Inquiry into universal access to reproductive healthcare

SPHERE

NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

Response to the Inquiry by the Senate Standing Committees on Community Affairs

December 2022

SPHERE
NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

6 December 2022

Senator Janet Rice
Chair, References Committee
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Senator Rice,

The national Women's Sexual and Reproductive Health Coalition, chaired by SPHERE (the SPHERE Coalition), welcomes the opportunity to make this submission to the Senate inquiry into universal access to reproductive healthcare.

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

The SPHERE Coalition is a cross-sectoral, multidisciplinary alliance comprising over 150 clinician experts and consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers with **a shared vision for improving women's sexual and reproductive health**.

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 to identify "*barriers to achieving universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies".*

The SPHERE Coalition has previously dedicated significant time, resources and expertise to the development of a series of evidence-based consensus statements that align closely to the terms of reference for this inquiry, including statements on:

- **Achieving access to effective contraception in Australia**
- **Achieving equitable access to abortion care in regional, rural and remote Australia**
- **Reproductive Coercion**
- **Implementation and monitoring of the National Women's Health Strategy 2020-2030: 'Maternal, sexual and reproductive health' priority area.**

This submission summarises the relevant findings and **30 key recommendations** within these consensus statements and identifies a set of **five imperative actions** to guide national leadership, investment and policy development.

We thank the Reference Committee members for their time and service to the inquiry and would welcome the opportunity to provide further evidence at an upcoming public hearing.

Sincerely,

Danielle Mazza

Professor Danielle Mazza
MD, MBBS, FRACGP, DRANZCOG, Grad Dip Women's Health, GAICD, CF
Chief Investigator and Director, SPHERE
Chair, SPHERE Coalition

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Summary of key recommendations for achieving universal access to sexual and reproductive health information, treatment and services that offer options to women[1] to empower choice and control in decision-making about their bodies.

Imperative actions:

1. Remove barriers to contraceptive access by providing **free contraception** and **incentivising primary care health practitioner training** in contraceptive service provision.

2. Ensure availability of essential sexual and reproductive health services (particularly for rural and regional Australian women) through **regional level planning, training and accountability for contraception and abortion access** via publicly funded community and hospital-based services.

3. Expand the health workforce by **enabling nurses, midwives and pharmacists to work to their full scope of practice in contraception and abortion care**, with appropriate remuneration and training opportunities.

4. Develop **coordinated public health campaigns and related education materials** to improve health literacy around rights and options for accessing effective contraception and abortion care.

5. Formally track progress on delivery of the outcomes of the National Women's Health Strategy by developing a **transparent, comprehensive, nationally agreed implementation plan** and **key performance indicators,** and **report** against these on an annual basis.

[1] The Coalition uses women as an inclusive and broad term that refers to and acknowledges the diversity in needs and experiences of all people who may access and use abortion and women's sexual and reproductive health services including other people who do not identify as women but can experience pregnancy and abortion and may need to access these services

Introduction

"Achieving the sexual and reproductive health outcomes set by the National Women's Health Strategy is an **urgent priority for all Australians**."

The **Centre of Research Excellence in Sexual and Reproductive Health in Primary Care (SPHERE)**, was funded by the National Health and Medical Research Council (NHMRC) in 2018 to advance the delivery of high quality, accessible sexual and reproductive health care for women in Australia through research and knowledge translation in evidence-based practice, workforce development and new models of primary care.

In April 2020, SPHERE led the establishment of the national Women's Sexual and Reproductive Health Coalition (the SPHERE Coalition), a cross-sectoral, multidisciplinary alliance of over 150 clinician experts and consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers.

