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Contraception Education and Reform Team – 2019 Report and Policy Proposal

About the authors

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We are multi-disciplinary team from across the UK and Europe and are currently all studying at the University of Edinburgh. As members of the Buchanan Institute, a student-led think tank which facilitates pursuits to enact change, we have followed our shared passion for reforming current contraceptive care and health in Scotland.
Below we share our personal motivations for participating in this project.

Ella

"My interest in contraceptive reform stems from a difficult experience with the progesterone only pill when I was younger. At the time I was struggling with recently diagnosed Chronic Fatigue Syndrome and didn't recognise that my impaired mental health was a side effect of the pill, rather than just part of my illness and being a teenager. That worries about contraception are still one of the most frequent conversations I have with friends, testifies to the scope of the problem and the lack of progress and legitimisation that have been realised."

Kristy

"My personal ideals are centred around righting the wrongs I see as reductive to the wellbeing of individuals within society in order to tackle inequalities. The Buchanan Institute has provided me with the perfect opportunity to make a difference to people's lives and gain insight into policy work in an area which I believe needs attention and reform. My personal experiences of contraception, as well as that of many people around me, have solidified this as a fundamentally important cause which I am passionate about. I truly hope that our work will bring about positive change."

Ellen

"I strongly believe that the voices of women should be at the heart of reproductive and sexual health considerations and I hope our work can help aid progression in this direction. I have ambitions of completing a PhD in Global Health Policy and want to commit my life to finding sustainable solutions to major health concerns, CERT has created my first experiences within this field, and it's made me all the more eager to start!"

Frieda

"Studying Sociology and Social Anthropology, I have been made acutely aware of social issues and inequalities. However, I found my courses to be very theoretical and wanted to be involved in creating real change which lead me to the Buchanan Institute. I felt strongly about female contraception having had negative experiences with the pill. Through CERT, I have experienced many of the struggles and successes of writing policy which will be hugely beneficial for my future ventures into policy."

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Introduction

We are the Contraception Education and Reform Team, a student-led project within the Buchanan Institute based at the University of Edinburgh. We are passionate about the creation of equal, comprehensive and accessible healthcare for all in Scotland; and through our commitment to these values we have found that contraceptive healthcare in Scotland is currently not meeting these demands, especially for the reproductive population. Through literature research, gatekeeper discussion and most importantly our fieldwork exploring the opinions and experiences by women in Scotland in relation to contraception, we have found there is a need to reform many areas of contraceptive care throughout the country. Our report highlights key issues in contraception in relation to side effects, education and healthcare, and proposes policy recommendations to reform current issues.

At the heart of our work is our deep commitment to listen to the experiences of women and amplify their voices in an attempt to reform current frameworks of contraception to make the majority of experiences positive and comfortable for women. Throughout all our work, we remain devoted to our core values of making the medical and educational frameworks in Scotland aware of, and committed to, female issues and perspectives. We hope that our work empowers others to question the services they receive and feel informed to make demands for positive contraceptive experiences. We will work tirelessly to reform current contraceptive frameworks in Scotland, to create an informed and satisfied nation, content with their contraceptive choices.

Scotland can and will have strong contraceptive care for all its citizens, and we at CERT will fight for every step of reform and constructive change going forward.

We hope you find our report informative, if you want to discuss our findings or wish to get involved in our team do not hesitate to contact us at BuchananCERTeam@hotmail.com

Ella Cheney, Kristy Lambert, Ellen McIntosh, and Frieda Rzewnicki.

Executive Summary

Three quarters of the female population in the UK aged between 16 and 49 used some form of contraception between 2006 and 2007 (Lader, 2007) and more recent studies suggest this number may be nearer to 87% (French et al, 2017). The extent which contraception is used across the UK demonstrates that research in this field is imperative in the protection of the reproductive and sexual health of British citizens. Our proposal will focus on the population of Scotland.

Individual experiences of different forms of contraception vary and are often unpredictable. Many women suffer from unwanted side effects whilst reportedly feeling uninformed, unprepared and unsupported for the various side effects which can present (Displayed in our Scope Survey, Published Online, 2019).

As quoted by the NHS, discontinuation rates of contraception among women in Lothian are currently as high as 33% annually (NHS Joint Formulary Lothian, 2011). This is important as many women discontinue use of their contraception altogether or "change to a less effective method", such as condoms (NHS Joint Formulary Lothian, 2011). Increasing discontinuation rates and use of less effective methods demonstrate that issues of contraception need to be taken seriously and policies which address high discontinuation rates of contraception need to be implemented in Scotland.

This policy brief demonstrates that increasing discontinuation rates must be addressed by creating a national framework of care and education on issues of contraception within Scotland. A need exists for motivated reform within the medical domain: to legitimise individual reports of side effects and attempt to address these reports in a comprehensive manner. True comprehensive medical care requires an informed populace. We argue that there must be reform to create consistent education on contraception in Scotland, with the eventual aim of empowering individuals to create this fully informed populace.

This paper proposes four key policy changes that need to be implemented to achieve sufficient contraception education and reform within Scotland.

1. The need for work and research of organisations specialising in contraception and sexual health (such as Brook and FSRH) to be recognised and integrated by national stakeholders (such as the NHS and education Scotland) to make pre-existing research available to the wider public.
2. There needs to be a change in the availability of information and education on contraceptive issues to the general public through the education system and

within medical arenas (such as in-depth information provided to GPs and education practitioners).

3. There needs to be change in the education of medical students around contraception. This requires a comprehensive syllabus on contraception being required within university medical and biomedical degrees in Scotland.
4. Further research is required in the medical realm on side effects of contraception, with adequate funding provisions, so healthcare providers can legitimise and address reports of side effects.

