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Provision of contraception and its influence on abortion.

Abstract

This article discusses the role of nurses in the provision of contraception, including long acting reversible contraception (LARC) the cost effectiveness of providing contraception and the influence this has on induced abortion. It will explore some of the reasons why women still have unplanned pregnancies despite freely available contraception in the UK.

Background and Introduction

The early part of the 20th century saw improvements in child and maternal mortality resulting in people in the developed world choosing to have smaller families. In the developed world for a variety of socio-economic reasons, the average number of years between the onset of sexual activity and childbearing is widening, leading to an increased demand for contraception to prevent unwanted pregnancy during the intervening years. Making the choice to have a smaller family relies on the availability and effective use of contraception. From the mid 20th century the development of modern methods of contraception has made fertility control easier to achieve. In developing countries during the past 40 years contraceptive use has risen from 10% to 60% thus reducing births. However, despite there being a wide range of contraceptive methods, which are freely available in the UK there are still large numbers of unintended pregnancies one in five pregnancies (22.3% in 2006) end in abortion every year[1]. Earlier onset of sexual activity, later marriage, smaller families and later childbearing means contraception may have to be used for up to 30 years, which leaves a lot of time in the interim for chosen methods of contraception to fail. Contraceptive practices have changed considerably in the last decade, with the introduction of LARC (See Box 1) and the role of the retail sector in the provision of emergency contraception. Whilst a variety of contraceptive methods are available (See Figure 1) the use of them is more complex. Some methods rely upon the motivation and knowledge of the user and have a higher failure rate than others. For numerous reasons many people find it difficult to use contraception consistently and correctly. High discontinuation rates, method switching and poor

compliance results in unintended pregnancies which are now less likely to continue to term than in the first half of the 20th century.

Cost implications - contraception versus abortion

Contraception & sexual health services are amongst the most highly utilized services in the N.H.S. It is estimated that about four million people use NHS contraception services each year. Roughly three quarters of those see a GP and the remainder attend specialist community contraception services[2] (family planning clinics and clinics run by voluntary organisations such as Brook) therefore nurses have a key role to play in the provision of contraception, advice and information to patients. The provision of contraception is important because it reduces the rate of unplanned pregnancy and allows spacing of families which in turn improves women's health. It is also considered that health care economics gain – for every £1 spent on contraception services, £11 is saved on other health care[3]. In terms of healthcare economics the savings are even more dramatic when comparing the cost of a visit to a contraception and sexual health clinic (CASH) against providing abortion services. The average cost to the NHS of first attendance at a CASH clinic is £36 and £29 for a follow-up visit compared to the average cost to the NHS of a termination of pregnancy carried out as a day case which is £827 for a surgical and £568 for a medical procedure[4]. Taking into account that there are nearly 200,000 abortions in the UK annually[5], this equates to a lot of savings. Of course as healthcare providers, we are not just concerned about financial savings but we must also consider the hidden costs of unwanted pregnancy and abortion including breakdown in family dynamics and the emotional and mental health issues which in some instances can be associated with abortion[6]. It is therefore important to consider the most cost effective and reliable method of contraception for the individual woman and her partner.

Long Acting Reversible Contraception (LARC)

NICE Clinical Guideline October 2005 (CG030) defines LARC as contraceptive methods that require administration less than once per cycle or month. They include intrauterine devices and systems (Mirena) IUD/IUS, injectable contraceptives (Depo Provera) and sub dermal implants (Implanon). In 2005-06 only 10% of women used LARC[7] this increased in 2007-08 to 23% of women using LARC[8]. LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use. IUDs, the IUS and the implant are more cost effective than injectable contraceptives

and increasing the use of LARC has the potential to reduce unwanted pregnancies. It is estimated that implementing LARC in England would deliver annual savings of £102.3 million and the initial cost of providing LARC should not restrain the use because LARC is effective and equally cost effective. LARC is suitable for most women (see Box 1).

