NEW ZEALAND Family Planning

CONTRACEPTION USE SURVEY 2020

Recommendations

1. Promote awareness and education about the full range of contraceptive options, including through holistic relationship and sexuality education in school.
2. Reduce stigma and shame, and normalise sexual and reproductive health issues, particularly among young people.
3. Invest in sexual and reproductive health services, including:
   a. make all sexual and reproductive health visits in primary care free to promote universal access to contraception;
   b. increase funding for training of primary care providers;
   c. provide adequate, sustainable, long term funding to Family Planning to meet client demand for services.

Introduction

Contraception is a component of quality primary health care. Many people use contraception for 30 to 40 years of their life. There should be equitable access to a full range of modern methods of contraception as a core health service, and the information and education needed to make informed decisions. Contraception enables people to make decisions about their health, life and future by determining when or whether to have a child. Reproductive autonomy is considered a human right and also central to gender equality.[1] There are health, social and economic benefits from access to contraception.

There are many types of contraception including barrier and hormonal methods, pills and devices, short and long-acting methods and sterilisation. In New Zealand, PHARMAC determines which contraceptives are funded. Unsubsidised contraceptives can be expensive, and/or inaccessible, in New Zealand. The use of long-acting reversible contraceptives (LARCs) – copper intra-uterine devices (IUD), hormonal intra-uterine systems (IUS) and implants – has increased internationally and in New Zealand over the past decade.[2,3]

Access to contraception has been demonstrated to be cost-effective. A 2014 study of publicly funded family planning programmes in the United States found that for every dollar invested, government

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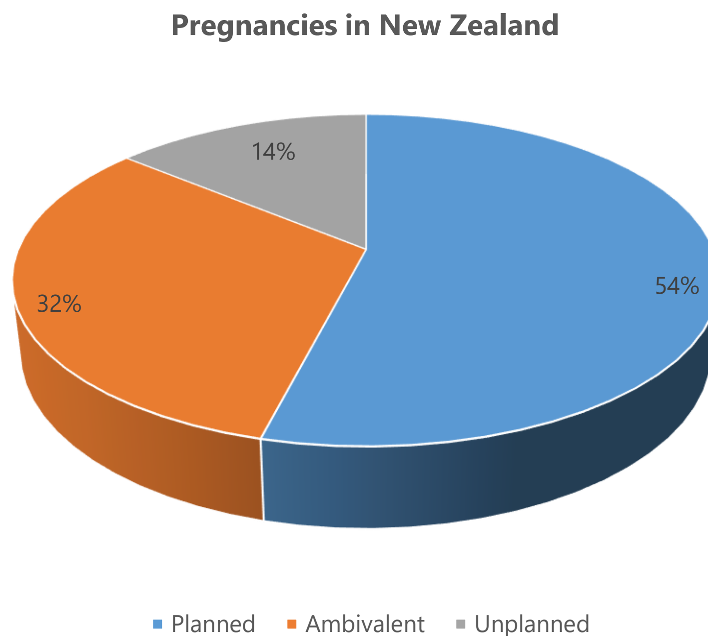
[1] Center for Reproductive Rights (2018) Breaking Ground 2018. Treaty Monitoring Bodies on Reproductive Rights. Retrieved from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Breaking-Ground-2018.pdf
[2] Family Planning client data - unpublished.
[3] Joshi, R., Khadilkar, S and Patel, M. (2015) Global trends in use of long-acting reversible and permanent methods ofcontraception: Seeking a balance. International Journal of Gynecology and Obstetrics. 131 S60-S63.

saves $7.09.[4] Savings relate to a range of improved health outcomes including reduced unintended pregnancy and abortion, as well as lower rates of cervical cancer, STIs and HIV and pre-term births.

There are high rates of unintended pregnancy in New Zealand. Ministry of Health research[5] found that 54% of people surveyed had planned their pregnancy, while 32% were ambivalent about a pregnancy and 14% reported unplanned pregnancy. The *Growing Up in New Zealand* longitudinal study found that 40% of mothers reported their pregnancies were unplanned.[6] Pregnancy planning is complex and personal. Information, education and services can help people make informed decisions about contraception methods to prevent unintended pregnancy.



SOURCE: MINISTRY OF HEALTH (2019) NEW ZEALAND HEALTH SURVEY 2014/2015. SEXUAL AND REPRODUCTIVE HEALTH DATA

There has been limited research about contraception use in New Zealand.

A recent Ministry of Health report based on 2014/2015 health survey data found that oral contraceptives and condoms were the most common methods of contraception used by women, with LARC use very low.[7] Sexually active Māori and Pacific women were less likely to have their contraceptive needs met than non-Māori and non-Pacific women.

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[4] Guttmacher Institute (2016) Fact Sheet: Publicly Funded Family Planning Services In The United States. March. Retrieved from: https://www.guttmacher.org/sites/default/files/factsheet/fb_contraceptive_serv_0.pdf.
[5] Ministry of Health. 2019. *Pregnancy Planning: Findings from the 2014/15. New Zealand Health Survey*. Wellington: Ministry of Health.
[6] Morton, S.M.B. et al. (2010) *Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Report 1: Before we are born.* Auckland: Growing Up in New Zealand.
[7] Ministry of Health (2019) *Contraception*: Findings from the 2014/15 New Zealand Heath Survey. Wellington: Ministry of Health.

Research[8] from 2016 exploring access to contraception among teenage Māori mothers highlighted the importance of improving communication about contraceptive options as a key aspect of ensuring equitable access to contraception, alongside improving access to services.[9] Family Planning is not aware of national research exploring awareness of contraceptive methods, or whether people are using their preferred method.

The most recent review of sexuality education in New Zealand schools[10] found inconsistent implementation of the curriculum including inconsistent provision of information about contraception. Only 22% of schools reviewed were found to have a good curriculum which covered all of the relevant aspects of relationship and sexuality education. Family Planning is not aware of any current national programmes to raise awareness and understanding of contraceptive options outside of a school setting.

We know that people access contraception from a range of health care providers including specialist sexual and reproductive health primary care services like Family Planning, and from general practice (GP), school-based and community-based health services. The cost of accessing services varies widely. Where visits are subsidised or free, there are varying critieria for accessing the subsidy depending on the provider. This patchwork of provision makes finding an affordable health practitioner who can meet a person's contraceptive needs challenging.

This survey is an opportunity to hear from people about their awareness of contraception, and their experiences using and accessing contraception.

Online Survey Results

In late May 2020, Family Planning launched an online survey to gather information about contraceptive use in New Zealand. We received 6,764 responses to the online survey. As with our previous online surveys, this was not intended to be a formal research project, but simply an online survey to gather information. The survey responses may not be representative of the views of all people in New Zealand. These limitations should be considered when viewing survey results. Quotes in this report may have been modified to protect privacy.

Demographics

The majority (55%) of respondents were 20 to 29 years of age and another 24% were between 30-39 years. Respondents were able to choose the ethnicity/ethnicities with which they identify, so the percentages add to greater than 100%. Eighty-five percent (85%) of respondents identified as NZ European. Māori and Pasifika respondents were underrepresented with 12% identifying as Māori and

