

# **Evaluation of Oral Contraception in Community Pharmacy Pilot in Southwark and Lambeth**

## **Final Evaluation Report**

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### **Oral Contraception in Community Pharmacy**

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## Executive summary

### *Background*

Teenage pregnancy is associated with poor social, economic and health outcomes for both mother and child and costs the National Health Service an estimated £63m a year. Many teenage pregnancies are unplanned, and in England in 2009 49% ended in termination. Improving access to contraception can contribute to a reduction in unintended pregnancies. Southwark and Lambeth have some of the highest teenage conception rates in Europe, and the highest in London. The teenage pregnancy termination rates in Southwark and Lambeth are higher than the UK: 66% and 60%, indicating that a high proportion of pregnancies are unintended.

### *Development of the pilot*

Community pharmacy has provided free emergency contraception (EC) since 2001, and local research found that Southwark and Lambeth service users wanted more information about contraceptive methods when receiving EC in pharmacies. Therefore, and in order to widen access to contraception, Lambeth and Southwark piloted an oral contraceptive service in community pharmacy. Pharmacists completed an MSc module at King's College London in Oral Hormonal Contraceptive Services and worked through a patient group direction (PGD) to provide combined oral contraceptives, progesterone only pills and information on and referral to long-acting reversible contraception (LARC) to women aged 16 and over.

### *Service provision*

Five pharmacies provided the service in Southwark and Lambeth. In the first 21 months 741 contraception consultations took place. The majority of these resulted in an initial supply of the pill (n=512); 181 in a subsequent pill supply, 36 in a general referral, 9 in a referral for LARC and 3 in an under-16 referral. 46.1% (n=236) of initial pill supplies were to women who had not previously used the pill. Most consultations (92.2%, n=675) were with clients aged 30 years or under, 66.1% (n=484) were with clients under 25 and 22.5% (n=165) were with those 19 years or under. The largest proportion of consultations (54.1%, n=324) were with black or black British clients; 32.2% (n=193) were with white clients; 35 (5.8%) were with clients from mixed ethnic groups; 21 (3.5%) were with Asian or British Asian clients; and 23 (4.3%) were with Chinese clients or those from another ethnic group. Nearly all clients were resident in Southwark or Lambeth (97.1%). A clinical notes audit showed pharmacists adhered to the PGD, made appropriate referrals and have provided a high quality contraceptive service.

### *Service user evaluation*

Questionnaires and a focus group showed that, overall, service users were happy with the service they received. Most of those who completed the questionnaires (96.9%, n=93) were very satisfied or satisfied with the service they had received, and all those who were asked (n=68) said they would recommend the service to a friend. Focus group participants were also happy with the service and in particular liked the convenience, as there was no need to make an appointment, they didn't have to wait long and the pharmacy felt local to them.

During evaluation, all mystery shoppers thought the service was a good idea and most would recommend the pharmacy they visited (81.3%). Assessments of the three pharmacies varied, but overall mystery shoppers were satisfied with the clinical service provided. However, information from counter staff about the service could be improved, and it was sometimes difficult to obtain an immediate consultation.

### *Impact*

EC provision in the pharmacy that provided the most contraception consultations dropped significantly in the year following introduction of oral contraception ( $p=0.001$ ), which may indicate some service users had switched from EC to oral contraception.

Data indicates that the service is reaching the target group of young, local women, and those who have not previously used oral contraception. Women from black or black British ethnic groups were over-represented and women from white ethnic groups under-represented in the service compared to the local population. Since young black African women are more likely to have a termination than the general population, this suggests we may be reaching those who most need the service.

### *Conclusions*

- Trained community pharmacists are able to provide an oral contraceptive service under a PGD.
- The service has been largely accessed by local women aged 20-24 years. Most consultations have been with black British, Caribbean and African women, and 46% of initial pill supplies have been to first time pill users.
- A large proportion of clients do not return for a subsequent pill supply. The main reason given for this is that the client has gone back to using EC or condoms, largely because they do not have a regular partner.
- Service users have valued the service highly, in particular the convenience, anonymity, drop-in system, long opening hours and lack of waiting time. Possible improvements could be made to accessing the service and signposting from counter staff.
- EC has declined in the pharmacy providing the most oral contraception.
- Local GP practices and sexual and reproductive health services have referred clients to the service, and therefore opened up the possibility of a future service model aiming to shift activity from GP and SRH services.

### *Recommendations*

- Consider expanding this service to appropriate pharmacies in Lambeth and Southwark, across London and nationally, in order to capitalise on shifting activity out of GP practices and sexual and reproductive health services, therefore freeing up these services to work with clients with more complex needs.
- Future training should be carefully considered in terms of sustainability, ensuring it is in line with training for other primary care professionals.
- Consider providing the service to women under 16 years where appropriate. This may help contribute to a reduction in teenage pregnancies.
- Before undertaking training, pharmacists should shadow a current pharmacist providing oral contraception to ensure they have a good understanding of the logistics of providing the service and are confident it is feasible in their pharmacy.
- Further work to improve patient pathways, signposting and referrals between all contraceptive services, including community pharmacy, is carried out.
- High quality, nationalised training in enhanced contraceptive counselling skills is developed and offered to all pharmacists in order to maximise on all opportunities to talk to young women about their contraceptive needs.
- Further research is conducted into individual patient pathways, contraceptive use and experiences, including a further mystery shopping evaluation of pharmacy contraceptive services.

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## 1. BACKGROUND AND METHODOLOGY

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### 1.1 Background

#### 1.1.1 National context

In the UK half of pregnancies are unplanned and a quarter end in termination<sup>i</sup>. This figure is higher for teenagers: in 2009 49% of teenage pregnancies ended in termination<sup>ii</sup>. Although pregnancy in young women is not biologically harmful, having children in adolescence is associated with poor social, economic and health outcomes for both mother and child<sup>iii</sup> and costs the National Health Service an estimated £63m a year<sup>iv</sup>. It is recognised that improving access to contraception can contribute to a reduction in unintended pregnancies<sup>v</sup>, and comparative studies suggest that this has been a factor contributing to lower teenage conception rates in some European countries<sup>vi</sup>.

The government has focused on preventing unintended teenage pregnancies through the National Teenage Pregnancy Strategy (DfES, 1999), National Strategy for Sexual Health and HIV (DH, 2001) and NICE guidance on long acting reversible contraception (LARC) (NICE, 2005). Recent government policy has focused on improving access to all methods of contraception, providing contraception education and information, and in particular the promotion of LARC.

It is widely accepted that community pharmacy has a key role to play in the provision of health services. Emergency contraception (EC) has been available in community pharmacies in the UK since 2001. Evidence shows that EC services in community pharmacy are good quality and increase contraceptive access for service users<sup>vii</sup>. Pharmacies often have longer and more consistent opening hours than general practice or sexual and reproductive health services (SRH), and do not require an appointment or a potential long wait.