Methodology

When conducting our research there were four key stages which impacted our methodology and facilitated the development of our policy proposals. To begin with we conducted literature research across academic disciplines and popular discourses present in the media relating to contraception within Scotland and the rest of the UK. We discovered a growing trend of dissatisfaction with contraception in the UK from the reproductive population (highlighted in Winter, 2017 & Hoggart, 2013). Through extensive research we identified three key modes of dissatisfaction; the delegitimisation of side effects of women on contraception, lack of nationalised education on contraceptive issues and disparities in medical care throughout the NHS.

Having identified this contemporary challenge in reproductive and sexual health, we began 'fact finding' and engaging with the work of many gatekeepers in this field. The most informative organisations, we felt, were the publications by charities and regulatory bodies associated with contraception operating at national and international levels. These charitable and regulatory institutions often provide frameworks which would allow the creation of all-encompassing care and education of contraception needs within Scotland. The Faculty of Sexual and Reproductive Healthcare (FSRH) provides specialised educational programmes and training for healthcare professionals in an attempt to equip them with the special skills and knowledge needed in this area of medicine. It also provides open access guidelines online which aim to create structures of comprehensive education and care for young people making healthcare choices (FSRH Clinical Effectiveness Unit, 2010). Specifically in Edinburgh, we discovered that Chalmers Sexual Health Centre aims to provide specialised care for an array of sexual health concerns across the population of Edinburgh. In our research process we found that there were many reliable and committed bodies already researching and attempting to create comfortable contraceptive care across Scotland and further afield. However, a main issue we found was despite the quantity of work demonstrating how to create exemplary healthcare which legitimises side effects of contraception and the need for comprehensive education, there were no dedicated national frameworks to allow this care to be implemented nationally. We wanted to see how this lack of national framework translated into common consensus of contraceptive issues in Scotland.

Through a scope survey which we created using an online 'google form' and published on online social media platforms such as Facebook, Twitter and Instagram, we recorded 309 responses from users of contraception who identify as female, with 67.9% of these respondents being Scottish. This scope survey asked participants to provide information on their use of contraception, opinions on their school education about contraception, experiences of medical professional care concerning contraception and also a section on improving contraception. The qualitative and quantitative data recorded from our scope survey is used throughout this report. A key theme which this survey found was the frustration many women detailed when retelling their experiences of side effects with the pill, many participants responded with sincere dissatisfaction at the delegitimisation of their side effects by medical care professionals. Furthermore, as well as highlighting personal dissatisfaction with contraceptive care and education, this scope survey also demonstrates the vast disparity between contraceptive experience amongst participants; a wide range of educational and medical experiences were recorded. This scope survey illustrates the presence of themes we had considered throughout literature and the real issues being caused for individuals within Scotland proving the need for policy reform.

Through identifying a core public health and education concern within Scotland and the gathering of data through the scope survey, we feel we have demonstrated a real need for reform in contraception care in the country. Having highlighted four key areas of policy reform (discussed in the Executive Summary section above) our research team have begun and are continuing to build communications with key gatekeepers and create public attention towards our activist stance for sexual and reproductive health reform. Through presenting our findings and policy considerations in this report we hope this will allow the distribution of our policy proposals across Scottish communities. This policy brief can also be used as a material starting point in the building of relationships with key gatekeepers in political, charitable, medical, and educational institutions. We feel our research and methodological considerations so far allows us to now be at the stage to communicate our findings and start to try and enact real change across Scotland. This research is presented and discussed below.

Key Findings

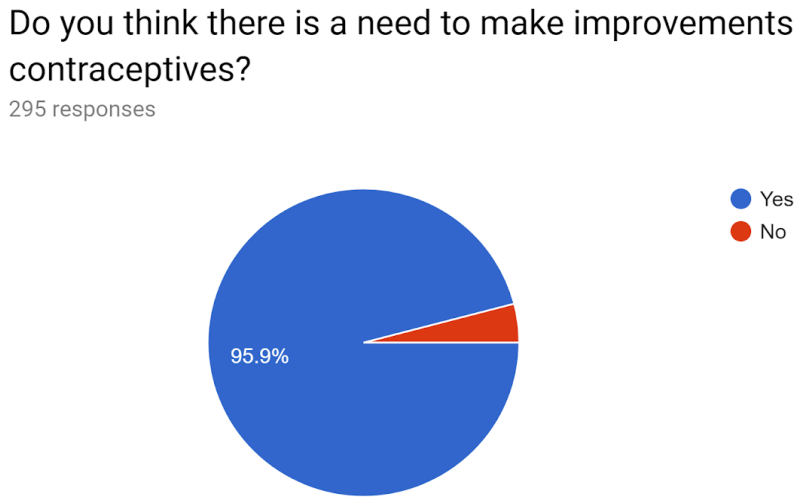

Figure 1: Responses of 295 participants to our online scope survey taken between 21/01 and 27/01/2019

Figure 1 demonstrates that 95.9% of the 295 respondents in our online scope survey who answered this question believed that there should be improvements made involving contraception in Scotland. Our research group has worked over the past six months to identify the current issues faced by the female population when receiving contraceptive education and care in Scotland and propose policy recommendations to reform contraceptive structures in an attempt to make them more comfortable, informative and positive for individuals receiving such care.

A key finding throughout is the importance of perceived side effects regarding contraceptive method satisfaction. We have found through literature review, a scope survey and communicating with women in Edinburgh that there is a deep frustration at the lack of care or attention to reports of side effects by medical practitioners. We propose that to reform such experiences there must be an uptake of contraceptive side effect research in the medical field as well as comprehensive guidelines for medical practitioners within the NHS to better handle side effects reports.

Through understanding side effects and enhancing contraceptive medical in Scotland, we argue there is a need for policy reform by medical professionals.

Through extensively researching charity and regulatory bodies related to contraception within the UK, we have found a vast array of research offering guidelines in the creation of satisfactory contraceptive care in medicine, however, the majority of these guidelines have not yet been adopted by the NHS or taught in degree programmes for general practitioners in training. We argue that there must be a national framework which implements guidelines dedicated to comprehensive contraceptive care by bodies such as those offered by NICE (see appendix A) across all healthcare institutions and spaces within the country in the creation of complete contraceptive care for all.