Prior to the announcement of the *Senate inquiry into universal access to reproductive healthcare* on 28 September 2022, the SPHERE Coalition led a comprehensive process of research and development of a series of evidence-informed consensus statements and policy and practice recommendations in response to the National Women's Health Strategy 2020-2030. These consensus statements are highly relevant to the scope and terms of reference (TOR) for the Inquiry, including:

- **TOR item a: cost and accessibility of contraceptives**, including: (i) PBS coverage and TGA approval processes for contraceptives; (ii) awareness and availability of long-acting reversible contraceptive and male contraceptive options, and (iii) options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions
- **TOR item b: cost and accessibility of reproductive healthcare**, **including pregnancy care and termination** services across Australia, particularly in regional and remote areas
- **TOR item c: 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
- **TOR item e: sexual and reproductive health literacy**
- **TOR item i: any other related matter** [concerning **Reproductive Coercion** and the **Implementation and monitoring of the National Women's Health Strategy 2020-2023: Priority Area 1 - Maternal, Sexual and reproductive Health**]

This submission summarises the critical barriers that we, as a Coalition, have identified in these key areas and the **five imperative actions** we believe are needed to address them:

1. Remove barriers to contraceptive access by providing **free contraception** and **incentivising primary care health practitioner training** in contraceptive service provision.
2. Ensure availability of essential sexual and reproductive health services (particularly for rural and regional Australian women) through **regional level planning, training and accountability for contraception and abortion access via publicly funded community and hospital-based services**.
3. Expand the health workforce by **enabling nurses, midwives and pharmacists to work to their full scope of practice in contraception and abortion care**, with appropriate remuneration and training opportunities.
4. Develop **coordinated public health campaigns and related education materials** to improve health literacy around rights and options for accessing effective contraception and abortion.
5. Formally track progress to deliver the outcomes of the National Women's Health Strategy by developing a **transparent, comprehensive, nationally agreed implementation plan** and **key performance indicators,** and **report** against these on an annual basis.

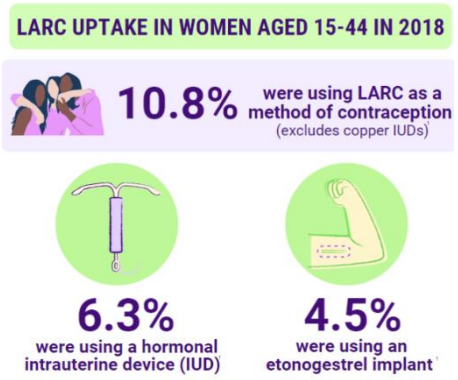
We propose **30 key recommendations** aligned to these imperative actions, with **responsibilities** delineated between the Australian Government, State and Territory Governments, professional colleges and training providers, primary health networks (PHNs), local hospital networks (LHNs) and service providers for Maternal and Child Health (MCH) and Domestic and Family Violence (DFV).

"It is only through this level of national **investment, planning, coordination, integration, transparency and accountability** that we will truly **empower all women to have the number of children they want when they want them** and achieve equitable access to high-quality sexual and reproductive healthcare for the six million women of reproductive age in Australia - **regardless of where they live**."

Equitable access to effective contraception

The problem

- One-quarter of women have experienced an unintended pregnancy in Australia[1], with rates even higher in non-urban areas[2].
- Unintended pregnancies may be attributed to non-use of contraception, inconsistent use or contraceptive failure[2], and can place significant physical, social and financial strain on women and their families[3,4].
- Younger women are more likely to experience an unintended pregnancy than older women[2,5], and are more likely to use less effective methods of contraception such as the oral contraceptive pill, condoms and withdrawal[6].
- The uptake of more effective methods such as long-acting reversible contraception (LARC) is relatively low in Australia, with only 11% of women aged 15-44 years using a LARC method such as intrauterine devices (IUD) and implants[7].
- Limited availability of healthcare practitioners trained in LARC insertion and removal procedures impedes uptake, particularly in rural and remote areas of Australia[8].



Critical barriers to achieving equitable access to effective contraception

Our research has demonstrated a high unmet need for effective contraception in Australia related to barriers that including high costs, misinformation among women and health practitioners, and limited number of health practitioners who can insert and remove LARCs.

