Challenges in Access to Intrauterine Contraception

Dr Ruth Holman, Dr Rosalynn Morrin
Sexual Health Department, NHS Ayrshire & Arran, Irvine, United Kingdom

Introduction

Improving access to long acting reversible contraception is a priority for the Faculty of Sexual & Reproductive Healthcare (FSRH)[1] and Scottish government policy makers[2]. The majority of contraception provision is via primary care but intrauterine contraception is not always provided by practices.

Method

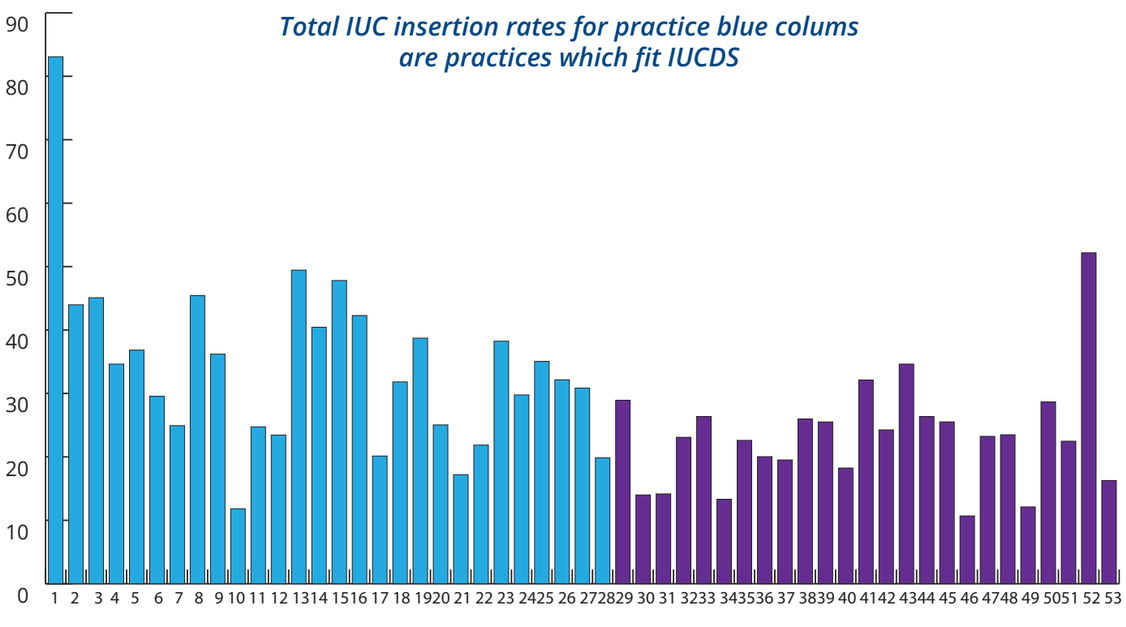
Prescribing data from the Public Health Scotland website and local prescribing data were analysed using Microsoft Excel to assess intrauterine contraception provision in GP practices and the local integrated sexual health service in our Health Board area.

Visits were made to GP Clusters and a questionnaire about barriers to service provision was circulated to the members of the local IUCD peer support group.Interventions to support IUC provision in primary care have been initiated.

Results

1. In 2021, populations at practices who do not fit IUCDs had a 1/3 lower rate of uptake of IUCDs

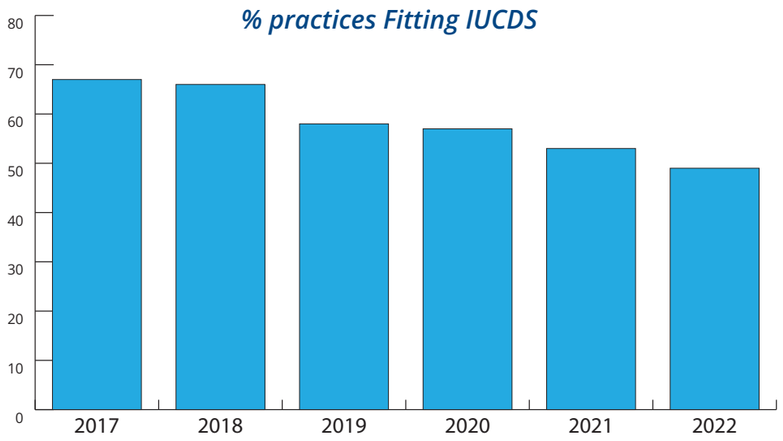
Total IUC insertion rates for practice blue colums are practices which fit IUCDS



Average rate of IUC insertion for practice population (i.e. SH and GP fits added together) 2021	
Practices which fit IUCDs	**34/1000**
Practices which don't fit IUCDs	**23/1000**

