Access to contraception for remote Aboriginal and Torres Strait Islander women: necessary but not sufficient

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Comprehensive sexual and reproductive health care contributes to the autonomy of Indigenous women

The World Health Organization has long promoted a human rights-based view of the importance of access to sexual and reproductive health (SRH) care, including a reliable method for managing the spacing of children.[1] Globally, this is important for improving the health and development of populations and limiting population growth. In Australia, overall rates of pregnancy in teenage women have been falling, although they are stable or even increasing in some disadvantaged subgroups, such as young women from remote areas or low socio-economic status backgrounds.[2] Sexual activity rates among Aboriginal and Torres Strait Islander and non-Indigenous young people are broadly similar. Teenage pregnancy rates among young Indigenous women, however, are higher, and teenage birth rates are much higher, as non-Indigenous young people have greater access to and use the option of terminating a pregnancy.[3,4]

Many unintended pregnancies are the result of a failure of contraceptive methods that require daily action by the woman.[5] Both globally and in the Australian setting, health care providers and policy makers have recognised the importance of long-acting reversible contraception (LARC) for reducing the rates of unintended pregnancy, particularly in adolescent women and those living with socio-economic disadvantage.[5] In Australia, the uptake of LARC methods has been relatively slow compared with Europe because of a combination of prescriber- and consumer-related factors.[6] In addition, Mazza and colleagues found that the rate of management of contraceptive problems was lower for Indigenous women attending for primary care than for non-Indigenous women (4.48% *v* 6.15% of consultations), and that their contraceptive problems were much less frequently managed by male doctors.[6] The reality for people living in rural and remote Australia is that their access to services taken for granted by urban residents is limited, as is their choice of provider.[7] In terms of SRH, this is particularly apparent in terms of access to termination of pregnancy, tubal ligation, and insertion of intra-uterine devices, where the limiting factor is often the lack of appropriately trained staff or of culturally acceptable services.

In this issue of the *MJA*, Griffiths and colleagues report that uptake and acceptance of LARC methods in a sample of Aboriginal women of reproductive age in the remote Western Desert of Western Australia is high.[8] Although teenage Aboriginal women were not the specific focus of their research, this mixed method study provides a welcome addition to our understanding of the uptake of contraception and of attitudes among Aboriginal women. But there is a broader issue at stake. For all young women, access to contraception is only one part of comprehensive sexual and reproductive care. This care needs to be embedded in a holistic primary health care system providing culturally appropriate support, and must include attention to the broader social determinants of health. The role of the Aboriginal and Torres Strait Islander health workforce, particularly the key role of the Aboriginal health practitioner/Indigenous health worker, is paramount in optimising access to this care. LARC is highly effective against unintended pregnancy, but provides no protection against sexually transmitted infections,[9] so that a wider range of strategies, grounded in the empowerment of young women, is critical.[10,11]

In some of the most disadvantaged communities in Australia, where unemployment rates are high, rates of school completion are low, overcrowding is prevalent, and consequential social dysfunction is common, young women might have few alternatives to early pregnancy. In this context, family and peer expectations can lead to acceptance of unplanned pregnancy as the norm, defining a familiar role in a community where fertility is important. If (and this is a big if) the young mother is able to access appropriate SRH care with adequate non-judgemental support, motherhood can initiate positive life changes.[10,12] Young women need education about their aspirations and life choices, building autonomy to a degree that enables them to make informed choices about contraception.

Back in 2006, Arabena[11] highlighted ways in which colonial power and control have targeted the reproductive health of Indigenous people, and the urgent need for Indigenous young people to reclaim their reproductive health rights. As a society, we need to ensure that we avoid perpetuating what she described as "insidious forms of structural violence" against Aboriginal and Torres Strait Islander young people, including systematised exclusion from the range of life and health service choices available to non-Indigenous young people in urban settings. This can be facilitated by ensuring equal access to high quality, culturally appropriate sexual and reproductive health care, and broad, strength-based relationship and life choices education.[3] Fortunately, some health promotion and SRH programs are now taking a more developmental, community-based approach to program design, implementation and evaluation, and are achieving encouraging results.[13] However, effective ground-up program development continues to be hampered by short funding and policy cycles, limiting the translation of learning from local advances into effective national policy and practice. Only when all young women have access to quality SRH care provided by non-judgemental and culturally safe health staff, and they are empowered in terms of their own reproductive decision making (as well as decisions about educational and employment options), will we be on track to closing the gap.

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