- **High costs for women:** There are a number of financial barriers to obtaining effective contraception in Australia, including costs of repeat prescriptions (e.g. oral contraceptive pill), contraceptive methods not subsidised on the PBS (e.g. vaginal ring and non-hormonal Copper IUD), and LARC insertion-related costs. Despite the long-term cost-effectiveness of LARC methods, the upfront costs and multiple appointments which may be required can make this unaffordable for many women[8].
- **High costs for providers:** A lack of financial incentives for general practitioners (GPs) and other health practitioners to undergo necessary training is a barrier to providing LARC services[8], particularly when GPs and other practitioners commonly have to bear the costs of the training themselves. Current IUD insertion training can cost approximately $2,000, excluding travel, loss of income and other associated costs.
- **Limited task-sharing opportunities**: Although registered nurses, nurse practitioners and registered midwives are well-placed to provide LARC insertion and removal services, as occurs in many other countries and in some settings in Australia[9-12], there is no remuneration available to support this model of task-shifting/sharing or to encourage nurses and midwives to undertake the training or provide this service.
- **Misinformation:** Lack of familiarity with, and misinformation about, LARC among both women and health practitioners is another key barrier to the uptake of these effective methods of contraception[8].
- **Lack of availability of community-based training sites:** There are currently minimal opportunities for training in community settings, particularly for IUD and implant insertion and removal training, and no integrated approaches for provision of training or contraceptive care.

Key Recommendations		Responsibility	Imperative Action	Inquiry ToR
1.	Provide free contraception for women (including costs associated with LARC insertion and removal)	Australian Government	1	a
2.	Embed training in contraceptive counselling and insertion/removal of LARC in all obstetrics and gynaecology, GP, practice nurse, nurse practitioner and midwife training programs (with ongoing support provided through continued funding of the AusCAPPS community of practice)	Professional colleges & training providers	1 & 2	a, c
3.	Provide appropriate remuneration for nurses, nurse practitioners and midwives providing contraceptive services, LARC insertion and removal procedures, and medical abortion care, as well as subsidised costs for related equipment	Australian Government	3	a
4.	Ensure appropriate remuneration and reimbursement for GPs providing LARC insertion and removal services, including through increased MBS rebates and subsidised costs for required equipment	Australian Government	1	a
5.	Increase access to immediate postpartum LARC before hospital discharge through provision of contraceptive counselling antenatally and postnatally, and in training for midwives and obstetric staff in IUD and implant insertions	State/Territory Governments / LHNs	2 & 3	a, c
6.	Improve health literacy about contraception and emergency contraception among community members (including development of easy-English resources)	Australian Government	4	a, e
7.	Ensure equitable access to relationships and sexuality education in schools, including age-appropriate content on contraceptive options (including LARC and emergency contraception)	Australian & State/Territory Governments	4	a, e
8.	Direct Primary Health Networks (PHNs) to: develop an integrated regional approach to contraception care that identifies gaps in service provision at a local level (with consideration of the needs of remote, rural and regional patients); commission health services to fill those gaps, and map the availability of services	Australian Government / PHNs	3	a
9.	Incentivise and fund GPs and other health practitioners to undertake LARC insertion/removal training in areas of need, as identified by regional reporting	Australian Government / PHNs	1	a, c
10.	Ensure alignment between policies on contraception and abortion provision and training with endometriosis policy initiatives, particularly with the establishment of GP endometriosis clinics (noting LARC is a key tool for managing endometriosis)	Australian Government	1 & 2	a, b

Further supporting evidence for these recommendations can be found in the Coalition's consensus statement on increasing access to effective contraception in Australia available here.

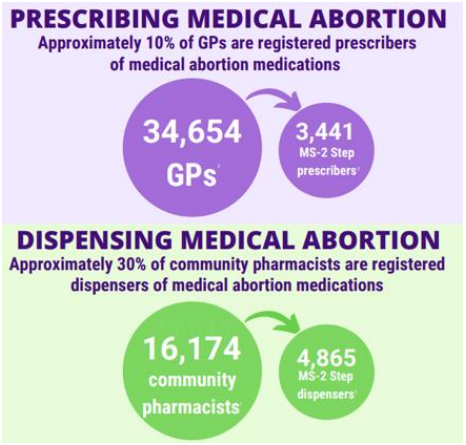
Equitable access to abortion care

The problem

- The rate of unintended pregnancy is disproportionately higher amongst those living in non-urban areas [13].
- Access to abortion services in Australia differs by geographical location due to few abortion providers in rural and regional areas, smaller communities and long distances required to access services [14].
- Access to abortion care is highly inequitable, with limited availability and inconsistent access to both medical and surgical abortion services and few publicly-funded options available in most states, particularly in rural and remote areas where approximately one-third of Australia's population live.

