Australian Government
Australian Institute of
Health and Welfare

Sexual and Reproductive Health

Monitoring Framework and Data Strategy

Caution: Some people may find parts of this content confronting or distressing, including content relating to pregnancy loss and termination of pregnancy. Please carefully consider your needs when reading the following information.

Contents

Summary

Sexual and reproductive health is fundamental to health and wellbeing across every stage of life for all people in Australia. Despite this, there are gaps in national data, statistics, and monitoring information in Australia.

The Australian Government has funded the AIHW to develop a national sexual and reproductive health (SRH) monitoring framework (the framework), data strategy and regular reporting to fill these gaps. The goal is to ensure there is timely and reliable information about sexual and reproductive health and services in Australia to help plan and deliver high-quality SRH services and improve outcomes, including in relation to equity, access and quality.

Purpose of this report

This document presents the draft framework and data strategy for public consultation.

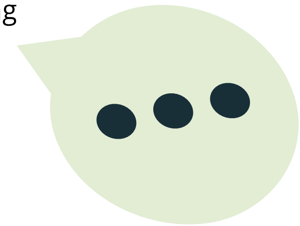
Public consultation will be open until 2 November 2025, with feedback to be submitted via the online portal. The AIHW will consider all submissions received.

Input is particularly sought on framework components and how they are arranged, including ensuring inclusivity and prioritisation of key elements, areas of measurement and data processes, data sources (existing and proposed), data stewardship, and guidance for ongoing stakeholder engagement.

Process to date

The draft framework and data strategy have been informed by reviews of the literature and data landscape as well as initial stakeholder consultations.

These consultations have included Australian Government and state and territory government agencies, policymakers, researchers, service planners, service administrators, peak bodies and advocates, health-care providers, people with lived experience, and community/not-for-profit organisations. Consultations included workshops, one-on-one meetings and engagement with existing advisory groups and committees.



Monitoring framework

The framework provides a conceptual structure to understand and respond to critical SRH information in Australia.

The framework identifies what is important to monitor to:

- align with policy and stakeholder priorities (Appendices A and B)
- inform evidence-based policy and service provision, and
- improve health-care outcomes throughout a person's life, including equity and access.

It is guided by the overarching question:

How timely, accessible and high-quality is sexual and reproductive health care for all in Australia?

The framework takes a person-centred, whole-of-life approach; focused on

- who is – and who is not – accessing sexual and reproductive healthcare when they need it
- what the barriers are to accessing SRH health care
- what the experiences are of those who do access care.

It looks at how equitable the design and delivery of sexual and reproductive health services are, the quality of services, and the contextual and systemic factors that shape SRH in Australia.

Priority areas

This work has been directed toward 5 initial policy priority topics with significant data gaps:

- menstrual disorders, symptoms and related conditions (including endometriosis)
- contraception
- pregnancy loss before 20 weeks' gestation (including miscarriage)
- termination of pregnancy, also known as abortion
- perimenopause and menopause.

These initial priority topics represent a starting point for the data strategy and reporting, with the intention to expand them over time to include other important areas of SRH.

Data strategy

The data strategy sets out a plan to collect and report reliable and timely SRH data. It proposes to improve the quality and availability of SRH information in three ways:

- **Maximising use of existing data collections:** through enhanced analysis and data linkage and undertake more complex analysis and bespoke analytical projects.
- **Enhancing existing or planned data collections:** by collaborating with owners of existing data collections to add questions or modules to existing surveys, develop consistent data standards, or improve data extraction from existing systems (for example, in primary care).
- **Options for new data collections:** establishing a new collection, or standardising and collating existing data where insufficient data exists or where further data development of existing sources is not feasible:
    - **National sexual and reproductive health survey:** a potential new ongoing national sexual and reproductive health survey would help address many gaps.
    - **National register on pregnancy loss before 20 weeks' gestation:** a national register on pregnancy loss would improve information on people experiencing pregnancy loss who require health care.
    - **Workforce survey and/or skills and practice audit:** an SRH workforce survey and/or skills and practice audit could fill a range of data gaps on the capacity and capability of the SRH workforce and services.
    - **Pharmacy data collection:** an ongoing SRH pharmacy data collection including PBS-subsidised and private/non-subsidised scripts would support monitoring of use, affordability and geographic accessibility of SRH-related medications over time.
    - **Service data collection:** an aggregate service-level data collection collating measures such as services provided and the reason for provision.

The data strategy and the framework are expected to support additional priority topics in the future and evolve to reflect the dynamic nature of SRH for all people in Australia and changing stakeholder information needs.

Next steps

After the public consultation, the AIHW will finalise the framework and strategy by the end of 2025. The following phase of this work will focus on data development activities and developing regular reporting mechanisms in relation to the initial priority topics. The first annual report will be released publicly in mid-2026.

1 Introduction

Sexual and reproductive health is fundamental to health and wellbeing across every stage of life for all people in Australia. Despite this, there are gaps in national data, statistics, and monitoring information in Australia which make it difficult to know the timeliness, accessibility and quality of sexual and reproductive health (SRH) care, and whether policy outcomes are being achieved.

The AIHW has been funded by the Australian Government Department of Health, Disability and Ageing to develop a national SRH monitoring framework (the framework), data strategy and regular reporting.

This document presents the framework and data strategy that is intended to guide data collection and monitoring that informs evidence-based policy and service provision and improves healthcare outcomes, including in relation to equity, access and quality.

The goal is to ensure there is timely and reliable information about sexual and reproductive health and services in Australia to help plan, deliver and improve SRH services and outcomes – and act as a go-to resource for policymakers, researchers, peak bodies, health services, patients and the interested public.

This document presents a summary of the process to date (Section 2), the draft SRH monitoring framework (Section 3) and data strategy (Section 4), intended to guide data collection and monitoring that meets Australia's SRH information needs.

1.1 Policy context

The framework provides a conceptual structure for data collection and reporting that responds to the overarching question looking at how timely and accessible SRH care is for all people throughout their lives in Australia. Equity, access and quality are critical considerations underpinning the topics and areas of measurement in this report.

The framework has been developed based on:

- the current policy context, such as the National Women's Health Strategy (Department of Health 2019b) and two recent SRH Senate inquiries (Community Affairs References Committee 2023; Community Affairs References Committee 2024) (see Appendix A for further detail)
- priorities and recommendations from:
    - existing jurisdictional frameworks (Queensland Sexual Health Framework 2021, Tasmanian SRH Strategic Framework 2024–2030)
    - national frameworks such as the draft Australian Health System Performance Assessment Framework
    - international frameworks and programs (Johnston et al. 2024; WHO 2017; WHO 2024b; UNFPA 2019; Data4Impact Project 2020; OECD 2025).

1.2 Purpose of this public consultation

Public consultation is a valuable and important opportunity to help shape the direction of the framework and strategy.

The public consultation will be open until **2 November 2025** and feedback can be submitted via the online portal. The AIHW will consider all submissions received.

Feedback is particularly sought on:

- the framework components and how they are arranged, including ensuring inclusivity and prioritisation of key elements
- areas of measurement and data processes proposed in the data strategy
- data sources (existing and in development) that could be included in reporting under the framework and strategy
- data stewardship and guidance for ongoing stakeholder engagement to support the process.

Box 1.2: Some questions to consider for specific feedback include:

- How well do you think this draft framework and data strategy will address your SRH data questions/needs?
- What are your recommendations for future priority areas of focus?
- How easy was it to understand the draft framework and data strategy, and why?
- How clear are the overall goals and proposed actions of the draft framework and data strategy respectively?
- Please suggest alternatives if improvements are needed for specific terminology in the draft framework and data strategy

After the public consultation, the AIHW will finalise the framework and strategy. The next phase will focus on data development activities and developing regular reporting mechanisms. The first annual report will be released publicly in mid-2026.

1.3 Inclusivity and visibility

Improved health outcomes for all people in Australia will be gained by strengthening the evidence base that informs decision-making in and for the health system. Accurate and responsive data is needed that makes visible the complex and evolving SRH concerns and priorities of diverse people within and between groups around the country.

Existing data is inadequate for effectively identifying and monitoring the evolving health needs for many in Australia. As part of the SRH data strategy and in reporting, the AIHW will work to develop and improve disaggregation categories.

During the consultations, stakeholders reported that there is limited or no centrally collated or accessible information on the needs and experiences of priority populations to inform access, quality and safety improvements (see section 2.3). Stakeholders expressed concern that limited information is known about people who do not have access to Medicare, people who use private services and people who use medications that are not on the PBS.

The AIHW welcomes guidance on terminology and good data practices that are inclusive and contribute towards improving the specificity of the data available to inform policies and SRH decision-making processes.

Culturally and linguistically diverse

Feedback received during the AIHW consultation process was that ‘culturally and linguistically diverse’ is problematic as a classification for reflecting the aspects of culture, language, race, ethnicity and migration status that impact SRH access and outcomes.

In this report, specific language is used where feasible and accurate (for example, ‘people without access to Medicare’ or ‘people on temporary visas’ or ‘refugees’). At other times, the term people with ‘culturally and linguistically diverse’ characteristics continues to be used as a placeholder until more appropriate categories are defined.

Sex and gender

Sexual and reproductive health is inclusive of many health issues experienced by people of all sexes and genders. Improved health outcomes for all people in Australia will be gained by ensuring the evidence base that informs decision making in and for the health system considers sex, gender, variations of sex characteristics and sexual orientation (NHMRC 2024). The standard for sex, gender, variations of sex characteristics and sexual orientation variables from the Australian Bureau of Statistics (ABS) standardises the collection and dissemination of data and will guide the data reporting and collection of the AIHW in relation to SRH (ABS 2021).

The AIHW recognises that the priority topics identified for the first phase of this workplan are focused primarily on SRH experiences typically associated with female sex characteristics.

In this report, a combination of sex- and/or gender-specific, gender inclusive and gender-neutral terms are used, often reflecting adherence with the scope/definitions present in existing datasets and publications. Many data collections only record 'male/female' or 'men/women' and it is not always clear where this relates to sex or gender. 'Transgender and gender diverse' has been used throughout this report (Zwickl et al. 2024).

First Nations people

For Aboriginal and Torres Strait Islander (First Nations) people, good health is more than the absence of disease or illness; it is a holistic concept that includes physical, social, emotional, cultural, and spiritual wellbeing, for both the individual and the community. This framework and data strategy seeks to reflect this and highlight SRH experiences of First Nations people, including in settings including Aboriginal Community Controlled Health Organisations (ACCHO) and other health services.

The AIHW already has trusted partnerships with First Nations communities, organisations and other stakeholders. The project team will seek guidance and advice from the AIHW Indigenous Statistical and Information Advisory Group (ISIAG) on the SRH monitoring framework and data strategy and reporting phases of this project. The team will also provide high level reporting on progress of the project to the AIHW First Nations Governance Group.[1] The AIHW is committed to the implementation of the Framework for Governance of Indigenous Data including the 4 guiding principles outlined below as well as ensuring that our commitments to the 4 Priority Reforms under the 2020 National Agreement on Closing the Gap are realised in the implementation plan of the SRH monitoring framework (NIAA 2024; NIAA 2020).

As processes and standards around SRH data collection and reporting are developed, the AIHW will strive to ensure that they reflect the diversity of people and their experiences of SRH accurately.

