



# **Sexual Health Needs Assessment – abortion**

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## Abortion

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. DH guidelines suggest it may be best to offer unrestricted access to all methods of contraception.<sup>1</sup>

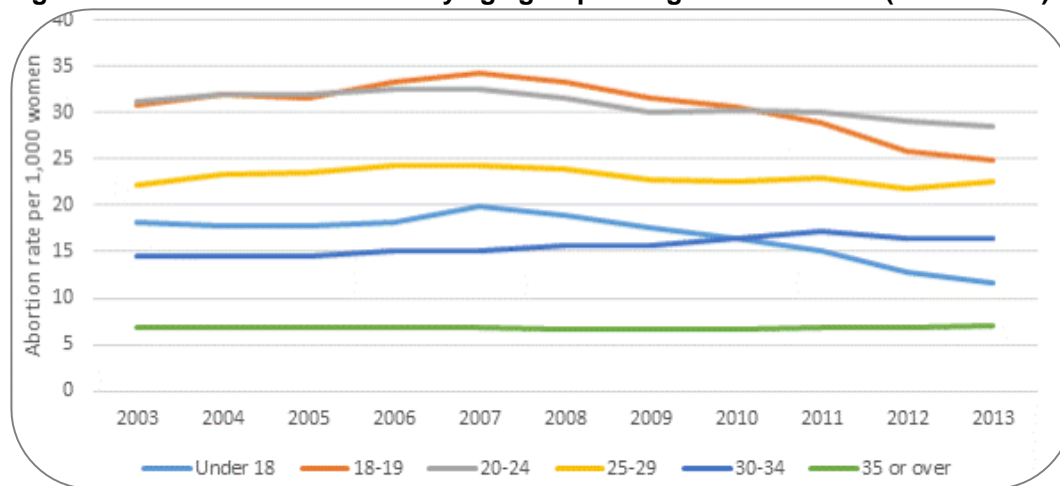
Since April 2013 the commissioning of abortion services became the responsibility of clinical commissioning groups (CCGs). However, it is essential for effective links and pathways with contraception services to ensure women are able to have access to contraception, both at the time of the abortion and as part of a follow up.

Abortion services should aim to provide high-quality, efficient, effective and comprehensive care which respects the dignity, individuality and rights of women to exercise personal choice over their management. Current evidence and best practice is identified within The Care of Women Requesting Induced Abortion (evidence-based clinical guideline no. 7).<sup>2</sup> The Royal College of Obstetricians and Gynaecology confirm that an abortion service should be an integral component of a broader service for reproductive and sexual health, encompassing contraception, management of STIs and support.

Women should also be advised of contraception and the greater effectiveness of long-acting reversible contraception (LARC).<sup>3</sup> This is included as a Required Standard Operating Procedure (RSOP) within section 13 'contraception and sexual transmitted infection screening' of the 'Changes to procedures for the approval of independent sector places for termination of pregnancy.'

*It states "...future contraception should have been discussed and, when possible, the chosen method should be initiated immediately. Particular attention should be given to the young and women who have had repeat conception and abortions; those who choose not to start immediately should be given information about local contraception providers in addition to their GP."*<sup>4</sup>

Although the overall rate of abortion for all women has stayed similar over the last ten years the rate has fallen in women aged under-25, but stayed the same or risen slightly in women aged 25 and over. For women resident in England and Wales (2013), the total number of abortions was 185,331. This was 0.1% more than in 2012 (185,122) and 2.1% more than in 2003 (181,582).

**Figure 1: Trend in abortion rates by age group in England and Wales (2003 – 2013)**

### Defining the issue

Changes in patterns of sexual behaviour have led to a number of health and social problems – including increased numbers of unplanned pregnancies – and Britain is notable for having one of the highest teenage pregnancy rates in Western Europe.<sup>5</sup> Abortion rates are an indicator of rates of unintended pregnancy, but they are also influenced by cultural and legal considerations. Overall, there has been a rising trend in long-term abortion rates over the past three decades though they do appear to have levelled off over recent years.