Critical barriers to achieving equitable access to abortion care

- **Low number of abortion providers in primary care:** There are relatively few abortion providers in the primary care setting and hospital system in Australia [15,16] and even fewer who can manage complex medical and gynaecological cases [17]. Only 3,441 out of approximately 34,654 registered GPs are active prescribers of medical abortion drugs [15]. About 30% of women in Australia live in regions in which there is no local GP provision of medical abortion including about 50% of women in remote Australia [18]. Whilst there is scope for task-sharing of this service between nurses and doctors in primary care, legislative barriers prevent nurses from becoming medical abortion prescribers [19,20]. This is a considerable barrier to provision of abortion care and is out of step with globally accepted normative standards [21,22]. There are also few community-based training centres available for medical and surgical abortion care in Australia.



- **Sparse and inconsistent public hospital provision:** Inconsistencies and sparse availability of abortion in public hospitals in many parts of Australia create further inequalities in access [23]. The low numbers, or in some cases, complete lack of public and private hospital abortion providers in some regional areas mean few referral pathways exist particularly for surgical abortion[24]. Many hospitals do not perform abortions as it may not be an explicit expectation under their service agreement [25], and some faith-based public and private hospitals prohibit provision of abortion and contraception [17,26].
- **Widespread community and professional stigma and conscientious objection:** Around 15% of Australian obstetrics and gynaecology fellows and trainees in 2009 were conscientious objectors of abortion [16]. Conscientious objection may be higher in regional and rural areas and amongst GPs with one study undertaken in regional Victoria finding that 38% of interviewed GPs referred women to another GP due to conscientious objection (62% of these GPs were trained overseas) [27]. Many GPs do not advertise that they are delivering abortion care due to concerns about stigma in the community [28], meaning many women do not know the location of a service or provider [29].
- **Few pharmacists dispensing medical abortion medicines:** Women and health providers can also face difficulties in knowing which pharmacies dispense medical abortion medicines. Additionally, certification to dispense medical abortion medicines is pharmacist-specific, meaning the certified pharmacist must be available to dispense the medicines. Currently only 4865 of 16,174 community

pharmacists are active dispensers of medical abortion medicines [15], and one in six pharmacists appear to be conscientious objectors[30].

- **Long distances to travel ("abortion deserts"):** The long distances women often have to travel for an abortion poses a significant barrier to access [31]. 'Abortion deserts', defined as areas where there are no GP prescribers and no surgical options and women have to travel more than 160km to access services [32], are common in rural and remote parts of Australia. Women must rely on hospitals and private clinics in metropolitan areas, which can pose financial and logistical challenges and delays to care. More than one in ten women require an overnight stay when accessing an abortion due to the long distance they are required to travel, and 4% have to travel outside their state of residence [33].

