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Reproductive health: Contraception, conception and change of life - Findings from the Australian Longitudinal Study on Women's Health

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3. SOCIOECONOMIC AND HEALTH BEHAVIOUR VARIATIONS IN THE USE OF CONTRACEPTIVES

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3.1 Key points

Use of contraception by women in the 1989-95 cohort by socioeconomic factors

- Women with higher levels of education were more likely to use the OCP (including the combined OCP and mini-pill) and hormonal IUD, and were less likely to use other contraceptives, and no contraception, compared with women with lower levels of education.

- Women who managed on their available income were more likely to use the OCP, and were less likely to use no contraception, compared with women who found it difficult to manage on their income.

- Women who had never married or were in a de facto relationship were more likely to use the OCP, condoms, hormonal IUD, and the implant, and were less likely to use no contraception, compared with women who were married.

- Women living in urban areas were more likely to use the OCP, and were less likely to use the implant, hormonal IUD and no contraception compared with women living in remote areas.

- The OCP and the implant were used in higher proportions by women who spoke English. Of interest use of the OCP was highest in women who spoke an Asian language when they were 40 to 45 years. Women who spoke an Asian or other non-English language were more likely to use condoms, and the implant was also used in higher proportions by women who spoke an Asian language (especially when they were 40 to 45 years). Women who spoke a language other than English were more likely to use no contraception, compared to women who spoke English or an Asian language.

Use of contraception by women in the 1989-95 cohort by health behaviour factors

- Women who consumed high levels of alcohol were more likely to use the hormonal IUD and less likely to use no contraception than women who consumed alcohol at a lower level. Women who were low risk drinkers when they were 18 to 23 years had higher use of the OCP. Women who did not drink has lower use of the implant and hormonal IUD when they were 40 to 45 years.

- Women who were physically inactive were more likely to use no contraception and less likely to use the OCP than women who were physically active, even at a low level.

- Women who were in the BMI overweight or obese ranges reported higher rates of implant use, other contraception, or no contraception (at Survey 1), and were less likely to use the OCP, compared with women who were in the healthy weight range.

- Women who smoked were more likely to use no contraception and were less likely to use the OCP and condoms, compared with women who did not currently smoke.

- Women who used marijuana or illicit drugs were more likely to use no contraception and less likely to use the OCP and condoms, compared with women who reported that they did not use marijuana or illicit drugs.

Use of contraception by women in the 1973-78 cohort by socioeconomic factors

- Women who were married or in a de facto relationship were more likely to use the OCP and condoms. Use of LARCs (defined as any non-daily method such as the hormonal IUD, copper IUD, implant, injection or vaginal ring) was highest in women who were married or separated/divorced/widowed. Women who had never married or were separated/divorced/widowed were more likely to use condoms or no contraception.

- Women living in urban areas were more likely to use no contraception and less likely to use the OCP and LARCs (at Survey 8), compared with women living in remote areas.

- The OCP was used in higher proportions by women who spoke English, whereas condom use, the withdrawal method, and no contraception were reported in higher proportions by women who spoke a European language. Women who spoke an Asian language had less use of LARCs.

Use of contraception by women in the 1973-78 cohort by health behaviour factors

- Women who consumed high levels of alcohol were less likely to use the OCP and no contraception, and were more likely to use condoms, compared with women who consumed lower levels of alcohol.

- Women who were physically inactive reported lower rates of OCP and condom use than women who were active.

- Women with a BMI in the overweight or obese categories were more likely to report no use of contraception but were less likely to use the OCP than women who were in the healthy weight category. Women in the underweight group at Survey 8 (40 to 45 years) had less use of LARCs.

- Women who smoked were less likely to use no contraception and the OCP than women who reported they did not currently smoke.

- Women who used illicit drugs were less likely to use the withdrawal method and more likely to use no contraception, compared with women who reported they did not use illicit drugs.

3.2 Introduction

This chapter describes the socioeconomic and health behaviour characteristics of women who use different types of contraceptives or no contraceptive methods. Data from women born 1989-95 and 1973-78 were used to examine contraceptive use by area of residence, education, marital status, ability to manage on income, workforce participation, country of birth, and language spoken at home. Additionally, contraceptive use by substance use, physical activity, and body weight was examined. This chapter concludes with a summary of relevant previously published research that has used ALSWH data.

3.3 Use of contraception methods by women in the 1989-95 cohort by socioeconomic and health behaviour characteristics

3.3.1 Use of the OCP

Chapter 2 showed how overall prevalence of use of the OCP (including the combined OCP or mini-pill) decreased over time, from 60% in Survey 1 when the women were aged 18 to 23, to 34% in Survey 6, when aged 24 to 30. This section describes how use of the OCP at Survey 1 and Survey 6 differed by socioeconomic characteristics and health risk behaviours. The percentages of women using each type of contraceptive method according to socioeconomic factors and health risk behaviours are shown in Table 3-1 to 3-Table 3-20. Detailed descriptions of these associations at the baseline and most recent surveys can be found in Appendix 11.3.

Table 3-1 Prevalence of OCP use according to socioeconomic factors among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Area of residence		
Major city	60.5	36.1
Inner regional	58.9	30.8
Outer regional	61.8	25.4
Remote/very remote	50.0	30.4

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Highest qualification		
Less than year 12	43.2	24.7
Year 12	62.7	27.6
Certificate/diploma/trade	50.8	28.3
University degree	66.4	37.0
Marital status		
Married	47.7	22.4
Defacto	59.8	37.5
Separated/divorced/widowed	66.7	27.3
Never married	60.9	38.5
Manage on income		
It is easy	59.4	36.0
It is not too bad	64.3	35.4
It is difficult some of the time	59.0	31.8
It is difficult all of the time	57.0	34.9
It is impossible	55.9	21.1
Country of birth		
Australia	60.5	34.3
Other English-speaking country	58.6	33.5
Other	50.5	29.9
Language spoken at home		
English	60.3	34.0
European language	53.8	18.8
Asian language	29.2	39.4
Other language	52.5	27.7

In summary, Table 3-1 shows that use of the OCP was highest at Survey 1 and Survey 6 among women born 1989-95 who lived in urban areas, had a higher level of education, were born in Australia or other English speaking country (only at Survey 1), were either not married, were in a de facto relationship or separated/widowed/divorced,

managed on their available income (at Survey 1) and spoke an Asian language (only at Survey 6) or English at home (only at Survey 1).

