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Unintended and unwanted pregnancy and their outcomes amongst reproductive age women in Australia: a national random CATI study

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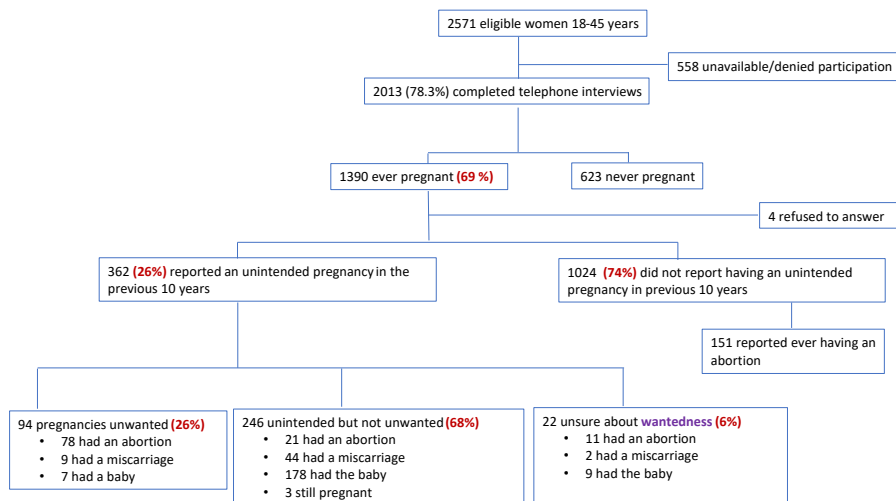
Rationale and aims

- Planned parenthood benefits for maternal and infant health.
- Monitoring and preventing unintended pregnancies (UIP) is therefore an important public health imperative .
- In the only previous Australian national household survey (2005), 18% of reproductive aged women (18-44) reported their most recent pregnancy ending in a birth was mistimed, and an additional 17% reported it as unwanted (*Hewitt et al, 2010*).
- **We aimed to conduct a contemporary national population study amongst women to assess UIP prevalence in the previous 10 years, the proportion unwanted, their outcomes and associated factors**

Methods

- **Computer-Assisted Telephone Interview (CATI)** survey of a random sample of Australian women aged 18-45
- **Conducted by Hunter Valley Research Foundation**
- **Female interviewers skilled in asking about sensitive issues**

Results



Women's characteristics

	Intended	UIP		
Married	792 (77.3%)	194 (53.6%)		986 (71.1%)
Living with a partner but not married	111 (10.8%)	69 (19.1%)		180 (13.0%)
In a relationship but not living together	33 (3.2%)	24 (6.6%)	<0.001	57 (4.1%)
Not in a relationship	88 (8.6%)	75 (20.7%)		163 (11.8%)
Number of pregnancies				
Once	179 (17.5%)	71 (19.6%)		250 (18.0%)
Twice	388 (37.9%)	77 (21.3%)		465 (33.5%)
3 times	240 (23.4%)	89 (24.6%)	<0.001	329 (23.7%)
4 or more times	217 (21.25)	125 (34.5%)		342 (24.7%)
Number of children				
0	41 (4.0%)	45 (12.5%)		86 (6.2%)
1	218 (21.4%)	67 (18.7%)		285 (20.7%)
2	482 (47.2%)	114 (31.8%)	<0.001	596 (43.2%)
3 or more	280 (27.4%)	133 (37.0%)		413 (29.9%)

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Contraceptive use at the time of the unintended pregnancy (n=362 women)

Contraceptive use at the time of unintended pregnancy		
No	205	56.6%
Yes	150	41.4%
Don't remember	7	1.9%
Primary contraceptive method used (n=149)		
OCPs	95	63.8%
Condoms	40	26.9%
LARCs	9	6.0%
Diaphragm/NuvaRing	2	1.3%
Withdrawal/Emergency contraception	3	2.0%

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Parental responsibilities and abortion decision (n=362 women)

Parent/step-parent at the time of unintended pregnancy		
No	171	47.2%
Yes	191	52.8%
Outcome of unintended pregnancy		
Had the baby	194	53.6%
Had a miscarriage	55	15.2%
Had an abortion/termination	110	30.4%
Still pregnant	3	0.8%

