Organon ANZ Submission to the Senate Select Committee Inquiry on Women's Health

October 2026

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ORGANON
Here for her health

Committee Secretary

Senate Standing Committee on Women's Health

Canberra ACT 2600

8 October 2026

To Whom It May Concern,

Organon Australia and New Zealand (Organon ANZ) welcome and commend the Senate Select Committee on Women's Health and the enduring prioritisation of women's health by the Government.

Organon is a global healthcare company dedicated to women's health. With a portfolio spanning more than 70 medicines and products across reproductive health, fertility, and other therapeutic areas relevant to women throughout their lives, Organon believes women are foundational to a healthier world. We envision a better and healthier every day for every woman.

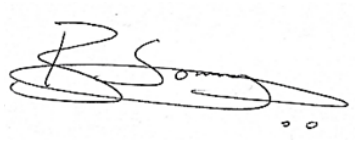
We are proud of our long-standing record of contributing evidence and policy analysis to Australian women's health reform, including a 2022 submission to the Senate Inquiry into Universal Access to Reproductive Healthcare and Organon-commissioned research into the prevalence and cost of unintended pregnancy in Australia.

Our submission includes 9 recommendations, and we would welcome the opportunity to answer any questions about these recommendations, or to provide further information on any of the areas covered. We consent to this submission being published on the Committee website and shared publicly online.

If we can be any of further assistance, please contact Elle Wotton (née McGlynn) on elle.mcglynn@organon.com.

Thank you for your consideration of this submission.

Yours sincerely,



Bilal Somra

Country Lead, Organon ANZ

Summary of recommendations

Terms of Reference	Recommendation
1M. Access and affordability issues relating to fertility and assisted reproduction treatments	**1.** Introduce a Medicare rebate for elective fertility preservation (EFP), distinct from existing medically indicated item numbers.
	2. Introduce a cost-offset mechanism for elective fertility preservation (EFP), such as a means-tested rebate or tax offset.
	3. Invest in national reproductive health literacy program and primary care counselling to support informed reproductive decision-making.
	4. Support and promote employer-sponsored fertility reimbursement schemes including non-medical egg freezing through tax guidance, so access is not limited to employees of large employers.
1A. Best-practice pregnancy and postpartum care models **1E. Antenatal and postpartum reproductive health support and education**	**5.** Embed contraceptive counselling, planning and provision as a standard component of maternity care. Develop and implement nationally consistent clinical guidance on postpartum contraception, integrated within antenatal, maternity and postnatal care pathways.
1D. Cost and accessibility of postpartum healthcare **1E. Antenatal and postpartum reproductive health support and education**	**6.** Expand MBS support for contraceptive counselling during pregnancy and the postpartum period, and ensure appropriate remuneration for contraceptive procedures, including long-acting reversible contraception (LARC) insertion and removal.
1F. Research, education and training on pregnancy and postpartum care for healthcare professionals	**7.** Implement contraceptive workforce training and education, embed contraceptive care competencies across health professional curricula, and enable appropriately trained specialists, GPs, midwives, nurses, nurse practitioners and Aboriginal Health Practitioners to provide contraceptive counselling and provision within their scope of practice.
1A. Best-practice pregnancy and postpartum care models **1E. Antenatal and postpartum reproductive health support and education**	**8.** Invest in nationally consistent, evidence-based reproductive health education and contraceptive resources before and after birth. Ensure information is accessible, culturally safe, and supports informed decision-making.
1D. Cost and accessibility of postpartum healthcare **1F. Research, education and training on pregnancy and postpartum care for healthcare professionals**	**9.** Enhance awareness, implementation and uptake of existing and future Government initiatives that support access to effective contraception, including targeted education and communication campaigns for healthcare professionals and the public.

Introduction

Growing need for and role of non-medical elective egg freezing in Australia

Australia's total fertility rate fell to a record low of 1.48 births per woman in 2024, and the 2026 Intergenerational Report projects a further decline to 1.34 by 2065-66 *(ABS-1)*.

