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15th January 2026

Enabling all high-risk women to receive aspirin during pregnancy

High-risk women in pregnancy more than halve their risk of pre-eclampsia when taking aspirin as recommended. We are writing to ask for your support in our efforts to make sure more of those women who are high-risk are able to get their Aspirin. We are concerned about some suggestions that may create barriers to women getting their much-needed aspirin e.g. discouraging women obtaining low dose aspirin over the counter.

We strongly support the aspirin guidance leaflet developed by the Greater Manchester Local Maternity and Neonatal System (GM LMNS). This resource is intended to support maternity providers in promoting compliance and confidence regarding aspirin prophylaxis during pregnancy. It will support maternity providers to promote compliance and confidence regarding aspirin prophylaxis during pregnancy. The leaflet includes informing women that they can buy aspirin over the counter if this is most convenient to them.

Aspirin is recommended within both local and national clinical guidelines for the prevention of pre-eclampsia necessitating premature delivery. Robust evidence from large randomised controlled trials demonstrates that aspirin is safe and effective in reducing the risk of pre-eclampsia; the incidence of pre-eclampsia in women identified as high risk is reduced by up to 60% when aspirin prophylaxis is appropriately implemented.

All pregnant women should undergo a risk assessment for aspirin suitability during their initial antenatal appointments. To be effective aspirin prophylaxis must be commenced prior to 16 weeks' gestation, typically at the booking visit. There are several established pathways for women to obtain ongoing supplies of aspirin following a recommendation by a healthcare professional. Aspirin may be supplied directly by midwives under Patient Group Directions (PGD), prescribed by general practitioners or obstetricians, or purchased over the counter. As it is not feasible to supply the full amount of aspirin for a whole pregnancy, arrangements need to be made to allow women to continue this medication until 36 weeks' gestation.

Barriers to accessing aspirin, such as the requirement for additional visits to hospital pharmacies or arranging repeat prescriptions, may disproportionately affect women whose first language is not English or those with limited access to transport, thereby exacerbating health inequalities. It is important that the recommended dose of aspirin is clearly

communicated to each woman as many prefer to purchase aspirin over the counter for convenience and assurance of continuity.

Enabling women to access ongoing supplies of aspirin through any of the aforementioned routes is clearly beneficial. Women receive comprehensive guidance on aspirin administration from qualified healthcare professionals, and the risk of adverse outcomes associated with over-the-counter procurement is minimal. Conversely, any impediment to the availability of aspirin poses significant risks. The consequences of a preventable case of preterm pre-eclampsia are profound, with potentially lifelong impacts on health and substantial associated healthcare costs.

In view of the above, we strongly urge all maternity providers to ensure their staff advise women on the various safe and effective means of obtaining aspirin, thereby supporting adherence to this essential preventative therapy from booking to thirty-six weeks' gestation.

Your faithfully,

Professor Jenny Myers

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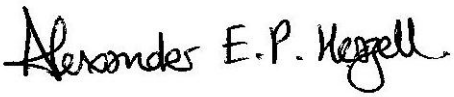

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