Emergency contraception given via a patient group direction

LEVONORGESTREL (Levonelle-2), a progestogen-only treatment, is now the recommended oral emergency contraception of choice (Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit, 2003). It superseded the ‘Yuzpe’ method (a combined oestrogen and progestogen hormonal emergency contraceptive) after a large randomised controlled trial showed that Levonelle-2 had improved efficacy and acceptability (Task Force on Postovulatory Methods of Fertility Regulation, 1998).

Levonelle-2
Levonelle-2 has no absolute contraindications (World Health Organization, 2000), thus increasing the range of women eligible to use it (although it is not suitable for women with acute, active porphyria). The licensing authority has changed its licence from a prescription-only medicine to one that can be sold over the counter in pharmacies to women aged 16 years or above. Women under 16 years are not excluded if they meet the Fraser criteria (Brittain, 1999).

One tablet is taken as soon as possible after unprotected sexual intercourse (up to 72 hours), and another is taken 12 hours later. If vomiting occurs within three hours, a replacement dose can be given. If an anti-emetic is required, domperidone is recommended.

The patient should be informed:
- That she may experience headache, breast tenderness, fluid retention, abdominal pain, nausea and/or vomiting;
- That her next period may be early or late;
- That she should use a barrier method of contraception until her next period;
- To return promptly if she experiences any lower abdominal pain, or if the subsequent menstrual bleed is abnormally light, heavy, brief or absent, or if she is otherwise concerned.

Patient group directions
Patient group directions (PGDs) are special regulations that allow appropriately qualified specialist nurses to provide a defined range of medications to clearly defined groups of patients who meet rigid inclusion and exclusion criteria (Brittain, 1999).

Several problems were identified with the emergency contraception services at Victoria Clinic (Box 1). This led to the introduction of a PGD allowing nurses trained in family planning to issue Levonelle-2 (Box 2).

Before this initiative, women attending the clinic requesting emergency contraception were seen by a

This article follows an NT Update, ‘Improving young people’s access to emergency contraception’ (19 August, p24)
doctor for assessment and treatment. This could often result in them being booked into already oversubscribed clinics and having to wait for long periods or being asked to return for an appointment within 72 hours of unprotected intercourse.

The PGD was designed to improve the accessibility of emergency contraception for women attending the Victoria Clinic. The aim was not only to minimise the time they spend in the clinic but also to reduce the time that elapsed between unprotected sexual intercourse and the woman taking the emergency contraception, as this is an important factor when calculating efficacy rates.

It is expected that 95 per cent of pregnancies will be prevented if Levonelle-2 is taken within 24 hours of unprotected intercourse. This figure falls dramatically to only 58 per cent efficacy if taken within 49–72 hours (Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit, 2003). The PGD also enabled nurse-led services to be established that target vulnerable high-risk groups. One such service is ‘Contact’ (an under-19s service) that issues emergency contraception quickly to women who often drop in during school lunch breaks and who may find it particularly difficult to wait to be seen.

When women attend for emergency contraception it is important to discuss future long-term contraception options and the potential risks of sexually transmitted infections (STIs).

The National Strategy for Sexual Health has clearly recommended a ‘one-stop shop’ for sexual health services (Department of Health, 2001), and women attending for emergency contraception at the Victoria Clinic are given the opportunity to explore and discuss these other important sexual health issues when seeing the specialist nurses who work under the PGD.

Any woman attending the clinic for emergency contraception without an appointment will be prioritised by the triage nurse and referred to an experienced family planning nurse for further assessment and supply of Levonelle-2. During this consultation the woman has the opportunity to discuss her short and long-term contraception options and, where possible and appropriate, she may be issued with her chosen long-term method.

The Levonelle-2 PGD was launched at the Victoria Clinic in 2001 and an audit tool was developed to examine the documentation on the first 100 women seen.

Results

The majority of women requesting emergency contraception were aged between 16 and 25 years (Fig 1). The reasons for requesting emergency contraception were:

- Condom failure (67 per cent);
- No method of contraception used (25 per cent);
- Missed contraceptive pills (8 per cent) (Fig 2).

Most women presented for emergency contraception within 48 hours of unprotected intercourse (Fig 3). Only 18 per cent attended the clinic 48–72 hours after unprotected intercourse.

Of the 100 women audited, 14 per cent had previously used emergency contraception on more than one occasion, yet almost half (45 per cent) still had no regular method of contraception.

This figure clearly highlights the important role family planning nurses can play in raising contraception awareness. As eight of the 23 women (35 per cent) screened for STIs had an infection, the development of nurse-led sexual health screening as part of the emergency contraception PGD would also appear to be essential.

