Organon ANZ

Submission to the Senate Inquiry into Universal Access to Reproductive Healthcare

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Introduction

Organon welcomes the Senate Inquiry into the universal access to reproductive healthcare and the barriers to achieving priorities under the National Women's Health Strategy and is pleased to provide a submission.

We would welcome the opportunity to answer any questions about this submission, other related issues, or to provide further information on any of the areas covered. Please let us know if we can be of further assistance in this inquiry, by contacting Luke Cornish on or Sam Howes on .

This submission may be published.

Summary of recommendations

Recommendation 1: *Collect and publish national data on contraceptive use, live births, miscarriage, and abortion, to inform policy goals and achievable outcomes.*

Recommendation 2: *Launch public health campaigns aimed at improving public contraceptive literacy, with reference to health practitioners, women and girls, and parents.*

Recommendation 3: *Make available fully funded training for registered nurses, midwives and nurse practitioners on contraceptive counselling, and insertion and removal of LARC devices, to allow task shifting to nurses in contraception, and alleviate pressure on the primary health system.*

Recommendation 4: *Reimburse registered nurses, midwives and nurse practitioners for the insertion and removal of LARC devices to provide Australian women with greater access to contraceptive choice.*

Recommendation 5*: Renumeration of GPs for a contraception consultation – additional MBS item number to permit time for clinicians to have a full discussion of all contraception options.*

Recommendation 6*: Remove barriers to contraceptive access by providing free contraception to women under 25 years.*

Summary

Unintended pregnancy is a major health issue in Australia, and an area of unmet need for Australian women. An unintended pregnancy may be an unwanted pregnancy, where no child was desired at all, or a mistimed pregnancy, where a pregnancy occurred earlier than wanted.[1]

It is estimated that one in four of all pregnancies are unintended.[2] Planned parenthood has important health benefits for both maternal and infant health.[3] Women living in rural and remote areas are 1.4 times more likely to experience an unintended pregnancy, suggesting that access to contraception and abortion services remains a problem in those areas.[4]

The negative consequences of unintended pregnancies can be prevented by facilitating a system that allows women to determine their own reproductive choices. Delivering universal access to sexual and reproductive health information, as well as offering options to women to empower choice and control in reproductive decisions - including contraception - forms part of the National Women's Health Strategy (2020-2030); hereafter, 'the Strategy'.

Under the Strategy, "*three key priority areas for action have been identified to improve maternal, sexual and reproductive health for Australian women and girls*". They are:

> ***1. Increased access to sexual and reproductive health care information, diagnosis, treatment and services;***
> *2. Increase health promotion activity to enhance and support preconception and perinatal health; and;*
> *3. Support for enhanced access to maternal and perinatal health care services.*[5]

The Strategy also classifies a 'key measure of success' as an 'increase in the availability and uptake of Long-Acting Reversible Contraception (LARCs)'.[6] The Strategy highlights the need for women to be supported with knowledge of all their contraceptive options.

The ability for women to decide if and when they want to have children is a basic human right and central to empowerment, reducing poverty, and achieving sustainable development.[7]

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[1] Bahk J, Yun S-C, Kim Y-m, Khang Y-H. Impact of unintended pregnancy on maternal mental health: a causal analysis using follow up data of the Panel Study on Korean Children (PSKC). BMC Pregnancy and Childbirth. 2015;15(1):85.

[2] Taft AJ et al. Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. Med J Aust. 2018; 209(9); 407-408.

[3] Ibid.

[4] Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Prevalence and distribution of unintended pregnancy: the Understanding Fertility Management in Australia National Survey. Australian and New Zealand Journal of Public Health. 2016;40(2):104-9.

[5] Commonwealth of Australia, Department of Health, National Women's Health Strategy 2020-2030. 2018; 23 (emphasis added).

[6] Ibid.

[7] International Federation of Gynecology and Obsetrics. Contraception and its benefits. 2021. Available at: https://www.figo.org/contraception-and-its-benefits [Date accessed: 10 Nov 2022].