We have also found that for the creation of an informed population there must be reform within education on contraceptive matters. The TIE campaign demonstrates how sex education can be reformed to be more inclusive and fitting for the needs of modern Scotland, through the success of their campaign to include LGBTQ studies in the Scottish curriculum (Brooks, 2018). We argue, in the creation of comprehensive contraceptive care in Scotland there must also be the creation of a national framework which teaches the young people of Scotland about their contraceptive choices and talks openly about issues such as side effects. For the creation of exemplary contraceptive care in Scotland there must also be adequate educational resources in place.

Below, our key findings are discussed more thoroughly and divided into three sections: side effects, healthcare, and education.

Our key findings and discussion read as follows:

1. Side Effects
    - Quote displaying key themes
    - Analysis and statistics correlated on Side Effects

2. Education
    - Quote displaying key themes
    - Analysis and statistics correlated on Education

3. Healthcare
    - Quote displaying key themes
    - Analysis and statistics correlated on Healthcare

"Poorer mental health, weight gain, low self-esteem and bad mood swings, ***completely changed me****"*

(Taken from on our scope survey, 2019, experience on combined pill, emphasis added)

Analysis on Side Effects

A myriad of non-discountable issues exist surrounding contraceptive side effects, including the high discontinuation rates of contraception, the lack of substantive research done on side effects, and the problems addressing them. It is important to clarify that there is no proven causal relation between taking hormonal contraception and weight gain, although it has been linked to worsened mental health (Skovlund et al., 2016 & FSRH Guideline: CHC, 2019; p42). However, our scope survey found that 27.3% of respondents listed weight gain as a physical side effect of contraception, illustrating the dichotomy between medical research and lived experience. This section will illustrate these issues surrounding the extensiveness and legitimisation of side effects and how we propose to amend this.

Vitzthum and Ringheim's study on Bolivian contraception found that "side effects, whether experienced or perceived, are central to the acceptability, use, and continuation of hormonal contraceptives" (2005; 13). This research indicates that continued use of hormonal contraception is related to individual emotional experience of use of each contraceptive. Complementing this research, Lindh et al. have found an increase in women choosing to discontinue hormonal contraception due to perceived side effects such as worsened mental health and weight gain (Lindh et al., 2016). With both studies finding a clear relation between negative side effects of contraception and women choosing to discontinue contraceptive use, it is clear that this is a major public health issue internationally, including in Scotland. The NHS Lothian Joint Formulary demonstrates Scotland's current challenge through citing high discontinuation rates of contraception among women as a continuing issue especially as "many women change to a less effective (contraceptive) method" (NHS Lothian, 2011).

Vitzthum and Ringheim's (2005) study displays a cause and effect relation between women discontinuing contraception and having unplanned pregnancies. Unplanned pregnancies (specifically within the teenage population) are a major health concern within Scotland as displayed in the 2015 Scottish Parliament report; we argue that through addressing contraceptive discontinuation rates and side effects associated with current contraception models, unplanned pregnancies in Scotland can be decreased.

The primary reason we have identified for the aforementioned discontinuation rates which can result in unplanned pregnancies are clearly side effects of contraception. In '*Young women's experiences of side-effects from contraceptive implants: a challenge to bodily control*', an article that discusses a qualitative study of 20 women on LARC, Hoggart and Newton address the side effects some women felt they had on the contraceptive implant: "As anticipated, bleeding was the most likely (10 cases). Others were: mood swings and changes

(including depression, crying, being emotional) (9), weight gain (9), acne (5), anaemia (3), headaches (3), stomach pains (2), discomfort at the insertion site (2), thinning hair (1), amenorrhoea (1) and increased thirst (1)." (Hoggart and Newton, 2013; 198). They also note that many of the participants in their study did not only experience one type of side effect but several. Hoggart and Newton attribute discontinuation rates amongst women in their study due to a feeling of loss of control over one's own body because of contraceptive side effects (ibid).

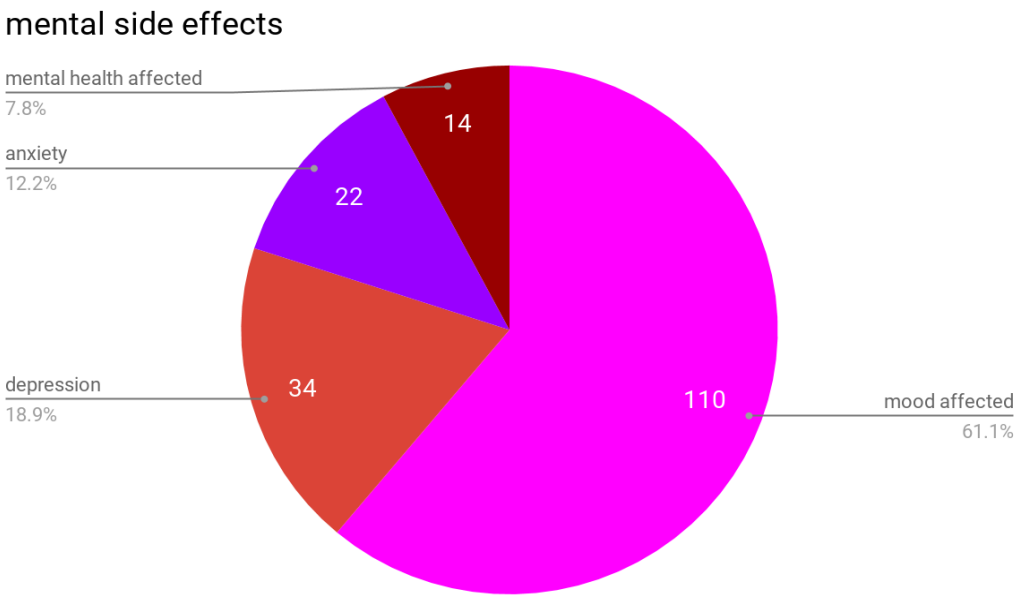

Figure 2: responses from online scope survey, response numbers lie within the segments