Factors associated with unintended pregnancy in Australia

- Age (a little less likely as women age)
- Marital status (more likely in any other status cf married)
- Gravidity (compared to majority with two births, women with one or >3+ twice as likely)
- Parity (four times as likely if you have never been pregnant than twice)
- *No other socio-demographic factor: SEIFA quintile, education, employment, area of residence, health care card, student, pension, health insurance, was significant*

Implications and conclusions

- ❖ Despite the availability of effective contraception in Australia, we found that about half of the unintended pregnancies were in women not using contraception.
- ❖ Highest proportion in women using contraception among those using OCP
- ❖ Research is required to explore the reasons for not doing so, and to determine where education would be most helpful.
- ❖ Clinicians and services should focus their attention on women at highest risk of unintended pregnancy, including those who have had three or more pregnancies. The immediate post partum and post-abortion periods are opportune times for intervening to avert unintended pregnancies.

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Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes

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Planned parenthood has reported that unintended and/or unwanted pregnancy is a leading public health goal.¹ In the only Australian national household survey about unintended or unwanted pregnancy (Australian 2005), 10% of women of reproductive age (15–44 years) reported that their most recent pregnancy was unintended, and a further 17% reported that the pregnancy was unwanted.²

We undertook a contemporary national population survey to assess the prevalence and outcomes of unintended pregnancy during the preceding ten years. Tenet female interviewers (Tenet Valley Research Foundation) undertook a national random telephone-assisted telephone (mobile and landline) survey (weekdays, 9 am–6 pm) during December 2014 – May 2015. Women aged 15–45 years with adequate English were asked whether they had had an unintended pregnancy during the past ten years, and whether any unintended pregnancy was unwanted. We also asked about the outcomes of all pregnancies. A population sample of 3000 was targeted to deliver a prevalence of unintended pregnancy of 10–30% with 95% power. La Trobe University Human Research Ethics Committee approved the study (reference, 14/205).

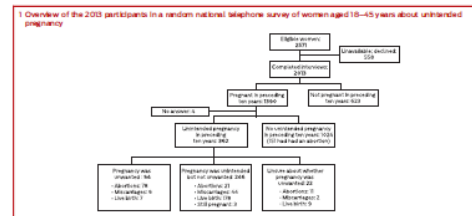
Of 2071 eligible women, 2033 (78.9%) completed interviews. A total of 1300 women (60.1%) had been pregnant during the past

ten years, including 362 unintended pregnancies (26%). Most unintended pregnancies (246, 68%) were reported as wanted; 94 (26%) were described as unwanted (Box 1).

Half the women with an unintended pregnancy gave birth (194, 53.6%), 110 (30.4%) had abortions, 35 (15.2%) miscarriages, and three (0.8%) were still pregnant at the time of the survey. Of the women who had been pregnant but did not report an unintended pregnancy, 14.7% (51 of 344) reported having had an abortion (Box 2).

Twenty-one of the 246 women (8.5%) with unintended but wanted pregnancies reported abortions. Of the 94 women with unintended pregnancies, 79 (83%) had abortions, nine (10%) had miscarriages, and seven (8%) carried the pregnancy to term. A total of 261 of 1300 women who had been pregnant (20.1%) reported abortions (Box 3).

Most women who had unintended pregnancies (205 of 362, 56.6%) reported not having used contraception at the time. Of the 150 women (41.6%) who had an unintended pregnancy while using contraception, 56 (38%) had used oral contraceptives and 40 (26.9%) had used condoms as their primary method, nine (6%) were using long-acting reversible contraception (Box 3).



