THE PRACTICE NURSE’S ROLE IN CONTRACEPTION CHOICE

Anne Scott outlines recommendations for contraception and how practice nurses can help patients make informed decisions about the method they choose.

Abstract

Contraception can play an important part in a woman’s life. Modern contraceptives provide a wide array of options for the effective prevention of unplanned pregnancy and sexually transmitted infections. The UK General Medical Services contract offers incentives to increase contraceptive service provision in general practice. This article considers contraception provision and the role of the nurse in enabling patients to make informed choices that reflect clinical best practice and the individual’s life circumstances.

Keywords

Contraception, women’s health, sexual health, patient choice, practice nurses, patient group directions

Practice nurses are often the first point of contact for women when deciding on contraception (Hearton 2012). Many women will, however, have already given some thought to, and quite reasonably have established preferences for, what method they would ideally want to use before sitting down with a practice nurse to discuss contraception.

Contraceptive choice is often influenced by a number of different factors and objective facts may not be the strongest determinants. For example, the experience of a friend who had a dreadful time with a particular method could weigh far more heavily than any amount of evidence to the contrary (Robinson 2009). Choice will also be influenced by age and the stage of an individual’s or couple’s reproductive life (Family Planning Association (FPA) 2011a). It is important for practice nurses to support their patients to consider their initial expressed preferences alongside those contraceptive methods that are most clinically suitable for them (National Institute for Health and Care Excellence (NICE) 2005, Faculty of Sexual and Reproductive Healthcare (FSRH) 2009).

Clinical suitability

The United Kingdom Medical Eligibility Criteria (UKMEC) provides evidence-based guidance and recommendations for clinicians advising on, and prescribing for, women about contraceptive methods (FSRH 2009). There are four UKMEC classification levels:

- **UKMEC 1** - a condition for which there is no restriction for the use of the contraceptive method.
- **UKMEC 2** - a condition where the advantages of using the method generally outweigh the theoretical or proven risks.

PROVISION OF preventive sexual health services in the UK has been calculated to save the NHS more than £2.5 billion a year (Department of Health (DH) 2001), and every one pound spent on contraception services is estimated to save the NHS £11 (McGuire and Hughes 1995). Evidence further showed that the NHS could save a further £30 million a year by improving contraception services, in particular by ensuring access to the full range of methods in a variety of settings (Armstrong and Donaldson 2005). It is established practice that general practice should always supply basic (level 1) contraceptive services (DH 2001). Patients have the added advantage of continuity of care if their general practice offers a full and comprehensive range of sexual health services – including contraception – with practice nurses being ideally placed to promote sexual health as part of healthy living advice (Hamphson 2006).
UKMEC 3 – a condition where the theoretical or proven risks usually outweigh the advantages of using the method. Provision of a method to a woman with a condition given a UKMEC category 3 requires expert clinical judgement and/or referral to a specialist contraceptive provider since use of the method is not usually recommended unless other methods are not available or not acceptable.

UKMEC 4 – a condition that represents an unacceptable health risk if the contraceptive method is used.

Table 1 (page 20) lists the contraceptive methods available that practice nurses should be familiar with if they are to advise women appropriately. It is beyond the scope of this article to summarise all of the conditions for each UKMEC category, but full details are available from the FSRH at www.fsrh.org/pdfs/ukmec2009.pdf.

A good holistic history is imperative to assessing medical eligibility for any contraception use and delivering patient-centred care. There are certain medical conditions when the combined methods should not be prescribed (UKMEC 4), and where careful consideration should be given before doing so (UKMEC 3). An example would be that a personal history of a definite venous thromboembolism remains an absolute contraindication to any combined hormonal method (FSRH 2009). The practice nurse should also consider other risk factors such as a high body mass index (BMI), cigarette smoking, hypertension and migraine (Robinson 2009).

These factors may not exclude the patient from receiving combined hormonal methods but need to be considered carefully. An example of this could be a BMI over 30kg/m², which would put the patient into UKMEC 2, or a BMI over 35kg/m² which would increase the risk to UKMEC 3.