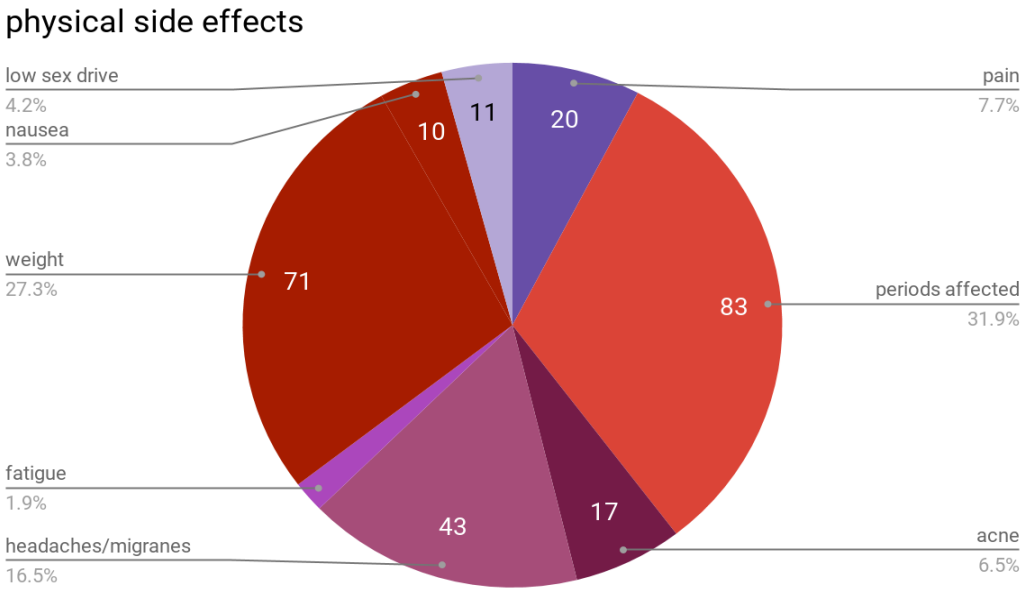

Figure 3: responses from online scope survey, response numbers lie within the segments

Figures 2 and 3 (above) demonstrate that the respondents of our scope survey often identified similar side effects of contraception as some of those addressed by Hoggart and Newton which indicates these issues are also reflected in current Scottish society. This finding is exacerbated by newspaper and magazine articles (demonstrated by Spratt, 2017 & Winter, 2017) that focus on women's personal negative experiences on hormonal contraception.

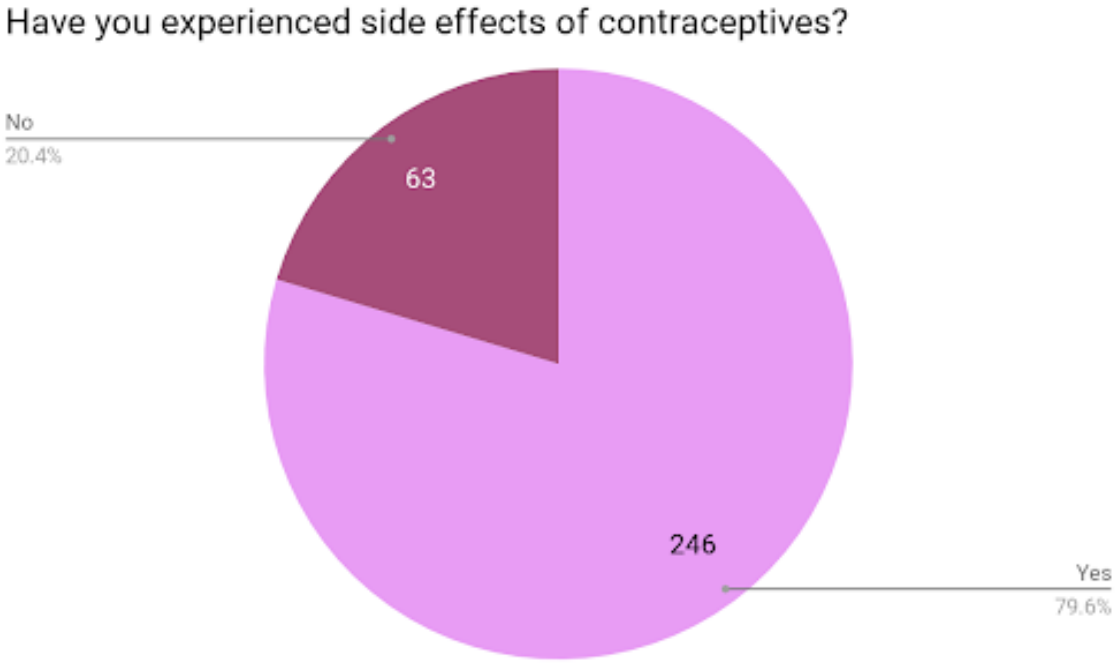

Figure 4: responses from online scope survey, response numbers lie within the segments

Furthermore, there is a continual disconnect between women and GPs throughout the process of first selecting contraception and then adapting to it. This disconnect is problematic for women who feel their side effects reports are not being legitimised. Our scope survey showed nearly 80% of respondents felt they had experienced side effects of contraception (see Figure 4). As there is little empirical scientific evidence on these side effects women often do not receive the care or consideration, they feel they deserve when making contraception choices. Spratt argues women find it immensely frustrating when they feel like their pain is not being heard or addressed by their doctor; a woman in the study reported feeling dismissed by her GP when talking about how she had been affected by contraception (Spratt, 2017). We argue that there is a clear disconnect between individuals seeking contraceptive care and medical professionals in the UK, in the consideration of side effects. When reforming contraceptive care, this policy brief argues, there must be more medical research into the side effects of contraception, so that the disconnect between doctors and patients can be bridged and side effects can be addressed in a more comprehensive manner. Below we discuss further the relationship of medical care and contraception in the current Scottish climate.

