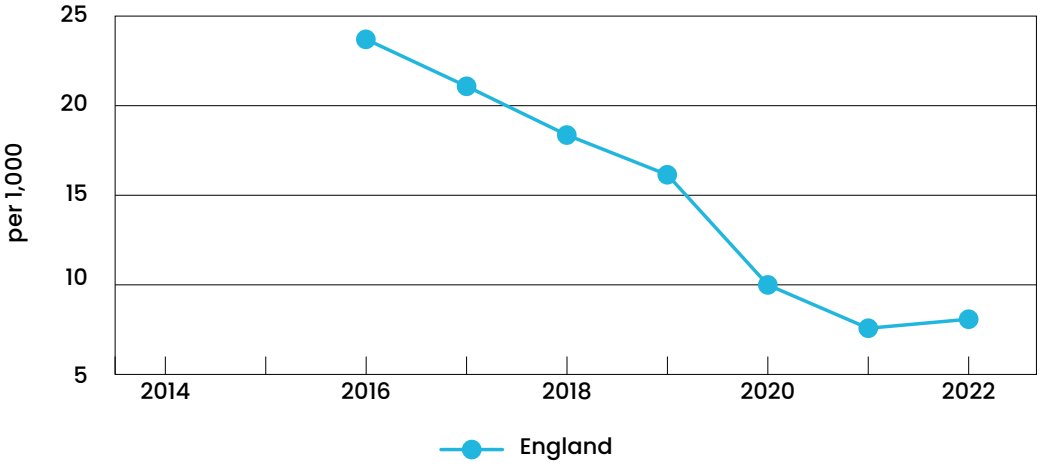


Table 3

Recent trend: ↓ Decreasing

Period	England				
		Count	Value	95% Lower CI	95% Upper CI
2016	●	255,041	23.6	23.5	23.6
2017	●	227,008	21.0	20.9	21.1
2018	●	199,147	18.3	18.3	18.4
2019	●	176,190	16.1	16.1	16.2
2020	●	108,985	10.0	9.9	10.0
2021	●	83,067	7.6	7.5	7.6
2022	●	90,009	8.1	8.0	8.1

Source: OHID, based on NHS England and Office for National Statistics data

Similarly, the number of women being prescribed the progesterone only mini-pill (POP) by both GPs and SRH services has dropped from a high of 1.57 in 2016 to 1.56 in 2022.[37] Taken together, the number of women being prescribed CHC and POP by GPs and SRH has therefore decreased from 3.84 million women in 2016 to 2.96 million in 2022 – a 23 per cent drop.[38]

As evidenced by the two public health datasets and our own survey, then, it seems that women are turning away from hormonal contraception, including contraceptive pills.

[36] *Source:* Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

[37] *See* Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk) *and* Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

[38] *See here:* Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)

Are women accessing oral contraception from pharmacies?

It is unclear whether the decrease in the number of women being prescribed oral contraceptive pills purely reflects changes in women's contraceptive preferences, or whether some women are accessing the COCP and POP from pharmacies instead of from GPs and SRH services.

We ran into barriers finding reliable data on pharmacists' prescriptions for COCP and POP. When BPAS requested the data from Community Pharmacy England, they stated that they did not have access to prescription volume data by a product type or class.[39] When BPAS submitted a Freedom of Information request (FOI) to NHS England asking for this information, we were told "NHS England does not hold the information you have requested."[40]

However, we do know that POP has only been available to women to purchase over the counter in pharmacies since 2021,[41] and that though NHS England commenced a pilot in 2021 involving pharmacies offering repeat supplies of oral contraception,[42] prior to 2023, pharmacists were not nationally commissioned to provide oral contraception.[43] Therefore, pre-2023 drops in COCP and POP cannot be explained solely by women accessing them in a different location.

After 2023, the situation becomes more complicated. In April 2023, the NHS started to commission the new Pharmacy Contraception Service (PCS) to provide oral contraception (OC), in order to widen access in the community, signpost service users to local sexual health services,[44] and create additional capacity in primary care and sexual health clinics to focus on more complex assessments. This was in line with the Government's Women's Health Strategy for England, announced in August 2022, which had flagged the role of community pharmacy in increasing choice in the ways people access care.[45]

At first, the PCS was only commissioned to provide the ongoing supply of OC, but from December 2023 the service also included initiation of OC.[46] As can be seen in the table below, which is based on publicly-available monthly statistics, thousands of community pharmacy contraceptive consultations[47] have taken place since the start of the PCS, and that number continues to rise, from around 20,000 in 2023 to nearly 34,000 in the first three months of 2024 alone.

[39] *Email from David Onuoha, MRPharmS, Service Development Manager, Community Pharmacy England to Dr Rebecca Steinfeld, Special Projects Lead, BPAS, 12th July 2024.*

[40] *Email from NHS England's Freedom of Information Communications Team england.foicrm@nhs.net to Georgina O'Reilly, Associate Director of Campaigns and Communications, BPAS, 25th July 2024.*

[41] *Since selling the contraceptive pill over the counter is a private service (non-NHS), there are no publicly available sources of data on this.*

[42] *See Pharmacy Contraception Service - Community Pharmacy England (cpe.org.uk)*

[43] *Since 2015, there was at least one locally commissioned service that enabled pharmacists to provide oral contraception. This was the Umbrella service in Birmingham. For a case study, see here: Service case study: Umbrella sexual health service - Community Pharmacy England (cpe.org.uk)*

[44] *NHS England » NHS Pharmacy Contraception Service*

[45] *Women's Health Strategy for England - GOV.UK (www.gov.uk)*

[46] *See section on "Pharmacy and appliance contractor dispensing data" here: Dispensing contractors' data | NHSBSA*

[47] *It should be noted that according to Community Pharmacy England, pharmacy owners get paid for a consultation, even when they decide it is not clinically appropriate to make a supply of an oral contraception and the NHSBSA data reports the number of consultations claimed, not the number of oral contraception prescriptions. Email from Rosie Taylor, Head of Service Development, Community Pharmacy England, to Dr Rebecca Steinfeld, Special Projects Lead, BPAS, 16th July 2024.*

Table 4: Number of Community Pharmacy Contraceptive Consultations, 2023-24, by month and type of consultation (ongoing or initiation)[48]

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Grand Total
2024 Ongoing	7,895	9,317	11,432										**28,644**	**33,833**
2024 Initiation	1,117	1,837	2,235										**5,189**	
2023 Ongoing	-	-	-	17	943	1,595	1,763	2,121	2,300	3,095	3,862	4,604	**20,300**	**20,839**
2023 Initiation	-	-	-	-	-	-	-	-	-	-	-	539	**539**	

Source: Dispensing contractors' data | NHSBSA, Pharmacy and appliance contractor dispensing data

It is likely that this number will continue to increase over time, with more women initiating or continuing their OC at their local community pharmacy, rather than through their GP or SRH service. But, for now, the increased uptake in contraception from pharmacists does not account for the much more significant decrease in the overall number of women being prescribed CHC and POP by GPs and SRH services. As stated above, that number has decreased from 3.84 million women in 2016 to 2.96 million in 2022 – a 23 per cent drop, representing 880,000 women.[49] Even with over 20,000 women seeing pharmacists for oral contraception in 2022, that still leaves approximately 860,000 women who did not access oral contraception either through their pharmacist or their GP or SRH services. Considering the wide discrepancy in these numbers, it is more likely that those women have either changed their method of contraception, or are no longer using contraception at all.

Why are women turning away from the Pill?

Based on our survey data, it appears women are turning away from the Pill mainly to avoid negative side effects, or because they do not want synthetic hormones in their bodies.

On negative side effects, respondents to our survey complained about a wide range of conditions that they attributed to the Pill: weight gain, acne breakouts, headaches, ulcers, acid reflux, blood clots, heavy bleeding, low mood, depression, anxiety, panic attacks, low libido, fatigue, and more. Several respondents commented that they preferred condoms because they did not involve hormones or side effects. Respondents told us:

[48] Source: Dispensing contractors' data | NHSBSA under the Pharmacy and appliance contractor dispensing data section.

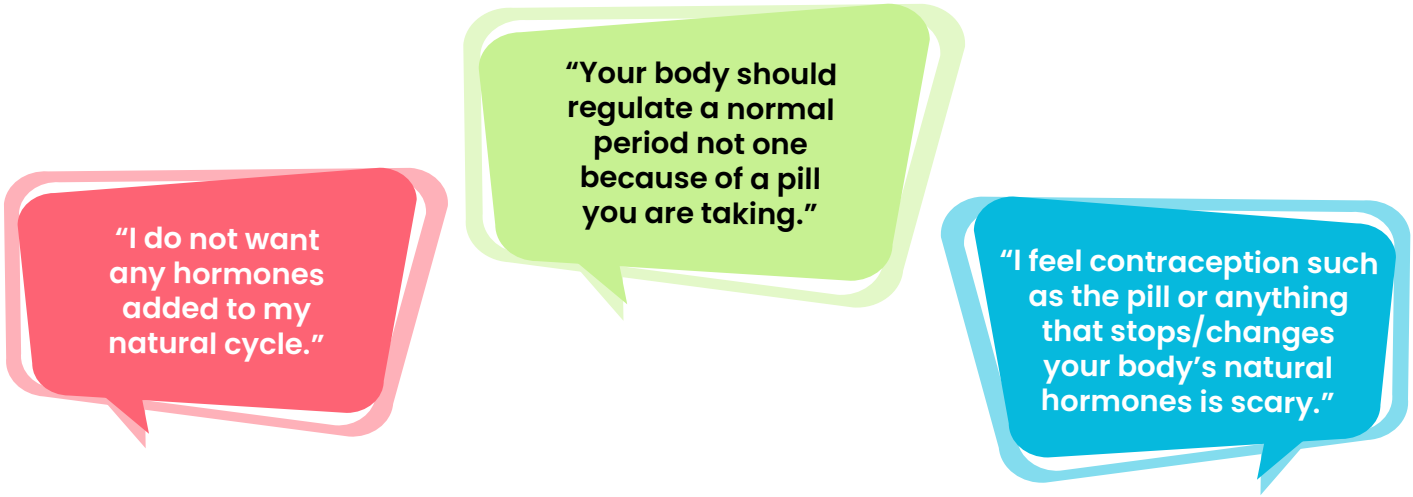
[49] Source: Sexual and Reproductive Health Profiles - OHID (phe.org.uk)

In some cases, these side effects were severe and life altering. For example, one respondent said that "The pill triggered irreversible hair loss for me. My self-esteem is ruined, and I am extremely depressed and want to hide from the world." Another said "I feel like I don't know who I am anymore. I've been on contraception since I was 18 years old and I'm now 30. I feel the implant and other hormonal options are emotionally controlling which is a horrific price to pay to prevent getting pregnant."

Respondents told us they had experimented with different oral contraceptive pills, but still experienced the same or similar side effects. One told us, "I have tried lots of different pills, and they have all had bad side effects I am still looking for one that works for me," while another said, "I've tried many different contraceptive options over the years and always had some terrible side effects and concerns over long term use."

It should be noted, though, that some women welcomed the non-contraceptive effects of hormonal methods. One told us that "I have started taking the Gedarel pill. Previously, we were using condoms, but I was getting really bad facial acne to the point where I was starting to feel really self-conscious. The pill has dealt with the skin problem, but I am aware that there are lots of possible negative side effects." Another said, "I have used the pill for over 10 years and have had no side effects and I have found it seriously helps with period pain."

For some respondents, the idea of not wanting hormones turned them off the Pill. They told us:



Older women also told us that the COCP was no longer suitable for them due to their age. For example, one said "Have been fine with combined pill and mini pill in the past but because of my age and previous migraines can nonlonger [sic] take combined and mini pill I'm fearful of forgetting every day." One said she felt the side effects of the Pill has worsened over time, commenting "I have been on the pill since I was 16 and I find that as I've got older the side effects are effecting my metal [sic] health, I feel more stressed and negative."

What is the influence of social media on contraceptive choices?

One of the influences implicated in changing attitudes towards contraception, and contraceptive use, is social media. In the UK, over 90 per cent of those aged 16-25 years use social media, with 47 per cent of young people turning to social media for information about contraception.[50] Analysis of contraception content on social media has shown a sharp rise in negative mentions of contraceptive methods.[51] And that rise in negative sentiment over the past decade coincides with a reduction in the uptake of hormonal contraception, suggesting that negative social media attention may be driving, in part, women's contraceptive decision-making. Consequently, the role of social media in contraceptive information gathering and decision-making needs to be explored.

[50] *Is social media influencing young people's contraception choices? – Brook*

[51] *Contraceptive content shared on social media: an analysis of Twitter | Contraception and Reproductive Medicine | Full Text (biomedcentral.com)*

Social media influencers and celebrities may have a considerable influence on users' behaviours, perhaps even more sway than clinicians. Though some healthcare professionals – including those working in sexual and reproductive healthcare – are utilising the power of social media to ensure their expertise reaches a wider audience,[52] many influencers active in this space lack medical qualifications or clinical expertise, even if they may have a wealth of their own contraceptive lived experience and can also provide a valuable platform for sharing others' personal experiences.

However, these experiences and perspectives are not the same as evidence-based information that has been subjected to randomised control trials and peer reviewed. Indeed, one study found that social media influencers were sharing inaccurate information, with most contraceptive content centred around hormonal contraception being harmful and their discontinuation in favour of fertility awareness-based methods (FABM), without satisfactory signposting to educational information and healthcare guidance.[53] One academic says that TikTok and Instagram are full of misleading information about birth control — and wellness influencers are helping drive these narratives.[54]

In addition, social media may have a disproportionate impact on younger people, who may not have the health literacy to assess the information critically, or to assess the risks and benefits to them personally. Natural Cycles (NC), for example, ran a highly influential and effective marketing campaign over 2016-18, with 50 per cent of its subscriber growth attributed to social media marketing.[55] Although NC provides an alternative option for many people, younger people on social media may not have the health literacy to critique the claims being made or assess the suitability of that approach for them.[56]

However, another way to look at the turn towards social media is as a reflection of the gap being left by official sources, such as healthcare professionals and educational institutions – or, even worse, by women being subjected to medical gaslighting and not feeling heard or respected in their choices.[57]

Social media is here to stay – and indeed can provide a useful role in the collection and dissemination of information about contraception. Younger generations are growing up with online content as an important source of information to inform their decisions about their health, and growing numbers of clinicians are adapting to that reality by using social media to communicate their medical expertise. It is important that clinicians and educational institutions continue to recognise and respond to the power and potential of social media, and that influencers and FemTech companies use their platforms responsibly. It is up to NHSE, clinicians, the RSH community, FemTech companies and social media influencers to lead the way in the dissemination of accurate and engaging content to combat misinformation.

