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Appendix E

Contraception: topic overview and data strategy

Caution: Some people may find parts of this content confronting or distressing, including content relating to pregnancy loss and termination of pregnancy. Please carefully consider your needs when reading the following information.

E.1 Topic overview

Background

The following topic overview is a summary of the key data gaps based on findings from literature reviews, data scoping and stakeholder consultation activities. Section E.2 identifies existing data sources and options for new data collection.

Access to contraception is a critical component of universal access to SRH and realisation of reproductive autonomy. Contraceptives are used by people of diverse genders, sexes and ages to prevent pregnancy, manage hormones (for example, for management of menstrual disorders and related conditions) and reduce STI and BBV risk. Different methods are suitable for different people, and each have their own limitations and benefits.

Data regarding the use of and access to all contraceptive methods is not consistently nationally collected or reported, which means that it is currently not known who is able to access their preferred or more effective forms of contraception and who is missing out. Survey data indicates potential unmet need, with a 2015 study estimating that between 33% and 41% of women in Australia who want to stop or delay childbearing were not using any method of contraception (United Nations 2024). There is little research describing contraceptive uptake and unmet need among people of other sexes and genders in Australia, for example in regard to vasectomies.

Published research and AIHW stakeholder consultations have identified common barriers to contraceptive access and use in Australia, including:

- Lack of access to accessible, comprehensive and accurate information about contraceptives (Dixon et al. 2014; Caddy et al. 2023; Liu et al. 2024; Power et al. 2022)
- Unequal/inequitable geographical distribution of contraceptive healthcare services and access to (all) contraceptive methods and choice (Stevenson et al. 2024; Garrett et al. 2015; AIHW Stakeholder Consultations 2025)
- Out of pocket costs, particularly non-PBS subsidised contraceptives and for individuals without Medicare (Women's Health Matters 2023; Power et al. 2022; AIHW Stakeholder Consultations 2025)
- Reproductive coercion and abuse, which can result in barriers to accessing and effectively using contraception (Women's Health Matters 2023; Sheeran et al. 2022, Morison 2022)
- Concerns about side effects and/or health impacts, particularly related to use of hormonal contraceptives (Dixon et al. 2014; Women's Health Matters 2023; AIHW Stakeholder Consultations 2025)
- Limited training in, and literacy pertaining, to all contraceptive methods among health professionals, including in primary and tertiary care settings (AIHW Stakeholder Consultations 2025).

Priority populations

Understanding experiences of different groups within the population is necessary to inform policy and ensure equitable healthcare access and outcomes in Australia. Recognising the intersectionality among different population groups is also central to understanding the complexity of these experiences. The following priority populations have been identified through the stakeholder consultation process and literature review, but this is not intended to be an exhaustive list. A full list of priority populations considered within the framework and data strategy is available in the Sexual and Reproductive Health Monitoring Framework and Data Strategy document, Section 2.3.

First Nations people

Historically, contraception has been used as a colonial tool to control and subjugate Aboriginal and Torres Strait Islander people. This has included the use of Depot Medroxyprogesterone Acetate (DMPA) and Intra Uterine Devices (IUDs) without informed consent, forced and coerced sterilisation, and the criminalisation of reproducing with other members of Aboriginal and Torres Strait Islander communities (Rademaker 2024). This history created health and wellbeing inequities for First Nations people and underpins the need for culturally appropriate, safe and acceptable contraceptive services in communities. Ongoing barriers to contraceptive access and uptake for Aboriginal and Torres Strait Islander people include distrust in health services, relatively low levels of sexual and reproductive health education and literacy, and limited access to culturally appropriate healthcare (Coombe et al. 2020; AHMRC 2023). First Nations people living in rural, regional and remote areas face additional barriers to contraceptive access (see below) (AIHW 2024).