"The way GPs (especially male) talk to young females about it. I was left very ***uncomfortable*** *and* ***judged*** *after an appointment with a senior male doctor who, aside from education, has no real-life experience of how contraceptives can affect women."*

(Taken from our scope survey, 2019, emphasis added)

Analysis on Healthcare

The accessibility of adequate, non-judgemental healthcare provisions for contraception has been highlighted as a key issue for women in Scotland. To illustrate this, a series of focus groups held with Scottish women found that participants found it difficult to initiate discussions about contraception with healthcare professionals. When discussions did occur, the information they received about contraception and their choices surrounding it was limited as many reported being simply "given what they asked for" (Glasier, Scorer & Bigrigg, 2008: p215). There was a tendency to choose what their peers were using rather than being engaged in an informative conversation with their GP about a wider selection of options (Glasie, Scorer & Bigrigg, 2008: p215). All the women that Glasie and colleagues heard from cited the necessity of improving the skills of those administering contraception as well as their desire for more information, choice, and a non-judgemental landscape to discuss options openly.

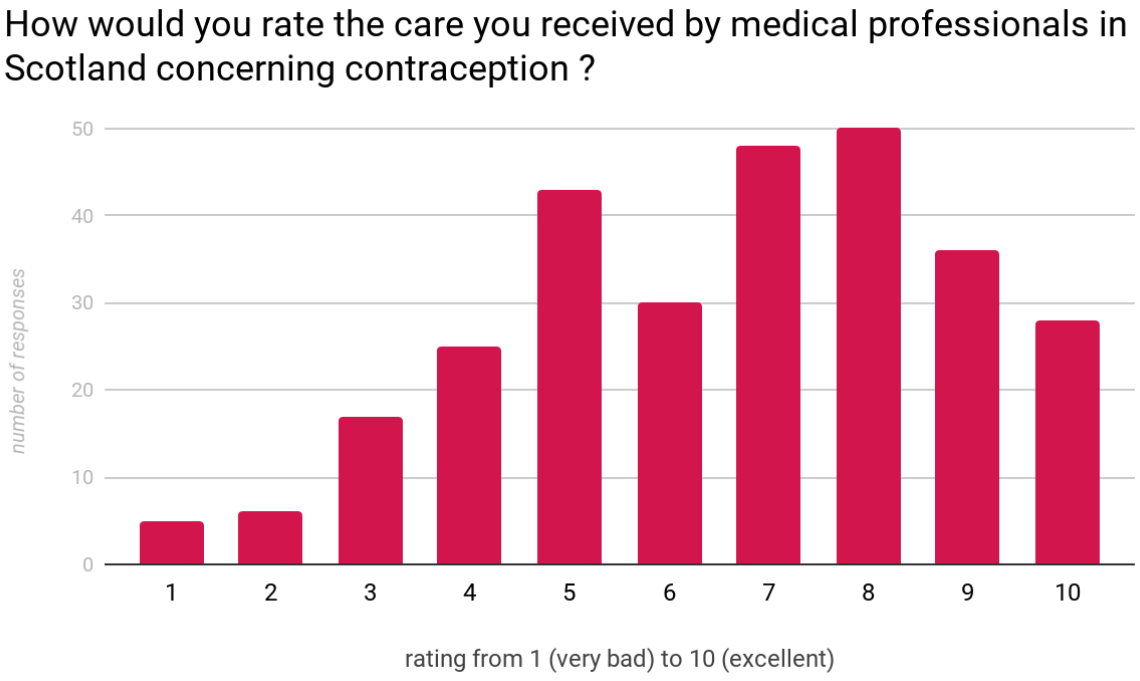

Figure 5: responses from online scope survey detailing opinion of medical held by participants, note 33.3% voted less than 6.

Anecdotally, our survey indicates that women in Scotland hold mixed views regarding the contraceptive care they have received from Scottish medical professionals. As Figure 5 demonstrates, 66.7% of the 288 respondents to this

question in our scope survey would rate contraceptive care as 6 or above on an opinion scale of 1 to 10. However, the remaining 33.3%, which accounted for 96 women overall, were less satisfied with the care they received. While this suggests that many were reportedly satisfied with medical professionals in Scotland, a significant proportion were not, which attests to the demand for universally bettered care. This is possibly attributable to the differences in GP and specialist care across regions.

The National Institute for Health and Care Excellence (NICE) advocate that health professionals (including pharmacists) who advise young people about contraception should be competent to help them compare the risks and benefits of the different methods, according to their needs and circumstances (2019). This extends to aiding understanding and management of any common side effects associated with contraception (NICE, 2019). This would contribute to creating an environment where women have the agency to make informed choices on contraception, rendering many issues experienced by women largely avoidable. The wider issue of limited agency to the institutional barrier to removal is indicated by the Hoggart and Newton study regarding side effects of contraceptive implants, where about a third of participants faced resistance when they asked for their implant to be removed following negative side effects (Hoggart & Newton, 2013).

In line with healthcare dissatisfaction, a lack of expansive information and recognition for side effects by general practitioners creates further issues in part due to a lack of comprehensive guidelines for GPs to follow when confronted with these cases. According to Sexual Health Scotland (2019), the Scottish Government advises people to visit a GP if they are experiencing adverse side effects. The already stated structural barriers to having open discussions on contraceptive issues exacerbate this problem, which stem in part from the lack of robust, scientific research into the correlation between mental health and contraception. One key issue is the tendency of doctors to prescribe antidepressants in place of considering that the form of contraception of individuals may be a contributing factor (Winter, 2017). This trend,

we argue, can be reformed through more extensive research into contraceptive side effects by the medical realm.

As with any faction of healthcare, there are issues regarding time, money and resources when enacting positive change. There are a number of charities which look at social issues surrounding contraception. For example, it has been advised by the FSRH Clinical Effectiveness Unit that, whenever possible, young people should be allowed as much time as they need during contraception consultations (2010). The time individuals have within consultations, however, is often impacted by the availability of healthcare resources, access to resources varies regionally within Scotland, thus the experiences of accessing contraceptive services varies greatly. For equality in contraceptive care there must be the creation of national guidelines to minimise regional disparities in accessing resources and support.