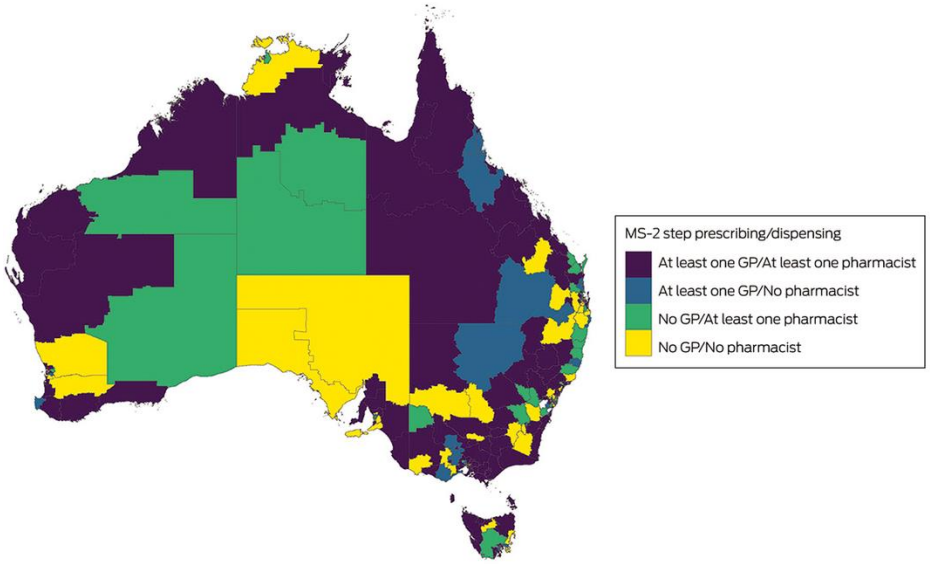


Figure 1. MS-2 Step prescribing and dispensing during 2019[2]

- **High out of pocket costs**: Across Australia there is a lack of affordable or no-cost abortion services [33-38]. Access to low-cost surgical procedures outside of public hospitals is difficult in most jurisdictions, and especially in rural areas where there are few providers [39]. Additional expenses may also include travel costs, overnight accommodation, taking time off work and childcare if required [39]. Two-thirds of women have to obtain financial assistance from one or more sources (e.g. partner, family members) to pay for their abortion [33]. Women not eligible for Medicare, including international students and women on temporary visas, must also pay for the procedure and other associated costs in full. While Medicare rebates are available for consultations concerned with medical abortion (including, since July 2021, those consultations delivered by telehealth [40]), out of pocket costs and gap payments still apply.
- **Low awareness of telehealth option among women:** Telehealth medical abortion is comparable in safety, efficacy and acceptability to in-person medical abortion services and can improve access [41,42]. However, whilst the availability of MBS telehealth item numbers has made telehealth medical abortion more accessible, medical abortion via telehealth is still limited by the small number of registered providers providing abortion care. Further, whilst Medicare-funded telehealth services can now be provided by GPs, non-government and private organisations, many women remain unaware of the availability of telehealth as a mode of delivery of these services [43,44].

[2] Ref: https://www.mja.com.au/journal/2021/215/8/early-medical-abortion-services-provided-australian-primary-care

Key Recommendations	Responsibility	Imperative Action	Inquiry TOR
11. Develop a national abortion care standard, data collection and reporting framework that includes key performance indicators (KPIs) similar to that which has been introduced in the UK	Australian Government	2	b
12. Support all local health networks and regional districts (e.g. HHSs, LHNs and PHNs) to report publicly against KPIs on an annual basis to monitor progress in achieving and maintaining the abortion care standards	Australian & State/Territory Governments, LHNs, PHNs	2 & 5	b

13. Lead a National Federation Reform Council process to mandate that at LHN level, major regional or tertiary hospital services provide comprehensive abortion care. In addition, these hospitals should provide:
• Care for
  ○ Women with complex medical/psychological, financial and/or social circumstances
  ○ Women at later gestations
  ○ Women referred from community-based health services for further management (including for complications)
• Abortion training for health professionals and students in hospital settings (including gynaecology and GP trainees, nurses, nurse practitioners, midwives and pharmacists)
• Collaborative support for regional medical and surgical abortion providers
And adequate funding should be directed to support of all of these services.
	Australian & State/Territory Governments, LHNs	2,3 & 5	b, c

14. Direct PHNs to develop an integrated regional approach to abortion care that involves:
• Identifying gaps in service provision at a local level (inc. remote, rural and regional areas)
• Commissioning one or more abortion services (surgical and/or medical) to fill those gaps. Services should:
  ○ Be delivered by suitably trained practitioners in accredited surgical facilities including day procedure centres and local hospitals (supported by larger tertiary hospital to deliver integrated care)
  ○ Provide abortion care training for primary care health professionals to build capacity and support sustainable service provision (inc. GPs, nurses, midwives, and pharmacists)
	Australian Government, PHNs	2,3 & 5	b, c

