



Original article

Postabortion Initiation of Long-Acting Reversible Contraception by Adolescent and Nulliparous Women in New Zealand

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 A B S T R A C T

Purpose: To describe changes in receipt of immediate postabortion long-acting reversible contraception (LARC) by adolescent and nulliparous women in New Zealand.

Methods: Nationally collected data on immediate postabortion receipt of an intrauterine method (intrauterine device [IUD]/intrauterine system [IUS]) or contraceptive implant were analyzed to describe proportions and demographic characteristics of women receiving LARC between 2007 and 2013. Changes in uptake over time were presented for adolescent, nulliparous, and parous women.

Results: Postabortion LARC uptake increased between 2007 and 2013, rising from 7.9% to 42.7% for adolescents and from 8.8% to 36.9% for nulliparous women. The increase was highest among nulliparous adolescents with a seven-fold increase in LARC uptake between 2007 and 2013. Adolescents had a five-fold increase and nulliparous women (of all ages) a four-fold increase. In 2013, IUD/IUS use was lowest among adolescents (22.4%) and increased with increasing age (43% by ages 40+ years), whereas implant use was highest among adolescents (20.3%) and decreased with increasing age (to 4.6% by age 40+ years). Nulliparous women had the lowest use of both IUD/IUS and implants in 2013, with 24.6% receiving an intrauterine method (compared with 43.2% for para 3+), and 12.3% an implant (compared with 17.5% for para 3+).

Conclusions: Despite an overall trend toward increased uptake of postabortion LARC by adolescent and nulliparous women, uptake in these groups still lags behind that of parous and older women. Reasons for differential uptake need to be explored and addressed if necessary to ensure all women have equitable access to the most effective methods of contraception.

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IMPLICATIONS AND CONTRIBUTION

Postabortion initiation of long-acting reversible contraception has increased among young and nulliparous women in New Zealand but remains lower than for older and parous women. Ensuring adolescent and nulliparous women receive up-to-date information and access to long-acting reversible contraception has the potential to further reduce abortion and adolescent pregnancy rates in New Zealand.

There has been growing international recognition of the need to promote and encourage use of long-acting reversible contraception, known as “LARC” (including intrauterine methods and subdermal implants), by young and adolescent women, to reduce rates

of unintended pregnancy and its consequences [1–8]. Younger women are at greatest risk for unintended pregnancy but typically favor methods with high failure rates including oral contraceptives (9% failure rate associated with typical use) and condoms (18% failure rate) [9,10]. By contrast, LARC methods not only have very low failure rates (<1%) [10] but lack reliance on user compliance for efficacy and have long duration of action. Importantly, adolescents are willing to use long-acting methods when given appropriate information and access to these methods at no cost [11]. There is good evidence that immediate postpartum or postabortion

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initiation of LARC significantly reduces rates of rapid repeat adolescent pregnancy and abortion within 12–24 months [3,12–16]. Adolescents initiating a LARC method have up to a 35-fold reduction in risk of experiencing a rapid repeat pregnancy within 2 years compared with their counterparts opting for a non-LARC method [15].

Historic concerns about links between intrauterine device (IUD) use, pelvic inflammatory disease and infertility have persisted [4,17,18] contributing to lower utilization rates among young and nulliparous women. The evidence is now clear that IUDs can safely be used by adolescents, nulliparous women and those with a history of pelvic inflammatory disease or sexually transmitted infections with no detrimental effects on future fertility [6,7,19]. Although rates of IUD expulsion may be higher among adolescents (14–19 years) than for older women, rates do not differ for nulliparous and parous women. A slightly higher rate of expulsion is expected with immediate postabortion IUD insertion [20]. However, this increased risk is balanced against significantly higher rates of uptake after immediate postabortion versus delayed insertion (because of failure to attend follow-up appointments) [21], and higher rates of method continuation by adolescents using long- versus short-acting methods (oral contraceptives or Depo-Provera) [22,23].

A number of large-scale projects have clearly demonstrated that when barriers such as cost, lack of access, and lack of provider and patient knowledge about LARC are removed, choice of long-acting contraception can be significantly increased with corresponding decreases in birth and abortion rates [11,24–26]. In the US contraceptive CHOICE project, 69% of 14–17 year olds and 61% of 18–20 year olds wanting to avoid pregnancy for at least a year opted for a LARC method when provided standardized counseling about all contraceptive methods (with emphasis on the superior effectiveness of LARC methods) and offered all methods at no cost [26].