[52] *For example, Dr Ellie Cannon:* Dr Ellie Cannon (@drelliecannon) • Instagram photos and videos

[53] What Do Social Media Influencers Say About Birth Control? A Content Analysis of YouTube Vlogs About Birth Control: Health Communication: Vol 38 , No 14 - Get Access (tandfonline.com)

[54] TikTok and Instagram are full of misleading information about birth control — and wellness influencers are helping drive these narratives (theconversation.com)

[55] Naturally creative - how Natural Cycles' marketing campaign achieved a massive uplift in brand awareness (campaignlive.co.uk)

[56] Social media and advertising natural contraception to young women: the case for clarity and transparency with reference to the example of 'Natural Cycles' | BMJ Sexual & Reproductive Health

[57] Women's Health Strategy for England - GOV.UK (www.gov.uk)

Are women turning away from Long-Acting Reversible Contraception – or can they just not access it?

Trends in the use of Long-Acting Reversible Contraception (LARC) – which includes hormonal and copper intrauterine devices, implants and injections – are challenging to interpret. In our survey, 14 per cent of respondents said LARCs are their current main method of contraception, while 25 per cent said they had used them previously. This drop echoes the public health data, which also suggests that women are turning away from LARCs.[58] For example, NHS data from SRH services shows significant drops across most LARCS: The hormonal intrauterine device (IUD), or copper coil, decreased from 54,200 users in 2014-15 to 47,900 users in 2022-23; the hormonal implant dropped from 138,900 to 103,800; and injectable contraceptives dropped from 85,300 to 33,200.[59]

The Fingertips data shows a similar pattern. As Figure 4 below shows, total prescriptions for LARC (excluding injections) remained relatively steady from 2014 to 2019, but then dropped from a high of 537,488 in 2019 to 490,879 in 2022.[60]

Figure 4: Total prescribed LARC excluding injections rate / 1,000[61]

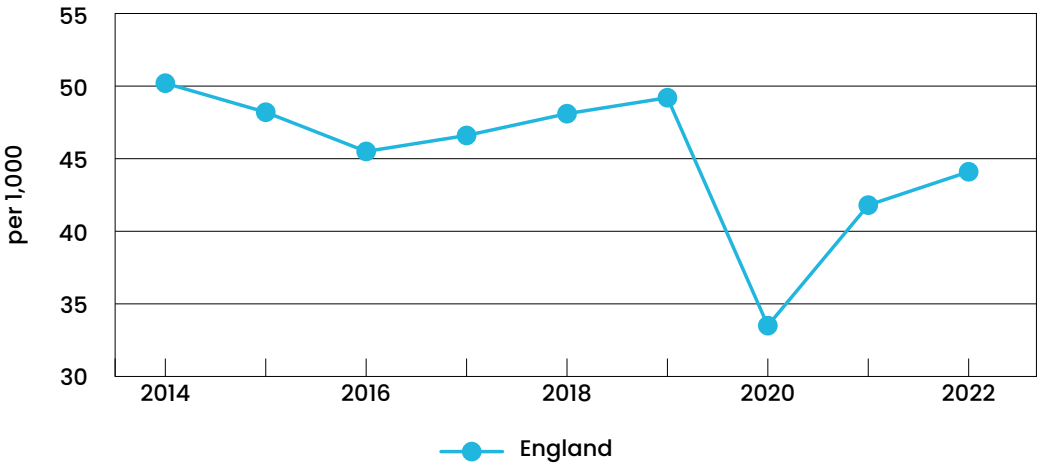


Table 5

Recent trend: ↓ Decreasing

Period		England			
		Count	Value	95% Lower CI	95% Upper CI
2014	●	533,335	50.2	50.0	50.3
2015	●	512,291	48.2	48.0	48.3
2016	●	492,634	45.5	45.4	45.6
2017	●	504,817	46.6	46.5	46.7
2018	●	522,869	48.1	48.0	48.3
2019	●	537,488	49.2	49.1	49.4
2020	●	365,754	33.5	33.3	33.6
2021	●	459,691	41.8	41.7	41.9
2022	●	490,879	44.1	44.0	44.3

Source: OHID, based on NHS Business Services Authority, NHS England and Office for National Statistics data

[58] *One important qualifier here: Since the drop in the numbers of women using Oral Contraceptives has been so dramatic, the percentage of LARCS as a proportion of all contraceptives has actually increased from 37 per cent in 2014-15 to 55 per cent in 2022-23, whereas by contrast the percentage of user-dependent contraceptives decreased from 63 per cent to 45 per cent over the same time period. See Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

[59] *Source: Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

[60] *Source: Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)*

[61] *Ibid.*

However, upon closer inspection things appear more complicated. The biggest drop in LARC prescriptions, according to the Fingertips data, was to 365,754 in 2020.[62] This likely reflects the impact of the COVID-19 pandemic, particularly the national lockdowns temporarily suspending healthcare facilities, like GPs surgeries and SRH services, where women could be fitted with coils and implants. In other words, in 2020, very few women would have been able to access healthcare services to receive a LARC even if they wanted one.

Since 2020, the number of LARCs being prescribed appears to be rising again, although prescriptions are still not back to the pre-pandemic high of 537,488 in 2019. According to SRHAD, the intra-uterine system (IUS), or hormonal coils, appear to be increasing in popularity: growing from 67,700 in 2014-15[63] to 74,900 in 2022-23.

Therefore, it remains to be seen whether the overall decrease in LARC prescriptions was a temporary reaction to the pandemic shutdown or a longer-term trend that reflects either women rejecting this type of contraception (because they experience it as invasive or painful to insert, or again do not want the hormones) or other barriers to access, such as long waiting times for insertion.

The ambiguity regarding attitudes towards LARCs is also reflected in our survey responses. Some respondents told us that they had very positive experiences of coils. For example, one respondent said that the "Mirena coil has been fantastic, no side effects, no discomfort, no period." Another said, "since being on the Mirena coil my periods are less heavy and i feel like i dont have as many side effects," and another said "I'm pleased with my current coil as it doesn't give me any side effects and don't have to remember to take any pills regularly. Both of those were challenging for me before."

Whereas others were less enthusiastic and told us "with having the coil I've had intense stomach pains and had intense bleeding," and "Mirena coil didnt [sic] agree with me at all and was very painful." The ambiguity in the data, then, is reflected in women's mixed experiences of this method of contraception.

[62] *See Sexual and Reproductive Health Profiles - Data | Fingertips | Department of Health and Social Care (phe.org.uk)*
[63] *Source: Statistics on Sexual and Reproductive Health Services (Contraception) - 2022/23*

What barriers are women facing in accessing contraception?

Findings from May 2024

There are certainly some indications that the decrease in LARC prescriptions may be due to barriers to access, in particular long waiting times. In a May 2024 survey BPAS conducted to better understand the factors involved in the decision to have an abortion, we asked whether women had faced barriers accessing contraception. Of the 1,311 respondents, 43 per cent said that they had been able to access the contraception they wanted, when they needed it, but a significant number (36 per cent) said they had been unable to access the contraception they wanted or had experienced excessive waiting times.[64]

Barriers to accessing contraception contributed to unwanted pregnancies and led to abortion.
Many respondents reported becoming pregnant while waiting for repeat Pill prescriptions or coil insertions.
Women told us:

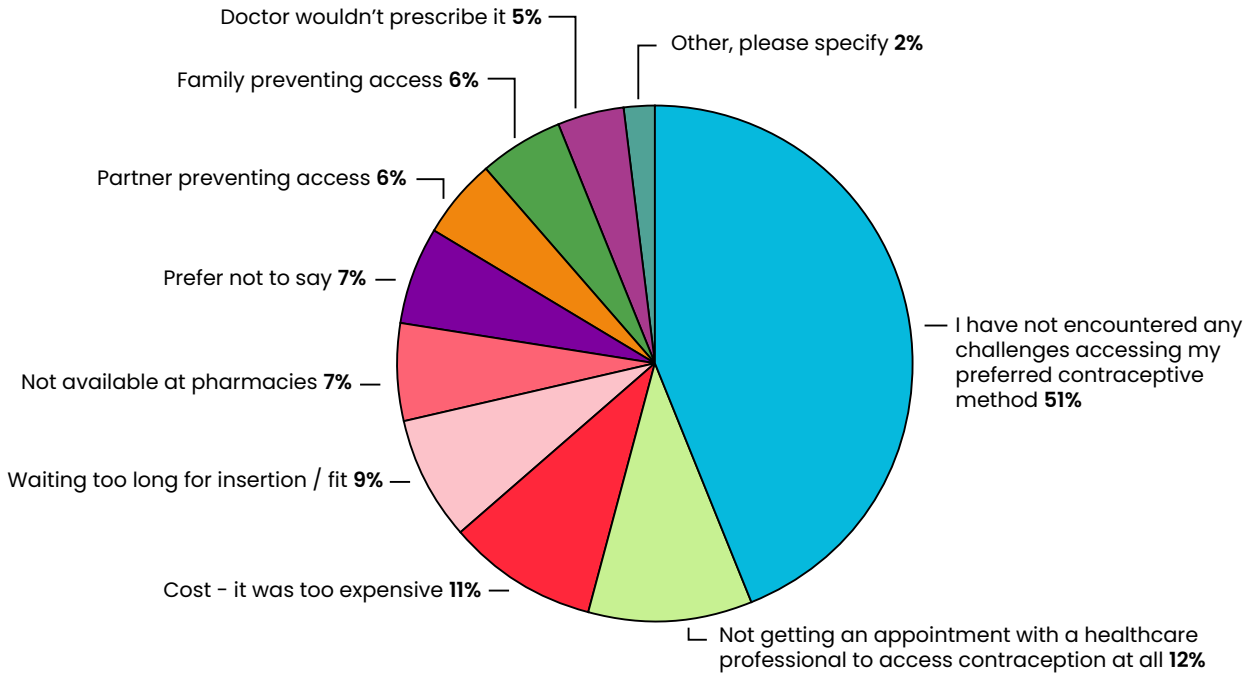
Findings from July 2024

Similar barriers to access are reflected in our July 2024 Censuswide survey data: Almost half of respondents (49 per cent) had encountered challenges accessing their preferred contraceptive method. Of those:

- 12 per cent said they could not get an appointment with a healthcare professional to access contraception at all
- 12 per cent said their partner or family prevented access
- 11 per cent said it was too expensive
- 9 per cent said they had to wait too long for insertion
- 7 per cent said it was not available at pharmacies
- 5 per cent said their doctor would not prescribe it

[64] costofliving_report (bpas.org)
[65] Ibid.

Figure 5: Challenges respondents encountered regarding access to their preferred contraceptive method[66]



Women told us:

"Contraception is hard to access as you can't get a gp appointment or sexual health clinic appointment for months, so I end up buying my own sometimes."

"it is impossible to see a doctor to talk through contraception options and I have to do that through Superdrug privately."

"I don't like visiting sexual health clinics as the appointments wait time is really long. I also find ringing the doctors is difficult."

[66] *Source: BPAS survey conducted by Censuswide, July 2024.*

These are worrying findings. However, when consulting the public health data to quantify the magnitude of the problem, it is impossible to identify waiting times to see GPs specifically for LARC insertions or OC pill prescriptions, since publicly available data on appointments in General Practice do not hold this information.[67]

Similarly, the new gynaecology waiting times dashboard developed by the Royal College of Obstetricians and Gynaecologists and LCP Health Analytics shows waiting times data for a range of gynaecological conditions, including menstrual health and recurrent miscarriages, but does not show data on waiting times for contraceptives from gynaecologists.[68] Its headline findings are that there are now more than 750,000 women waiting for gynaecological services, and that the gynaecology waiting list in March 2024 was more than 2,000 per 100,000 people in England – a higher number than for any other elective care, such as cardiology and dermatology.[69] Based on that apparent de-prioritisation of women's health services, it would seem likely that waiting times for contraception across the UK may be similarly lengthy. However, no publicly available data seems to hold the information required to verify that hypothesis and quantify the longest and average waiting times.

In June 2024, BPAS submitted a Freedom of Information (FOI) request to NHS England (NHSE) seeking data on waiting times for LARCs insertions and removals, as well as GP appointments for OC pill prescriptions across England. In July 2024, NHSE responded that they did not hold the requested information, as GP data does not specify the purpose of appointments or treatments provided.[70]

Against a backdrop of record high abortion rates, women are telling us that they are becoming pregnant – and having abortions – while waiting months for coil insertions. Though the responsibility for commissioning most contraception has been devolved to local authorities and Integrated Care Systems (ICSs), NHSE has national commissioning powers for some services, including contraception provided as an additional service under the GP contract.[71] And as the body with overall responsibility for delivering healthcare, including women's healthcare, NHSE has a broader responsibility to identify patterns, quantify problems and address barriers to contraceptive access. It is our hope that in light of the findings of this report, NHSE will begin to gather comprehensive information about waiting times for coil insertions across England and set out a plan to reduce those waiting times, so that woman have improved contraceptive choice and can avoid unintended pregnancy.

[67] *See https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice*
[68] *RCOG Waiting times (lcp.com)*
[69] *RCOG Waiting times (lcp.com)*
[70] *Email from Freedom of Information, NHS England to Dr Rebecca Steinfeld, Special Projects Lead, BPAS, 16th July 2024.*
[71] *Commissioning local HIV sexual and reproductive health services - GOV.UK (www.gov.uk)*

Are women increasingly using Fertility Awareness-Based Methods?

Our BPAS survey found that 1 in 20 respondents are using fertility awareness-based methods (FABM), including 4 per cent who are using FABM with a digital app, and 1 per cent who are using the rhythm method without an app. The highest proportion of app users are aged 26-35 years (5 per cent).

Fertility Awareness Methods (FABM) – also known as Natural Family Planning – include a wide range of approaches, and due to these methods not requiring a prescription or healthcare consultation, it is difficult to assess trends. FABM includes the calendar-based rhythm method, as well as basal body temperature checking, cervical fluid monitoring, a combined sympto-thermal method (temperature and fluid checking), and ovulation testing.

Sometimes these methods are used alongside data-gathering apps with predictive algorithms that aim to identify "safe" and "unsafe" days for women to have unprotected sex (for those using the app for contraception), as well as fertile windows (for those who have flipped the settings to try to get pregnant). These FABMs can operate with various levels of efficacy.