Table 3-2 Prevalence of OCP use according to health risk behaviours among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Alcohol consumption		
Low risk drinker	63.2	37.4
Non-drinker	51.0	20.4
Rarely drinks	56.6	31.5
Risky drinker	50.0	37.2
Smoking		
Never smoked	64.0	36.3
Ex-smoker	57.2	24.9
Current smoker	45.9	29.5
Physical activity		
Inactive	51.3	29.2
Low	59.6	30.9
Moderate	61.0	34.9
High	61.0	36.8
BMI Category (kg/m^2)		
Underweight (<18.50)	64.0	39.1
Healthy (18.59 - 24.99)	64.1	37.0
Overweight (25.09 - 29.99)	55.0	32.4
Obese (30.00 or more)	44.4	29.3
Use of marijuana[a]		
Every day	-	24.0
Once a week or more	-	22.9
About once a month	-	23.6
Every few months	-	33.9
Once or twice a year	-	31.6
Never	-	35.8

[a] Use of marijuana only asked at Survey 6

The data in Table 3-2 shows use of the OCP was highest at Survey 1 and Survey 6 among women born 1989-95 who did not currently smoke, were low risk drinkers (at Survey 1) were more physically active, had a lower BMI, and did not use, or had low levels of use, of marijuana or other illicit drugs (Survey 6 only).

3.3.2 Use of condoms

Overall prevalence of condom use decreased over time, from 45% in Survey 1 to 31% in Survey 6. It is important to note that condoms can be used for contraception, STI prevention, or both. The following tables show the associations between condom use at the baseline and most recent surveys according to socioeconomic factors and health risk behaviours (Table 3-3 and Table 3-4). Detailed descriptions of these associations at the baseline and most recent surveys can be found in Appendix 11.3.

Table 3-3 Prevalence of condom use according to socioeconomic factors among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Area of residence		
Major city	44.4	32.1
Inner regional	45.6	29.1
Outer regional	46.3	26.1
Remote/very remote	42.3	31.6
Highest qualification		
Less than year 12	38.5	31.5
Year 12	48.4	27.3
Certificate/diploma/trade	40.1	26.1
University degree	44.2	33.2
Marital status		
Married	29.7	22.5
Defacto	31.2	25.6
Separated/divorced/widowed	33.3	30.9
Never married	49.6	39.8
Manage on income		
It is easy	46.1	32.4

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
It is not too bad	46.5	29.9
It is difficult some of the time	43.4	32.6
It is difficult all of the time	44.6	30.7
It is impossible	42.0	30.0
Country of birth		
Australia	44.8	31.0
Other English-speaking country	44.0	29.5
Other	48.5	41.3
Language spoken at home		
English	44.6	30.8
European language	30.8	31.3
Asian language	62.5	48.5
Other language	57.5	27.7

In summary, Table 3-3 shows that use of condoms was highest at Survey 1 and Survey 6 among women born 1989-95 who were born in a non-English speaking country (mainly at Survey 6), were not married and spoke an Asian or other non-English language at home.

Table 3-4 Prevalence of condom use according to health risk behaviours among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Alcohol consumption		
Low risk drinker	44.9	32.5
Non-drinker	44.4	26.2
Rarely drinks	44.1	30.2
Risky drinker	49.2	27.3
Smoking		
Never smoked	46.5	32.3
Ex-smoker	42.6	27.6
Current smoker	39.5	27.2

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Physical activity		
Inactive	45.3	31.7
Low	42.8	28.2
Moderate	46.3	30.5
High	45.1	33.3
BMI category (kg/m^2)		
Underweight (<18.50)	47.9	27.8
Healthy (18.59 - 24.99)	43.6	31.6
Overweight (25.09 - 29.99)	46.0	31.4
Obese (30.00 or more)	47.2	30.6
Use of marijuana[a]		
Every day	-	24.0
Once a week or more	-	22.9
About once a month	-	31.5
Every few months	-	27.9
Once or twice a year	-	34.1
Never	-	31.1

[a] Use of marijuana only asked at Survey 6

In summary, Table 3-4 shows that use of condoms was highest at Survey 1 and Survey 6 among women born 1989-95 who did not currently smoke, and did not use, or had low levels of use, of marijuana or other illicit drugs.

3.3.3 Use of the implant

Chapter 2 showed how overall prevalence of implant use was largely consistent across the surveys at 10% to 12%. The following tables show the associations between implant use at the baseline and most recent surveys according to socioeconomic factors and health risk behaviours (Table 3-5 and Table 3-6). Detailed descriptions of these associations at the baseline and most recent surveys can be found in Appendix 11.3.

Table 3-5 Prevalence of implant use according to socioeconomic factors among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Area of residence		
Major city	9.3	9.0
Inner regional	12.7	11.4
Outer regional	13.4	9.9
Remote/very remote	11.5	8.9
Highest qualification		
Less than year 12	8.9	9.0
Year 12	10.3	7.9
Certificate/diploma/trade	12.5	9.5
University degree	8.4	9.8
Marital status		
Married	5.8	5.8
Defacto	12.4	10.7
Separated/divorced/widowed	22.2	16.4
Never married	9.7	10.7
Manage on income		
It is easy	11.1	10.1
It is not too bad	8.7	8.9
It is difficult some of the time	10.9	9.5
It is difficult all of the time	10.2	10.4
It is impossible	12.6	13.3
Country of birth		
Australia	10.4	9.9
Other English-speaking country	6.0	6.0
Other	9.7	2.5
Language spoken at home		
English	10.4	9.8
European language	0.0	0.0
Asian language	8.3	15.2
Other language	5.0	10.6

Table 3-5 shows that use of the implant was slightly higher at Survey 1 among women born 1989-95 who lived in regional and remote areas and were born in Australia. Use of the implant was highest at both Survey 1 and Survey 6 among women born 1989-95 who were separated/divorced/widowed and highest at Survey 6 by women who spoke an Asian language.

Table 3-6 Prevalence of implant use according to health risk behaviours among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Alcohol consumption		
Low risk drinker	9.6	10.1
Non-drinker	7.8	4.9
Rarely drinks	11.9	9.9
Risky drinker	9.2	8.3
Smoking		
Never smoked	9.5	9.9
Ex-smoker	10.9	9.0
Current smoker	12.5	8.0
Physical activity		
Inactive	13.2	8.0
Low	11.0	10.2
Moderate	9.3	8.5
High	9.9	9.9
BMI category (kg/m^2)		
Underweight (<18.50)	5.3	6.8
Healthy (18.59 - 24.99)	8.7	8.5
Overweight (25.09 - 29.99)	13.1	11.0
Obese (30.00 or more)	16.4	10.9
Use of marijuana[a]		
Every day	-	10.7
Once a week or more	-	8.5
About once a month	-	9.5
Every few months	-	9.7
Once or twice a year	-	11.7
Never	-	9.0

[a] Use of marijuana only asked at Survey 6

In summary, use of the implant was higher at Survey 1 among women born 1989-95 who were smokers and had a higher BMI (as well as Survey 6).