The recent National Survey of Sexual Attitudes and Lifestyles (Natsal-3) estimates that one in six (16.2%) pregnancies experienced in the past year score as unplanned, 29% as ambivalent, and just over half (55%) as planned.<sup>6</sup> Based on 2012 conception data this means just under 380,000 pregnancies in England were considered unplanned or ambivalent in 2012. Whilst pregnancies resulting in births were far more likely to be planned than those ending in abortion, the finding that four in 10 pregnancies ending in abortion were planned or ambivalent cautions against equating abortion and unplanned pregnancy.

Pregnancies in young, single women are most likely to be unplanned. Pregnancies in the 16-19 age group account for only 7.5% of the total number of pregnancies for all ages, but 21.2% of those are unplanned. As there are more pregnancies in women aged 20-34 years, the majority of unplanned pregnancies occur in this age group. Factors associated with unplanned pregnancies were having first sex before the age of 16, lower educational levels, and not living with a partner.

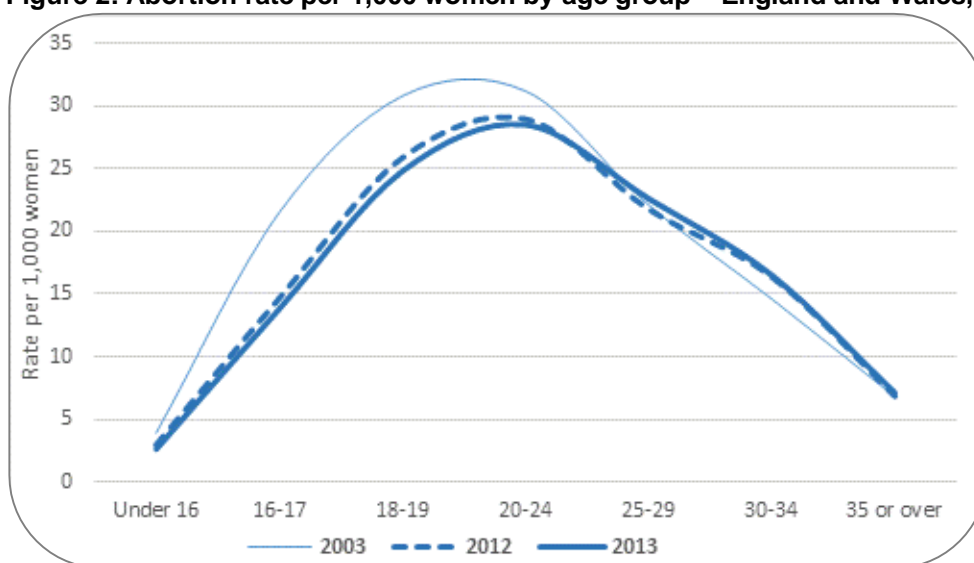
The fact that 88% of British women at risk of pregnancy use contraception also suggests that a large number of unintended pregnancies are due to improper contraceptive use rather than non-use of contraception. Increased uptake of LARC in

the UK and elsewhere would reduce unintended pregnancies at a fraction of the cost, thereby relieving the NHS and other national health care organisations of a significant burden.<sup>7</sup>

### Who is at risk and why?

Teenage pregnancy has been a major government priority for several years and is now the focus of a [Public Health Outcomes Framework](#) indicator. However, the abortion rate per 1,000 women peaks at about age 22 and declines only gradually thereafter, and while rates have fallen in those aged under-25 since 2003, it has risen slightly among those aged 25 and over (figure 2). The consequence of this is that 83% of abortions in England in 2012 were in women aged 20 and over.

**Figure 2: Abortion rate per 1,000 women by age group – England and Wales, 2003, 2012 and 2013**



Abortion statistics also show that rates for those aged over-25 have increased over the past ten years and indicate that significant numbers of women aged over-25 have unplanned pregnancies.<sup>8</sup>

It is important that all women are able to access the full range of contraception from a choice of providers in order to avoid unplanned pregnancy, and restricting access to services by age can therefore be counterproductive and ultimately can increase costs.<sup>9</sup>

### Level of need in Lancashire's population

The number of abortions serves as an imperfect proxy for unplanned pregnancy and is reported at clinical commissioning group (CCG) level. Across Lancashire there were 3,454 legal abortions in 2013. Most abortions occurred in the 20-24 age group (>30%) across all localities, though more than a quarter (27%) were to women aged 30 and over.

