

Interim Report: Feedback Survey

The Sustainable Health Review Interim Report feedback survey consisted of 14 questions. The responses to the open feedback questions are detailed below. Responses to questions 9-12 have been published in a summarised report on the SHR website.

Your Personal Details	
1. Title	Mr <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/>
2. First Name(s)	
3. Surname	
4. Contact Details	
5. Organisation	Sexual Health Quarters (SHQ) formerly Family Planning WA
6. Location	<input checked="" type="checkbox"/> Metropolitan <input type="checkbox"/> Regional WA <input type="checkbox"/> Outside WA
7. Are you providing a response on behalf of your group/organisation or as an individual? (Required)	<input checked="" type="checkbox"/> Group/organisation <input type="checkbox"/> Individual <input type="checkbox"/> Other, please specify: _____
Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)	
<input checked="" type="checkbox"/> I consent to my feedback being published <input type="checkbox"/> I consent to my feedback being published anonymously <input type="checkbox"/> I do not consent to my feedback being published	

The next two questions will allow you to provide more detailed feedback on how to maximise improvements in each of the Directions or suggest other areas or actions for the Sustainable Health Review Panel to consider to develop a more sustainable health system.

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

Direction 1

In relation to better health outcomes SHQ would like the panel to consider:

- 1) The impact unintended pregnancy is continuing to have on the health of Western Australians
- 2) Emphasising the significant medical, social and economic benefits of Long Acting Reversible Contraceptives (LARCs)
- 3) Advocating for Western Australians to have improved access to safe abortion services within the public health care system
- 4) Advocating for improved pre-pregnancy counselling, antenatal and post-natal contraceptive care and advice
- 5) Acknowledging reproductive coercion as a form of family violence and advocating for improved research, awareness and laws to support people affected by it
- 6) Increasing their references to marginalised groups including the complex health needs of LGBTIQ people

Direction 5

In relation to equity in country health SHQ would like the panel to consider

- 1) Strategies to increase access to training options in LARCs, abortion services, and sexual and reproductive health
- 2) Strategies to reduce the escalating incidence of gonorrhoea and syphilis in rural areas, with a focus on preventing unintended pregnancy in communities with endemic rates
- 3) Strategies to increase screening of pregnant women in endemic regions for syphilis and gonorrhoea to reduce the impact on fetal morbidity and mortality
- 4) Increasing training and research in screening tools for family and domestic violence, and training of staff to recognise and manage those affected by it
- 5) Increased rural health facilities and services for vulnerable adults and children experiencing family and domestic violence

Direction 8

In relation to data, SHQ would like the panel to consider

- 1) Implementing unified reporting methods around unintended pregnancy and abortion rates to inform strategies on service delivery
- 2) Implementing consistent reporting strategies around intimate partner violence and reproductive coercion whilst maintain confidentiality
- 3) Ensuring our systems maintain patient and client confidentiality at all times

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

SHQ would like the panel to consider including a direction regarding improved reproductive and sexual health services in the state. We believe there is overwhelming evidence that Western Australians are not receiving adequate education or access to contraception and abortion care. Western Australian clinicians are not receiving adequate education in sexual and reproductive health matters. As such, we are seeing rising unintended pregnancy rates among rural teenagers, escalating gonorrhoea and syphilis rates, and the potential for increased stigmatisation of marginalised groups.

Sexual and Reproductive Health Training in WA: Summary

Access to doctors who have the skills and knowledge in the area is currently a significant barrier to increasing the uptake of LARC. There is a large gap in access to training in sexual and reproductive health, and trainees are finding it increasingly difficult to fulfil the practical requirements of the Diploma of the Royal Australian College of Obstetrics and Gynaecology (RANZCOG) as well as the fellowship of the RANZCOG in basic contraceptive and abortion care. Since 30 June 2017, there has been no family planning clinics offered at any of the major centres in Obstetrics and Gynaecology in the State, and there is limited access to publicly funded abortion. This poses significant issues in both the unmet need for training of doctors, and a limit in access to service provision.

Training in reproductive and sexual health is essential to improving community awareness of the contraceptive types available, uptake of LARC, and a reduction in the rate of unintended pregnancy. Australia has one of the highest unintended pregnancy rates in the developed world and this poses a significant public health issue to the community.

A lack of adequate training in sexual and reproductive health puts medical professionals at grave risk of perpetuating a chain of misinformation, falling well short of best patient care. Education must include theoretical training in contraception and abortion, practical skill training with patients who are not sedated, as well as management of the complications and problems which can arise. It could be viewed as irresponsible not to train doctors properly in sexual and reproductive health. A lack of training will inevitably result in a reduction in LARC uptake in Western Australia, a further increase in unintended pregnancy, and a huge social and economic burden on the State.