A further point to note regarding healthcare is that, particularly in recent years, there has been a wave of discussions relating to a desire for male contraception. Enthusiasm for its introduction was cited by a significant number of our scope survey respondents when asked what they think needs to be improved. Evidence elsewhere suggested that both men and women are increasingly open to the idea of new forms of male contraception. This is particularly prominent due to the association of high failure rates of condoms and difficulties with vasectomies and vasectomy reversal (Chao et al, 2014). Significantly, a trial study of a male contraceptive gel is set to take place in Manchester and Edinburgh involving men aged 18-50 in a stable relationship with a women aged 18-34 (NHS Manchester University, 2019). This is suggestive of possible transformations into the forms of contraception available, with a potential shift in expectations of female responsibility.

However, introducing forms of contraception for males will not fix all the issues discussed in this report. There is the risk that even if men do have access to contraception, the responsibility for safe sex will still remain on women; this is

highlighted by an informant of Newton's 2012 paper who experienced men refusing to wear condoms during sex, thus making the contraceptive choices of women bear full responsibility for the outcomes of sexual intercourse (p198). Although, male contraception may challenge some of these issues, we believe only through active reform within present social, medical and educational structures will real change be achieved.

"Tell girls about the injections and iuds [sic] and implants when you tell them about the pill! Also, real info on how effective the pill is. More info about interaction with other medicines. In schools more (anything) about how contraception can affect sex and pleasure, not just scary stuff about babies"

(Taken from our scope survey, 2019)

Analysis on Education

Social research has demonstrated that women choose the type of contraception they use based on what is deemed acceptable in their social circles (Vitzthum and Ringheim, 2005). The extent of society's influence on a member of the reproductive population's supposed agency surrounding their contraceptive choices raises serious questions as to the efficacy of emphasis on personal responsibility present in many medical conceptualisations of contraception. We contend that society's responsibility lies in sufficiently equipping this population with the knowledge and confidence to choose and manoeuvre between the various forms of contraception. The combination of emancipation of these societal acceptabilities and arming our populace to avoid the issues encountered with contraception begins first and foremost with education of our young people.

The literature concerning contraception is, by and large, concentrated and themed upon health and side effects over education. Figure 6 demonstrates that 16.9% of respondents from our scope survey had begun sexual relations prior to contraceptive education and Figure 7 details that 82.2% respondents felt that their education lacked sufficient breadth sit in contrast to this. These results clearly demonstrate that issues exist within contraceptive education and that, although difficult to compile due to the multitude of accompanying factors, Scotland needs more extensive discussion and research into the best methods of teaching contraception and the issues that arise.

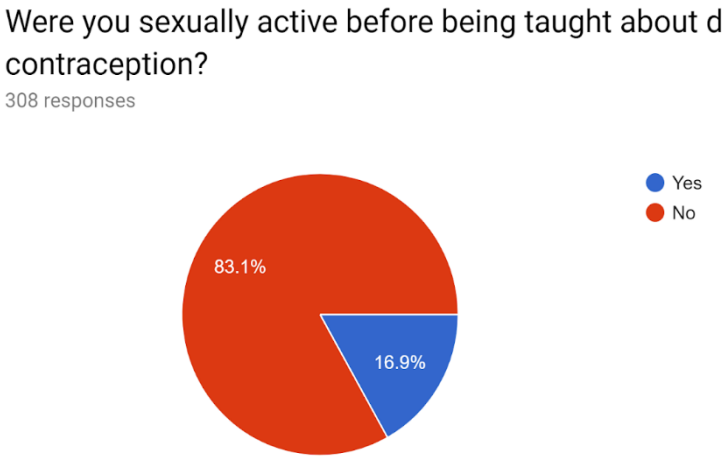

Figure 6: responses from CERT Scope Survey, 2019

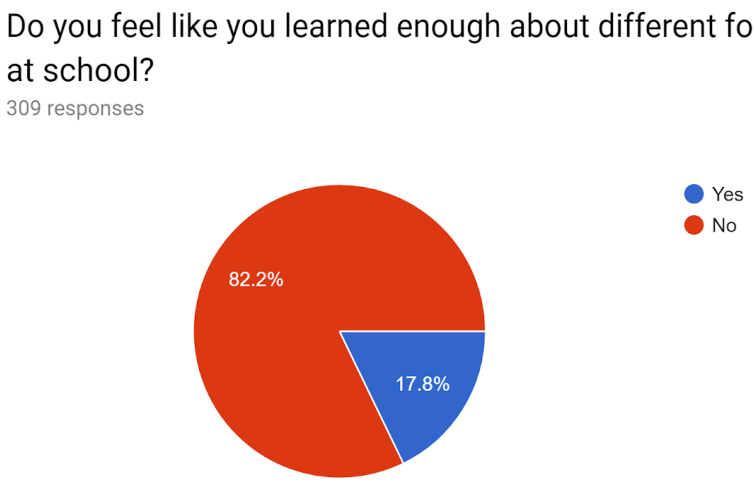

Figure 7: responses from CERT Scope Survey 2019

The vast importance of sexual education in schools, specifically regarding contraception considering levels of sexual activity amongst teens, is not to be underestimated. The Scottish education system suffers from massive inconsistencies in the application of the guidelines of sexual health. Lessons can vary between being taught by specialists from charities such as Brook in Edinburgh to being taught by non-specialist teachers within schools. While it is possible that teachers provide exemplary education on contraception, many are not sufficiently equipped from an information perspective or simply not confident talking to students they teach maths to about more intimate subjects. These disparities are highlighted by the concerns of sexual healthcare professional Eric Chen; "Teachers not always entirely comfortable to talk about certain issues. Also, a problem of resources i.e. some schools have an entire team dedicated to PSE, others do not." (Taken from interview with Eric Chen, 2019).