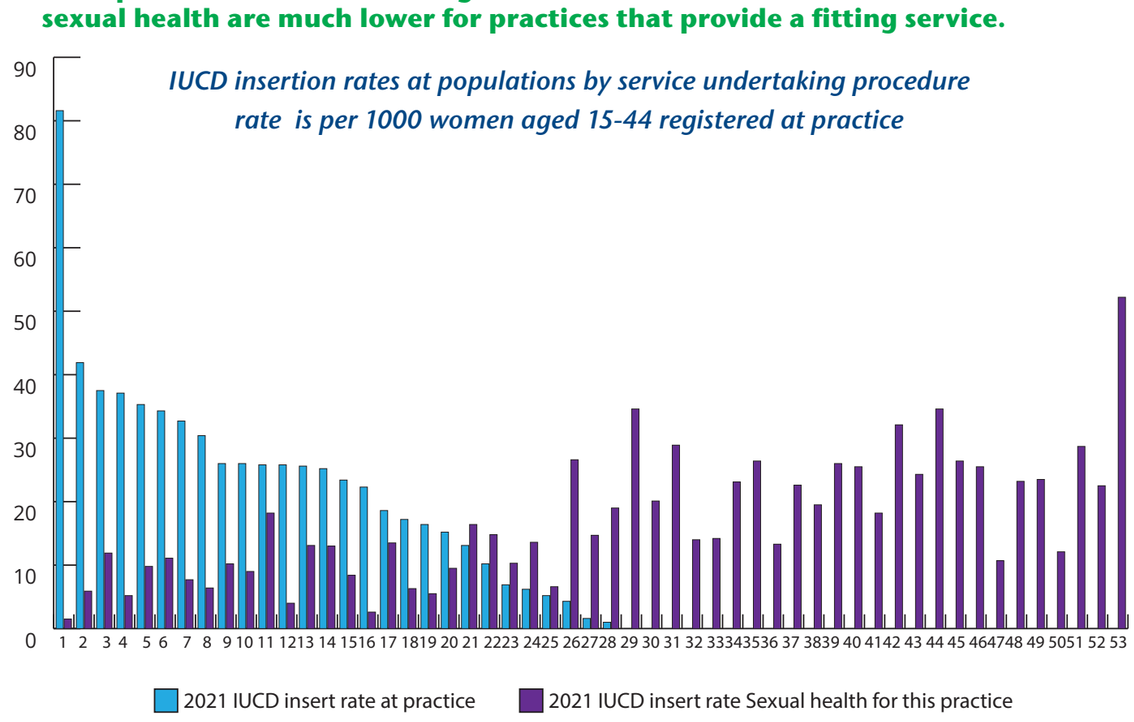
2. The number of practices fitting IUCDs has declined from 67% in 2017 to 49% in 2022

% practices Fitting IUCDS



3. Patients from practices that do not provide intrauterine contraception access IUCD provision at the local integrated sexual health service but insertion rates in sexual health are much lower for practices that provide a fitting service.

IUCD insertion rates at populations by service undertaking procedure rate is per 1000 women aged 15-44 registered at practice

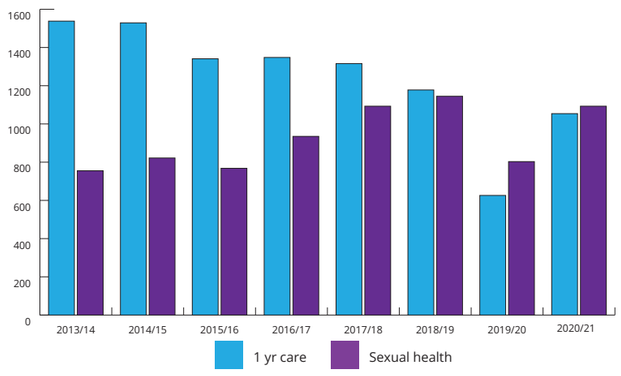


Patients from practices that do not provide intrauterine contraception access IUCD provision at the local integrated sexual health service but insertion rates in sexual health are much lower for practices that provide a service

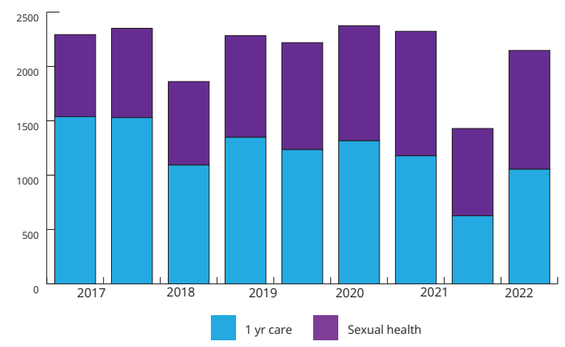
4. IUCD provision in primary care has declined by 31% since 2013/14 (1538 inserts in 2013/14, 1054 inserts in 2021/22, a decrease in the insertion rate per 1,000 women aged 15-49 from 19% to 14%)

The sexual health department has not been able to absorb the extra workload.

