Sexual Health Needs Assessment – contraception

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November 2015

www.lancashire.gov.uk

Lancashire County Council

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Contraception

Councils are now mandated to arrange for the provision of 'open access sexual health services' for everyone in their area including free contraception and access to all methods of contraception. Department of Health guidelines suggest it may be best to offer unrestricted access to all methods of contraception.[1]

User-dependent methods of contraception (UDM)

In 2012/13, oral contraceptives were the most consistently popular method of contraception chosen by women attending NHS community contraceptive clinics. The second most common primary method of contraception for women was the male condom with one in five choosing this method. The contraceptive patch is also included in this category.

Diagram 1: user-dependent methods of contraception

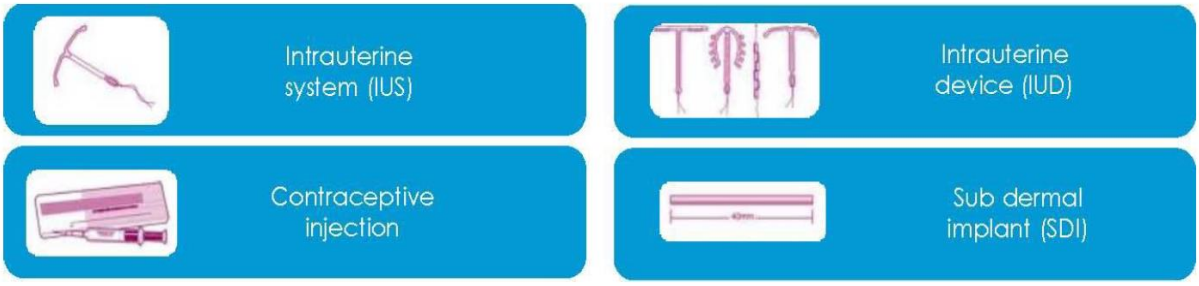
Long-acting reversible contraception

Long-acting reversible contraceptives (LARC) are defined as methods of contraception that require administration less than once per month and the use of LARC as a primary method of contraception amongst women has been slowly increasing over the last few years and now accounts for three in ten of all women attending NHS community contraceptive clinics. LARCs are not user-dependent methods of contraception and as such are not reliant on regular user adherence.

There are four types of LARC: injections, implants, intrauterine devices (IUDs) and intrauterine systems (IUS), all of which are 99% effective. The injections are required every 8-12 weeks, implants will last up to 3 years, IUDs 5-10 years and IUS 5 years. The National Institute for Health and Clinical Excellence (NICE) advises that LARC methods, such as contraceptive injections, implants, IUDs and IUS, are highly effective

as they do not rely on daily compliance and are more cost effective than condoms and the pill.[2]

Diagram 2: long-acting contraceptives



LARCs are safer than the pill or condoms. In typical use, 8 women out of 100 get pregnant using the pill over a year, but less than 1 woman in 1,000 will get pregnant using LARC. Each LARC is totally reversible and does not affect fertility.[3]

Emergency contraception

There are a number of different forms of emergency contraception; the intrauterine contraceptive device (IUCD) is the most effective and is available at contraception and sexual health services (CASH).