EVIDENCE FOR SHQ'S POSITION

Approximately 559,000 women of reproductive age (14-44) lived in Western Australia in 2016 (1). The rate of unintended pregnancy is a significant public health issue. Unintended pregnancy is associated with significant social, economic, and health burdens. The worldwide and Australian rates of unintended pregnancies are falling in more recent years and this has been attributable to the availability of LARCs and contraception generally. There are, however, several barriers in Western Australia to women to be able to access doctors who can discuss,

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

insert, manage and remove LARCs. This has the potential to increase unintended pregnancy rates, and further increase the discrepancy in access to reproductive health care for marginalised women in the State.

Equitable and affordable access to a full range of contraceptive methods is essential to reducing the rate of unintended pregnancy. Long-acting reversible contraceptive methods are highly effective (over 99%), reversible forms of contraception and have been proven to be an effective strategy in preventing unintended pregnancy. Individuals and couples seeking contraception should be given accurate evidence-based information on the safety, efficacy, advantages and disadvantages of all options (2).

The most common contraceptive methods used in Australia are oral contraceptives (91% efficacy) and condoms (82% efficacy) (3). Despite evidence showing many benefits, uptake of LARC is low in Australia in comparison to other developed countries. In 2016, it was found 6.1% women across Australia utilised an IUD as compared to 33 percent of women choosing oral contraceptives and 30% women using condoms (3). Access to doctors who have skills and knowledge in the area is a significant barrier to increasing this uptake.

The impact of unintended pregnancy on the community

Of the 213 million pregnancies that occurred worldwide in 2012, 40%—about 85 million—were unintended (4). Reported rates in the US and the UK are 49% and 41% respectively (4, 5). Despite nearly 80% of Australian women of reproductive age reportedly using a contraceptive method, an estimated 50% of pregnancies in Australia are unintended (6). Approximately one in four pregnancies in Australia are terminated (6).

Data suggests that children born to teenage mothers have a 63% increased risk of being born into poverty. 90% of teenagers across the world drop out of high school education, and up 20% have another pregnancy as a teenager. Teenage mothers are 22 times more likely to be living in poverty than the general population (7).

Australia has a teenage pregnancy rate of 87 births per 1000 women in some rural and remote areas (1). Fertility data among Indigenous Australians in rural Australia is higher than the rest of the country. In 2015, Aboriginal and Torres Strait Islander women had more babies and had them at younger ages than non-Indigenous women; teenagers had 16% of the babies born to Aboriginal and Torres Strait Islander women, compared with 2.8% of those born to all mothers. The median age of Indigenous mothers was 25.1 years, compared with 31 years for all mothers. The fertility rate of teenage Indigenous women (58 babies per 1,000 women) was nearly five times that of all teenage women (12 babies per 1,000) (1).

In 2015, total fertility rates were 2,271 births per 1,000 for Aboriginal and Torres Strait Islander women and 1,807 per 1,000 for all women (Table 3) [1]. The highest total fertility rate for Aboriginal and Torres Strait Islander women was for those in WA (3,014 babies per 1,000 women), followed by NSW (2,317 per 1,000) and Qld (2,312 per 1,000).

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

Unintended pregnancies have significant consequences both socially and economically (5, 8). In the UK, it is estimated that the healthcare and social costs of unintended pregnancies can be as much as £1 billion per year. Estimates for the US puts the cost of abortions, miscarriage management, antenatal care, births and infant medical care for unintended pregnancies at around US\$9.6–US\$12.6 billion per annum (5). Currently there is limited Australian information about the economic cost of unintended pregnancy.

Unintended pregnancies have significant public health impacts: births resulting from unintended or closely spaced pregnancies are associated with adverse maternal and child health outcomes. Birth spacing intervals of less than six months are associated with an increased risk of maternal mortality. Birth-to-pregnancy intervals of around 18 months or shorter are associated with elevated risk of infant, neonatal and perinatal mortality, low birth weight, small size for gestational age, and pre-term delivery (9).

Efficacy of contraceptive methods available in Australia

LARC is the most effective at preventing pregnancies due, in part, to minimal adherence requirements and long duration. Other methods, such as oral contraceptives and condoms, can be effective at preventing pregnancies, but only when strict adherence is consistently maintained (10-13). Findings indicate that the risk of contraceptive failure among women who use oral contraceptives or a vaginal ring is 20 times greater than the risk among women who use LARC (6). Improving the uptake of highly effective LARC methods is essential to reducing unintended pregnancies, and so interventions to increase LARC uptake have been made a national health priority in the UK and the US.