Since the inception of this pilot, further government papers outlining the expanding role of pharmacy have been released, including the NHS White paper, 'Equity and Excellence: Liberating the NHS' and 'Healthy Lives, Healthy People: Our strategy for public health in England', which emphasises the role of pharmacy in public health.

#### 1.1.2 Local context

The London boroughs of Southwark and Lambeth have some of the highest teenage conception rates in Europe, and the highest rates in London: 63.2 and 59.5 per 1000 female population aged 15-17 respectively (DfE, 2011). In addition, in 2009 66% of teenage pregnancies in Southwark and 60% in Lambeth led to terminations, indicating the high proportion of teenage pregnancies that are unintended. In 2005 there were an estimated 16,693 young women aged 15-24 in Southwark. In this age group nearly half of the population was white British, and nearly a quarter black African or Caribbean<sup>viii</sup>. Conception rates were higher in Black Caribbean, Black African and mixed race groups, and 74% of Black African teenage pregnancies end in abortion. The highest termination rate is amongst 18-19 year olds, and 33% of those under 25 in South East London have had a repeat termination<sup>ix</sup>.

In 2008-9, 7441 EC consultations took place in Southwark community pharmacies, and local research reported that service users wanted more information about contraceptive methods when receiving EC in pharmacies<sup>x</sup>. Providing these service users with information on all methods of contraception, as well as immediate access to oral contraception may contribute to a reduction in unintended pregnancies and enable contraception to be accessed by service users who would not otherwise access it.

## 1.2 Development of the pilot

### 1.2.1 Aims of the pilot

In 2007 Southwark and Lambeth Primary Care Trusts (PCTs) together with the Modernisation Initiative identified the potential of community pharmacy to provide oral contraception. The pilot received funding initially from Guys and St Thomas' Charity through the Modernisation Initiative, and later by the Department of Health through NHS London. The objectives of the pilot were:

- To design and develop a nationally accredited training for pharmacists to provide a high quality contraceptive service, contributing to the development of a skilled multi-disciplinary, multi-agency workforce to deliver sexual health services
- To provide oral contraception in community pharmacy under a patient group direction (PGD), as well as effective signposting and referral to other contraceptive and sexual health services
- To build capability and capacity within other London PCTs to further develop contraceptive services in community pharmacy

The expected outcomes of the pilot were:

- A contribution to a reduction in unintended pregnancies
- An increase in access to oral contraception and LARC
- A decrease in EC uptake
- An increase in oral contraceptive and LARC uptake

### 1.2.2 Patient group direction

A steering group was established with relevant stakeholders and a PGD developed for the supply of oral contraception without prescription by community pharmacists, which was finalised in July 2009. The PGD enabled qualified pharmacists to provide initial and subsequent supplies of 14 types of combined oral contraceptives (COCs) and 4 types of progesterone only pills (POPs) to women aged 16 years and over.

### 1.2.3 Development of training

A partnership was established with the Department of Pharmacy and Florence Nightingale School of Nursing and Midwifery at King's College London (KCL) and a 15 credit MSc module developed in Oral Hormonal Contraception Services. This course involved 5 days of lectures and clinical assessment skills, 3 CPPE distance learning modules (Contraception, Child Protection and Emergency Hormonal Contraception), 20 hours' clinical placement at a sexual health service under supervision of a nurse or doctor mentor, and submission of a portfolio.

### 1.2.4 Pharmacy recruitment

Expressions of interest were invited from pharmacies in Southwark and Lambeth, and initially two Lambeth and two Southwark pharmacies were identified and chosen to provide the service. The pharmacies were chosen on account of a minimum of two years' provision of sexual health services, high EC provision and their location in areas of high teenage pregnancy. Two pharmacists per pharmacy were required to be trained in order that the service could be adequately covered. This did not exclude pharmacies with a single pharmacist, as long as another pharmacist was trained in order to cover absences.

### 1.2.5 Pilot costs

The pilot was awarded funding from the Modernisation Initiative and NHS London. Approximate costs of the pilot are detailed in Table 1.

**TABLE 1**  
**Approximate costs of oral contraception in pharmacy pilot**

Item	Cost per unit	Unit type	Total cost
Project Management	£36,000	Per annum	£72,000
Pharmacy training (including start-up costs)	£4,000	Per pharmacist	£156,000*
Pharmacy pilot payment (< 150 consultations)	£1,000	Per pharmacy per quarter	£10,000
Advertising and information-sharing	£6,000	Overall	£6,000
Evaluation	£1,000	Overall	£1,000
Other / management / training / small studies	£10,000	Overall	£18,000
<b>TOTAL APPROXIMATE COSTS</b>			<b>£263,000</b>

\*This includes costs for pharmacists from five PCTs across London

Pharmacists were initially paid an indicative rate based on an estimation of consultations conducted, time, set-up costs and participation in evaluation. After the first year of the pilot (October 2010) or after conducting 150 consultations, pharmacists were paid a fee for each consultation. The current cost per contraceptive consultation is detailed in Table 2. The service was mainstreamed as an enhanced service in April 2011.

**TABLE 2**  
**Oral contraception consultation in community pharmacy consultation costs (as of January 2012)**

Item	Cost
Initial contraception consultation where pill is supplied	£20 (excluding drug cost)
Subsequent contraception consultation where pill is supplied	£7 (excluding drug cost)
Contraception consultation with no supply of pill	£10
Pill supply	cost of pill plus VAT

### 1.3 Data collection and evaluation methodology

#### 1.3.1 Pre-service focus groups

Three focus groups were conducted with local residents between August and October 2009 in order to ascertain levels of knowledge of contraception, acceptable places to access contraception, acceptability of proposed service and suggestions for marketing and advertising.

#### 1.3.2 Training evaluation

Evaluation forms were given to pharmacists and clinical mentors after the first course (July 2009) in order to assess the quality and appropriateness of the training.

#### 1.3.3 Service data collection

In order to evaluate the outcomes of the service, participating pharmacies submitted monthly data on the number and type of consultations, types of pills supplied, whether it was an initial or subsequent supply (client returning for a further pill supply) and the route of access. This report details the data collected between October 2009 and June 2011. Data was collected for the first 12 months from the first three pharmacies offering the service on the duration of the consultation. Data on ethnicity was compared to ONS local population data<sup>xi</sup>.

#### 1.3.4 Clinical notes audit

A clinical notes audit was conducted by Southwark sexual health consultants in August 2010 in the pharmacy where most consultations had taken place. 180 randomly selected client notes taken between October 2009 and August 2010 were assessed in order to confirm pharmacists' adherence to the PGD and appropriate referring.



### *1.3.5 Service user questionnaires*

Self-completed anonymous structured questionnaires including Likert scales were given to clients during consultations between November 2009 and June 2010 at the first three pharmacies offering the service. Questionnaires assessed client satisfaction and further data on individual contraceptive service use and were returned to the pharmacist for collection by the PCT.

