CONSENSUS STATEMENT

REDUCING UNINTENDED PREGNANCY FOR AUSTRALIAN WOMEN THROUGH INCREASED ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTIVE METHODS JULY 2017

GOAL:

TO REDUCE UNINTENDED PREGNANCY FOR AUSTRALIAN WOMEN THROUGH INCREASED ACCESS TO LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC*) METHODS.

*For the purpose of this work, reference to LARC methods specifically means the progestogen only implant and hormonal and copper intrauterine devices (IUDs), and not progestogen depot injections.

THIS CONSENSUS STATEMENT IDENTIFIES:

- goals for effective and equitable contraceptive management
- current priorities for action
- recommendations for action to progress these priorities.

It reflects the views expressed by participants in a workshop facilitated by the Australian Healthcare and Hospitals Association on 19 May 2017, with representation from health consumers, health professionals, experts in the field and service providers, under the guidance of a Steering Committee.

DISCLAIMER

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UNINTENDED PREGNANCY IS A SIGNIFICANT HEALTH ISSUE FOR AUSTRALIAN WOMEN.

Unintended pregnancies are those that are unexpected, mistimed or unwanted. An estimated 40-50% of Australian women have had an unintended pregnancy during their reproductive lives,[1,2] with rates disproportionately high among those who had experienced sexual coercion, were socioeconomically disadvantaged and/or were living in a rural area. For the men involved, being born overseas was an additional factor associated with an increased rate of unintended pregnancy.[2]

There are several options for women facing an unintended pregnancy: parenting (with a partner or alone), adoption, foster care or abortion. It has been estimated that 80,000 abortions occur each year in Australia.[3] The potential repercussions of an unintended pregnancy vary across social and cultural settings,[4] but the social, psychological, physical, educational and economic impacts can be significant, for example:

- Women who experience unintended pregnancy are at a greater risk of negative mental health outcomes and experiencing physical abuse while pregnant.[4,5] Evidence suggests unintended childbearing is associated with a significantly increased risk of maternal depression, anxiety and a decline in psychological well-being or psychosocial conditions.[4]
- Women who experience unintended pregnancies may be more likely to have negative health behaviours during pregnancy, tend to initiate prenatal care later and are less likely to breastfeed.[5]
- Children born to mothers whose pregnancies were unintended are less likely to benefit from positive parent-child relationships. They are more likely to have poorer mental and physical health and poorer educational and behavioural outcomes.[5,6]
- Unintended pregnancy in adolescence can interfere with a woman's pursuit of education, while the ability to plan pregnancies is associated with attainment of education, participation in the workforce, increased earning power and a reduced gender pay gap.[6]

CONTROL OVER WHEN OR IF TO CONCEIVE IS A PREREQUISITE FOR WOMEN'S EQUALITY OF OPPORTUNITY.

The release of the oral contraceptive pill in Australia in 1961 led to a momentous change in women's lives, giving them freedom to avoid unintended pregnancies and plan parenthood. With control over their reproductive future, more women entered the workforce and this led to ongoing social change towards equal pay for equal work and freedom from discrimination.[7]

While Australian women were early adopters of the pill, there are still high levels of use despite more effective options now being available. It has been estimated that 33% are using oral contraceptives, 30% condoms and 19% sterilisation as their primary contraceptive method.[8]

WOMEN NEED TO BE SUPPORTED TO MAKE AN INFORMED CHOICE.

There is a range of contraceptives available in Australia, with variations in effectiveness, ease of use, cost, side effects and satisfaction.

The priorities, needs and preferences of individual women need to be promoted in contraception decision-making.[9]

THE HEALTH, EDUCATION AND SOCIAL SYSTEMS NEED TO ENABLE WOMEN TO EXERCISE THEIR CHOICE EQUITABLY.

Policy, regulatory, workforce and funding factors within the health, education and social systems can enable or hinder women to exercise informed choice in contraceptive decision-making. These need to support equitable access.

DESPITE WIDESPREAD CONTRACEPTION USE IN AUSTRALIA, UNINTENDED PREGNANCIES STILL OCCUR.

Inconsistent contraceptive use plays a major role in putting women at risk of unintended pregnancy. Sixty percent of Australian women who have had an unintended pregnancy were using at least one form of contraception, with the oral contraceptive pill the form most frequently cited (43%), followed by the condom (22%).[1] Failure of contraception with oral contraceptive pills is largely attributable to the requirement for daily pill-taking.