Studies have shown that, with typical use, some FABMs supported by a mobile-based application are as effective as some methods of hormonal contraception, like the COCP and POP. Natural Cycles, for example, which is the first FABM app that is a CE-marked Class IIb medical device (CE0123) for use as a method of birth control,[72] claims to be 93 per cent effective with typical use.[73] This claim is based on several peer-reviewed studies, including one of more than 12,000 U.K. users of the app.[74] The percentage is comparable to the combined pill, which the NHS says is 91 per cent effective with typical use.[75] However, since Natural Cycles is a non-hormonal method, it is perhaps best compared to other non-hormonal options, like the copper coil (over 99 per cent effective with typical use) and condoms (82 per cent effective with typical use).[76]

Natural Cycles told us that they have "conducted rigorous, peer-reviewed studies to ensure our effectiveness, and continues to monitor our effectiveness rates to ensure that they align with the published data."[77] They also told us that "The size of the trials (more than 22,785 women for the study published in 2017) and the number of trials conducted in different geographies support real-world evidence of the product's contraceptive effectiveness."[78] And they said that "we are not trying to argue that Natural Cycles should be used instead of the birth control pill, or that it is more effective; rather, we see Natural Cycles as a more effective and efficient way for women to track their own fertility using FABM principles and use that information to make informed decisions about their reproductive health, whether that involves preventing or planning pregnancy."[79]

[72] *What are the certifications behind NC° Birth Control? – Customer Support | Contact Us | Natural Cycles*
[73] *How Effective is Natural Cycles ? | Compare Birth Control*
[74] *Natural Cycles app: contraceptive outcomes and demographic analysis of UK users - PubMed (nih.gov)*
[75] *How well contraception works at preventing pregnancy - NHS (www.nhs.uk)*
[76] *Ibid.*
[77] *By email, Carlee Klein, Natural Cycles to Dr Rebecca Steinfeld, BPAS, 20th September 2024.*
[78] *Ibid.*
[79] *Ibid.*

Nevertheless, some have challenged[80] the impartiality and reliability of the studies[81,82,83] upon which the claims about Natural Cycles' effectiveness are based.[84] One critic points out that these studies' authors include the founders or current employees, suggesting a possible conflict of interest.[85] Organisations across the sector, including the FSRH, have called for more large-scale, independent trials of fertility apps to assess their effectiveness in order to enable women to make evidence-based decisions.[86]

Against those concerns, it should be noted that it is not uncommon for tech, or pharma, companies' founders to be named authors if there is an element of IP or patented information that is required for the study.

Another concern centres around the need to distinguish between contraceptive effectiveness in terms of typical use and perfect use. Significant differences exist between the two metrics for methods requiring user input, such as barrier methods and oral contraceptives, whereas LARCs show minimal differences between typical and perfect use due to their low user involvement.[87] In response to three complaints against Natural Cycles' claim to be a "Highly accurate contraceptive app" and "Clinically tested alternative to birth control methods," the Advertising Standards Authority (ASA) noted that, "The Natural Cycles app required considerably more user input than most forms of contraception, with the need to take and input body temperature measurements several times a week, recording when intercourse had taken place, supplemented with LH measurements, abstention or alternative methods of contraception during the fertile period."[88] Not surprisingly, then, the ASA report stated:

> **"We noted from the studies that the reporting of intercourse was low with only 32% of cycles inputting such data, and that only 9.6% of cycles were considered as perfect-use, where the app had been used precisely as instructed. Given the very low level of perfect-use by users of the app and the significant difference between the effectiveness of the app when in perfect- and in typical-use, we considered that it would be misleading to base an accuracy claim on the perfect-use results and that the relevant data was the level of effectiveness seen in typical-use."**[89]

The ASA concluded that "the claims "Highly accurate contraceptive app" and "Clinically tested alternative to birth control methods" were misleading."[90]

This may explain our survey finding that shows ever use of FABM is higher than current use. Our survey found that whilst 10 per cent of respondents have used a FABM tracking app, like Natural Cycles, for contraception, only 4 per cent said they were using it as their current main method of contraception.[91] The high user involvement and gap in effectiveness between perfect and typical use may be leading women to experiment with FABM methods and apps, and then switch to something else that they find easier to use.

[80] *Would you trust a smartphone app as a contraceptive? | Nursing Times*
[81] *Fertility awareness-based mobile application for contraception (tandfonline.com)*
[82] *Perfect-use and typical-use Pearl Index of a contraceptive mobile app - ScienceDirect*
[83] *Natural Cycles app: contraceptive outcomes and demographic analysis of UK users - PubMed (nih.gov).*
[84] *Perfect-use and typical-use Pearl Index of a contraceptive mobile app - ScienceDirect*
[85] *Would you trust a smartphone app as a contraceptive? | Nursing Times*
[86] *Sexual and reproductive health experts call for more independent research on fertility apps (fpa.org.uk)*
[87] *How well contraception works at preventing pregnancy - NHS (www.nhs.uk)*
[88] *NaturalCycles Nordic AB Sweden - ASA | CAP*
[89] *Ibid.*
[90] *Ibid.*
[91] *Source: BPAS Censuswide survey, July 2024.*

Concerns about the contraceptive effectiveness of FABM apps are compounded by concerns about the digital health divide and widening health inequalities. These apps often require access to specific hardware, software, and subscription services, as well as the digital and health literacy to use them reliably. Natural Cycles, for example, is the only FABM app licenced as a contraceptive device, but its current annual cost of £49.99 and lack of availability through the NHS make it inaccessible for many. This raises concerns about health inequalities, as only those who can afford these tools can access the full range of contraceptive options. Since a national healthcare system should aim to reduce, not exacerbate, these inequalities, questions arise about whether FABM apps licensed as contraceptives should, then, be commissioned by healthcare service providers.

In addition, there is justifiable anxiety about data privacy and security of the intimate health information being shared with these companies,[92] especially when this data could be used in prosecutions for alleged illegal abortions.[93] Indeed, British police are already testing women for abortion drugs and requesting data from menstrual tracking apps after unexplained pregnancy losses.[94]

Irrespective of these concerns, the NHS data on contraceptive activity occurring at SRH services shows that the only user-dependent method that appears to be increasing in popularity is Natural Family Planning: The numbers of women using that method increased from 7,700 in 2014-15 to 8,800 in 2022-23,[95] doubling from 1 per cent to 2 per cent as a proportion of total methods.[96] Meanwhile our survey suggests an even higher percentage are currently using FABM – 5 per cent.

Though this increase is significant, the overall numbers seem small, especially when compared to the large numbers of worldwide users claimed by FemTech companies. Natural Cycles reported 250,000 UK users in 2018,[97] a number likely to have grown, particularly during the pandemic when access to other contraceptives was limited. Clue, a menstrual tracking app, claimed 10 million active users globally in 2024,[98] while Flo, another menstrual tracking app, claimed 380 million users[99] Yet, the lack of country-specific data and the difficulty in determining how many people actually use these apps for contraceptive purposes as opposed to menstrual tracking or trying to conceive make it hard to gauge the true number of users in the U.K.

We asked Natural Cycles about their active user numbers and trends, but they declined to share specific data, stating that they do not disclose user numbers by market. However, they revealed having over 4 million registered users globally across 160 markets, with the U.S. as their largest and fastest-growing market.[100] While there is a rise in women turning to FABM in the U.K., Natural Cycles has not observed a corresponding increase in U.K. users to account for this trend. They noted that many U.K. women might be turning to less effective forms of FABM, such as period trackers, or even using no contraception. It is alarming that some women may be relying on less effective FABM methods, such as using period tracking apps not intended for contraception or practicing FABM without the guidance of a licensed app or impartial contraceptive counselling. These concerns have prompted Natural Cycles to seek clarification from the NHS on why clinically evaluated and approved medical devices like Natural Cycles are not endorsed as reliable alternatives.[101] Clue and Flo did not respond to similar inquiries.

[92] *See, for example, UCLA's Dr Aparna Sridhar presentation on "Tech-Forward Contraception: The Impact of AI and Social Media on Reproductive Health" in Bilbao: Program-for-website-2603.pdf (escrh.eu)*

[93] *The abortion privacy dangers in period trackers and apps - BBC News*

[94] *British police testing women for abortion drugs - Tortoise (tortoisemedia.com)*

[95] *Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

[96] *Ibid.*

[97] *The Natural Cycles app: does it work? – Full Fact*

[98] *About Clue (helloclue.com)*

[99] *Flo - ovulation calendar, period tracker, and pregnancy app*

[100] *Email from Julie, Customer Care Advocate, Natural Cycles to Dr Rebecca Steinfeld, Special Projects Lead, BPAS, 9th July 2024.*

[101] *Email from Agnes Ahlquist, Press Team, Natural Cycles to Dr Rebecca Steinfeld, Special Projects Lead, BPAS, 9th July 2024.*

The broader issue is that while there is anecdotal evidence and some data suggesting a shift from hormonal contraception to FABM apps, there are no reliable statistics on how many women in the U.K. are using these apps as contraception. This uncertainty is exacerbated by confusion with what is considered as a FABM, where women might be using period tracking apps or simple calendar methods without additional tools or professional support. This raises concerns about informed choice, highlighting the need for healthcare providers, educational systems, and private companies to ensure that women have access to clear, evidence-based information to make informed contraceptive decisions that are right for them.

Research indicates that women are increasingly using FABM apps due to dissatisfaction with hormonal contraception and its side effects. A study involving interviews with women in the U.K. who used these apps without intending to get pregnant found that motivations included a desire for a non-hormonal alternative, better understanding of their bodies, life-stage considerations, and involving partners in contraceptive decisions. However, tensions arose around finding a method that was both convenient and offered a sense of control while managing sexual behaviour responsibly.[102]

In conclusion, while FABM are gaining popularity as alternatives to hormonal contraception, several concerns need to be addressed. The lack of reliable data on the number of women in the U.K. using either a FABM app licensed as a contraceptive or a period tracking app unlicensed for contraception creates uncertainty, while the digital health divide exacerbates access issues, making these tools inaccessible to those who cannot afford them. Moreover, the effectiveness of these methods in the real world, especially when used without additional guidance for those who may not have sufficient literacy or health literacy to use them reliably, remains in question. To ensure informed contraceptive choice, it is crucial that healthcare providers, regulators, education systems, and private companies work together to provide clear, evidence-based information.

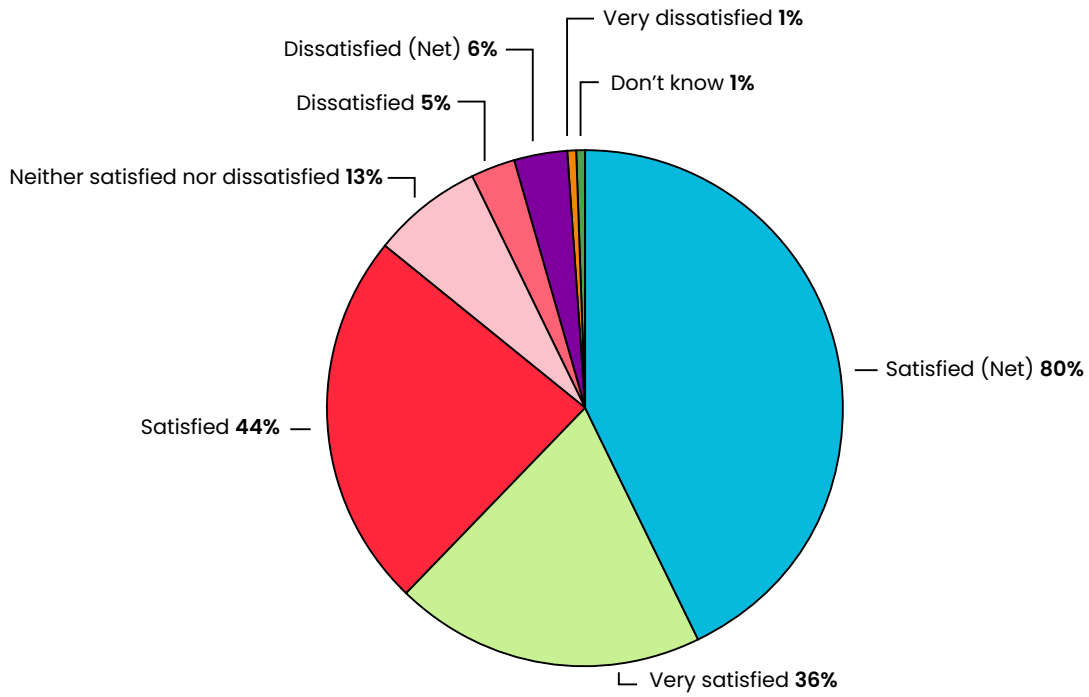
In the meantime, it is important to recognise that both digital and traditional FABM tools, like hormonal contraception, may not be suitable for everyone. Currently, it is the user's responsibility to determine if FABM is appropriate for them, as these methods are not prescribed by the NHS.

[102] *Digitised Fertility: The Use of Fertility Awareness Apps as a Form of Contraception by Lea Dudouet :: SSRN*

How satisfied are women with current contraceptive options?

