Correspondence in response to:

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Title: **Accessible, acceptable and equitable: a range of contraceptive methods are still needed**

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McNee and colleagues explore the change in contraceptive methods among those seeking abortion in 2018 and 2023 using cross-sectional self-reported data from the British Pregnancy Advisory Service (BPAS). The BPAS is highly valued and provides much needed accessible reproductive health services and the paper raises important issues.

The analysis highlights the more commonplace use of medical terminations earlier in pregnancy. They also report that the use of long-acting reversible contraception fell from 3% to 0.6%, and hormonal contraception methods from 18.8% to 11.3% in their population. However, the analysis does not necessarily support their conclusion that use of ‘fertility awareness-based methods’ (FABM) are associated with attending BPAS for abortion. The data suggest that the decline between the chosen years in the use of hormonal contraceptives and the increase in FABM is a trend but it does not imply a causal link with more people seeking abortions.

The authors seem to selectively focus on FABM. For example, in “What this Study Adds” the focus is on the shift from ‘reliable hormonal methods’ to ‘less reliable FABM’ with no mention of the greater increase in women not using contraception. Meanwhile, ‘other method’ use decreased from 22% to 16%. This decrease potentially goes against the argument that people are shifting from hormonal to non-hormonal based methods. The authors do not consider that with FABM, people often use a mixed method approach e.g., a condom on fertile days, that greater awareness through FABM might be driving the earlier less invasive forms of termination or that the older age of those seeking terminations might suggest success in avoiding pregnancy in the younger age groups.

The analysis which includes limited detail, shows that there is simply an association between the year and method of contraception recorded. Although they acknowledge

that the transition to different data collection methods could result in bias, it would have been ideal to account for such confounding factors through multivariate or sensitivity analyses. [1] Additionally, the category ‘None’, includes ‘no method reported’ or ‘unsure’ which is not the same as ‘none’. This is likely to have biased their analysis.

The ‘Women’s Health Strategy for England’, has highlighted contraception as a crucial component. [2] The reality for many is that this has not necessarily translated into accessible equitable preventative healthcare. Despite women needing and wanting contraception many women do not have access to modern, or indeed any contraception methods or the ability to control their fertility. [3] This is particularly pronounced for some populations including young women, [4] minoritised communities,[5] or those who are incarcerated, who encounter additional challenges restricting access. [6]

‘Hormonal hesitancy’ concerns are very real, [5] and as evidence of other health risks, related to hormonal contraception, such as breast cancer, are published [7] simply attributing this to the influence of social media is simplistic; Users also draw on embodied knowledge and personal experience to make decisions. [8, 9] We concur that although developments in reproductive health technology, such as FABM have taken place, we have not reached the 'techno-utopia' [10] we might dream of. This technology often over-promises and underdelivers.

The paper fails to provide sufficient information to determine the multifactorial drivers. A missed opportunity. To address these issues, a concerted effort is needed to conduct and publish responsible and robust research that can help us to understand contraceptive decision making and barriers to access and use. The good news story here may be about the increase in the proportion of medically managed terminations rather than mistrusting women’s ability to manage technology.


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