¹ Judith Lumley Centre, La Trobe University, Melbourne, VIC. ² University of Melbourne, Melbourne, VIC. ³ University of Sydney, Sydney, NSW. ⁴ Royal Prince Alfred Hospital, Sydney, NSW. ⁵ Monash University, Melbourne, VIC. ⁶ Australian Institute of Statistics, Canberra, ACT. ⁷ La Trobe University, Melbourne, VIC. ⁸ La Trobe University, Melbourne, VIC. <http://dx.doi.org/10.1016/j.pwsc.2016.05.001>

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Access, equity and costs of induced abortion services in Australia: a cross-sectional study

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The safety and efficacy of the combined mifepristone and misoprostol regimen for medically induced abortion has been well established.¹⁰ In Australia, however, despite the availability of legally induced abortion, a long history of legal and policy restrictions on the receipt of mifepristone prevented nationwide use of medical abortion until 2013.¹¹ That year, the Medical Services, a subsidiary of Mater Spine International, received approval from the Therapeutic Goods Administration to import, register and distribute mifepristone for a medical abortion up to 10 days gestation, and to register and distribute clinicians to service delivery.¹² Subsequently, the medicine was subsidised on the Pharmaceutical Benefits Scheme (PBS) for 100%, and inclusion for use extended up to 14 weeks (10 days).¹³

Abstract

Objectives: To examine access and equity to induced abortion services in Australia, including factors associated with presenting beyond nine weeks gestation.

Methods: Cross-sectional survey of 2,236 women aged 18 years attending for an abortion at 14 (3) Mater clinics. Associations with late presentation assessed using multivariate logistic regression.

Results: Over a third of eligible women opted for a medical abortion. More than one in 10 (11.2%) stayed overnight. The median Median out-of-pocket cost of a medical abortion was \$100, compared to \$100 for a surgical abortion at 40 weeks. Beyond 12 weeks, costs rose considerably. More than two-thirds (68.1%) received financial assistance from one or more sources. Women who travelled at least 100 km (AOR 2.0, 95%CI 1.2-3.3), had no prior knowledge of the medical option (AOR 2.1, 95%CI 1.4-3.3), had difficulty paying (AOR 1.5, 95%CI 1.2-1.9) and identified as Aboriginal and/or Torres Strait Islander (AOR 2.1, 95%CI 1.2-3.4) were more likely to present at 10 weeks.

Conclusions: Abortion costs are substantial, increase at later gestations, and are a financial strain for many women. Prior knowledge, geographical and financial barriers restrict medical status. Implications for public health: Policy reform should focus on reducing costs and enhancing early access.

Keywords: Induced abortion, abortion costs, abortion access, medical abortion, Australia.

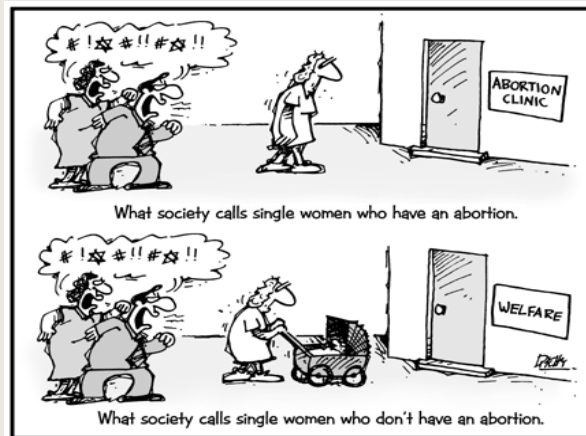
In Australia, the number of verified practitioners and pharmacy dispensers is growing, including in non-metropolitan areas.¹⁴ However, fundamental issues around access remain. Public service provision is very limited and poorly coordinated, and when available, restricted to a few facilities located in major cities. Most women rely on fee-charging private provision, and while Medicare (Australian public health insurance) subsidises care across Australia, they still face out-of-pocket costs. Service provision is also unevenly distributed by region, with the state and territory abortion legislation, which

in certain jurisdictions, is not in line with current medical evidence and/or standards.¹⁵ In the Northern Territory, for instance, the medical option is not currently offered, as the law permits abortions only within hospitals, preventing general practitioners from offering medical abortions within their community-based practices.¹⁶ In 2005, it was estimated that the Australian age-standardised abortion rate was 10.7 per 1,000 women.¹⁷ However, this estimate is unreliable as national statistics on abortion in Australia vary in reliability and comparability due to limitations of publicly available data.

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The authors have stated the following conflicts of interest: Dr Goldstone is the Medical Director of Mater Spine International in Australia. This can open access to the services of the Centre for Reproductive Health and Monash University, which can provide and distribute in any manner, and may be subject to a fee. Dr Lucha is a sole proprietor and no modifications or adaptations are made.
Supplementary material is available at www.aotj.org.

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