Discussion of safer sex practice and sexual health screening are important components of the emergency contraception consultation and were documented in 98 per cent of proformas. Following a discussion about STIs, 55 per cent of women made an appointment for screening. However, 58 per cent of these did not attend (Fig 4), which highlights the importance of offering screening at the time women present for emergency contraception.

Where appropriate, as part of the emergency contraception consultation women are issued with further contraception, yet almost half (45 per cent) still had no regular method of contraception. They were then encouraged to return for a family planning appointment. Of the 100 women audited, 45 made follow-up family planning appointments, but 26 (42 per cent) failed to attend.

FIG 1. THE AGE OF WOMEN REQUESTING EMERGENCY CONTRACEPTION

FIG 2. REASONS WOMEN GAVE FOR REQUESTING EMERGENCY CONTRACEPTION

KEYWORDS Emergency contraception, Audit, Public health

REFERENCES


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For related articles on this subject and links to relevant websites see www.nursingtimes.net
Fertility Regulation
Task Force on Postovulatory Methods of Contraception; Geneva: World Health Organization. Criteria for Contraceptive Use. Family Planning. Medical Eligibility Improving Access to Quality Care in World Health Organization 428–433. The family planning nurses at the Victoria Clinic have developed a high level of expertise in sexual health issues. They will soon be able to offer asymptomatic sexual health screening for all women attending for emergency contraception.

A recent study conducted in Scotland offered chlamydia screening to all women attending for emergency contraception (Kettle et al, 2000). Of 838 attendees included in the study, the prevalence rate was 7.6 per cent in women aged 24 years or under and 5.3 per cent in women aged 25–29 years.

Although screening for STIs is generally more reliable if undertaken at 7–10 days post-risk of infection, the Scottish study clearly highlights the benefits of carrying out opportunistic screening.

Our own audit findings have also shown that most women do not return for follow-up – even if they make an appointment to do so. Offering a sexual health screen at the time of presentation will at least detect STIs that are already present.

This type of service could also incorporate the option of testing for chlamydia in urine samples for those women unable or unwilling to be examined at that time. The development of such services would also help to ensure that doctors are able to use their skills and expertise to treat patients presenting with ‘acute’ symptoms or problems.

Future developments
A ‘one-stop shop’ is being developed at the Victoria Clinic, where women will have the opportunity to access emergency contraception, plan for their future contraceptive needs and be screened for STIs.

A further development of the PGD is to incorporate the most recent recommendations from the Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit (2003). This should include supplying emergency contraception as a one-off ‘stat’ dose for women who may have difficulties with the more usual 12-hour split dose currently used.

It is hoped that the Victoria Clinic will develop greater links with and integrate relevant community services, such as GPs and pharmacists, to help with appropriate referrals for sexual health and contraception.

Finally, it is hoped that Levonelle-2 could be supplied to women who use condoms or diaphragms as their main method of contraception. This would ensure that the emergency contraception could be taken within minutes of unprotected intercourse, thus offering optimal efficacy.

Discussion
The wider availability of Levonelle-2 has increased the speed and access to emergency contraception for women. However, there are several drawbacks:

- Levonelle-2 is offered at pharmacies under strict PGD guidelines at a cost of about £20–25. This cost may prevent women with low or no incomes taking advantage of this option – especially women under 19 years of age, who are considered at particularly high risk of unwanted pregnancies and are more likely to be in full or part-time education without a regular income;
- Pharmacists do not always have private areas where an assessment of the need for emergency contraception and any risks can be carried out. Confidentiality in sexual health matters is usually of paramount importance and lack of privacy may be a factor in the low uptake figures;
- The very nature of an emergency contraception attendance makes it an ideal opportunity to discuss future contraception and sexual health issues. However, pharmacists may not always have the training or time to undertake this role.

Introducing a PGD means that nurses trained in family planning are now able to assess patients and supply Levonelle-2 as emergency contraception. Prior to this initiative, emergency contraception was traditionally provided by medical staff, who may or may not have had formal training in family planning.

The possibility of being seen by a non-specialist doctor, together with time constraints, makes it likely that some women attending for emergency contraception left without having had the opportunity to discuss a more reliable long-term method of contraception. This means there is a distinct advantage to trained family planning nurses supplying Levonelle-2.

The family planning nurses at the Victoria Clinic have developed a high level of expertise in sexual health issues. They will soon be able to offer asymptomatic sexual health screening for all women attending for emergency contraception.

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