Contraception and its ethical considerations

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Abstract

Access to appropriate contraception not only has direct benefits for women's health and wellbeing but also has a broader positive impact on society as a whole. Obstetricians and gynaecologists play a key role in counselling women. Decisions regarding contraceptive choices must take into account women's preferences, cultural and religious beliefs as well as any co-existing medical issues.

This article outlines three commonly encountered scenarios and the ethical and legal issues that may affect the choice of contraceptive.

Keywords adolescent gynaecology; contraception; emergency contraception; ethics; sterilisation

Introduction

The availability of effective contraception not only reduces the number of unsafe abortions but also allows women to plan the size of their family and space their pregnancies. Teenage pregnancy has a well-documented association with infant mortality, poor access to education, poverty and poor maternal emotional health and the UK still has one of the highest teenage pregnancy rates in Europe. Women in the UK currently have access to a wide range of contraceptive choices and need comprehensive information regarding their options to enable them to choose a method and use it effectively.

Clinical assessment of women seeking contraception

History taking

Pregnancy must be excluded in any patient requesting contraception; this is aided by undertaking a detailed menstrual and sexual history. The need for emergency contraception (EC) should be assessed as part of contraceptive counselling. Sexual history is particularly important in women under the age of 25 or those who have a new sexual partner as these women are at higher risk of sexually transmitted infections (STI).

As part of the menstrual history the pattern and duration of menstrual bleeding and the desire for regular cycles needs to be established as this may indicate the need for the non-contraceptive benefits of contraception. Cervical screening history should be evaluated and screening arranged if appropriate. Abnormal vaginal bleeding should be investigated prior to commencing intrauterine contraception or hormonal contraception. A past contraceptive history should be obtained including compliance with previous methods and the presence of any adverse effects. A past gynaecological and obstetric history should be taken as well as establishing whether they are currently breastfeeding and plans for any future pregnancy.

A history of past and current medical conditions and family history should be sought and patients should be asked about migraine and cardiovascular risk factors such as smoking, obesity, venous thromboembolism, hypertension and hyperlipidaemia. A drug history including prescribed medication, over the counter medication, herbal preparations and supplements should be taken in order to assess the risk of drug interaction with hormonal methods of contraception. The UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) can be used to assess whether a medical condition or current circumstances (e.g. breastfeeding, postpartum status, age) precludes the use of a particular contraceptive (Table 1).

Women with conditions that pose a significant risk to their health during pregnancy or those taking teratogenic drugs should be counselled regarding the most reliable contraceptive choices including long acting reversible contraception (LARC). A women's personal preference regarding contraception and her understanding of its efficacy, risks, benefits and the attitude of her partner toward contraception should be discussed. The importance to her of avoiding pregnancy should be explored as well as lifestyle, social, cultural or religious factors which may influence choice, acceptability and compliance with contraception.

Clinical examination

The clinical examination should include a blood pressure measurement, weight and calculation of body mass index (BMI). Women who request sterilisation, intrauterine contraception or barrier contraception (diaphragm or cervical cap) will require a bimanual examination. The presence of pathology such as fibroids may require further investigation as they may limit contraceptive choices. Routine screening for STIs is not required unless women are symptomatic or at deemed at high risk after taking a detailed sexual history. Symptomatic women and high-risk women should be offered screening.

Intrauterine contraceptives should not be inserted in symptomatic women until they have completed treatment and their symptoms have resolved. Asymptomatic women can be offered intrauterine contraception and prompt treatment can be initiated after fitting if an infection is subsequently identified.

Contraceptive counselling in young patients

Case 1

A 14-year-old girl attends the family planning clinic requesting contraception. She has been using condoms but would like to discuss alternative methods. She has no significant past medical or surgical history and does not take any regular medication.

How would you assess this patient?

A full gynaecological history including sexual history is particularly important in young women as there is a higher rate of both unintended pregnancy and STI compared to older

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UK medical eligibility criteria for contraceptive use (UKMEC)

UKMEC	Definition of category
Category 1	A condition for which there is no restriction for the use of the method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable
Category 4	A condition which represents an unacceptable health risk if the method is used

Table 1

women. A comprehensive social history with sensitive exploration of home circumstances, issues in current or past relationships may help identify children at risk.

What are the ethical issues in this case?

1. **The law in relation to sexual activity in young people and safeguarding**

The legal age to consent to sexual activity in the UK is 16, however one third of young people have already engaged in sexual activity prior to this age. Although sexual activity under the age of 16 is illegal, if there is no evidence of abuse or exploitation it is unlikely that sexual activity amongst consenting adolescents of a similar age would result in prosecution. Under the Sexual Offences Act 2003, children under the age of 13 are not deemed capable of consenting to sexual activity and in this case offences are considered more serious. Healthcare providers are considered to be protecting a child if they give healthcare advice or treatment to prevent a pregnancy or STI in children even in those under 13.

The possibility of abuse should be considered in under-16s and a risk assessment carried out. There should be a named contact that acts as local lead for child protection who can be contacted for advice where there are concerns.

2. **Capacity and consent**

In the UK capacity to consent to medical treatment or examination is presumed in those over the age of 16, below this age however capacity must be demonstrated. Children under 16 are considered competent to consent to treatment provided they have sufficient intelligence to understand fully the treatment proposed.

A person is said to have capacity if they can:

- Understand the proposed treatment
- Understand the risks and benefits of treatment and the alternatives
- Understand the implications of not having treatment
- Retain the information provided for long enough to weigh up their options and come to a decision
- Communicate the decision they have made

In the UK it is lawful to provide contraceptive advice and treatment without parental consent provided the criteria for Fraser competence are met. Fraser competency refers to a set of guidelines set out by Lord Fraser in his judgement of the Gillick case in 1985 (Table 2). This case involved a challenge to Department Of Health guidelines that allowed doctors to give contraceptive advice and treatment to under 16s without parental consent.

3. **Confidentiality**

Confidentiality is often a key concern amongst young people accessing sexual health services. Maintaining confidentiality often encourages adolescents to continue to seek advice and support when needed. Where there are concerns regarding competence, child abuse or exploitation confidentiality may have to be breeched.

What are the contraceptive options for this patient?

Young women should be counselled regarding all contraceptive options, age does not preclude them from having methods including LARC or intrauterine contraceptives. The progestogen only injection is UKMEC category 2 in under 18s due to the potential for bone mineral density loss and should only be considered if alternatives are unsuitable. Consideration needs to be given to their individual risk of STIs and their ability to comply with treatment and follow up. Contraceptive failure rates are estimated to be twice as high in women under 20, she should thus be advised that only barrier methods offer protection against STIs.

In the UK condoms and the oral contraceptive pill remain the most popular contraceptive choices amongst young people; however failure rates are higher with both these methods compared to LARCs which are less user dependent (Table 3). There is a high discontinuation rate amongst pill users often due to actual or perceived side effects; this highlights the importance of counselling regarding potential adverse effects and arranging follow up to assess compliance.

Criteria for Fraser competence

A doctor could proceed to give advice and treatment provided he/she is satisfied in the following criteria:

1. That the girl (although under the age of 16 years of age) will understand his/her advice;
2. That he/she cannot persuade her to inform her parents or to allow him/her to inform the parents that she is seeking contraceptive advice;
3. That she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
4. That unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
5. That her best interests require him/her to give her contraceptive advice, treatment or both without the parental consent.

Table 2

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