16 February 2024

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Senate Committee,

SPHERE, the NHMRC Centre of Research Excellence in Women's Sexual and Reproductive Health in Primary Care, is a collaborative research centre comprising national and international experts in sexual and reproductive health.

The National Women's Sexual and Reproductive Health Coalition, led by SPHERE, was formed in 2020 to advocate for improved and equitable women's sexual and reproductive health care in Australia. The Coalition is a cross-sectoral, multidisciplinary alliance comprising over 150 clinician experts, consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers who have a **shared vision for improving women's sexual and reproductive health**. The Coalition includes national and international representatives from universities, government, industry and peak bodies.

Achieving the sexual and reproductive health outcomes set by the National Women's Health Strategy is an urgent priority for all Australians. We applaud the Australian Parliament for its support in establishing this inquiry, and below we summarise key evidence and our recommendations relating to the intersection of pregnancy, contraception, and abortion, with menopause and perimenopause.

1. The risk of unintended pregnancy and abortion among women in later reproductive years

Fertility in women significantly declines after 44 years of age, nonetheless, conceptions in later reproductive years do occur. Women in the perimenopausal age group are often unaware of their risk of pregnancy as they underestimate their fertility, are unaware of their need to use contraception, or mistakenly believe that menopausal hormone therapy is contraceptive (Cho, 2018; McNamee & Bateson, 2017). Previous US research indicates that women aged 40-44 years have the second highest rate of unintended pregnancy after the age group under 25 years (Finer et al., 2011). In addition, Australian research reports that 43% of participants who reported an unintended pregnancy in the previous ten years were aged over 30 years (Taft et al., 2018). Pregnancies over the age of 40 carry significant maternal and neonatal risks including increased risk of chromosomal abnormalities, miscarriage and premature delivery as compared to younger women (Frederiksen et al., 2018). Unintended pregnancies can have serious consequences for women and their families, including adverse maternal and neonatal outcomes (Omani-Samani et al., 2019), psychological distress (Sasaki et al., 2022), and reduced quality of life (Schwarz et al., 2008). In addition, the costs of an unintended pregnancy can put significant financial pressures on individuals, their families, communities, and our economy (Organon, 2022) The proportion of pregnancies resulting in induced abortion is greater for younger and older age groups including women >44 years (Family Planning NSW).

2. Ensuring access to contraceptive counseling and suitable contraception for perimenopausal women.

Contraception is an important consideration during a perimenopausal-related consultation. Guidelines for healthcare providers in Australia and other countries suggest that women over the age of 40 should be informed that effective contraception is still required until after menopause to prevent unintended pregnancies (Australasian Menopause Society; McNamee & Bateson, 2017; Family Planning Victoria). Women of older reproductive age may also experience perimenopausal symptoms including heavy and irregular menstrual bleeding that can be effectively managed with hormonal contraceptives (McNamee & Bateson, 2017). Suitable perimenopausal contraceptives include progestogen only products. These include long-acting reversible contraception (LARC) methods such as the implant and progestogen containing intrauterine devices (IUDs) and also the progestogen only pill (POP). Slinda (a drospirenone containing POP) is the favoured oral approach to perimenopausal contraception because of its beneficial effects in relation to bleeding control and that it does not contain oestrogen. However, it is not currently available on the PBS and therefore means that one of the best perimenopausal contraceptives incurs significant out of pocket cost for women ($76.99 for 3 months at chemist warehouse (PBS listed medication costs up to $31.60 or $7.70 if you have a concession card)) potentially putting it out of reach of many women experiencing cost of living pressures .

The SPHERE Coalition has advocated strongly that there should be no out of pocket costs for contraception (SPHERE Coalition, 2023) and also for the implementation of policy that supports increased uptake of LARCs to prevent unintended pregnancy and reduce the need for abortion in Australia (SPHERE Coalition, 2022). The use of IUDs like Mirena are recommended for the management of heavy menstrual bleeding and for endometrial protection with menopause hormone therapy (Pearson et al., 2022). Despite the long-term cost-effectiveness of LARC methods, the upfront costs and multiple appointments required for LARC insertion can make this unaffordable for many women (Mazza et al., 2017).