Nurses and contraception provision

Nurses can provide contraception in a variety of settings such as community contraceptive clinics, sexual health clinics, general practice surgeries, schools, outreach centres and walk in centres. The RCN Guide: *Contraception and sexual health in primary care*: *Guidance for nursing staff* (Publication code 002 016) states that nurses working in primary care provide a diverse range of services in the area of contraception and sexual health. This diversity reflects the wide range of experience and training among individual nurses. However, they caution that some doctors may expect nurses to provide services, which they are not trained or competent to perform and they make explicit that nurses should not extend their role if they lack the competence to practise safely. Likewise, this is also enshrined in the NMC code of professional conduct (2002). Additionally, nurses' role in contraception is extended only via a CASH Module (previously Family Planning training) which is a 30 Credit module at Level 3 requiring attendance at block theory modules plus120 hours of supervised practical sessions or training in nurse prescribing and the use of patient group directions (PGD). Nurses can now prescribe if they have undertaken the nurse independent prescribing course (Non medical prescribing within their own field of competency). Nurses can use PGD to supply/administer contraception, emergency contraception, hormonal and copper bearing IUD's. Non medical prescribing and use of PGD has been a major driver towards extending the role of nurses in contraception provision. (A template PGD for the supply or administration of emergency hormonal contraception is available on the RCN website at www.rcn.org.uk under the Sexual Health Forum pages).

How nurses benefit

Nurses will benefit in another area of their professional practice the new Quality Outcomes Framework (QOF) indicators for 2009/2010 agreed a package of QOF

changes with NHS Employers and the General Practitioners Committee (GPC) that sexual health and contraception receive 8 new points plus 2 points from current CON indicators, CON 1 and 2 (which will be removed) The three new indicators, as recommended in the 2008 expert panel report are:

Quality Outcomes Framework: Changes and New Indicators for 2009/10

- **SH 1:** The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year. (4 points)

- **SH 3:** The percentage of women prescribed an oral or patch contraceptive method in the last year who have received information from the practice about long acting reversible methods of contraception in the previous 15 months (3 points; thresholds 40 – 90%)

- **SH 4:** The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription (3 points; thresholds 40 – 90%)

How patients benefit

Eighty two percent of women who have an unwanted pregnancy used at least one method of contraception at the time they became pregnant. This failure rate is not usually due to ineffective contraception, but to inconsistent or incorrect use of contraception, or not using any method at all. The British pregnancy advisory service (BPAS) report that approximately 40% of their clients say they didn't use contraception at the time they conceived[9]. However, we must recognize that contraception does fail. Seventy one percent of contraception used in the United Kingdom is either oral contraception (45%) or condoms (26%) (Figure 2). It is unfortunate that the two most popular contraceptives in the UK are condoms and the pill, because incorrect and inconsistent use of both methods is common. In the UK and the USA, the majority of unintended pregnancies occur among women who claim to have been using condoms, pills or no contraception[10]. In a Finnish study of the history of contraceptive choices and the risk of repeat abortion, subjects mainly

reported use of condoms, no contraception or combined oral contraceptives at the time of an unplanned pregnancy. [11] and from my own anecdotal experience of working in a pre-assessment termination of pregnancy clinic, women reported the same choice of contraceptive method. Real-life efficacy of various contraceptive methods in the prevention of pregnancy has been suggested to depend on a user's capacity to conceive, frequency and timing of intercourse, degree of compliance with the method and efficacy of the method itself.[12]

Conclusion

Many factors influence contraceptive choice and women recognize the importance of using effective contraception. Pills and condoms are most familiar and acceptable, but women are poorly informed about LARC. Long acting reversible contraception has the potential to reduce unintended pregnancies; however in the UK these methods are underused. The cost of unintended pregnancy and abortion both in economic and emotional terms must be avoided not only for the personal distress of the woman but also for the cost to the NHS. Therefore nurses have an increasingly greater opportunity to make change happen within the field of sexual and reproductive health and the opportunity to learn and utilise new skills. They have the opportunity make a difference to the lives of women and their families at the same time earning QOF points for implementation and making budgetary savings. There has never been a better time for nurses to be involved in the provision of contraception.