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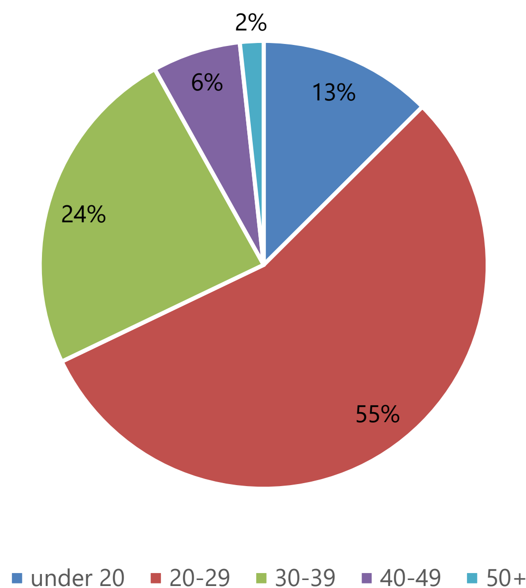
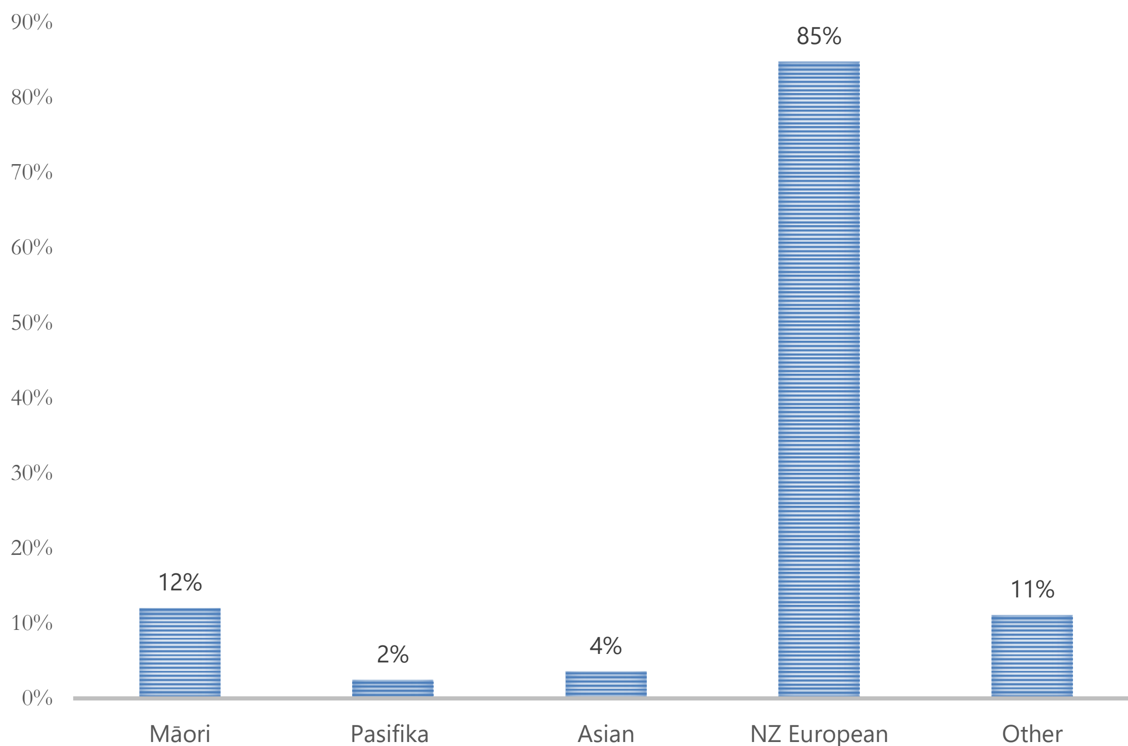
[8] Lawton, B. et al (2016) E Hine: access to contraception for indigenous Māori teenage mothers. *The Journal of The Royal New Zealand College of General Practitioners*. Volume 8(1). Pg. 52-59.

[9] Ministry of Health (2010) *Kōrero Mārama: Health Literacy and Māori Results from the 2006 Adult Literacy and Life Skills Survey*. Wellington: Ministry of Health

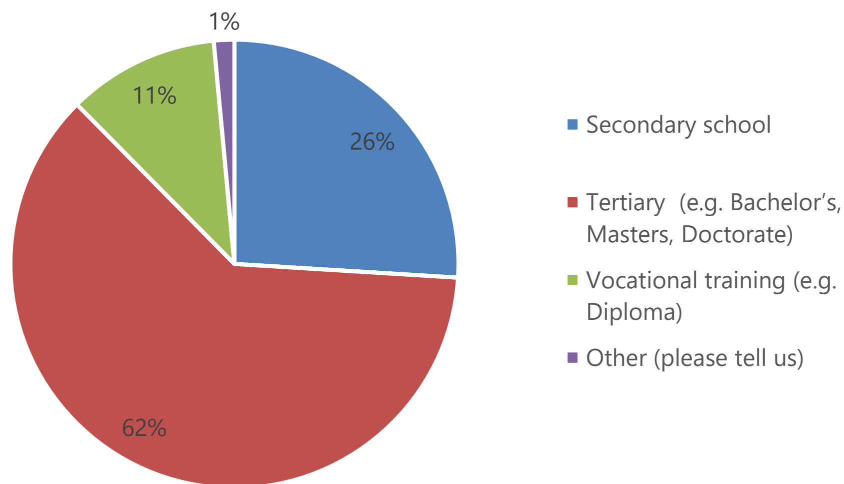
[10] Education Review Office (2018) *Promoting wellbeing through sexuality education*. September. Retrieved from: https://www.ero.govt.nz/assets/Uploads/Promoting-wellbeing-through-sexuality-education.pdf

2% of respondents identifying as Pasifika. Respondents were from all regions of New Zealand and aligned well with distributions based on Census 2018 data, with the exception of respondents from Wellington and Canterbury being over-represented and respondents from Auckland and Bay of Plenty under-represented. Almost all of the survey respondents identified as female (98%), which is not surprising given that most people who use contraception identify as women. One per cent (1%) of respondents identified as male and 1% as gender diverse or another gender. Among survey respondents, 89% reported being sexually active.



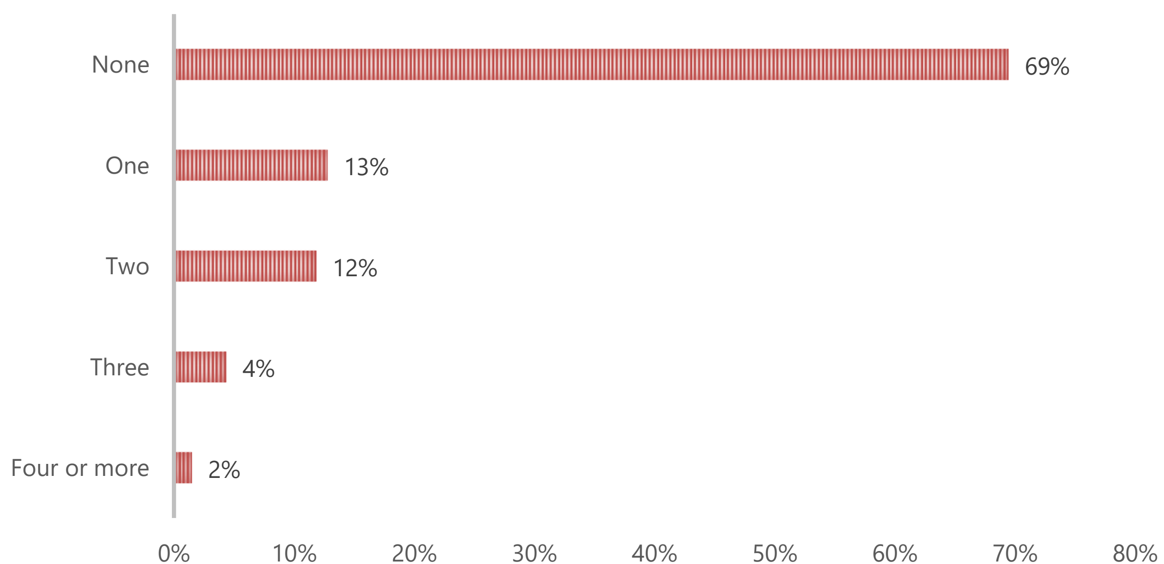


Over half of respondents (62%) had some sort of tertiary education as their highest level of education and 11% reported having vocational training. Twenty-six per cent (26%) reported secondary school education as their highest level.



Most survey respondents were not religious (75%). Seventeen per cent (17%) identified as Christian, and about 7% were other religions including Hinduism, Islam, and Māori beliefs and philosophies.

Most survey respondents did not have children (69%) but about one-third (31%) had one or more children.