For further information see:

Appendix A: Policy context

Appendix B: Stakeholder engagement and key themes from consultations

Appendix K: References

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[1] See for example the National Disability Research Partnership, "Embedding Co-Design in Your Research", ndrp.org.au/resources/co-design

2 Process

Feedback from this public consultation is particularly sought on how we can ensure that we are making visible important areas in SRH through enhanced data disagregation and appropriate terminology on priority topics.

The framework and data strategy have been informed by a review of available literature, the current data landscape and consultation with a diverse range of stakeholders. These include Australian Government and state and territory government agencies, policymakers, researchers, service planners, service administrators, peak bodies and advocates, health-care providers, people with lived experience, and community/not-for-profit organisations. Consultations included workshops, one-on-one meetings and engagement with existing advisory groups and committees.

Topic overview reports (Appendices D-H) summarise learnings from the literature and data landscape review and input from stakeholders across the five priority topics, including in relation to equity and access. They also include a data strategy to analyse existing data and address gaps identified.

Figure 2.1: Monitoring framework and data strategy development process to date

1
Identify Priority Topics
Policy priorities with significant data gaps

2
Topic Overview Reports
Collate local & international evidence for each topic

3
Establish NMEAG
National Miscarriage Expert Advisory Group

4
Stakeholder Consultation Workshops
15 topic, profession and approach-based workshops

5
Public Consultation
Monitoring Framework & Data Strategy available for public consultation

More than 70 Bilateral meetings
with key individuals and organisations

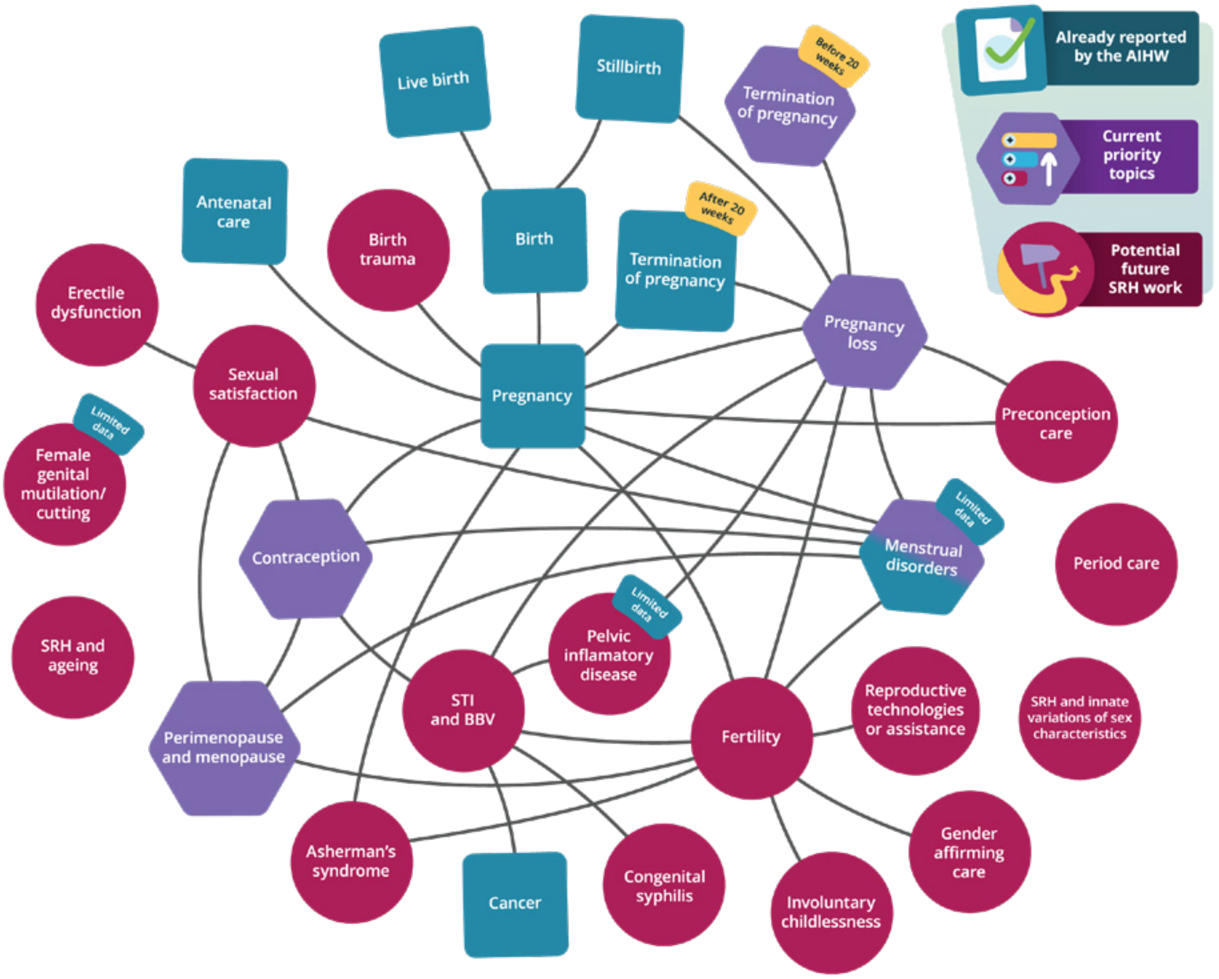
Internal AIHW consultation
for SRH integration and collaboration across AIHW

2.1 Priority topics

Sexual and reproductive health (SRH) across the life course encompasses a vast range of topics (see Figure 2.1). A key component of the early stages of this project was therefore to define the scope of the work and identify initial priority topics in line with current policy priorities and with significant data gaps.

The framework was developed to apply across all areas of SRH; however, for the data strategy and initial reporting it was necessary to identify initial priority topics to focus data development activities on areas of current policy priority with significant information and data gaps. This was done through early stakeholder consultations and a review of relevant policy priorities and recent Senate inquiries (see Appendices A and B).

Figure 2.1: Mapping of sexual and reproductive health topics



The priority topics identified as a start for monitoring and reporting on SRH in Australia are:

- **Menstrual disorders, symptoms and related conditions**, which includes menstrual disorders, some of their underlying causes, and associated symptoms. Menstrual disorders are disruptions related to the menstrual cycle such as heavy menstrual bleeding and painful periods. These can be due to underlying chronic conditions, such as endometriosis, or their cause may be unknown (see Appendix D). People may also experience symptoms that are not only experienced during the menstrual cycle, such as pelvic pain, and may indicate an underlying condition.
- **Contraception**, commonly known as 'birth control', or the act of preventing pregnancy using pharmaceutical, procedural or behavioural methods (Bansode et al. 2023). Contraceptives are used by people of diverse genders, sexes and ages to prevent pregnancy, manage hormones (for example, for management of menstrual disorders) and reduce risk of sexually transmitted infections (STI). Access to contraception, and contraceptive choice, is a critical component of universal access to SRH and realisation of reproductive autonomy (see Appendix E).
- **Pregnancy loss** is a common reproductive health experience that can have significant physical, emotional, and psychological impacts on all individuals involved in the pregnancy. For the purposes of this work program, pregnancy loss is defined as the unplanned loss of a pregnancy before 20 weeks' gestation[2] and includes miscarriage as well as other types of pregnancy loss (see Appendix F).

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[2] In stakeholder consultations, the term 'pregnancy loss' was preferred to miscarriage as it encompasses all forms of pregnancy loss, for example, ectopic pregnancy and molar pregnancy, in addition to miscarriage. The AIHW will use both 'miscarriage and 'pregnancy loss' where appropriate, reflecting the terminology used in the literature or data sources being referenced. Where 'miscarriage' is used, it is intended to align with the original source material or clinical coding, while pregnancy loss includes a broader spectrum of experiences.

- **Termination of pregnancy**, also known as abortion, involves intentionally ending a pregnancy by removal of the embryo or foetus and placenta from the uterus, most often by taking medications or undergoing a surgical procedure (see Appendix G). Termination of pregnancy (TOP) has been decriminalised in all Australian jurisdictions, yet quality TOP care is not universally accessible (Community Affairs References Committee 2023; Vallury et al. 2023) (see Appendix G).
- **Menopause** occurs when the reproductive capacity of a person ceases, signified by the absence of a menstrual period for one year. Menopause is preceded by **perimenopause** – a time characterised by changes in menstrual period frequency and regularity, the onset of oestrogen deficiency symptoms, and physical changes to the body and its functioning – which typically lasts 4 or more years (AMS 2022). Understandings of experiences, impacts and barriers to care are limited (see Appendix H).

Topic overview reports were developed for each of the 5 initial priority topics. These included reviews of the literature and the data landscape, including data gaps. The stakeholder consultation process led to a refined list of critical data gaps and priorities for data development that have directly informed the development of the data strategy (see Appendices D, E, F, G and H).

For further information see:

Appendix D: Menstrual disorders, symptoms and related conditions: Topic overview and data strategy

Appendix E: Contraception: Topic overview and data strategy

Appendix F: Pregnancy loss (including miscarriage): Topic overview and data strategy

Appendix G: Termination of pregnancy: Topic overview and data strategy

Appendix H: Perimenopause and menopause: Topic overview and data strategy

Appendix K: References

Appendix L: Glossary

2.2 Complexity of SRH

These health concerns interact across different stages of life and can have a significant impact on a person's physical and mental health. Events occurring earlier in life, such as age at menarche, also impact on experiences later in life. For example, having the first menstrual period before 11 years of age is strongly associated with onset of menopause prior to age 45, endometriosis is associated with 1.8 times the rate of pregnancy loss compared with those without endometriosis, and people who have a history of recurrent pregnancy loss and/or stillbirth have a higher risk of experiencing premature or early menopause (Huang et al. 2020; Liang et al. 2023; Mishra et al. 2017). These events are also related to broader health issues such as infertility, chronic pain and poorer mental health.

The initial 5 priority topics represent a starting point, with the intention to expand them over time to include other important areas of SRH. Figure 2.1 shows a mapping of SRH topics and their relationships and includes reporting that is already undertaken by the AIHW, the 5 initial priority topics in this data strategy, and possible future topics where information gaps exist.

2.3 Stakeholder engagement and consultation

The AIHW acknowledges that there are many stakeholders engaged with this work and appreciates the diverse input that has informed the drafting of the framework and data strategy to date.

The AIHW has engaged with a broad range of stakeholders to inform development of the draft framework and data strategy (see Appendix B and M). Broad and ongoing stakeholder engagement is central to ensuring that the framework and data strategy deliver data and information that meet the needs of stakeholders.

Throughout the consultation process, stakeholders acknowledged that there is a need for improved, systematic data collection on SRH throughout life for all people in Australia. Stakeholders expressed a need for data to better understand the current state of SRH in Australia, address barriers to access, shed light on people's needs and experiences, and to improve policy, services and outcomes over time (see Appendix B). Other cross-cutting issues raised by stakeholders in the consultations include:

- **Financial cost and inconvenience:** the out-of-pocket costs and challenges of diagnosis and treatment can be very high, especially if people need to take time off work or travel away from their homes. Cost is anticipated to be a major barrier to access for people, and especially so for priority populations.
- **Workforce challenges, limitations and improvements:** Stakeholders would like data to understand patient experiences within the SRH system, including qualitative data. There is also demand for data that measures workforce training in SRH, and ideally, tracks improvements in SRH literacy and competency – as well as scope of practice changes to increase workforce capacity.