Beyond variation in teaching, the course structures themselves vary. As sexual health is non-examined subject matter, it is difficult to precisely ascertain the extent of consistency in the application of national frameworks and course structures. Whilst homogeneity of education in a subject so deeply entwined with our varying cultures is not desirable, a level of National framework is still necessary to ensure we are offering a high enough level of contraceptive education to our young people.

Educational consistency and sufficiency extends beyond the creation of an informed populace through our school system to higher education's creation of highly

informed future GPs. Preliminary discussions with medical students and sexual health experts have illustrated a lack of both breadth and depth of education in contraception. Directed education on a variety of contraceptive types promotes comfort in prescribing them to better advise and facilitate a patient's preferences. Ideally, this could be amended with sexual health clinical placements so students become comfortable discussing the variety on offer to patients, but the time pressures of medical training mean this is not a universally realistic solution. Eric Chen indicates the importance of time and resource constraints when reforming education; "constraints on education i.e. training medics to provide all methods," is limited by time and "a lot of external pressure to cover different topics" in medical schools (Taken from interview with Eric Chen, 2019)

We intend to do more research on this matter both amongst medical students at universities across Scotland and amongst the staff and lecturers to better grasp inconsistencies across universities and the kinds of education on offer, as well as collecting ideas on progress they would like to see being made. We argue however that more time and resources are required to ensure our young medical professionals are equipped to deal with the specific demands of contraception care in Scotland.

The challenges that arise from the lack of literature and the time and monetary constraints within teaching do not render reform impossible- just difficult. We do feel that education around contraceptive can change for the better in Scotland with dedicated and focused research and policy reforms. The TIE campaign has demonstrated that sex education can progress and change in Scotland through their work enabling and encouraging the teaching of LGBTQ+ geared sexual health lessons (TIE, 2018). Their approach connecting gatekeepers to produce their goals with the invaluable knowledge of experts in the field is one we wish to emulate particularly as we move forward beyond this first report (TIE, 2018).

Next Steps: Lobbying Gatekeepers

Regarding next steps our think-tank research project is now at the stage of communicating with a vast range of gatekeepers whom we feel can add to our current understandings and help implement our proposed policy reforms. Moving forward, we also wish to create a public discussion around contraceptive care and education in Scotland to allow a space for the reproductive population to highlight their own experiences and have their own ideas for reform listened to. Having completed our primary research and highlighted key policy reforms, our next steps will be launching our research group in the Autumn of 2019 to allow for public uptake of our ideas and the creation of relations with key gatekeepers who are discussed below. As there is a need to implement change in contraceptive care at a local, national and international level we have thus, listed our considerations of institutional gatekeepers in this light.

As we are student researchers at the University of Edinburgh, local in this report refers to the community of Edinburgh. Local institutions who we feel can enact change are; Chalmers Sexual Health Clinic, Edinburgh University Student Association, Edinburgh University Medical School, local places of Education such as SQA syllabus high schools and the local population of reproductive individuals who can use their experiences to inform and detail need for change. Through communicating and working with local gatekeepers, we feel our work can enact real change quickly and comprehensively. For example, if our universities medical training syllabus included detailed and discursive information on contraception it could pave the way for better medical professional understandings of contraception across the community and beyond.

However, as we feel there is a need for a national framework for contraceptive education and healthcare in Scotland there will be a strong focus on engaging national gatekeepers. National gatekeepers include; National Health Service (NHS) Scotland, the Scottish Parliament, the General Medical Council (GMC) and national charities such as Brook. Through working with national gatekeepers, we wish to allow the reform of contraception care in Scotland, to challenge the current disparities and diversities experienced across the country.

There is also a need to consider international gatekeepers such as the Faculty of Sexual and Reproductive Health (FSRH) and the World Health Organisation (WHO). International gatekeepers can provide information on current worldwide research on sexual and reproductive health and also demonstrate case studies of other countries worldwide who have different frameworks in place for the healthcare and education of contraceptive issues.

Through communicating and building relationships with gatekeepers at a local, national and international level, we aim to reform the contraceptive experiences of the reproductive population in Scotland. This reform can be achieved through the creation of national comprehensive frameworks of education and medicine which legitimise frustrating and dis-satisfactory experiences with contraception in Scotland and aims to change them.

Conclusion

The research and discourse in this report aims to shed some light on the slew of contraceptive issues the reproductive population have to cope with. While our report establishes that there is an array of exemplary medical and educational support in contraception, the extent of disparity of access and reception calls for pressing change. In order to meet our objectives – the integration of research by specialist organisations by national stakeholders, expanded access of contraceptive information and education, a more comprehensive syllabus of contraceptive issues for medical students, and further attention given to side effects - we argue for comprehensive reform. Exemplary models of education and care must be perpetuated at a national level.

- We propose that there is a need for the NHS and Medical Regulatory Bodies, such as the MHRA (Medicines & Healthcare products Regulatory Agency) to legitimise experiences of side effects associated with contraception, by producing more medical research on this issue and having sufficient guidelines to address this.

- For a more informed medical practice around contraception in Scotland there is a need for the NHS to universally adopt the guidelines published and advocated by organisations such as the FSRH (Faculty of Sexual and Reproductive Health) within a national framework with the aim of reducing regional disparities.

- Reform at two levels of education is needed to create both an informed populace and better-informed general practitioners. Secondary schools must have access to a national syllabus which provides comprehensive contraceptive information for all. Meanwhile, Universities must reform current curriculums to include specialised and in-depth knowledge on how to provide adequate contraceptive care to all.

This report has been an amalgamation of all our efforts this year focusing on bettering our understanding of the issues that surround contraception through extensive discussion with gatekeepers and the people that it impacts. CERT's 2019 goals centre around the problems raised in these conversations: legitimising the side effects people so often have to contend with, promoting agency of contraceptive choice through a more informed populace and introducing new frameworks in medicine to allow the best contraceptive care for the reproductive population. We

intend to expand our network of interested gatekeepers to together endeavour towards the progress we seek for the reproductive population.