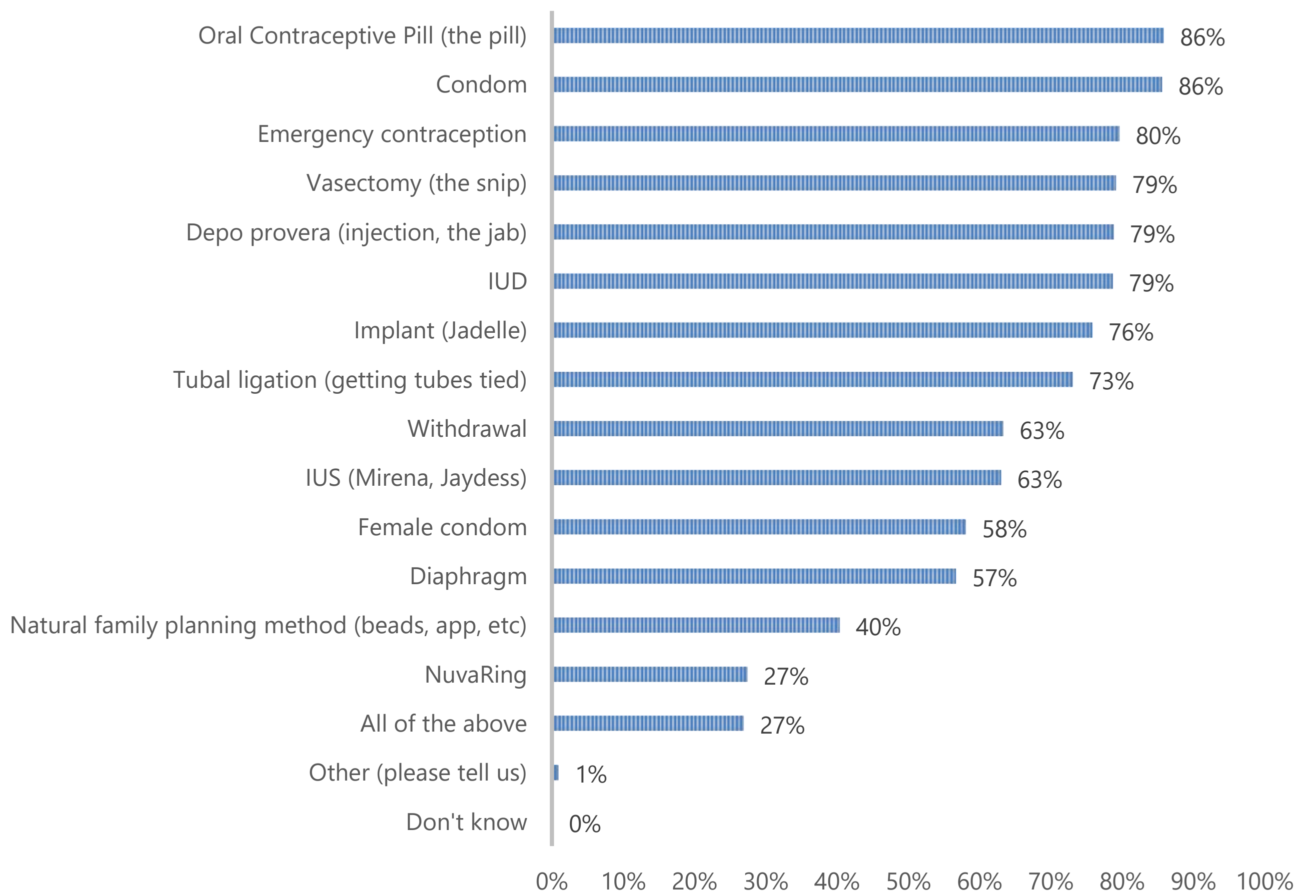


Data was not disaggregated by any of these demographic characteristics as Family Planning doesn't have the capacity to conduct that level of analysis or to conduct any tests to determine statistical significance of any differences by characteristics.

Awareness of contraceptive methods

Respondents were asked which methods of contraception they had heard about. A list was provided, however, it was not exhaustive. There were a few methods which were not included, namely the contraceptive patch and sponge. Percentages of respondents who had heard about individual methods should be viewed with caution because respondents who ticked they were aware of all methods – the "all of the above" option – would not be included in the percentages for individual methods of contraception. Because of this, the true percentage of respondents who are aware of some methods could be higher.

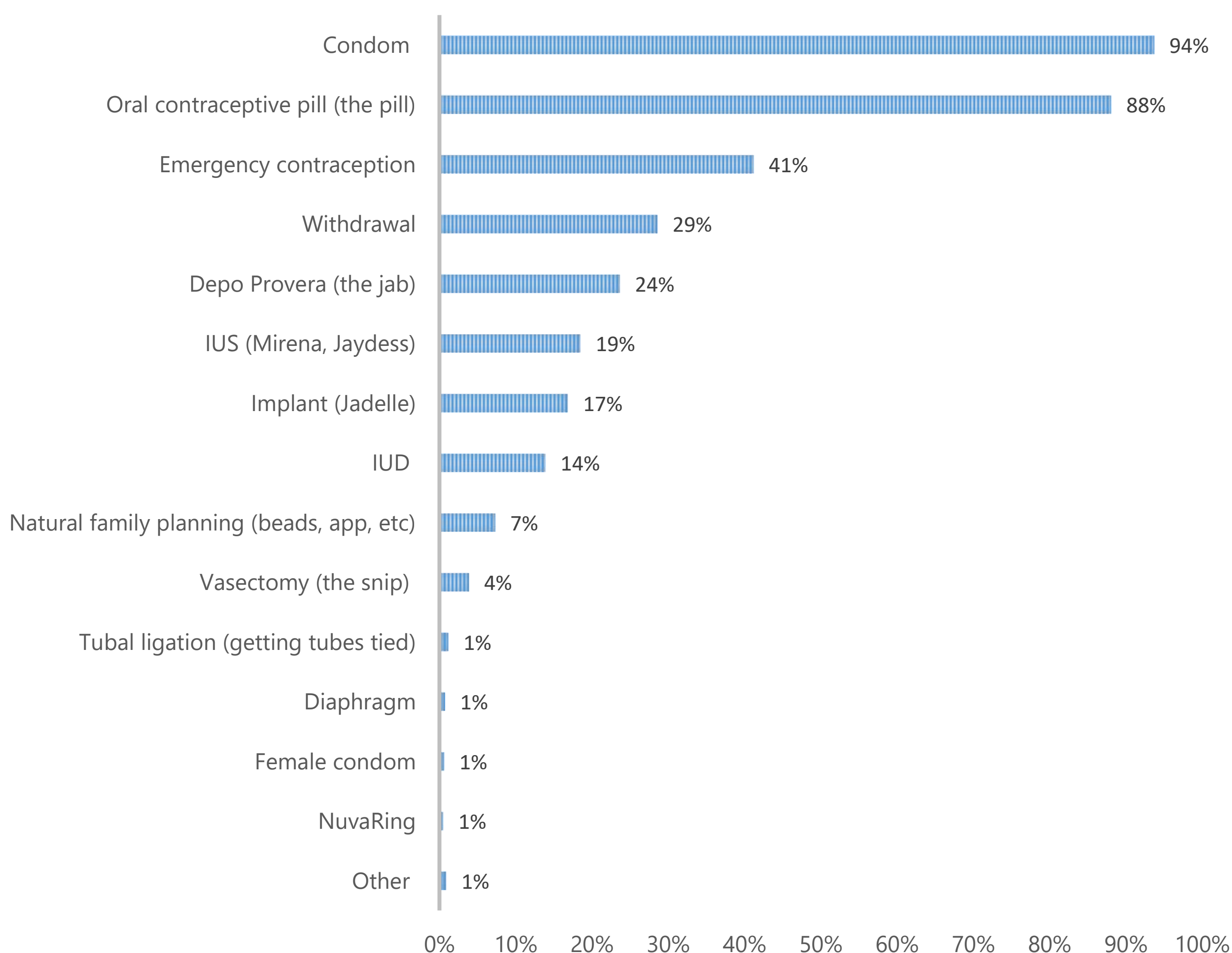
Respondents were most likely to have heard about condoms and the oral contraceptive pill (the pill). Respondents were least likely to have heard about the NuvaRing, natural family planning methods and the diaphragm. A notable proportion of respondents had not heard of the three types of long-acting reversible contraceptives (LARCs), the IUD, implant and IUS (21%, 24% and 37% respectively). Just over a quarter (27%) of all respondents reported they had heard about all of methods of contraceptives listed in the survey.