This is well below the replacement level of approximately 2.1 births per woman required to maintain population size in the absence of migration *(AIFS)* and reflects three key demographic shifts including:

1. Delayed childbearing
2. Smaller family sizes, and
3. A growing proportion of individuals remaining childless.

These trends are commonly attributed to a combination of financial and social challenges including, rising cost of living pressures, housing affordability challenges, concerns about availability and cost of childcare and uncertainty associated with climate change.

Against this backdrop, the median age of mothers in Australia is now 32.1, when natural fertility has already begun to decline *(ABS-2)*.

As Australians continue to delay parenthood, increasing numbers of women are considering elective fertility preservation (EFP) as a means of preserving future reproductive options. EFP, also referred to as planned oocyte cryopreservation or non-medical egg freezing, refers to the cryopreservation of oocytes in the absence of a current medical indication such as cancer treatment or other gonadotoxic therapies.

In Australia, women seeking fertility preservation for medical indications can access reimbursement. However, EFP is not publicly funded, resulting in women bearing the full cost themselves. Depending on the clinic, this can range from AUD $8,000-15,000 per cycle, in addition to $300 to $600 per year in ongoing storage fees. Research indicates access is often determined by financial capacity rather than reproductive need. Financial barriers are the major reason why patients are unable to access fertility preservation services *(Abat et al, 2026)*.

Despite these barriers, demand for EFP has grown substantially, with the number of women undertaking planned egg freezing **increasing from 55 in 2009 to 4,919 in 2023**, as reported by Australian and New Zealand Registry Data (ANZARD) *(Fitzgerald et al, 2026)*.

This growing demand has been accompanied by a marked increase in public awareness and discussion of fertility preservation. In the last 12 months alone, more than 2,400 media articles have been published on elective fertility preservation, reflecting increasing recognition of the role these services can play in family-building planning.

Beyond the clinical and social benefits of helping individuals achieve their desired family size, there is growing evidence that investment in fertility care delivers broader economic benefits. A 2025 Australian analysis by *Connolly et al* estimated that every A$1 of government expenditure on assisted reproductive technology (ART) generates A$2.68 in future net tax revenue, with ART-

conceived children contributing an estimated A$1.29 billion in lifetime net fiscal benefit from a single annual treatment cohort. **These findings suggest that improving access to fertility treatment and preservation should be viewed not only as a health policy measure but also as a long-term investment in Australia's future workforce and economic productivity.**

While EFP should not be considered a solution to declining fertility rates, expert consensus from *Abat et al*. highlights it's a value in supporting reproductive autonomy, expanding future family-building options, and potentially contributing to national fertility rates. The authors argue that fertility preservation should be considered part of a broader national investment in reproductive health, alongside measures such as affordable childcare, parental leave, counselling and housing support. Without a coordinated policy approach, reproductive healthcare risks becoming increasingly disconnected from contemporary family-building patterns.

Embedding Contraceptive Counselling and Provision of Routine Maternity Care

Australia has made important progress in strengthening contraceptive care. Organon welcomes recent government initiatives, including the AusCAPPS support network, AUSLARC scholarships, LARC Centres of Excellence, and recent MBS reforms supporting LARC insertion and removal, which are helping to expand healthcare professional education, training and access to highly effective contraceptive methods.

While these initiatives represent significant advances**, further action is needed to improve the quality, consistency and integration of contraceptive counselling and provision, particularly during pregnancy and the postpartum period** when women have frequent contact with healthcare services and opportunities for preventive care are greatest. In addition, greater efforts are needed to support awareness, implementation and uptake of existing government initiatives to ensure women and healthcare professionals can fully benefit from these investments.

International and Australian evidence suggests that embedding contraceptive counselling and provision within routine maternity care can improve access to effective contraception and support pregnancy spacing goals (Nelson et al. 2022; Cavallaro et al. 2020; Botfield et al. 2022; CoSRH 2025).