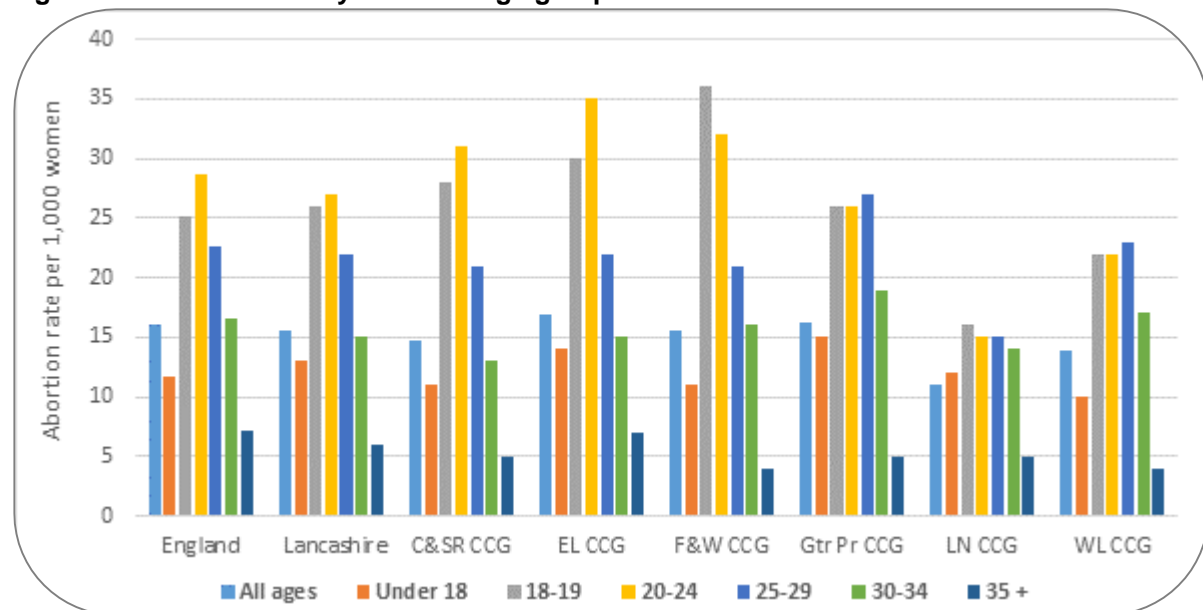
**Table 1: Number of abortions in Lancashire by age group (2013)**

Age	Lancashire	Chorley & South Ribble CCG	East Lancashire CCG	Fylde & Wyre CCG	Greater Preston CCG	Lancashire North CCG	West Lancashire CCG
All ages	3,454	462	1,206	399	725	379	283
Under 18	269	33	100	32	50	33	21
18-19	403	48	124	56	84	54	37
20-24	1,091	146	382	126	231	117	89
25-29	757	107	259	82	179	67	63
30-34	512	65	172	61	111	59	44
35+	422	63	169	42	70	49	29

Source: Abortion Statistics, England and Wales: 2013. Dept of Health, June 2014

When these numbers are converted to rates and compared to England, Lancashire has a slightly lower abortion rate overall than the national average (15.6 per 1,000 compared to 16.1 nationally) though rates vary across the area from 11.1 per 1,000 in Lancashire North CCG to 16.9 in East Lancashire CCG. No area has rates which vary significantly from the national average. Figure 3 shows the abortion rates across the CCGs by age group.

