Uptake of long-acting reversible contraception after medical termination of pregnancy in rural and regional women of Northern Tasmania

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Introduction

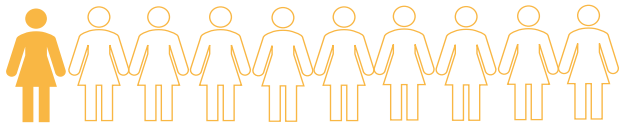
Only 10-11% of Australian women of reproductive age use long-acting reversible contraception (LARC) (1, 2). For women who have experienced a medical termination of pregnancy (MTOP), LARC may be more appealing. LARC reduces future unintended pregnancy and recurrent abortion in these women (3). LARC also offers pragmatic advantages for women who may have financial or geographic barriers to accessing health care.

Aim

We aimed to test the hypothesis that the rate of LARC use in Northern Tasmanian women post-MTOP would be higher than in the general Australian population.

Methods

This was a retrospective study performed from September 2018 until June 2021 at two centers in Northern Tasmania. Women who received treatment for MTOP were included. Analysis was conducted using simple statistical methods.



Australian data: women who choose LARC

Northern Tasmanian women post-MTOP: women who choose LARC

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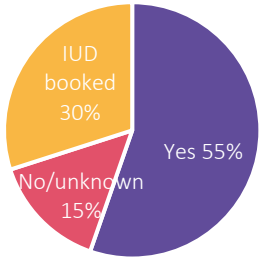
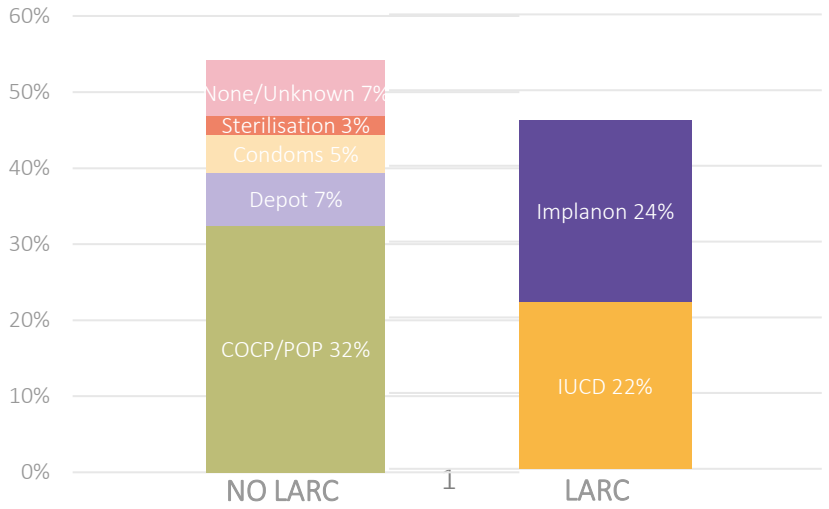
Results

Of the 429 women who had a MTOP, 46% chose LARC following. All women lived in rural or regional areas and 44% of women had a health care or pension card. Of those who chose LARC, 53% opted for an implant and 47% chose an IUCD. 53% of women had commenced the LARC by the two week follow up visit and a further 29% had a LARC insertion booked.

LARC insertion by 2 week follow up



Contraceptive choice: Northern Tas Women post-MTOP



Discussion

Compared with national figures for all reproductive aged women, LARC use appear to be significantly higher in our population. In 2018, a population-based study estimated that 10.8% of women aged 15-44 used a LARC (1). This was consistent with a cross-sectional study in 2017 which suggested that 9.8% of women used a LARC (2).

A study in 2014 of urban and rural women who had either medical or surgical TOP also indicated a higher rate of LARC (27.4%) compared to the general Australian population, though not as high as in our study (3). A limitation of our study is that the comparator population is not from the same population as the cohort. A case control study is planned as future research.

Conclusion

Women will frequently choose a LARC if offered after MTOP. This has implications for clinical practice. Clinics who provide MTOP have an opportunity to improve the health outcomes of women by increasing LARC provision as part of their service. Women with barriers to accessing reliable contraception may especially make use of improved LARC availability and will benefit as a result.

References

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