People living in regional, rural and remote areas

Barriers to contraceptive uptake among people living in rural and remote areas in Australia include shame and concerns about confidentiality (Coombe et al. 2020), higher costs of contraceptives (Stevenson et al. 2024), and fewer health practitioners trained in LARC insertion (Mazza et al. 2017). Affordability is a particular barrier for people in rural and remote areas who do not have Medicare cards (Stevenson et al. 2024). Even so, data from Victoria suggests a higher rate of claims for PBS-subsidised contraceptives per 1,000 women of reproductive age in regional and rural areas when compared with metropolitan areas (Victorian Women's Health 2024).

People with disabilities and/or who are neurodivergent

People with disabilities face systemic barriers to accessing comprehensive sexual and reproductive health services, including limited access to appropriate education and support, and a higher likelihood of having their health concerns and experiences of violence dismissed or ignored (WDV 2021). Adolescents and young adults with mild to moderate intellectual and/or developmental disabilities have been found to be as likely to be sexually active as their peers without disabilities (Roden et al. 2020). However, they are less likely to receive comprehensive sexuality education and often have limited knowledge about contraceptive methods, leading to misinformation, ineffective use, and unintended pregnancies (Roden et al. 2020; Vallury et al. 2024; Ransohoff et al. 2022).

In Australia, people with disabilities—particularly women and girls—have also been subjected to forced sterilisation and the removal of their children, practices that remain legally sanctioned under certain conditions and that have been widely condemned as human rights violations (WWDA 2019; AGAC 2025). The final report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability detailed experiences of sterilisation and denial of reproductive rights for people with disability (Commonwealth of Australia 2023). Recommendation 6.41 called on the Australian Government and state and territory governments to amend or enact laws prohibiting non-therapeutic sterilisation of people with disability. Recommendation 6.41(d) noted that data collection on involuntary sterilisation should include any authorisations of sterilisation made by a court or tribunal (Commonwealth of Australia 2023).

Young people

In Australia, adolescents are the least likely age group to use the most effective forms of contraception (Richters et al. 2016). A 2021 national survey reported that 10% of sexually active 13–18-year-olds in Australia did not use contraception during their most recent vaginal sexual experience, with just over 50% reporting that they used a condom (Lawrence et al. 2015; Power et al. 2022). Similarly, between 2013 and 2017 approximately 11% of women aged 18-28 reported not using any contraceptive method at the time of their last vaginal sex (Harris et al. 2022). Young women aged 20-24 report the highest need for contraception compared to other age groups (FPNSW 2019). Barriers to effective contraceptive use among young people include difficulty talking to their partner about contraception, not knowing where to access contraception, cost, and limited knowledge about the effectiveness of different contraceptive methods (Garrett et al. 2015; Power et al. 2022).

People who are culturally and linguistically diverse, including recent migrants

In Australia, women from migrant or refugee backgrounds and who do not speak English are less likely to use modern contraception, and more likely to use less effective contraceptive methods (including condoms and withdrawal), than other Australian women (MCWH 2021a; MCWH 2021b; Mazza et al. 2017; Richters et al. 2016). A lack of knowledge, misinformation, limited accessible and trustworthy information, inadequate access to interpreters and bilingual staff, and cultural norms and stigma can be barriers to contraceptive use among migrant and refugee women in Australia (Liu et al. 2024; Robbers et al. 2024; Community Affairs Reference Committee 2023). Cost of health care and contraceptive commodities is a particular barrier for people without access to Medicare, including international students and temporary workers (Robbers et al. 2024; Kanan 2025; AIHW Stakeholder Consultations 2025).

People experiencing family, domestic and sexual violence and coercion

People experiencing violence, including reproductive coercion and abuse (RCA), often face unique barriers to contraceptive access. RCA includes behaviours aimed at controlling the reproductive autonomy of a woman or person who can become pregnant and is both a form of violence and significant risk factor for further harm. People experiencing RCA may experience sabotage of contraceptive methods, fear partner retaliation for making certain reproductive choices, limited autonomy in reproductive decision-making, and limited or monitored access to healthcare (MacDonald et al. 2023; IPPF 2024). Violence can also intersect with other forms of marginalisation, such as disability, homelessness, or cultural background, compounding the risk of unintended pregnancy and poor reproductive health outcomes. Trauma-informed, confidential, and accessible contraceptive services are essential to support the reproductive autonomy and safety of people experiencing RCA and other forms of domestic and family violence (MacDonald et al. 2023).