Women can conceive again as early as three weeks after birth if they are not exclusively breastfeeding or using contraception. Closely spaced pregnancies are associated with increased risks of adverse maternal and infant outcomes, including preterm birth, stillbirth and neonatal mortality (Thiel de Bocanegra et al. 2014; Hanley et al. 2017; Wang et al. 2022).

Accordingly, international organisations including WHO, FSRH and ACOG recommend an interpregnancy interval of at least 18 months, ideally around two years, while RANZCOG recommends timely postpartum contraceptive counselling and access to a woman's preferred contraceptive method, including immediate postpartum LARC provision where clinically appropriate (WHO 2022; FSRH 2020; ACOG 2018; RANZCOG 2024).

Despite the importance of pregnancy spacing, Australian evidence suggests contraceptive counselling is not routinely embedded within antenatal, maternity or postpartum care, despite women consistently reporting a desire for information and support from trusted healthcare providers during these periods (Li et al. 2023; Botfield et al. 2023; Cheney et al. 2024; Arefadib et al. 2025).

The recommendations included in this submission have the potential to embed contraceptive counselling and provision within routine maternity care, strengthen funding mechanisms, expand workforce capability and scope-of-practice pathways, improve awareness and uptake of government-funded contraceptive initiatives, and deliver nationally consistent, evidence-based education resources.

Together, these measures would improve access to effective contraception, including LARCs, support informed reproductive decision-making, maximise the impact of recent government investments and help women achieve their pregnancy intentions while improving maternal and infant health outcomes (WHO 2025; RANZCOG 2024; FSRH 2020; CoSRH 2025; Botfield et al. 2022; Perkins et al. 2024).

Recommendations

Assisted Reproductive Treatment

Terms of Reference	Recommendation
1M. Access and affordability issues relating to fertility and assisted reproduction treatments	1. Introduce a Medicare rebate for elective fertility preservation (EFP), distinct from existing medically indicated item numbers.

Dedicated MBS item numbers should be established, or current MBS eligibility criteria expanded, to allow fertility treatment to be accessible without a clinical diagnosis of infertility. This would extend funding to elective fertility preservation alongside existing medically indicated items (MBS-1). Reimbursed Fertility preservation should include both oocyte cryopreservation and the subsequent ART treatment required to utilise stored oocytes. Funding the full continuum of care would reduce downstream financial barriers.

At present, Medicare benefits are payable only for clinically relevant ART services necessary to treat infertility, which excludes women seeking fertility preservation before any diagnosis (MBS-1). This sits alongside a clear funding disparity. Male fertility preservation has a dedicated item (13260) for cryopreservation before gonadotoxic treatment, yet women must rely on general ART items (13200 and 13201), which were designed for IVF cycles and oocyte retrieval in women with diagnosed infertility.

This reform matters because the current structure recognises male fertility preservation as a distinct healthcare need while leaving female fertility preservation unrecognised. The inequity is increasingly out of step with professional guidance and patient demand. The ESHRE fertility preservation guideline recognises oocyte cryopreservation for age-related fertility loss as a legitimate indication and notes growing demand for these services (Anderson et al., 2020). Dedicated or broadened items would remove the reliance on a diagnosis that does not reflect the purpose of preservation, giving women an equitable pathway to plan their reproductive futures.

The reform supports Government priorities on health equity, informed reproductive choice and long-term demographic and workforce outcomes, by reducing the financial barriers that currently limit access to fertility preservation. International examples show that governments are moving in this direction. For example, France reimburses across the fertility preservation and treatment pathway, and evidence suggests that comprehensive coverage improves follow-through on using stored oocytes and lowers the cost per live birth compared with partial coverage (Yang et al., 2022). Japan, Singapore and South Korea have also expanded public support through subsidies and other funding mechanisms (Pistollato et al., 2025).

Terms of Reference	Recommendation
1M. Access and affordability issues relating to fertility and assisted reproduction treatments	2. Introduce a cost-offset mechanism, such as a means-tested rebate or tax offset for EFP.