Contraceptive use – ever

Ninety-eight per cent (98%) of survey respondents reported using contraception. This is consistent with data from the United States, which suggests that most women have used contraception at some point in their lives.[11]

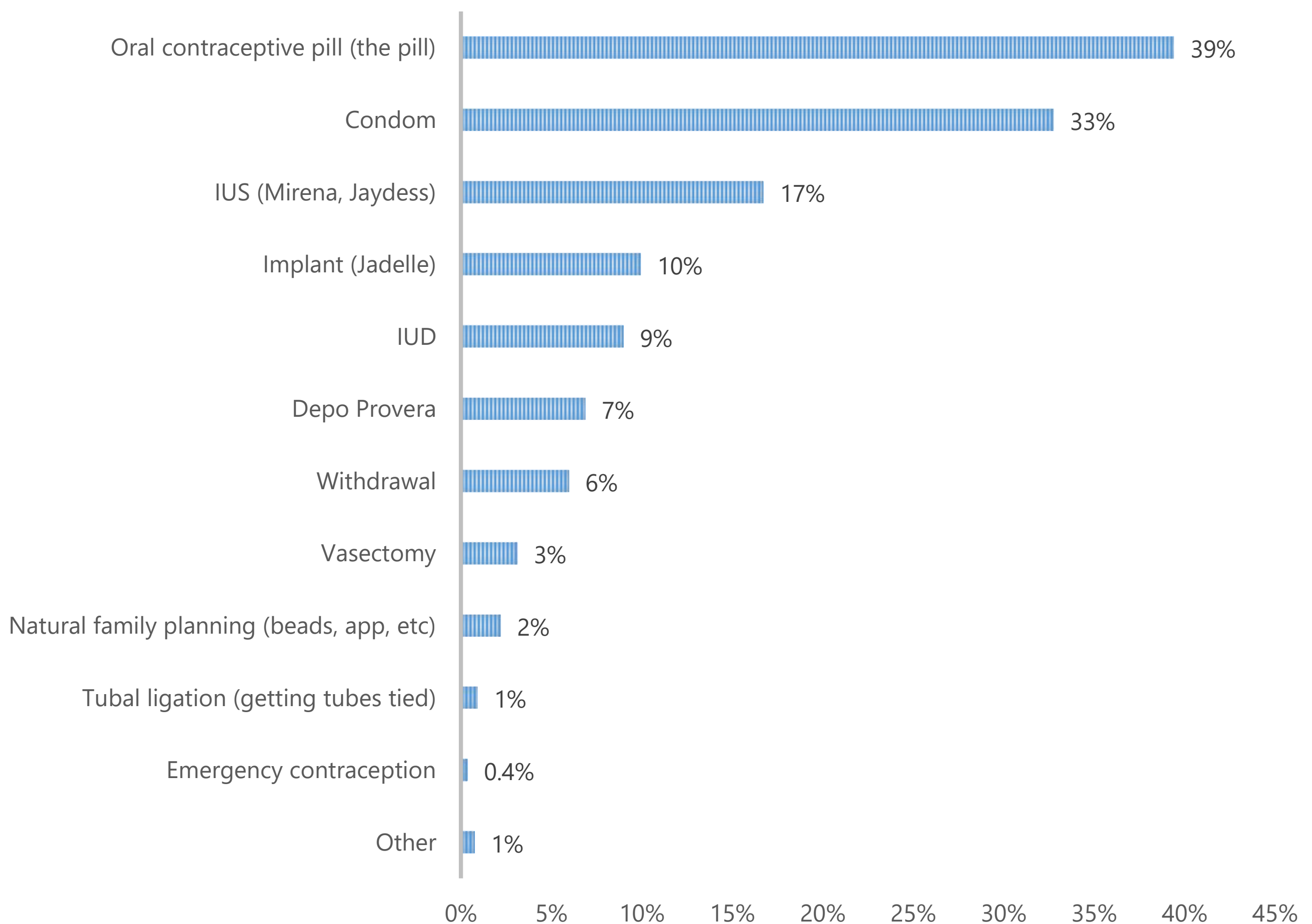
Respondents could tick as many methods as needed. The most common methods that people reported they had used were condoms (94%) and the oral contraceptive pill (88%), followed by emergency contraception (41%), withdrawal[12] (29%) and Depo Provera (24%). Long-acting reversible contraceptives (LARCs) and natural family planning methods were less likely to have been used by respondents with 19% reporting having ever used IUS, 17% the implant and 14% the IUD. Seven per cent (7%) of respondents had used natural family planning methods like counting beads. About 5% of respondents reported having used permanent contraception like a vasectomy. A common write-in answer was the patch, which works like a nicotine patch and is not available in New Zealand.



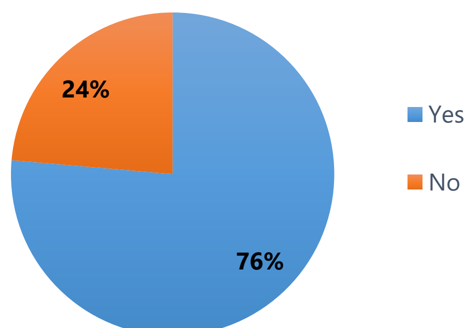
[11] Daniels K, Mosher WD, Jones J. (2013) *Contraceptive methods women have ever used: United States, 1982–2010. National health statistics reports; no 62*. Hyattsville, MD: National Center for Health Statistics.
[12] Where a person withdraws their penis from the vagina before ejaculation. This is not an effective method of contraception.

Contraceptive use – current

Seventy-nine per cent (79%) of survey respondents reported currently using contraception. Among people who reported they were currently using contraception, the oral contraceptive pill (39%) and condoms (33%) were by far the most commonly used contraceptive method. Among LARCs, the IUS (Mirena/Jaydess) was the most commonly used (17%), followed by the implant (10%) and the IUD (9%). Total LARC use among respondents was 36%. Depo Provera and the withdrawal method were similarly used, with 7% and 6% respectively.



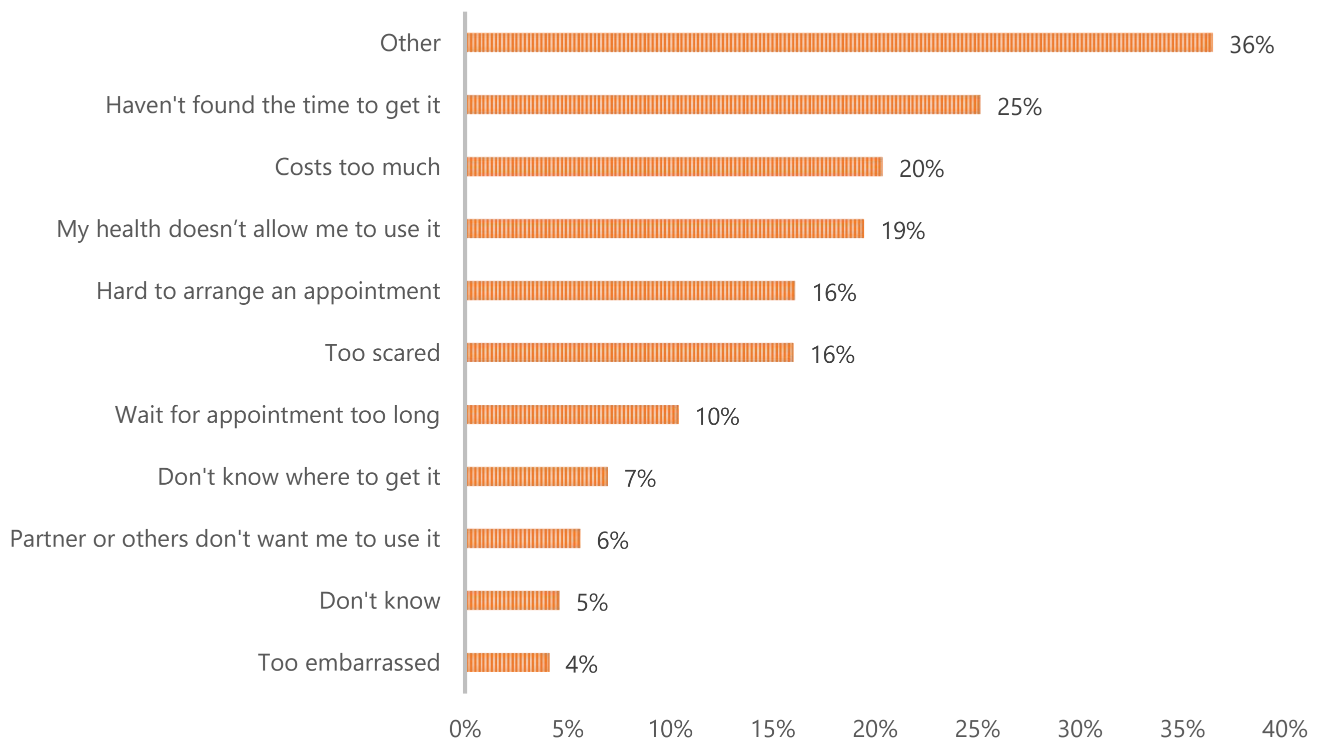
Among respondents currently using contraception, 76% reported that it was their preferred method, but 24% reported it was not.