Critical data gaps and priority areas for data development

Through the literature review and consultation process the AIHW identified 5 overarching data gaps relating to access to contraceptives in Australia, along with a series of priority areas for data collection and development to begin to address these.

Table E.1 Critical data gaps and priority areas for data development

Data Gaps	Priority Areas for Data Development
Comprehensive national data on contraceptive use.	Collate and disaggregate[1] national data over time by: • Contraceptive type (combined hormonal contraception, progestogen-only pills, emergency contraceptive pills, intrauterine contraception – hormonal and non-hormonal, implants, vaginal ring, injectables, barrier methods, withdrawal, tubal ligation and vasectomy, fertility awareness-based methods) • Demographic and geographical characteristics • Cost/affordability • Timing of uptake throughout life stages, including national trends following policy changes To: • Evaluate the impact of policy on contraceptive access and use, and • Inform health system planning and resource allocation. • Use pharmacy data to monitor affordability and geographical accessibility of PBS-subsidised and private/non-subsidised scripts, as well as a focus on accessibility of emergency contraceptive pills.
Provider capacity and service delivery for contraceptives, particularly LARCs.	• Monitor the number of providers trained and actively delivering LARC insertion and removal services. • Map the geographical distribution of LARC providers by type (e.g. GPs, nurses, specialists). • Assess provider knowledge and prescribing practices in primary care, including alignment with current contraceptive and clinical guidelines.

1 Age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socioeconomic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.)

Data Gaps	Priority Areas for Data Development
Patient access, autonomy, and quality of contraceptive care.	• Monitor patient autonomy and agency in contraceptive decision-making. • Assess whether individuals can access and use their preferred contraceptive methods, and identify barriers where preferences are unmet. • Track wait times for LARC insertion and removal procedures, and permanent contraceptive procedures (e.g., vasectomy, tubal ligation). • Evaluate the prevalence and impact of reproductive coercion and abuse, including screening practices, response protocols and supports available. • Monitor access to pain relief during LARC insertion and removal procedures, disaggregated by demographic and geographical characteristics.
Limited capacity to disaggregate information to understand reasons for contraceptive use (pregnancy prevention, menstrual disorder management, STI prevention, etc).	Development of existing surveys to include reason for contraceptive use.
National data regarding contraceptive literacy, including among priority population groups.	Measurement and monitoring of: • contraceptive health literacy, disaggregated by population and geography, and • the accessibility of accurate and appropriate (culturally, linguistically, practically) information resources (including on social media)

NOTE: Where "disaggregation" is used, this is referring to disaggregation by geographic and demographic characteristics, including regarding all priority populations listed in Section 2.3 of the monitoring framework.

E.2 Data strategy for contraception

The context and scope of each section of this table is described in Appendix J.

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Collate and disaggregate national data over time by: • Contraceptive type • Demographic and geographical characteristics • Cost/affordability • Timing of uptake throughout life stages, including national trends following policy changes • Reason for contraceptive use	Total use for all methods - disaggregated geographically and by patient and provider characteristics. Proportion of total contraceptive use attributed to each method, disaggregated by patient characteristics. Total sales, by method, location, service type. Contraceptive deserts (areas where some or all methods have low or no uptake). Out of pocket costs, all methods (with and without PBS subsidies). Total expenditure (public). Acceptability. Reasons for use across all methods and user groups.	Health records Pharmacy/ prescription data Medicare records National surveys Longitudinal cohort studies	PBS MBS NHMD ABS NHS data ALSWH ASHR LSAC HILDA Jean Hailes National Women's Health Survey SSASH NNAPEDCD	Partially available - refer to Appendix J	Explore additional analysis of National administrative data collections (e.g. PBS, MBS, health expenditure data). Explore data linkage opportunities (National Health Data Hub). Expand/add questions to national surveys/ longitudinal studies.	**Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection. **National survey:** Develop an ongoing nationally representative SRH survey.	2.1; 2.2;2.3 3.1 4.1 13.1 O5; O6; O7