**Figure 3: Abortion rates by CCG and age group: 2013**

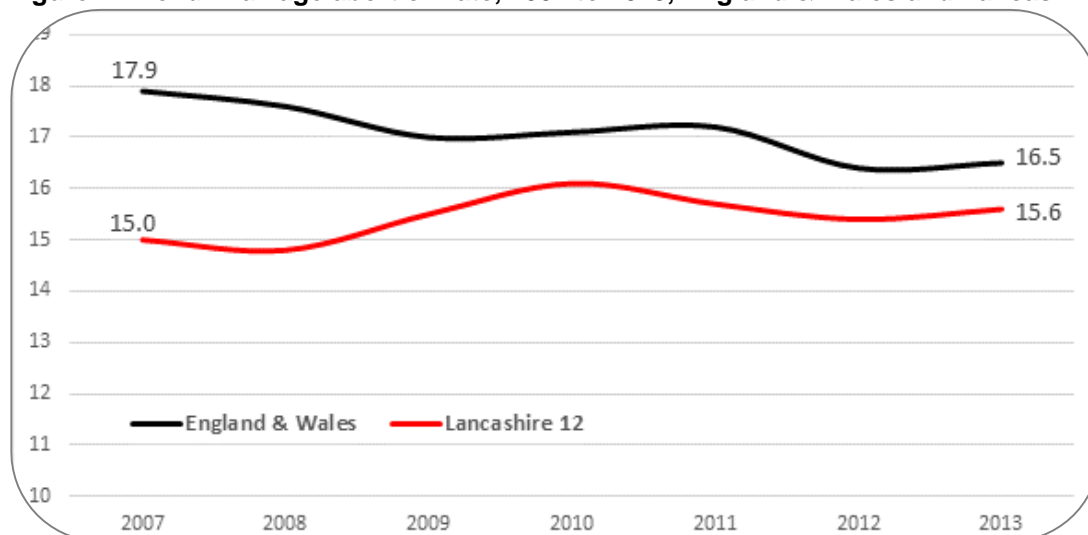


It can be seen that abortion rates across Lancashire generally reach their peak between ages 20-24 though there are slightly higher rates in the under-20's than the national average. Across the CCGs, Chorley and South Ribble, and East Lancashire follow the national pattern in that their abortion rates are highest in the 20-24 age group while Fylde and Wyre, and Lancashire North have slightly higher rates in the 18-19 age group. Greater Preston and West Lancashire show marginally higher rates in the 25-29 age group.

### Change over time

Due to changes in the way data is collected we can only look back over the past seven years for Lancashire's abortion rates. The trend has shown a slight rise since 2007 in contrast to the decline in abortion rates nationally, though rates in Lancashire have been consistently lower than the England and Wales average.

**Figure 4: Trend in all age abortion rate, 2007 to 2013, England & Wales and Lancashire**



### Ethnic group

Self-reported ethnicity was first included as part of the abortion statistics in 2002, and recording had reached 96% by 2013. Of women whose ethnicity was recorded, 76% were reported as white, 9% as Asian or Asian British and 9% as black or black British.<sup>10</sup> This differs from the ethnicity population estimates based on the 2011 census where 86% are reported as white, 7.5% as Asian or Asian British and 3.3% as black or black British.

The Sexual Health Balanced Scorecard gives a regional ethnic breakdown for abortions for those under-25 in 2009-11. Across the North West 86% were reported as white, 3.6% as Asian or Asian British and 2.4% as black or black British.<sup>11</sup>