There were 1,192 respondents who reported on what was stopping them from using their preferred method of contraception. There was a variety of reasons, with most respondents (36%) offering a write-in response after ticking “other”.

Among respondents who ticked one of the reasons provided in the survey, the most frequent related to common barriers to health care access. Respondents reported not using their preferred method because they have not found the time to get it (25%), followed by cost (20%), hard to arrange an appointment (16%), wait for an appointment too long (10%) and don’t know where to get it (7%).

Nineteen per cent (19%) reported that their health doesn’t allow them to use their preferred method, while 16% said they were scared to use their preferred method. Six per cent (6%) reported they are not using their preferred method because their partner or others do not want them to use it and 4% said they were too embarrassed to use their preferred method.



There was a broad range of write-in responses for what was stopping people using their preferred method of contraception, from people being nervous about side effects from contraception to wanting their partner to get a vasectomy but the partner would not.

"I would like to go back on the jab [Depo Provera], *but worry about getting my IUD taken out, and about the effect the jab will have on my mental health."*

"Am on pill on top of IUD because many things have gone wrong, but I don't enjoy being on the pill, haven't found a method that works yet."

"Partner isn't keen on getting a vasectomy."

"I was treated terribly when I went to get help funding my IUD. The person I spoke with clearly disapproved of my choice and not only offered me no help, but asked me very inappropriate questions, and made me feel disgusting. I still can't figure out if I could have got funding, as different professionals told me differently. I never would wish for another young woman to go through that."

"…Was told that because I haven't had children it would be too hard to get one [Mirena] fitted, and no-one at our doctors was capable of doing it so I would have to go elsewhere."

"Need more advice in what it would involve and any side effects. Work hours mean it's difficult to get anything done as well."

"I wish I had been able to have a long discussion with someone about what my options were when I was in my late teens – instead I went to my doctor and asked for the pill because that was what I knew about. The Mirena would have been a better option for me years before I knew it existed."

"Planning to have another baby in the near future so feel it would be easier to take the pill than get the IUD put in and taken out again."

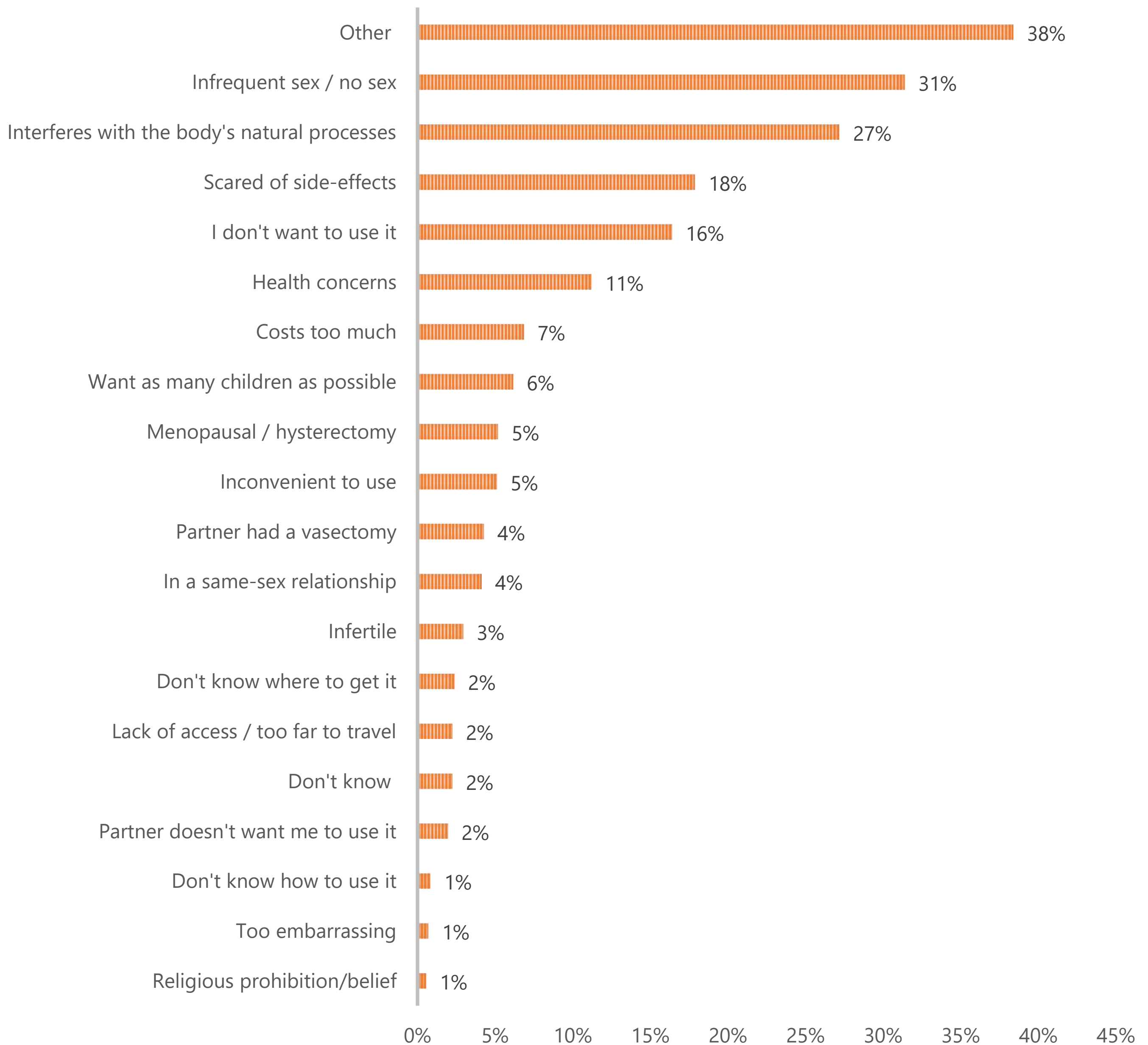
"I live an hour or so from the nearest Family Planning."

"I am fortunately able to choose which type of contraceptive I want because I can afford to be engaged with primary care. However, I have to pay for appointments, repeats and scripts. I am also aware implanted devices are expensive to get unless you are funded. There is a lot of cost involved and that cost invariably falls on women to bare."

Over 1,400 people responded when asked why they were not using contraception. Unfortunately, the answer option about not using contraception because of being pregnant, or wanting to become pregnant, was worded poorly. It read: "Want as many children as possible." This error was made because the survey was adapted from one that has previously been used in another country where this response option would be more appropriate. This error likely skewed results. Many of the write-in responses indicated that people were not using contraception because they were pregnant or trying to become pregnant.

However, some people reported not using contraception for other reasons.

- Sixteen per cent (16%) reported they just didn't want to use it, 18% said they were scared of the side effects and 27% said that it interferes with the body's natural processes.
- Other answers included that a person had health concerns (11%), felt it cost too much (7%) or felt it was inconvenient to use (5%).



"Everything I have tried hasn't worked for me."

"The pill effects my moods and my partner won't wear a condom. I've asked him to get a vasectomy as we are done having kids. It isn't a priority for him. I'd like to get a Mirena but Family Planning won't help and nor will my doctor. Not sure what else to do."

“Every contraception I have tired gives me horrible side effects.”

“Don't want to put anything in my body.”