### *1.3.6 'Mystery shopper' visits*

'Mystery shopper' visits using seven young women aged 16-18 years recruited from Southwark Youth Council were conducted in the first three pharmacies offering the service between April and May 2010. The methodology outlined in *Mystery Shopping in Sexual Health: A Toolkit for Delivery* (Baraitser et al., 2008) was adapted for use in this study. Five aspects of the oral contraception service were assessed: advertising, confidentiality and helpfulness of counter staff, ease of obtaining a consultation, quality of consultation and patient satisfaction.

### *1.3.7 Service user focus group*

Participating pharmacists recruited service users to a focus group, the aim of which was to gain feedback on their experiences of the service, and determine their views on accessing contraception from a range of services.

### *1.3.8 Contraception refusal*

Data was collected from the first two pharmacies providing the service between April and July 2010 on why EC users refused a further contraceptive consultation. Service users were asked why they were not interested in contraception; results were recorded by the pharmacist and given to the PCT.

### *1.3.9 Subsequent pill supply follow-up*

In December 2010, the pharmacy where the most contraceptive consultations were conducted contacted 125 service users who had been given an initial pill supply (64 by text message and 61 by phone) in order to ascertain reasons why service users did not return for subsequent supplies.

### *1.3.10 LARC referrals*

Following a training session on oral contraception and LARC, between June and September 2011 all pharmacies providing sexual health services in Southwark were asked to offer specific LARC referrals to all EC service users. Patient data was then checked against local sexual health service records to ascertain if any of those referred had attended the service during the three month period.

### *1.3.11 EC reduction*

EC provision taken from monthly monitoring forms submitted by community pharmacies was assessed in the pharmacies providing contraception and in pharmacies across the two boroughs.

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## **2. OUTCOMES**

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### **2.1 Training**

#### *2.1.1 Completion of training course*

To date, three courses have been run at KCL:

- The first course was completed by seven Southwark and Lambeth pharmacists in July 2009.



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- A second course was completed by four Southwark pharmacists as well as seven pharmacists from Croydon and six from City & Hackney PCTs in January 2011.
- A third course was completed by two Southwark and three Lambeth pharmacists, as well as four pharmacists from Croydon and five from Kingston in July 2011.

#### 2.1.2 Training evaluation

Seven pharmacists (100% of those completing the course) and seven clinical mentors (39% of those involved) completed the evaluation forms in July 2009. All of the pharmacists were either fairly or very satisfied with all aspects of the course (other than one pharmacist who was not very satisfied with the resources).

Most (72%) of the pharmacists felt the KCL teaching element of the course was the right length of time, and the remainder (28%) thought it was too long. 57% felt that the allocated self-study time (13.5 hours self-study and 16.5 hours for CPPE modules) was a realistic amount of time, and the remainder (43%) needed more time.

All the pharmacists were fairly or very satisfied with most aspects of the clinical placements. For example, all the pharmacists were very satisfied that what they learned during the clinical placements was relevant to providing the oral contraceptive service. There were mixed views from pharmacists on whether 20 hours of clinical placements was an appropriate length of time. 56% thought that it was appropriate, 28% felt it was not long enough and 16% felt it was too long.

42% of sexual health providers were fairly satisfied and 16% very satisfied with the clinical placement aspect of the training. (The remaining 42% did not answer.) In terms of the length of the clinical placements, views were mixed. 57% did not feel that the times slots (4 hour sessions) were sufficient for the pharmacists to achieve their competencies as per their learning contracts and the remainder thought this was enough time. 42% did not think 20 hours overall was sufficient for the pharmacists to achieve their training objectives, 16% thought it was ok, 26% thought it was too long and 16% did not answer.

#### 2.1.3 Recommendations for future training

In conclusion, the training course was highly rated by both pharmacists and clinical mentors. Pharmacists who have gone on to provide an oral contraception service have continued to emphasise the importance of the clinical placements as preparation for contraceptive counselling. Whilst there were some concerns about the length of the course, including the allocated study time and clinical placements, these varied, and clinical placements are in line with those undertaken by other primary care professionals. The university has adapted the course in response to feedback from participants and has continued to receive very positive feedback from subsequent students.

Using a university-accredited course has enabled pharmacists' knowledge and competencies to be carefully assessed before commencing service provision, which ensures they are capable of providing a high quality clinical service. In addition, it has enabled pharmacists from across London – and in theory, nationally – to obtain the same qualification, facilitating them to run the same quality of service, and has provided training that is in line with that provided to other primary care professionals.

Course costs are shown in Table 3. In order to improve the sustainability of the service it is recommended that the NHS considers how it supports the costs of training, in line with what is provided for other health professionals such as nurses and GPs. It is also

suggested that the training is reviewed by clinical leads, to ensure that the most cost-effective method of clinically preparing pharmacists is being used. E-learning combined with clinical placements or an in-house NHS-based course could also be considered as alternatives.

**TABLE 3**  
**Current approximate costs of training pharmacists to provide oral contraception**

Course fees	£580
Clinical placement	c. £700*
Locum cover for pharmacists	c. 1620
<b>TOTAL</b>	<b>c. £2,900</b>

\* It should be noted that in 2011/12 clinical placement costs were included in the service contract, and therefore not funded by the pilot.

## 2.2 Service provision

### 2.2.1 Participating pharmacies

Between October 2009 and June 2011, five pharmacies in Southwark and Lambeth provided oral contraception, the characteristics of which are outlined in Table 4. Two pharmacists from a large multiple chemist also completed training in January 2011. One trained pharmacist was moved to another branch of the multiple, and the other started service provision in December 2011.

**TABLE 4**  
**Characteristics of pharmacies providing oral contraception between October 2009 and June 2011**

	Pharmacy 1	Pharmacy 2	Pharmacy 3	Pharmacy 4	Pharmacy 5
<b>Type of pharmacy</b>	Small multiple Chemist	Independent Chemist	Independent Chemist	Independent Chemist	Independent Chemist
<b>No. of trained pharmacists</b>	Two	One	One	One	Two
<b>Period of service</b>	Oct. 2009 to present	Oct. 2009 to Sep. 2010	Jan. 2010 to Jun. 2010	Jan. 2011 to present	Jun. 2011 to present
<b>Number of consultations</b>	641	13	18	63	6
<b>Average consultations per month</b>	31	1	3	11	6

The number of consultations provided has varied greatly between pharmacies. The pharmacy that conducted the most contraception consultations has always provided significantly higher numbers of EC than other pharmacies in Southwark and Lambeth, and therefore may have had more opportunity to offer the service. Issues of staff retention or staff being moved to other branches have been a major barrier to providing a consistent oral contraception service, and have resulted in some services ceasing to run. The set-up of the pharmacy and the pharmacist's approach to leaving the counter to conduct the consultation also appears to have influenced the ability of pharmacists to provide the service. Finally, differences in local demographics could have affected the number of consultations pharmacies were able to provide.