3.3.4 Use of the hormonal IUD

Chapter 2 showed the overall prevalence of use of the hormonal IUD increased from 2% at Survey 1 to 13% at Survey 6. The following tables show the associations between the hormonal IUD use at the baseline and most recent surveys according to socioeconomic factors and health risk behaviours (Table 3-7 and Table 3-8). Detailed descriptions of how use of the hormonal IUD at Survey 6 differed by socioeconomic and health risk behaviours can be found in Appendix 11.3.

Table 3-7 Prevalence of the hormonal IUD use according to socioeconomic factors among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Area of residence		
Major city	2.3	13.2
Inner regional	1.7	11.1
Outer regional	2.8	16.5
Remote/very remote	3.8	17.7
Highest qualification		
Less than year 12	2.6	6.7
Year 12	1.2	11.5
Certificate/diploma/trade	3.2	12.0
University degree	2.9	14.1
Marital status		
Married	2.3	9.6
Defacto	3.1	15.1
Separated/divorced/widowed	11.1	14.5
Never married	1.9	13.9
Manage on income		
It is easy	1.6	16.3
It is not too bad	1.9	12.4

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
It is difficult some of the time	2.4	11.8
It is difficult all of the time	3.2	13.3
It is impossible	0.7	17.8
Country of birth		
Australia	2.2	13.0
Other English-speaking country	3.9	16.3
Other	0.0	14.9
Language spoken at home		
English	2.3	13.6
European language	0.0	12.5
Asian language	0.0	6.1
Other language	0.0	10.6

The table shows that use of the hormonal IUD was highest at Survey 6 among women born 1989-95 who lived in more remote areas, had higher levels of education, and were either not married or were in a de facto relationship.

Table 3-8 Prevalence of the hormonal IUD use according to health risk behaviours among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Alcohol consumption		
Low risk drinker	2.4	15.4
Non-drinker	0.8	6.0
Rarely drinks	2.1	10.7
Risky drinker	1.5	16.5

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Smoking		
Never smoked	2.0	13.2
Ex-smoker	2.8	13.5
Current smoker	2.6	13.2
Physical activity		
Inactive	2.6	11.4
Low	2.0	12.3
Moderate	2.0	12.8
High	2.4	14.3
BMI category (kg/m^2)		
Underweight (<18.50)	2.3	9.8
Healthy (18.59 - 24.99)	1.9	14.0
Overweight (25.09 - 29.99)	2.6	12.1
Obese (30.00 or more)	3.5	13.5
Use of marijuana[a]		
Every day	-	10.7
Once a week or more	-	20.3
About once a month	-	18.9
Every few months	-	17.2
Once or twice a year	-	15.1
Never	-	12.2

[a] Use of marijuana only asked at Survey 6

In summary, use of the hormonal IUD was highest at Survey 6 among women born 1989-95 who used marijuana weekly or monthly and were low risk or risky drinkers.

3.3.5 Use of no contraception

Chapter 2 explored how the overall prevalence of use of no contraception more than doubled, increasing from 9% when the women were aged between 18 to 23 years to around 21% by the time they were 24 to 30 years, likely reflecting these women becoming pregnant and planning for pregnancy. The following tables show the associations between use of no contraception at the baseline and most recent surveys

according to socioeconomic factors and health risk behaviours (Table 3-9 and Table 3-10). Detailed descriptions of these associations at the baseline and most recent surveys can be found in Appendix 11.3.

Table 3-9 Prevalence of use of no contraception according to socioeconomic factors among women born 1989-95 at their baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Area of residence		
Major city	8.9	19.3
Inner regional	8.3	25.9
Outer regional	8.8	27.4
Remote/very remote	11.5	29.1
Highest qualification		
Less than year 12	20.3	34.8
Year 12	6.9	29.2
Certificate/diploma/trade	13.9	29.8
University degree	5.9	16.8
Marital status		
Married	26.2	41.2
Defacto	9.6	15.8
Separated/divorced/widowed	0.0	21.8
Never married	7.7	13.3
Manage on income		
It is easy	7.8	15.9
It is not too bad	7.5	22.1
It is difficult some of the time	8.8	22.3
It is difficult all of the time	10.6	20.1
It is impossible	13.3	34.4
Country of birth		
Australia	8.8	20.7
Other English-speaking country	8.6	23.9
Other	9.7	24.8

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Language spoken at home		
English	8.9	20.6
European language	15.4	50.0
Asian language	12.5	6.1
Other language	10.0	34.0

The table shows use of no contraception was highest at Survey 1 and Survey 6 among women born 1989-95 who lived in more remote areas, had a lower level of education, were married, had more income stress and spoke a European or other language at home (only at S6).

Table 3-10 Prevalence of use of no contraception according to health risk behaviours among women born 1989-95 at baseline and most recent surveys

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Alcohol consumption		
Low risk drinker	6.6	15.5
Non-drinker	18.5	44.5
Rarely drinks	11.1	25.0
Risky drinker	13.8	19.8
Smoking		
Never smoked	7.0	18.7
Ex-smoker	10.2	29.1
Current smoker	15.8	27.1
Physical activity		
Inactive	13.7	27.7
Low	10.4	26.3
Moderate	7.3	22.5
High	8.1	15.7
BMI category (kg/m^2)		
Underweight (<18.50)	6.9	26.3

	Survey 1 (2012/13) Aged 18-23 %	Survey 6 (2019/20) Aged 24-30 %
Healthy (18.59 - 24.99)	8.2	18.7
Overweight (25.09 - 29.99)	9.1	21.7
Obese (30.00 or more)	12.7	23.6
Use of marijuana[a]		
Every day	-	32.0
Once a week or more	-	25.4
About once a month	-	23.6
Every few months	-	17.7
Once or twice a year	-	16.2
Never	-	21.6

[a] Use of marijuana only asked at Survey 6

Overall, use of no contraception was highest at Survey 1 and Survey 6 among women born 1989-95 who did not drink alcohol, currently or no longer smoked, used illicit drugs, had more frequent use of marijuana, were less physically active and had a BMI in the obese category (only at Survey 1).

3.3.6 Use of other contraception

Chapter 2 showed the use of other contraceptives remained steady at between 3 to 5% between Surveys 1 to 6. Descriptive information about how use of other contraception may have differed by demographic characteristics or health risk behaviours can be found in Appendix 11.3.