This submission seeks to outline the unmet need illustrated by Australia's high rates of unintended pregnancy, the barriers preventing higher LARC uptake, and potential solutions to overcome these barriers.

For the sake of this submission, 'women' takes the meaning of all people who identify as women. We recognise that contraceptive care applies to people with a uterus also.

High LARC uptake is widely regarded as a solution to unintended pregnancy

Long-Acting Reversible Contraception (LARC), such as the contraceptive implant and intrauterine devices, are more than 99 per cent effective and enable rapid return to usual fertility upon removal.[8] Their success in preventing unintended pregnancy may be a result of not requiring a person to do anything on a daily basis or when they have sex to protect against pregnancy.[9] A 2016 study found that 73 per cent of women who experience an unplanned pregnancy were using at least one form of contraception, with the oral contraceptive pill the most frequently cited (39 per cent).[10]

Research and international examples suggest that LARC use reduces the incidence of unintended pregnancy,[11] and that LARC users have high continuation and satisfaction rates.[12] Clinical guidelines, opinion leaders and peak bodies both in Australia and internationally recommend the increased use of LARC.[13][14] Presumably, it is for this reason that an increase in LARC uptake in Australia has been made a priority of the Strategy.

Despite this national focus, LARC uptake in Australia is on the decline.[15] Urgent government intervention is required to reverse this trajectory.

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[8] Family Planning NSW. Long Acting Reversible Contraception (LARC) Fact Sheet. 2018. Available at: https://www.fpnsw.org.au/factsheets/individuals/contraception/long-acting-reversible-contraception-larc [Date accessed: 10 Nov 2022].

[9] Ibid.

[10] Coombe J. et al. Contraceptive use at the time of unintended pregnancy: Findings from the Contraceptive Use, Pregnancy Intention and Decisions study. *Australian Family Physician*. 2016; 45(11):842-48.

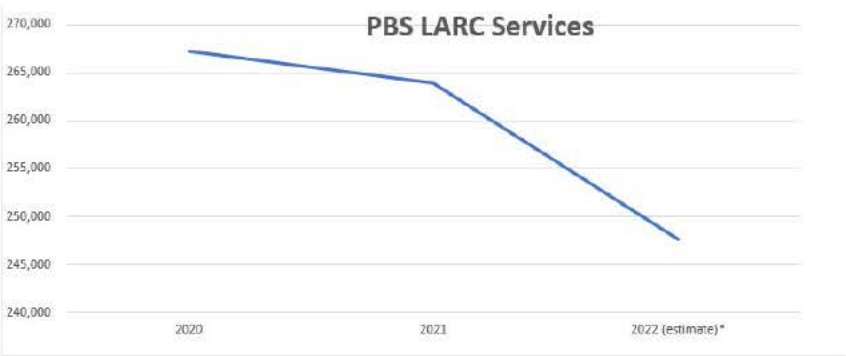
[11] Secura G, Madden T, McNicholas C et al. Provision of no-cost, long-acting contraception and teenage pregnancy. N Engl J Med. 2014; 371(14):1316-23.

[12] Peipert F.J, Zhao Q, Allsworth J, Petrosky E, Madden T, Eisenberg D, et al. Continuation and Satisfaction of Reversible Contraception. Obstet Gynecol. 2011; 117(5); 1105-1113.

[13] Family Planning Alliance Australia. Long acting reversible contraception (LARC): Position Statement. 2014. Available at: https://www.familyplanningallianceaustralia.org.au/wp-content/uploads/2014/11/24448-Family-Planning-A4-Flyer_Proof3.pdf [Date accessed: 10 Nov 2022]

[14] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Long acting reversible contraception. Melbourne: July 2017.

[15] Medicare Statistics website. Available at: http://medicarestatistics.gov.au/statistics/pbs_item [Date accessed: 10 Nov 2022].