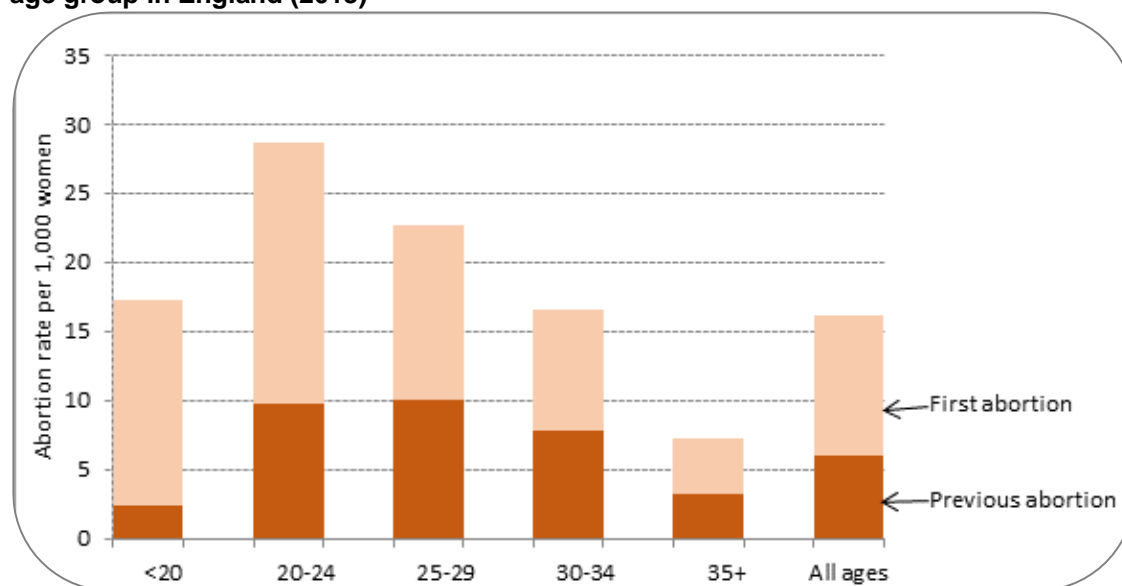
## Repeat abortions

Abortion has become more widely available, and less stigmatised. This means that women may well be more likely to report having had a previous abortion than they would in the past. Figure 5 shows the England abortion rates (2013) by age group, split into those who have or have not undergone an abortion before. Overall, 37% are 'repeat' abortions.

The discussion of 'repeat abortion' tends to focus on teenagers, but as the national statistics note, this is 'a complex issue associated with increased age and women being older when they have their first planned pregnancy. This allows for a longer time for exposure to pregnancy risks'. Simplistic attempts to stigmatise 'repeat' abortion ignore the fact that women who will have more than one abortion are less likely to be teenagers than older women who have had previous abortions when they were younger, and there may be a decade between the first and subsequent abortion.<sup>12</sup>

Across England the proportion of abortions which are 'repeat' is 45% in the over-25's age group and 27% in the under-25's.

**Figure 5: Abortion rate per 1,000 women, showing split between first and previous abortions by age group in England (2013)**

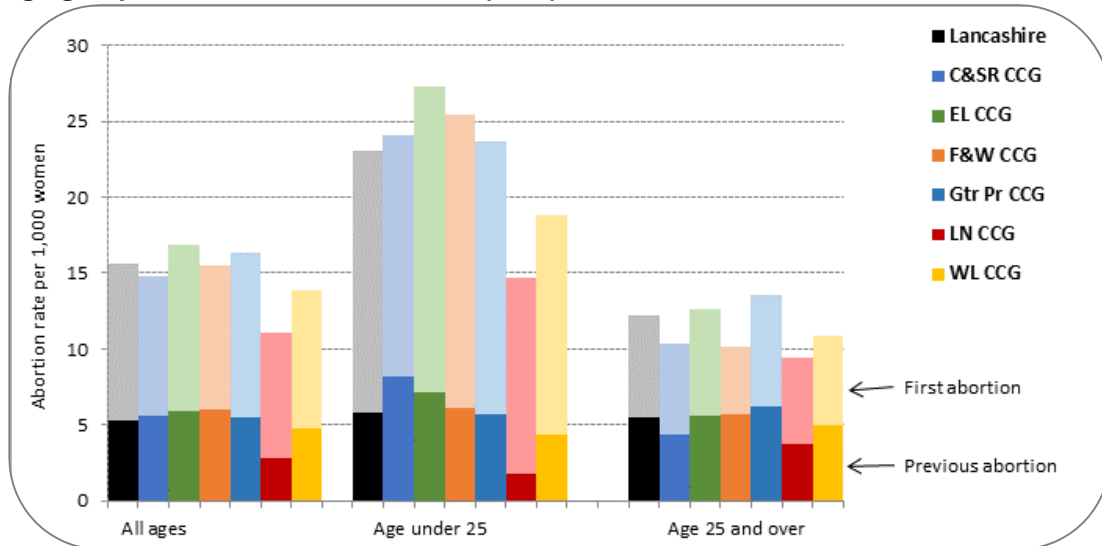


The same level of detail is not available at a local level but we do know just over a third (34%) of women in Lancashire who have an abortion have had a previous abortion; this compares to 37% nationally. This rises to 45% for women aged 25 and over which is the same as the national average, while a quarter (25%) of women aged under-25 have had a repeat abortion (27% nationally).<sup>13</sup> Figure 6 shows repeat abortions across Lancashire and the CCGs for women all ages, under-25 and over-25.