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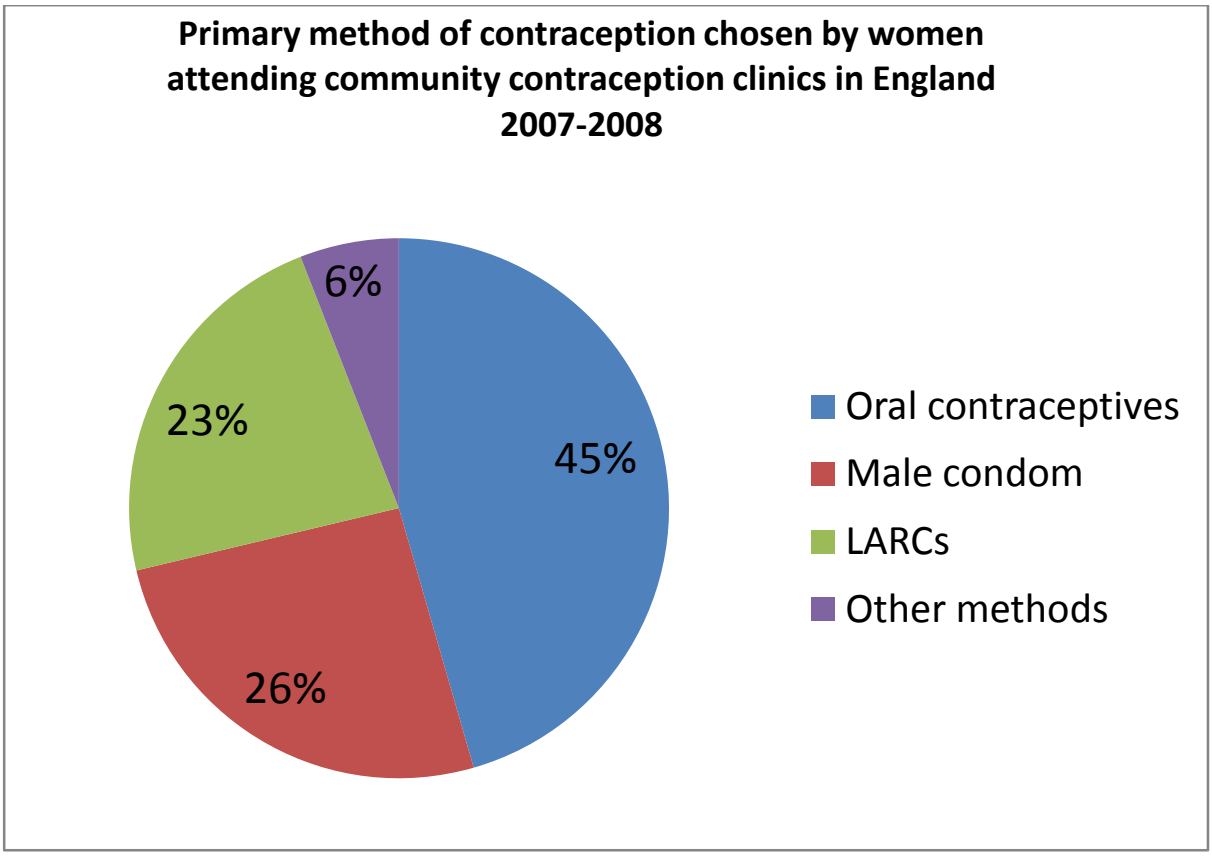
Figure 2


Primary method of contraception chosen by women attending community contraception clinics in England 2007-2008
6%
23%
45%
26%
Oral contraceptives
Male condom
LARCs
Other methods

Box 1 All LARC methods are suitable for

- Nulliparous women
- Women who are breastfeeding
- Women who have had an abortion – at time of abortion or later
- Women with BMI > 30
- Women with HIV – encourage safer sex
- Women with diabetes
- Women with migraine with or without aura – all progestogen-only methods may be used
- Women with contraindication to oestrogen

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