We hope you have enjoyed our report, and, like us, have become inspired to reform contraceptive care and education in the creation of comprehensive and engaged medical and educational practice on women's issues within Scotland.

Glossary of Key Terms

- **Deligitimisation**: Often used in relation to side effects, this refers to instances of limited attention given to the occurrence of undesirable or unexpected side effects as a key issue within contraceptive care.
- **Discontinuation**: The ceasing of contraceptive use, either in favour of another method such as using condoms or using no contraception at all.
- **Hormonal contraception**: Methods of contraception which have a hormonal component such as increasing estrogen levels. These are comprised of emergency contraception, low-dose pills, and long-acting reversible methods such as the intrauterine system (IUS), popularly known as 'the coil', and the implant.
- **Non-hormonal Contraception**: Methods of contraception which have no hormonal component. These include condoms and the intrauterine device (IUD), popularly known as 'the copper coil'.
- **Regulatory Institutions**: Professional bodies which oversee and moderate policy, practices and provisions within the area of contraception and contraceptive health.
- **Reproductive Health**: This refers to the health of one's reproductive system in all related areas, including the able to access accurate and appropriate contraceptive care and services.
- **Reproductive population**: All individuals with the ability to give birth to a child, such as having a reproductive system.
- **Vasectomy**: The technical term used to describe a medical procedure wherein sterilisation occurs.

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Appendices

Appendix A: Long-Acting Reversible Contraception Clinical Guidelines (CG30)

Appendix A:

1.1 Contraception and principles of care

1.1.1 Contraceptive provision:

1.1.1.1 Women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods. [2005]

1.1.1.2 Women should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated. [2005]

1.1.1.3 Contraceptive service providers should be aware that:

- all currently available LARC methods (intrauterine devices [IUDs], the intrauterine system [IUS], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use
- IUDs, the IUS and implants are more cost effective than the injectable contraceptives
- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies. [2005]

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- increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies. [2005]

1.1.2 Provision of information and informed choice

1.1.2.1 Women considering LARC methods should receive detailed information – both verbal and written – that will enable them to choose a method and use it effectively. This information should take into consideration their individual needs and should include:

- contraceptive efficacy
- duration of use
- risks and possible side effects
- non-contraceptive benefits
- the procedure for initiation and removal/discontinuation
- when to seek help while using the method. [2005]

Appendix A summarises information about LARC methods that should be discussed with women.

1.1.2.2 Counselling about contraception should be sensitive to cultural differences and religious beliefs. [2005]

1.1.2.3 Healthcare professionals should have access to trained interpreters for women who are not English speaking, and to advocates for women with sensory impairments or learning disabilities. [2005]

1.1.3 Contraceptive prescribing

1.1.3.1 A medical history – including relevant family, menstrual, contraceptive and sexual history – should be taken as part of the routine assessment of medical eligibility for individual contraceptive methods. [2005]

1.1.3.2 Healthcare professionals helping women to make contraceptive choices should be familiar with nationally agreed guidance on medical eligibility and recommendations for contraceptive use. [2005]

1.1.3.3 When considering choice of LARC methods for specific groups of women and women with medical conditions, healthcare professionals should be aware of and discuss with each woman any issues that might affect her choice (see sections 1.2, 1.3, 1.4 and 1.5 and appendix A). [2005]

1.1.3.4 Healthcare professionals should exclude pregnancy by taking menstrual and sexual history before initiating any contraceptive methods. [2005]
1.1.3.5 Healthcare professionals should supply an interim method of contraception at first appointment if required. [2005]
1.1.3.6 Healthcare professionals should ensure that informed consent is obtained from the woman whenever any method of LARC is being used outside the terms of the UK Marketing Authorisation. This should be discussed and documented in the notes. [2005]
1.1.3.7 Women who have a current venous thromboembolism (VTE) and need hormonal contraception while having treatment for the VTE should be referred to a specialist in contraceptive care. [2005]

1.1.4 Contraception and sexually transmitted infection

1.1.4.1 Healthcare professionals providing contraceptive advice should promote safer sex. [2005]
1.1.4.2 Healthcare professionals providing contraceptive advice should be able to assess risk for sexually transmitted infections (STIs) and advise testing when appropriate. [2005]
1.1.4.3 Healthcare professionals should be able to provide information about local services for STI screening, investigation and treatment. [2005]

1.1.5 Contraception for special groups

1.1.5.1 Healthcare professionals should be aware of the law relating to the provision of advice and contraception for young people and for people with learning disabilities. Child protection issues and the Fraser guidelines should be considered when providing contraception for women younger than 16 years[1]. [2005]
1.1.5.2 Women with learning and/or physical disabilities should be supported in making their own decisions about contraception. [2005]
1.1.5.3 Contraception should be seen in terms of the needs of the individual rather than in terms of relieving the anxieties of carers or relatives. [2005]
1.1.5.4 When a woman with a learning disability is unable to understand and take responsibility for decisions about contraception, carers and other involved parties should meet to address issues around the woman's contraceptive need and to establish a care plan. [2005]

1.1.6 Training of healthcare professionals in contraceptive care

1.1.6.1 Healthcare professionals advising women about contraceptive choices should be competent to:

- help women to consider and compare the risks and benefits of all methods relevant to their individual needs
- manage common side effects and problems. [2005]

1.1.6.2 Contraceptive service providers who do not provide LARC in their practice or service should have an agreed mechanism in place for referring women for LARC. [2005]

1.1.6.3 Healthcare professionals providing intrauterine or subdermal contraceptives should receive training to develop and maintain the relevant skills to provide these methods. [2005]

1.1.6.4 IUDs and the IUS should only be fitted by trained personnel with continuing experience of inserting at least one IUD or one IUS a month. [2005]

1.1.6.5 Contraceptive implants should be inserted and removed only by healthcare professionals trained in the procedure. [2005]

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