SOME CONTRACEPTIVE METHODS ARE MORE EFFECTIVE THAN OTHERS.

A key way to reduce unintended pregnancy is to use more effective, less user-dependent methods of contraception, such as the long-acting reversible contraceptive (LARC) methods (implant/IUDs).*

ONCE CHOSEN, WOMEN OF ALL REPRODUCTIVE AGES REPORT HIGH LEVELS OF SATISFACTION WITH LARC METHODS.

Misinformation about LARC methods is a major barrier to women choosing them (e.g. the availability of different types of contraception, how LARC methods work, the perceived lack of suitability for young women or nulliparous women, changes to bleeding patterns with LARCs, and the reversibility of their activity).[15]

However, when women are provided with comprehensive, accurate, unbiased counselling, LARC methods are preferred and have been shown to have the highest rates of satisfaction and 12-month continuation compared with other combined hormonal methods (e.g. oral contraceptive pill, vaginal ring).[16]

THE USE OF LARC METHODS IS WIDELY SUPPORTED, IN AUSTRALIA AND INTERNATIONALLY.

Clinical guidelines, key opinion leaders and peak bodies, in Australia and internationally, recommend increasing the use of LARC methods as the most effective reversible contraceptive, within the context of informed choice.[10-13] The use of LARC methods is supported as a public health priority.[14]

THERE ARE ECONOMIC BENEFITS TO SUPPORTING INCREASED ACCESS TO LARC METHODS.

There is international evidence that LARC methods are more cost effective (to the health system) than oral contraceptives and male condoms, as typically used, and this is not sensitive to modest changes in discontinuation rates, failure rates, duration and frequency of follow-up consultations, and/or ingredient costs.[17]

UPTAKE TO LARC METHODS REMAINS LOW IN AUSTRALIA RELATIVE TO COMPARABLE COUNTRIES. REDUCING UNINTENDED PREGNANCY THROUGH INCREASED ACCESS TO LARC METHODS REQUIRES FOCUS ON HEALTH SYSTEM ENABLERS.

KEY BARRIERS TO EQUITABLE ACCESS TO EVIDENCE-BASED CONTRACEPTIVE MANAGEMENT IN AUSTRALIA INVOLVE:

CONTRACEPTIVE KNOWLEDGE

Misconceptions persist around the use of LARC methods, for both health professionals and women. These may relate to such concerns as their appropriateness in certain populations (e.g. outdated beliefs that 'IUDs shouldn't be used in nulliparous women' or young women, 'IUDs shouldn't be used post-delivery', or 'LARCs shouldn't be used in populations at high risk of sexually transmissible infections') or the management of adverse effects (e.g. changed menstruation patterns).[15]

There is no 'gold standard' clinical practice guideline on contraceptive management that is applied across all health professions and practice environments, that is endorsed by all relevant bodies, and that is free and easy to access. Commonly-used reference sources may not present information in a manner or with sufficient detail to guide health professionals in dispelling myths about LARC methods, managing adverse effects (e.g. changes to bleeding patterns) and accurately supporting women's informed choice for contraception.

Consumer information may be too generic and not directed to, or resonate with all women and in particular vulnerable groups. There is a lack of information designed for specific audiences, such as for those with low literacy and low health literacy, those on low incomes, those from culturally and linguistically diverse backgrounds (e.g. refugee, asylum seekers, migrants), Aboriginal and Torres Strait Islander people, women of varying ages (12 to 55 years), women with specific medical conditions (e.g. cardiac disease, diabetes), people living with disabilities, homeless people, men, those experiencing domestic violence, those in care and protection and justice services.[18]

FUNDING MODELS, SERVICE MODELS AND PATHWAYS OF CARE

LARC methods can be accessed through general practices, family planning and some sexual health services, and abortion services. They can also be accessed through midwifery services (if the midwife has appropriate endorsement), gynaecology services (although these may be private and therefore costly), and some hospital-run contraceptive clinics (although these may be difficult to get into due to long waiting lists).