The uptick in the popularity of FABM, combined with the downturn in the use of both oral contraceptives and LARCs, suggests that women may be disillusioned with current contraceptive options. Yet, on the surface, our survey data shows that 80 per cent of respondents are satisfied with their current main method of contraception.[103]

Figure 6: Respondents' satisfaction or dissatisfaction with their current main contraceptive method, when thinking overall about its effectiveness, ease of access, and any side effects they may have experienced.[104]



However, 1 in 16 respondents are in fact dissatisfied with their current main method of contraception, and that proportion increases in relation to specific issues. In particular:

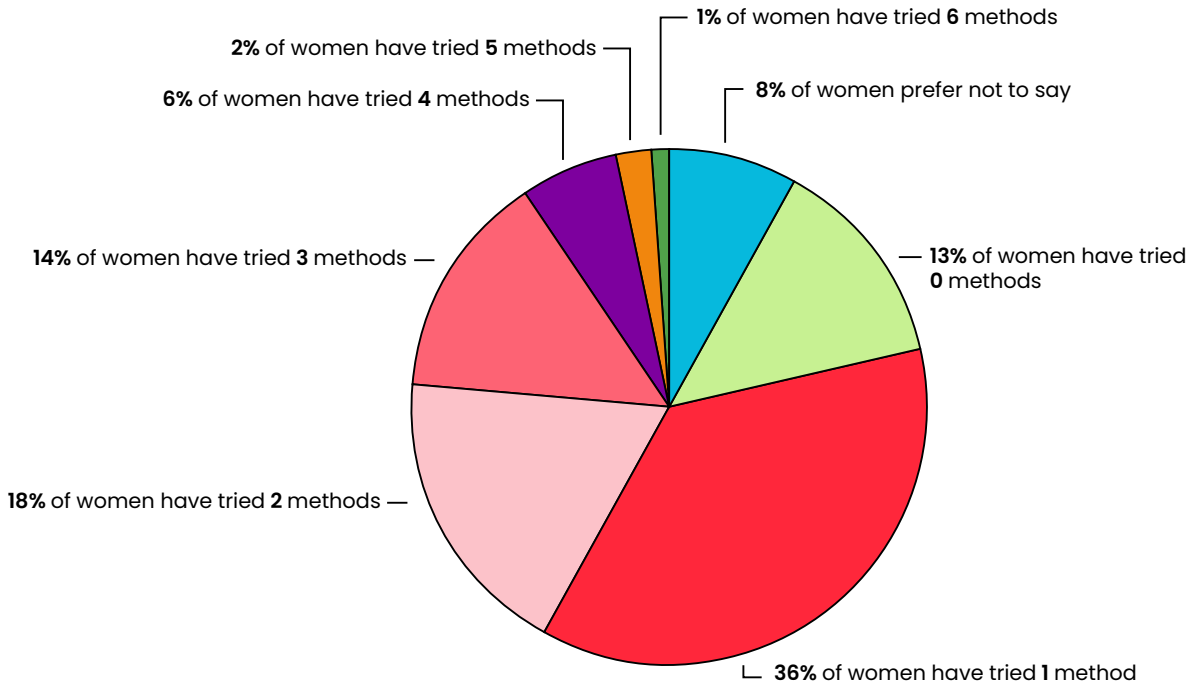
- More than 1 in 7 (15 per cent) are dissatisfied[105] with side effects.
- 1 in 12 (8 per cent) are dissatisfied[1] with ease of access
- 1 in 16 (6 per cent) respondents are dissatisfied[1] with ease of use
- 1 in 25 (4 per cent) respondents are dissatisfied[1] with effectiveness of pregnancy prevention

When extrapolated to population level, these figures suggest that a considerable number of women are dissatisfied with their current contraceptive, especially with its side effects.

Dissatisfaction is further reflected in our finding that women are trying lots of different contraceptives to find one that works for them. Our survey data shows that 84 per cent of respondents who have used contraception have changed their method of contraception at least once.[106] On average, respondents changed their method of contraception twice. As can be seen in the graph below, 18 per cent had tried two methods, 14 per cent had tried three methods and 1 per cent had tried six methods.

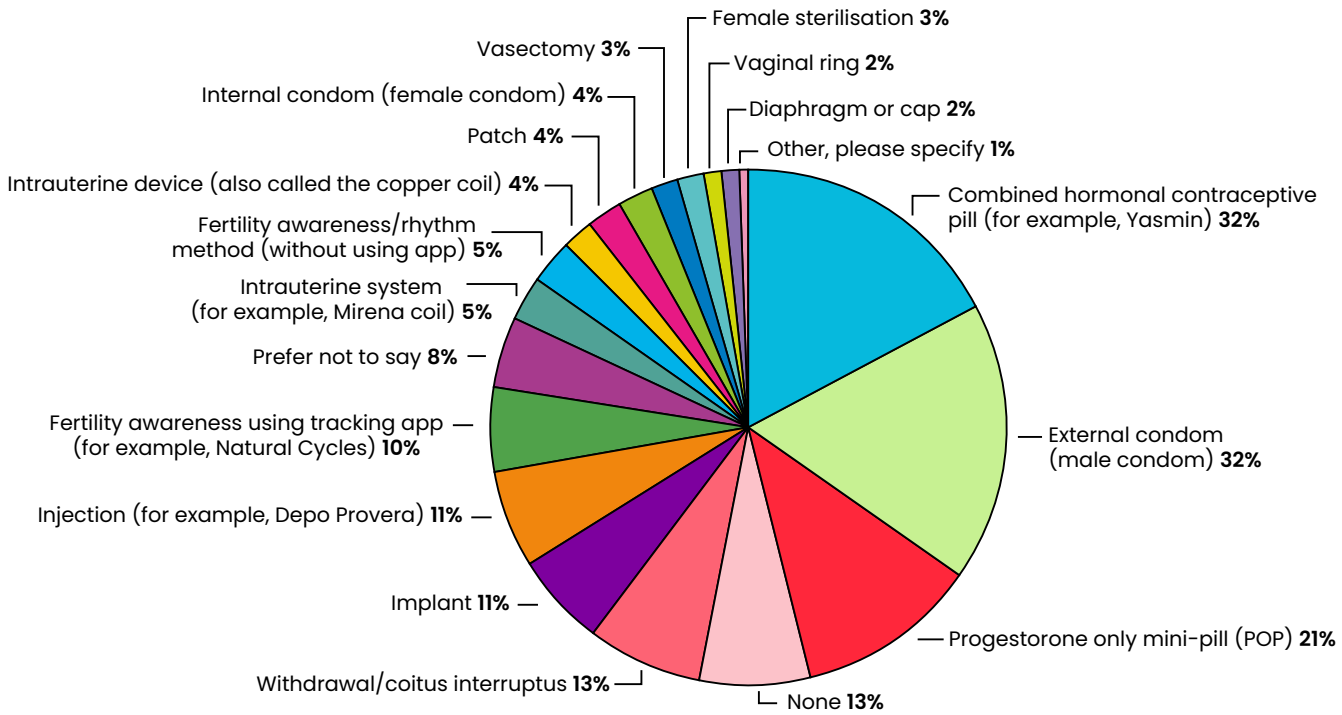
[103] *'Satisfied' and 'Very satisfied' answers combined.*
[104] *Source: BPAS survey conducted by Censuswide, July 2024.*
[105] *'Dissatisfied' and 'Very dissatisfied' answers combined.*
[106] *Reverse of 'N/A - I have never changed my method of contraception' and 'Prefer not to say' answers combined.*

Figure 7: The number of methods of contraception respondents have previously used in their lifetime.[107]



The topmost previously used methods were oral contraception (44 per cent) and male condoms (32 per cent), as can be seen in Figure 8:

Figure 8: The methods of contraception respondents previously used in their lifetime.[108]



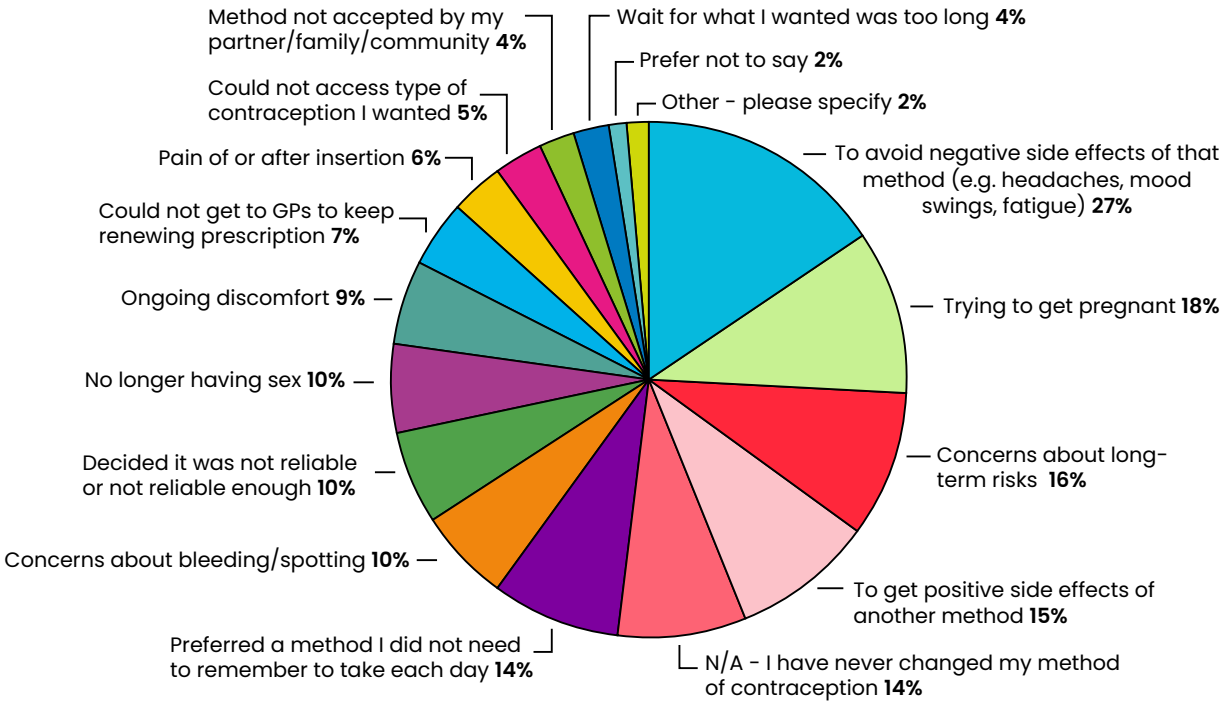
[107] *Source: BPAS survey conducted by Censuswide, July 2024.*

[108] *Ibid.*

Respondents cited the following factors as their main reasons for changing their contraception, as shown in Figure 9 below:

- To avoid negative side effects of that method (e.g. headaches, mood swings, fatigue) (27 per cent)
- Trying to get pregnant (18 per cent)
- Concerns about long-term risks (16 per cent)
- To get positive side effects of another method (e.g. regulating periods, reducing frequency or intensity of periods, skin benefits) (15 per cent)

Figure 9: Reasons respondents have changed their method of contraception.[109]



Many individuals encounter challenges in finding a suitable contraceptive method. Reproductive health expert Sarah Cairns-Smith says that, on average, people try three different methods, with about one-fifth trying more than five. This suggests people often struggle to find a method that works for them, and for some, this struggle lasts a lifetime. A key concern is that individuals may stop trying different methods not because they have found satisfaction, but because they realise the limited range of options available.[110]

Caroline Criado Perez similarly emphasizes the difficulty in accurately measuring whether people are satisfied with their contraception. She argues that the only clear indicator of dissatisfaction is when someone stops using a particular method. However, given the choice between using a method they are unhappy with or risking unintended pregnancy, most women continue with the method despite their dissatisfaction. According to Perez, this reflects a lack of alternatives, as many feel stuck with options that do not meet their needs.[111]

In summary, women may stay on contraception not because they are satisfied or happy with it, but because the alternative is unwanted pregnancy, and because the other contraceptive options are often only a different delivery mechanism of the same, or similar, set of hormones, which they may have already tried. These positions do not suggest deep satisfaction, but rather resignation.

[109] *Source: BPAS survey conducted by Censuswide, July 2024.*
[110] *The contraceptive headache - Tortoise (tortoisemedia.com)*
[111] *Ibid.*

Are there inequalities in access to, and experiences of, contraception?

Though digital fertility control methods may reflect and reinforce health inequalities due to their subscription costs, on the surface, other methods of contraception do not at first appear to reflect similar inequalities. As can be seen in the table below, in 2022-23 for example, there is only one percentage point difference in women's main method of contraception being LARC or a user-dependent method between those in the most deprived versus least deprived deciles.[112] Of those in the most deprived centile, 58 per cent use LARC and 42 per cent use a user-dependent method as their main method, whereas in the least deprived decile 57 per cent use a LARC and 43 per cent use a user-dependent method as their main method.[113] At first glance there appears to be minor difference.

Table 6: Key measures from Sexual and Reproductive Health Services by Index of Multiple Deprivation (IMD) decile, England, 2022/23[114]

IMD decile	Percentages / rates			
	Measure			
	Females with main method: LARC - Percent [2]	Females with main method: user dependent - Percent [2]	Females aged 13 to 15 provided emergency contraceptives - per 1000 population [3,5]	Females aged 13 to 54 using services - percent of population [4,5]
1 (Most deprived)	58	42	3	5
2	55	45	2	6
3	54	46	2	5
4	54	46	2	5
5	54	46	1	4
6	55	45	1	4
7	55	45	1	4
8	56	44	1	4
9	56	44	1	3
10 (Least deprived)	57	43	1	3

Footnotes to Table 6

1. IMD deciles based on 2019 deprivation scores for English Lower Super Output Areas (LSOAs) produced by the Office for National Statistics.
   IMD decile breakdown excludes records where there was insufficient information to map to an IMD decile or where the person was resident outside of England.
   More information on IMD data can be found at the following link:
   https://www.gov.uk/government/collections/english-indices-of-deprivation
2. A person contacting a service multiple times during the year will only be counted once. See appendix C for details of the methodology used for the choice of contact.
   Calculation excludes persons where no main method of contraception was recorded during the year.
   Please note, the age profile of females using SRH services is not consistent across IMD deciles, which is likely to have an influence on this data, as LARC uptake varies across age groups.
   LARCs - Long Acting Reversible Contraceptives.
3. A person provided emergency contraception multiple times by the same service during the year will only be counted once. Age is based on the first contact for emergency contraception during the year.
   Excludes people who were resident outside of England.
4. A person contacting a service multiple times during the year will only be counted once. Age is based on the first contact during the year.
   Excludes women who were resident outside of England.
5. Calculations based on ONS resident population estimates for mid 2020. This differs from other tables which have rates based on mid 2021 estimates, but which are not yet available at LSOA level.

Source for Table 6

Sexual and Reproductive Health Activity Dataset. Population data from the Office for National Statistics. ©2023, NHS England

[112] *Source: Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

[113] *Ibid.*

[114] *Source: Statistics on Sexual and Reproductive Health Services (Contraception) - 2022/23*

However, a closer look at the data reveals some crucial differences: 1) the locations where women in the most and least deprived deciles access their contraception, and 2) the higher prescription of injectables to women in the most deprived decile. For example, in 2022, the rate of LARC use (excluding injections) was 36.6 per 1,000 women in the most deprived centile, as opposed to 53.7 per 1,000 women in the least deprived centile, while the England average was 44.1 per 1,000 women.[115] There was a higher rate of women in the most deprived decile receiving LARC from SRH services, whereas a higher proportion of women in the last deprived decile received LARC from GPs.[116]

Regarding women prescribed short-acting combined hormonal contraception by GP practices, the England national average in 2022 was 117.0 per 1,000 women, whereas women in the most deprived areas have a rate of 93.3 per 1,000 women and women in least deprived areas have a rate of 141.1 per 1,000 women.[117] However, the same pattern is observed as with LARCs, where women in the most deprived decile showed a higher rate of being prescribed short acting combined hormonal contraception by SRH services: 8.3 per 1,000 women as opposed to 5.8 per 1,000 women.[118]

Injectables buck this trend, showing women from the most deprived decile being prescribed injectable contraception at higher rates by both GPs (26.5 per 1,000 women as compared to England average 25.8 and least deprived 17.4) and at SRH services (5.5 per 1,000 women as compared to England average 3.7 and least deprived 1.8).[119] This suggests more women in the most deprived decile in England are being prescribed injectables than those in the least deprived.