3.4 Use of contraception by women in the 1973-78 cohort by socioeconomic and health behaviour characteristics

3.4.1 Use of the OCP

Chapter 2 showed the overall prevalence of OCP use was approximately 47% when women were aged 18 to 23, then peaked at 55% three years later, and then gradually declined to 20% by the time the women were 40 to 45 years.

This next section describes how use of the OCP between Survey 1 and Survey 8 (when the women were aged 40 to 45) differed by socioeconomic characteristics and

health risk behaviours. The following tables show the associations between OCP use at the baseline and most recent surveys by these factors (Table 3-11 and Table 3-12). Detailed descriptions of these associations at the baseline and most recent surveys, as well as descriptions of notable trends between the surveys are also included.

Table 3-11 Prevalence of OCP use according to socioeconomic factors among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Area of residence		
Major city	43.3	18.9
Inner regional	47.1	20.9
Outer regional	56.3	19.8
Remote/very remote	58.3	20.4
Highest qualification		
Less than year 12	49.9	23.9
Year 12	45.0	23.4
Certificate/diploma/trade	52.0	19.7
University degree	46.3	18.6
Marital status		
Married	63.1	19.1
Defacto	74.7	19.1
Separated/divorced/widowed	50.0	22.9
Never married	41.6	19.0
Manage on income		
It is easy	43.0	20.7
It is not too bad	47.3	18.4
It is difficult some of the time	49.7	20.7
It is difficult all of the time	44.5	20.3
It is impossible	38.3	11.8
Labour force participation[a]		
Part-time	47.0	18.9
Full-time	57.8	20.7
Unemployed/not in labour force	36.1	15.4

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Country of birth		
Australia	47.4	19.9
Other English-speaking country	46.9	12.2
Europe	38.5	17.9
Asia	18.3	11.1
Other	35.0	25.0
Language spoken at home		
English, born in Australia	48.6	20.3
English, born outside Australia	45.2	12.6
European language	26.8	14.3
Asian language	8.5	18.2
Other language	12.5	12.5

[a] Asked at Survey 3

Socioeconomic factors

At Survey 1, OCP use was highest in women living in outer regional and remote areas (about 57%) compared with 47% and 43% in women living in inner regional and major cities, respectively. For women living in outer regional and remote areas, use remained as high at the next survey when women were aged 22 to 27 years, then dropped to around 20% by Survey 8. For women living in inner regional and major cities use increased between Survey 1 and 2 by around 10%, before gradually declining to about 20% at Survey 8.

At Survey 1, OCP use was between 45% and 52% in women regardless of how much education they had attained. At Survey 2, use of the OCP had increased by about 10% in women with a year 12 or university level education (each to 55%). By Survey 8 when the women were aged 40 to 45, use was between 19% and 24% in all women.

Regarding marital status, OCP use at Survey 1 was highest in women who were in a defacto relationship (75%) or married (63%) compared with women who were separated (47%) or had never married (42%). Due to low numbers, data on women who were divorced could only be used from Survey 4 onwards, when they were 28 to

33 years (OCP was used by 46%). At Survey 8, use of the OCP was 27% in women who were divorced and about 20% in women who had never married, were in a de facto relationship, separated or were married. [1]

Use of the OCP at Survey 1 was highest in women who found it not too bad or difficult some of the time to manage on their income (about 48%), around 44% in women who found it easy or difficult all of the time, and 38% in women who found it impossible. For women who found it easy to manage on their income this percent rose to 58% at Survey 3 when they were 50 to 55 years, and rose to 54% in women who found it not too bad. By Survey 8, OCP use was around 20% in women who found it easy, not too bad, difficult some of the time or difficult all of the time, and 12% in women who found it impossible to manage on their income.

Use of the OCP at Survey 2 was 60% in women who worked full-time and 50% in women who worked part-time. Data for those who were not in the labour force was first available from Survey 3 (36% used the OCP). By Survey 8 use of the OCP was similar for the women regardless of whether or how much they participated in the labour force, at around 17%.

Use of the OCP at Survey 1 was around 47% in women who were born in Australia or another English speaking country, about 38% in women born in Europe, and was lowest, at 18% for women born in Asia. Use for all women peaked at Survey 2 or 3: at around 55% for women born in Australia, another English speaking country or Europe and 33% for Asian born women. At Survey 8, use was around 19% for women born in Australia or Europe and about 12% for women born in Asia or another ESB country. [2]

Women who spoke English at home had higher rates of using the OCP at Survey 1 (46%), compared to women who spoke a European language (27%). For English speaking women, use peaked at Survey 2 or 3 (at around 55%), while use peaked at 45% for women who spoke a European language. At Survey 8, use was highest in women who spoke English (and were born in Australia) (20%) compared with women

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[1] *There were too few women who were widowed to make meaningful interpretations.*

[2] *There were too few women born in another non-ESB country to make meaningful conclusions.*

who spoke English but were not born in Australia or who spoke a European language (14%).[3]

Table 3-12 Prevalence of OCP use according to health risk behaviours among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Alcohol consumption		
Low risk drinker	50.7	19.4
Non-drinker	25.0	18.1
Rarely drinks	45.1	20.0
Risky drinker	42.5	20.9
Smoking		
Never smoked	42.3	20.0
Ex-smoker	54.6	17.5
Current smoker	52.0	21.2
Physical activity[a]		
Inactive	53.2	16.6
Low	52.5	20.5
Moderate	59.1	23.1
High	55.6	17.6
BMI category (kg/m^2)		
Underweight (<18.50)	45.0	20.6
Healthy (18.59 - 24.99)	48.7	19.0
Overweight (25.09 - 29.99)	43.4	19.9
Obese (30.00 or more)	36.4	20.1
Use of illicit drugs[a]		
Never	51.4	22.5
Only ever used Marijuana - not in last 12 mths	62.4	18.4
Only ever used Marijuana – used in last 12mths	60.4	18.2

[3] *There were too few women who spoke an Asian or other non-ESB language to make meaningful interpretations.*

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Used multiple/single drug other than Marijuana – not last 12 mths	56.1	16.4
Used multiple/single drug other than Marijuana ≥ once last 12 mths	51.9	13.1

[a] Asked at Survey 2

Health risk behaviours

At Survey 1, OCP use was highest in women who were low risk drinkers (50%) followed by those who drank alcohol rarely or at risky levels (about 43%). Use was much lower in women who were non-drinkers (at 25%). By Survey 2, use of the OCP was higher by in all groups by around 9%, except for the women who drank at risky levels where the prevalence was around 20% higher. By Survey 8, use was around 20% for women regardless of their alcohol consumption.[4]

OCP use at Survey 1 was higher in women who were smokers and ex-smokers (around 53%) and about 10% less for women who were non-smokers. In women who were non-smokers, use of the OCP was higher at Survey 2 (at 56%) and had declined to 20% at Survey 8. For women who were smokers and ex-smokers, use gradually declined to about 19% at Survey 8.