Medicare and Practice Nurse Incentive Programme payments are inadequate to cover the costs of insertion of LARC devices (in particular for IUDs); there may be 'gap' fees. The need for patients to contribute high fees upfront, relative to less effective forms of contraception, impacts on equitable access. Services may also introduce models of practice that require a multiple number of patient consultations (e.g. three visits), which are not always evidence-based, to off-set the overall costs of insertion provision. However, this shifts costs (both financial and in time) to the patient.[18,19]

Further, MBS items associated with insertion and removal of LARC devices are restricted to GPs, whereas trained registered nurses, midwives and nurse practitioners can also competently perform these procedures. While services provided by eligible nurse practitioners and eligible midwives (particularly those in private practice) are able to prescribe and can attract a Medicare benefit, the majority of nurses and midwives are not currently able to work to their full scope of practice, impacting the efficiency with which services can be offered and potentially the availability of these services, particularly in rural and remote locations.[18]

In the hospital setting, women may be referred outside the hospital for insertion of LARC methods in a primary care setting, shifting the cost of the medicine and insertion to the PBS/MBS. Timely access to services may not be available and additional upfront costs are imposed on the patient. This can prevent women from pursuing insertion,[18] and further risk of unintended pregnancy in the interim period.

DISTRIBUTION OF A SKILLED WORKFORCE

A lack of familiarity among health professionals with the provision of LARC methods can influence the advice given to women and their availability for insertion. A lack of training in the area, a lack of follow-up support (e.g. supervision, mentoring), and needing to undertake a sufficient volume of insertions to maintain skills have been identified by health professionals as barriers, particularly in regional/rural areas. Without adequate numbers of health professionals in regional/rural primary care confident in providing LARC methods, women are faced with the need to attend specialists, which can increase wait times, travel and costs.[15]

AUSTRALIAN DATA

Data to inform policy and practice changes is currently drawn from the PBS (reimbursed medicines only, no data from private market; copper IUDs are classed as medical devices and so not included in data), the MBS (only procedures where benefits are claimed; no data from public hospital or private clinics), surveys and quantitative studies. There are no reliable, routinely collected data on contraceptive use in Australia, nor on the outcomes of unintended pregnancies (e.g. abortion rates), to inform policy and practice changes.[19]

GOALS:

WOMEN ARE SUPPORTED TO MAKE AN INFORMED CHOICE ABOUT CONTRACEPTION.

VALUE IN CONTRACEPTIVE CARE IS ACHIEVED.

DATA AND RESEARCH INFORMS CONTRACEPTIVE POLICY AND PRACTICE.

GOALS	PRIORITIES 2017	RECOMMENDATIONS FOR ACTION	
WOMEN ARE SUPPORTED TO MAKE AN INFORMED CHOICE ABOUT CONTRACEPTION	Secondary students: • Curriculum[20] reflects an evidence-informed approach to contraceptive management.	Networks of excellence are established and promoted to support public and independent schools with delivering developmentally appropriate reproductive and sexual health education.	State/territory Departments of Education and the Australian Council for Health, Physical Education and Recreation (ACHPER)[22] to lead work in this area.
	• There is an alignment of education provided with the National HPV Vaccination Programme.[21]	Education about contraceptive use is provided to all males and females aged 12–13 years in conjunction with the National HPV Vaccination Programme.[21]	The Commonwealth Department of Health to lead work in this area.
	Consumers across the lifespan: • Awareness is raised around unintended pregnancy, effective prevention available and methods of access. • The information needs of specific audiences is addressed, in particular those of vulnerable groups.	There is a public health campaign, to include targeted and accessible information for vulnerable groups who have specific information needs. The Australian Commission on Safety and Quality in Health Care Question Builder[23] is adapted for contraceptive care.	The Commonwealth Department of Health to lead work in this area.
	Health professionals: • National contraceptive management guidelines are developed for Australia, which are applicable and accessible across all health professionals and practice settings. • Localised health pathways for access to LARC are in place and promoted to health professionals and consumer.	Guideline development is guided by a group of experts from relevant professional colleges, associations, health services and peak bodies in this area. Free online access to the guidelines is provided to all health professionals. Information in the guidelines is translated for specific professions and services through education and targeted messaging, and referenced in Health Pathways (or equivalent).	The Commonwealth Department of Health to provide funding for guideline development. Health professional colleges and associations, health services and other bodies (e.g. PHNs) to lead work for their respective professions and services.