If direct public reimbursement of EFP services is not feasible, a cost-offset mechanism, such as a means-tested rebate or tax offset can be introduced. Access to EFP should not be determined by a woman's income, her employer, or her relationship status.

Existing fertility rebate schemes in Australia already provide a precedent for targeted financial support. For example, the NSW Government's Fertility Treatment Rebate-2 provides eligible women with a $2,000 rebate to help offset the costs of IVF and other ART treatments, recognising out-of-pocket costs are a barrier to care *(Services NSW-1).*

This approach would enable more women to make timely reproductive choices based on their personal and clinical circumstances rather than social barriers or financial capacity, while offering government a pragmatic and scalable alternative to comprehensive public funding.

Terms of Reference	Recommendation
1M. Access and affordability issues relating to fertility and assisted reproduction treatments	3. Invest in national reproductive health literacy program and primary care counselling to support informed reproductive decision-making.

Improving national reproductive health literacy is essential to informed family planning and to the effectiveness of broader reproductive healthcare initiatives. The Australian Government should fund a nationally coordinated reproductive health literacy program, invest in evidence-based fertility awareness resources for educators and healthcare professionals, and support public education campaigns on reproductive ageing and fertility preservation options.

Fertility preservation counselling should also be integrated into routine reproductive health consultations through updated clinical guidelines, healthcare provider training, and appropriate Medicare funding for pre-conception and fertility counselling services.

Primary care providers are often the first point of contact for people seeking fertility and family planning advice, and effective fertility care in these settings depends on access to evidence-based guidance, educational resources and clear referral pathways (Jones et al., 2025).

Currently, reproductive health education focuses largely on contraception, sexually transmitted infections and the prevention of unintended pregnancy, with limited attention to fertility, reproductive ageing, fertility preservation and the factors that influence future fertility. This gap

has real clinical consequences. Women who freeze oocytes at younger ages achieve live birth rates of 43-70%, compared with 17-38% among those who freeze at 38-40 years or older, so timely awareness directly shapes outcomes (Korkidakis et al., 2025; Greenwood et al., 2018).

Women who receive accurate information about success rates, oocyte yield and available options are better equipped to act at a more favourable clinical time point, and those who proceed after structured counselling report higher satisfaction and lower regret than those who proceed without counselling or under time pressure (Korkidakis et al., 2025; Greenwood et al., 2018).

Terms of Reference	Recommendation
1M. Access and affordability issues relating to fertility and assisted reproduction treatments	4. Support and promote employer-sponsored fertility reimbursement schemes including elective fertility preservation through tax guidance, so access is not limited to employees of large employers.

Employer-sponsored fertility benefits are increasingly used to support workforce wellbeing, talent retention and gender equity, yet access is concentrated among large employers. This means entitlement depends on the size of a person's employer rather than their individual need. A Mercer survey found that only 11% of companies with 500 or more employees, and 19% of companies with 20,000 or more employees, offered an egg-freezing benefit, showing that even where employer schemes are well established, coverage remains limited and uneven (Mercer, National Survey of Employer-Sponsored Health Plans). The same survey found that 62% of employers reported improved competitiveness in attracting and retaining talent, and 79% of employers reported positive impacts on diversity, equity and inclusion objectives. By helping employees align family-building goals with education and career pathways, these programs also support workforce participation and long-term economic productivity.

Organon ANZ's own Fertility Reimbursement Policy, provides up to $3,000 annually for fertility and ART services, demonstrates a practical employer-led model. Employers can play an important role in supporting reproductive health, but employer-based schemes alone cannot deliver equitable access. Government guidance and financial incentives are needed to make these benefits viable and consistent across workplaces of all sizes.