Given the long and problematic history of injectable contraception being targeted at specific groups, and the broader history of state intervention in people's reproductive lives, this gives cause for concern.

A 2021 report from the University of Lancaster, in collaboration with BPAS, Decolonising Contraception, and Shine Aloud UK, found that marginalised communities have expressed concerns about the disproportionate promotion of LARC methods to their groups. These concerns range from limited access to appointments due to funding cuts, to fears of being pressured into using LARCs or delaying their removal. The report highlights the UK's history with the contraceptive injection Depo-Provera, which was controversially promoted to black, poor, and migrant communities, leading to accusations of coercion.[120] The findings showed that while LARC services are not always accessible to those who want them, healthcare providers also face pressure to prioritise LARC use over other contraceptive methods, compromising informed decision-making and user rights.[121]

A recent report from the Advisory Group on Contraception (AGC), in partnership with the English HIV & Sexual Health Commissioners Group, echoes these concerns. It calls for greater efforts to reach overlooked communities, such as homeless women, refugees, and those in the criminal justice system, who face significant barriers in accessing reproductive healthcare. The fragmentation of women's health services, while challenging for all, disproportionately impacts these vulnerable groups, deepening existing disparities in healthcare access.[122]

[115] Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[116] Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[117] Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[118] Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[119] Source: Sexual and Reproductive Health Profiles - Data - OHID (phe.org.uk)
[120] LARC Report - Final laid up.pdf (cdn-website.com) p. 9.
[121] *LARC Report - Final laid up.pdf (cdn-website.com)
[122] Breaking barriers Inequalities in access to contraception in England by AGC and the English HIV & Sexual Health Commissioners Group, 2024.

The AGC conducted a survey and interviews with women who identified as being marginalised, representing groups including migrant women without English as a first language, women living in temporary or sheltered accommodation, women with physical disabilities, women with mental health conditions, and victims of sexual violence and/or sexual assault.[123] They found that the current system, in particular fragmentation between services and limited appointment availability, impedes women's right to choose. They also found that limited means for information and education around contraceptive methods are disempowering many women from making an informed choice, or forcing them to seek information elsewhere, increasing the risk of encountering harmful misinformation.[124]

In many cases, they explained, their findings exposed concerning inequalities in women's access to, and experiences of, contraceptive care. They said that women with physical disabilities were the most likely to report access to contraception being difficult or very difficult; Gypsy, Roma and Traveller communities and women living in temporary or sheltered accommodation reported significantly lower than average awareness of different contraceptive methods; and marginalised women overall were much more likely to report difficulties making an appointment with their GP. Despite these challenges, the AGC also found that many women – including from the most marginalised communities, such as sex workers – told them that specific clinics or healthcare professionals had gone to great lengths to provide high-quality, non-judgemental care.[125]

The AGC report concluded that while most survey respondents found it easy to access contraception, this overall figure hides the challenges that many women face, including being forced to use services they did not prefer, long wait times, or being pushed into certain methods without proper counselling. As the AGC concludes, simply meeting basic needs is not enough; it is essential for healthcare systems to provide a wide range of accessible options to support women's right to choose their preferred contraceptive method, despite the strain on services.[126]

It is evident, then, that the official statistics neglect deeper problems and inequalities in both access and experiences between women from the most and least deprived groups, especially those in the most marginalised communities. These hard truths need to be acknowledged by all those working in sexual and reproductive health, and inequalities need to be tackled with urgency and commitment.

[123] *Their survey, which was open to all women living in England requiring contraception, was completed by 1,068 respondents.*
[124] *Breaking barriers Inequalities in access to contraception in England by AGC and the English HIV & Sexual Health Commissioners Group, 2024.*
[125] *Ibid.*
[126] *Ibid.*

The Future of Contraception

What are the future alternatives to hormonal contraception and why is innovation so slow?

Considering that women appear to be turning away from hormonal contraception (predominantly oral contraceptive pills, but also possibly LARCs), and that there are concerns about the current effectiveness and accessibility of FABM, we need to understand what alternatives there might be. Demand is evident for effective contraceptives, with fewer negative side effects, and that share the burden of pregnancy prevention between male and female sexual partners.

What innovations are afoot?

Some contraceptive innovation still appears firmly rooted in delivering the same cocktail of hormones in different ways. These include variations in the doses, materials, designs, sizes and inserters of existing contraceptive devices – but not fundamental overhauls in the hardware itself. One example is the new intrauterine ball, Ballerine, which is essentially an updated version of the copper coil made up of copper pearls in a spherical shape as opposed to a t-shape.[127] Other hardware innovations include a long-acting microchip implant of hormones that women could control through an app on their smart phone, and cervical array microneedle patches (MAPs) that slowly release hormones directly into the cervix, as well as a range of on-demand contraceptives like fast-dissolving inserts, electrospun, drug-eluting fabrics, and bio-adhesive films.[129] So-called software innovations include improvements in access, in particular better training and devices for inserting coils immediately post-partum.[128]

Although promising to improve the delivery of some current contraceptive options, there are questions about whether these innovations have been developed in consultation with potential users or will appeal to them. As others have said, "User preference data can and should be collected at all stages of product development,"[129] as a matter of principle and to ensure these devices are likelier to be acceptable to their intended future users. In other words, women's voices should be at the forefront of contraception innovation. Without them, women's contraceptive needs are unlikely to be met.

So why is innovation so slow?

In short, high bars to contraceptive research and development, a misreading of the market, and ultimately a longstanding neglect of women's reproductive health.

Part of the problem lies in the fact that contraceptive innovation – like all innovation in the field of medicine and medical devices – is incredibly slow, expensive, risks a loss of investment if the method "busts,"[130] and can flop if problems are unearthed after clinical trials, resulting in expensive litigation.[131] Added to this are the high hurdles in developing and marketing drugs that are administered to healthy individuals, where the efficacy and safety bar is very high.[132] These factors often scare off investors.[133]

[127] *IUB Ballerine - The New Contraceptive Coil | The Lowdown*

[128] *For an overview of contraceptive innovation, see this presentation from the 17th European Society of Contraception (ESC) Congress, here from 3 hours 32 mins: cdn.nirestream.com/v/embed/YkcitQfwm9HmeMDqrH91A-o-GD8cpmcOFwEIlDxDgSE*

[129] *new contraceptive revolution: developing innovative products outside of industry†,‡ | Biology of Reproduction | Oxford Academic (oup.com)*

[130] *See here for more: The "boom and bust phenomenon": the hopes, dreams, and broken promises of the contraceptive revolution - Contraception (contraceptionjournal.org)*

[131] *See, for example, women in the US suing the maker of Norplant because of scarring left by the removal of the device Women sue over painful implants | New Scientist and similarly against Paragard, which allegedly caused problems on removal Paragard Lawsuit Update – Forbes Advisor*

[132] *Sarah Cairns-Smith (bcg.com)*

[133] *See Sarah Cairns-Smith in The contraceptive headache - Tortoise (tortoisemedia.com)*

However, the problem extends deeper than that. Beyond the usual constraints of medical research, an indifference to women's health appears to lie at the heart of the problem. Cairns-Smith highlights that reproductive health has long been neglected due to its association with women's health, which faces taboos and lacks representation among decision-makers, many of whom are not women. This neglect is reflected in funding disparities: In the US, for example, the US National Institutes of Health (NIH) allocates just 1.1 per cent of its budget to women's health and STIs, with only 21 per cent of that focused on contraception and reproduction. This low level of investment hampers progress compared to other fields. While pharmaceutical companies typically spend 20 per cent of sales revenue on R&D for new products, only 2 per cent is allocated to contraception, as they focus on cheaper line extensions of existing products rather than developing new mechanisms.[134]

There may also have been a fundamental misreading of the contraceptive market. As mentioned previously, while there appears to be a variety of choices, the reality is that there are far fewer real options, forcing consumers to settle for what is available. This skewed perception misguides market signals, leading biotech and pharmaceutical companies to deprioritise contraception when deciding where to invest. With intense competition for investment, women's health often loses out, resulting in limited advancements in contraceptive options and continued reliance on existing products.[135]

Will male contraceptives finally equalise the contraceptive gender burden?

Currently, only two contraceptive options are available for men in the UK: condoms and vasectomy. In our July survey, 15 per cent of respondents said they were currently using male condoms as their main method of contraception, while 32 per cent said they had used condoms as a previous method, a decline of almost 50 per cent. These findings mirror the public health data, which indicates that male condom use may be declining. SRHAD data shows the number of women using male condoms has more than halved in the last decade, from 141,200 in 2014-15 to 64,400 in 2022-23.[136]

Meanwhile, in 2022-23, the public health data indicated that only a small number of men had vasectomies in England – 10,700 – which is the same as the number of women undergoing female sterilisation.[137] The options available for men are limited, and the numbers using them appear to be small and declining.[138]

This is in striking contrast to the current gender equality movement.

In an age that strives for gender equality, women and men alike have been asking why women should bear the almost exclusive responsibility of pregnancy prevention. Given the well-known side effects of female contraception, which are intolerable for some, and the fact that women are only fertile for a few days each month, whereas most men are fertile every day of the year, the unequal burden of responsibility seems particularly unfair.

[134] *See Sarah Cairns-Smith in The contraceptive headache - Tortoise (tortoisemedia.com)*

[135] *Ibid.*

[136] *Source: Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital*

[137] *See Table 12 Statistics on Sexual and Reproductive Health Services (Contraception): Data Tables - NHS England Digital.*

[138] *Stephanie Page estimates that in the U.S. 30 per cent of contraception is done by men either using condoms or having vasectomies. It is unclear what the percentage is in the U.K.*

In recent studies of men's attitudes towards male contraception, relieving the burden of these side effects from their female partners or taking contraceptive responsibility when their partners cannot tolerate hormonal contraception at all, have both been motivations for men wanting to take long-acting reversible contraception of their own.[139] Finally having control over their own fertility has been a strong motivator too, in principle and to avoid the financial repercussions for men and/or their partners of unplanned pregnancy. A 2017 survey in the US, supported by the Male Contraceptive Initiative, of 1,500 men aged 18-44 showed 85 per cent wanted to prevent pregnancy and 60 per cent noted shared responsibility as a motive to use.[140] It also showed that 46 per cent of men said they were interested in taking a pill before intercourse, though there was also interest in gels and other forms of contraception.[141]

More recent research led by Stephen Kretschmer from health consultancy DesireLine shows similar results.[142] He set out to determine whether men want additional male contraceptive options beyond male condoms and vasectomies, and if so which options, as well as whether women would trust men to use male contraceptives to protect them from pregnancy. His 2022 cross-country survey of thousands of men and women, asked "how soon" respondents would use a new product to assess the level of desire and urgency for it, based on the different attributes of various products.[143] His results showed a very high demand overall, with 49 per cent of men in the US saying they would use a male contraceptive within a year of a product being available.[144] They also showed high trust overall from women of men using contraceptives to protect them from pregnancy, as well as a high level of ability to talk openly with a partner about contraception. Women said they would generally not keep it a secret if they were using a female contraceptive.[145]

The main concern amongst men in the US – and across all countries – was the form of contraceptive administration (i.e. whether it is a pill, gel or injection). Gel on the shoulder and pills were most popular across all countries, while more invasive forms were least popular.[146] This tracks with women's diverse preferences. As Stephanie Page, lead investigator in the NIH-funded research into the promising male contraceptive NES-T gel, points out, like women, different men like different types of contraception, and preferences may be driven by what men in different contexts see their female partners using. She also posits that as men become more used to non-invasive methods, their appetite for injectables may increase.[147]

But what do women think?

Our recent survey shows women are overwhelmingly supportive of long-acting reversible male contraceptives. As Figure 10 below shows, we found that:

- Over three quarters (76 per cent) of respondents said they were open to a sexual partner using a method of male contraception (a pill, gel or reversible injection) if it were available.[148]
- Of those, nearly half (45 per cent) said they would use male contraception only with a long-term sexual partner who they were in a relationship with, while 19 per cent said they would use it with any sexual partner, including someone they were casually dating or with whom they had a one-night stand.
- Of the 76 per cent who said they were open to a sexual partner using male contraception, only 19 per cent they would still use their own contraception too.
- Only 18 per cent of respondents said they were not open to a sexual partner using a method of male contraception.