*Lead agencies have been identified, with the expectation that a collaborative approach is pursued involving all levels of government across the health, social and education sectors, consumers, health professionals and professional colleges and associations, health services and other stakeholders involved with women's health, as appropriate.

GOALS	PRIORITIES 2017	RECOMMENDATIONS FOR ACTION	
VALUE IN CONTRACEPTIVE CARE IS ACHIEVED	The costs and benefits of preventing unintended pregnancy in Australia are understood.	In the immediate term, an evaluation of the direct health care costs incurred through use of different contraceptive methods is undertaken and published, with a full economic evaluation to follow.	The Council of Australian Governments (COAG) to lead work in this area, supported by the Australian Health Ministers' Advisory Council (AHMAC).
	Financing of contraceptive methods supports equitable access to LARC methods. Preferential access for vulnerable populations is facilitated.	MBS items for insertion and removal of implants and IUDs adequately reflect the cost of providing the service and the public health benefit.	Led through the current MBS Review.[24]
		Models of care are funded that allow implant and IUD insertion and removal by trained registered nurses, midwives and nurse practitioners. Practice outcome payments piloted to support nurse involvement.	The Commonwealth Department of Health to lead work in this area.
		Innovative models for LARC methods in hospital (e.g. LARC methods in maternity imprest and standard postnatal care for vulnerable populations) are supported and evaluated.	State/territory Departments of Health to lead work in this area, including within the National Framework for Maternity Services.[28]
		The provision of LARC methods is included in work to progress a bundled pricing approach[25] for maternity care.	The Independent Hospital Pricing Authority to lead work in this area.
		A program to offer LARC methods to women aged <25 years at no cost, and without limiting the health services at which the service is provided, is piloted.	The Commonwealth Department of Health to lead this work.
	Models of care support implant and IUD insertion and removal by trained registered nurses, midwives and nurse practitioners.	Evidence for nurse and midwife involvement in LARC methods in primary healthcare, with a particular focus on regional Australia and vulnerable populations, is translated in practice.	The National Health and Medical Research Council (NHMRC) and the Department of Health recognise the alignment between this and their strategy[26] and Medical Research Future Fund priorities[27], respectively.
	Models of care support access to LARC methods through maternity care.	Contraception management is built into: • prenatal care guidelines, allowing LARC prescription and dispensing prior to hospital so that insertion can occur immediately post-delivery, where appropriate.* • postnatal care guidelines.	State/territory Departments of Health to lead work in this area, including within the National Framework for Maternity Services.[29] The Commonwealth Department of Health to lead this work.
	Training programs are accessible to GPs, nurses and midwives to increase the numbers skilled in implant and IUD insertion and removal.	A training model that supports equitable access to LARC methods. Education programs that lead to registration for medical practitioners, nurses and midwives to include implant and IUD insertion and removal within their curriculum.	Relevant professional colleges and health services to lead work in this area. The Commonwealth Department of Health to provide funding to support training at no cost to health professionals for this health priority.

*This recommendation for action is not aligned with the Product Information(s) for LARCs (as defined within this document i.e. implant and IUD)

GOALS	PRIORITIES 2017	RECOMMENDATIONS FOR ACTION	
DATA AND RESEARCH INFORMS CONTRACEPTIVE POLICY AND PRACTICE	Existing data sources and collection practices refined to inform contraceptive policy and practice in Australia.	Contraceptive data extracted from general practices is used to drive improvement in the quality use of these medicines.	NPS MedicineWise to support work in this area through MedicineInsight.[29]
		Data to inform contraceptive policy and practice is included in a future primary healthcare national minimum data set (NMDS).	The Commonwealth Government to lead work in this area.
	Accurate collection of pregnancy outcomes data, in particular abortion numbers, to inform contraceptive policy and practice in Australia.	The notification of abortions is introduced consistently nationwide, informed by existing processes, e.g. inSA, WA and NT.	COAG to lead work in this area. An expert group be convened to inform approach to data collection.
	The alignment of LARC services with population need is monitored.	Regional needs assessments are undertaken.	Primary Health Networks to lead work in this area, as relevant to their populations.
	Politicians are engaged in the area of women's reproductive health.	A Parliamentary Friends Group on reproductive health is formed.	Interested stakeholders to lead.

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