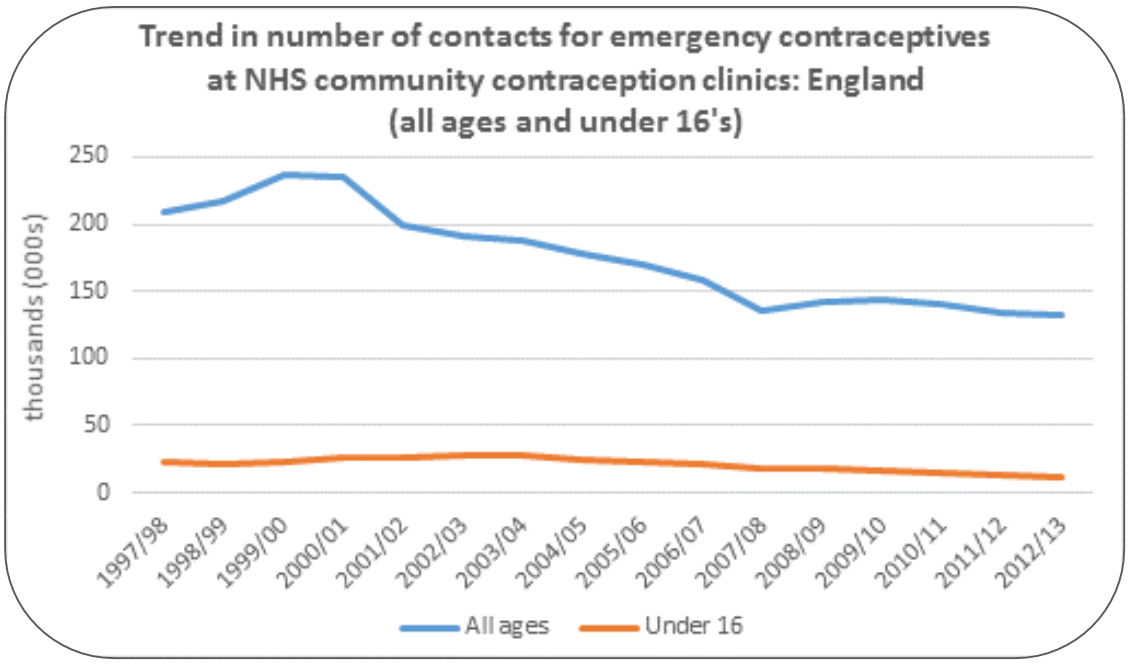
Emergency hormonal contraception (EHC)

EHC provides women with a means of preventing unintended pregnancy following any unprotected sexual intercourse, other names for EHC include ‘post-coital contraception’ and the 'morning after pill’ (including Ellaone). Women can access emergency hormonal contraception from a number of providers, including all local CASH services (formerly family planning clinics), general practice and walk in centres. Pharmacies are the main provider of emergency hormonal contraception and are commissioned to provide access to EHC for up to 72 hours. If women require emergency contraception beyond 72 hours post unprotected sexual intercourse they are referred to either CASH or primary care for Ellaone or an IUD.

Use of EHC is closely linked to a reduced rate of unplanned pregnancies for women of all ages. The availability of EHC is essential in reducing the teenage conception rate and also the number of unplanned pregnancies which result in termination. Studies indicate that making EHC available over the counter has not led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception.[4]

Data from the Health & Social Care Information Centre (HSCIC) on the number of contacts at NHS clinics for emergency contraceptives across England clearly shows a downward trend.[5] Contacts in the under-16 age group did remain fairly static but have declined slightly over the last five years from 18,400 in 2007/08 to 11,800 in 2012/13.

Figure 1: Trend in contacts for emergency contraception across England



Source: KT31 and SRHAD return, HSCIC

Across Lancashire* a total of 216 Lancashire pharmacies issue emergency contraception via a patient group directives (PGD). Pharmacists are required to undertake additional training in order to provide this service. If the pharmacy does not provide emergency contraception for free they are required to refer women to pharmacies currently providing free EHC. The list of pharmacies currently participating (at time of print) across Lancashire is available via www.best2know.co.uk.