[139] *See research shared by Stephen Kretschmer from DesireLine at the ESC Conference in Bilbao in May 2024, from 1 hour 25 minutes: cdn.nirestream.com/v/embed/77TD1kOBLPF4cF1YeqsHsu0qaMji6QCNAu8K35x7kI8*

[140] *mci_consumerresearchstudy.pdf (malecontraceptive.org)*

[141] *Ibid.*

[142] *Nearly half of US men interested in taking new male contraceptives post-Dobbs decision - Male Contraceptive Initiative*

[143] *Attributes included form, frequency, time to onset, time to reverse, efficacy, impact on sex drive, testes, ejaculation, energy, mood and STI protection.*

[144] *cdn.nirestream.com/v/embed/77TD1kOBLPF4cF1YeqsHsu0qaMji6QCNAu8K35x7kI8 from 1 hour 25 mins*

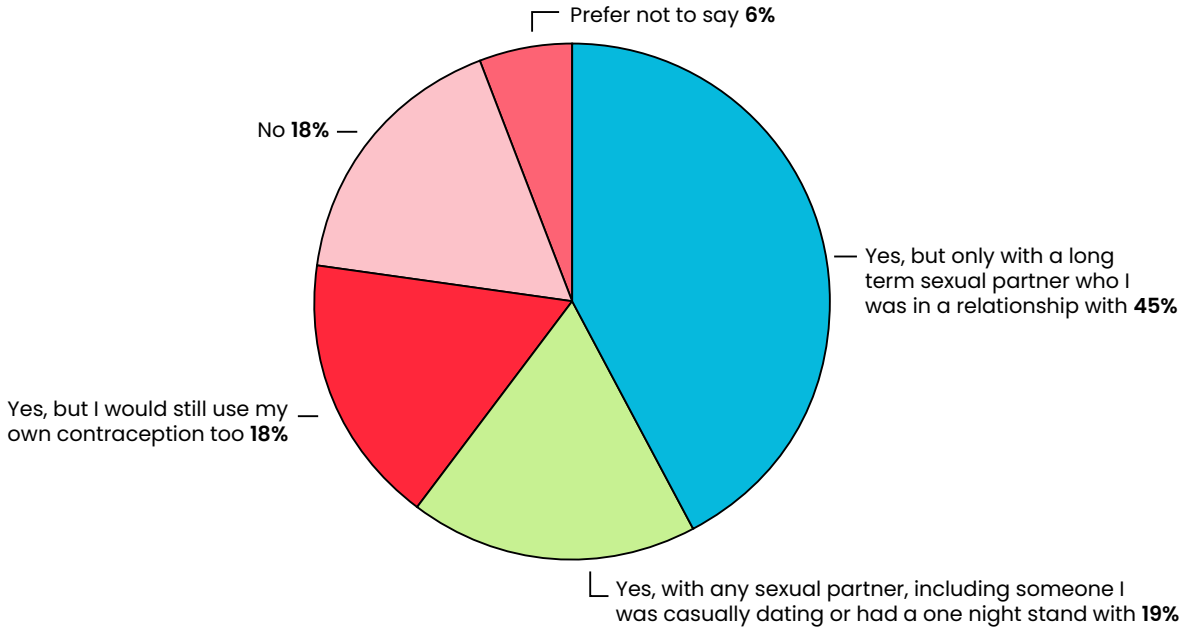
[145] *Ibid.*

[146] *Ibid.*

[147] *Stephanie Page from 1 hour 58 mins: cdn.nirestream.com/v/embed/77TD1kOBLPF4cF1YeqsHsu0qaMji6QCNAu8K35x7kI8*

[148] *'Yes, but only with a long-term sexual partner who I was in a relationship with', 'Yes, with any sexual partner, including someone I was casually dating or had a one-night stand with', and 'Yes, but I would still use my own contraception too' answer options combined.*

Figure 10: Respondents' openness to a sexual partner using a contraceptive method for men – a pill, gel or reversible injection to prevent pregnancy – if it were available.[149]



These figures suggest that there is an enormous appetite for new male contraception in the UK. They also challenge the claim that women would not trust men to use male contraception reliably – since of the 76 per cent who said they were open to a sexual partner using male contraception, only 19 per cent they would still use additional contraception while 81 per cent would cease using their own contraception, indicating a high level of trust in relying on men for contraception.

Respondents told us:

"I wouldn't trust a man to take control if I got pregnant or not. Women should be able to control what happens to their body."

"I am very interested in male contraceptives; women have carried the burden for too long."

"Male contraceptive pill would be good and help equality, but concern is still over STIs if not with a partner you know and trust."

"Contraception always seems to be women's responsibility, when it should be equal."

[149] *Source: BPAS survey conducted by Censuswide, July 2024.*

Why has innovation in male contraception been so slow? And how close are we to having a male Pill?

Male contraception is not only in the interests of women and of fairness, but it can also empower men to take control of their bodies and lives too, in a similarly transformative way as the Pill did for women. There is clearly demand for male contraception amongst both men and women. Which raises the question of why innovation has been so slow and why there are not more male contraceptives on the market.

Part of the problem lies in the hurdles to drug development mentioned above, namely the resistance to developing and marketing drugs that will be administered to healthy individuals, where the efficacy and safety bars are extremely high. Since biological males do not (currently) have the ability to become pregnant and therefore directly benefit from male contraception, this is especially true in relation to developing contraceptives for men. Some have also claimed that, were male contraceptives to be developed, women would not trust men to use them reliably, and that since women would still bear the primary burden of unplanned pregnancy, they would continue to use their own contraception, rendering novel male contraceptives effectively pointless.

There have been clinical barriers too: First, researchers assumed sperm production would need to be reduced to zero, or at least that there would need to be no sperm in semen. Further down the line, research suggested that the number of sperm in ejaculate would have to be limited below a certain level. It was then discovered that it is actually very difficult to give men testosterone orally because it metabolised too quickly or required too frequent dosing (alongside a fatty meal), and that a second hormone would be needed to make an effective male contraceptive. According to Stephanie Page, the goal now is to combine androgen and progestin as one compound for an oral or long-acting injectable form of male contraception that could become the male pill.

Progress in the development of long-acting reversible contraception for men

There has been good recent progress in relation to male contraceptives. The Population Council, with support from the US National Institutes of Health, has been developing a transdermal NES/T gel, which could be applied to a man's shoulders and upper arm daily.[150] It consists of intratesticular testosterone and Nestorone, a synthetic progestin, which suppress gonadotrophins and sperm production. Since 2018, the trial sites for this innovative gel have spread across the world, from Africa to Europe and the US. Their Phase IIb Evaluation of NES/T gel enrolled 462 couples, with 201 completing one full year of efficacy. Most men (85 per cent) showed suppression of sperm output to below 1 million per millilitre, with the average time to sperm suppression being between 4 to 12 weeks. Men commented "It was easy" and "I wish we could keep using it." And the women said "Better for my relationship… I'm much happier," and "Wish I didn't have to go back on my old method."[151]

There has been other progress in the last decade too. Alongside there being a few companies interested in male contraceptive development, there are now two advocacy groups – the Male Contraception Initiative and the International Consortium of Male Contraception (ICMC) – and Expert Guidelines have been published. There is also now funding for this work: The Male Contraceptive Initiative and the Bill & Melinda Gates Foundation are supporting Stephen Kretschmer's DesireLine work, while the NIH is supporting Page's work. There is a Male Contraceptive Clinical Trials Network spanning the globe, with bases at the Universities of Edinburgh and Manchester.

[150] *See Dr Regine Sitruk-Ware presentation at the ESC in Bilbao in May 2024 here from 1 hour 42 mins:* *cdn.nirestream.com/v/embed/77TD1kOBLPF4cF1YeqsHsu0qaMji6QCNAu8K35x7kI8*

[151] *Ibid.*

What is still needed are regulatory guidelines for male contraceptives, long-term safety studies for any new molecules, public-private partnerships to take forward the research, and low-cost options for easy access.[152]

There is a clear case for investment: Male contraception can fill unmet needs, give men new options, promote gender equality, enable men to take responsibility for their sexual and reproductive behaviour, decrease maternal mortality (indirectly), and engage men in contraceptive use and decision-making in ways that support women's reproductive choices.[153] It can be an adjunct to female contraceptive methods – not a replacement – and another way of advocating for women and reducing the incidence of unplanned pregnancy, as well as empowering men to take control of their fertility and share the burden of contraceptive responsibility.

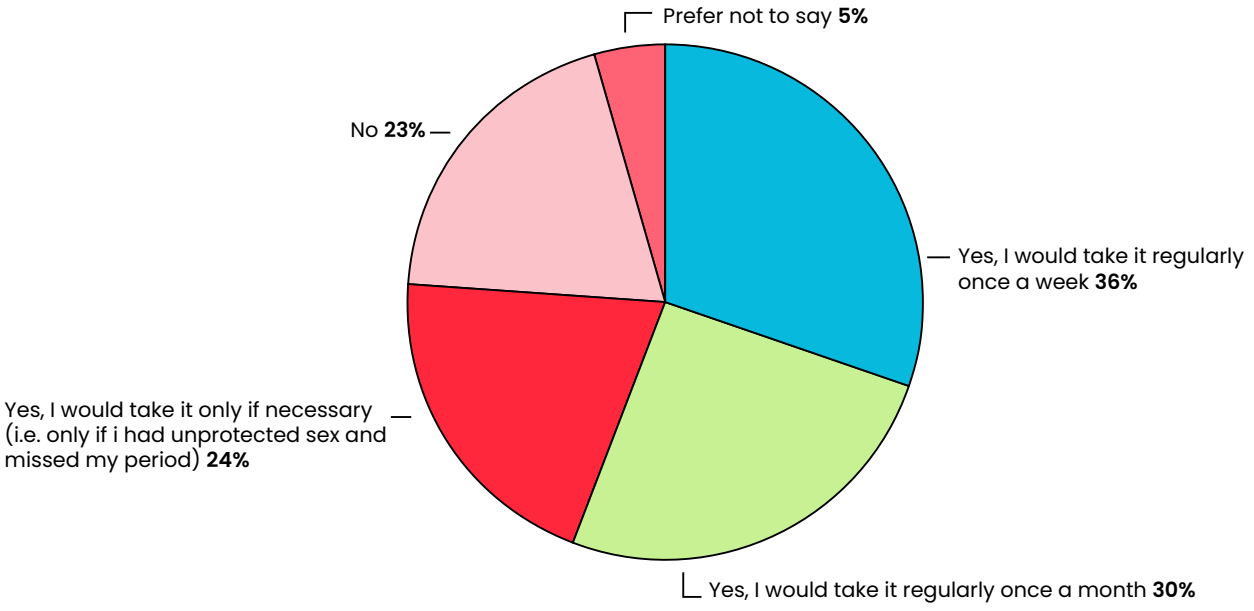
Long-acting reversible male contraception is no longer a pipe dream – it is a reality. With several promising male contraceptives in development, the future of contraception is, finally, looking more equal.

Are contragestives the future? And what exactly are they?

Contragestives may be the revolutionary future of fertility control that women have been desperately waiting for. Our survey found that women are overwhelmingly enthusiastic about these non-hormonal alternatives to existing contraceptives, which could be taken regularly once per week or month, or on demand. As Figure 11 below shows, we found that:

- Nearly three quarters (72 per cent) of respondents said "yes" when asked if they would be open to taking a non-hormonal pill either regularly or only, if necessary, in order to control their fertility.[154]
- Of those, the most popular option was taking the pill weekly (36 per cent), followed by monthly (30 per cent), while almost a quarter (24 per cent) said they would take it only if necessary (i.e. only if I had unprotected sex and missed my period).
- Less than a quarter (23 per cent) of respondents said they were not open to taking such a non-hormonal pill.

Figure 11: Respondents' openness to using a new method of fertility control for women: a non-hormonal pill, taken either regularly (i.e. once a month or once a week) or only if necessary (i.e. only if they had unprotected sex and missed their period).[155]



[152] *See Dr Regine Sitruk-Ware presentation at the ESC in Bilbao in May 2024 here from 1 hour 42 mins: cdn.nirestream.com/v/embed/77TDIkOBLPF4cF1YeqsHsu0qaMji6QCNAu8K35x7kI8*

[153] *Ibid.*

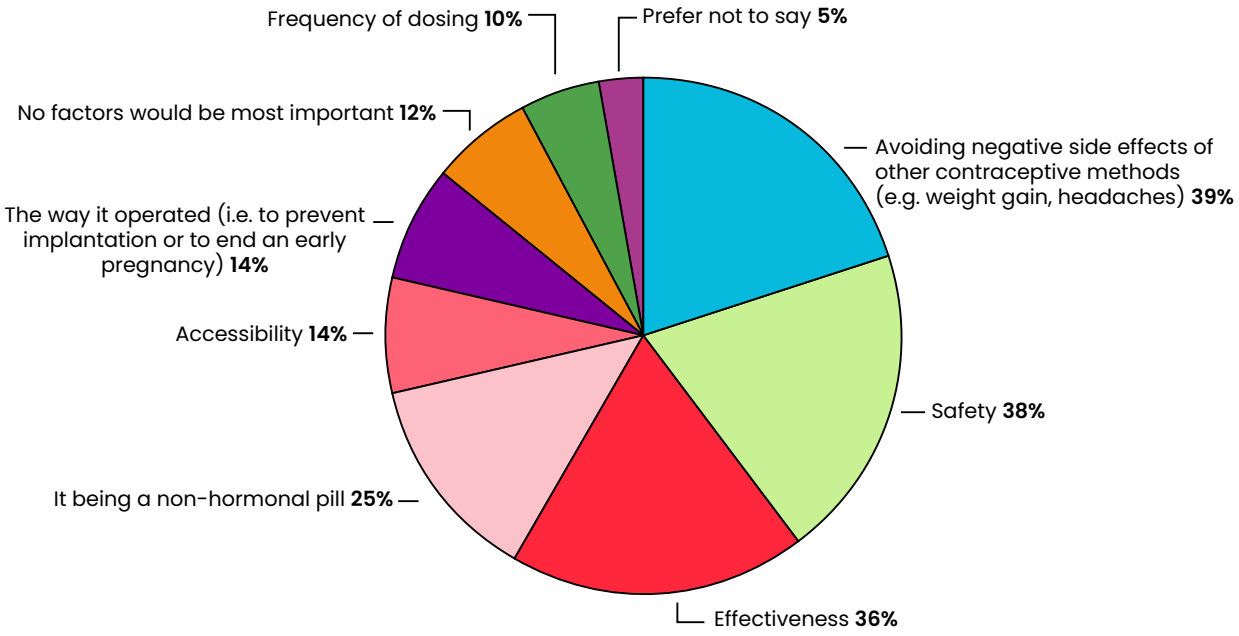
[154] *Reverse of 'No' and 'Prefer not to say'.*

[155] *Source: BPAS survey conducted by Censuswide, July 2024.*

This shows a significant jump in demand since our last survey on this issue nearly a decade ago. A BPAS survey in 2015 found that 48.4 per cent of women (out of a sample of 1,000) would consider a once-a-month pill that could work after a fertilised egg has implanted in the lining of the womb.[156] Meanwhile, our latest data in July 2024 suggests that nearly three quarters of women in the UK may be open to using non-hormonal pills that could work in the luteal phase and beyond.

Furthermore, the main factors influencing women's openness to taking such a non-hormonal pill were side effects, safety, and effectiveness – and not the mode of operation (i.e. preventing implantation or ending an early pregnancy) – as the graph below shows:

Figure 12: Factors that would be most important to respondents' decision to use a new non-hormonal method of fertility control for women that could be taken either regularly (i.e. once a month or once a week) or only if necessary (i.e. only if they had unprotected sex and missed their period).[157]



We found:

- Of the 83 per cent who said there would be factors influencing their decision to take a non-hormonal fertility control pill, the most cited factors were avoiding negative side effects of other contraceptive methods (e.g. weight gain, headaches) (39 per cent), safety (38 per cent) and effectiveness (36 per cent).
- Only 14 per cent said the way it operated (i.e. to prevent implantation or to end an early pregnancy) would be one of the most important factors influencing their decision to take a non-hormonal fertility control pill.
- 12 per cent said no factors would be most important to their decision to take a non-hormonal fertility control pill.

[156] *Are new contraceptive methods being blocked by UK abortion laws? | Glamour UK (glamourmagazine.co.uk)*

[157] *Source: BPAS survey conducted by Censuswide, July 2024.*

Women told us:

But what exactly are contragestives?