Contraception care during post-partum

Terms of Reference	Recommendation
1A. Best-practice pregnancy and postpartum care models **1E. Antenatal and postpartum reproductive health support and education**	5. Embed contraceptive counselling, planning and provision as a standard component of maternity care. Develop and implement nationally consistent clinical guidance on postpartum contraception, integrated within antenatal, maternity and postnatal care pathways.

The Australian Government should embed contraceptive counselling, planning and provision as a standard component of maternity care, supported by nationally consistent clinical guidance on postpartum contraception that is integrated within antenatal, maternity and postnatal care pathways. This guidance should support routine counselling during pregnancy and after birth, clearly define roles across maternity providers, and enable same-visit access to contraception, including immediate postpartum LARC provision where clinically appropriate. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommend timely postpartum contraceptive counselling and access to a woman's preferred method, including immediate postpartum LARC (RANZCOG 2024).

The absence of national guidance leads to variation in practice, unclear provider responsibilities and missed opportunities for care. Women who are not exclusively breastfeeding or using contraception can conceive again from 21 days postpartum (FSRH 2020), and closely spaced pregnancies are associated with higher risks of preterm birth, stillbirth, neonatal mortality and adverse maternal outcomes (Hanley 2017; Dorney 2020). WHO, FSRH and ACOG recommend an interpregnancy interval of at least 18 months, ideally around two years (ACOG 2018; FSRH 2020; WHO 2022). Yet Australian studies show contraceptive counselling is often not provided during pregnancy, in hospital or at the six-week postnatal check (Li 2023; Perkins 2024), despite women consistently saying they want this support from trusted maternity care providers (Freeman Spratt 2023; Li 2023).

The evidence indicates this approach can work. Effective postpartum contraception, particularly immediate postpartum LARC provision, reduces unintended and short-interval pregnancies and may generate healthcare cost savings (WHO 2025; Patel 2025; Dorney 2020). Because women have frequent contact with maternity services during pregnancy and after birth, these settings offer a practical, high-value opportunity to deliver preventive care. A nationally consistent approach would help women achieve their pregnancy intentions, improve maternal and infant health outcomes, and reduce avoidable demand on the health system.

Terms of Reference	Recommendation
1D. Cost and accessibility of postpartum healthcare **1E. Antenatal and postpartum reproductive health support and education**	6. Expand MBS support for contraceptive counselling during pregnancy and the postpartum period, and ensure appropriate remuneration for contraceptive procedures, including long-acting reversible contraception (LARC) insertion and removal.

While the Government's 2025 MBS reforms, including expanded access through nurse practitioners and bulk-billing incentives, have improved access to contraceptive services and the provision of highly effective methods, high-quality contraceptive care extends beyond the procedure itself.

To achieve this, MBS support should be expanded for contraceptive counselling during pregnancy and the postpartum period, including ensuring appropriate remuneration for contraceptive procedures. This should extend on the MBS rebate changes introduced in November 2025 including for long-acting reversible contraception (LARC) insertion and removal. Effective care involves shared decision-making, discussion of reproductive goals, assessment of medical eligibility, counselling on efficacy and side effects, and consideration of individual preferences and cultural factors.

The current funding model does not adequately recognise the time and expertise this counselling requires, particularly during antenatal and postpartum care, where consultations are complex and difficult to fit within standard timeframes. Australian GPs consistently report inadequate remuneration as a barrier to comprehensive postpartum contraceptive care (Perkins 2024; Perkins 2026; Fitzgerald 2025), and GPs and midwives frequently cite time constraints as a barrier to counselling (Perkins 2024; Perkins 2026; Fitzgerald 2025; Cameron 2017; Cheney 2024). As a result, many women report receiving little or no in-depth contraceptive counselling during pregnancy or after birth (Li 2023), meaning the investment already made in LARC access is not fully realised.

Structured contraceptive counselling improves contraceptive uptake and informed decision-making (Nelson 2022; Cavallo 2020), and counselling combined with access to LARCs reduces unintended pregnancies and short interpregnancy intervals, delivering downstream health and economic benefits (Nelson 2022; Gariepy 2015; Patel 2025; Thiel de Bocanegra 2014). International postpartum contraception programs have also demonstrated favourable return on investment by preventing short interpregnancy intervals and unintended pregnancies (Public Health England 2021; CoSRH 2025).