	2020	2021	2022 (estimate)*
Total LARC PBS Services	267,267	263,882	247,658

*2022 has been annualised due to availability of PBS data until August 2022

Source: *Medicare Statistics website (http://medicarestatistics..gov.au/statistics/pbs item.jsp)*
Data: *IMPLANON-NXT, KYLEENA and MIRENA PBS & RPBS Items processed from January 2020 to August 2022*

Terms of Reference E: Sexual and reproductive health literacy.

Recommendation 1: Collect and publish national data on contraceptive use, live births, miscarriage and abortion, to inform policy goals and achievable outcomes.

In 2022, Organon ANZ commissioned a whitepaper measuring the extent and impact of unintended pregnancy in Australia, prepared by HTAnalysts.[16] This research found that 40 per cent of all pregnancies in 2020 were unintended, and that the costs to women, government, and employers were substantial.[17]

There is limited national data on unintended pregnancy available in Australia, particularly for Aboriginal, Torres Strait Islander and remote populations. Accordingly, to develop this report, key opinion leaders and experts in the field of reproductive and sexual health were consulted to inform the selection of the most appropriate data sources and methodological approach.[18] Whilst this whitepaper was an important step forward in collating and assessing resources on unintended pregnancy, collecting, and reporting national data remains a significant barrier.

On contraception use, data to inform policy and practice changes is currently drawn from the PBS (reimbursed medicines only, no data from the private market; copper IUDs are classed as medical devices and so excluded from the data), the MBS (only procedures where benefits are claimed; no data from public hospitals or private clinics), surveys and quantitative studies.[19]

It is similarly challenging to estimate the abortion rate in Australia, as most states and territories do not frequently report abortion data, and published national data have been incomplete.[20]

To effectively inform policy and practice changes, robust data on current prescription and use of contraceptives in Australia are required.[21] National data should also include epidemiological data of live births, abortions, still births, miscarriage, with particular reference to Aboriginal, Torres Strait Islander and remote populations. The reporting of this data on an annual basis should be mandated.

This national resource should inform the Australian government's approach towards sexual and reproductive health policy, and measure the success of any policy interventions.

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[16] HTAnalysts on behalf of Organon, 'Impact of unintended pregnancy.' June 2022, Available at: https://www.organon.com/australia/wp-content/uploads/sites/16/2022/09/ORG01_Report_FINAL_28June2022.pdf [Date accessed: 10 Nov 2022].

[17] Ibid.

[18] Ibid.

[19] Australian Healthcare and Hospitals Association. Consensus statement. 2017. Available at: https://www.shinesa.org.au/media/2018/03/Consensus_statement_Reducing-Unintended-Pregnancy.pdf [Date accessed: 10 Nov 2022].

[20] Keogh LA, Gurrin LC, Moore P. Estimating the abortion rate in Australia from National Hospital Morbidity and Pharmaceutical Benefits Scheme data. Med J Aust. 2021;215(8):375-6.

[21] Mazza D, Bateson D, Frearson M, Goldstone P, Kovacs G, Baber R. Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. Aust NZJ Obstet Gynaecol. 2017; 57: 206-212.

Terms of Reference A. ii. Awareness and availability of long-acting reversible contraceptive options

Recommendation 2: Launch public health campaigns aimed at improving public contraceptive literacy, with reference to health practitioners, women and girls, and parents.

Australia has relatively low uptake of LARC by international standards.[22] While there is no routine national data collection on contraception available, survey data has suggested that contraceptive implants, intrauterine devices (IUD) and injectable contraceptives are used by fewer than 10 per cent of Australian women.[23] By comparison, in the UK, it was found that 46 percent of women in contact with sexual and reproductive health services for contraception were using a LARC, with LARC uptake increasing over the past ten years.[24] It is estimated that 30 per cent of women in Sweden use a LARC.[25]

Key opinion leaders and clinicians often reference a lack of information, and misinformation, when discussing low LARC uptake in Australia.[26] Previous research identifies a lack of awareness about LARCs among women.[27] Research suggests that achieving global benchmarks of LARC uptake will only be achieved if misperceptions of risks relating to LARCs amongst health professionals and consumers are addressed.[28]

