Public Health Association of Australia: 
Policy-at-a-glance – Contraception Policy

Key message: PHAA will
1. Work with policy makers, service providers, professional bodies and educators to improve access to safe affordable contraception services.
2. Advocate for the development of a national comprehensive sexual and reproductive health strategy

Summary: Advice and provision of contraception is an essential health service and is cost effective in reducing the impact of unintended pregnancies on individuals and the health system. All potentially sexually active people who are capable of becoming pregnant or causing pregnancy should be provided with accurate information about all contraceptive options and have access to whichever method is both medically suitable and acceptable to them. All forms of contraception should be affordable and governments should ensure that access is provided to those unable to cover the costs of suitable contraception. There is a need for increased training and awareness of Long Acting Reversible Contraception (LARC) and Emergency Contraception (EC).

Audience: Federal, State and Territory Governments, policy makers and program managers.

Responsibility: PHAA’s Women’s Health Special Interest Group (SIG).

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Contraception Policy

The Public Health Association of Australia notes that:

1. There is a range of contraceptive methods available in Australia. There are limited data on contraceptive usage however it appears that condoms, the combined oral contraceptive pill and sterilisation remain the most commonly used methods. (1,2)

2. Contraception methods include the following (8):
   a. **Barrier Methods**
      Barrier contraception such as male and female condoms, diaphragms and cervical caps prevent sperm from entering the cervix and uterus thus preventing fertilisation. Male and female condoms are the only methods of contraception that also minimise the risk of transmitting or contracting sexually transmissible infections (STI).
   b. **Fertility awareness based methods**
      These methods involve avoiding vaginal intercourse during the parts of the menstrual cycle when conception can occur. There are typically high pregnancy rates relative to other contraceptive methods due to the difficulties of accurately predicting fertility and the challenges of abstinence.
   c. **Short Acting Reversible Contraception**
      Oral contraceptive pills, both combined and progestogen only, and the combined contraceptive vaginal ring are methods requiring daily or monthly administration.
   d. **Long Acting Reversible Contraception (LARC)**
      By definition, LARC includes methods requiring administration less than monthly. The LARC methods available in Australia include the contraceptive injection, the contraceptive implant and the intrauterine devices (both copper and hormonal). The contraceptive injection lasts around 14 weeks, the contraceptive implant lasts three years while the hormonal IUD lasts five years and copper IUDs last 5-10 years.
   e. **Sterilisation**
      Female sterilisation involves permanently blocking or cutting and tying the fallopian tubes to prevent an ovum from passing. Male sterilisation involves a vasectomy to prevent sperm from joining the ejaculate fluid. These methods should be regarded as permanent as there is no guarantee of successful reversal.

3. The Long Acting Reversible Contraceptive (LARC) methods are more effective at preventing unintended pregnancy (3,4), have high continuation rates (4) and require minimal upkeep by the patient compared to other methods. LARC methods require more invasive and potentially more expensive initiation.

4. LARC methods are underutilised in Australia. (1,2,5,6) While the reasons for this are likely to be multifactorial, misperceptions about the suitability of LARC methods, particularly of IUDs for young women, also contribute. (7) Raising awareness, accessibility and extending their use as first line methods could reduce unintended pregnancy and abortion (8).
5. Some hormonal methods are used for their non-contraceptive benefits, such as decreasing heavy menstrual bleeding or period pain and the management of acne and other disorders. Barrier methods can also protect against sexually transmissible infections (STI). (9)

6. Early access after birth or abortion to effective contraceptive methods can reduce the risk of rapid repeat pregnancy. (10,11)

7. Emergency Contraception (EC) in the form of the Emergency Contraception pill (ECP) or copper IUD can prevent conception up to five days after unprotected intercourse.(12)

8. There is much misunderstanding about the role, safety, timing, mechanism of action and accessibility of EC within the general community. (13,14)

9. Some health professionals claim a conscientious objection to advising on, prescribing or dispensing contraception, particularly EC. (15)

10. Emergency contraception methods include:
   a. **Emergency contraceptive pill**
      The efficacy of the EC pill available in Australia declines with time after intercourse and there is some emerging evidence of decline with increasing bodyweight.(16)
   b. **Copper IUD**
      The copper IUD is more effective than the EC pill (12,17) but access to IUD insertion is very limited.