Access to contraceptive services – good practice

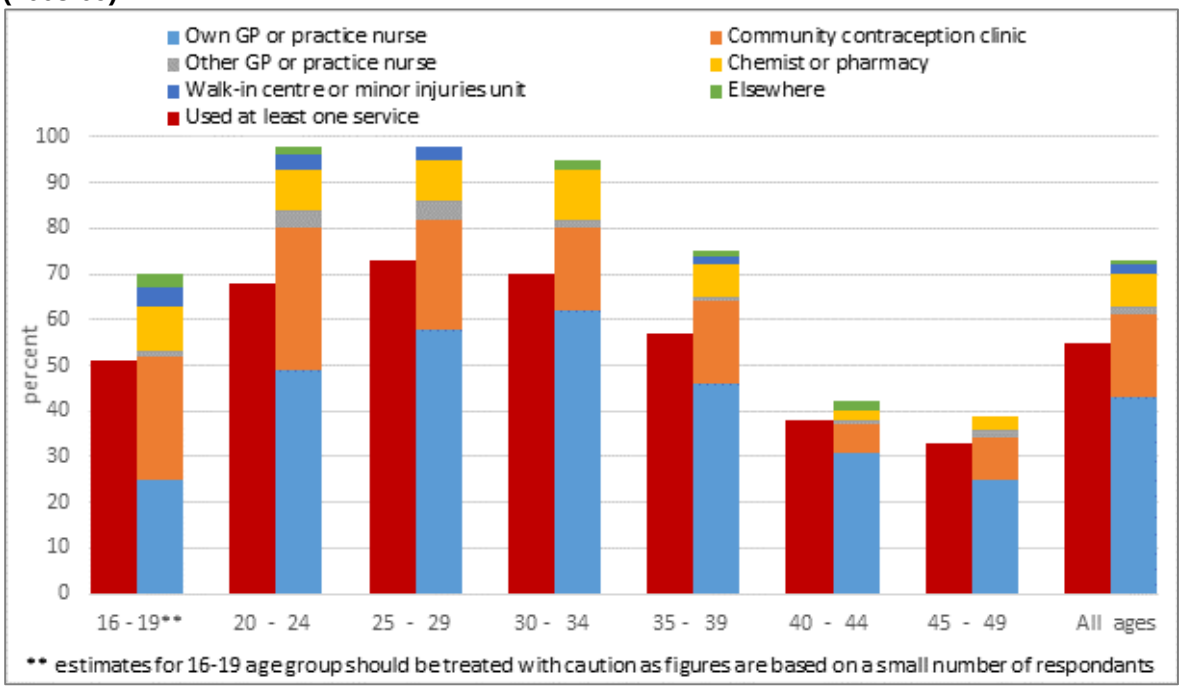
Although no longer published, previous data from the Office for National Statistics gives an indication on the use of family planning services by women of different ages.[6]

Over half of women aged 16-49 (55%) had used one or more family planning service during the five years prior to interview and this percentage was similar to most previous years. Service use was greatest among 25-29 year olds (73%) and lowest among those aged 45–49 (33%). Within each age group GPs/practice nurses were the most popular

* Lancashire refers to the 12 districts in the county council area; Lancashire-14 incorporates the 12 districts and the two unitary authorities of Blackburn with Darwen and Blackpool.

source of contraception, with the exception of 16–19 year olds who were as likely to use community contraceptive clinics as they were to use their own GP/practice nurse.

Figure 2: Use of family planning services during the previous five-year period, by age, in England (2008-09)



Percentages by individual service sum to more than service use as respondents could give more than one answer.
Source: Contraception and Sexual Health 2008/2009, Office for National Statistics

Most NHS contraception is administered in general practice, but for some people, obtaining contraception services from their GP is not a feasible or preferred option. Such groups may include young people with confidentiality concerns, patients of single-handed male GPs, or asylum seekers, gypsy travellers, homeless people and others not registered with a GP.

To meet their needs, the NHS has in the past commissioned community contraceptive clinics, a responsibility which passed to local authorities on 1st April 2013. Councils are now mandated to arrange for the provision of open access sexual health services, including “free contraception, and reasonable access to all methods of contraception”. The term ‘open access’ means that services cannot be restricted to those living or having a GP in the area. ‘Reasonable’ access is not defined, but DH guidelines suggest that in practice it may be best to offer unrestricted access to all methods of contraception.

Cost effectiveness of contraception

It has been shown that all methods of contraception are cost effective, providing net savings per pregnancy averted or per couple-year of protection.[7] Investment in contraception therefore makes sense by reducing the financial burden on the NHS and by improving outcomes for women by reducing the number of unintended pregnancies.

Using existing methodology it is possible to estimate that, based on up-to-date costs of the different contraceptive methods and the proportion of women using each method, for every £1 invested in contraception over £11.09 is saved, whilst that rises to £13.42 for every £1 invested in LARC methods.[8] All currently available LARC methods are more cost effective than the combined oral contraceptive pill, even at one year of use.

The England average for spend on contraceptive prescriptions was around £8.96 per head of female reproductive age population (15-44 years old), per annum in 2010/11 which is the latest year where data are available.

Defining the data

Information on contraceptive use is collected from NHS community contraceptive clinics (family planning clinics and clinics run by voluntary organisations such as Brook advisory centres) but excludes services provided in out-patient clinics and those provided by general practitioners.