A comparable physical activity question was first asked at Survey 2 when the women were aged 22 to 27. At this survey, use of the OCP was highest in women who participated in high and moderate levels of physical activity (around 57%) and was about 6% lower in women who participated in low levels of physical activity or who were inactive. By survey 8, use of the OCP was between 17% and 23% in women regardless of how much physical activity they did.

OCP use at Survey 1 was higher in women who were of a healthy weight (49%), followed by underweight or overweight (44%). Women who were in the obese BMI

[4] *There were too few women who were high risk drinkers to make meaningful interpretations about their use of the OCP.*

category used the OCP the least (36%). Women in all BMI groupings showed higher OCP use at Survey 2 or 3 (increase of around 9%). By Survey 8, use was about 20% in women regardless of their weight.

Unlike in the 1989-95 cohort surveys, a single question about drug use for non-medicinal purposes was used in the 1973-78 cohort, starting from Survey 2 (when the women were aged 22 to 27). The question asked the women to separately indicate if they had used marijuana and any other illicit drugs, using the response options of 'never', 'in the last 12 months' or 'more than 12 months ago'. Use of OCP at Survey 1 was highest in women who had used marijuana recently or more than 12 months ago (about 60%) compared with around 54% in women who either never used illicit drugs or had ever used other illicit drugs. At Survey 8, use of the OCP was 22% in women who had never used illicit drugs, and between 13% and around 17% in women who had used ever marijuana or an illicit drug.

3.4.2 Use of condoms

Chapter 2 showed overall prevalence of condom use was about 19% when women were aged 18 to 23, then peaked at 33% 10 years later, and then gradually declined to 23% by the time the women were 40 to 45 years.

The following tables show how use of condoms between Survey 1 and Survey 8 (when the women were aged 40 to 45) differed by demographic characteristics and health risk behaviours (Table 3-13 and Table 3-14). Detailed descriptions of these associations at the baseline and most recent surveys, as well as descriptions of noteworthy trends between the surveys are also included.

Table 3-13 Prevalence of condom use according to socioeconomic factors among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Area of residence		
Major city	20.7	25.2
Inner regional	19.1	18.9
Outer regional	14.9	20.5
Remote/very remote	20.7	25.2
Highest qualification		
Less than year 12	17.0	23.9
Year 12	18.8	17.1
Certificate/diploma/trade	20.9	22.2
University degree	21.4	24.5
Marital status		
Married	16.6	24.6
De facto	12.3	17.6
Separated/divorced/widowed	0.0	19.9
Never married	20.7	25.5
Manage on income		
It is easy	18.8	25.4
It is not too bad	18.5	23.3
It is difficult some of the time	19.4	23.0
It is difficult all of the time	23.0	19.9
It is impossible	18.1	21.6
Labour force participation[a]		
Part-time	30.2	26.5
Full-time	33.3	20.5
Unemployed/not in labour force	30.2	26.7
Country of birth		
Australia	19.4	23.3
Other English-speaking country	21.4	22.2
Europe	17.9	32.1
Asia	11.7	17.8

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Other	30.0	41.7
Language spoken at home		
English, born in Australia	19.3	22.8
English, born outside Australia	20.8	23.6
European language	20.2	32.8
Asian language	17.0	24.2
Other language	16.7	18.8

[a] Asked at Survey 3

Socioeconomic factors

At Survey 1, condom use was around 15% to 20% for women regardless of where they lived. Use increased by Survey 4, when the women were aged 28 to 33 years to around 30%. By Survey 8, use was slightly higher in women living in major cities or remote areas (26%) compared to women living in all other areas (around 20%).

At Survey 1, condom use was between 17% and 21% in women regardless of how much education they had attained. At Survey 4, use of the condom had increased by about 10% in all women, and by Survey 8 when the women were aged 40 to 45, use was around 17% in women with a year 12 level of education and only slightly higher in women with all other levels of education (22%).

Regarding marital status, condom use at Survey 1 was around 18% in married women and those who had never married, and was lower, at 12%, in women who were in a de facto relationship. Due to low numbers, data on women who were divorced and separated could only be used from Survey 4 onwards, when they were 28 to 33 years (about 40% of women in each group used condoms). At Survey 8, use of condoms was about 17% in women who were divorced, were in a de facto relationship or were

separated. Use in women who were never married or were married at Survey 8 was 25%. [5]

Use of condoms ranged between 18% and 23% in women at Survey 1, was around 32% at Survey 3 and 4, and 22% at Survey 8 regardless of how well the women reported managing on their income.

Use of condoms at Survey 2 or 3 was around 28% in women regardless of whether or how much they participated in the labour force. By Survey 8 use of condoms ranged from 20% to 26% for all women.

Use of condoms at Survey 1 was around 20% in women who were born in Australia, another English speaking country or Europe, and 12% in women born in Asia. Regardless of where women were born use peaked between Surveys 3 and 5. Women who spoke a European language had the highest peak in condom use at around 40%, compared with about 33% in women born in other countries. At Survey 8 condoms were used by 20% of women born in Australia, another English-speaking country or Asia, and 32% in women born in Europe. [6]

There was no difference in use of condoms in women at Survey 1 by the language they spoke at home (around 19%). Between Survey 3 and 5, use peaked at about 40% in women who spoke English (but were not born in Australia), a European or Asian language at home, compared to 31% in those who spoke English (and were born in Australia). At Survey 8, condom use was higher in women who spoke a European (33%) language at home, compared with women who spoke English or an Asian language (23%).[7]

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[5] *There were too few women who were widowed to make meaningful interpretations.*

[6] *There were too few women born in another non-ESB country and who used condoms to make meaningful interpretations.*

[7] *There were too few women who spoke another non-ESB language to make meaningful interpretations.*

Table 3-14 Prevalence of condom use according to health risk behaviours among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Alcohol consumption		
Low risk drinker	21.2	24.2
Non-drinker	11.5	18.5
Rarely drinks	15.8	24.4
Risky drinker	33.5	17.1
Smoking		
Never smoked	17.7	23.1
Ex-smoker	19.1	25.1
Current smoker	23.4	19.3
Physical activity[a]		
Inactive	21.7	21.0
Low	24.9	21.0
Moderate	27.9	25.2
High	29.5	25.9
BMI category (kg/m^2)		
Underweight (<18.50)	19.3	26.5
Healthy (18.59 - 24.99)	19.3	24.8
Overweight (25.09 - 29.99)	20.0	23.8
Obese (30.00 or more)	18.4	20.1
Use of illicit drugs[a]		
Never	26.3	22.1
Only ever used Marijuana - not in last 12 mths	26.3	24.9
Only ever used Marijuana – used in last 12mths	27.0	25.0
Used multiple/single drug other than Marijuana – not last 12 mths	27.5	23.2
Used multiple/single drug other than Marijuana ≥ once last 12 mths	30.7	24.8