The extent to which adolescent and nulliparous women have historically and are currently prescribed LARC methods in New Zealand is not known. The Multiload Cu375 intrauterine device (CuIUD; Swords, Dublin, Ireland) has been fully subsidized and freely available for many years in New Zealand but the Mirena levonorgestrel-releasing intrauterine system (LNG-IUS; Made in Finland for Bayer NZ Limited, Auckland, New Zealand) costs upward of USD220 (NZ \$300) so is anecdotally less frequently prescribed. The two rod Jadelle levonorgestrel (LNG; Made in Finland for Bayer NZ Limited, Auckland, New Zealand)-releasing implant was subsidized by the New Zealand government in 2010 so became widely available at no or low cost, having previously been less readily available and at a cost of USD185 (NZ \$250). Once subsidized, use of the LNG-implant increased greatly [27], and there is some evidence to suggest this was particularly true of younger age groups [28]. Data from a single public hospital clinic indicated that adolescent postabortion IUD use increased from 8.3% in 2007 to 22.5% in 2012 [28].

We sought to describe changes in the postabortion initiation of long-acting methods in New Zealand for the period 2007–2013 to determine whether uptake by adolescent and nulliparous women reflects international recommendations that LARCs be deemed first line contraceptive choices for these groups.

Methods

This retrospective analysis of nationally collected data on postabortion LARC use involved data for all abortions carried out

in all clinics in New Zealand between 2007 and 2013. Ethical approval was granted by the University of Otago Human Ethics Committee-Health (11 June 2014, ref D14/179).

Setting

Abortion is provided as a core publically funded health service in New Zealand performed at one of 22 licensed facilities (including one private fee-for-service clinic). Women must be seen by a general practitioner or family planning doctor for confirmation of the pregnancy, diagnostic tests, and referral to an abortion service. Abortion is legal (up to 19 weeks) providing two certifying consultants agree that one of several grounds are met—most commonly “danger to mental health” [29].

Data collection

The registered medical practitioner performing the abortion must complete a two page form detailing the patient's ethnicity, date of birth, pregnancy history, residency status, grounds for performing the abortion, type of procedure, complications, contraception used at conception, and since 2007 long-acting contraceptive method inserted at the time of the procedure (if any). The completed form is forwarded to the Abortion Supervisory Committee (ASC) which is appointed by Parliament, under the Contraception, Sterilisation, and Abortion Act 1977. The ASC has the responsibility of reviewing the provisions of the abortion law in New Zealand, and the operation and effect of those provisions in practice [29]. Selected data from the form are collated and analyzed for annual reporting purposes by Statistics New Zealand (StatsNZ) on behalf of the ASC. Information on intrauterine methods (IUD/IUS) inserted at the time of an abortion have been collected on the ASC form since 2007, and implant insertions since 2011, but have not previously been published.

A customized data extract was requested from StatsNZ for the years 2007–2013. The data extract included collated data on IUD/IUS (2007–2013) and implant insertions (2011–2013), as well as insertions by age band (<20, 20–24, 25–29, 30–34, 35–39, and 40+), parity (0, 1, 2, 3+), previous abortion (0, 1, 2, 3+), age band by parity and ethnic group. In New Zealand, ethnicity refers to the ethnic group or groups to which an individual feels they belong and is collected via self-report using the standardized New Zealand 2001 census question [30]. Ethnic group was reported using total count, whereby individuals identifying with more than one ethnic group are included in each of those groups [31]. For confidentiality reasons, StatsNZ provided data in partially collated form rather than individual-level data.

Analyses

Proportions of women receiving LARC methods (total LARC, IUD/IUS, and implants) were calculated together with 95% confidence intervals for the years 2007–2013 to examine change in uptake over time. For the years 2007 and 2013, rates of LARC use were calculated and compared for selected demographic characteristics of recipients (age, ethnicity, parity, previous abortion, and parity by age). To calculate the magnitude of changes in IUD/IUS and total LARC use over time, the proportion of LARC recipients in 2013 was divided by the proportion of recipients in 2007 for each demographic subgroup. Numbers of abortions provided and receipt of LARC methods by adolescents (ages 19 and younger), nulliparous, and parous women were collated to

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