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## Bridge-It trial—a step towards better contraception services

The findings of the UK Bridge-It trial, reported by Sharon Cameron and colleagues in *The Lancet*,<sup>1</sup> show a new way to get contraception to those who need it—and a potentially important improvement to contraceptive services. This trial targets women obtaining emergency contraception in pharmacies, providing them with a supply of progestogen-only pills alongside the emergency contraceptive levonorgestrel.

The success of this trial suggests fresh approaches can help to meet the need for contraception in the general population. The next step for policy makers and services is to look more widely, across the diverse population, at unmet needs for contraception and redesign more services to meet them.

In the UK, emergency contraceptive pills can be bought in pharmacies without a prescription. All contraceptive methods are free from clinics at the point of delivery. The Bridge-It trial invited women aged 16 years or older to participate. The intervention group received a 3-month supply of the progestogen-only pill plus a rapid access card to a participating sexual and reproductive health clinic. The control group received standard care (pharmacists advised women to attend their usual contraceptive provider). At the 4-month follow-up, use of effective (hormonal or intrauterine) contraception (primary outcome measure) was 20·1% higher (95% CI 5·2–35·0) in the intervention group (mean 58·4%, 48·6–68·2) than the control group (mean 40·5%, 29·7–51·3;  $p=0\cdot011$ ).<sup>1</sup> Of 636 participants, 4-month follow-up data were available for 406 (64%) women: 198 (63%) of 315 in the intervention group versus 208 (65%) of 318 in the control group. Reported use of the progestogen-only pill was higher in the intervention group (71 [35·9%] vs 15 [7·2%]), but there was no increase in the use of long-acting reversible contraception (13 [6·5%] vs 23 [11·1%]).<sup>1</sup>

A key strength of the Bridge-It trial is that it was done in a real-world setting, showing that it is feasible for pharmacists to provide this service and that participants used the provided bridging method. This intervention could also have helped women to learn about and try a new contraception method.<sup>1</sup>

Limitations of the trial include loss to follow-up and inadequate detail to show who might benefit from the intervention and for how long.<sup>1</sup> At the 4-month follow-up, participants could have still had unused pills from the trial, have unintentionally misreported recent use as current use, or have overstated use in the intervention group. Nevertheless, providing the progestogen-only pill in a convenient way would most likely increase uptake, particularly because the method is controlled by the user and is easy to start and stop (25% of those in the intervention group stopped using the progestogen-only pill because of side-effects).<sup>1</sup>

Details about the experiences of diverse social groups are largely absent from the trial report; ethnicity and parity are mentioned briefly without explanation. Previous work<sup>2</sup> shows that different groups access emergency contraception from different places and we hope that the authors will be able to use qualitative data collected during the trial to show the nuances and details related to the diversity of participant experiences.<sup>3</sup>

This intervention should be implemented widely and with care. UK pharmacists must be trained to support women, including young people who might feel judged, and those presenting after sexual assault who will need referral to appropriate services. Advice on sexually transmitted infections prevention might be needed for those changing from using condoms to the progestogen-only pill. Applicability of the trial outside the UK is unclear, but this approach might be worth investigating elsewhere. Although the progestogen-only pill is not as effective as long-acting reversible contraception,<sup>4</sup> other considerations are important for those who need emergency contraception and are not using hormonal methods; for instance the progestogen-only pill can be started just 48 h before sex, which would be compatible with infrequent planned sex, or with the start of a relationship where future sexual activity is uncertain.

The Bridge-It trial shows that supplying contraception in an innovative way has the potential to improve uptake. The question remains on how to improve uptake further and ensure diverse needs are met. There is little community participation in designing contraceptive services, and knowledge is limited on how different types of contraception—and patterns of health care—suit different people’s lives and preferences.

Researchers, policy makers, and service providers should work with communities to identify and codesign more interventions to meet people’s needs. Future efforts need to include the voices of people who use and those who do not use existing services, and take an intersectional approach to identify and address contraceptive needs that are likely to differ depending on characteristics such as age, relationship type, gender identity, disability, cultural background, employment status, and the ability to attend clinics.

We declare no competing interests.

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