Contraceptive prevalence in Australia

Although 66% of Australian women between 16-49 currently report using contraception, the use of LARCs in the Australian context is low (9%), compared to 18% internationally (15). In the BEACH study of female patients aged 12-54 years who consulted a GP for contraception, 69% were for oral contraception, 8.6% were for contraceptive injection, 4.9% were for contraceptive implant and 2.0% were for IUDs (16). In the US longitudinal Contraceptive CHOICE Project, when women were offered the full range of contraceptive options, 75% of women chose LARC, and more than 80% of young people chose LARC. The satisfaction rate of an IUD after one year was 80%, compared to satisfaction with the combined oral contraceptive pill (COCP) which was <50% (17)

Benefits of LARC

LARC methods are:

- highly effective as a result of their “fit-and-forget” technology (limited effort required by user to maintain long-term effective protection)
- have few contraindications
- have a good safety profile
- high satisfaction and continuation rates

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

- cost-effective compared to shorter acting methods at one year of use (12)
- have been shown to significantly reduce unintended pregnancy, teenage birth rates and abortion rates when promoted on a large scale (13-15).

LARC and younger women

- Increasing the accessibility of LARC has been proven to be effective in reducing unintended pregnancy among young women (11), and their use in this population is endorsed by the American College of Obstetricians and Gynecologists, the Centers for Disease Control and Prevention, and the World Health Organization (18).
- Compared with the pill, patch and ring, LARC methods have reduced likelihood of noncompliant use, making them particularly suitable for adolescents (19).
- In the Contraceptive CHOICE Project, when presented with a range of contraceptive options, 40% of young women aged 14-17 years chose the contraceptive implant, and over 40% of young women 18-20 years chose an IUD (17).
- Healthcare providers can help to reduce the rate of rapid repeat pregnancy (RRP) (pregnancy within the first two years of a teenage birth) by facilitating teenage mothers' access to LARC (20).

Cost-effectiveness of LARC methods

Cost-effectiveness analyses of different contraceptive methods have favoured LARC use:

- A UK study reported that despite the high start-up costs related to health service delivery, all LARC methods were more effective and less costly than the combined oral contraceptives (4).
- In the US, apart from the irreversible methods, LARC methods have been found to be the least expensive and most effective contraceptive methods. From a cost savings perspective, if 10% of US women aged 20-29 years switched to a LARC method, then approximately US\$375 million per year could potentially be saved from the cost of unintended pregnancies and contraception use (5).
- Currently there is limited Australian information about the cost-effectiveness of LARC. A current study (ACCORd) will include an economic evaluation that accounts for the cost structure of the Australian health system, including issues such as reimbursement by the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) and out-of-pocket costs to women. It will demonstrate where the burden of costs falls in increasing the use of LARC (individuals vs the health system), as well as any potential cost-savings from using LARC both for government and women (21).
- According to a recent abstract presented at the Australasian Sexual Health Alliance (ASHA) conference, women who switched from an oral contraceptive pill (OCP) to a LARC would realise annual cost savings of \$113-\$157, adjusted for the possibility of early discontinuation. If LARC uptake in Australia increased to that in comparable countries, net savings to the Australian Government are estimated at \$68 million over five years. Cost savings arise because LARC device costs are incurred once, compared to OCP costs which are faced each year contraception is used, for visits to general practitioners, and OCPs themselves, with close to 60 per cent of Australian women using unsubsidised OCPs and bearing all costs (15).
- Women at high risk of pregnancy but not using any prescribed contraception would face costs

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

in adopting a LARC (\$36-\$194 per person). However, the overall benefit for these women from avoided termination of pregnancies and miscarriages (\$121-\$185 per year), outweighs these costs. By increasing LARC usage to international rates for Australian women at high risk of unintended pregnancy, the Australian Government would achieve net savings of \$20 million over five years (15).

Barriers to Uptake of LARC

Barriers to IUD insertion and uptake include:

- Low level of awareness among consumers of the availability, safety and appropriateness of LARC methods (3, 19).
- Low knowledge and experience of LARC methods amongst health professionals (3).
- Time required for counselling about these methods (19-20).
- Higher initial costs pose a substantial barrier to greater utilisation (21). In the Contraceptive CHOICE Project, 70% of adolescent women chose a LARC method when cost was not a factor.
- Inadequate GP remuneration
- GP time constraints
- Lack of knowledge of benefits by both practitioners and patients
- Concerns about safety of use
- Limited access to training for GPs

Increasing LARC uptake

Several interventions to increase LARC uptake have been tested overseas:

- Counselling has been shown to be effective in increasing uptake of IUDs (17)
- Acceptability of implants is enhanced by effective counselling, particularly pre-insertion, even in the presence of side effects.
- Counselling and providing LARC at no-cost has proven to be an effective intervention in several settings
- Training of healthcare providers has been shown to be a significant factor in the provision of LARC methods (18)

These studies reinforce the importance of counselling women and educating healthcare providers about LARC methods.