A quarterly data collection known as the sexual and reproductive health activity dataset (SRHAD) started in 2010/11 and it is currently running alongside the KT31 return.[9] Not all fields that are collected via KT31 are available via SRHAD. Information on clinic sessions for people aged under-25 is not available and as the majority of organisations are now returning data via SRHAD, they are no longer presented. Also, first contacts for women in relation to sterilisation and for men in relation to vasectomy cannot be ascertained via SRHAD.

Contraception in community contraceptive clinics – key facts

The NHS Information Centre publishes annual data on the prescribing of contraceptives in community contraceptive clinics.[10] However, these data do not give the full picture of contraceptive use because:

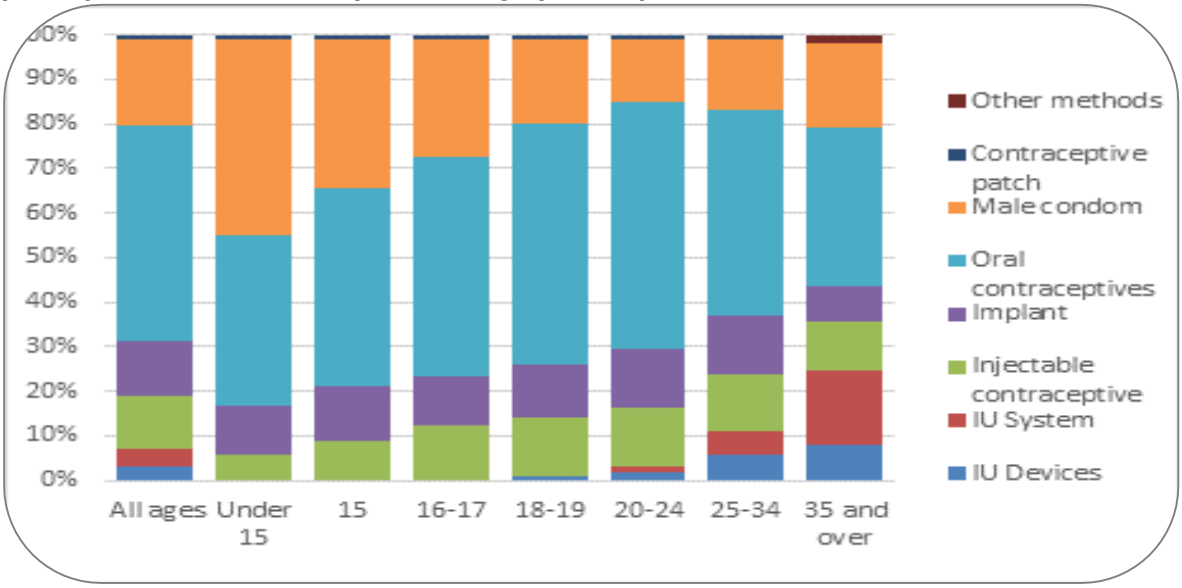
- they do not include prescriptions for contraception given in general practice – certain demographics or age groups may be more likely to access their contraception through a GP rather than a community contraceptive clinic; and
- the dataset only records contraceptives prescribed at first contact – women may return to the clinic to try another contraceptive option and these contacts would not be captured.

Recognising these limitations, the data shows that across England during the period April 2012 to March 2013:

- There were 2.3 million attendances at NHS community contraceptive clinics made by 1.3 million individuals.
- 1.2 million women and 149,000 men attended NHS community contraceptive clinics.
- Oral contraception was the primary contraceptive method of 47% of women and it remains the most common primary method. It was the most common method of contraception for those in almost every age group.
- Use LARC now accounts for 30% of primary methods of contraception among women. This is an increase from the previous year (28%).
- There were 125,000 contacts in relation to EHC, a decrease of 3% on 2011-12.
- Almost one in three women in England requested LARC from NHS contraceptive services (30%, or 272,000), a small rise on the previous year where 28% of women requested LARCs (259,000).
- The male condom was the preferred method of contraception in almost two-thirds of men (63% or 94,800 out of 149,000).

Methods of contraception vary widely by age and figure 3 shows the contraceptive choices made by women in the North West attending community contraceptive clinics in 2012/13, broken down by age group. User-dependent methods are most commonly used by women aged under-20 (mainly oral contraception and the male condom) with almost half, 46% choosing oral contraception. Oral contraception choice is highest in the 18-24 year age group at 54%. In the age groups 25-34 and 35+ LARC use is much higher with more than two-thirds of women choosing one of these methods.