When asked about preferred data availability and reporting formats, stakeholders expressed the need for a range of formats according to the end use of the data. Table 2.3 summarises stakeholder groups and the key SRH data and information needs each identified. These will be used to shape the development of ongoing reporting of the AIHW SRH work program.

For further information see:

Appendix B: Stakeholder engagement and key themes from consultations

Appendix M: Acknowledgments and stakeholders consulted

Table 2.3: Summary of stakeholder groups, their information needs, and preferences for data

Stakeholders	Information needs	Preferences for data
Commonwealth and jurisdictional government agencies	Collect, share and use SRH data Data linked to improved outcomes, such as to see return on investment	Want analysis (what it means and why) and raw data Value shareable content: data summaries and trends
Policymakers (local, state, Commonwealth)	Look ahead, and try to understand the issues, trends, outliers and anomalies	Like summary information that gets to the point fast because they write briefs for Ministers, taskforces and project teams at very short notice
Researchers	Dive deep into the data to build stronger evidence and provide advice on clinical practice, trends or priority population groups	Find raw data most useful and will often add it to other data and/or their own analysis Need to be made aware of the data limitations Use data to promote and measure intervention impacts
Service planners	Determine budget allocations and seek additional resources where needed	Want granular, localised data and disaggregated data to target initiatives and services to specific populations Want to better understand segments that their organisations service and relevant trends or learnings
Service administrators[3]	Review raw data and local level data as well as disaggregated data to understand issues/ trends and populations that their organisations, or others, service	Those that need to report against government targets and sector indicators find raw data most useful Value videos and content to help explain data to others

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[3] Includes Primary Health Networks, community and not-for-profit sector health services/service providers, SRH clinics, ACCHOs, and private sector

Stakeholders	Information needs	Preferences for data
Peak bodies and advocates representing consumers and people with lived experience	Inform submissions, influence policy or local planning, and educate consumers	Want data to describe and quantify need, prevalence, barriers to access and inequity Interested in highlights and analysis of key issues and trends; raw data, and open and flexible datasets as well
Health-care providers[4]	Understand how the incidence of disease is changing, consumer behaviours, overarching trends Professional organisations use data to advocate on behalf of their members to governments, research institutions and other bodies	Want to see data linked with other relevant data sets Want highlights and analysis of key issues and trends
Media and individual consumers, including visitors to the AIHW website	Be informed and for some to publish information for their audiences	Want easy-to-understand 'quick bites' and specific information supported by simple navigation and search functions to drill down further into trends Like simple visualisations to help explain the data

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[4] Includes nurses, clinicians, and other health-care providers who work with patients and may collect or use local area data. Also includes professional colleges and associations.

2.4 Guiding principles

Guiding principles have been identified as supporting high-quality, evidence-based, and equitable responses to SRH and have been used to guide the development of the framework (Box 2.4).

Box 2.4: Guiding principles

- A human rights framework that acknowledges that all people have the right to enjoy the highest attainable standard of SRH, in line with rights to life, health, privacy, security, education, and freedom from discrimination and torture (OHCHR 2025; Melville and Corbin 2024).
- A person-centred and life course approach to monitoring that focuses on key aspects of who is and who is not experiencing sexual and reproductive health care and positive outcomes, and when.
- An approach that considers an understanding of health and well-being in relation to SRH conditions, including contributing to data to inform burden of disease estimates for SRH conditions.
- A focus on equity of SRH access and outcomes and service quality, beyond just ‘availability’. "*Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically*" (WHO 2025a).
- An approach that considers care delivered with the assistance and support of clinical guidelines, where confidentiality and privacy are trusted and assured, and service- and public-facing feedback mechanisms are functioning for quality improvement and accountability to stakeholders.
- A socio-ecological approach that enables measurement of, and exploration of interrelationships between, factors that influence SRH at individual, interpersonal, institutional and broader environmental and policy levels. This includes consideration of the contextual factors that shape SRH in Australia.
- An approach that complements and works alongside existing national and global SRH frameworks. The AIHW has aimed to develop a mechanism through which to supplement and fill gaps in existing frameworks, and to bring together priorities, indicators, research and data across the topic areas.
- An approach that considers outcomes of the National Agreement on Closing the Gap, including throughout implementation (Department of the Prime Minister and Cabinet 2020).

2.5 Priority populations

Research and consultations identified that it is critical for the framework to facilitate improved understandings about the experiences of all Australians to inform policy and service design that enables equitable SRH access and outcomes.

For each of the priority topics there are also a range of population groups who face additional barriers to SRH care, and experience poorer SRH outcomes (see list below, and Appendices D-H). Additional groups may be identified in new or integrated data assets in the future. Existing data is inadequate for effectively identifying and monitoring the SRH needs and changes for people, within and between diverse population groups.

The reviews of literature and consultations identified that it is critical for the framework to facilitate improved understandings about these experiences. It is intended that data collected and reported against the framework will enable disaggregation by population, provider and service characteristics to the greatest extent possible. Recognising the intersectionality among different population groups is also central to understanding the complexity of these experiences. Acknowledging that disaggregation of existing data may not be immediately possible for all cohorts, improving the ability of data to be reported by priority groups will be a key focus of the data strategy, including for people who are (in alphabetical order):

- culturally and linguistically diverse, including recent migrants and refugees
- experiencing family, domestic and sexual violence and coercion
- experiencing socioeconomic disadvantage, including those not in education employment or training
- First Nations people
- have innate variations of sex characteristics
- ineligible for Medicare, including those on temporary visas
- lesbian, Gay, Bisexual, and Queer
- living in closed settings, including prisons, detention centres and residential rehabilitation centres
- living in regional, rural and remote areas
- living in insecurity, including unstable housing or experiencing homelessness
- living with chronic and/or complex health needs, including people with disabilities and/or who are neurodivergent
- transgender and gender diverse
- transacting or selling sex and / or
- young people.

2.6 A life course approach

Sexual and reproductive health and wellbeing evolve throughout the course of a person's life. Taking a life course approach to developing SRH data involves recognising and measuring SRH experiences and access to health care throughout the different stages of development from birth to pre-puberty, to ageing and post-menopause. This approach allows for an understanding of sexual experiences and reproductive intentions and choices, risk, vulnerability, and physiological influences on health outcomes, as well as varying levels of access to health services and information across the course of their lives. A life course approach also means understanding how social, institutional and political contexts shape and gatekeep the pathways available to individuals (Baxter et al. 2022).

Developing a comprehensive understanding of SRH across the life course is critical for informing the timing and focus of health interventions, policies and services that maximise positive impacts on health. If done well, a life course perspective to data monitoring can facilitate understandings of optimal health trajectories, and critical life periods in which health measures and interventions have the greatest potential to impact health and wellbeing trajectories for different population groups (Burton-Jeangros et al. 2015). A life course perspective requires repeat measurement and benefits from data linkage processes.

For further information see:
Appendix K: References

3 Monitoring framework

Feedback from this public consultation is particularly sought on the framework components and how they are arranged, including ensuring inclusivity and prioritisation of key elements.

The framework provides a conceptual structure for monitoring, understanding and responding to critical SRH issues in Australia. It promotes a coherent view of what is important to monitor to:

- align with policy and stakeholder priorities
- inform evidence-based policy and service provision
- improve health-care outcomes throughout a person's life, including equity and access.

The framework has been designed to apply to all areas of SRH, to support the addition of future priority topics. The approach taken aligns with international definitions and global health frameworks and has been guided by the principles outlined in section 2.4.

Box 3.1: Defining sexual and reproductive health and rights (SRHR)

"Sexual and reproductive health refers to a broad range of services that cover access to contraception, fertility and infertility care, maternal and perinatal health, prevention and treatment of STI, protection from sexual and gender-based violence, and education on safe and healthy relationships.

Experiencing sexual and reproductive health means that a person has complete physical, mental and social well-being in all matters relating to their reproductive system and its functions. In everyday life, this means that people are able to have satisfying and safer sex, to have healthy pregnancies and births, and decide if, when and how often to have children.

Access to sexual and reproductive health services is a human right and should be available to all people throughout their lives, as part of ensuring universal health coverage. This not only contributes to improved health outcomes, but also to gender equality and wider development" (WHO 2025b).

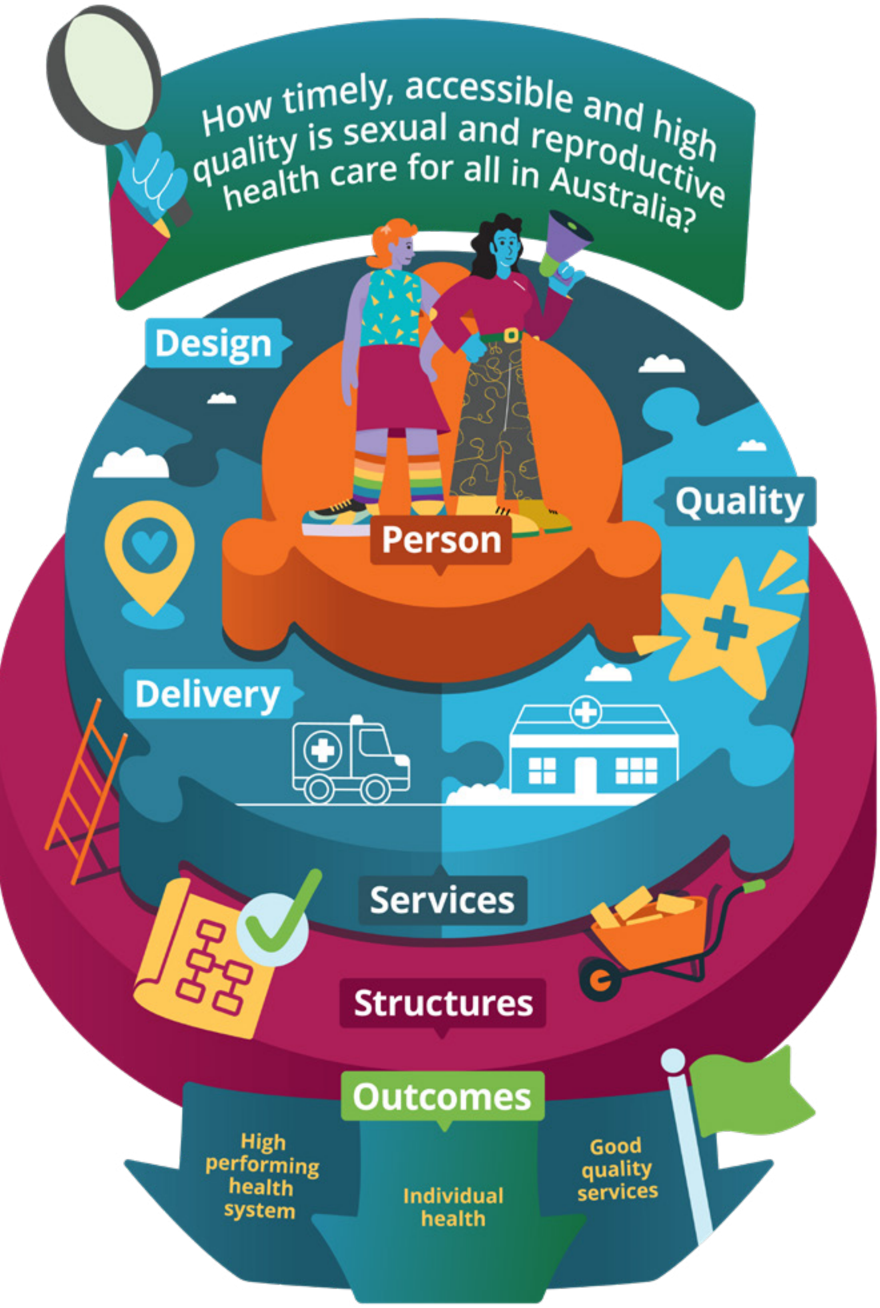
3.1 The framework's components

The framework provides a conceptual structure for data collection and reporting that responds to the overarching question:

> **How timely, accessible and high quality is sexual and reproductive health care for all in Australia?**

Figure 3.1 shows a model of the framework and lays out the key conceptual elements. The socio-ecological approach is illustrated in concentric layers, representing the contexts in which individuals access and experience SRH. The desired health outcomes are a result of actions that occur within and between these 3 levels.