### 2.2.2 Consultation data

Contraceptive consultations conducted in all five pharmacies are shown in Table 5. In total, 741 consultations were carried out. The majority of consultations (69.1%, n=512) resulted in an initial supply of contraception. COC was most commonly supplied (724

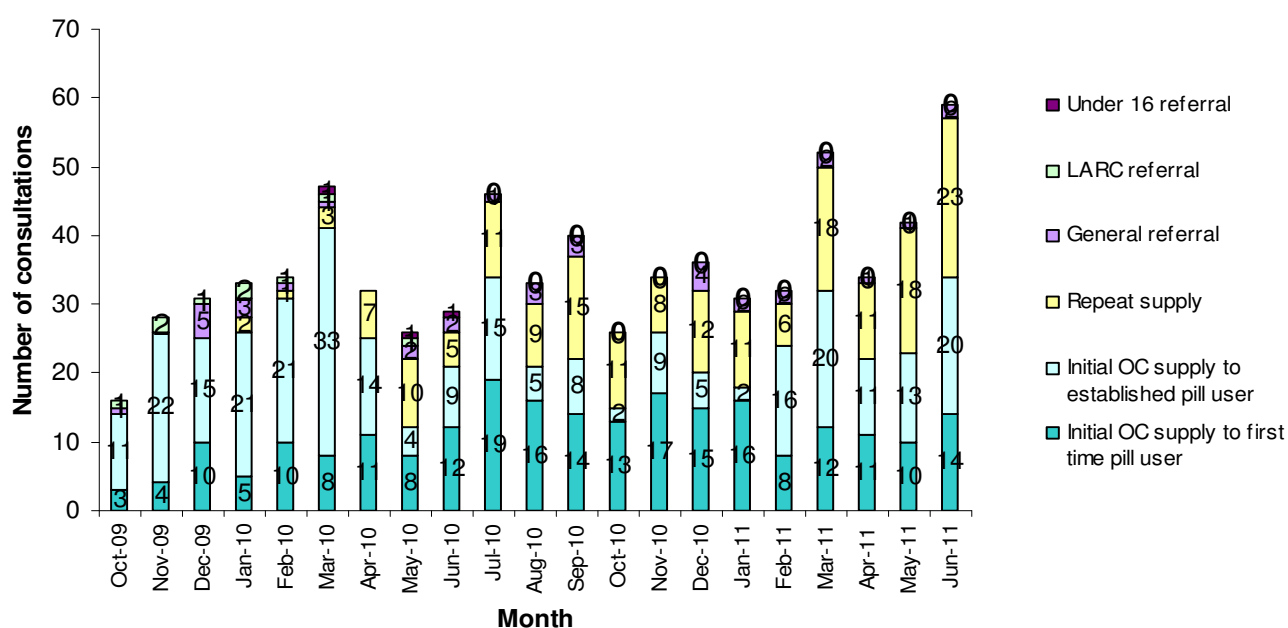
packs), of which Microgynon 30 constituted 65.1% (n=471) of drug supplies. POP was less commonly supplied (196 packs), of which Cerazette constituted 64.3% (n=196) of drug supplies. Nearly half (46.1%, n=236) of initial supplies of pills were to first-time pill users. General referral includes a referral to general practice or sexual and reproductive health clinic for a client who requests oral contraception but is not covered by the PGD, specifically requests a pill that is not covered by the PGD or where the pharmacist has concerns about the supply.

**TABLE 5**  
**Outcomes of contraceptive consultations in all pharmacies between October 2009 and June 2011**

Outcome of consultation	Number	Percentage
Total consultations	741	100.0%
Consultations resulting in initial supply of OC to established pill user	276	37.2%
Consultations resulting in initial supply of OC to first-time pill user	236	31.8%
Consultations resulting in subsequent supply of OC	181	24.4%
Consultations resulting in general referral	36	4.9%
Consultations resulting in LARC referral	9	1.2%
Consultations resulting in under 16 referral	3	0.4%

A breakdown of consultations provided each month is shown in Figure 1. Subsequent pill supplies were only provided in Pharmacies 1 and 4. In the first six months of service, pharmacy 4 provided a higher proportion of subsequent supplies (14.3% of consultations, n=9) compared to Pharmacy 1 (3.5% of consultations, n=6). However, only Pharmacy 1 made any LARC referrals (n=9). It is possible that the local demographic is different (service users were slightly older at Pharmacy 4), the services have been accessed through different routes, or the service provided by the pharmacist has influenced the number of service users returning.

**FIGURE 1**  
**Breakdown of contraceptive consultations in all pharmacies between October 2009 and June 2011**



**2.2.3 Accessing the service**

Data was collected for 81.2% of oral contraception consultations on how service users accessed the service. A large proportion of consultations (40.0%, n=241) had been requested directly by clients. 45.5% (n=274) of consultations had occurred following a

discussion with the pharmacist during provision of EC. General practice, other pharmacies and sexual health clinics had made referrals for 75 (12.5%) consultations, and 12 (2.1%) consultations had occurred as a result of a conversation with the pharmacist when the client attended the pharmacy for a reason other than EC.

A limitation with this data is that it includes those who returned for subsequent pill supplies (n=181), who presumably would have requested the service directly. Therefore, it could be assumed that the actual number of first consultations that happened as a result of a discussion with the pharmacist during an EC consultation is higher than the data indicates. It is also of note that 75 consultations occurred as a result of a referral from another service, including local GP practices. The initial intention of the service was to capture unmet need rather than shift activity out of existing services. However, this is an area for future consideration as it could represent a cost saving and free-up capacity in GP and sexual and reproductive health services to focus on more complex cases.

#### 2.2.4 Service user demographics

Age data was collected for 98.8%, postcode data for 98.0% and ethnicity data for 80.8% of oral contraception consultations.

##### Postcode

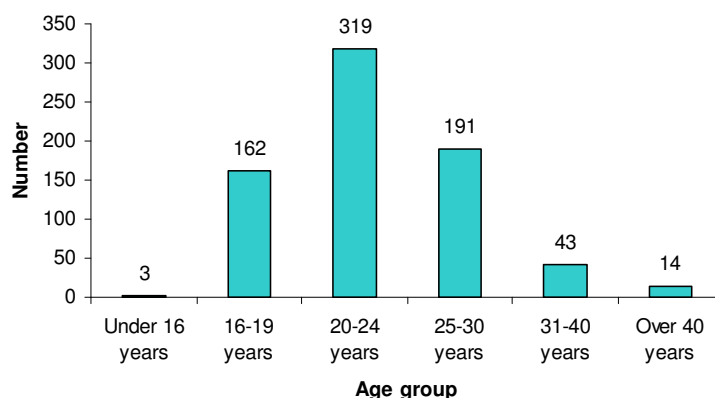
Of data collected, consultations mainly occurred with clients living in Southwark or Lambeth (97.1%, n=705). This indicates that the service is reaching its target group of local women.

