REDCLIFFE BASE HOSPITAL EXPERIENCE OF CONTRACEPTION UPTAKE POST TERMINATION OF PREGNANCY

Dr Sheree Gatty

Obstetrics and Gynaecology Department, Redcliffe Base Hospital

Introduction

Unplanned pregnancies are common. It is estimated up to 50% of all Australian pregnancies are unplanned, up to one third of these are terminated and only 10% of patients accept post termination contraception. (1). Termination of pregnancy (TOP) has a significant impact on patients, practitioners and the wider community emotionally, physically and economically. Long-acting reversible contraception (LARC) have the highest compliance rate and have been shown to reduced repeated terminations.

Pregnancy termination is a service provided by Queensland Health, including Redcliffe Base Hospital (RBH). To ensure the provision a of safe, efficacious and holist service the Queensland Health TOP Clinical Guideline was developed in 2019, is revised regularly (latest October 2023) and implemented locally in 2021 (2). The guidelines provide protocols for; but not limited to, patient work up, counselling, treatment options, treatment provision and post treatment contraception.

Aim

This audit aimed to establish the current uptake of contraception post pregnancy termination at the RBH Gynaecology Department during the period of TOP Clinical Guideline implementation.

Method

A retrospective audit of patients who underwent medical (mTOP) or surgical (sTOP) termination of pregnancy at the RBH between January 2022 and August 2023 was undertaken. Included in the audit were patients who sort TOP care <20 weeks gestation at RBH or underwent feticide at a tertiary facilities and delivered at RBH for socioeconomic and/or mental health indications. Excluded from the audit were patients whose care was transferred to other health departments or indication for TOP was not socioeconomic and/or mental health. Patients lost to follow-up were included. Data was sourced from the RBH TOP clinic; dedicated gynaecology clinic, patient pool, collected from handwritten charts and ORMIS and VIEWER electronic records The data was collated, analysed and sored (password protected) on Microsoft Excel.

Demographics

A total of 78 patients were included in the audit. 81 patients were captured by the search; two were excluded as TOP indication was not socioeconomic and/or mental health and one patient was transferred to another healthcare facility. Two patients were lost to follow–up. The average age was 27.5 years with a range of 14 years to 37 years. Of these patients, 14 (18%) identified as first nations.

Results

During the 21 month study period, 48 patients underwent their first TOP, 30 patients had a repeated TOP and one patient underwent two TOP treatments. Of the 78 TOP treatments 28 (36%) were mTOP, 48 (62%) were sTOP and two (2%) were deliveries after feticide at a tertiary facility. All (100%) of RBH patients had discussion regarding previous contraception and future contraception. Contraception use prior to TOP was 7%, 6 patients. 69 (88.5%) of all TOP patients accepted post treatment contraception. All First Nations patients accepted post TOP contraception. Of the patient who accepted contraception, 48 (70%) consented to LARCs and 28 (60%) had them inserted at the point of sTOP treatment.

Table One: Contraception Uptake

	Primip	Previous TOP	Pre-TOP contraception*		Contraception Post TOP						
			Barrier	Hormonal Pill	Declined	Hormonal Pill	Depo Inj	Implanon	IUD	Bilateral Salpingectomy	Vasectomy
All Patients (N = 78)	30	29	3	3	9	9	2	16	32	3	3
mTOP Patients (N=28)	11	8	0	0	4	1	1	7	11	0	3
sTOP patients (N=48)	18	21	3	3	5	8	1	7	21	3	0
fetocide (N=2)	1	0	0	0	0	0	0	2	0	0	0

*compliant use

Discussion

The aim of this audit was to establish the outcome of implementing the Queensland Health TOP Clinical Guidelines at the RBH. The audit found that six patients were using contraception as prescribed pre-TOP and 65 (83%) were prescribed contraception post treatment including, 48 (62%) LARCs. Previous Australian studies had a contraception uptake rate of 10% (1). A higher contraception acceptance rate at RBH is suggested to be due to comprehensive pre-TOP counselling. It was documented that all (100%) patients had a comprehensive contraception discussions. Studies have shown open dialogue and information provision over multiple health care interactions increased contraception uptake and medium to long term adherence (4,5).

Higher LARC uptake also improves contraception adherence. Australian studies have shown that LARCs relatively decrease future unplanned pregnancies compared to hormonal pills and barrier contraception (4,5). The RBH LARC uptake was 62%, which is higher compared to a recent South Australian retrospective study which found 13% of TOP patients accepted a LARC post treatment (2). Age did not influence contraception rate uptake at RBH however, 42% of younger patients; <25years, opted for oral contraceptive pill (OCP) compared to 20% of patients over 30 years old. The sTOP patients at RBH had LARC inserted at time of surgery. mTOP patients had prescriptions provided or were booked into the RBH Mirena Clinic. Of the 11 mTOP patients who were booked to the Mirena clinic, ten attended.

As with all studies involving contraception, the most significant limitation of this audit is quantifying long term adherence. sTOP treatment option is advantageous to contraception adherence as it lends to point of care treatment of TOP and LARC insertion. 17 patients had prescriptions provided for OCP, depo injection or Implanon, adherence to these long term is unknown. As a health service, RBH is considering increasing point of care contraception; specifically LARC provision. Consideration is being given to LARC insertion at time of mTOP; for example providing medical management first dose medication concurrently with Implanon insertion or depo injection. This would require appointments with increased visit times and partnership with the pharmacy department.

Lastly, nine RBH TOP patients declined contraception. Of these patients, eight declined due to previous side effects to contraception and one patient declined as considering a child within the foreseeable future. As discussed, all patients received contraception counselling with a consultant gynaecologist and no barriers were created to TOP treatments if contraception was declined. Providing counselling in a non-judgemental environment significantly improves contraception adherence (5) and continuity of care with general practitioner was promoted with clinic letters encouraging future contraception discussions.

References

1. Luke E Grzeskowiak et al. Long-acting reversible contraception use after medial abortion is associated with reduced likelihood of a second medical abortion. [Internet]. 2021. [cited 2023 September 25]. Available Long-acting reversible contraception use after medical abortion is associated with reduced likelihood of a second medical abortion - PubMed (nih.gov).
2. Queensland Clinical Guidelines. Termination of pregnancy. Guideline No. MN19.21-V9- R24. Queensland Health.2020. [cited 2024 January 15]. Available from: http://www.health.qld.gov.au/qcg
3. Pregnancy Advisory Centre South Australia. Unplanned pregnancy services. 2021. [cited 2023 August 2]. Available from Unplanned pregnancy services | SA Health
4. World Health Organization. Abortion care guideline. 2022. [cited 2023 August 2]. Available from: https://who.int.
5. Royal College of Obstetricians and Gynaecologists. Best practice in comprehensive abortion care. Best Practice Paper No. 2. [Internet]. June 2015 [cited 2023 Octobter 11]. Available from: https://www.rcog.org.uk.