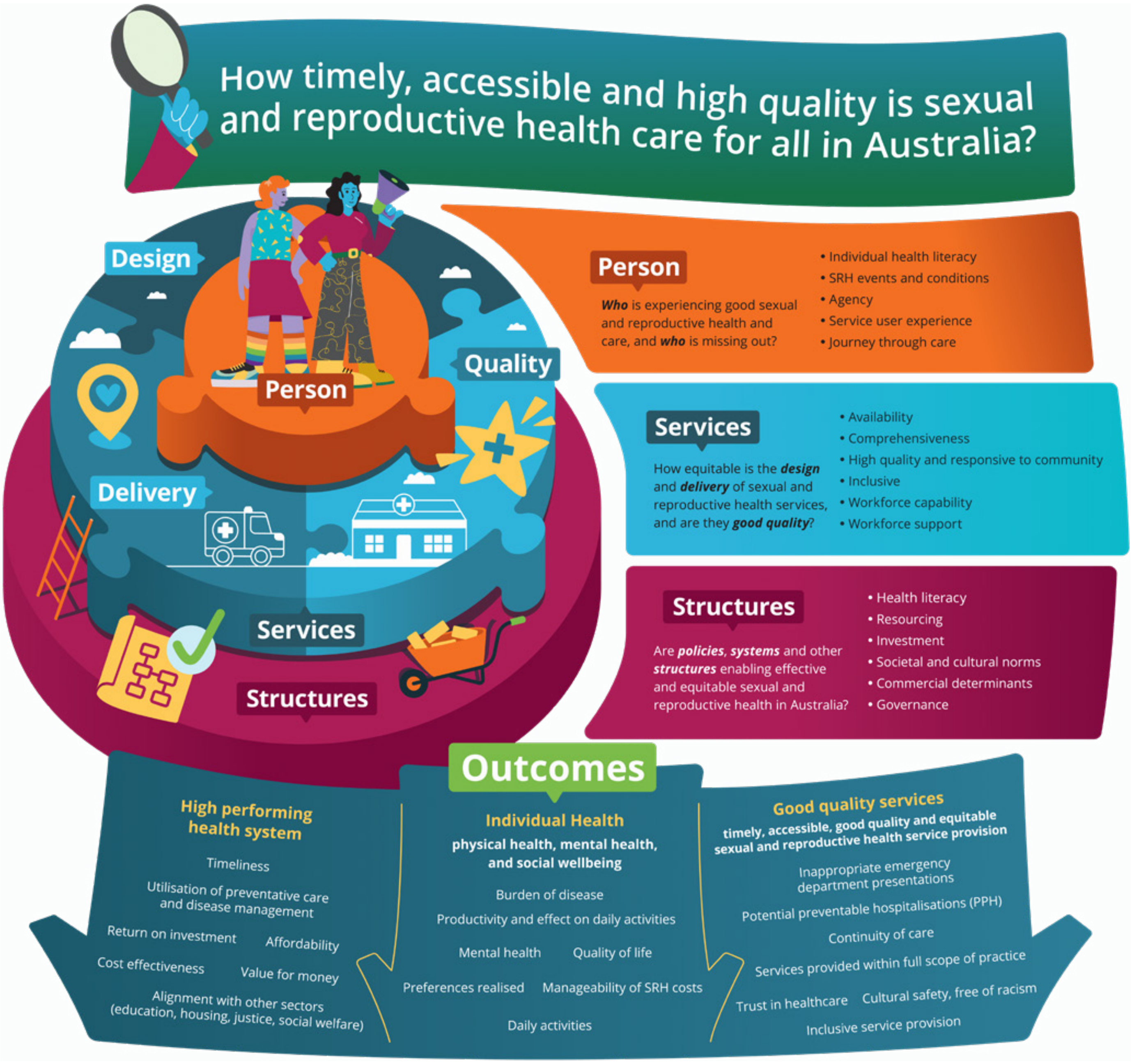
Figure 3.1: SRH monitoring framework



Within each level, the framework includes domains (Figure 3.2) and sub-domains (Figures 3.3–3.5) that reflect priority areas of potential measurement and monitoring of: SRH prevalence, determinants of SRH, equity, service design, delivery and quality, and experiences of care, and connects these to outcomes (Figure 3.2–3.5). The domains and sub-domains are organised at the 3 levels of person, services, and structures and address 3 guiding questions:

- **Person:** Who is experiencing good sexual and reproductive health and care, and who is missing out?
- **Services:** How equitable is the design and delivery of sexual and reproductive health services, and are they high-quality?
- **Structures:** Are policies, systems and other structures enabling effective and equitable sexual and reproductive healthcare in Australia?

Figure 3.2: SRH monitoring framework: detailed



How timely, accessible and high quality is sexual and reproductive health care for all in Australia?

Person

Who is experiencing good sexual and reproductive health and care, and ***who*** is missing out?

- Individual health literacy
- SRH events and conditions
- Agency
- Service user experience
- Journey through care

Services

How equitable is the ***design*** and ***delivery*** of sexual and reproductive health services, and are they ***good quality***?

- Availability
- Comprehensiveness
- High quality and responsive to community
- Inclusive
- Workforce capability
- Workforce support

Structures

Are ***policies, systems*** and other ***structures*** enabling effective and equitable sexual and reproductive health in Australia?

- Health literacy
- Resourcing
- Investment
- Societal and cultural norms
- Commercial determinants
- Governance

Outcomes

High performing health system

Timeliness
Utilisation of preventative care and disease management
Return on investment
Affordability
Cost effectiveness
Value for money
Alignment with other sectors (education, housing, justice, social welfare)

Individual Health

physical health, mental health, and social wellbeing

Burden of disease
Productivity and effect on daily activities
Mental health
Quality of life
Preferences realised
Manageability of SRH costs
Daily activities

Good quality services

timely, accessible, good quality and equitable sexual and reproductive health service provision

Inappropriate emergency department presentations
Potential preventable hospitalisations (PPH)
Continuity of care
Services provided within full scope of practice
Trust in healthcare
Cultural safety, free of racism
Inclusive service provision

The following sections describe the levels of the framework in more detail, including the domains, sub-domains and outcomes (further details and descriptions are in Appendix C).

Person

Who is experiencing high-quality sexual and reproductive health and care, and who is missing out?

The first part of the framework focuses on monitoring SRH care and outcomes by identifying who is and is not experiencing good SRH. Areas of measurement to assess good SRH could include if it is timely, free from stigma, results in a positive or desired outcome. Individual (intrapersonal) and interpersonal determinants are the focus, including characteristics and experiences of people that relate to their experiences of SRH, and outcomes relate to physical and mental health and social wellbeing of a person. People live within families, communities and the wider society - their personal circumstances can impact their behaviours and ability to exercise agency and autonomy in general and in relation to SRH. Data in this part of the framework would be collected, analysed and reported by cohorts of people to make visible who is and is not experiencing good SRH around Australia.

Figure 3.3: Person: domains, subdomains and outcomes

Who is experiencing sexual and reproductive health and care, and ***who*** is missing out?

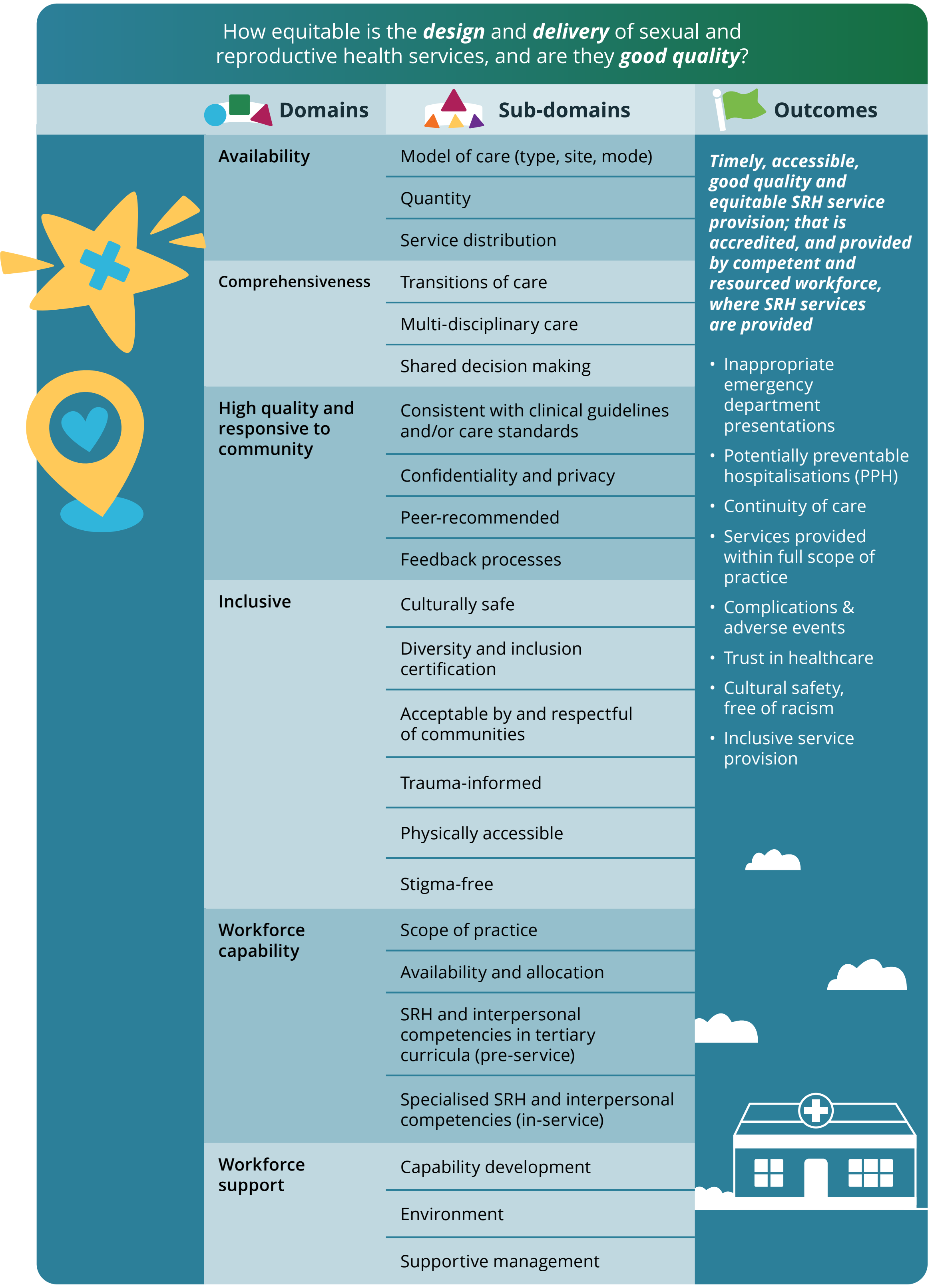
Domains	Sub-domains	Outcomes
Individual health literacy	Knowledge	***Physical health, mental health & social wellbeing*** • Burden of disease • Productivity and effect on daily activities • Mental health • Quality of Life • Preferences realised • Manageability of SRH costs • Unmet need
	Appropriate delivery	
SRH events and conditions	Prevalence	
	Incidence	
	Recurrence	
Agency	Autonomy	
Service user experiences	Cost to service user	
	Wait times	
	Distance	
Journey through care	Care pathways	
	Referrals	

Services

How equitable is the design and delivery of sexual and reproductive health services, and are they high-quality?