The government’s Sexual Health Improvement Framework cites evidence that the provision of contraception, particularly LARC, by abortion services can greatly reduce the rate of repeat abortions, and has been shown to be much more effective than a referral to a family planning clinic.<sup>14</sup>

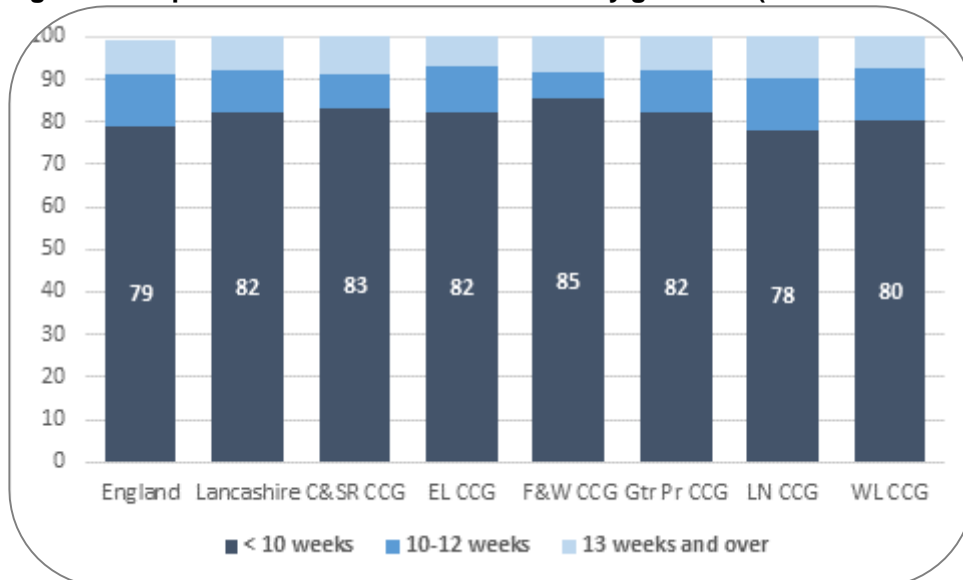
**Figure 6: Abortion rate per 1,000 women, showing split between first and previous abortions, by age group, Lancashire and the CCGs (2013)**



**Gestation**

The vast majority of abortions are performed at under 13 weeks (92% in 2013). There has also been a continuing increase in the proportion of abortions that are performed under 10 weeks since 2003. Across England, in 2013, 79% of abortions were performed at under 10 weeks, compared to 77% in 2012 and 58% in 2003 and there were corresponding decreases in the proportion performed later than 10 weeks. Across Lancashire 92% of NHS-funded abortions were carried out within 13 weeks and 82% within 10 weeks. Figure 7 shows the proportion of abortions done by gestation.

**Figure 7: Proportion of NHS funded abortions by gestation (number of weeks) by CCG**



Department of Health policy is that women who are legally entitled to an abortion should have access to the procedure as soon as possible as evidence shows that the risk of complications increases the later the gestation.<sup>15</sup> Although current policy emphasises the importance of women being able to access abortion, particularly early on in pregnancy, it has not significantly reduced demand for abortions in the second trimester which account for approximately 9% of all abortions. Although one of the reasons for later abortions may be foetal anomalies (most abnormalities are not detected until after 14 weeks of pregnancy) only 1.5% of all abortions are for this reason.

### **Importance of open access contraception services**

The importance of open access to services is illustrated by the fact that 40% of women with unplanned pregnancies using British Pregnancy Advisory Service (BPAS) counselling services in 2011-12 reported problems accessing contraception, either from their GP or from a clinic. Issues included unsuitable opening hours and restrictions on the methods available.<sup>16</sup>

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.

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.