We make the following recommendations in relation to contraception and the use of LARC in the management of perimenopausal symptoms:

- Regional level planning by Primary Health Networks (PHNs) that involves:
  - Development of an integrated regional approach to contraception care.
  - Identifies gaps in service provision at a local level by mapping the availability of services.
  - Commissions health services to fill those gaps, including the establishment of training in community settings, and map the availability of services.

- Increase access to long-acting reversible contraceptives (LARC):
  - Incentivise and fund GPs and other health practitioners to undertake LARC insertion/removal training in areas of need, as identified by regional reporting.
  - Appropriately remunerate health professionals for LARC insertion and removal.

- Provide no cost contraception for women (including costs associated with LARC insertion and removal

- Maintain locally administered public funds to assist patients to cover indirect costs of abortion where services are not provided in the local public hospital.

- MBS support for medical abortion and LARC insertion through increased rebates and appropriate remuneration:
  - Continue to support telehealth rebates for sexual and reproductive health through the MBS.

- Provide appropriate remuneration for healthcare practitioners.
- Subsidise costs for medical equipment for contraception services.
- Introduce new MBS item numbers for consultations for non-medical health practitioners to facilitate task-sharing of early medical abortion and LARC insertion/removal.

- Expand scope of practice of health practitioners:
  - Ensure LARC provision and administration is included in the scope of practice of nurses, midwives, Aboriginal Health Practitioners and pharmacists.
  - Develop appropriate funding models that support scope of practice, including rebates, remuneration and subsidies for different health practitioners.

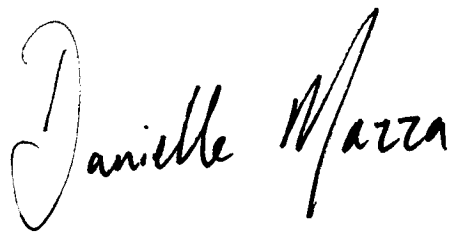
- Workforce training and support:
  - Embed training in contraceptive counselling, and insertion/removal of LARC in all obstetrics and gynaecology, GP, practice nurse, nurse practitioner and midwife training programs.
  - Provide continued funding of the AusCAPPS community of practice

- Incentivise workforce training in areas of need:
  - Provide incentives and fund GPs and other health practitioners to undertake training. in contraception care as identified by regional planning.

- Improve health literacy about contraception and emergency contraception among community members (including development of resources in easy-English and other languages).

I would be happy to present to the committee on these issues and answer any questions the committee may have. Please do not hesitate to reach out

Sincerely,



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Chair, SPHERE Coalition

The SPHERE Coalition meets monthly to discuss, gather, synthesise and disseminate evidence relating to women's sexual and reproductive health care. Over the last two years they have produced over 12 consensus statements on issues relating to equitable access to contraception that add further evidence to this inquiry. Our consensus statements can be found here, and include the following:

Contraception-related issues:

- Increasing access to effective contraception in Australia: A consensus statement
- Coalition consensus statement on the provision of long-acting reversible contraception during the COVID-19 pandemic - Updated statement
- Shortage of norethisterone-containing pills in Australia: Advice for GPs - Updated statement
- Contraceptive method considerations for individuals with active COVID-19 infection: a consensus statement
- Provision of emergency contraception: a consensus statement
- A consensus statement on 52 mg Levonorgestrel-releasing IUD as emergency contraception: examining the evidence

Abortion-related issues:

- A consensus statement on achieving equitable access to abortion care in regional, rural and remote Australia
- Using telehealth to provide early medical abortion during the COVID-19 pandemic and beyond: a consensus statement
- Evidence-based practice and policy recommendations regarding early medical abortion: a consensus statement
- Nurse and midwife-led provision of mifepristone and misoprostol for the purposes of early medical abortion: a consensus statement
- A consensus statement on publicly funded abortion service provision: a duty of care

Reproductive coercion:

- A consensus statement on reproductive coercion

National Women's Health Strategy 2020-2030:

A consensus statement on implementation and monitoring of the National Women's Health Strategy 2020-2030: 'Maternal, sexual and reproductive health' priority area