The Public Health Association of Australia affirms the following principles:

11. A comprehensive sexual and reproductive health strategy can be expected to deliver the best health outcomes by addressing elements including:
   a. school-based education for safe respectful relationships
   b. increasing health literacy with respect to contraception and prevention of unintended pregnancy
   c. a social determinants framework which takes account of factors such as partner violence and access to financial resources
   d. service development and planning which ensures equitable access to good quality services
   e. workforce development for health professionals, educators and others
   f. monitoring, data collection, evaluation and research

12. Advice and provision of contraception is an essential health service and is cost effective in reducing the impact of unintended pregnancies on individuals and the health system (8,18)

13. All potentially sexually active people of reproductive age should have the opportunity to access accurate information and choice about contraceptive options which are safe, reliable and acceptable to them.

14. All forms of contraception should be affordable and governments should ensure that access is provided to those unable to cover the costs of suitable contraception

15. Consultations regarding contraception should also include advice on safe sex practices to minimise the risk of STI as well as unintended pregnancy.
16. Health professionals with a conscientious objection to contraception use should disclose this to their patients and direct the patient to another health professional or health service where they may receive unbiased advice.

17. Training and awareness raising may be required for health professionals around the suitability and benefits of LARC methods to ensure these methods are included as first line options in contraception consultations.

18. The role of nursing professionals in contraception information provision and service delivery, including implant and IUD insertion, should be supported, especially in rural and remote areas where teenage fertility is high.

19. Training of health care providers and awareness raising of the general public is required to dispel myths about EC and to ensure women are aware of its efficacy beyond “the morning after”.

20. Doctors and other health care providers should include discussion about EC in all general contraception consultations.

21. Patient information on contraceptive options should contain information about EC—where and when it should be used and how accessed.

22. To increase accessibility the ‘advance supply’ of EC pill should be encouraged and facilitated by health care providers for all sexually active fertile women.

23. Pharmacists should be educated about existing guidelines that facilitate supply of EC.

The Public Health Association of Australia believes that the following steps should be undertaken:

24. Organisations should support and collaborate in the development of a comprehensive national sexual and reproductive health strategy.

25. Research and training should be adequately funded, as for other areas of health practice, to ensure ongoing adequacy of service provision, quality of care and service improvement in contraception provision.

26. Professional bodies including RACGP, RANZCOG, Pharmaceutical Society of Australia, Pharmacy Guild of Australia, SHFPA should be supported to provide training to medical practitioners and pharmacists to ensure that people are provided with current, accurate information on their contraceptive options and that their choice is available and accessible.

27. Professional bodies should ensure their members are aware of the requirements to disclose and refer in the case of conscientious objection.

28. State and Territory and Federal Governments should ensure that health curricula for delivery in schools include detailed information about vulnerability to pregnancy in relation to a lack of use, incorrect or inconsistent use of contraception, the risks and benefits all forms of contraception including LARC methods and EC.

29. Research should be undertaken into the barriers and enablers of effective contraceptive uptake and use, in particular LARC use, in the Australian context to inform programs for health professional and community education.
30. Medicare rebates and pharmaceutical benefits for contraceptive consultations, prescriptions and administration should be set at levels which adequately support this work, and do not lead to financial disincentives for health professionals or those seeking contraception.

31. State governments should ensure that public hospitals and other funded services provide contraception services which complement and support primary care services.

32. Education for health care providers needs to strengthen awareness that ECP is a safe, effective contraceptive method for reducing the number of unwanted pregnancies in Australia and does not work by causing abortion.

33. A comprehensive consumer education program should be developed by health care providers and public health advocates to ensure the public are given quality health information about EC and its over-the-counter availability in Australia.

**The Public Health Association of Australia resolves to undertake the following actions:**

34. The Board, Women’s Health Special Interest Group and State/Territory Branches of the Association will work with policy makers, service providers, professional bodies and educators to improve access to safe affordable contraception services. They will advocate for:
   a. The development of a comprehensive sexual and reproductive health strategy, addressing the domains identified in the Melbourne Proclamation (19) and the Association’s earlier call to action and sexual and reproductive health background paper (20)
   b. Improved professional and community education to support access to all suitable contraceptive options.
   c. Reduction in barriers to contraceptive access such as cost and geographic location.
   d. Particular attention to improved information about and access to LARC and EC when appropriate.

**ADOPTED 2014**
First adopted at the 2014 Annual General Meeting of the Public Health Association of Australia. The latest revision has been undertaken as part of the 2014 policy review process.

**References:**