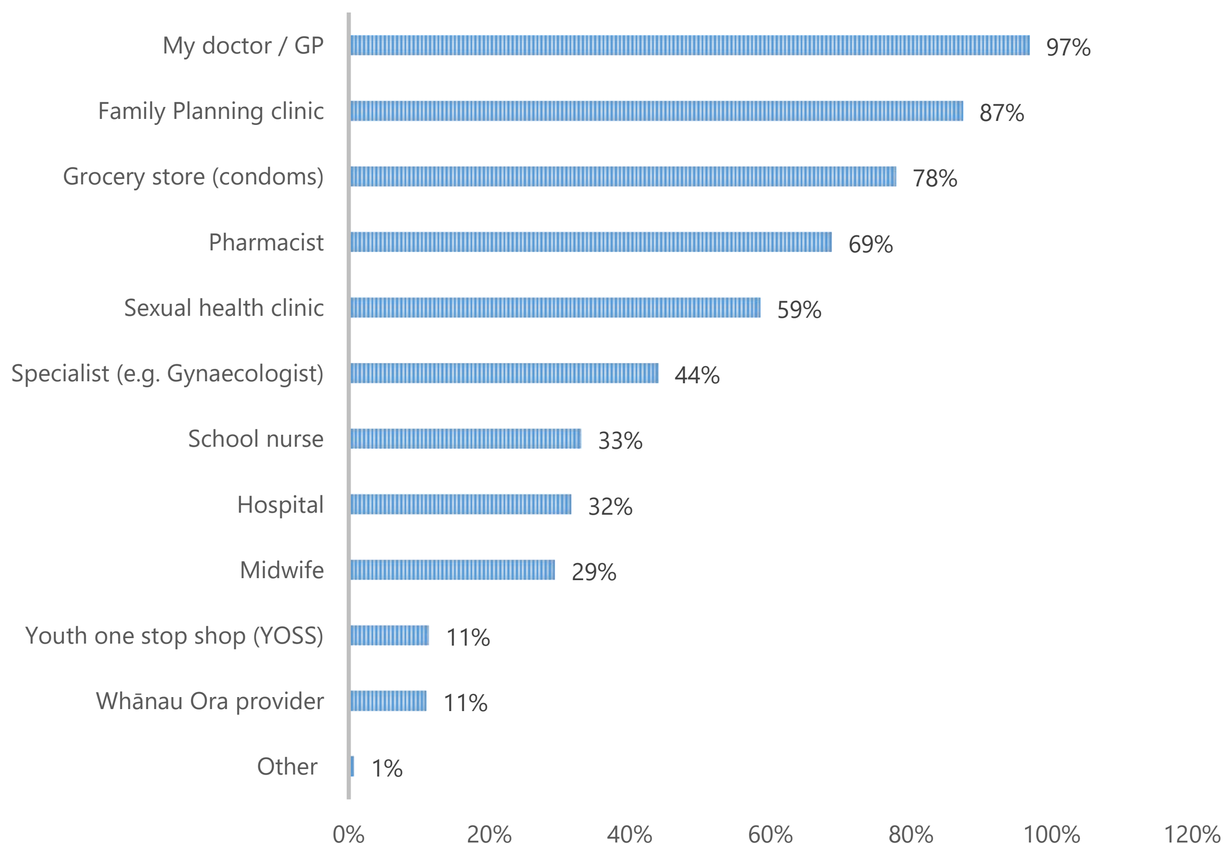
“Bad experiences previously with others I have used leaving me sceptical to try the options I have left.”

“Haven't had time to get around to making an appointment to get it. Went in and asked one time but they said appointments are not available for another 7 weeks. [Thought I’d] maybe try a drop in session and then COVID happened. So long story short it’s because of lack of access.”

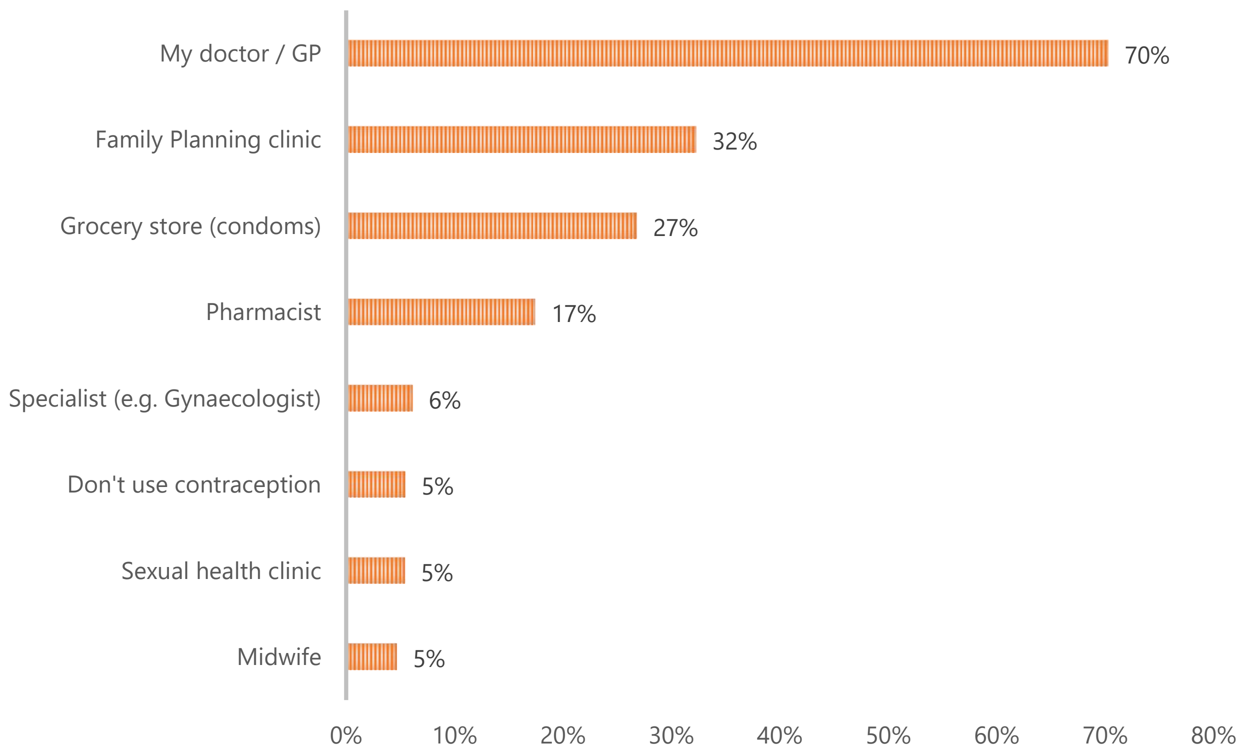
Where people get contraceptive information and services

We asked people to identify the places they knew where you could get contraception, and we gave them options to choose from a list.

The majority of respondents knew you could get contraception from a GP (97%) and most knew you could go to Family Planning (87%). Respondents also reported knowing about getting condoms from grocery stores (78%). A majority of respondents knew you could get contraception from pharmacists (69%) or from a sexual health clinic (59%). Smaller proportions of survey respondents knew a specialist doctor like a gynaecologist (44%), a school nurse (33%) and midwife (29%) could provide contraception. The small percentage of people knowing about getting contraception from Youth one-stop shops and Whānau Ora may reflect the demographic profile of survey respondents.



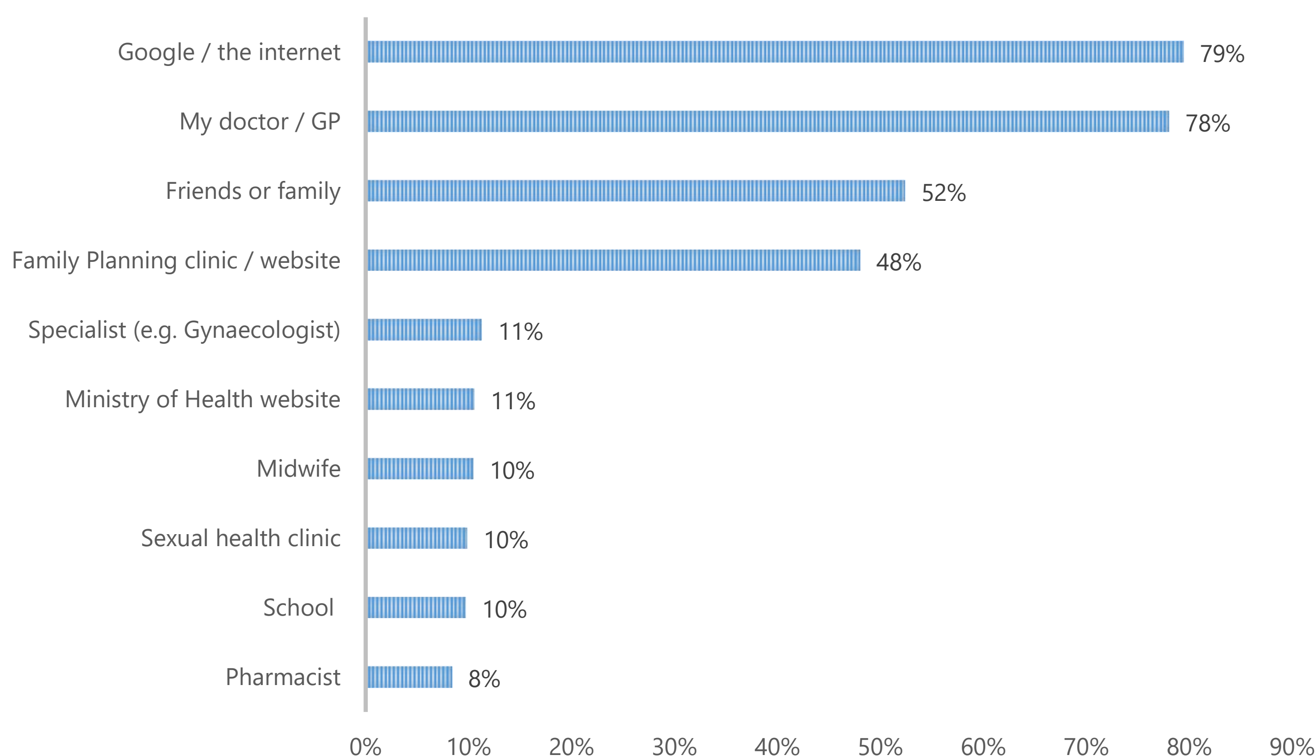
Unsurprisingly, people reported getting contraception from a smaller range of providers. The most common source of contraception was a person's regular doctor or GP (70%); Family Planning (32%); grocery store for condoms (27%); pharmacist (17%); specialist doctor like a gynaecologist (6%); sexual health clinic (5%) and a midwife (5%). Other providers (e.g. school nurses) received fewer than 5% of responses by survey participants.



