# How has long-acting reversible contraceptive provision at Family Planning clinics in Aotearoa New Zealand changed since PHARMAC funded intra-uterine systems for contraception?

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Our article How has contraceptive provision at Family Planning clinics in Aotearoa New Zealand changed between 2009, 2014 and 2019: a cross-sectional analysis, published in the 30 July issue of the *New Zealand Medical Journal*, noted that the full impact of the PHARMAC funding change to the intra-uterine system (IUS) could not be detected because of the timing of our research. This letter provides more recent data on IUS starts among Family Planning clients following the funding change.

Here we report de-identified administrative data (refer to our article for more information about research methodology and terminology) about the type of long-acting reversible contraceptive (LARC) start provided to Family Planning clients for three months (November–January) across four time-periods from November 2017 to January 2021. Three months of data, rather than a full year's, are reported because of the impact of COVID-19 on the number of LARC starts in 2020 and 2021. While Family Planning continued seeing clients during COVID-19 lockdowns, the number of in-person consultations for LARC starts were fewer than under normal circumstances. We present the actual number of LARC starts by ethnicity and LARC starts as a proportion of all types of LARCs, but we have not conducted any further statistical analysis. The data are for observation; they are not formal research findings.

The data show that, since PHARMAC started funding IUS for contraception at the end of November 2019, there has been a large increase in IUS starts (Table 1) and IUS starts as a proportion of all LARC starts. The percentage increase of IUS starts from 2018/19 to 2020/21 is nearly 400% among Pasifika clients, 200% among Māori clients and about 140% among NZ European/Other. In contrast, the number of IUS starts remains relatively consistent when comparing the two periods prior to funding (2017/18 and 2018/19). It is interesting to note that our original research found a statistically significant reduction in intrauterine contraceptives (IUC) starts for Pasifika clients (25% to 19%) between 2009 and 2019, presumably because of the subsiding of the implant from 2010. Although these data show the greatest increase in IUS starts for Pasifika clients between 2018/19 and 2020/21, in 2020/21 Pasifika are still the ethnic group least likely to start an IUS compared to a copper intrauterine device (IUD) and implant. This information provides another example of

the need for more information about factors influencing contraceptive decision-making by ethnicity.

These data support the findings and conclusions in our original research article, indicating that the cost of IUS was a barrier to access prior to the funding decision. However, it does not provide any other information about the observed differences in contraceptive starts by ethnicity. As noted in the original article, contraceptive starts are influenced by a range of factors, of which cost is only one. For example, cost does not explain why Māori and Pasifika clients start implants at much higher proportions than NZ European/Other clients in 2020/2021, since all LARCs are funded during this time.

Contraceptive starts are influenced by other factors, such as client preference and clinician influence. For example: How does the lived experience of contraception among family and friends impact contraceptive decision-making? How does clinician preference and/or unconscious bias impact the way that information is delivered to clients? When considering equity in access to contraception for Māori and Pasifika people, the potential impact of racism within the health sector cannot be ignored.[1,2] Further research is needed to fully understand the observed differences in contraceptive starts by ethnicity.

As stated in the original research article, Family Planning data cannot be compared with data from other primary care providers because this information is not collected consistently or comprehensively. This means policies on contraceptive access in primary care are not currently based on evidence. Policies must enable people to choose the contraceptive type that works best for them by removing barriers to accessing contraception and also by protecting people against bias and coercion.[3]

Reproductive rights—the right to decide if and when to have a child and to have control of reproductive decision-making and fertility—is central to wellbeing and self-determination, and any barriers to people exercising these rights fully should be identified and addressed.


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**Table 1:** Number and proportion of LARC starts by type and ethnicity in four periods.

| | | 2017/18 No. of starts | 2017/18 % as a proportion of all LARC starts | 2018/19 No. of starts | 2018/19 % as a proportion of all LARC starts | 2019/20 No. of starts | 2019/20 % as a proportion of all LARC starts | 2020/21 No. of starts | 2020/21 % as a proportion of all LARC starts |
|---|---|---|---|---|---|---|---|---|---|
| **Asian** | **Implant** | 118 | 35% | 150 | 38% | 156 | 34% | 162 | 36% |
| | **IUD** | 154 | 46% | 167 | 42% | 88 | 19% | 103 | 23% |
| | **IUS** | 62 | 19% | 79 | 20% | 214 | 47% | 190 | 42% |
| **Māori** | **Implant** | 244 | 57% | 319 | 61% | 237 | 44% | 247 | 48% |
| | **IUD** | 117 | 27% | 133 | 25% | 63 | 12% | 50 | 10% |
| | **IUS** | 68 | 16% | 72 | 14% | 242 | 45% | 214 | 42% |
| **NZ European/ Other** | **Implant** | 694 | 36% | 754 | 35% | 555 | 22% | 673 | 26% |
| | **IUD** | 714 | 37% | 784 | 37% | 396 | 16% | 460 | 18% |
| | **IUS** | 547 | 28% | 593 | 28% | 1529 | 62% | 1419 | 56% |
| **Pasifika** | **Implant** | 122 | 59% | 139 | 64% | 125 | 53% | 122 | 53% |
| | **IUD** | 67 | 32% | 61 | 28% | 33 | 14% | 27 | 12% |
| | **IUS** | 18 | 9% | 16 | 7% | 80 | 34% | 80 | 35% |

IUS: Intra-uterine system. IUD: copper intrauterine device.

**Competing interests:**
Beth Messenger, Amy Beliveau and Mike Clark report they are employees of Family Planning. Beth Messenger also reports she is Chair of the New Zealand College of Sexual and Reproductive Health, and that she was a member of the Ministry of Health National Contraception Guidelines Steering Group.

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