Contraception

Policy Position Statement

Key messages:

Preventing unintended pregnancies through increasing access to effective contraceptive use is a public health goal. Advice and provision of effective contraception is an essential health service and is cost-effective in reducing the impact of unintended pregnancies on individuals, the health system and society. All people of reproductive age should receive health education that is free of discrimination and enables them to choose contraceptive options that are safe, reliable, affordable and acceptable. Service planners must focus attention on improving information about and access to Long-Acting Reversible Contraception (LARC) and Emergency Contraception (EC).

Key policy positions:

1. Improve access to safe, affordable, and acceptable contraception services.
2. Increase access to Long-Acting Reversible Contraception (LARC) and Emergency Contraception (EC).
3. Advocate for an implementation and monitoring plan for the National Women's Health Strategy 2020-2030.

Audience: Federal, State and Territory Governments, policymakers, service planners and program managers, PHAA members, media.

Responsibility: PHAA Women's Health Special Interest Group

Date adopted: September 2023

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Citation: Contraception: Policy Position Statement [Internet]. Canberra: Public Health Association of Australia; 2014 [updated Sep 2023]. Available from: URL

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Policy position statement

PHAA affirms the following principles:

1. Preventing unintended pregnancies through effective contraceptive use is a public health goal.[1] Advice on, and provision of, effective contraception is an essential health service.

2. Sexual and reproductive health is a fundamental human right.[2] All people of reproductive age should receive comprehensive and age-appropriate sexual and reproductive health education, including content on contraception options and emergency contraception.

3. All forms of contraception should be accessible and affordable. Governments should ensure universal access for priority groups, in particular young persons, First Nations Australians, people who are socioeconomically disadvantaged, and those in rural and regional areas. These priority groups may require specialised settings and funding arrangements to ensure equitable access to contraception.

4. The need for contraception is not limited to cis-gender, heterosexual women. Transmasculine people (assigned female at birth) and sexual minority women (bisexual or lesbian) require tailored contraceptive information and care.[3]

5. Health professionals involved in the provision of contraception should be aware of the suitability and benefits of LARC methods to ensure these methods are included as first-line options in contraception consultations.

PHAA notes the following evidence:

6. Advice on, and provision of, effective contraception is cost-effective in reducing the impact of unintended pregnancies on individuals, the health system and society.[1,4,5]

7. Unintended pregnancies are associated with non-contraceptive use, failure of contraception and ineffectual use of contraception.[6] It is estimated that one quarter of Australian women have experienced an unintended pregnancy, with women living in a rural location or experiencing socioeconomic disadvantage being disproportionately affected.[6]

8. Effective contraceptive methods available in other countries, such as the combined hormonal contraceptive patch and the self-injectable depo-medroxyprogesterone acetate should be made available in Australia.[7]

9. There are no routinely collected contraception usage data that are reliable and complete. However, oral contraceptives, condoms, and LARC are the most commonly used methods depending on geographical location, health issues, age, and reproductive life course stage.[8,9]

10. LARC are the most effective methods to prevent unintended pregnancy, are acceptable, and have high continuation and satisfaction rates.[10-14] The use of LARC methods has increased in Australia, though remains under-utilised compared with other contraceptive options, such as oral contraceptives and condoms.[12, 15] Contributing factors to under-utilisation include misperceptions about the suitability of LARC methods, a lack of provider training in LARC insertion/removal, and affordability.[16]

11. The EC pill and copper intra uterine devices (IUDs) can prevent conception up to five days after unprotected intercourse.[17] There is considerable misunderstanding of EC within the general population, notably regarding accessibility, safety, mechanism of action, and the effective timeframe.[18]

12. Early access to contraception education and LARC insertion after birth or termination of pregnancy is acceptable to most women and can reduce the risk of rapid repeat unintended pregnancy.[19-21]

13. The safety of various contraceptive methods for use in the context of specific health conditions and characteristics is outlined in the World Health Organization (WHO) medical eligibility criteria for contraceptive use.[22] This has been adapted by the UK Faculty of Reproductive and Sexual Healthcare and adopted by Family Planning organisations in Australia.

14. During emergencies, such as the global COVID-19 pandemic, it is critical to ensure the continuity and maintenance of contraception services, particularly LARC, to prevent unintended pregnancies.[23] This should include self-care contraception options, such as the self-administration of injectable contraception, and access to telehealth services.[24]

15. The provision of development and humanitarian aid funding by the Australian government is necessary to provide access to sexual health and family planning services in developing nations and crisis-affected communities. The provision of contraception services reduces the rate of unintended pregnancy and maternal mortality.[25, 26]

16. Sexual and reproductive health is a fundamental human right.[2] Implementing this policy would contribute towards the achievement of UN Sustainable Development Goals 3 – Good Health and Wellbeing and 5 - Gender Equality.

PHAA seeks the following actions:

17. An implementation and monitoring plan for the *National Women's Health Strategy 2020-2030*: Maternal, sexual and reproductive health priority area which includes appropriate consultation with government and non-government stakeholders and funding for implementation and evaluation.

    Research should be adequately funded to better understand the barriers and enablers of effective contraceptive cost effectiveness, uptake and use (particularly LARC use). Findings will inform the provision of quality services, the improvement of services and the monitoring of contraception provision.

18. Adequate Medicare rebates and pharmaceutical benefits are required for contraceptive consultations, prescriptions and administration that do not lead to financial disincentives for health

professionals or those seeking contraception. Contraception, EC and the provision of LARC insertion/removal services should be free of charge for at-risk groups.

19. Healthcare provider training in contraception counselling and insertion and removal procedures of LARCs should be mandatory in general practitioner, obstetrics and gynaecology, nurse practitioner and midwifery training programs.

    State governments should ensure that public hospitals and other funded services provide contraception services that complement and support primary care services, and reduce geographic location barriers to access.

20. Professional bodies should ensure their members are aware of the requirements to disclose and refer in the case of conscientious objection. Governments and health services should ensure sufficient availability of non-objecting health professionals to safeguard contraception access.

21. State, Territory and Federal Governments should ensure that schools' health curricula include detailed information about contraception, including LARC methods and EC.

PHAA resolves to:

22. Advocate for the above steps to be taken based on the principles in this position statement.

ADOPTED September 2023
(First adopted 2014, revised and re-endorsed 2017 and 2020)

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