No interventions designed to increase LARC uptake among Australian women have been tested. The prescription and use of LARC in Australia is very low despite clinical practice guidance and statements by peak bodies advocating an increase in the use of LARC. General practice is the 'first line' in the delivery of contraception to women and the management of sexual and reproductive health concerns; therefore, interventions aimed at increasing LARC uptake in the general practice setting are critical and likely to have the most impact.

Conclusion

The rate of unintended pregnancy is considered a significant public health issue. Despite the

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

evidence that indicates increased LARC uptake is effective in reducing unintended pregnancy, use of LARC is low among Australian reproductive aged women. Strategies are needed to increase the awareness and acceptability of LARC amongst both women and healthcare providers.

There is a large gap in access to training in sexual and reproductive health in Western Australia, and trainees are finding it increasingly difficult to fulfil their practical requirements. Training in reproductive and sexual health is essential to improving community awareness of the contraceptive types available, uptake of LARC, and a reduction in the rate of unintended pregnancy. Without adequate training, it will inevitably result in a reduction in LARC uptake in WA, a further increase in unintended pregnancy, and a huge social and economic burden on the State.

REFERENCES

1. Australian Bureau of Statistics. Australian Demographic Statistics. In: Statistics ABo, editor. Canberra: Australian Bureau of Statistics; 2016.
2. Long Acting Reversible Contraception (LARC) Position Statement [press release]. 2014.
3. Richters J, al. e. Contraceptive practices among women: the second Australian study of health and relationships. *Contraception*. 2016;94:548-55.
4. Institute G. Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends. 2014.
5. Guttmacher Institute. Unintended pregnancy in the United States. 2016.
6. Choice Cb.
7. Regan PL. Leading Safe Choices. RCOG Conference; Birmingham, UK2016.
8. Sedgh G, Singh S, Hussain R. Intended and Unintended Pregnancies Worldwide in 2012 and Recent Trends. *Studies in Family Planning*. 2014;45(3):301-14.
9. World Health Organisation, editor Report of a WHO Technical Consultation on Birth Spacing. WHO Technical Consultation on Birth Spacing; 2005 2007; Geneva, Switzerland: World Health Organisation.
10. Diedrich J, Zhao Q, Madden T, Secura G, Peipert JF. Three-year continuation of reversible contraception. *Am J Obstet Gynecol*. 2015;213(6):662.
11. Peipert J, Zhao Q, Allsworth J, Petrosky E, Madden T, Eisenberg D, et al. Continuation and satisfaction of reversible contraception. *Obstet Gynecol*. 2011;117(5):1105-13.
12. Faculty of Sexual and Reproductive Healthcare. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC). 2016.
13. Allen RHMDMPH, Cwiak CAMDMPH, Kaunitz AMMD. Contraception in women over 40 years of age. *Canadian Medical Association Journal*. 2013;185(7):565-73.
14. Ricketts S, Klingler G, Schwalberg R. Game change in Colorado: widespread use of long-acting reversible contraceptives and rapid decline in births among young, low-income women. *Perspect Sex Reprod Health*. 2014;46(3):125-32.
15. Bateson D, Lacey S, Concepcion K, McGeechan K, Estoesta J. A Cost-Benefit Analysis of Long Acting Reversible contraception Use in Australia: Family Planning NSW; 2017 [cited 2018 6.2.18]. Available from: <https://az659834.vo.msecnd.net/eventsairaeuprod/production-ashm-public/d3e2100a66f64ce59310dbc97c603bf2>.

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?

16. Mazza D, Harrison C, Taft A, Brijnath B, Britt H, Hobbs M, et al. Current contraceptive management in Australian general practice: an analysis of BEACH data. *Medical Journal of Australia*. 2012;197:110-4.
17. Washington University. The Contraceptive Choice Project. Available from: <http://www.choiceproject.wustl.edu/>
18. Blumenthal P, Voedisch A, Gemzell-Danielsson K. Strategies to prevent unintended pregnancy: increasing use of long-acting reversible contraception. *Hum Reprod Update*. 2011;17(1):121-37.
19. McNicholas C, Peipert J. Long-acting reversible contraception for adolescents. *Curr Opin Obstet Gynecol*. 2012;24(5):293-8.
20. Lewis LN, Doherty DA, Hickey M, Skinner SR. Predictors of sexual intercourse and rapid-repeat pregnancy among teenage mothers: an Australian prospective longitudinal study. *Medical Journal of Australia*. 2010;193(6):338-42.
21. Mazza D, Black K, Taft A, et al. Increasing the uptake of long-acting reversible contraception in general practice: the Australian Contraceptive Choice Project (ACCORd) cluster randomised controlled trial protocol. *BMJ Open* [Internet]. 2016 6.2.18.
22. Cronin J, Office of the Chief Medical Officer. Intrauterine device use in Western Australia: not for public release without prior permission of the Department of Health 2017.