In short, "Contragestion refers to a method that works after ovulation and throughout [the] luteal phase and beyond."[158] Contragestives can operate in a number of ways, depending on when during the menstrual cycle the contragestive is taken. They disrupt the traditional binary between contraception and emergency contraception, on the one hand, and abortifacients or early medical abortion (EMA), on the other. Contragestives can be used as luteal phase contraceptives either mid-cycle around the time of ovulation or later in the cycle after both possible fertilisation and implantation have occurred, but before a missed period. However, they can also be used post-implantation either regularly or on-demand after unprotected sex and a missed period, to bring on that late period. In that latter sense, they may work as a form of very early medical abortion, without a woman knowing, or needing to know, whether she is pregnant.

There are clear benefits to contragestives: They would provide an alternative choice to the need to take daily hormones, or have a device fitted or removed; They could be used longer after sex than current emergency contraceptives, or used only rarely when a woman's menstrual period is delayed; They would end the challenges of needing to obtain and initiate contraception before having sex, which can be daunting for both women and men;[159] And, as legal scholar Sally Sheldon explains, "this blurring of the received boundary between contraception and abortion might be seen as an advantage that would render the technology attractive to some in a context where abortion is a far more stigmatised treatment."[160] For these reasons, and as our survey shows, they are likely to be extremely popular with women.

[158] *Is contragestion the future? | BMJ Sexual & Reproductive Health*
[159] *Embracing post-fertilisation methods of family planning: a call to action | BMJ Sexual & Reproductive Health*
[160] *The regulatory cliff edge between contraception and abortion: the legal and moral significance of implantation - PubMed (nih.gov)*

One group of contraceptive researchers has observed, "Although such methods would displease abortion opponents, they would likely be welcomed by many women."[161] They explain that, from the point of view of women, the mode of operation may not matter. They argue that "the essential value of this [contragestive] method lies precisely in the attributes it shares with abortion: it is an efficacious, extremely safe, easily administered, postcoital means for reducing the serious medical and personal risks associated with unintended pregnancy."[162] Moreover, they point out that "Abortion is legally available in the UK, the USA, Canada, most of Europe, India, China and many other countries with established pharmaceutical industries that are capable of developing and marketing a new drug product. Most of the British and North American public supports access to abortion, particularly in early pregnancy."[163]

Other academics agree, citing surveys that suggest, at least in theory, a substantial proportion of women from various populations would favour methods that prevented pregnancy through postovulatory effects. It is one mechanism of action of the intrauterine device (IUD), which is a highly popular method of contraception.[164] One survey from Scotland of over 400 women seeking insertion of IUDs, abortion and Emergency Contraception (EC), showed a very high proportion of respondents were accepting, in theory, of contraceptive methods that worked by preventing implantation (83 per cent) or disrupting implantation (75 per cent).[165] A survey from the US showed clear demand for missed period pills, which similarly work to bring on menses.[166]

Do contragestives actually exist? What is happening in the clinical trials?

In practical terms, there are strong indications that effective contragestives could be brought to market soon. Several studies have evaluated the use of mifepristone, which is an antiprogesterone agent commonly used as an abortifacient, as a luteal phase contragestive.[167] Mifepristone has multiple potential antifertility actions: It can delay or inhibit ovulation in the preovulatory, or follicular, phase of a woman's cycle, and its anti-progesterone properties can inhibit implantation of the embryo in the luteal phase.[168] As Rebecca Gomperts, the founder of global abortion providers Women on Web and Women on Waves, explains: In different doses, taken at different times in a woman's reproductive lifecycle, mifepristone works as either contraception, emergency contraception, abortion medication or to induce labour.[169] However, though it has been more than 30 years since Kristina Gemzell Danielsson published a letter in The Lancet about the possibilities of mifepristone as a contraceptive – it is still not licensed for that use.[170]

Since then, one study that evaluated the use of mifepristone as an early luteal phase contraceptive concluded it had "good contraceptive efficacy."[171] The study was conducted in North India and gave a study group of 86 women 200-mg mifepristone tablets to take on the 16th day of their menstrual cycle, and a control group of 92 women combined oral contraception (COC). Subjects were followed for drug adherence, satisfaction, side effects, and failure. The results showed the acceptability of mifepristone, with fewer side effects than COC, good satisfaction, and a high compliance rate. The study concluded that mifepristone can be used as a once monthly contraceptive pill effectively.[172]

[161] *Embracing post-fertilisation methods of family planning: a call to action | BMJ Sexual & Reproductive Health*
[162] *Ibid.*
[163] *Ibid.*
[164] *Is contragestion the future? | BMJ Sexual & Reproductive Health*
[165] *Ibid.*
[166] *Could "Missed Period Pills" Be the Future of Reproductive Health Care? - Ms. Magazine (msmagazine.com)*
[167] *For more on the multiple uses of mifepristone see Clinical Utility of Mifepristone: Apprising the Expanding Horizons - PMC (nih.gov)*
[168] *Evaluation of mifepristone as a once a month contraceptive pill - ScienceDirect*
[169] *cdn.nirestream.com/v/embed/YkcitQfwm9HmeMDqrH91A-o-GD8cpmcOFwEIlDxDgSE from 1 hour 35 mins.*
[170] *Contraception with mifepristone - The Lancet*
[171] *Evaluation of mifepristone as a once a month contraceptive pill - ScienceDirect*
[172] *Ibid.*

More recently, Gomperts and Professor Kristina Gemzell Danielsson, who is the Principal Investigator (PI), have started running trials in Moldova, and soon in the Netherlands, investigating the use of mifepristone on a weekly regimen of 50mg.[173] The Moldova trial is progressing with promising results,[174] and in Autumn 2024, the Women & More trial is set to begin in the Netherlands.[175] The goal of the study: "If this research shows that mifepristone 50mg is a good contraceptive, then registration with the authorities is the goal. This means there will be more choice in contraceptives in the future."[176]

Alongside trials using mifepristone as a luteal phase contraceptive – the first sense of contragestion – there has also been research into using contragestives as a post-implantation form of fertility control. When used to bring on a missed period, contragestives are functioning as "period pills" or "missed" or "late" period pills that women can take if their period is late, and they suspect that they are pregnant when they do not want to be – without the need for confirmation.[177] The concept of interventions that ensure non-pregnancy, without first establishing whether a pregnancy exists, is not new, and exists cross-culturally in different parts of the world. Both Bangladesh and Cuba, for example, formally promote menstrual regulation as a fertility control option, and the concept is culturally resonant in at least some parts of Burma/Myanmar, India, Indonesia, and throughout Latin America.[178] However, since this approach is untested in English law, it remains uncertain whether "termination" would legally apply to an undetected pregnancy.[179]

One study that overviews all the different uses of mifepristone explains that "Mifepristone may hold promise for "menstrual regulation" and induction in case of missed dates of the period for women who do not have access to medical confirmation of pregnancy and for women who do not want to determine pregnancy. Various doses (150 mg, followed by misoprostol, 600 mg single dose) have been studied with promising results."[180] That study cites a randomised clinical trial of mifepristone (formerly called RU486) for induction of delayed menses, which included 16 women, half of whom received a single 600 mg dose and half of whom received a placebo. Four of eight women in each treatment group proved to be pregnant. Seven of eight who received mifepristone were not pregnant at two-week follow-up, in contrast to four of eight who received the placebo. They concluded, "Mifepristone may hold promise for "menstrual regulation" for women who do not have access to medical confirmation of pregnancy or who choose not to have this determination made."[181]

Moreover, there are trials underway experimenting with other drugs that could be used as contragestives. US-based Gynuity Health Projects is supporting trials assessing whether the emergency contraceptive ulipristal acetate, commonly known as Ella-one, could be used in combination with misoprostol to induce abortion – showing that this drug could also have multiple purposes when used in different dosages at different points in the menstrual cycle.[182] They are also working with colleagues in West Africa to increase access to fertility control methods, including abortifacients, despite restrictive laws. As they explain, "The service we have in mind could be offered with either a combined regimen of mifepristone and misoprostol (combi-pack or separately packaged), misoprostol alone or potentially other medicines currently registered and available in the region."[183] This highlights that contragestives can take many forms and there are exciting initiatives and promising trials taking place across the globe.

[173] *From 1 hour 35 mins:* cdn.nirestream.com/v/embed/YkcitQfwm9HmeMDqrH91A-o-GD8cpmcOFwEIIDxDgSE
[174] *Ibid.*
[175] Women and More
[176] *Purpose of the study — Women and More*
[177] Home | Missed Period Pills
[178] Period Pills Today | Missed Period Pills
[179] The regulatory cliff edge between contraception and abortion: the legal and moral significance of implantation - PubMed (nih.gov)
[180] Clinical Utility of Mifepristone: Apprising the Expanding Horizons - PMC (nih.gov)
[181] A randomized clinical trial of mifepristone (RU486) for induction of delayed menses: efficacy and acceptability - PubMed (nih.gov)
[182] ISRCTN - ISRCTN35625202: Evaluating ulipristal acetate and misoprostol for induced abortion through 63 days of pregnancy
[183] *See "Develop a "Missed Menses Pill"/Menstrual Regulation Method" here:* Medication Abortion - Gynuity Health Projects

So why aren't contragestives available yet?

It is important to recognise that this new form of fertility control will likely encounter hurdles before reaching women. These hurdles are not primarily in drug development[184] or in establishing the effectiveness or safety of repurposing existing drugs for novel purposes. Rather, they are mostly conceptual, political, and legal hurdles. As Danielle Choucroun writes, "mifepristone introduces a clear break in the binary representation of female birth control contraception/abortion."[185] That may be conceptually welcome by many, including women wishing to avoid pregnancy regardless of the mode of operation and without the need for pregnancy confirmation. However, it goes against a binary that is long-established in law in many jurisdictions – including in England and Wales – as well as in some social convention.

As the pioneering researchers above admit, "Both the UK and USA governments define pregnancy as beginning at implantation (US Code of Federal Regulations 45 CFR 46.202), implying that a method that acted after fertilisation but before implantation should not be considered abortifacient. However, not everyone is comfortable with this definition. Interrupting the course of pregnancy after implantation is abortion by any definition."[186] In other words, when contragestives operate after implantation, they cause an abortion, and when they operate after fertilisation, some regard that as an abortion. Sheldon agrees, explaining that "Implantation is, in many countries, taken to represent the dividing line between abortion and contraception, with these two practices generally treated as if they are readily distinguishable and appropriately subject to very different regulation."[187]

In England, there are legal barriers to introducing contragestives that could operate both before and after implantation. As legal scholar Sally Sheldon explains: "This is not as a result of modern, democratic deliberation of the ethical and clinical merits and risks of such treatments but is rather an unconsidered consequence of archaic legislation, framed at a time when they were unimaginable. This legislation offers a 'regulatory cliff edge' between methods of fertility control that operate before implantation and those that operate after it."[188]

But, as Sheldon argues, we need to rethink that supposed bright red line of implantation. She argues, "drawing a bright line at the moment of implantation offers a far from satisfactory basis for the future development of techniques of fertility control that operate in early pregnancy."[189] Instead, as she explains, "it is determined by a statutory phrase that is a product of a world, which 'in matters sexual was almost unimaginably different from ours' (para 332), having been passed by a Victorian Parliament within which women had no voice. This is an indefensible basis for the regulation of health services that matter so intimately to modern women."[190]

In her view, there needs to be "a modern, democratic debate, informed by current medical science"[191] about the significance of implantation. Currently, as she points out, there is no empirical data, no survey, for example, canvassing public opinion on where the dividing line should fall between contraception and abortion, what factors should be relevant to this decision and what regulatory implications this should have.[192]

[184] *Though Professor Kristina Gemzell explained in a meeting with BPAS on 16th July 2024 that pharmaceutical companies are not enthusiastic about pursuing research into the multiple fertility control purposes of mifepristone because it does not have a patent.*

[185] *Contragestion: Build Back Better – Ego Journal*

[186] *Embracing post-fertilisation methods of family planning: a call to action | BMJ Sexual & Reproductive Health*

[187] *The regulatory cliff edge between contraception and abortion: the legal and moral significance of implantation - PubMed (nih.gov)*

[188] *Ibid*

[189] *Ibid*

[190] *Ibid*

[191] *Ibid*

[192] *Ibid*

A related barrier is the abortion association of mifepristone, which may also be off-putting for investors, legislators, and regulators, as well as for some women. Since mifepristone is currently used as an abortifacient, in combination with misoprostol, as part of the EMA drug regimen, that could be a hindrance to it becoming licensed as either Emergency Contraception or contraception. According to Gomperts, the potential of women stockpiling mifepristone to use as an abortifacient came up as a funding issue with the Dutch Government backing the forthcoming clinical trials in the Netherlands. There was concern that women could store the 50mg mifepristone tablets they were given during the trial to use for future abortions.

Why we need a conceptual revolution in fertility control

Against these concerns are strong counterarguments: mifepristone is widely used, has a good safety profile, and the potential problem of stockpiling has not stopped other drugs from being legalised and even sold directly off the shelf. Paracetamol, for example, is sold everywhere, can be purchased in fatal quantities, and there are indeed many paracetamol overdose suicides – yet there is no discussion about removing it from the market. By contrast, with mifepristone, even before the trials are complete, and without any evidence of women stockpiling it and "misusing" it, there is distrust about women abusing it.[193] As Gomperts says, this shows a deep mistrust in women's decision-making and choices.

As one group of researchers lament, "Sadly, the world fails to learn that restricting access to medications or procedures that may end pregnancy does not prevent abortion. Ultimately, it is by expanding options of highly effective fertility control that we can prevent more unintended pregnancies and benefit women and the society as a whole."[194]

We need to prioritise bringing contragestives from clinical trials into women's hands. To achieve this, we need governments to step up and clarify whether existing legislation facilitates their use or needs amending to create the legal framework to expand reproductive health options for women. We need funders to support researchers to run the clinical trials that will establish the most effective and safest drug regimens with the least side effects. And we need women's health advocates around the world to support the development of contragestives and to embrace the conceptual fluidity – revolution perhaps – entailed in getting them into women's hands.[195]

[193] *cdn.nirestream.com/v/embed/YkcitQfwm9HmeMDqrH91A-o-GD8cpmcOFwEIIDxDgSE from 1 hour 35 mins.*

[194] *Is contragestion the future? | BMJ Sexual & Reproductive Health*

[195] *This echoes the call made in Is contragestion the future? | BMJ Sexual & Reproductive Health*

Conclusion

Now, more than ever, we need to push for bolder innovation in contraception – clinically and conceptually. BPAS remains steadfast in our commitment to supporting the autonomy of women and people needing contraception over their reproductive health. The time is now to accelerate progress, to advocate for modern solutions like contragestives, and to ensure that every barrier to contraceptive access is broken down. By embracing these advancements, we can offer women more choices, more freedom, and more control over their reproductive futures.