This level of the framework focuses on monitoring the design and delivery of SRH services, with a focus on the extent to which they are equitable and high-quality. Areas of measurement to assess this could include considering if people are accessing the right services, the nature and type or interpersonal interactions between people and health care providers, and if the care pathways are desirable and efficient and reaching those who need them. Outcomes at this level include aspects of workforce support and capacity, accreditation and inclusivity, and physical and cultural safety.

Figure 3.4: Services: domains, subdomains and outcomes



How equitable is the ***design*** and ***delivery*** of sexual and reproductive health services, and are they ***good quality***?

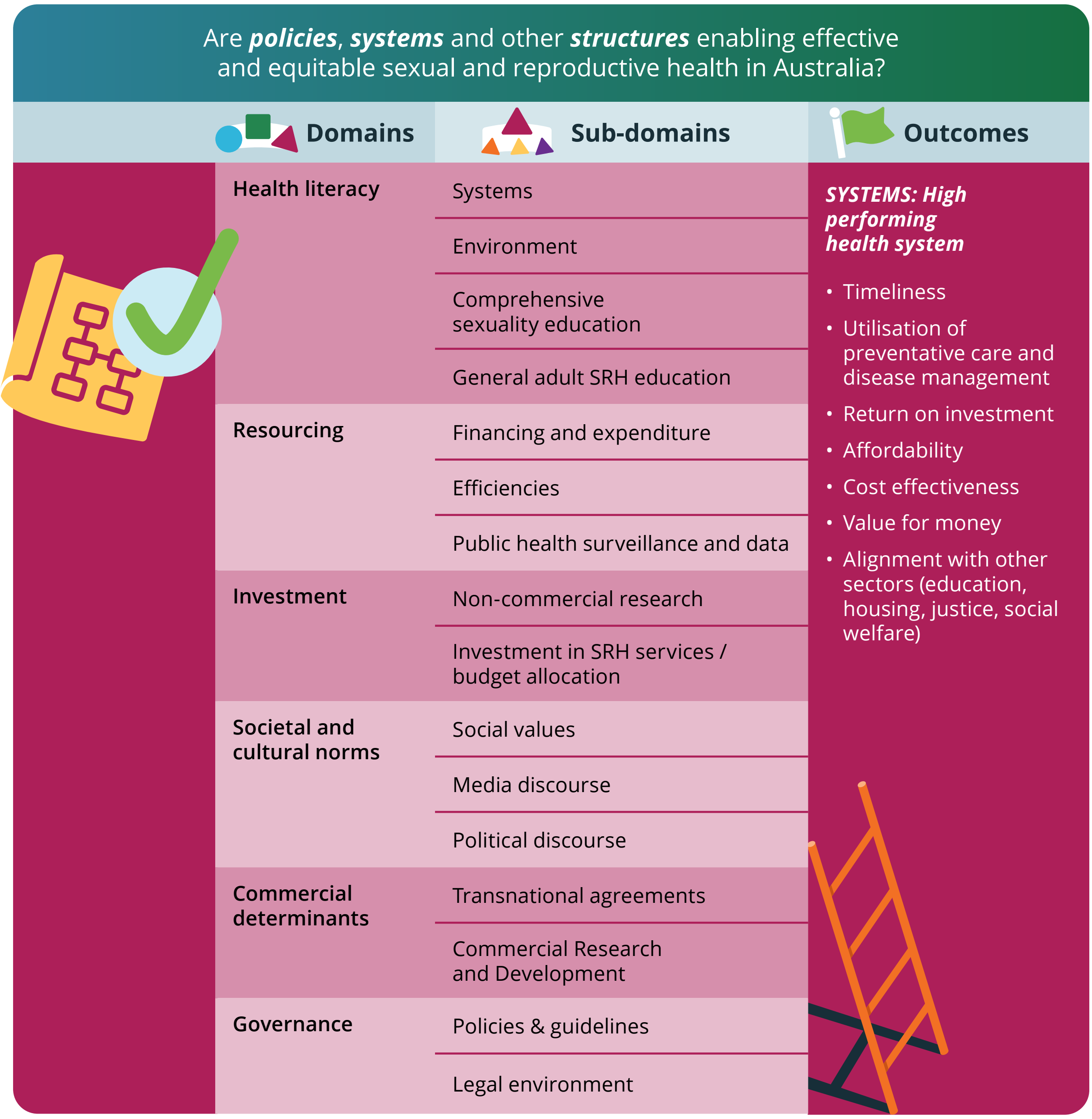
Domains	Sub-domains	Outcomes
Availability	Model of care (type, site, mode)	***Timely, accessible, good quality and equitable SRH service provision; that is accredited, and provided by competent and resourced workforce, where SRH services are provided*** • Inappropriate emergency department presentations • Potentially preventable hospitalisations (PPH) • Continuity of care • Services provided within full scope of practice • Complications & adverse events • Trust in healthcare • Cultural safety, free of racism • Inclusive service provision
	Quantity	
	Service distribution	
Comprehensiveness	Transitions of care	
	Multi-disciplinary care	
	Shared decision making	
High quality and responsive to community	Consistent with clinical guidelines and/or care standards	
	Confidentiality and privacy	
	Peer-recommended	
	Feedback processes	
Inclusive	Culturally safe	
	Diversity and inclusion certification	
	Acceptable by and respectful of communities	
	Trauma-informed	
	Physically accessible	
	Stigma-free	
Workforce capability	Scope of practice	
	Availability and allocation	
	SRH and interpersonal competencies in tertiary curricula (pre-service)	
	Specialised SRH and interpersonal competencies (in-service)	
Workforce support	Capability development	
	Environment	
	Supportive management	

Structures

Are policies, systems and other structures enabling effective, equitable and high-quality sexual and reproductive health in Australia?

This level of the framework considers measurement and monitoring of health and other policies, systems and structures that influence the accessibility and effectiveness of SRH care and equity of SRH outcomes. This includes societal, cultural, and religious values as well as other structural determinants of health. For example, the Organisation for Economic Co-operation and Development has highlighted the need to measure the legal and social context in which SRH is situated (OECD 2025). At the systems level, outcomes that aid in assessment of health system performance were identified and where relevant are aligned with those proposed in the draft Australian Health Performance Framework (AHPF) framework.

Figure 3.5: Policies, systems and structures: domains, subdomains and outcomes



Are ***policies***, ***systems*** and other ***structures*** enabling effective and equitable sexual and reproductive health in Australia?

Domains	Sub-domains	Outcomes
Health literacy	Systems	***SYSTEMS: High performing health system*** • Timeliness • Utilisation of preventative care and disease management • Return on investment • Affordability • Cost effectiveness • Value for money • Alignment with other sectors (education, housing, justice, social welfare)
	Environment	
	Comprehensive sexuality education	
	General adult SRH education	
Resourcing	Financing and expenditure	
	Efficiencies	
	Public health surveillance and data	
Investment	Non-commercial research	
	Investment in SRH services / budget allocation	
Societal and cultural norms	Social values	
	Media discourse	
	Political discourse	
Commercial determinants	Transnational agreements	
	Commercial Research and Development	
Governance	Policies & guidelines	
	Legal environment	

For further information see:

Appendix C: Descriptions of domains, sub-domains and outcomes for the sexual and reproductive health monitoring framework

Appendix I: Visual summary of the monitoring framework

4 Data strategy

Feedback from this public consultation is particularly sought on:

- areas of measurement and data processes proposed in the data strategy
- data sources (existing and in development) that could be included in reporting under the framework and strategy.

This data strategy summarises what stakeholders and the topic overviews (Appendices D-H) indicated are important in terms of key data gaps and how to measure and monitor these, in relation to the priority topics. This is cross-referenced with the relevant domains and subdomains of the monitoring framework (section 3), noting that each priority topic will only relate to a subset of the domains/subdomains depending on the critical data gaps and priorities for data development for each topic. The data strategy focuses on the five initial priority topics that AIHW will initially report on but these topics can be expanded in the future.

A data strategy for each of the priority topics is included in the Topic overview and data strategy appendices (Sections D2, E2, F2, G2, H2) and provides a high-level summary of:

- current data sources that exist and could fill a data gap
- existing data sources that could be expanded to potentially fill data gaps if data elements were added or by data linkage, or the quality of that source was improved
- potential options for developing a new data source where no national data currently exists, either via establishing a new data collection or by standardising and collating existing data.

The data strategy presented in this section is an overarching strategy, whereas Appendices D-H focus on the data strategy for each of the five initial priority topics. The data strategy and framework allow for including other topics in future.

The AIHW notes that emerging data sources will require continual monitoring to ensure that the proposed data strategies remain relevant and do not duplicate effort.

What is needed to improve SRH data?

Continuous improvement and integration of data collections and systems is needed to build a comprehensive picture of SRH in Australia. Cost effective and systematic solutions, including the use of existing and future data linkage infrastructure, are required to facilitate improvement in the availability, accuracy and timeliness of SRH information. It is of critical importance to understand how to integrate SRH data to support evidence-based policy, healthcare delivery, service improvement and best practice. Accurate data that are accessible in a timely fashion are crucial to needs-driven and policy-relevant research.

The focus of this work is on addressing gaps in information and data and to not duplicate work currently being undertaken or in development. This data strategy supports further development of existing data sources where possible but also suggests the creation of new data collections/ collection mechanisms where:

- no data currently exists, or
- an existing data source requires significant changes to improve the quality or comparability of data items or requires significant inclusion of additional data items that would likely be impractical.

Equity, priority populations and disaggregation

Equity in access to SRH care and outcomes is a central theme throughout this work, with recognition of the needs of diverse communities and population groups (see section 2). In response to feedback and priorities identified throughout the consultation process, the AIHW will aim to develop data collections and report data in a way that supports meaningful analysis of equity issues. This includes geographical disaggregation, as well as, wherever possible, ensuring data can be used to identify population groups who are currently underserved by or experiencing particularly salient barriers to access to SRH care and commodities.

4.1 Data sources assessment criteria

When identifying data collections that were fit for purpose for inclusion in the data strategy, the following elements were considered:

- **Geographical coverage** (preferably national, or feasible to expand across all/most jurisdictions)
- **Representativeness** (of the target population, including priority populations, and of service providers, including types, public/private)
- **Frequency** (how frequently is the data source updated, will there be subsequent – or are there past - surveys or data collections to enable ongoing monitoring or reporting of time series data)
- Includes at least some **relevant SRH data** elements/items[5].

