# Fertility and Preconception Health

## Policy Position Statement

**Key messages:**

Women and men should be empowered with adequate fertility and preconception health-related knowledge to enable informed reproductive decisions.

Health promotion programs and campaigns should include information about the impact of lifestyle factors on fertility and reproductive outcomes. Research should be undertaken to inform fertility and preconception health promotion strategy development and implementation and evaluation of outcomes.

Fertility and preconception health promotion should be an intrinsic part of women's and men's sexual and reproductive health and family planning education and services.

**Key policy positions:**

1. A Medicare Item Number for reproductive health and preconception care appointments should be created.
2. Expansion of existing national fertility and preconception health promotion programs and services, inclusive of targeted interventions for special populations.
3. An integrated sexual and reproductive health education strategy should be developed and integrated into all health professionals' education.
4. The integration of fertility and preconception health in health education and health promotion programs including those with an impact on chronic disease.

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

**Responsibility:** PHAA Women's Health Special Interest Group

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# Fertility and Preconception Health Policy Statement

# Policy position statement

## PHAA affirms the following principles:

1. Women and men should be empowered with adequate fertility and preconception health-related knowledge to enable informed reproductive decisions.
2. Fertility and preconception health promotion should be an intrinsic part of women's and men's sexual and reproductive health and family planning education and services.
3. Health promotion programs and campaigns should include information about the impact of lifestyle factors on fertility and reproductive outcomes.

## PHAA notes the following evidence:

4. Parenthood is a life goal for most people. Contrary to the common stereotype that parenthood is more important for women than men, studies indicate men desire parenthood as much as women do.[1, 2]
5. Optimum parental preconception health benefits reproductive outcomes.[3]
6. Potentially modifiable factors that adversely affect fertility and reproductive outcomes include increasing female and male age; parental obesity, smoking and heavy alcohol use; poor diet; physical inactivity and mis-timing of intercourse.[4-6]
7. Potentially modifiable factors that adversely affect infant and child health outcomes include maternal folate supplementation, alcohol intake, obesity, interpregnancy weight gain, and short interpregnancy intervals.[7]
8. Improving early fetal life environments can reduce the risk of non-communicable diseases and improve the health of offspring over their life course.[8]
9. Evidence indicates that there is an association between maternal occupational exposure to solvents and congenital anomalies in the offspring.[9]
10. In Australia, current trends that reduce the chance of people achieving their childbearing aspirations and increase the risk of obstetric and neonatal complications include:
    - Age of childbearing is increasing[10]
    - 49-60% of women and 67-78% of men aged 25-44 years are overweight or obese;[11] and
    - 15% of people aged 18 to 44 years are daily smokers.[11]
11. Declining fertility rates are often portrayed as being the result of women delaying childbearing to pursue other life goals such as career and travel. However, research indicates that the lack of a partner or one willing to commit to parenthood are main reasons for the postponement of childbearing.[1]
12. Emerging technologies such as egg freezing and Anti-Mullerian Hormone ("AMH") testing are being promoted to women as viable options for avoiding age-related infertility, often without caveats related to implications, costs, and success rates.[12, 13]

13. Increasingly people use assisted reproductive technology ("ART") to overcome age-related infertility. In 2016, almost one quarter of women accessing ART were aged 40 years or older. The chance of a live birth per started treatment cycle was 25.5% for women aged 30-34 but 5.6% for those aged 40-44.[14]

14. A national survey of Australian men and women aged 18 to 45 years who were planning to have a child found the majority underestimated, by about 10 years, the age at which male and female fertility starts to decline; about 40% were unaware of the adverse effects of obesity and smoking on fertility and had inadequate knowledge of when in the menstrual cycle a woman is most likely to conceive.[12] Furthermore, an international study found that most people overestimate the effectiveness of ART.[15]

15. There is emerging evidence about the efficacy of fertility and preconception health education interventions with studies reporting positive effects on knowledge, behaviour, or maternal and neonatal health outcomes.[16-22]

16. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goals 3 – Good Health and Wellbeing.

17. Healthcare professionals may not feel confident discussing preconception health and fertility with patients. Insufficient knowledge and patient acceptance have been cited as barriers to discussion.[23-26]

18. There are barriers to accessing appropriate fertility and preconception health services including absence of a specific Medicare Item Number for fertility and preconception consultations, limited services in regional and remote areas, and disparities in genetic carrier screening.[27]

19. Special populations including LGBTQIA+ individuals,[28] persons with disability[29, 30] and persons from migrant and refugee backgrounds[31] require access to tailored fertility and preconception health services that meet their needs.

## PHAA seeks the following actions:

20. Family-centred preconception health services should offer tailored, individualised support prior to conception to both healthy couples and those with complex, chronic illnesses.

21. Research should be undertaken to inform fertility and preconception health promotion strategy development, implementation, and evaluation of outcomes.

22. Research should be undertaken on how to improve the uptake of preconception care guidelines, such as the recent RACGP and RANZCOG guidelines, by health professionals and gauge women's and men's attitudes towards preconception care.

23. Development and implementation of an integrated sexual and reproductive health education strategy in teaching and health professionals' education which includes fertility and preconception health optimisation.

24. Expansion of existing national fertility and preconception health promotion programs and services, inclusive of targeted interventions for special populations.

25. The integration of fertility and preconception health in health education and health promotion programs including those with an impact on chronic disease.
26. Increase awareness about the factors that influence fertility, benefits of preconception health optimisation, and limitations of assisted reproductive technology treatment in alleviating age-related infertility.
27. Create an extended Medicare Item Number for reproductive health including fertility management or optimisation and preconception health care including genetic and infectious disease screening and behaviour change counselling.

## PHAA resolves to:

28. The PHAA National Office and Branches, with advice from the Women's Health Special Interest Group, will advocate to State and Commonwealth governments to implement the actions listed above.
29. Promote the Melbourne proclamation, *Advancing sexual and reproductive wellbeing in Australia* adopted by the Family Planning Alliance and PHAA in 2014.

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**(First adopted 2013, revised in 2016 and 2019)**

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