Terms of Reference	Recommendation
1F. Research, education and training on pregnancy and postpartum care for healthcare professionals	7. Implement contraceptive workforce training and education, embed contraceptive care competencies across health professional curricula, and enable appropriately trained specialists, GPs, midwives, nurses, nurse practitioners and Aboriginal Health Practitioners to provide contraceptive counselling and provision within their scope of practice.

Contraceptive workforce training and education should be implemented to embed contraceptive care competencies across health professional curricula, and enable appropriately trained GPs, midwives, nurses, nurse practitioners and Aboriginal Health Practitioners to provide contraceptive counselling and provision within their scope of practice. Nationally consistent education standards should cover contraceptive counselling, reproductive life planning, postpartum contraception and LARC competencies across medical, nursing, midwifery and allied health training, supported by expanded continuing professional development to build workforce confidence and service availability.

Workforce capability is critical to equitable access to contraceptive care, and current gaps undermine the investment made in funding and service reform. Maternity clinicians, midwives and child and family health nurses report that postpartum contraceptive counselling is not routinely embedded in care, despite frequent contact with women, due to unclear responsibilities, limited training and the absence of structured care pathways (Arefadib 2025; Cheney 2024; Botfield 2023). Between 67 and 86 per cent of midwives report no formal contraception training and identify this as a key barrier to counselling (Botfield 2021; Cheney 2024). Among GPs and GP registrars, lack of training, supervision and procedural experience are significant barriers to LARC provision (Perkins 2024; Turner 2021). The result is inconsistent care and missed opportunities.

Trained midwives performed 265 contraceptive implant insertions in NSW public hospitals, demonstrating the feasibility of expanding immediate postpartum LARC provision (Botfield 2022). Australian research also finds that access to training and clinical support increases LARC provision among GPs (Perkins 2024; Turner 2021). Internationally, Scotland and the UK have embedded postpartum contraception competencies within maternity services, with training and service models that support routine postpartum LARC provision (Public Health England 2021; CoSRH 2025; Young 2024).

Terms of Reference	Recommendation
1A. Best-practice pregnancy and postpartum care models **1E. Antenatal and postpartum reproductive health support and education**	8. Invest in nationally consistent, evidence-based reproductive health education and contraceptive resources before and after birth. Ensure information is accessible, culturally safe, and supports informed decision-making.

A nationally consistent, evidence-based reproductive health education program should be invested in by the Government with contraceptive resources before and after birth, ensuring that information is accessible, culturally safe and supporting women with informed decision-making when it matters most.

These resources should be embedded across antenatal and postnatal care, giving women clear, balanced information on fertility return, pregnancy spacing and contraceptive options. They should be available through a range of channels, in multiple formats and languages, and tailored to priority populations, including First Nations women, culturally and linguistically diverse communities, women in rural and remote areas, young people, and those with low health literacy.

Women need accurate information to make informed decisions about family planning after childbirth, yet it is not consistently provided, with Australian studies reporting that counselling is not reliably delivered in routine maternity care (Li 2023; Freeman-Scott 2023). Many women are also unaware of the recommended interval between pregnancies, and closely spaced or unintended pregnancies carry significant physical, psychological, social and economic impacts for women and families (Li 2023; Wang 2022).

Meanwhile, social media is an increasingly important source of reproductive health information and can amplify myths about contraceptive safety, side effects and fertility return, influencing decision-making (John 2025). LARC uptake in Australia is low, at 11% of women aged 15 – 44, compared with many similar high-income countries, despite LARCs being among the most effective reversible methods (Grzeskowiak 2021).