Data collections that are either one-off studies (i.e. will not be repeated), do not have sufficient coverage or are not representative of the target population, or have small sample sizes that cannot be generalised to the Australian population, have not been considered suitable to address national information needs over time. However, relevant data items from such studies would be considered as examples (to enable comparability and use of validated questions) during any new data development. For example, there are several state-level population health surveys that could be used to inform the development of a national survey by utilising existing questions and/or methodologies where relevant.

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[5] Future data development work will also consider data sources as appropriate for use and development based on: potential for data linkage; ethics and consent processes; privacy issues; capacity to access data/ governance and data transmission arrangements; data ownership; costs; and will be assessed against the AIHW/ABS data quality assessment framework.

Data sources that were considered include national administrative datasets and data collections, linked data assets, jurisdictional administrative datasets and collections, data from service providers, and survey data with national coverage. Smaller surveys, such as those performed at the jurisdictional level, are out of scope as they cannot be combined for national coverage.

Appendix J (section J.2) includes the list of data sources that were considered for the initial scoping phase of SRH data. Other data sources may be important to consider in the future as additional priorities emerge and are identified and added to this work program.

4.2 Development of existing data collections

This section highlights existing data sources currently available for analysis and reporting or those that could be further developed to enhance comprehensiveness and/or quality in relation to the initial priority topics.

National administrative data

Several national administrative data collections have data that are available for analysis and reporting on limited aspects of SRH, including:

- National Hospital Morbidity Database (NHMD)
- National Non-Admitted Patient Emergency Department Care Database (NNAPEDCD)
- National Non-Admitted Patient episode-level Databases (NNAP(el)D)
- Medicare Benefits Schedule (MBS)
- Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS)
- National Elective Surgery Waiting Times Data Collection (NESWTDC)
- National Perinatal Mortality Data Collection (NPMDC)
- National Health Expenditure Database (NHED)
- National Congenital Anomalies Data Collection (NCADC).

Survey data and longitudinal studies

Some existing large-scale surveys in Australia currently include SRH questions relevant to the initial priority topics and could be used to report prevalence estimates where available, and additional information in some cases. When reviewing these data sources for relevancy, typically the most recent questionnaire has been used. However, in some instances, relevant SRH questions are repeated at different intervals, and these surveys have been included. Relevant surveys include the:

- Australian Longitudinal Study on Women's Health (ALSWH) (currently the most comprehensive source of national SRH data for women)
- Australian Study of Health and Relationships (ASHR)

- Household, Income and Labour Dynamics in Australia (HILDA)
- ABS National Study of Mental Health & Wellbeing (includes National Health Survey (NHS), National Health Measures Survey (NHMS) and National Aboriginal and Torres Strait Islander Health Survey (NATSIHS))
- Australian Survey of Secondary Students and Sexual Health (SSASH)
- Longitudinal Study of Australian Children (LSAC)
- Jean Hailes National Women's Health Survey
- Australia's Disability Strategy Survey.

Where possible, opportunities will be explored to expand these collections, either via additional data items or linkage, however, often a significant amount of development would be required to existing collections to address the current data gaps and the priority areas for development/monitoring, particularly across multiple topics. Adding a substantial number of new questions to existing surveys is often not possible due to the need to preserve time series data and avoid substantially increasing the survey length (often existing questions need to be removed to add new questions). As such, the need for new SRH questions would need to be balanced with the value of retaining existing questions and final decision-making on additional data items sits with data custodians and their relevant advisory groups. Therefore, developing a new survey that is specific to sexual and reproductive health may be a preferable option to address this and allow for expansion of additional priority topics in future (see National Sexual and Reproductive Health Survey section).

Data linkage and data assets

Data linkage can be used to investigate different facets of health and service access and enhance the analysis possible with existing administrative datasets and some surveys. There are a range of data linkage assets held or under development by the AIHW and other data custodians such as the ABS. The key data assets the AIHW recommend further exploring, include:

- The AIHW's National Health Data Hub (NHDH), which draws together core administrative health, disability and aged care datasets and provides opportunities for future analysis.
- The Person Level Integrated Data Asset (PLIDA) is a secure data asset held by the ABS, combining information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) over time.

Australian Burden of Disease Study

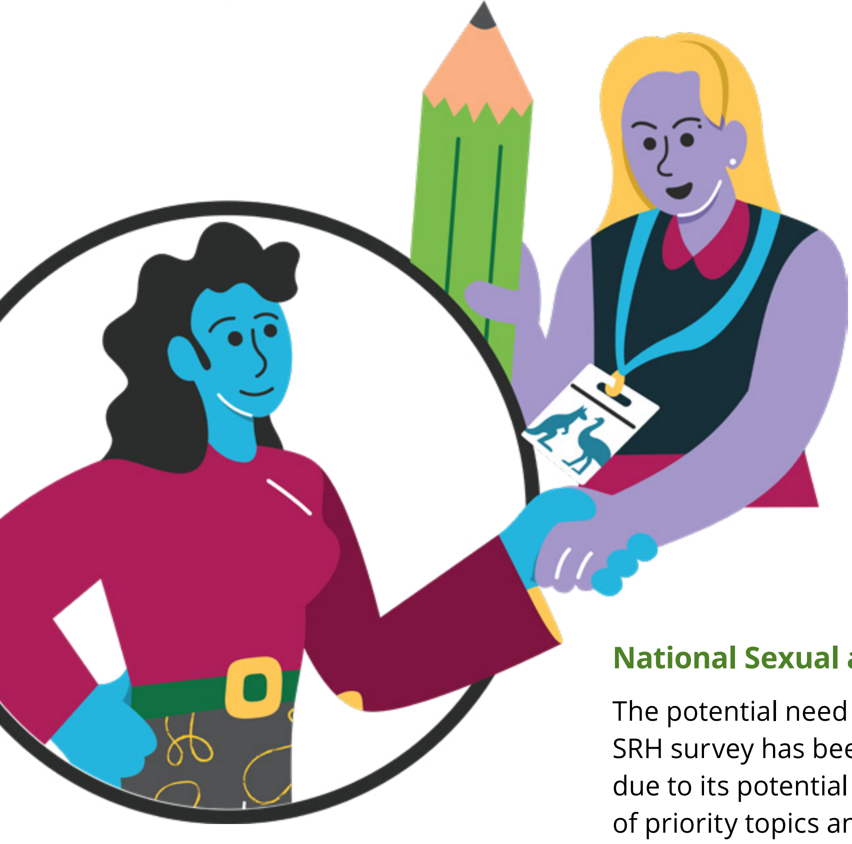
The Australian Burden of Disease Study (ABDS) produces estimates of the health impact of over 200 diseases and injuries on the Australian population as well as the proportion of this burden that is attributable to modifiable risk factors. A separate study is also conducted to produce burden of disease estimates for the First Nations population. The ABDS draws on data from a range of different data sources to estimate incidence, prevalence, severity and mortality for the conditions included. The latest study (Australian Burden of Disease Study 2024) includes burden of disease estimates for a number of sexual and reproductive health conditions (such as STIs, endometriosis, PCOS, infertility and pregnancy loss before 20 weeks' gestation). The 2026 Study (planned for release in December 2026) will look to expand this list to potentially include some additional SRH conditions that are considered high priority such as menopause and perimenopause, menstruation and menstrual cycle disorders and termination of pregnancy. The ABDS will be a key data source for outcome measures in the SRH Monitoring Framework and Data Strategy going forward.

Australia's Disease Expenditure database

Australia's Disease Expenditure database provides estimates of spending in the health system by condition, age group and sex. It includes spending on hospital services, primary health care, and referred medical services. The database uses the Australian Burden of Disease study condition groups and provides estimates for well care, including family planning.

The database includes cost from all sources of funding across the health system, such as Australian state and territory governments, private health insurance, and out of pocket payments by patients. Estimates are derived from data sources including the NHMD, and Health Expenditure Database among others.

This information could be used to determine the spending attributed to SRH conditions and well care across the life course and over time. This could provide valuable insights into how costs are being distributed among government, private health insurers, and individuals, to identify conditions or well care which disproportionately rely on private insurance or out-of-pocket costs to patients.



4.3 Establish new data collections

Several priority areas for data development, as identified in the data strategies for each of the priority topics, have no known data sources or in progress data development activities. Creating new data collections may therefore be required to address the significant number of identified information gaps. However, establishing and maintaining new data collections would require significant investment.

National Sexual and Reproductive Health Survey

The potential need for a nationally representative ongoing SRH survey has been noted as a key data development activity due to its potential to support monitoring of a large breadth of priority topics and data gaps.

The development of a new nationally representative sexual and reproductive health survey would provide self-reported information on patterns and trends over time on a broad range of sexual and reproductive health topics, including but not limited to:

- SRH literacy
- prevalence and severity of symptoms, conditions and events
- preferences and use of SRH-related medications and methods
- unmet need in relation to SRH services or treatment
- health seeking behaviours
- impacts on economic productivity, quality of life and a person's physical and mental health
- impacts on family planning
- stigma in SRH care
- affordability, availability and quality of care.

A national SRH survey would allow for self-reported data to be captured on people who do not have contact with the health system. This would be particularly valuable information to collect among people who have experienced a miscarriage or symptoms related to menstrual disorders or menopause, but have not had contact with a healthcare service.

An ongoing 3-yearly survey would enable patterns and change over time to be monitored to inform and evaluate policy. A survey could be developed to be as representative of the Australian population as possible, including of priority population groups and geographic areas.

While the survey would aim to improve representation of key priority populations such as culturally and linguistically diverse populations and First Nations people, some priority populations would still likely not be captured through this vehicle (such as people experiencing homelessness).

National pregnancy loss register

A national register for completion by healthcare providers across different sectors would allow greater coverage of pregnancy loss before 20 weeks' gestation (including miscarriage) (PL) than what is currently available (limited to hospital datasets), including greater insights into:

- pregnancy loss prevalence, types and gestation
- clinical information, including associations with other (reproductive) health experiences and outcomes
- contact with the health system and care pathways
- quality of care and wait times
- and enabling lower levels of disaggregation by patient, provider and service characteristics and geography and future data linkage opportunities.

The benefit of having a pregnancy loss register in addition to pregnancy loss information in a national survey is that it would be completed by a health professional, allowing the provision of more detailed clinical information and the ability to disaggregate data to lower levels of granularity for priority populations and geographic areas. It would also enable data linkage with other administrative data collections.

Workforce survey, skills and practice audit

An SRH workforce survey and/or skills and practice audit could potentially fill gaps about health care provider self-reported SRH literacy, confidence around diagnosis, treatment and procedures (where relevant), screening and other care practices. This could also include an audit of skills and training and whether health care providers are working to their full scope of practice (including barriers and facilitators of this) and received training in providing culturally safe care. Information on locations of different SRH providers and services offered could assist with the generation of service maps and geographical breakdowns by urban, regional and remote areas, which would help inform policy. This data collection could also be used to gather information on alignment of practices with clinical guidelines, and conscientious objection.

4.4 Standardise and collate existing data

National data standards

Several topics would benefit from establishing national data standards, including agreed definitions, for use across primary, tertiary, public and private settings to facilitate routine, consistent data collection and reporting. Data quality needs to be improved through the development of consistent data standards that reflect diagnostic criteria to inform consistent data collection and improve data extraction from existing systems (for example in primary care).

