The inequity of access to contraception for women in Aotearoa: an unfair, unsafe and ineffective system

Leanne Te Karu, Tangimoana Habib, Sue Crengle

He wahine naana i taakiri te koohaetanga o te ata
(A woman incites the dawn of a day)
—naa Rahui Papa

The World Health Organization (WHO) and the United Nations (UN) are aligned in statements that safe, effective, appropriate and accessible contraception is a fundamental human right. New data from the Health Quality & Safety Commission’s (the Commission) Atlas of Healthcare (the Atlas) contraception domain show that in Aotearoa New Zealand systemic issues impact adversely on this right, and the extent of the impacts differ by ethnicity. The burden of giving birth falls upon women. The burden of contraception, similarly, has become almost entirely the responsibility of women, and this burden falls unfairly, ineffectively and inequitably.

This is evidenced in the Commission’s new Atlas domain, which uses data from 2016–2018 to describe the rates that different kinds of contraception are dispensed in Aotearoa New Zealand by district health board (DHB), age and, crucially, ethnicity. We acknowledge the Commission for bringing this information together. It is a matter of urgent concern that the Atlas shows significant variation certainly between DHBs, but crucially by ethnic group, for all indicators. Furthermore, DHB-level data mask variation by urban and rural residence status.

The most common method of contraception in Aotearoa New Zealand is the oral contraceptive, colloquially known as ‘the pill’. Women of European/other descent were more likely to be able to access an oral contraceptive compared with Māori (20% versus 11% dispensed at least once in 2018). This difference between European/other and Māori increased when regular dispensing of oral contraceptives is considered (11.4% versus 4.6%). The Atlas also demonstrates similar inequities for Pasifika women.

There are alternatives to oral contraceptives—Jadelle progestogen implants, intra-uterine contraception systems (IUS) and sterilisation.

Māori women were twice as likely than European/other descent women (1% versus 0.5%) to receive Jadelle implants, colloquially known as ‘the rods’—a form of long-acting reversible contraception (or LARC) where two small progestogen-releasing rods are inserted subcutaneously in the inside of the upper arm. However, Jadelle implants have been the subject of multiple reports of issues with removal, insertion and breakthrough bleeding and are widely used only in developing countries (such as sub-Saharan Africa).

A higher proportion of Māori women underwent sterilisation procedures (considered permanent) compared to non-Māori women (0.5% versus 0.3% for women of European/other descent).

There are significant barriers to accessing these alternative methods, including fees for insertion of LARC and, at the time, costs associated with the use of Mirena or Jaydess intra-uterine contraception systems for contraceptive purposes.
Numbers were particularly small for all women receiving the PHARMAC-funded Mirena. This is unsurprising given funded availability was through the PHARMAC Special Authority (SA) system for women with heavy menstrual bleeding until 2019. The Mirena, while having excellent acceptability, was otherwise prohibitively expensive to purchase (~NZ$340 in 2018). Although both Mirena and Jaydess are now fully subsidised without SA for contraceptive purposes, there are usually associated costs for general practice appointments and costs for insertion and removal. These associated costs present a further barrier to this form of contraception for everyone, and particularly for Māori women. Given the SA requirement is no longer in place, we await changes to facilitate greater access to these IUSs.

It bears restating—the percentages of New Zealand women using these alternative methods to oral contraception is very small, between 0.6% and 0.3%. They in no way compensate for the inequities by ethnicity in use of oral contraceptives and point in fact to the probability of significant unmet need for contraception among Māori women.

In 2013, a review commissioned by the Ministry of Health (the Ministry) recommended the Ministry develop both a clear vision and strategic action plan with strong leadership and support for sexual and reproductive health alongside “ensuring services provided to Māori and Pasifika are delivered in ways that are culturally appropriate.” The Atlas demonstrates that neither of these has occurred. Young Māori mothers may discuss contraception ‘choices’, but the reality for them is they lack the privilege of choice. Rather, contraception is often inaccessible, unaffordable, inappropriate and unavailable within a system that is not always approachable.

The complexities of termination are beyond the scope of this letter, but we argue that the scrutiny of those accessing secondary prevention of pregnancy (termination) is an indictment not on those women, but on a system that is fragmented for all and non-existent for some. We assert the biomedical approach is not working, and a holistic and Indigenous view is overdue and critical.

These data reveal the consequences of a fragmented contraceptive service without a proper national framework for all women. As Māori women and as health professionals, we call on the Ministry of Health to respond to this letter, but more importantly to the needs of all women, and importantly with a pro-equity approach to ensure those least privileged have priority. At the very least this needs the clear vision and strategic action plan called for in 2013, and a clear process of consultation that comprehensively includes the views of Māori and Pasifika women on what a pro-equity and culturally appropriate system of sexual and reproductive health should look like in Aotearoa.
COMPETING INTERESTS:
Leanne Te Karu reports she was an independent member of the Contraception panel to the Atlas of Variation Health Quality Safety Commission. Tangimoana Habib was an independent member of the Contraception panel to the Atlas of Variation Health Quality Safety Commission. She was a member of the Abortion Supervisory Committee from 2011 to 2020. Dr Crengle reports personal fees from Invercargill Medical Centre, personal fees from Well-South PHN and personal fees from RNZCGP, outside the submitted work.

AUTHOR INFORMATION:
Leanne Te Karu: Department of General Practice and Primary Health Care, University of Auckland.
Dr Tangimoana Habib: Te Kohao Health Miro o te Ora Primary Healthcare Service, Hamilton.
Associate Professor Sue Crengle: Department of Preventive and Social Medicine, University of Otago.

CORRESPONDING AUTHOR:
Leanne Te Karu, Department of General Practice and Primary Health Care, University of Auckland
leanne.te-karu@auckland.ac.nz

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REFERENCES