Despite efforts to implement a 'LARC first' approach to clinical practice, a recent survey of women's attitudes towards contraception found that LARC was considered 'a serious' contraception, and only considered after dissatisfaction with other methods - usually the pill - if at all.[29]

In their qualitative study of Australian women and health care professionals' views on LARC, Garrett et al. found that mothers and healthcare providers *'were implicated in frequently passing on misinformation about IUDs.'*[30] They noted the importance of

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[22] Family Planning Alliance Australia. Long acting reversible contraception (LARC): Position Statement. 2014. Available at: https://www.familyplanningallianceaustralia.org.au/wp-content/uploads/2014/11/24448-Family-Planning-A4-Flyer_Proof3.pdf [Date accessed: 10 Nov 2022].

[23] Ibid.

[24] National statistics, Sexual and Reproductive Health Services England (Contraception) 2019/20: Part 2: Methods of contraception. 10 December 2020, Available at: https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2019-20/methods-of-contraception [Date accessed: 10 Nov 2022].

[25] Hellstrom A, Danielsson K, Kallner H. Trends in use and attitudes towards contraception in Sweden: results of a nationwide survey. The European Journal of Contraception & Reproductive Health Care, 2019; 24(2):154-160.

[26] Bateson D, Harvey C, Williams J, Black K. Intrauterine contraception: why are so few Australian women using this effective method. MJA. 2011; 194(6):324.

[27] Spies E, Natoshia M, Askelson MPH, Gelman E, Losch M, Young Women's Knowledge, Attitudes, and Behaviours Relating to Long-Acting Reversible Contraceptives. Women's Health 2010; 20(6):394-399.

[28] Bateson D, Harvey C, Williams J, Black K. Intrauterine contraception: why are so few Australian women using this effective method. MJA. 2011; 194(6):324.

[29] Coombe J, Harris ML, Loxton D. Examining long-acting reversible contraception non-use among Australian women in their 20s: findings from a qualitative study. Cult Health Sex. 2019;21(7):822-836.

[30] Garrett CC et al. Understanding the low uptake of long-acting reversible contraception by young women in Australia: a qualitative study. BMC Women's Health 2015; 15:72.

educating both young women and health care professionals on LARC, as well as parents of children, to prevent this misinformation.[31]

It is for this reason that a wide-reaching public campaign on contraception is necessary. Access to clear information on the benefits and limitations of various contraceptive methods is imperative to promote informed contraceptive choice, and to overcome misperceptions and myths broadly perpetuated in the community.[32]

Previous consensus statements have called for a public health campaign to include targeted and accessible information for vulnerable groups that raises awareness of unintended pregnancy, effective prevention available, and methods of access.[33]

A public health campaign combating misinformation about contraception including links to credible public health sources through social and digital media channels would improve public contraceptive literacy.

[31] Ibid.

[32] Mazza D, Bateson D, Frearson M, Goldstone P, Kovacs G, Baber R. Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. Aust NZJ Obstet Gynaecol. 2017;57: 206-212.

[33] Australian Healthcare and Hospitals Association. Consensus statement. 2017. Available at: https://www.shinesa.org.au/media/2018/03/Consensus_statement_Reducing-Unintended-Pregnancy.pdf [Date accessed: 10 Nov 2022].

Terms of Reference C. iii) Workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals.

Recommendation 3: Make available fully funded training for registered nurses, midwives and nurse practitioners on contraceptive counselling, and insertion and removal of LARC devices, to allow task shifting to nurses in contraception, and alleviate pressure on the healthcare system.