Establishing national data standards for SRH would help ensure consistent terminology, definitions and coding thereby enabling accurate, comparable and complete data collections. Standardised data elements and coding systems (such as the ICD-10) reduce variability, improve data quality and support linkage between health services, registries and population surveys. This consistency is needed to enable reliable monitoring of trends, equity and outcomes and facilitates benchmarking across regions, strengthening the evidence base for policy, service planning and research. This will ultimately lead to improving the capacity to identify gaps, target interventions and enhance health outcomes.

National Primary Health Care Data Collection

Nationally consistent primary health care data is a known information gap for effective population health monitoring, research, policy and planning. The AIHW is working to fill this gap by developing processes for the governance, standardisation, collection, analysis and reporting of primary health care data within Australia. This work will ultimately form a National Primary Health Care Data Collection (NPHCDC).

The initial scope of the NPHCDC will be the collection, analysis and reporting of general practice data, with a view to develop and incorporate broader primary health care data, including nursing, Aboriginal Community Controlled Health Organisations, and allied health, into the collection as soon as practicable.

A lack of nationally agreed and implemented standards is a significant barrier to the availability of quality, comprehensive data from Australia's primary health care sector.

As part of the development towards a NPHCDC, the AIHW is undertaking a program of activities to establish the foundations for a national collection. These include developing data governance arrangements, a data model, a data dictionary and undertaking small scale demonstration projects in partnership with Primary Health Networks and data extractors. As part this program, AIHW are investigating the usefulness of general practice data for closing key sexual and reproductive health data gaps.

The National Primary Health Care Data Collection will be a national patient- practice- and organisation-level general practice data collection which may include items relevant to SRH. The collection is currently in the early phases of development with no data currently available.

Other healthcare data sources

Other potential sources of national healthcare data to explore include:

- My Health Record - a secure portal where healthcare providers and patients can upload clinical documents. While this is a potentially rich source of information, national representativeness is likely to be an issue that will need to be addressed.
- MedicineInsight data and the feasibility of using it to determine General Practitioner practice patterns of prescribing and patient care.
- Australian Clinical Data for Interoperability (AUCDI) – CSIRO, under the Sparked program are developing a collection of data groups and data models representing the clinical (patient care) requirements for data entry, data use and sharing of health information supporting patient care including for sexual and reproductive health.
- National Primary and Acute Care Data Linkage Project - this partnership across all Commonwealth, state and territory health departments, AIHW, Primary Health Networks, general practice and Aboriginal Community Controlled Health Organisations is developing a proposal for linking de-identified data from general practices with other health data by leveraging existing infrastructure and successes across jurisdictions to provide better insights into patient journeys across the health system. This project is subject to funding.

Pharmacy data collection

Further exploration of pharmacy data is required to determine data quality, feasibility, mechanisms for supply, governance and ethics. This could result in development of an ongoing national pharmacy data collation exercise, including PBS-subsidised and private/non-subsidised script and sales data typically not currently reflected in national administrative datasets. This would support monitoring of use, affordability and geographic accessibility of sexual and reproductive health-related medications and commodities over time. This would provide important information to inform and evaluate policy in relation to the accessibility of SRH medications and commodities across and beyond the 5 priority topics.

Other service level data sources

A service-level data collection(s) could be developed using data on services provided and the reason for provision. Data from service providers and other sources could potentially be standardised and collated to form these collections. Potential services could include:

- Endometriosis and pelvic pain clinics (EPPC)
- Medicare Urgent Care Clinics (UCC) data
- Healthdirect (national virtual public health information service)
- Private SRH service data
- Jurisdictional TOP notification data.

State and territory health services data

At the state and territory level, organisations that are major providers of specialised sexual and reproductive health services may be a source of SRH data. Some of these organisations also play a role in workforce training and research. Administrative data could provide insight on access to services for priority populations, including patients without a Medicare card. Other facets of access that could be investigated include acceptability of care through patient experience surveys or workforce capacity through data from training programs.

In relation to TOP, five jurisdictions currently have a system of (mandatory) notification of TOPs (by healthcare providers). While not standardised, TOP notification forms include at least some patient and geographical information. These datasets likely provide critical insights into TOP prevalence, type, gestation, and patient characteristics. Work to standardise and consolidate these datasets could provide a highly valuable dataset and level of disaggregation beyond what PBS, MBS and hospital data currently allow.

There are also several key sexual and reproductive health organisations, community health services and specialised clinics in Australian states and territories that collect SRH data. The useability and quality of the data collected in these organisations will be explored.

Consultation with relevant jurisdictional health departments and sexual and reproductive health organisations to gain insight into the feasibility of data provision, standardisation and aggregation would be required to progress this.

4.5 Data governance

As the data strategy is implemented, the AIHW is aware of ensuring appropriate data governance and privacy protections are embedded at all stages of the process.

This includes ensuring compliance with the Privacy Act 1988 (Cwlth), confidentiality provisions in the Australian Institute of Health and Welfare Act 1987 (Cwlth), and other relevant state and territory and Commonwealth legislation to ensure the protection of privacy, and confidentiality, and appropriate safeguards of the data. The use of the Five Safes framework will also reinforce management of the privacy and confidentiality of data.

For further information see:

Appendix D: Menstrual disorders, symptoms and related conditions: Topic overview and data strategy

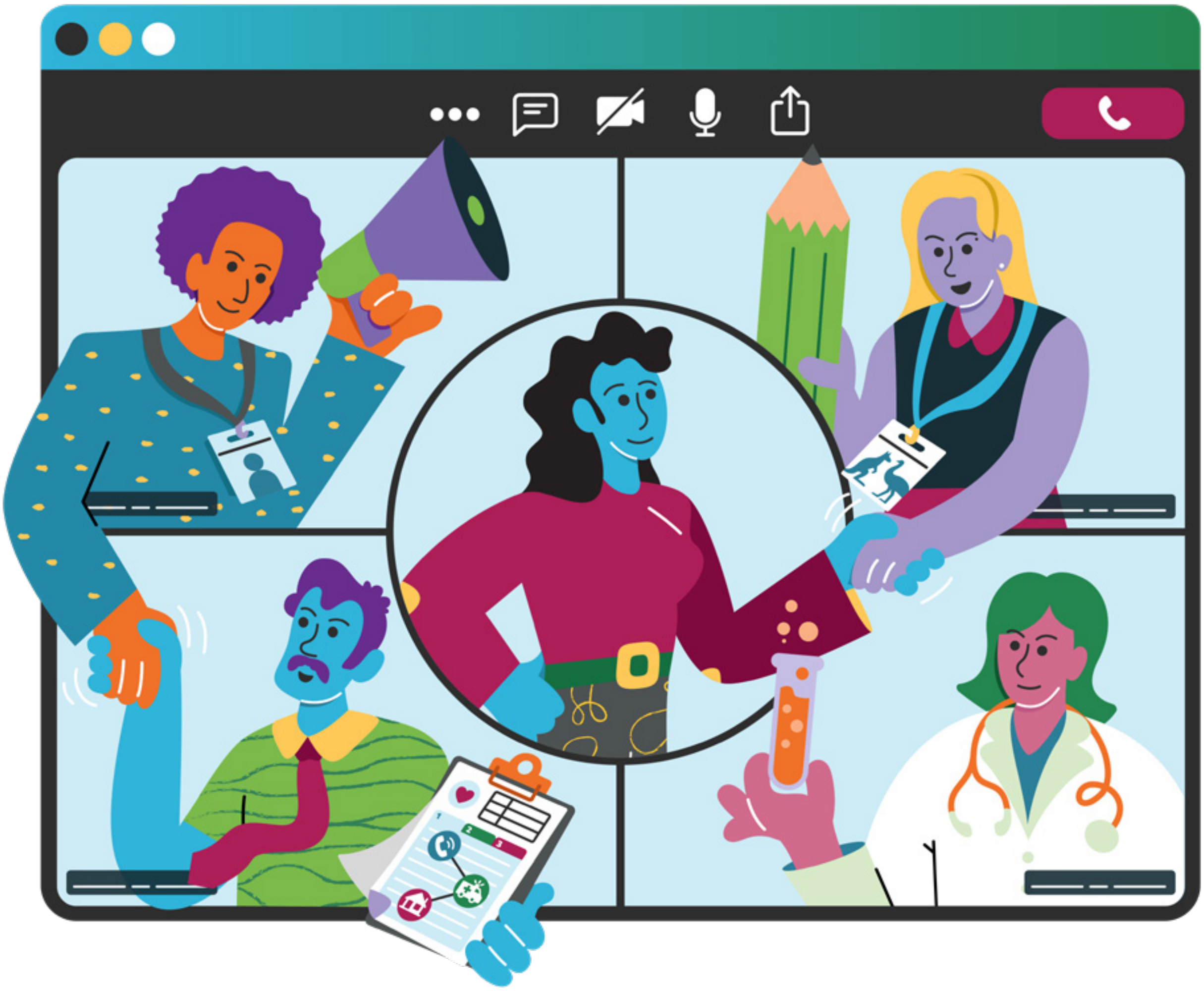
Appendix E: Contraception: Topic overview and data strategy

Appendix F: Pregnancy loss (including miscarriage): Topic overview and data strategy

Appendix G: Termination of pregnancy: Topic overview and data strategy

Appendix H: Perimenopause and menopause: Topic overview and data strategy

Appendix J: National data sources by topic



5 Stakeholder engagement and governance

Feedback from this public consultation is particularly sought on data stewardship and guidance for ongoing stakeholder engagement to support the process.

The AIHW is a strong strategic partner that works with a broad range of stakeholders. Partnership and collaboration are cornerstones of the framework and data strategy, and this work will be supported through governance and advisory committees.

5.1 Current governance and advisory arrangements

Current governance and advisory processes that have been established for this work include:

- **SRH Steering Committee:** oversees the work program and provides advice on the strategic directions of the project, governance, key project deliverables, milestones and other planning matters to ensure appropriate processes and consultation steps are undertaken and the work delivered is of high-quality. Membership of the Steering Committee consists of the AIHW and the Australian Government Department of Health, Disability and Ageing.
- **National Miscarriage Expert Advisory Group:** provides clinical and technical expert advice regarding data needs, sources, gaps and opportunities, and definitions related to pregnancy loss (including miscarriage) for the purposes of national data collection. Terms of reference and membership are available on the AIHW website: National Miscarriage Expert Advisory Group.

5.2 Future governance and ongoing engagement

Following the finalisation of the framework and data strategy, it is anticipated that ongoing advisory arrangements will be required to advise and inform the implementation of the framework, data strategy and the development of reporting. It is anticipated that this will include a diverse range of stakeholders and data providers and include ongoing community engagement.

These arrangements will be established once the framework and data strategy are finalised to ensure they reflect the final documents following public consultation.