##### Age

Age data is shown in Figure 2. Most consultations (92.2%, n=675) were with clients ≤30 years, 66.1% (n=484) were with clients ≤24 and 22.5% (n=165) with those ≤19 years. This indicates that the service is reaching the teenage target group, although the majority of service users (43.6%, n=319) were 20-24 years. The pilot aimed to target women under 25, as they are shown to have high levels of repeat terminations in Lambeth and Southwark<sup>xii</sup>. The service was only provided to women 16 and over, and since the service has been successful with this group, it is worth considering offering the service to women under 16 in the future.

**FIGURE 2**

**Age data for oral contraception consultations in all pharmacies October 2009 to June 2011**



##### Ethnicity

Ethnicity data of oral contraception consultations compared to local ethnicity data is shown in Figure 3. The largest proportion of consultations (54.1%, n=324) were with service users from black African, black British, black Caribbean or other black ethnic

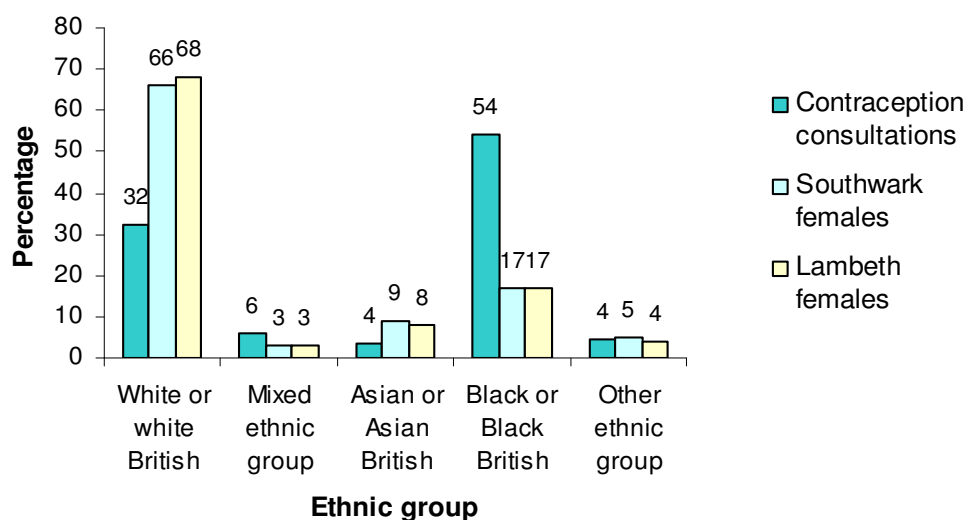
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groups; 32.2% (n=193) were with white British, white Irish or other white ethnic groups; 35 (5.8%) were with service users from mixed white and black Caribbean, white and black African, white and Asian or other mixed ethnic group; 21 (3.5%) were with Asian British, Indian, Bangladeshi or other Asian service users; and 23 (4.3%) were with Chinese service users or those from another ethnic group.

The majority of consultations occurred with women from black or black British ethnic groups. This does not reflect the female population in Southwark and Lambeth, which is made up of 17% black or black British groups. Conversely, white ethnic groups were under-represented in the oral contraception consultations: white or white British service users constituted 32% of consultations, compared to 66% and 68% of the female population in Southwark and Lambeth respectively.<sup>xi</sup>

One limitation of the data is that although it is known how many consultations occurred with each age or ethnic group, data for individuals is not known, so it is not possible to determine, for example, the ethnicity of service users under 20. In addition, data only exists for consultations, not individual service users, and we do not know which service users have received initial or subsequent supplies.

**FIGURE 3**  
**Ethnicity data for oral contraception consultations in all pharmacies October 2009 to June 2011, compared to ONS data for Southwark and Lambeth female residents aged 16-59**



**2.2.5 Consultation duration**

The duration of the consultation was collected for 97.2% (n=384) of consultations. Table 6 shows mean average consultation times for all pharmacies.

**TABLE 6**  
**Mean average duration of oral contraception consultations between October 2009 and September 2010**

Type of consultation	Mean average time (standard deviation)
Initial supply to first-time pill user	21 minutes (±0.0027)
Initial supply to established pill user	20 minutes (±0.0038)
Subsequent supply	17 minutes (±0.0024)
General referral	15 minutes (±0.0033)
LARC referral	13 minutes (±0.0023)
Under 16 referral	11 minutes (±0)

Consultations have ranged from 7 to 45 minutes, and varied greatly in duration between pharmacies. For example, Pharmacy 3 had a mean average consultation time of 36 minutes, compared to Pharmacy 1's mean average of 19 minutes. This could be attributed to a number of factors, but of the three pharmacies where consultation time was measured, the one with the shortest average consultation time has continued to be able to provide a consistent service. Some pharmacists have reported difficulty providing consultations at times when the pharmacy is busy, although other pharmacists manage to provide them. It is recommended that pharmacists shadow a current provider before agreeing to the oral contraception course to better ensure the service is feasible in their pharmacy.

#### *2.2.6 LARC referrals*

Nine pharmacies made 29 referrals for EC users into LARC services in the three month period June to September 2011. Patient details were checked against service users attending Southwark and Lambeth services but none of the 29 referred had attended for LARC by one month after the three month period. This result suggests the importance of maximising on any opportunity to provide service users with contraception 'on the spot'. It is suggested that more work is done to improve signposting and referrals between all sexual health and contraceptive services, and that direct LARC referrals from community pharmacy are piloted. In addition, further mapping of individual patient pathways and contraceptive experiences would be of use in future service design.

### **2.3 Service audit and evaluation**

#### *2.3.1 Clinical notes audit*

Although community pharmacists provide a number of services under PGDs, a clinical notes audit was conducted as this was a new service. The audit demonstrated that the pharmacists were providing a good service, appropriate referrals had been made to general practice and sexual and reproductive health, oral contraception was offered to service users using condoms or EC, and LARC was promoted.

#### *2.3.2 Subsequent pill supply follow-up*

125 service users were contacted, 64 by text message and 61 by phone, of which 63 responded (50.4% response rate). Service users had obtained the pill from the pharmacy between 19 October 2009 and 28 October 2010. The age of those contacted ranged from 16 to 40 years with the mean average age being 23 years. The time lag between first supply of the pill and date of contact ranged between 1 and 14 months, with the mean average being seven months.

Of those 63 service users who the pharmacy had contact with, 20 (32%) had come back to the pharmacy for a subsequent supply of the pill. 15 of these had continued taking the pill without issue. Three had returned for a change of pill. Two had stopped the pill then restarted it, both of whom said they were more serious about taking the pill now, one of them as a consequence of having had an abortion.