[a] Asked at Survey 2

Health risk behaviours

At Survey 1, condom use was highest in women who were risky drinkers (35%) followed by those who drank alcohol at a low risk level or rarely (about 18%) or were non-drinkers (11%). By Surveys 3 and 4, use of condoms remained highest in women who were risky drinkers (38%), and was around 32% in women in the other alcohol consumption categories. By Survey 8, condom use was about 22% in women regardless of how much or whether they drank.[8]

Condoms were used at Survey 1 by around 20% of women regardless of whether they currently or had ever smoked. Use peaked at Surveys 3 to 5 (to around 33%) and then fell to around 21% at Survey 8 in all women.

At Survey 2, use of condoms was highest in women who participated in high and moderate levels of physical activity (around 29%) and was around 23% in women who participated in low levels or were inactive. Use remained highest in women with the most physical activity (high or moderate levels) across the Surveys, peaking at around 33% at Surveys 3 or 4. By Survey 8, use remained highest in the most active women (26%) compared to those who were less active or inactive (around 21%).

Condom use at Survey 1 was about 19% in women regardless of their BMI. Use of condoms rose to around 32% in women of all body weights over the next few Surveys before declining to between 20% and 26% by Survey 8.

Unlike in the 1989-95 cohort Surveys, a single question about drug use for non-medicinal purposes was used in the 1973-78 cohort, starting from Survey 2 (when the women were aged 22 to 27). The question asked the women to separately indicate if they had used marijuana and any other illicit drugs, using the response options of never, in the last 12 or more than 12 months ago. Use of condoms at Survey 2 (by around 28% of women), Survey 4 (around 33%) and Survey 8 (around 24%) was equivalent in women regardless of their drug use.

[8] *There were too few women who were high risk drinkers to make meaningful interpretations about their use of condoms*

3.4.3 Use of long acting LARC methods

Chapter 2 showed the overall prevalence of LARC use was about 11% when first asked in Survey 5, when women were aged 31 to 36. This gradually increased to 24% by the time the women were 40 to 45 years, at Survey 8. For the purposes of data collected from the 1973-78 cohort, LARCs include the injection, hormonal and copper IUDs, vaginal rings and implants.

The following tables show how use of LARCs between Survey 5 and Survey 8 differed by demographic characteristics and health risk behaviours (Table 3-15 and Table 3-16).

Table 3-15 Prevalence of use of LARCs according to socioeconomic factors among women born 1973-78 at their baseline and most recent surveys

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Area of residence		
Major city	8.7	23.0
Inner regional	13.8	24.9
Outer regional	13.9	28.9
Remote/very remote	12.2	30.6
Highest qualification		
Less than year 12	13.9	16.5
Year 12	14.8	23.4
Certificate/diploma/trade	9.7	23.3
University degree	10.0	25.4
Marital status		
Married	12.0	27.5
Defacto	9.0	19.7
Separated/divorced/widowed	12.0	23.3
Never married	7.6	16.4
Manage on income		
It is easy	8.0	25.0
It is not too bad	10.7	24.8

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
It is difficult some of the time	11.8	23.2
It is difficult all of the time	13.5	22.2
It is impossible	12.0	31.4
Labour force participation		
Part-time	13.4	25.9
Full-time	9.0	24.7
Unemployed/not in labour force	9.6	17.0
Country of birth		
Australia	10.7	24.9
Other English-speaking country	11.1	26.7
Europe	3.2	10.7
Asia	10.6	8.9
Other	15.4	16.7
Language spoken at home		
English, born in Australia	11.0	24.9
English, born outside Australia	11.7	23.6
European language	5.9	21.8
Asian language	5.4	9.1
Other language	0.0	18.8

Table 3-15 shows that there were few consistent differences in use of LARCs by socioeconomic factors. Possible differences were that use of LARC methods was higher at Survey 8 among women born 1973-78 who were married or separated/widowed/divorced and lived in more remote areas and lower in women who spoke an Asian language at home. See Appendix 11.3.2 for more description.

Table 3-16 Prevalence of use of LARCs according to health risk behaviours among women born 1973-78 at their baseline and most recent surveys

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Alcohol consumption		
Low risk drinker	10.7	26.1
Non-drinker	8.4	17.7
Rarely drinks	11.0	22.1
Risky drinker	12.3	27.2
Smoking		
Never smoked	10.5	24.8
Ex-smoker	10.7	24.0
Current smoker	11.0	23.1
Physical activity		
Inactive	11.6	25.1
Low	12.2	22.2
Moderate	8.7	24.9
High	9.8	25.8
BMI category (kg/m^2)		
Underweight (<18.50)	9.6	11.8
Healthy (18.59 - 24.99)	8.8	23.5
Overweight (25.09 - 29.99)	12.1	23.0
Obese (30.00 or more)	13.3	28.0
Use of illicit drugs		
Never	11.1	23.8
Only ever used Marijuana (not in last 12 mths)	11.4	27.6
Only ever used Marijuana (used in last 12mths)	14.5	31.8
Used multiple/single drug other than Marijuana (not last 12 mths)	8.6	20.2
Used multiple/single drug other than Marijuana (≥ once last 12 mths)	8.6	27.7

Table 3-16 shows that there were few consistent differences in use of LARCs by health risk behaviours with the exception of lower use of LARCs at Survey 8 in women who were underweight. More descriptions can be found in Appendix 11.3.2.

3.4.4 Use of the withdrawal method

Chapter 2 showed the overall prevalence of the withdrawal method was steady at around 11% between Surveys 5 and 8. The following tables show how use of the withdrawal method between Survey 5 and Survey 8 differed by demographic characteristics and health risk behaviours (Table 3-17 and Table 3-18).