Figure 3: First contacts with women at NHS community contraceptive clinics in the North West by primary method of contraception and age (2012/13)



Source: NHS Contraceptive Services, England – 2012/13, Health & Social Care Information Centre

Although we do not have the same age breakdown for Lancashire, we do have the proportions of first contacts with women who attended NHS community contraceptive clinics by provider. Table 1 shows approximately 40% of those first contacts were with women aged 20-34, while 25% were for women aged under-20 years. First contacts for contraceptive reasons make up almost 80% of all contacts. The variation in age groups by provider may be a reflection of the age group the service is targeted at, for example, Blackburn and Burnley Brook are services for those under-25.

Table 1: Contacts with women by provider, by age group (2012/13)

	Total first contacts with women (all reasons)	Total first contacts with Women (Contraception reasons only)[1]	First contacts with women **under 20** (all reasons)		First contacts with women **aged 20-34** (all reasons)		First contacts with women **aged 35+** (all reasons)	
England	**1,199,100**	**897,600**	**242,352**	***27%***	***466752***	***52%***	***179520***	***20%***
North West	**230,400**	**179,500**	**57,440**	**32%**	**89,750**	**50%**	**34,105**	**19%**
Assura Blackpool LLP	5,000	4,100	451	11%	2,583	63%	1,066	26%
Blackpool PCT	11,200	9,200	3,680	40%	4,232	46%	1,288	14%
Lancashire Care NHS Foundation	13,700	10,200	2,550	25%	5,100	50%	2,550	25%
North Lancashire Teaching PCT	2,700	2,400	1,008	42%	1,104	46%	288	12%
Southport & Ormskirk Hospital Trust (West Lancashire part)	15,600	11,600	2,900	25%	6,032	52%	2,668	23%
Blackburn Brook	3,300	2,600	1,560	60%	1,040	40%	-	-
Burnley Brook	2,200	2,000	1,120	56%	880	44%	-	-

Table 2 shows the contraceptive method of women for whom their first contact is for contraceptive reasons only. In Lancashire-14 slightly more choose LARC (33%) than the national average (30%) and 67% choose user-dependant methods (UDM).

Table 2: Choice of contraceptive method for women who have a first contact for contraceptive reasons only, 2012/13.

	Long Acting Reversible Contraceptives (LARCs) total		User dependant methods		Other methods[2]
England	269,280	30%	610,368	68%	2%
North West	57,440	32%	122,060	68%	0%
Assura Blackpool LLP	1,845	45%	2,214	54%	0%
Blackpool PCT	3,864	42%	5,336	58%	0%
Lancashire Care NHS Foundation	3,264	32%	6,936	68%	0%
North Lancashire Teaching PCT	768	32%	1,632	68%	1%
Southport and Ormskirk Hospital NHS Trust (West Lancashire part)	4,060	35%	7,540	65%	0%
Blackburn Brook	520	20%	2,080	80%	1%
Burnley Brook	440	22%	1,560	78%	0%

The figures above are based on first contacts with women at NHS community contraceptive clinics only.

To get a more complete picture of contraceptive use and choice of methods across Lancashire, prescribing data has been analysed. Across Lancashire there were almost 170,000 prescriptions for contraception within a primary care setting. Table 3 provides a breakdown of each contraceptive type and the numbers of prescriptions dispensed. Care should be taken when interpreting this information as the total number of prescriptions is not representative of the number of women who have received each contraception method: in other words, it is not patient linked.

Table 3: Number of types of contraception and percentage of total contraception prescribed within a primary care setting

		England	Lancashire-12	
Contraception method		**%**	**No.**	**%**
LARC	IUD	0.5%	700	0.4%
	IUS	1.6%	1,823	1.1%
	Injectable	11.4%	22,121	13.1%
	Implant	1.8%	2,833	1.7%
	Total LARC	**15.3%**	**27,477**	**16.2%**
UDM	Oral contraceptives	83.6%	140,227	82.8%
	Contraceptive patch	0.8%	1,418	0.8%
	Other	0.3%	183	0.1%
	Total UDM	**84.7%**	**141,828**	**83.8%**
Total contraception		**100%**	**169,305**	**100%**

Source: Public Health England STI & HIV Portal, LASER reports, 2014

Women attending general practice for contraception were more likely to be prescribed the oral contraceptive pill than any other method. The oral contraceptive pill is a very effective form of contraception when taken as prescribed.