The evidence indicates that accessible, culturally appropriate resources can address these gaps. Accessible, evidence-based and culturally appropriate reproductive health information can help correct misconceptions and improve equitable access to contraception for priority populations, including First Nations women, culturally and linguistically diverse communities, women in rural and remote areas, and those with lower health literacy (Hickey 2021; Metusela 2017; Mengesha 2017).

Nationally consistent resources would also complement the workforce and funding reforms recommended in this submission, ensuring women are informed and supported to choose the contraceptive method that best suits their circumstances.

Terms of Reference	Recommendation
1D. Cost and accessibility of postpartum healthcare **1F. Research, education and training on pregnancy and postpartum care for healthcare professionals**	9. Enhance awareness, implementation and uptake of existing and future Government initiatives that support access to effective contraception, including targeted education and communication campaigns for healthcare professionals and the public.

Organon ANZ commends the Australian Government's recent investment in initiatives that improve access to a broader range of effective contraceptive options for Australian women, including new PBS listings, AUSLARC training scholarships, increased MBS rebates for LARC insertion and removal, bulk-billing incentives, expansion of eligible providers to include nurse practitioners, the AusCAPPS support network, and the establishment of LARC Centres of Excellence. These initiatives represent significant progress in strengthening contraceptive access, workforce capability and women's reproductive healthcare.

Despite these investments, uptake of long-acting reversible contraception (LARC) in Australia remains low by international standards (Grzeskowiak et al. 2021) and appears to have remained relatively stable over the past 12 months. Analysis of Pharmaceutical Benefits Scheme (PBS) claims data indicates little change in the use of contraceptive implants and intrauterine devices (IUDs) following the introduction of recent reforms in November 2025 (Prospection PBS 10% dataset). Similarly, analysis of publicly available Medicare Benefits Scheme (MBS) data suggests that the reforms have had limited impact on overall LARC insertion and removal service volumes to date, while uptake of the new item numbers associated with bulk-billing incentives and nurse practitioner-provided services remains low (Medicare Benefits Schedule MBS-2).

These findings suggest a prioritisation on implementation to support these policy reforms is required. Research commissioned by Organon in July 2026 identified relatively low awareness among general practitioners of recent MBS reforms for LARC services, with 59% aware of the increased rebates, 40% aware of the bulk-billing incentive, and only 25% aware of both measures (Organon Data on File). This suggests that awareness and utilisation of existing initiatives among healthcare professionals may be limiting the extent to which women benefit from recent government investments.

To maximise the return on existing and future investments, Organon recommends enhancing efforts to increase awareness, implementation and uptake of contraceptive initiatives among healthcare professionals and the public. This could include targeted education campaigns, integration of information into clinical software and professional development activities, public awareness initiatives, and ongoing monitoring of program utilisation and outcomes. Strengthening implementation of existing initiatives would help translate policy investment into greater access to highly effective contraception and improved reproductive health outcomes for Australian women.

About Organon

At Organon, our vision is to create a better and healthier every day for every woman around the world. The current women's health gap equates to 75 million years of life lost due to poor health or early death every year, globally (McKinsey Health Institute 2024).

Despite having a longer life expectancy, women spend **25%** more of their lives in poor health compared to men (McKinsey Health Institute 2024).	While health issues can arise at any stage of life, the **health burden women face often occurs during their working years.** (McKinsey Health Institute 2024).	**More than half (56%)** of women's health burden comes from conditions that are more prevalent or manifest differently in women. (McKinsey Health Institute 2024).

Addressing this gap could:

Add an average of **7 days** of healthy living for every woman, every year. (McKinsey Health Institute 2024).	Boost the global economy by at least **$1 trillion.** (McKinsey Health Institute 2024).	**Result in a $3 return for every $1 invested in women's health globally.** (McKinsey Health Institute 2024).

At Organon, we recognise the importance of closing this gap and the need to transform the landscape of women's health, which is why our product portfolio, which encompasses more than 70 products and devices, seeks to address conditions that uniquely and disproportionately affect women. Among this, is a long-standing legacy supporting families who experience infertility.

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