Use of the combined oral contraceptive pill by under 16s

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Summary

The General Practice Research Database was used to examine prescribing of the combined oral contraceptive pill for females aged under 16 in England and Wales in 1997. From these data, calculations were made to estimate prevalence for these countries; family planning clinic return data were combined with the general practice estimates to give an overall figure of 4.2 per 100. This extent of use is low considering the amount of sexual activity now occurring. A weak effect of population density on prescribing was found, with higher rates in the more rural areas.

Key words

contraceptives, oral; family planning: attitudes, knowledge, practice; family practice; physician’s practice patterns; prescriptions, drug

Key message points

- Prescribing of the combined oral contraceptive pill to girls aged under 16 by general practitioners is low in contrast to the high degree of sexual activity.
- The prescribing rate is higher in more rural areas.

Introduction

There has been a trend of earlier menarche in developed countries during the last century. In the last 40 years the median age of sexual debut has fallen from 21 years to 13-15 in 1989/90, to 7.4 per 100 in 1998/99. This compares with current rates of pill use were calculated for each age. Contributing practices were categorised by population density in a manner preserving confidentiality of the practices.

Results

Table 1 shows the prevalence of combined pill prescribing in the GPRD. Of the 24 620 young women aged 13-15 years, 1.7% received prescriptions. Applying similar proportions to the population of England and Wales (930 028 females aged 13-15) gives an estimate of 15 700 females. The equivalent figure for England and Wales (unpublished KT31 returns for Wales) family planning clinics for the 12-month period 1st April 1997 to 31st March 1998 was 23 490. To calculate the estimate of the prevalence of use from both general practice and clinic outlets, it was assumed that women attending GP surgeries and women attending family planning clinics are mutually exclusive. An estimate of the prevalence rate of use from both general practice and clinic outlets is 4.2 per 100. This compares with an estimate of 30 per 100 for the 16-19 year age group calculated in similar fashion to that for the 13-15 age group.

Combined pill prescribing rates by population density category of contributing practice is shown in Table 2. The most densely populated category was major cities, the intermediate category was suburban areas and the least
densely populated category was rural areas. There was a significant trend (p = 0.016) for the prevalence of females receiving the combined pill and population density; rural areas were observed to have a higher prevalence of females receiving the pill.

Discussion

Only 4.2% of 13-15 year old women received a prescription for the combined pill in 1997, and yet as many as one third of women aged under 16 are sexually active.

The figure of 30% for the annual prevalence of combined pill use in females aged 16-19 years in England and Wales compares with a point prevalence of 22% in Great Britain in the 1995 General Household Survey (personal communication, ONS 1999). Published figures are 17% for 16-17 year olds and 30% for 18-19 year olds. One would expect annual prevalence figures to be higher than point prevalence figures; also there will be some inflation of the summed general practice and clinic data due to double counting. Allowing for these two phenomena, the similarity of these two data sources provides some validation for the quality of the electronic data for the under 16 age group.

This estimate of contraceptive uptake is necessarily crude as general practitioner records do not contain information on condom use. The General Household Survey gives us information on the extent of use of the combined pill together with condoms (‘Double Dutch’) which has now become a fairly common practice, but only in older teenagers. Also, contraceptive use in teenagers is difficult to measure as it is often very much an on-off phenomenon. Those whose prescriptions were captured in this study would have been unlikely to have continued the pill throughout 1997. Also, the figures from this study will tend to be an underestimate, as some teenagers will be using the pill for acne and dysmenorrhoea at least for some of the time.

Reasons for this low use probably include: reluctance to attend a medically orientated service outlet, risk-taking behaviour, sporadic sexual activity, worries over safety especially after the 1995 pill scare, and confusion among teenagers as to the law relating to under 16s.

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Table 2

<table>
<thead>
<tr>
<th>Population density (persons/km²)</th>
<th>No. of females receiving combined pill</th>
<th>Base population</th>
<th>Rate per 100</th>
<th>95% Confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;150</td>
<td>55</td>
<td>2745</td>
<td>2.00</td>
<td>1.51 to 2.60</td>
</tr>
<tr>
<td>150-1999.9</td>
<td>283</td>
<td>15 453</td>
<td>1.83</td>
<td>1.62 to 2.04</td>
</tr>
<tr>
<td>2000 and over</td>
<td>327</td>
<td>21 836</td>
<td>1.50</td>
<td>1.34 to 1.66</td>
</tr>
</tbody>
</table>

Somers’ D test for trend p = 0.016

Conclusion

The use of the combined pill is low in the under 16s. Low use of effective contraception must partly explain why the UK has the highest teenage birth rate in Western Europe. However, there are many other factors to take into consideration: a lack of ‘openness’ in discussing sex, ignorance about sex and relationships, poor employment opportunities and poverty. More work is needed on uptake of contraceptive services by young people from different outlets and in areas classified according to a deprivation index.

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References

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