It is possible that women attending general practice for contraception may be referred to a community contraceptive clinic for a LARC method, such as an IUD or IUS. However this may be putting an additional hurdle in the way of women accessing the LARC

method of their choice. Ideally women should be able to have the LARC method of their choice fitted at their local general practice by a qualified

Prescribing data on contraception provision

Prescribing analysis and cost (PACT) data uses NHS prescription forms to calculate how much pharmacists and GPs who dispense should be paid as reimbursement for medicines dispersed to patients within primary care settings in England.[11] PACT data contains items that have been prescribed and dispensed. Items that were not dispensed – prescriptions that were not collected – are not included in the data. Please note data presented here is only from PACT; contraception prescribed or bought outside of PACT are not included (for example, data from community sexual and reproductive health services, pharmacies and young people's services).

Total figures for the two different methods of contraception, LARC and UDM, prescribed within a primary care setting are presented in table 4. Care should be taken when interpreting this information as the total number of prescriptions is not representative of the number of women who have received each contraceptive method.

Table 4: number of types of contraception and percentage of total contraception prescribed within a primary care setting, 2013

Area	LARC		UDM		Total prescribed
England		**15.3%**		**84.7%**	
Lancashire	**27,477**	**16.2%**	**141,828**	**83.8%**	**169,305**
Burnley	2,993	21.4%	10,968	78.6%	13,961
Chorley	2,622	13.6%	16,644	86.4%	19,266
Fylde	1,243	17.0%	6,076	83.0%	7,319
Hyndburn	2,108	19.0%	8,971	81.0%	11,079
Lancaster	2,813	13.3%	18,336	86.7%	21,149
Pendle	1,841	16.7%	9,181	83.3%	11,022
Preston	2,947	18.0%	13,392	82.0%	16,339
Ribble Valley	1,330	13.6%	8,479	86.4%	9,809
Rossendale	2,257	21.8%	8,120	78.2%	10,377
South Ribble	3,341	16.6%	16,762	83.4%	20,103
West Lancashire	1,978	13.8%	12,334	86.2%	14,312
Wyre	2,004	13.8%	12,565	86.2%	14,569

Source: Public Health England, HIV & STI Portal - LASER reports

Recommendations

Table 1 indicates that access to CASH clinics are primarily those aged 20-34 with those under-20 only representing 25% of the whole. There could be a number of reasons for this, including the lack of dedicated young people's provision in some areas of Lancashire, for example Lancaster has no dedicated provision and has a high young people population as it has two universities.

- Greater provision of dedicated young people's services in areas with greater populations of young people.

Whilst women are expected to have full choice in relation to contraception, uptake of LARC is an important feature of contraceptive usage, In respect of LARC, most providers exceed 30% uptake, whereas, one of the young people's services is only achieving a 20% uptake. There is a likely correlation between low uptake and young people, as the calculation for other providers includes all ages. In addition, there is a need to ensure that all services offer not just subdermal implants, but also IUD, not currently available at all young people's service.

- All services offer all contraceptive methods at all sites and at all times.
- Promotion of LARC is prioritised.

It is clear that in common with the England average, in primary care oral contraception is the most popular form of contraception issued, however this differs across Lancashire. However, it is of note that this differs across Lancashire, with Burnley and Pendle having a greater uptake of LARC and Lancaster the lowest, despite Lancaster having a large population of young people and two universities.

- To encourage general practice to provide information regarding all methods of contraception for women.
- To increase numbers of GPs able to offer LARC.
- To consider inter-practice referral systems to enable GPs to offer the service to both registered and non-registered populations.

Contraception usage in abortion services and maternity services is a clinical commissioning group responsibility

- Maintain and promote access to contraception for women post abortion and post-natal.

References

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[5] HSCIC, NHS Contraceptive Services, England - 2012-13, Community contraceptive clinics

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[8] Bayer Healthcare, 2013. Contraception Atlas 2013. November 2013

[9] SRHAD Sexual and Reproductive Health Activity Dataset

[10] HSCIC, 2013, NHS Contraceptive Services in England in 2012-13, KT31 and SRHAD return, Health and Social Care Information Centre

[11] PACT