only answers with 5% or more included in graph.

Information about contraception

Respondents reported getting information about contraception from the internet and their doctor/GP in similar proportions (79% and 78% respectively). Fifty-two per cent (52%) got information from family or friends and 48% from a Family Planning clinic or website. These were by far the most common sources of information, with fewer people reporting getting information from other health care providers, the Ministry of Health website or school. Other providers (e.g. Whānau Ora) received fewer than 5% of responses by survey participants.



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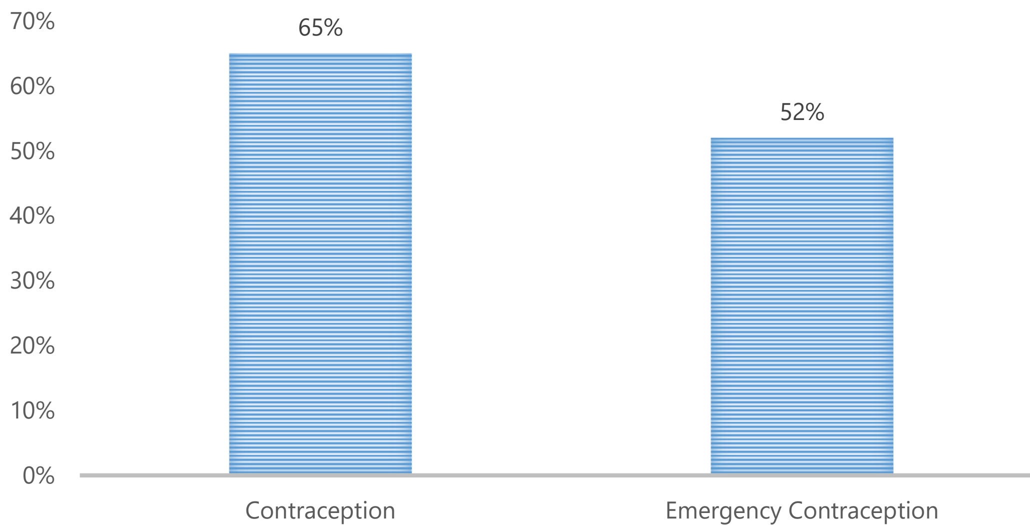
Conscientious objection

The survey asked about conscientious objection to contraception by a health practitioner. Conscientious objection is when a health care practitioner or worker will not provide a service because they are morally or personally opposed to it. Law permits conscientious objection for contraception, sterilisation and abortion.

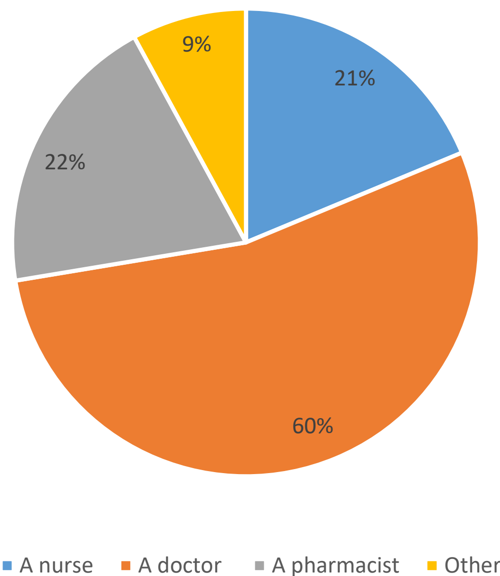
Positively, most people did not report experiencing a health practitioner who refused to provide contraception due to their personal or moral beliefs. Yet 5% (290 people) reported having this experience.

Slightly more respondents reported that they had experienced a health practitioner opposed to contraception generally (65%) than emergency contraception (52%).



Of those who indicated they had been refused contraception, most reported that a doctor (60%) had refused to provide contraception, followed by a pharmacist (22%), a nurse (21%) or another health practitioner (9%) like a school nurse or a gynaecologist.

What type of health practitioner conscientiously objected?



"I was warned by a nurse not to ask the doctor at after-hours about contraceptive options or advice with an unplanned pregnancy due to his religious beliefs. It has made me nervous to talk to other professionals with questions around sexual health and contraception."

"I needed the ecp and healthline said I could go there. When I went there the receptionist laughed as did the triage nurse and they said 'next time try abstinence'."

"My doctor's office - they don't provide EC [emergency contraception]."

"I became pregnant after the only pharmacist open declined to give the morning after pill after a ripped condom and [I] couldn't get into the after hours doctor. I think if you are the only place open that can offer this form of contraception you should have to provide it."

"Conscientious objection is ridiculous. If doctors/pharmacists etc aren't willing to help with reproductive health they should find a new career. At the very least, it should be very obvious to consumers. Any other professionals would be done for false advertising."

What do you think needs to happen to make sure all people in New Zealand can get the contraception that works best for them?

We asked survey respondents an open-ended question about what needs to happen to ensure all New Zealanders can access effective contraception. We received over 5,000 comments. Family Planning does not have the capacity to conduct a robust, systematic analysis of these qualitative survey responses. However, after limited review, three primary themes were apparent. Respondents believe the following needs to happen:

- **make services affordable and accessible** (e.g. make services free, stop requiring so many visits for repeat prescriptions, ensure health practitioners can offer all the options to avoid multiple appointments to get preferred method, make sure people know where to go for the method they want, shorten waits).
- **raise awareness and provide education about contraceptive options** (e.g. provide education in schools, ensure health practitioners can explain the pros and cons of each method, make sure people understand side effects and what options are available to them over their life course).
- **reduce stigma and normalise contraception** (e.g. make it a standard question to ask about in a health consultation, talk about it in schools, don't make people feel uncomfortable for asking about it, destigmatise sex in general to support conversations happening).

"It all needs to be subsidised by the government. I currently pay $50 for 3 months' worth of pills. I have been on every single other contraceptive available, and they didn't work. It is all so ridiculously expensive."

"The specific contraceptive pill that I use [as it is best for my individual circumstances] is not subsidised so is almost $100 for three months, which adds up, especially when you add the cost of the doctor visit to that too."

"Doctor education is really important. I've heard so many women being told myths about contraception by doctors, like that only married women are allowed the IUD. And sometimes they act like you're a silly woman for having concerns that are perfectly valid. Sometimes doctors set themselves up as the expert on what choice a woman should make, like they know her better than she knows herself. And sometimes you get judged for your contraception not working, again, you're a silly woman….when actually the rates of effectiveness, even with perfect use, are not perfect."

“I think it’s very hard for trans and non-binary people to get contraception. I’ve been misgendered by doctors and pharmacists and it puts me off potentially trying a contraceptive method that could be better for me.”