The application of UKMEC criteria varies with contraceptive method, and each method and category need to be considered separately (FSRH 2009). While physical examination is not usually required, if an intrauterine device (IUD) or intrauterine system (IUS) is being considered, it is worth checking if an up-to-date sexual health screen is available to avoid introducing infection into the uterine cavity. It is also a good opportunity to ensure cervical screening is up to date (Guillebaud 2009). A follow-up visit after initiation of any contraception is advised to assess any problems, check blood pressure and to discuss any compliance issues if necessary.

For combined hormonal contraception this follow-up appointment is normally three months later, and for intrauterine contraception it is six weeks (FSRH 2009, Guillebaud 2009). Face-to-face counselling should be backed up by written information. A randomised control trial conducted in a primary care setting found that if FPA leaflets were widely available and accessible there was an associated threefold increase in good combined oral contraceptive pill (COCP) knowledge at three-month follow up (Little et al 1998).

It is not appropriate for the practice nurse to simply state that UKMEC 1 and 2 are safe, while 3 and 4 are unsafe. Someone who falls into UKMEC 3 with one condition could still be considered to use that method but would need careful consideration and clinical judgment should be exercised. However, when an individual has multiple conditions scoring highly, use of the contraceptive may pose an unacceptable health risk. If practice nurses feel they are unable to make this decision then referral onwards to specialist contraceptive services may be necessary.

Psychosocial needs and life circumstances

In striving to provide consistent clinical information and apply the UKMEC criteria, it is important to avoid inadvertently adopting a one-size-fits-all approach. A good holistic history has to consider the social, physical and psychosocial factors that influence the patient’s sexual health (NHS Greater Glasgow and Clyde 2010). The practice nurse should also take the opportunity to re-evaluate and assess such issues at patient reviews. An understanding of an individual’s life circumstances and psychosocial needs can help practice nurses enable their patients to choose the most effective contraceptive method that will best suit them at that particular time in their lives (Luthra 2007, Hearton 2012).

Women’s contraceptive needs change throughout their lives. A single woman, with no plans for a family in the foreseeable future, will have different contraceptive requirements from a woman in a committed relationship who is considering trying to conceive in the near future.

The Equality Act 2010 highlights the need to consider age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. For example, it is important to be able to tailor the consultation to the specific cultural background and concerns of the patient, and to avoid simplistic stereotyping of individuals who belong to different minority ethnic communities (Brook 2009).

Similarly, the risk of sexually transmitted infections is not the sole provenance of young people, with increasing cases being diagnosed in those aged 50 years and over (Von Simson and Kulasegaram 2012). Research has found that many lesbian and
biseXual women felt that their healthcare practitioner, having assumed that they were heterosexual, offered them inappropriate sexual health advice, including unwanted – and unnecessary – information on contraception (Hunt and Fish 2008). Similarly, while research has found that many people with learning disabilities are able and willing to talk about sexual health, they often feel that they have limited opportunities to do so, not least because of the restrictions that carers and staff can place on them (Simpson et al 2006). It should also be acknowledged that, while this article has focused on the role of the practice nurse in supporting women’s choices, contraception should not be considered as an exclusively female concern in the case of heterosexual couples. Practice nurses should encourage male partners to engage with the consultation and make them feel involved in any discussion or decision (Hampson 2006).

The importance of a tailored approach is most keenly felt in relation to providing contraceptive advice and support to patients under 16 years of age. The Sexual Offences Act (2003) and the Sexual Offences (Scotland) Act 2009 determine that sexual activity under the age of 16 is unlawful. While this should not impinge on the nurse’s ability to provide confidential sexual health advice, the nurse must be satisfied that there are no concerns about abuse or exploitation (Scottish Parliament 2009). The Age of Legal Capacity (Scotland) Act 1991 allows that a child under the age of 16 has the legal capacity to consent to his or her own treatment where certain conditions are met. This is a set of criteria that must apply when clinical practitioners are offering contraceptive services to under 16s without parental knowledge or permission (NSPCC 2012). The Fraser Guidelines, sometimes referred to as whether the young person is ‘Gillick competent’, state that the following requirements should be fulfilled:

- The young person will understand the professional’s advice.
- The young person cannot be persuaded to inform their parents.
- The young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment.
- Unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer.
- The young person’s best interests require them to receive contraceptive advice or treatment with or without parental consent. Although this judgment referred specifically to doctors, it is also considered to apply to other health professionals, including practice nurses. Irrespective of what the advice given is, it is important to tailor the consultation in an age-appropriate fashion, not least to balance the duty of care to, and confidentiality for, a young person. The Department of Health’s You’re Welcome quality criteria provides useful suggestions for how best to deliver such young people friendly support (DH 2007). However, practice nurses who feel they are unable to make the decision regarding a young person’s ‘competence’ based on the Fraser guidelines should signpost the individual to another appropriate professional who can.