### **Discriminatory practice**

An inquiry by the All-Party Parliamentary Group on Sexual and Reproductive Health in the UK has uncovered evidence of access to contraception services nationally being restricted on the basis of method, place of residence and age (discriminating against those over-25), or limited to those with a GP referral. It concludes that such restrictions detract from patient choice and personal responsibility, and calls for them to be lifted as a matter of urgency.<sup>17</sup>

## Recommendations

Whilst the commissioning responsibility for abortion care lies with CCGs, the recommendations relate to the needs as determined by the data within this HNA.

### Access

- Commissioners and providers of abortion services should have local strategies in place for providing information for women and healthcare professionals on routes of access, including self-referral.
- Commissioners should ensure that women have access to abortion services locally.
- Commissioners should ensure that abortion providers do not restrict access on the grounds of age, ethnicity, religious beliefs, disability, sexual orientation, marital status or the number of previous abortions.
- Services should identify issues which make women particularly vulnerable (for example, child protection needs and domestic abuse/gender-based violence) and refer/signpost them on to appropriate support services in a timely manner.
- The total time from seeing the abortion provider to the procedure should not exceed 10 working days.

### Contraception

- Commissioners should ensure that services meet the recommendations relating to:
  - contraception after the abortion;
  - antibiotic prophylaxis;
  - screening for sexually transmitted infections (STIs); and
  - information provision after the abortion.
- The CCGs need to work with abortion providers to ensure that they are providing contraception services and that they are linked into the wider network of contraceptive services in their area.
- Commissioners should utilise national, regional and local data to inform the referral pathways.
- Service re-design for contraception should include flexible opening times and ensure that all methods of contraception are available at all sites and at all times.
- Provision of additional contraception services via primary care should be promoted and access made easier.
- Commissioners should ensure that contraceptive advice and provision is available in maternity units.

## References

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- <sup>1</sup> DH, 2013. Commissioning Sexual Health services and interventions – Best practice guidance for local authorities.
- <sup>2</sup> The Royal College of Obstetricians & Gynaecologists, 2011. The Care of Women Requesting Induced Abortion (Evidence-based Clinical Guideline No. 7).
- <sup>3</sup> NICE, 2005 Long acting reversible contraception, National Collaborating Centre for Women's and Children's Health. National Institute for Health and Care Excellence, October 2005
- <sup>4</sup> DH, 2014. Changes to procedures for the Approval of Independent Sector places for termination of pregnancy. May 2014
- <sup>5</sup> The Family Planning Association (fpa), *Teenage Pregnancy* factsheet (data sourced from United Nations Statistics Division, Statistics and Indicators on Women and Men, Table 2b, Indicators on Child-bearing, July 2010).
- <sup>6</sup> Wellings K et al, 2013. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) *The Lancet*, Vol 382, Issue 9907, p1807-1816, December 2013
- <sup>7</sup> Mavranezoulli I, 2008, The cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence (NICE) clinical practice guideline. *Hum Reprod.* 2008; 23:1338–45.
- <sup>8</sup> Ibid.
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- <sup>10</sup> Mavranezoulli I, 2008, The cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence (NICE) clinical practice guideline. *Hum Reprod.* 2008; 23:1338–45.
- <sup>11</sup> PHE Sexual Health Balanced Scorecard, 2012.
- <sup>12</sup> BPAS, 2014. 'Repeat' abortion and 'late' abortion: the reality behind the controversy. *Reproductive review*, British Pregnancy Advisory Service, May 2014.
- <sup>13</sup> Mavranezoulli I, 2008, The cost-effectiveness of long-acting reversible contraceptive methods in the UK: analysis based on a decision-analytic model developed for a National Institute for Health and Clinical Excellence (NICE) clinical practice guideline. *Hum Reprod.* 2008; 23:1338–45.
- <sup>14</sup> Wellings K et al, 2013. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) *The Lancet*, Vol 382, Issue 9907, p1807-1816, December 2013
- <sup>15</sup> Ibid.
- <sup>16</sup> British Pregnancy Advisory Service, 2012
- <sup>17</sup> All-Party Parliamentary Group on Sexual and Reproductive Health in the UK July 2012 *lthy lives? The cost of curbing access to contraception services.* July 2012