Three service users (5%) were accessing the pill from elsewhere; two from a sexual and reproductive health clinic and one from her GP. 40 service users (63%) had not returned nor were planning to return for a subsequent supply of the pill. The reasons given for not wanting a subsequent supply are shown in Table 7.



**TABLE 7**  
**Number of service users presenting various reasons for not returning for a subsequent pill supply**

Reason for not returning for a subsequent pill supply	Number
Using condoms and/or EC/ no regular sex	18
Moved out of the area	7
Developed side-effects from pill	6
Now using LARC method	3
Was not serious about taking the pill	2
No sexual partner	2
Decided to have a baby	1
Did not like pill	1

Four service users who had not returned for a repeat supply had been given EC by the pharmacy since being given the contraceptive pill, and four further service users mentioned they preferred EC to the pill as a regular method of contraception. Of those using condoms and/or EC, nine gave 'no longer having a regular partner' as the reason for preferring this method to the pill.

It is suggested that further research into individual patient experiences is conducted in order to establish what pharmacy contraception services can do to improve consistent contraceptive use. It is recommended that pharmacists continue to provide a holistic contraception service including provision of EC, condoms and oral contraception, as well as wider discussion and signposting to all other types of contraception. Pharmacists should continue to promote LARC at all opportunities, and provide client-centred contraception counselling. It is suggested that enhanced contraceptive counselling training could be developed for all pharmacists providing any sexual health services, in order to maximise on opportunities with EC users.

### 2.3.3 Contraception refusal

Table 8 outlines the reasons given for refusal of a contraceptive consultation by 269 EC service users. Interestingly, the most frequent reason was that the service user was already using oral contraception.

**TABLE 8**  
**Number of EC service users providing various reasons for refusing a contraception consultation**

Reason	Number
Service user already using oral contraception	55
Service user still considering oral contraception or LARC	49
Service user concerned about weight gain	41
Service user prefers condoms	37
Service user has appointment elsewhere for oral contraception	24
Service user already using LARC	22
Service user not in long-term relationship/ sexually active	13
Service user concerned about other side effects	6
Service user has no time for consultation	4
Service user concerned about fertility	4
Service user has an appointment elsewhere for LARC	3
Service user concerned oral contraception 'messes up body'	3
No contraception works for service user	2
Service user was under 16	2
Service user has tried all types of contraception	2
Service user prefers withdrawal method	1
Service user wants break from oral contraception	1



## 2.4 Service user evaluation

### 2.4.1 Pre-service focus groups

Three focus groups consisting of the following people were held before the service started:

- Focus group 1: 16 young people (12 female and 4 male) aged between 15 and 21 recruited through Southwark Youth Council
- Focus group 2: 17 mothers aged between 18 and 39 recruited through a Sure Start training centre
- Focus group 3: 10 women aged between 24 and 43 who worked at NHS Lambeth

Overall, knowledge of contraceptive methods and where to access contraception was good across the three focus groups. Pharmacies were seen by all groups to be in a good position to provide contraception. The overall perception was that pharmacies were easier to access than GP practices, participants liked speaking to pharmacists and found pharmacies to be in good locations. However, there was a general concern regarding confidentiality speaking to counter staff, as well as negative perceptions about the attitude of counter staff. There were concerns from focus groups 2 and 3 regarding the competency of pharmacists to provide clinical services.

### 2.4.2 Service user questionnaires

The questionnaire was returned by 99 clients (response rate of 38.1%). For 84.4% (n=81/96), the pharmacy they visited was their local pharmacy. When asked where else clients would access contraception from if the service was not available in the pharmacy, 62.8% (n=59/94) would have accessed it in a family planning clinic, 45.7% (n=43/94) from a GP, 34.0% (n=32/94) from a practice nurse and 20.2% (n=19/94) at a genito-urinary medicine service. However, 10.6% (n=10/94) would not have accessed contraception elsewhere if they had not been offered it in the pharmacy, implying that the service has been accessed by new users.

The majority of respondents (88.3%, n=83/94) reported having had a discussion with the pharmacist about LARC. Most (87.5%, n=84/96) were very satisfied with the contraception service they received in the pharmacy, nine respondents were satisfied, no respondents reported dissatisfaction but three were very dissatisfied (no further information was provided). Most respondents (96.9%, n=94) reported being very comfortable or comfortable talking to the pharmacist about contraception, no one was uncomfortable, although three people were very uncomfortable (no further information was provided). All those who responded (n=96) were happy with the privacy. Finally, of those asked, all those who responded (n=68/72) would recommend the service to a friend.

### Quotes from service user questionnaires

*"The pharmacist gave me time to explain myself and answered all my questions properly"*

*"I felt very comfortable and at ease talking with the pharmacist"*

*"I am very delighted with this service... I will definitely be using it again"*

### 2.4.3 'Mystery shopper' visits

Seven mystery shoppers conducted seven visits to Pharmacy 1, six visits to Pharmacy 2 and six visits to Pharmacy 3. The experiences of mystery shoppers differed greatly across and within the three pharmacies.

### Advertising

All mystery shoppers saw the poster advertising the service in pharmacies 1 and 3, and 60% saw the poster in pharmacy 3. 81% (13/16) thought the poster would attract people to access contraception in the pharmacy. The percentage of mystery shoppers

who saw leaflets on contraception or sexual health varied between 80% in pharmacy 1 to 20% in pharmacy 3.

#### *Helpfulness of counter staff*

Mystery shoppers' experiences of counter staff were mixed, even within each pharmacy, with some mystery shoppers finding counter staff very friendly and helpful and others finding them unfriendly and unhelpful. There was some confusion from the counter staff between requests for oral contraception and for EC. Mystery shoppers were also not always given consistent information on when they could access the oral contraception service.

#### *Ease of obtaining a consultation*

Twelve out of 17 mystery shoppers were offered an immediate consultation. This varied greatly between pharmacies (80% of mystery shoppers in both Pharmacy 1 and Pharmacy 2 were offered an immediate consultation, but only 50% in Pharmacy 3). During the debriefing session, mystery shoppers reported that the worst thing about the service was difficulty in accessing a consultation in some pharmacies. The mystery shoppers stated that they would be happy to return for an appointment if it was at a time convenient for them. They also suggested that pharmacies which cannot guarantee an immediate consultation should clearly advertise the times that the pharmacist is available to provide contraception, as some of the mystery shoppers received confusing and conflicting information regarding this.

#### **Comment from mystery shopper**

*"Originally I was told that there were not enough staff for me to have a consultation because one of the counter staff was going on their lunch break. However, the pharmacist went out of their way to ask the counter staff to take their break half an hour later. Meanwhile the pharmacist did the consultation with me. For any young person, this would be better than being told to come back another day. They won't feel rejected this way and are more likely to return once they decide what they feel is best for them."*

#### *Quality of consultation*

Overall, feedback on the consultation with the pharmacist was very positive, again with some variance between pharmacies. Most mystery shoppers felt that the pharmacists were knowledgeable on oral contraception (75%-100%) and LARC (67%-100%) and that they provided information that was easy to understand. Fewer respondents thought the pharmacists were knowledgeable about other sexual health services (25%-80%).