**Implications for practice**

**Using standardised assessment tools** Many practice nurses use standardised assessment tools, as they provide a consistent structure for questions, ensuring no important information is missed, especially clinical risk factors (Kemp and Richardson 1994). Importantly, these tools need to be used flexibly in the contraception assessment, and professional judgment must be applied to adjust the questions according to a patient’s specific needs (Guillebaud 2009). While individual clinics may develop local assessment tools to promote consistency, these should be evidence based, whether they use a paper pro-forma or a computerised system (Jolley 2002, French 2007). Ultimately, good communication skills are essential in sexual history taking. While computerised assessment tools provide a valuable means of standardising data collection and facilitating clinical audit, they need to be used carefully to avoid de-humanising the consultation by reducing direct interaction between the practice nurse and patient (Bergeson 2006).

**Applying patient group directions** Many practice nurses issue or administer treatment under the guidance of patient group directions (PGDs) (NHS Executive 2006). A PGD is defined by the Nursing and Midwifery Council (NMC) as a ‘written instruction for the supply and/or administration of a named licensed medicine for a defined clinical condition’ (NMC 2008). PGDs allow a range of specified registered health professionals to supply and/or administer a medicine directly to a patient with an identified clinical condition (Campbell 2004). However, it is vital that all practice nurses working with PGDs must be assessed as clinically competent to do so (Freer 2003) and must comply with the standards set by the NMC (NMC 2008).

**Encouraging sexual health literacy** It is important to encourage greater evidence-based sexual health literacy among as many women as possible. Given the wide – and potentially confusing – array of contraceptive methods that are available, practice
Table 1  Contraceptive methods