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor affordability and geographical accessibility of PBS-subsidised and private/ non-subsidised scripts, including (with a focus on) accessibility (uptake and provision) of emergency contraceptive pills.	Uptake and out of pocket costs, all methods (with and without PBS subsidies), disaggregated by geographical, patient and provider characteristics.	Health records National surveys Pharmacy data	MBS PBS NHMD HILDA	Partially available - refer to Appendix J	Explore data linkage opportunities. Expand/add questions to national surveys/ longitudinal studies.	**Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection.	4.1; 4.3 O6
Monitor the number, proportion, type and distribution of providers trained and actively delivering LARC insertion and removal services.	Proportion healthcare providers (relevant) offering contraceptive services (by type). Proportion healthcare providers confident/ sufficiently trained (LARC insertion and removal). Location and characteristics of providers. Unmet need for LARC insertion and removal training.	Health records Workforce surveys Clinical audits Training provider data Data linkage	MBS PBS NHMD	Very limited / fragmented - refer to Appendix J Requires significant development	Explore data linkage opportunities. Explore data collected by SRH services.	**Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions:** • Explore potential value of collating data from training providers. • Explore potential use of jurisdictional contraception provider maps (Vic, Qld) data. • Explore feasibility of developing geo-mapped database of healthcare providers and data on service availability and accessibility.	6.1; 6.2; 6.3 10.1; 10.2 11.1 O11; O16; O17

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor the geographical distribution of contraception providers by contraception and professional type (e.g. GPs, nurses, midwives, specialists), disaggregated.	Location and characteristics of providers.	Health records Medicare records Pharmacy/ prescription data National surveys Workforce surveys	PBS MBS NHMD	Partially available - refer to Appendix J	Explore data linkage opportunities.	**Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection. **Workforce survey:** Once existing data collated, explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions** • Explore potential use of jurisdictional contraception provider maps (Vic, Qld) data. • Explore feasibility of developing geo-mapped database of healthcare providers and data on service availability and accessibility.	6.1; 6.2; 6.3 10.2
Assess provider knowledge and prescribing practices in primary care, including alignment with current contraceptive and clinical guidelines.	Knowledge of, and confidence providing, high quality contraceptive services.	Workforce surveys	No data currently exists	No data currently exists	n.a.	**Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey.	8.1 10.3; 10.4 17.1

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor patient autonomy and agency in contraceptive decision-making.	Changes in preferences over time. Access to methods choice (practical). Access to informed decision-making (information, provider support).	Health records Medicare records Pharmacy/ prescription data National surveys Longitudinal cohort studies Provider mapping	LSAC HILDA	Very limited / fragmented - refer to Appendix J Requires significant development	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative SRH survey. **Pharmacy data:** Explore feasibility of establishing an ongoing national pharmacy data collection.	1.1; 1.2 3.1 7.3 O5; O13
Assess whether individuals can access and use their preferred contraceptive methods and identify barriers (to uptake and provision) where preferences are unmet (including access to pain relief).	Ability to identify and access preferred methods. Barriers to preferred method use.	National surveys Health records (primary care)	NHMD NESWTDC HILDA	Very limited / fragmented - refer to Appendix J Requires significant development	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative SRH survey. **Primary health care data:** Explore feasibility of using the national primary health care data collection (once available).	1.1; 1.2 3.1 4.1; 4.2; 4.3 5.1; 5.2 O5; O7; O13; O14; O15