Table 3-17 Prevalence of use of the withdrawal method of contraception according to socioeconomic factors among women born 1973-78 at their baseline and most recent surveys

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Area of residence		
Major city	11.1	12.1
Inner regional	8.8	8.4
Outer regional	9.9	9.4
Remote/very remote	9.4	12.2
Highest qualification		
Less than year 12	7.4	9.2
Year 12	13.3	11.7
Certificate/diploma/trade	11.5	12.0
University degree	9.7	10.4
Marital status		
Married	11.4	11.5
Defacto	13.4	15.0
Separated/divorced/widowed	13.2	8.2
Never married	6.4	6.2
Manage on income		
It is easy	9.3	7.9
It is not too bad	10.9	12.0
It is difficult some of the time	10.6	11.1
It is difficult all of the time	11.7	11.7
It is impossible	10.7	11.8
Labour force participation		
Part-time	10.7	12.7

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Full-time	9.6	9.3
Unemployed/not in labour force	13.4	13.0
Country of birth		
Australia	10.3	10.7
Other English-speaking country	12.3	11.1
Europe	16.7	10.7
Asia	15.8	20.0
Other	0.0	0.0
Language spoken at home		
English, born in Australia	10.0	10.2
English, born outside Australia	10.7	11.8
European language	16.6	18.5
Asian language	18.2	15.2
Other language	13.6	6.3

In summary, use of the withdrawal method was highest at Survey 8 among women born 1973-78 who were in a de facto relationship and spoke a European language at home. See Appendix 11.3.2 for more description.

Table 3-18 Prevalence of use of the withdrawal method of contraception according to health risk behaviours among women born 1973-78 at their baseline and most recent surveys

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Alcohol consumption		
Low risk drinker	10.6	10.9
Non-drinker	9.1	11.5
Rarely drinks	10.7	10.9
Risky drinker	11.1	9.5
Smoking		
Never smoked	9.1	10.3
Ex-smoker	13.9	11.9

	Survey 5 (1996) Aged 31-36 %	Survey 8 (2018) Aged 40-45 %
Current smoker	12.0	12.7
Physical activity		
Inactive	10.5	9.5
Low	11.1	11.1
Moderate	9.2	9.1
High	11.1	12.4
BMI category (kg/m^2)		
Underweight (<18.50)	19.7	23.5
Healthy (18.59 - 24.99)	12.0	12.7
Overweight (25.09 - 29.99)	7.6	10.7
Obese (30.00 or more)	7.1	7.8
Use of illicit drugs		
Never	7.3	8.3
Only ever used Marijuana (not in last 12 mths)	10.0	11.5
Only ever used Marijuana (used in last 12mths)	12.0	13.6
Used multiple/single drug other than Marijuana (not last 12 mths)	15.4	14.0
Used multiple/single drug other than Marijuana (≥ once last 12 mths)	15.2	16.8

There were few consistent differences in use of the withdrawal method by health risk behaviours apart from a trend for higher use by women who were underweight or who used illicit drugs. See Appendix 11.3.2 for more description.

3.4.5 Use of the fertility awareness period method or emergency OCP

Chapter 2 showed the overall prevalence of the fertility awareness period method (around 5%) or use of the emergency OCP (1%) between Surveys 5 and 8. Descriptive information about emergency OCP use can be found in Appendix 11.3.3.

3.4.6 Use of no contraception

Chapter 2 showed the overall prevalence of use of no contraception was 30% when women were aged 18 to 23, and dropped slightly over the next few surveys before rising to 27% by the time the women were 40 to 45 years. The following tables show the associations between use of no contraception at the baseline and most recent surveys by these factors (Table 3-19 and Table 3-20). Detailed descriptions of these associations at the baseline and most recent surveys, as well as descriptions of interesting trends between the surveys are also included.

Table 3-19 Prevalence of use of no contraception according to socioeconomic factors among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Area of residence		
Major city	32.8	26.9
Inner regional	29.9	30.3
Outer regional	26.5	25.6
Remote/very remote	19.2	12.2
Highest qualification		
Less than year 12	26.9	31.2
Year 12	33.3	28.3
Certificate/diploma/trade	24.9	28.1
University degree	28.6	26.4
Marital status		
Married	14.1	21.5
Defacto	6.5	32.4
Separated/divorced/widowed	40.0	34.6
Never married	35.2	39.9
Manage on income		
It is easy	35.9	24.8
It is not too bad	31.1	26.7
It is difficult some of the time	27.8	27.9
It is difficult all of the time	27.7	31.6

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
It is impossible	37.2	29.4
Labour force participation[a]		
Part-time	26.6	23.8
Full-time	20.7	28.6
Unemployed/not in labour force	31.6	31.2
Country of birth		
Australia	30.0	26.5
Other English-speaking country	25.5	31.1
Europe	41.0	28.6
Asia	68.3	42.2
Other	30.0	33.3
Language spoken at home		
English, born in Australia	29.0	26.7
English, born outside Australia	28.4	31.5
European language	50.0	24.4
Asian language	72.3	36.4
Other language	66.7	43.8

[a] Asked at Survey 3

Socioeconomic factors

At Survey 1, use of no contraception was highest in women living in major cities and inner regional areas (about 31%), 26% in those living in outer regional areas and 19% in those in remote areas. Over the next few surveys use by women living in major cities and regional areas then dropped to percentages in the low twenties before rising to about 28% at Survey 8. For women living in remote areas, use rose by about 8% between Survey 3 and Survey 4, before dropping to 12% by Survey 8.

Use of no contraception was around 30% at Survey 1, and about 28% at Survey 8 in women regardless of their level of attained education.

Associations between use of no contraception and marital status were mixed. At Survey 1, no use of contraception was highest, at 35%, in never married women, and much lower, 14% and 7% in women who were married or in a de facto relationship,

respectively. For never married women, percentage use of no contraception dropped to be in the low twenties throughout Surveys 2 to 5 before rising to 40% at Survey 8. Women who were married showed their highest use of no contraception at Survey 3 (27%) before this dropped to 22% by Survey 8. In women in a de facto relationship, use of contraception was less than 20% until Survey 5, when it rose to 32% by Survey 8. Due to low numbers, data on women who were separated or divorced could only be used from Survey 3 and Survey 5 onwards, respectively. For women who were separated, use ranged from 32% at Survey 3, 18% at Survey 4 and then 33% by Survey 8. For divorced women, use of no contraception was 26% at Survey 5 and then rose to 34% by Survey 8.[9]

Use of no contraception at Survey 1 was 36% in women who found it easy to manage on their income, and around 29% in women who found 'not too bad', 'difficult some of the time' or 'difficult all of the time'. At Survey 8, use of no contraception was between 25% and 32% in women regardless of how well they managed on their income.[10]

Use of no contraception was about 18% (at Survey 2) in women who worked full-time or part-time and 32% in women who were not in the labour force (at Survey 3). By Survey 8 use of no contraception was around 30% for women who worked full-time or were not in the labour force and 24% for women who worked part-time.