<table>
<thead>
<tr>
<th>Method</th>
<th>Combined pill</th>
<th>Nuvaring</th>
<th>Patch</th>
<th>Progestogen-only pill (POP)</th>
<th>Injection – Depo-Provera</th>
<th>Implant – Nexplanon</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How effective it is</strong></td>
<td>More than 99% if used correctly.</td>
<td>More than 99% if used correctly.</td>
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<tr>
<td><strong>How it works</strong></td>
<td>Stops ovulation and thickens cervical mucus.</td>
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<td>Stops ovulation and thickens cervical mucus.</td>
<td>Produces a thick, mucus plug in the cervix, which acts as a chemical barrier to sperm penetration. Newer pills behave like a combined pill, with suppression of ovulation being the main mode of action.</td>
<td>Releases progestogen over a 12-week period, preventing ovulation, thickening cervical mucus and causing the lining of the uterus to become thin.</td>
<td>A small flexible rod containing progestogen that is inserted just under the skin in the upper arm. Releases progestogen over a 12-week period, preventing ovulation, thickening cervical mucus and causing the lining of the uterus to become thin.</td>
</tr>
<tr>
<td><strong>Notes</strong></td>
<td>Different varieties available: monophasic, biphasic, triphasic, and the everyday pill. The monophasic pill contains the same amount of oestrogen as progesterone and is the most commonly used.</td>
<td>Removed on day 22, and reinserted after a seven-day break, during which withdrawal bleeding occurs.</td>
<td>Each patch stays on for seven days; three patches are used followed by a seven-day break.</td>
<td>A good alternative for women who cannot take oestrogen (for example, smokers over 35 years of age). POPs have a three-hour window so timing is important. A newer POP, Cerazette has a 12-hour window and could be considered in women with a history of poor compliance.</td>
<td>When a woman stops taking Depo-Provera her fertility can take up to a year to return to normal, so it would not be a suitable method to suggest to any woman who is planning a pregnancy in the near future.</td>
<td>Fertility is unaffected and will quickly return to normal when the implant is removed.</td>
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<tr>
<th>Intrauterine device – Mirena</th>
<th>Cap</th>
<th>Intrauterine device (IUD)</th>
<th>Condoms (male and female)</th>
<th>Sterilisation (male and female)</th>
<th>Natural family planning</th>
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<tr>
<td>More than 99% if used correctly.</td>
<td>T-shaped plastic device that releases progesterone into the uterine cavity. This causes suppression of the endometrium, which becomes thin, preventing implantation. In addition, the cervical mucus is thickened, making it hostile to sperm.</td>
<td>92-96 per cent effective when used with spermicide. More than 99% if used correctly.</td>
<td>Male condoms are 98% effective and female 95% effective if used correctly.</td>
<td>This is a permanent method, suitable for people who are sure they never want children or do not want more children. About one in 2,000 male sterilisations fail. One in 200 female sterilisations fail.</td>
<td>If used according to instruction and teaching, this can be 99% effective.</td>
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<tr>
<td>More than 99% if used correctly.</td>
<td>A flexible latex or silicone device, used with spermicide, is put into the vagina to cover the cervix. This stops sperm from entering the uterus. Made of copper and works by providing a toxic environment to sperm, preventing fertilisation and inhibiting implantation.</td>
<td>Male: thin latex or rubber sheath worn over erect penis. Female: worn inside the female, lining the vagina. Both stop sperm entering the vagina.</td>
<td>Male: the tubes (vas deferens) that carry sperm from the testicles to the penis are cut, sealed or tied. Female: the fallopian tubes are cut, sealed or blocked by an operation. This stops the egg and sperm meeting.</td>
<td>The fertile and infertile times of the menstrual cycle are identified by noting the different fertility indicators. Sex can then be timed to the least fertile time of the female’s cycle.</td>
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<td>Can remain in situ for five years. Irregular bleeding and spotting can be common during the first six months of use, but often there is no bleeding at all.</td>
<td>Can be put in any time before sex. Women need to be individually fitted. Needs to be left in for six hours after sex.</td>
<td>Can remain in situ for five to ten years. Periods may be heavier, longer or more painful.</td>
<td>Putting a condom on, or in, can interrupt sex. When a male condom is used the male needs to withdraw from the vagina while still erect to avoid spillage from the condom. Male condoms are widely available and are free from many genitourinary medicine services. Female condoms are not so widely available. Both can help protect against sexually transmitted infections.</td>
<td>It does not interrupt sex. It cannot easily be reversed. Once the operation has worked, contraception doesn't have to be thought about. All operations carry some risk, but the risk of serious complications is low.</td>
<td>Can take three to six cycles to learn effective fertility sign monitoring. Electronic monitors, for example, are available (persona). This measures hormonal changes in urine samples. Persona predicts the fertile and infertile times of the menstrual cycle. If used correctly it can be 94% effective.</td>
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nurses must be able to provide accurate information to enable their patients to make informed choices (FPA 2011b). A variety of reliable websites are available to further signpost women to if they wish to source contraceptive information directly (such as www.talkchoic.co.uk), many of which also provide access to online tools that allow women to make contraceptive choices by answering questions related to their lifestyle, medical history and their contraception-related priorities (Brook 2012, FPA 2012). Practice nurses should, however, ensure that any such online resources signposted to are reputable, with their content reliable and presented responsibly.

Regular continuing professional development
The NMC code of professional conduct states that practitioners must maintain knowledge and skills throughout their working lives, and are responsible for delivering care based on current evidence-based research (NMC 2004). In 2003, NHS Education for Scotland produced a framework document, A Route to Enhanced Competence in Sexual and Reproductive Health Nursing, and in 2009 the RCN produced its framework document, Sexual Health Competencies: An Integrated Career and Competency Framework (NHS Education for Scotland 2007, RCN 2009). These resources effectively promote a self-reflective approach to continuous learning, encouraging practice nurses to identify gaps in knowledge and skills while planning an effective way of filling any gaps and allowing them to progress confidently through levels of competence.

Conclusion
The role of practice nurses in the provision of contraception and sexual health is ever increasing, as is the complexity of the issues that they have to help their patients to navigate. To provide patient-centred care it is important that practice nurses update their skills, knowledge and resources continually, and are supported to do so, while always engaging with the specific needs of their patients.

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Conflict of interest
None declared

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