“I am a [working mother] with 4 children under 11 years old. Life is hectic and having services that make my life easier is a necessity."

“Make it free. Not everyone is able to access free clinics and only can go to their doctors. Make appointments for contraception free.”

“Education about what is available. Funding to reduce the cost for vulnerable people. Access through schools for those who cannot talk to family about their needs. Encouragement to seek out info and reduce the stigma around contraception and sex in general.”

“The Jadelle ended up costing far too much with three different appointments because the first two doctors weren’t able to do it. Paid for three consultations….”

“Education – te ao Māori approach align with connections to our heritage and guidance.”

“Having appointments that are easier to get to for working people. Being able to get contraception easier through chemists/supermarkets (pills etc) sometimes it is too hard to get an appointment with Family Planning and it may be easier to just not bother.”

“Educate all people. I particularly mean in schools, and I mean educate all school pupils, not just girls/people with uteruses. It is a lot of pressure on young women/people with uteruses to be the ones responsible for contraceptives, so to properly educate everyone else and make sure the responsibility is on all partners in a relationship would make it much more effective. It would help to remove the stigma.”

“Make it free – both the contraception method and any appointments needed to get it. As a teenager on the pill, it was annoying only to get three months at a time and needing a new prescription every 6 [months]. I feel there were far better options for me, but everyone was given the pill.”

“When [mothers] are coming for contraception after birth, we are often time constrained. This means that when we present, some of us want to do the consent and procedure immediately. I have had a Family Planning nurse place procedure barriers in front of me - due to me getting a Mirena and needing to go in for the consent and then going back to get the Mirena put in. Time is of the essence… The fact that we have to try and organise a babysitter twice is horrendous.”

“Make it cheaper. In small towns with no Family Planning clinics etc the only real option is going to the GP which costs around $50 each time.”

“Lessen the stigma around sex and using contraception. It can be hard to talk about sex and contraception because it can feel embarrassing for some.”

"Education in schools. Discussions within families and between friends. I think people know of a few of the traditional methods of contraception but not so much about some of the new long acting ones. I think women are unfairly burdened with the responsibility of contraception and more could be done to educate men about contraception options and responsibilities. It is easy to get access to condoms and the pill now. It's so much easier for me to go to my pharmacy to be prescribed the pill. But I would love to get a Mirena – but I would have to take time off work to have it done at my GP. I used to love going to Family Planning when I lived in a smaller region, but now I'm in a big city it's almost impossible to get a timely appointment at Family planning. The service is very under-resourced given the fantastic number of services they can provide."

Discussion

The words 'data desert' have been used to describe the status of research around contraception use in New Zealand. Over the past two decades, there has been only one national investigation of contraceptive use among women of reproductive age and scant research on particular aspects of contraceptive use. While this survey does not purport to take the place of academic research, it is a useful mechanism for gathering information to start conversations, raise questions and inform future studies.

An overarching message from this survey, which is something Family Planning knows well, is that contraception can be complicated. It is a journey to find the right contraception based on both individual preferences as well as health issues and life circumstances. For some people, it's easy to find what works. For others, it is not, with numerous barriers and challenges along the way including cost, information and access to services.

This survey showed that less than a third of people reported knowing all of the methods on our list of contraceptives. It also found that about a quarter of people are not using their preferred method of contraception. Respondents offered many, many examples of not being well served by our health system when it came to their contraceptive needs. Paying for multiple visits because they couldn't get the contraception they wanted, experiencing long wait times for appointments, being given incorrect or incomplete information from a provider and feeling pushed into using something that wasn't right for them all appear to be common place.

Many respondents reported experiencing substantial side effects with many methods of contraception. Women who report concerns like irregular bleeding, anxiety and weight gain have historically been expected to simply put up with it. With more contraceptive options now available, and perhaps improved gender equality, there is an increased awareness of finding a suitable option.

Stigma and shame surrounding contraceptive use appears to be alive and well in 2020. This is especially true for young people. There were many comments about the need to normalise conversations about contraception. There were some interesting suggestions like making it a standard question for health consultations or offering parents reduced uniform fees if they attended

a course on the issues. People suggested talking about safe sex at every opportunity. We know that doesn't happen now.

While the numbers were small, we were concerned to see people reporting they were not using their preferred method of contraception, or not using any contraception, because their partners or others didn't want them to use it. We know from Women's Refuge research[13] that women experiencing intimate partner violence often experience reproductive coercion, where they are pressured by a partner about whether to get pregnant or have a child.

It was disturbing to see that 290 respondents reported experiencing a health practitioner refusing to provide contraception due to conscientious objection. The stigma, shame and barriers to accessing contraception caused by this are unacceptable. For a modern health system, which is focused on equity and inclusiveness, to allow this sort of discriminatory behaviour is unconscionable. While conscientious objection is unfortunately allowed by law, professional bodies should actively discourage health practitioners who object to contraception, abortion and sterilisation from pursuing a career where they may encounter people seeking these services.

The survey responses are consistent with the little research we have on these issues in New Zealand. Researchers have previously found that there are gaps in providers' knowledge about the full range of contraceptive options and in their ability to adequately inform people about benefits and drawbacks of each method.[14,15] Lack of provider knowledge and competence can lead to people being pushed into using methods which may not be right for them or simply giving up.

People also have different contraceptive needs over the course of their lives. For example, someone wanting to prevent pregnancy for five years will have different contraceptive needs than someone who is going to try to get pregnant in a few months. Health issues such as blood pressure, heavy bleeding and breast feeding all impact contraceptive decision making. Equally, there may be personal considerations which make some methods better than others. For example, it may not be possible to visit a health provider every three months for an injection, or a young person may feel worried that people will see an implant in their arm. Cost is also a key consideration, with some methods having high up-front costs and others ongoing costs, such as repeat prescriptions. Informed consent for decision-making about contraception is essential. While LARCs work for some people, they do not work for others. The pill is still a preferred option for many people. However, the pill shouldn't be prescribed without explaining all of the other options available. This was clearly the case for many survey respondents, particularly when they were young.

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[13] Burry, K et al (2018) *Reproductive Coercion in Aotearoa New Zealand*. National Collective of Independent Women's Refuges.

[14] Lawton, B et al. (2016). *Pounamu: E Hine: access to contraception for indigenous Māori teenage mothers. Journal of Primary Health Care.* Mar;8(1):52-9.

[15] Duncan, R, Paterson, H, Anderson, L and Pickering, N. (2019) *'We're kidding ourselves if we say that contraception is accessible': a qualitative study of general practitioners' attitudes towards adolescents' use of long-acting reversible contraceptives (LARC)*. Journal of Primary Health Care. 11(2):138–145.

Given the complexities of contraceptive decision making, it is essential that health practitioners providing contraception are capable, knowledgeable, and non-judgemental.

Raising awareness and educating people about contraceptive options would help to improve health literacy and support people being empowered to understand their rights to access the most effective contraception for them. It is well understood that relationship and sexuality education in school is inconsistent, leaving many young people without the information they need to make informed decisions.

What it means for us

As an organisation, we were pleased to see many supportive comments. People know that Family Planning is a good place to go to get a full range of contraceptive options, and that we are often more affordable than other providers. However, comments about our services were not all positive. It was helpful to get constructive feedback on how we could continue to improve. One of the biggest issues expressed by respondents was that our waiting times were too long. This is something we are all too aware of, and have discussed publicly. The reality is that we have not had a meaningful funding increase in 12 years making it very difficult for us to manage increasing demands and changing contraceptive needs. For example, we know that a far greater percentage of our clients are deciding to use LARCs, which require longer and more complex appointments than pill prescriptions.

While we are a primary care provider, we have specialist knowledge and are highly trained in delivering comprehensive sexual and reproductive health services. We know contraception. It's what we do every day. While we encourage other health practitioners to become experts in contraception, there is a clear and important role for us to play as a specialist primary care provider whose mission is exclusively focused on sexual and reproductive health and rights.

Recommendations

1. Promote awareness and education about the full range of contraceptive options, including through holistic relationship and sexuality education in school.
2. Reduce stigma and shame and normalise sexual and reproductive health issues, particularly among young people.
3. Invest in sexual and reproductive health services, including:
    a. make all sexual and reproductive health visits in primary care free to promote universal access to contraception;
    b. increase funding for training of primary care providers;
    c. provide adequate, sustainable, long term funding to Family Planning to meet client demand for services.