The limited number of health care practitioners that are currently willing and able to provide long-acting reversible contraception remains a barrier to women accessing care. This number of practitioners could be increased by task-sharing contraception care with appropriately trained registered nurses, nurse practitioners and registered midwives.[34]

A recent study examining the role of midwives in a hospital setting saw 27 midwives successfully upskill in the insertion of contraceptive implant devices.[35] This research found that midwives were well placed to provide contraceptive counselling and carry out contraceptive implant insertions for women post-partum.[36] The research also suggested this task-sharing may reduce pressures on other medical staff.[37]

An earlier study saw nurses successfully trained in the insertion and removal of contraceptive implants in a hospital setting, and supervising doctors were unanimous in their agreement that nurses could *'play a greater role in the provision of contraceptive implant procedures in Australia.'*[38]

It is estimated that over 60 per cent of general practice clinics employ at least one nurse who undertakes a number of preventative care activities on behalf of the general practitioner, including pap smears and chlamydia tests.[39] These primary care nurses could alleviate pressure from general practitioners and address patient needs by providing LARC education and the insertion and removal of contraceptive implant devices.[40]

Abroad, nurses play a greater role in contraception care. In Sweden, most contraception prescriptions are issued by nurse midwives, only a small number by

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[34] NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care (SPHERE), Women's Sexual and Reproductive Health Coalition Policy Recommendations for the 2022 election. 2022. Available at: https://www.spherecre.org/coalition [Date accessed: 10 Nov 2022].

[35] Botfield J, Tulloch M, Contziu H, Wright S, Phipps H, McGeechan K, Bateson D, Black K. Feasibility, acceptability, and sustainability of postpartum contraceptive implant provision by midwives in NSW public Hospitals. Women Birth. 2022; 35(5):e439-e445.

[36] Ibid.

[37] Ibid.

[38] Botfield J, Wright S, Fenwick S, Cheng Y. Training nurses in contraceptive implant procedures: implications for practice in Australia. Collegian. 2021; 28(1):114-120.

[39] Garrett CC et al. Understanding the low uptake of long-acting reversible contraception by young women in Australia: a qualitative study. BMC Women's Health 2015; 15:72.

[40] Ibid.

gynaecologists, and almost none by general practitioners. [41]

To facilitate greater participation in contraception care, training for nurses, nurse practitioners and midwives must be fully accessible, including for the insertion and removal of LARC devices. This task shifting would relieve pressure on the healthcare system.

[41] Hellstrom A, Danielsson K, Kallner H. Trends in use and attitudes towards contraception in Sweden: results of a nationwide survey. The European Journal of Contraception & Reproductive Health Care. 2019; 24(2):154-160.

Terms of Reference C. iii) Workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals.

Recommendation 4: Reimburse registered nurses, midwives and nurse practitioners for the insertion and removal of LARC devices to provide Australian women with greater access to contraceptive choice.

Currently, the MBS items relating to the insertion and removal of LARC devices are only available to doctors. Whilst nurses, midwives and nurse practitioners can insert LARC devises once trained to do so,[42] they do not have access to the MBS item number for this service.

The creation of effective funding models for LARC insertions and removals performed by nurses, midwives and nurse practitioners has been previously recommended.[43] It remains an essential step to increase LARC uptake in Australia.

[42] Pearson S, Stewart M, Bateson D. Implanon NXT: Expert tips for best-practice insertion and removal. Aust Fam Physician 2017;46(3):104-108.

[43] Mazza D, Bateson D, Frearson M, Goldstone P, Kovacs G, Baber R. Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. Aust NZJ Obstet Gynaecol. 2017; 57: 206-212.

Terms of Reference C. iii) Workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals.

Recommendation 5: Renumeration of GPs for a contraception consultation – additional MBS item number to permit time for clinicians to have a full discussion of all contraception options

Accepting that one of the key barriers to LARC use in Australia is patient and clinician education, incentivising general practitioners to discuss all contraceptive options with women presenting for contraception may assist overcoming this barrier in a primary health setting.