#### **Comment from mystery shopper**

*"The quality of information was good and the pharmacist knew what they were talking about. The pharmacist also took the time to explain things, for example, what your BMI is and how to work it out. The pharmacist also said, when I said I was interested in LARC, where I can go to get more information."*

#### *Overall satisfaction*

Overall, most mystery shoppers were satisfied or very satisfied with the service they received (80%-100%), most would recommend getting contraception at the pharmacies they visited to a friend (60%-100%), and all mystery shoppers thought that providing contraception in pharmacies was a good idea.

#### **Aspects of the service mystery shoppers liked**

*"It was very friendly and non-judgemental."*

*"Quality of information"*

*"The pharmacist really knew what he was talking about"*

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*“They offered information about other types of contraception which meant I didn’t have to ask specifically, showing that they are being thorough in the service in they deliver and making sure young people know all their options.”*

#### **Aspects of the service mystery shoppers would improve**

*“They might want to think about having more staff so they turn less people away until another time. They shouldn’t use the excuse that there is not enough staff, it might put the young person off from returning.”*

*“The organisation of the service.”*

#### **Comments from mystery shoppers on providing oral contraception in pharmacy**

*“It is a quick way to get contraception, and it is very private, unlike a clinic where everyone will know what you are going in there for.”*

*“It is more convenient for young people and you could reach more young people through this method.”*

*“It’s in areas that young people find to be close to them, easier access and it’s not a long wait compared to going to a clinic.”*

#### *2.4.5 Service user focus group*

Six contraception service users (aged between 22 and 28 years) were recruited from two pharmacies to take part in a focus group in April 2011. The aim of the focus group was to find out more about service users’ experiences of accessing contraception from pharmacy, to ascertain if service users were happy to use other services for contraception, and to find out their views on pharmacists referring to LARC providers.

Overall, focus group participants were happy with the contraception service in community pharmacy. They found that pharmacy provides a very easily accessible contraceptive service compared to GPs (where you need to book and wait for an appointment) and reproductive and sexual health clinics (where there is often an extremely long wait).

Participants were mostly willing to access contraception from their GP but, due to having to book in advance, the limited opening hours and long waits for appointments, they would prefer to use other services for contraception. Participants were also happy to access contraception from sexual and reproductive health clinics, but did not like the very long waiting times. Pharmacy appeared to be the preferred option for those who had accessed contraception there, largely due to convenience.

Participants discussed many negative experiences of LARC, although there were some positive experiences. However, it was thought that all health professionals, including pharmacists, should capitalise on every opportunity to talk to women in detail about their contraceptive choices, and give them as much information as possible, including where they can access it. Service users thought that maximising on these opportunities would help women to think about their contraceptive needs and therefore avoid unintended pregnancies.

#### *2.4.6 Summary and recommendations*

Service users and mystery shoppers were very happy that the service existed, and thought it was a good idea to provide contraception in community pharmacy. They particularly liked the convenience and anonymity of the service – they did not need to make an appointment, they did not need to wait too long, the service was local to them and no one knew what they were visiting the pharmacy for. Although some of the participants in the pre-pilot focus groups were concerned about the clinical competence of pharmacists to provide oral contraception, this was not borne out in any of the service evaluation, and overall, feedback on the consultation and information provided

by pharmacists was positive. However, some mystery shoppers reported that the pharmacists were not very knowledgeable on other sexual health services, so this is perhaps an area for improvement when signposting.

Mystery shoppers reported very varied experiences, both in different pharmacies and within the same pharmacy. Those pharmacies that experienced staffing issues from the beginning of the pilot received less positive feedback overall. The variation of experiences within the same pharmacy largely concerns obtaining a consultation, which was not always easy in the two pharmacies that have subsequently stopped service provision, and depended on the presence or availability of the trained pharmacist. As per pharmacy contracts, counter staff and locum pharmacists should be fully informed of the services available. They should offer a future appointment to service users in the absence of the trained pharmacist, and signpost them to other services in the area. It is recommended that the mystery shopping evaluation should be run again, including the pharmacies that have since started providing the service.

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### **3. SERVICE IMPACT**

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#### **3.1 Teenage pregnancy**

It is not possible to know at this stage if the service contributed to a reduction in teenage pregnancies, as the latest available conception data is from 2009.

#### **3.2 Access to and uptake of contraception**

Access to and uptake of oral contraception has been increased. Community pharmacy provided 741 consultations, offering longer opening hours than many other contraceptive services, a drop-in service and minimal waiting times. 236 service users who had not previously used the pill were supplied with it, and 10% of service users completing evaluation forms said they would not have accessed contraception elsewhere if it was not available in the pharmacy.

Evaluation indicated that some of the oral contraception service users would not have accessed contraception had it not been offered in the pharmacy. In addition, 46% of initial pill supplies were to first time pill users, and 45.5% of consultations happened as a result of an EC consultation. This suggests that young women who are using EC, have not used the contraceptive pill before and who would not otherwise have accessed contraception are using this service.

#### **3.3 Emergency contraception uptake**

EC uptake has significantly decreased in Pharmacy 1 (a paired sample for means T test showed  $p=0.001$ ) – where most contraception consultations occurred – although not in Pharmacies 2 or 3, nor across Lambeth and Southwark as a whole. EC data was not available for 2011 and therefore was only analysed in the first three pharmacies providing the service. Pharmacies 2 and 3 provided only small numbers of oral contraception and no subsequent supplies. It is recommended that further analysis of EC figures be conducted in Pharmacies 4 and 5, in order to ascertain if the decrease in EC in Pharmacy 1 is as a result of service users changing to a more sustained contraceptive method. Whilst anecdotally, pharmacists report that some previously frequent EC users have changed to oral contraception, it is recommended that further research be conducted into individual patient pathways and contraceptive use.

#### **3.4 Future service modelling**

The pilot has demonstrated that community pharmacists can provide a competent contraceptive service, with the possibility of future developments to widen

contraceptive service scope within pharmacy. Future savings could be attained through the following aspects.

### 3.4.1 Reduction in cost of terminations

The cost of an elective medical TOP in Southwark was £431 in 2011/12. Evidence suggests that providing good access to contraception can help prevent TOPs. Therefore the increased access to contraception that the current community pharmacy service has provided (46% of new contraceptive supplies were to first time pill users) may contribute to a saving from a reduction in unintended pregnancies and therefore terminations.