No woman should be falling pregnant whilst on the waiting list for her preferred contraceptive method. Getting GP appointments should not be a barrier, nor should cost. And partners or family members should not be blocking women from accessing contraception. But all of this is happening, and it needs to change. Breaking down these barriers is not just a matter of improving convenience; it is a matter of reproductive justice, ensuring that every woman has timely access to the contraception that best suits her needs.

Looking forward, contragestives present an exciting opportunity as the contraceptive method of the future. By offering women a flexible, non-hormonal alternative, contragestives could revolutionise fertility control. These methods blur the lines between contraception and abortion. That might unsettle some. But it offers women unprecedented control over their reproductive choices. We are calling on decision-makers, regulators, pharmaceutical companies, research funders and healthcare providers to invest in greater contraceptive innovation – including contragestives – so that women can benefit from their remarkable potential in the near future.

What we are offering is a future where women are in full control of their contraception, their bodies, and lives. We are ready. Join us and let us bring about this contraception revolution, together.

Calls to Action

Together, we can empower women and people needing contraception to take back control. But, to do so, we are calling on decision-makers, policymakers, regulators, pharmaceutical companies, research bodies, and healthcare professionals to make the following changes urgently. These calls to action call for improvements in access to existing options and, crucially, aim to broaden the future choices available to women. They focus on investing in novel forms of fertility control, tackling waiting times for long-acting reversible contraception, and improving current contraceptive choices.

To invest in the future of fertility control, we call on the following:

1. **The Department of Health and Social Care to allocate greater funding to contraceptive innovation** and work with other departments, public health agencies and research councils to accelerate innovation.
2. **All those involved in contraceptive innovation to ensure greater user involvement**, at all stages of the design and development process.
3. **Research bodies and pharmaceutical companies to invest in the introduction of contragestive fertility control in the UK.**
4. **Parliamentarians to remove any barriers in existing law that would inhibit clinical trials around, or the introduction of, contragestives.**
5. **The Medicines and Healthcare products Regulatory Agency (MHRA) to review mifepristone licensing to facilitate the introduction of contragestives.**
6. **Research bodies, pharmaceutical companies and the MHRA to accelerate access to long-acting reversible male contraception** (pill, gel, and injection) to share the contraceptive burden of responsibility more fairly.

To tackle waiting times for long-acting reversible contraception (LARC), we call on the following:

7. **UK Health Security Agency (UKHSA), NHSE, local authorities and Integrated Care Systems (ICSs) to identify and publish the data on waiting times, nationally and locally, on insertions and removals of LARCs** (coils, implants, and injections), as well as on seeing GPs for oral contraceptive pill prescriptions (initial and renewals).
8. **NHSE, local authorities and ICSs to reduce waiting times for accessing contraception**, especially LARCs, to avoid unintended pregnancies. Specifically, we call for the production of local plans to reduce waiting times for access to contraception to nationally-agreed levels. These plans should include more appointments, adequate staffing and an expansion of contraception locations.
9. **NHSE to centralise data on contraceptive prescribing and use** to enable stakeholders to easily identify patterns, problems, and backlogs.

To improve current contraceptive choices, we call on the following:

10. **The MHRA to reclassify emergency contraception to a General Sales Label** (GSL) so that it is easily accessible from a wider range of outlets.
11. **NHSE, local authorities, Integrated Care Systems (ICSs) and others responsible for commissioning contraception should consider procuring male condoms** to be available on prescription for free to men and women of all ages across all parts of England..
12. **FemTech, social media influencers, clinicians, and those in the sexual and reproductive health community to take a lead in combatting contraceptive misinformation on social media** by producing accurate and engaging content on contraception across media and social media channels.

Appendix 1: Censuswide survey questions

Qa. What age group are you?

18-25

26-35

36-45

end if respondent is aged 16-17 or 46+

Qb. What gender do you identify with?

Male [SCREEN OUT]

Female

Non-Binary

Trans*Male

Trans*Female [SCREEN OUT]

Agender

Other [SCREEN OUT)

Prefer not to answer [SCREEN OUT]

Qc. Where do you live?

East of England

Greater London

East Midlands

West Midlands

North East

North West

Northern Ireland

Scotland

South East

South West

Wales

Yorkshire and the Humber

Qd. What is your ethnic group?

White - English / Welsh / Scottish / Northern Irish / British

White - Irish

White - Gypsy or Irish Traveller

White - Any other White background

Mixed descent - White and Black African

Mixed descent - White and Black Caribbean

Mixed descent - White and Asian

Mixed descent - Any other mixed

Asian - Indian

Asian - Pakistani

Asian - Bangladeshi

Asian - Chinese

Any other Asian ethnic group

Black - African

Black - Caribbean

Any other Black / African / Caribbean ethnic group

Arab

Any other ethnic group

Prefer not to say

Qe. Which of the following best reflects your annual household income?

£15,000 or less

£15,001 – £25,000

£25,001 – £35,000

£35,001 – £45,000

£45,001 – £55,000

Over £55,000

I do not wish to divulge this [SCREEN OUT]

[QUOTA : Minimum 100 respondents in each household income bracket]

Caveat: Please note that some of the questions in this survey concern sensitive health issues. All responses will be treated anonymously, in strict confidentiality and in line with the 2018 General Data Protection Regulation (GDPR). No personally identifiable information will be linked to the results. At any point you are free to select 'prefer not to say' where provided, or if you do not wish to proceed altogether, please close your browser window.

Q1. What is your current main method of contraception, if any? (tick one)

Combined hormonal contraceptive pill (for example, Yasmin)

Progesterone only mini-pill (POP)

Intrauterine system (for example, Mirena coil)

Intrauterine device (also called the copper coil)

Implant

Injection (for example, Depo Provera)

Patch

Vaginal ring

Diaphragm or cap

Internal condom (female condom)

External condom (male condom)

Fertility awareness/rhythm method (without using app)

Fertility awareness using tracking app (for example, Natural Cycles)

Withdrawal/coitus interruptus

Vasectomy

Female sterilisation

Other, please specify

None [Skip Q2]

Prefer not to say [Skip Q2]

Q2. How satisfied or dissatisfied are you with your current main contraceptive method? Please respond while thinking about its effectiveness, ease of access, ease of use, and any side effects you may have experienced? Please elaborate on your answer.

Matrix

Columns:

Very satisfied

Satisfied

Neither satisfied nor dissatisfied

Dissatisfied

Very dissatisfied

Don't know

Rows:

Overall

Effectiveness

Ease of access

Ease of use

Side effects

Q3. What challenges, if any, have you encountered regarding access to your preferred contraceptive method? (Tick all that apply)

Not getting an appointment with a healthcare professional to access contraception at all

Waiting too long for insertion / fit

Not available at pharmacies

Doctor wouldn't prescribe it

Cost – it was too expensive

Partner preventing access

Family preventing access

Other – please specify

I have not encountered any challenges accessing my preferred contraceptive method *exclusive*

Prefer not to say *exclusive*

Q4. What methods of contraception have you previously used in your lifetime? (Tick all that apply)

Combined hormonal contraceptive pill (for example, Yasmin)

Progesterone only mini-pill (POP)

Intrauterine system (for example, Mirena coil)

Intrauterine device (also called the copper coil)

Implant

Injection (for example, Depo Provera)

Patch

Vaginal ring

Diaphragm or cap

Internal condom (female condom)

External condom (male condom)

Fertility awareness/rhythm method (without using app)

Fertility awareness using tracking app (for example, Natural Cycles)

Withdrawal/coitus interruptus

Vasectomy

Female sterilisation

Other, please specify

None *exclusive* [Hide if 'None' is not selected at Q1] [Skip Q5]

Prefer not to say *exclusive* [Skip Q5]

Q5. Why, if ever, have you changed your method of contraception? (Tick all that apply)

To avoid negative side effects of that method (e.g. headaches, mood swings, fatigue)

To get positive side effects of another method (e.g. regulating periods, reducing frequency or intensity of periods, skin benefits)

Concerns about bleeding/spotting

Concerns about long-term risks

Pain of or after insertion

Ongoing discomfort

Could not access type of contraception I wanted

Wait for what I wanted was too long

Could not get to GPs to keep renewing prescription

Preferred a method I did not need to remember to take each day

Decided it was not reliable or not reliable enough

No longer having sex

Trying to get pregnant

Method not accepted by my partner/family/community

Other – please specify

N/A – I have never changed my method of contraception *exclusive*

Prefer not to say *exclusive*

Q6. Imagine a new method of fertility control for women: a non-hormonal pill, taken either regularly (i.e. once a month or once a week) or only if necessary (i.e. only if you had unprotected sex and missed your period). Would you be open to using such a method if it was available? (Select all that apply)

Yes, I would take it regularly once a week

Yes, I would take it regularly once a month

Yes, I would take it only if necessary (i.e. only if I had unprotected sex and missed my period)

No *exclusive*

Prefer not to say *exclusive*

Q7. In relation to this new method of fertility control for women, which factors would be most important to your decision to take that non-hormonal pill? (Select up to three)

Effectiveness

It being a non-hormonal pill

Frequency of dosing

Safety

Accessibility

Avoiding negative side effects of other contraceptive methods (e.g. weight gain, headaches)

The way it operated (i.e. to prevent implantation or to end an early pregnancy)

Other – please specify

No factors would be most important *exclusive*

Prefer not to say *exclusive*

Q8. Imagine a contraceptive method for men, a pill, gel or reversible injection to prevent pregnancy. Would you be open to a sexual partner using such a method if it were available? (Select all that apply)

Yes, but <u>only</u> with a long-term sexual partner who I was in a relationship with.

Yes, with <u>any</u> sexual partner, including someone I was casually dating or had a one-night stand with.

Yes, but I would still use my own contraception too

No. *exclusive*

Prefer not to say *exclusive*

[Respondents cannot select both 'Yes, but only with a long-term sexual partner who I was in a relationship with.' and 'Yes, with any sexual partner, including someone I was casually dating or had a one-night stand with.']

Q9. Please share anything else you'd like us to know about your contraceptive experiences or views. We are particularly interested to hear your thoughts about a new non-hormonal method of fertility control for women and about male contraception. We are also interested to hear, in your own words, about your contraceptive journey over the years, including the methods you've used, any changes you've made, the reasons behind those changes, and any options you wish were available for you to use.

[FREE TEXT BOX]

Nothing else to add

Prefer not to say

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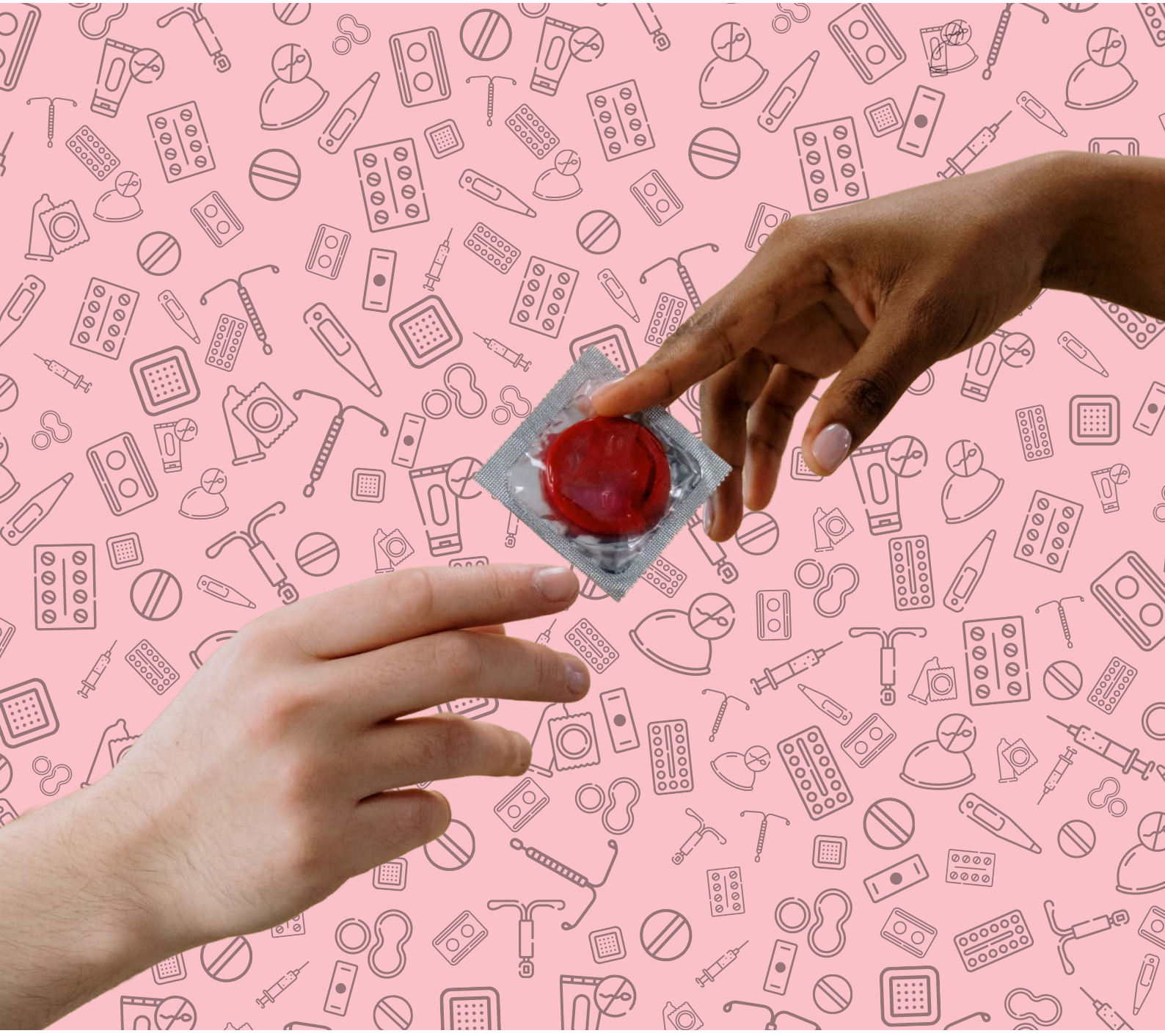

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