The UK has engaged in similar policy intervention. The British National Health Service (NHS) introduced policy reform in primary care through a 'pay-for performance' (P4P) scheme that linked primary care practices' income to performance targets.[44] Revised targets introduced in 2009-2010 remunerated primary care physicians to offer full choice of contraception, including advice about LARC to women aged 13 to 54 years attending for contraceptive care.[45]

Researchers examining the success of the program found a 13.4 per cent increase in LARC uptake, and a 38.3 per cent reduction in the abortion rate compared with what would have been expected without the scheme, following the introduction of the policy.[46]

It is important to ensure that any incentive introduced is controlled and monitored to prevent any form of coercion.

Women in Britain have access to free contraception.[47] This is an important consideration when assessing the suitability of a similar scheme in Australia. However, some have previously noted that adoption of a similar model to the UK's, but with increased and realistic MBS rebates, may improve GP participation in LARC provision.[48]

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[44] Ma R, Cecil E, Bottle A, French R, Saxena S. Impact of a pay-for-performance scheme for long-acting reversible contraceptive (LARC) advice on contraceptive uptake and abortion in British primary care: An interrupted time series study. PLoS Med 17(9): e1003333.

[45] Ibid.

[46] Ibid.

[47] Ibid.

[48] Mazza D, Bateson D, Frearson M, Goldstone P, Kovacs G, Baber R. Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. Aust NZJ Obstet Gynaecol. 2017; 57: 206-212.

Terms of Reference A. Cost and accessibility of contraceptives.

Recommendation 6: Remove barriers to contraceptive access by providing free contraception to women under 25 years.

High up-front costs have been identified as a barrier to LARC use among women.[49] Clinicians, particularly those servicing rural and remote areas of Australia, also identified cost as a barrier to LARC uptake.[50]

A study of Australian women's choice of post-abortion contraception noted that some women, particularly those who are younger or from areas of high socioeconomic disadvantage, may have faced difficulty finding the extra money required for upfront payment of their chosen LARC method.[51]

Providing free contraception services, including medical appointments, associated tests and contraceptive prescriptions, free of charge for young women under 25 years would eliminate this barrier, and has been recommended by SPHERE, NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care.[52]

Similar approaches have been affective in other countries. In the United States, researchers of the Contraceptive CHOICE Project concluded that girls and women who were provided contraception at no cost and educated about reversible contraception and the benefits of LARC methods had rates of pregnancy, birth and abortion that were much lower than national rates for sexually active teens. [53]

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[49] Garrett CC et al. Understanding the low uptake of long-acting reversible contraception by young women in Australia: a qualitative study. BMC Women's Health 2015;15:72.

[50] Mazza D, Bateson D, Frearson M, Goldstone P, Kovacs G, Baber R. Current barriers and potential strategies to increase the use of long-acting reversible contraception (LARC) to reduce the rate of unintended pregnancies in Australia: An expert roundtable discussion. Aust NZJ Obstet Gynaecol. 2017; 57: 206-212.

[51] Goldstone P, Mehta Y, McGeechan K et al. Factors predicting uptake of long-acting reversible methods of contraception among women presenting for abortion. Med J Aust. 2014; 201: 412–416.

[52] NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care (SPHERE), Women's Sexual and Reproductive Health Coalition Policy Recommendations for the 2022 election. 2022. Available at: https://www.spherecre.org/coalition [Date accessed: 10 Nov 2022].

[53] Secura G, Madden T, McNicholas C et al. Provision of no-cost, long-acting contraception and teenage pregnancy. N Engl J Med. 2014; 371(14):1316-23.

Organon

Organon is a global healthcare company formed in June 2021 through a spin-off from Merck & Co., Inc., New Jersey, United States (MSD outside of the United States and Canada). We launched with the vision to create a better and healthier every day for every woman and seek to deliver innovation, improve access, and expand choice to help address the unmet medical needs of women.

Across the globe, women have vast unmet medical needs. For decades, very few companies have dedicated resources to innovation and improving women's health. At Organon, we are guided by our purpose – to help women and girls achieve their promise through better health. By addressing gender-related disparities in health, we are building a more sustainable future for women, families, economies, and society.