Use of no contraception was around 28% at Survey 1 and 8 in women who were born in Australia or another English-speaking country.[11]

Women who spoke a European language at home had a higher rate of using no contraception at Survey 1 (50%), compared to women who spoke English (28%). Use of no contraception then ranged between 17% and 26% over the subsequent few surveys for all women. By Survey 8, between 24% and 32% of women who spoke a

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[9] *There were too few women who were widowed to make meaningful interpretations.*

[10] *Note: There were too few women who found it impossible to manage on their oncome to make meaningful interpretations.*

[11] *Note: There were too few women who were born in Europe, Asia or another non-English speaking background country to make meaningful interpretations.*

European language or English (regardless of where they were born) did not use contraception.

Table 3-20 Prevalence of use of no contraception according to health risk behaviours among women born 1973-78 at their baseline and most recent surveys

	Survey 1 (1996) Aged 18-23 %	Survey 8 (2018) Aged 40-45 %
Alcohol consumption		
Low risk drinker	25.4	24.8
Non-drinker	61.1	36.2
Rarely drinks	35.1	28.8
Risky drinker	18.0	27.8
Smoking		
Never smoked	37.7	27.0
Ex-smoker	21.3	27.0
Current smoker	19.9	27.4
Physical activity[a]		
Inactive	20.1	29.8
Low	20.1	30.3
Moderate	15.6	23.9
High	17.6	24.5
BMI category (kg/m^2)		
Underweight (<18.50)	32.2	23.5
Healthy (18.59 - 24.99)	28.8	24.7
Overweight (25.09 - 29.99)	32.1	27.8
Obese (30.00 or more)	43.8	29.5
Use of illicit drugs[a]		
Never	23.6	28.0
Only ever used Marijuana (not in last 12 mths)	12.9	23.6
Only ever used Marijuana (used in last 12mths)	13.7	20.5
Used multiple/single drug other than Marijuana (not last 12 mths)	14.5	30.2
Used multiple/single drug other than Marijuana (≥ once last 12 mths)	14.6	25.5

[a] Asked at Survey 2

Health risk behaviours

At Survey 1, use of no contraception was highest in women who were non-drinkers (61%) followed by those who drank alcohol rarely (35%), at low risk levels (25%) or risky levels (17%). By Survey 8, use was around 25% for women who drank alcohol at low risk or risky levels and 30% for those who drank rarely. Use of no contraception was highest at Survey 8 for those who did not drink (36%).[12]

Use of no contraception at Survey 1 was higher in women who were non-smokers (38%) compared with smokers and ex-smokers (around 20%). For all women, use of no contraception at Survey 8 was about 27%.

Use of no contraception was around 18% at Survey 2, and between 24% and 30% at Survey 8 in women regardless of how much physical activity the woman did.

Use of no contraception at Survey 1 was higher in women with a BMI in the obese category (44%), followed by those with a BMI in the underweight, healthy weight or overweight categories (about 30%). Use of no contraception was between 24% and 29% at Survey 8 by all women regardless of their BMI.

Use of no contraception at Survey 2 was highest in women who had never used any illicit drug (24%) and about 14% in women who had used marijuana or illicit drugs, regardless of when. At Survey 8, use of no contraception was between 24% and 30% in women regardless of their drug use.

3.5 Previously published ALSWH research

Several authors have examined contraceptive use by women in the ALSWH 1973-78 cohort. A brief summary of the key findings from studies over the past 10 years and their implications for policy is presented here.

Lucke and Herbert (2014) examined factors associated with the uptake of long-acting reversible (implant, IUD, injection); permanent (tubal sterilisation, vasectomy), and traditional (OCP, condoms, withdrawal, fertility awareness period) contraceptive

[12] *Note: There were too few women who were high risk drinkers to make meaningful interpretations about their use of no contraception.*

methods among 5,849 women in the 1973-78 cohort who responded to Surveys 3, 4 and 5.

Compared to women living in major cities, women in inner regional areas were more likely to use long-acting (OR =1.26, 95%CI 1.03-1.55) or permanent contraceptive methods (OR=1.43, 95%CI 1.17-1.76). Women living in outer regional or remote areas were more likely than women living in cities to use long-acting (OR=1.65, 95%CI 1.31-2.08) or permanent contraceptive methods (OR=1.69, 95%CI 1.43-2.14). Women with a baby were less likely to use LARC (OR=0.37, 95%CI 0.23-0.58) or permanent contraceptive methods (OR=0.16, 95%CI 0.09-0.29), and women with school aged children were more likely to be using LARC (OR=1.83, 95%CI 1.43-2.33) or permanent contraceptive methods (OR=4.39, 95%CI 3.54-5.46) compared with women with pre-school aged children. The likelihood of using LARC and permanent contraceptive methods increased with the number of children a woman reported having. Married women were more likely to use permanent contraceptive methods compared with those who were single or living with a partner. Use of LARC methods (but not permanent methods) was associated with a BMI category of overweight or obese. Women were more likely to use permanent contraceptive methods if they reported poorer access to a GP (OR=1.27, 95%CI 1.07-1.52) compared to those who reported excellent or good access to a GP. The finding of higher use of LARC and permanent contraceptive methods by women living outside major cities had not previously been reported in a non-clinical sample. The authors speculated that increased use may reflect that fertility levels are higher outside of major cities and that LARC methods may be the preference for women who do not have easy regular access to GPs or pharmacies.

3.6 Summary

This chapter has presented the prevalence of use of different types of contraception among women in Australia by socioeconomic and health behaviour characteristics. The analyses are simple unadjusted cross sectional associations. Longitudinal analyses focussed on LARC use are presented in Chapter 5. There were mixed associations between socioeconomic factors and contraception use between cohorts. Of women in the 1989-95 cohort, higher socioeconomic status (reflected by higher

levels of education and less income stress) was associated with greater use of the OCP and condoms, and less use of the implant or no contraception, in contrast to the 1973-78 cohort, where these associations were not found. Women in the 1989-95 cohort living in remote or rural areas had a higher prevalence of implant use or no use of contraception. In comparison, women born in 1973-78 who lived in rural and remote settings had higher use of the OCP. In both cohorts, women who spoke a non-English language at home had higher use of condoms and no use of contraception. A general trend found in both cohorts with respect to health behaviour characteristics was that women who reported engaging in less healthy behaviours (e.g., illicit drug use, smoking, low physical activity) or had a BMI in the overweight or obese categories were more likely to not use contraception.

3.7 References

Lucke J & Herbert D. (2014). Higher uptake of LARC and permanent contraceptive methods by Australian women living in rural and remote areas. *Australian & New Zealand Journal of Public Health*, 38(2): 112-116.

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