15. Develop materials to increase public awareness of abortion care options (inc. telehealth), informed by women's needs and preferences	Australian & State/Territory Governments	4	b, e
16. Continue provision of telehealth rebates for sexual and reproductive health, including abortion care	Australian Government	2	b
17. Continue to support medical abortion care through time-based MBS item numbers (face to face and telehealth); a specific	Australian Government	2	b

	Medicare item number for medical abortion should not be introduced			
18.	Provide abortion care for free for all women including international students and those on temporary visas	Australian Government	2	b
19.	Harmonise abortion legislation across all states and territories in Australia	Australian & State/Territory Governments	2	b

Further supporting evidence for these recommendations 11-16 can be found in the Coalition's consensus statement on achieving equitable access to abortion care available here. Recommendations 17-19 have arisen from Coalition consensus in the development of this submission.

Reproductive coercion and abuse

The problem

- Reproductive coercion and abuse (RCA) is a distinct form of Domestic and Family Violence (DFV) associated with other forms of gender-based violence, including coercive control, and intimate partner and sexual violence[45].

- RCA encompasses behaviours that interfere with a person's reproductive autonomy[46,47] and include actions at the interpersonal level to control pregnancy outcomes against a person's will that:
    - prevent pregnancy by means such as forcing a termination of pregnancy (abortion) or forced contraception use (e.g. IUD insertion); or
    - promote pregnancy by means such as contraceptive sabotage (deliberately tampering with a condom or oral contraception to decrease effectiveness) or forcing a continuation of an unwanted pregnancy[45].
- RCA is a public health problem of global concern associated with higher rates of unintended pregnancies, abortion, and negative reproductive, maternal, parental, and child health outcomes[46].
- Whilst not isolated to the pandemic, COVID-19 is likely to have exacerbated RCA, as evidenced by an increase in recorded unwanted pregnancies, increased alcohol and other drug consumption, and other factors linked to DFV[48].

Critical barriers to addressing reproductive coercion

- **Clinical practice**: Some women are more likely to disclose DFV to a primary care provider such as a general practitioner (GP), rather than presenting to DFV services[49]. Primary care providers, however, have identified lack of training and adequate referral services, particularly in rural settings, as barriers to responding to DFV/RC[50].
- **Education and training**: Inclusion of RCA prevention and response in curriculum and in-service training is inconsistent across primary care settings and professional disciplines.

Other considerations

- **Access to contraceptive counselling and methods:** Across global settings, women experiencing RCA are reported as more likely to use effective, female-controlled forms of contraception to reduce unwanted pregnancies given male partners are less likely to use condoms, signalling the role of effective contraception counselling as a component of the clinician's response[51].
- **Policy and legislation**: Legislation is currently before several state parliaments to criminalise coercive control in Australia, but this Coalition does not believe inclusion of RCA within the criminal code would assist in the WHO recommended best practice of 'woman-centred care' for those disempowered by DFV[52]. Criminalising RCA risks creating additional barriers to disclosure if the affected person is concerned their partner may be incarcerated or that a legal response would endanger their individual or family's safety[53]. A person who may not otherwise disclose RCA might tell a health provider within a therapeutic setting about an unwanted pregnancy or one that is too close to a previous pregnancy. A discussion about these RCA signs may be a sign to prompt further enquiry about all aspects of DFV given the association with other forms. Growing public interest, policy formulation, and legislature is ahead of expert consensus and a strong evidence base for RCA public health policies and interventions.

Key Recommendations		Responsibility	Imperative Action	Inquiry ToR
20.	Embed sensitive enquiry for RCA in the provision of primary care of people at risk, particularly in sexual and reproductive health services, the provision DFV support, and Maternal and Child Health (MCH) services	Australian Government, PHNs, DFV support providers, MCH services, Professional colleges & training providers	1, 2 & 3	i
21.	Integrate mandatory RCA training in primary care organisations and others involved in DFV response	PHNs, DFV support providers, Professional colleges & training providers	2 & 3	c, i
22.	All people experiencing RCA should be offered counselling for and access to effective contraception methods (such as LARC) from a qualified health provider	PHNs	1, 2 & 3	a, i
23.	Include information about RCA in relationships and sexuality education offered throughout the lifespan	Australian & State/Territory Governments	4	e, i
24.	DFV community awareness campaigns should include RCA and be based on meaningful community engagement and community identified priority needs.	Australian & State/Territory Governments	4	i
25.	RCA should remain outside of the criminal code and mandatory reporting of reproductive coercion should not be a requirement of health providers	Australian & State/Territory Governments	N/A	i

Further supporting evidence for these recommendations can be found in the Coalition's consensus statement on reproductive coercion available here.