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Track wait times for LARC insertion and removal procedures, and permanent contraceptive procedures (e.g. vasectomy, tubal ligation).	Time from LARC decision/ referral to procedure (LARC insertion or removal, sterilisation procedure), disaggregated by geographical, patient and provider characteristics.	Health records (hospital, outpatient, private, primary care)	NHMD NESWTDC	Partially available - refer to Appendix J	Explore additional analysis of National administrative data collections (e.g. NHMD).	**Primary health care data:** Explore feasibility of using the national primary health care data collection (once available). **Services data:** Explore feasibility of establishing a data collection with private services and outpatient data, including for non-subsidised patients and services where MBS/PBS rebates are not accessed.	4.2 O7; O16; O17
Evaluate the prevalence and impact of reproductive coercion and abuse (RCA), including screening practices, response protocols and supports available.	Prevalence of RCA, directions/types. Victim survivor characteristics. Impact of RCA on contraceptive use and preferences realised. Extent of RCA screening across all relevant services.	National surveys Health records (primary care) Clinical audits Patient experience surveys	No data currently exists	No data currently exists	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative SRH survey. **Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions:** Consider supporting/conducting qualitative research studies.	2.1 3.1 8.1; 8.2 9.4 10.3; 10.4 O4; O5; O22

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Monitor access to pain relief and/ or sedation during LARC insertion and removal procedures, disaggregated by demographic and geographical characteristics.	Provision of options and uptake of analgesia (all types) and/or sedation, disaggregated by geographical, patient and provider characteristics.	Health records (hospital, primary care) National surveys	MBS NHMD	Very limited/ fragmented data – refer to Appendix J Requires significant development	Explore opportunities for addition of questions to existing relevant surveys.	**Primary health care data:** Explore feasibility of using the national primary health care data collection (once available). **Other suggestions**: • Explore potential use of jurisdictional contraception provider maps (Vic, Qld) data. • Explore feasibility of developing geo-mapped database of healthcare providers and data on service availability and accessibility.	6.1; 6.2; 6.3 8.1 9.4; 9.5 10.1; 10.2
Measurement and monitoring of contraception health literacy, disaggregated.	Knowledge of methods, effectiveness, cost, availability, appropriateness. Awareness of service/ provider types and options.	National surveys	No data currently exists	No data currently exists	Expand/add questions to national surveys/ longitudinal studies. Explore data linkage opportunities.	**National survey:** Develop an ongoing nationally representative SRH survey. **Other suggestions**: Undertake a social media content analysis.	1.1

Priority area for development	What to monitor (areas of measurement) [a]	How to measure it [b]	Potential data sources [c]	Current status [d]	Options for development of existing data sources	Options for new data collections: establish a new collection or standardise and collate existing data	MF domains, subdomains and outcomes
Measurement and monitoring of the accessibility of trustworthy and appropriate (culturally, linguistically, practically) information resources.	Presence and use of trustworthy information: • in various formats (text, oral, video), • in language, • culturally appropriate, • Easy English. Provision of accessible information by healthcare providers.	National surveys Resource audit	No data currently exists	No data currently exists	n.a.	**Workforce survey:** Explore the value of developing a national audit of healthcare providers or workforce survey. **Other suggestions** • Explore options to evaluate/audit information resources available. • Qualitative research studies to understand cultural safety, inclusiveness, and experiences.	1.2 12.1; 12.2; 12.3; 12.4

Note: The focus of this work is on addressing gaps in information and data and to not duplicate work currently being undertaken or in development.

(a) The aim is to report priority populations for all areas of measurement where possible. This includes age, geographic region (patient, provider, pharmacy) – LGA, SA3, PHN, state, remoteness, ethnicity, language spoken at home, sexual orientation, gender identity, household income, disability type (e.g. autism), socio-economic status, migrant status, residency/visa/Medicare status, homelessness, provider type (nurse, general practitioner etc.).

(b) In the absence of comprehensive prevalence/primary data, multiple supplementary data sources may need to be used.

(c) Only nationally representative data collections with established time-series data are included in this table (see section 4.1 Data sources assessment criteria for more information). Other data sources out-of-scope for this table, that may be considered for future research include: ACT Women's Health Survey, Victorian Women's Health Survey. PATH Survey, Australian Women's Midlife Years survey.

(d) 'Very limited/fragmented data' indicates that only one or two data points/questions are available in the current source; whereas 'Partially available' means that it includes data that could partially answer some of the priority areas for development but still requires significant development/expansion. Refer to Appendix J for a summary of existing national data sources that capture some SRH data across the initial priority areas.

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