### 3.4.2 Reduction in cost of unintended pregnancy

Another indirect saving from community pharmacy contraception services reaching unmet need is the prevention of unintended pregnancies, which cost the NHS an estimated £63 million a year. Reducing the number of unintended teenage pregnancies by widening access to contraception could reap cost savings. In addition to increasing contraceptive provision, providing pharmacists with contraception training and sexual health counselling skills may improve their overall sexual health service, including EC and Chlamydia testing services, also reducing sexual health service costs. There are also social costs associated with unintended pregnancies and TOPs that pregnancy prevention would mitigate against.

### 3.4.3 Cash release from reduction in EC

As evidenced, oral contraception-providing pharmacies can see a significant decrease in EC. In Pharmacy 1 there was an average cash release of £666 per month through a reduction in EC.

### 3.4.4 More cost effective delivery method

Table 9 shows the cost comparisons between a contraception consultation provided by community pharmacy, GP and SRH clinic.

**TABLE 9**  
**Current pharmacy consultation costs vs GP and SRH**

	Community pharmacy (current model)	GP (potential cost <sup>xiii</sup> )	SRH (2011/12 tariff)
Consultation cost (1 <sup>st</sup> pill supply including drug cost) <sup>1</sup>	£24.95	£40.95 <sup>2</sup>	£50.53
Cost saving per consultation of pharmacy service (1 <sup>st</sup> supply)		<b>£16 saving<sup>2</sup></b>	<b>£25.58 saving</b>
Consultation (subsequent pill supply including drug cost)	£16.90	£45.90 <sup>2</sup>	£50.53
Cost saving per consultation of pharmacy service (subsequent supply)		<b>£29 saving<sup>2</sup></b>	<b>£33.63 saving</b>

<sup>1</sup> Drug cost is calculated on an average cost of COC/POP provided by community pharmacy and including VAT. Assuming first supply includes one pill pack and subsequent supply includes two pill packs

<sup>2</sup> GPs are paid on a block contract and therefore it should be noted that this is not a direct cost saving. However, where an appointment is conducted in community pharmacy rather than GP it frees up capacity

There is a direct cost saving from shifting contraception activity from SRH into community pharmacy, as well as indirect cost savings from shifting contraception activity from GP and SRH into community pharmacy, which are achieved through freeing up capacity within primary and secondary care to deal with complex client needs. It is likely that there has been a significant shift in activity, as well as the service having captured new



service users. An estimated 230 consultations per annum have been shifted out of GP/SRH, at a cost saving of £2,010 a year, based on the following: the average number of consultations provided in all pharmacies combined per month to date is 35, which results in an estimated 420 consultations per year. Currently 45.5% of oral contraception consultations occur as a result of a client attending for EC, indicating 54.5% of consultations (230) could result from shifting activity out of GP/SRH services.

In light of the fact that the service has seen an unexpected shift from GP and sexual and reproductive health, it is suggested that the service model is reconsidered. Three possible future service models are outlined in Table 10.

**TABLE10**  
**Future options for oral contraception service models**

	<b>Model 1</b>	<b>Model 2</b>	<b>Model 3 (preferred)</b>
<b>Description</b>	Addressing unmet need	Increased provision of contraception	Managing demand across services
<b>Aim</b>	To increase access to contraception for women at high risk of unintended pregnancy	To increase access to contraception for all women, particularly those at risk of unintended pregnancy	To increase access to contraception for all women and shift activity from GP and SRH into community pharmacy
<b>Providers</b>	6 pharmacies (12 pharmacists) in teenage pregnancy hotspots (Peckham, Walworth, Bermondsey/Rotherhithe, Camberwell and Nunhead/Peckham Rye)	15 highest EC-providing pharmacies (30 pharmacists)	30 highest EC-providing pharmacies (60 pharmacists)
<b>Access criteria</b>	Women aged 16 and over (consider expanding to 13-16s)	Women aged 16 and over (consider expanding to 13-16s)	Women aged 16 and over (consider expanding to 13-16s)
<b>Care pathway</b>	-Following EC supply -Targeted advertising	-Following EC supply -Referral from GP/SRH -Targeted advertising	-Following EC supply -Referral from GP/SRH -Widely advertised
<b>Model of care</b>	-Oral contraception initial and subsequent supplies -LARC information and referral	-Oral contraception initial and subsequent supplies -LARC information and referral	-Oral contraception initial and subsequent supplies -LARC information and referral
<b>Advantages</b>	-Most pharmacies already up and running -Few providers means only the best pharmacies provide the service -Service should reach those with most need	-Shifts some activity out of GP/SRH -Enough providers to maintain consistent service even if trained pharmacists leave employment	-Shifts activity out of GP/SRH -Enough providers to maintain consistent service even if trained pharmacists leave employment
<b>Disadvantages</b>	-Misses the opportunity to shift more cost away from GP/SRH -Could miss unmet need in other areas of the borough -Risk of inconsistent service if trained pharmacists leave employment	-Misses the opportunity to shift more cost away from GP/SRH	-Risk that not all pharmacists will provide a high number of consultations which could affect pharmacists' competency over time

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## 4. CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS

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### 4.1 Conclusions

- Trained community pharmacists are able to provide an oral contraceptive service under a PGD.
- The service has been largely accessed by local women aged 20-24 years. Most consultations have been with black British, Caribbean and African women, and 46% of initial pill supplies have been to first time pill users.
- A large proportion of clients do not return for a subsequent pill supply. The main reason given for this is that the client has gone back to using EC or condoms, largely because they do not have a regular partner.
- Service users have valued the service highly, in particular the convenience, anonymity, drop-in system, long opening hours and lack of waiting time. Possible improvements could be made to accessing the service and signposting from counter staff.
- EC has declined in the pharmacy providing the most oral contraception.
- Local GP practices and sexual and reproductive health services have referred clients to the service, and therefore opened up the possibility of a future service model aiming to shift activity from GP and SRH services.

### 4.2 Recommendations

- Consider expanding this service to appropriate pharmacies in Lambeth and Southwark, across London and nationally, in order to capitalise on shifting activity out of GP practices and sexual and reproductive health services, therefore freeing up these services to work with clients with more complex needs.
- Future training should be carefully considered in terms of sustainability, ensuring it is in line with training for other primary care professionals.
- Consider providing the service to women under 16 years where appropriate. This may help contribute to a reduction in teenage pregnancies.
- Before undertaking training, pharmacists should shadow a current pharmacist providing oral contraception to ensure they have a good understanding of the logistics of providing the service and are confident it is feasible in their pharmacy.
- Further work to improve patient pathways, signposting and referrals between all contraceptive services, including community pharmacy, is carried out.
- High quality, nationalised training in enhanced contraceptive counselling skills is developed and offered to all pharmacists in order to maximise on all opportunities to talk to young women about their contraceptive needs.
- Further research is conducted into individual patient pathways, contraceptive use and experiences, including a further mystery shopping evaluation of pharmacy contraceptive services.



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