Implementation and monitoring of the National Women's Health Strategy 2020-2033: Maternal, sexual and reproductive health priority area

The problem

- While the National Women's Health Strategy (2020-2030) has received broad cross-sectoral support for outlining a national approach to improving health outcomes for women and girls in Australia [54], it lacks the mandated regular monitoring and reporting of outcomes to track progress that have been introduced alongside similar strategies internationally, such as those implemented across the UK [55-57].
- The priority areas and associated actions in the strategy are quite broad and not comprehensive, the measures of success are not directly transferrable as key performance indicators, and it is not evident how these will be implemented, tracked or achieved.
- At the launch of the Strategy in April 2019 it was announced that $52.2 million would be provided to organisations working in the area of improving women's health [58]. However, it is not clear how this funding has been allocated, the implementation plan for funded projects, or how these will be monitored or evaluated, both as individual projects or against the priorities and actions outlined in the Strategy.

What's needed to implement and monitor the national strategy?

- **Transparent implementation, data collection, monitoring and reporting:** There is a critical need for a transparent implementation and monitoring plan for reporting progress against the National Women's Health Strategy (with data collection to support this), a clear evaluation plan to measure impact and success, clarity on the level and nature of funding being made, and stronger communication and engagement with consumers and stakeholders. These elements will be crucial to monitor change and impact, inform service provision, ensure accountability and transparency, and promote optimal outcomes for women and girls in Australia.
- **Unified commitment, investment and leadership:** As a Coalition of sexual and reproductive health experts and stakeholders from around Australia, we seek a commitment from the Australian government and government agencies on developing a transparent approach to implementation, monitoring and reporting of the National Women's Health Strategy. This will enable the goals of the Strategy to be met for the improvement of women's sexual and reproductive health access and equity throughout Australia.

Key Recommendations	Responsibility	Imperative Action	Inquiry ToR
26. **Undertake a national consultation process with government and non-government representation from all states and territories, including metropolitan, regional and remote areas of Australia, to inform the development of:** a. **An implementation plan outlining:** i. how the key outcomes outlined in the strategy will be achieved (noting that approaches need to be social, clinical and data driven with a focus on priority populations) ii. the associated timeframes iii. a detailed budget to support the achievement of the key outcomes iv. currently funded projects and plans for future projects b. **A set of key performance indicators (KPIs)** for the purposes of monitoring and reporting against the implementation of the Strategy and approaches to data collection for this purpose	Australian & State/Territory Governments	5	a, b, c, e, i
27. Publish the implementation plan and KPIs	Australian & State/Territory Governments	5	a, b, c, e, i
28. Allocate funding to support the achievement of the key outcomes of the Strategy	Australian & State/Territory Governments	5	a, b, c, e, i
29. Allocate funding for a formative evaluation process that focuses on timely and disaggregated data collection and monitoring against each KPI and enables future research on priority areas	Australian & State/Territory Governments	5	a, b, c, e, i
30. Publish an annual progress report, reporting at both state/territory and national levels on outcomes and KPIs	Australian & State/Territory Governments	5	a, b, c, e, i

Further supporting evidence for these recommendations can be found in the Coalition's consensus statement on the National Women's Health Strategy here.

About the SPHERE Coalition

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, chaired by SPHERE, was formed in 2020 to advocate for equitable sexual and reproductive health care in Australia. The Coalition is a cross-sectoral, multidisciplinary alliance comprising over 150 clinician experts and consumers, representatives from peak bodies and key stakeholder organisations and eminent Australian and international researchers with 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.

The 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 and medical abortion, including the use of telehealth, nurse- and midwife-led models, and publicly-funded care. 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

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