Numbers of intrauterine devices provided in primary care and sexual health by year[3]



Total number of intrauterine contraceptive devices provided showing proportion done in each setting[3]



Engagement with primary care

Staff revealed 2 overriding themes as the greatest barriers to offering a service - overwhelming daily General Medical Services workload demand and the financial reimbursement / viability for providing IUC insertions. Practices wanted help, and anticipate doing less LARC activity, due to unremitting workload and workforce pressures.

Feedback included:

- fitters retiring, everyone too busy to train to replace.
- struggling to cover daily workload, hard to squeeze in LARC appointments against overwhelming demand for core services (LARC is an enhanced service).
- GP recruitment is challenging across the Board -many practices are "just keeping heads above water".
- remuneration doesn't cover time cost. Locum cost to backfill clinical time significantly greater than procedure reimbursement.
- Room availability for LARC appointments.
- No room availability for a sexual health department outreach clinic.
- Loss of confidence with gap with Covid lockdown.
- Fitters de-skilling.
- Beds a problem, particularly with a high BMI - would like a Gynae bed.
- Practice in a deprived area reported a high DNA rate for LARC appointments, in spite of the practice team contacting patients the day before and text message reminders (also witnessed in a pilot LARC outreach clinic done by sexual health in conjunction with public health).
- Concern about adverse events.

Response

Public Health working with the Sexual Health Department, appointed an experienced GP to a part time role as Public Health Lead for Primary Care Sexual Health , who (in relation to LARC) has:

a) Piloted a cluster LARC clinic supporting access to LARC for a big practice (13,000+) that offers no LARC provision and has no room capacity for an outreach service. Service specification, information governance and data-sharing agreements were prepared. Clinic has been running for over 2 years, with positive feedback from attendees.
b) Updated LARC Enhanced service specifications.
c) Standardised intrauterine contraception and implant procedure documentation (for use across the Health Board, including in Maternity and by non-prescribers).
d) Developed intrauterine contraception and implant supporting information to help new fitters set up a service.
e) Sent out bi-annual Sexual Health email updates.
f) Established a well-attended quarterly, TEAMS lunchtime "Coil fitters" peer support group in conjunction with a Sexual & Reproductive Health Consultant to discuss e.g. interesting/ challenging cases, guidance updates. This provides CPD for reaccreditation.The TEAMS channel provides easy access to documentation.
g) Driven creation of a training video (funded by Public Health) for staff assisting with IUC insertion procedures in response to a request for help with training from Primary Care.
h) Become a Faculty Recognised trainer and provided training for Letters of Competence
i) Supported provision of relevant information in the Professionals section of the local sexual health website.
j) Worked with public health to arrange distribution of FPA patient information leaflets to all practices as it was recognised through discussions at cluster meetings that practices were unaware of these being available (funded through public health).
k) Facilitated use of public health underspend to provide Gynae couches with leg supports for 17 practices. (awaiting further funding opportunity to purchase more).
l) Presented a paper to Primary Care management requesting LARC Enhanced Service tariffs are reviewed (outcome awaited).

Conclusions

There are significant challenges in meeting the goal of improving access to intrauterine contraception as part of long acting reversible contraception provision. These are being addressed locally but without additional funding adequate resourcing, access to intrauterine contraception may decline further, due to the competing pressures on primary care.

Uptake of intrauterine contraception is lower overall when unavailable through the primary care provider. Travel to access IUCD fitting services in a sexual health clinic could be a barrier for some. Ensuring staff in all practices remain able to offer advice and counselling about IUCDs and the range of contraceptive methods, will be imperative for improving access to LARC and meeting policy aims of the FSRH and Scottish Government.

References

1. Scottish Government Women's Health Plan Scottish Government 2021 https://www.gov.scot/publications/womens-health-plan
2. The FSRH Hatfield Vision, Faculty of Sexual And Reproductive health 2023 https://www.fsrh.org/news-and-advocacy/the-fsrh-hatfield-vision
3. https://publichealthscotland.scot/publications/long-acting-reversible-contraception-larc-key-clinical-indicator-kci/long-acting-reversible-methods-of-contraception-larc-in-scotland-year-ending-31-march-2022/

NC23-00171