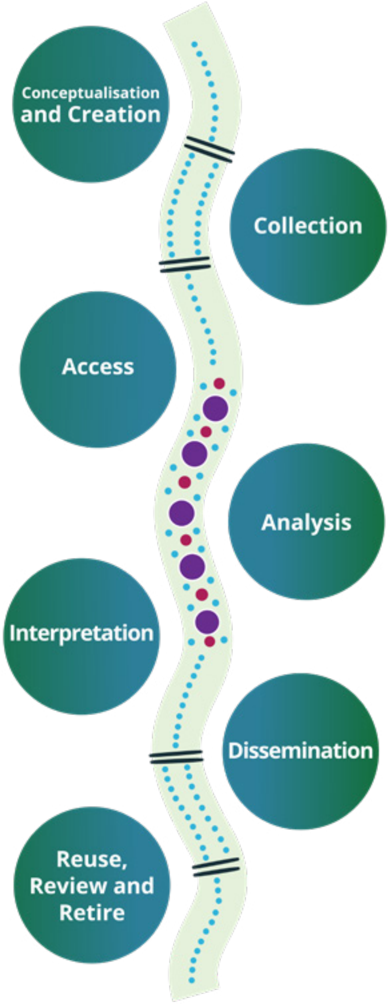
Given the differences in health services governance, structures, and models of care across Australia, the way health data is entered, collected, and interpreted may be challenging to assimilate. Engagement with jurisdiction health departments, Primary Health Networks and other providers of SRH services will be crucial to inform and facilitate SRH data development and ensure reporting mechanisms are appropriate and fit-for-purpose for end-users.

As noted in section 1, the AIHW is committed to the implementation of the Framework for Governance of Indigenous Data including the 4 guiding principles outlined below as well as ensuring that our commitments to the 4 Priority Reforms under the 2020 National Agreement on Closing the Gap are realised in implementing the framework and data strategy (NIAA 2024; NIAA 2020).

Ongoing stakeholder and community engagement across the data lifecycle (Figure 5.1) will guide AIHW's implementation of the SRH work program, by:

- partnering with communities, including First Nations people and other priority populations,
- building data-related capabilities with and for key stakeholders,
- providing knowledge of data assets, and
- building an inclusive data system.

Figure 5.1: Engagement throughout the data lifecycle



Source: National Indigenous Australians Agency (2024) Framework for Governance of Indigenous Data, Commonwealth of Australia

The AIHW will establish additional trust-based partnerships and work with communities and key stakeholders to implement the framework and data strategy, promoting and developing meaningful engagement processes that include people with lived experience.[6]

- The AIHW welcomes guidance through this consultation process on data stewardship and guidance for ongoing stakeholder engagement to ensure rigour, accuracy and inclusivity in our measurement and reporting data about access and equity to SRH in Australia.

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[6] See for example the National Disability Research Partnership, "Embedding Co-Design in Your Research", ndrp.org.au/resources/co-design

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Authorship

This report has been authored by the AIHW Sexual and Reproductive Health Unit, including in alphabetical order: Shivali Amin, Cathy Claydon, Deanna Eldridge, Susan Manners, Brooke Petzke, Lucy Stackpool-Moore, Nellie Thomson and Kari Vallury. Contributions by Adrian Webster and Geoff Callaghan are gratefully acknowledged.

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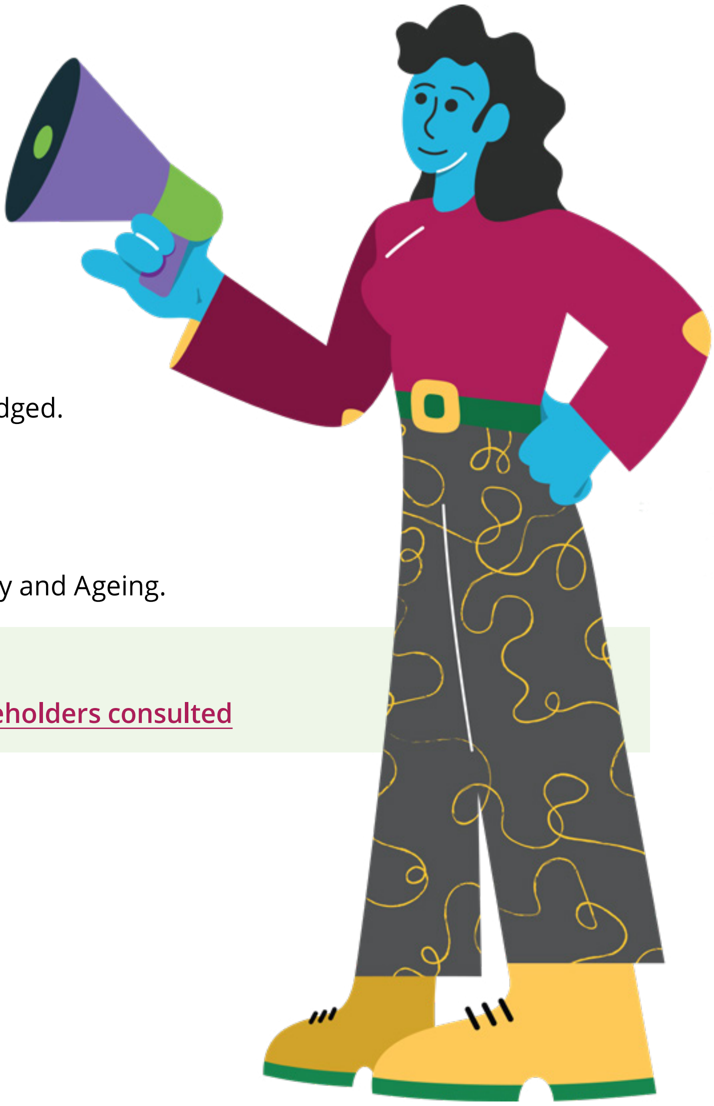
For further information see:

Appendix M: Acknowledgments and stakeholders consulted



Abbreviations

ABS	Australian Bureau of Statistics
AUB	Abnormal Uterine Bleeding
AHPF	Australian Health Performance Framework
AIHW	Australian Institute of Health and Welfare
EPAS	Early Pregnancy Assessment Service
GP	General Practitioner
HCP	Health Care Provider
HMB	Heavy Menstrual Bleeding
MHT	Menopausal Hormone Therapy
MIM	Medically Induced Menopause
LARC	Long-Acting Reversible Contraception
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Gender Diverse, Intersex, Queer/Questioning, Asexual
MF	Monitoring Framework
MTOP	Medication Termination of Pregnancy
NMEAG	National Miscarriage Expert Advisory Group
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PCOS	Polycystic Ovary Syndrome
POI	Premature Ovarian Insufficiency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
STOP	Surgical Termination of Pregnancy
TOP	Termination of Pregnancy
UNFPA	United Nations Population Fund
WHO	World Health Organization

Data Sources

ACCHO	Aboriginal Community Controlled Health Organisations
ACSQHC	Australian Commission on Safety and Quality in Health Care
ALSWH	Australian Longitudinal Study on Women's Health
ANZARD	Australian and New Zealand Assisted Reproduction Database
EPPC	Endometriosis and Pelvic Pain Clinics
HILDA	Household, Income and Labour Dynamics in Australia
LSAC	Longitudinal Study of Australian Children
MBS	Medicare Benefits Scheme
NCADC	National Congenital Anomalies Data Collection
NESWTDC	National Elective Surgery Waiting Times Data Collection
NHDH	National Health Data Hub
NHMD	National Hospital Morbidity Database
NNAPEDCD	National Non-admitted Patient Emergency Department Care Database
NPHED	National Public Hospital Establishments Database
NPMDC	National Perinatal Mortality Data Collection
PATH	The Personality and Total Health Through Life Study
SSASH	The Australian Secondary Students and Sexual Health Study
ASHR	The Australian Study of Health and Relationships
PEPP Talk	Periods, Pain and Endometriosis

Glossary

Term	Meaning
Abnormal uterine bleeding	Variation from normal menstruation, or from a normal menstrual cycle pattern. This includes abnormalities of the frequency, regularity, flow volume and duration of bleeding, intermenstrual bleeding, and unscheduled bleeding on gonadal steroids (Abnormal Uterine Bleeding) (Munro et al. 2018).
Adenomyosis	A condition where tissue similar to the lining of the uterus grows in the muscle layer of the uterus (Healthdirect 2024).
Contraception	Commonly known as 'birth control', the act of preventing pregnancy using pharmaceutical, procedural or behavioural methods (Bansode et al. 2023). Of note, 'contraceptives' – methods or devices used to prevent pregnancy – are commonly used for purposes other than pregnancy prevention. Use of the word 'contraception' in this report refers to contraceptive methods and devices used for any reason, including and beyond pregnancy prevention.
Dysmenorrhea	Painful menstruation, often referred to as period pain. It can be from menstruation alone - primary dysmenorrhea, or as a result of an underlying cause - secondary dysmenorrhea (Christensen 2024).
Early menopause	Menopause occurring between 40–45 years of age is called early menopause, with a reported prevalence of 12% (AMS 2022).
Endometriosis	An inflammatory disease where tissue similar to the lining of the uterus grows in other parts of the body (Endometriosis Australia 2023).
Equity	The absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically" (WHO 2025a).
Health care provider (HCP)	An individual who practises a profession relating to the provision of health care. Health care providers may be required to maintain profession-specific registration with a national board under the National Registration and Accreditation Scheme or be self-regulated. A health care provider may also be referred to as a health practitioner, clinician or profession-specific description (ACSQHC, 2025).
Heavy menstrual bleeding (HMB)	A type of abnormal uterine bleeding. Also known as menorrhagia, HMB is excessive menstrual bleeding which interferes with physical, social, emotional and/or material quality of life (Committee on Adolescent Health Care 2019).

Term	Meaning
Incidence	The number of new cases (of an illness or event, and so on) in a given period.
Intersectionality	Refers to the ways in which different aspects of a person's identity can expose them to overlapping forms of discrimination and marginalisation. For example, gender inequity results in women having fewer opportunities for living in a safe and equal society where they enjoy equal power, can access resources and opportunities and are treated with dignity, respect and fairness. This can be compounded by other forms of disadvantage or discrimination that people may experience on the basis of Aboriginality, age, disability, ethnicity, gender identity, race, religion, sexual orientation, occupation or other attributes (DoHAC 2021).
Long-acting reversible contraception (LARC)	A term used to refer to contraceptives that are highly effective at preventing pregnancy, are long acting and are reversible when removed. The term LARC is usually used to refer specifically to intrauterine devices (both copper and hormonal) and the implant, and this is how it is used in this report. We note that some researchers also include DMPA injections as LARCs.
Medication/ Medical Termination of Pregnancy (MTOP)	In Australia MTOP involves taking two medications, mifepristone and misoprostol, marketed as MS-2 Step. In Australia, MTOP is most often used to refer to an Early Medical Abortion (EMA), which is the approved use of MS-2 Step up to 63 days gestation. Internationally, as endorsed by the WHO, mifepristone and misoprostol are often used up to 12 weeks' gestation. In Australia, after 63 days gestation, mifepristone and/or misoprostol may also be used to medically induce a TOP, commonly referred to as a medical induction (of labour).
Medically Induced Menopause (MIM)	Medically Induced Menopause is when menopause happens because of surgery or treatment, rather than naturally. It happens earlier than you would normally have gone through menopause and is the direct result of an operation or medicine (Inherited Cancers n.d).
Menopause	Menopause refers to the final menstrual period and is said to have occurred when there have been no menstrual periods for one year. The average age of menopause in Australian women is 51 years (range 45–55 years) (AMS 2022).
Menopausal Hormone Therapy (MHT)	MHT are hormones that are prescribed during the menopause transition and menopause to alleviate oestrogen deficiency symptoms such as hot flushes, mood swings, vaginal dryness and to prevent or treat osteoporosis (AMS 2022).

Term	Meaning
Miscarriage (also referred to as 'spontaneous abortion' or 'threatened abortion')	The involuntary, spontaneous loss of an intrauterine pregnancy prior to 20 weeks' gestation. This includes complete, incomplete, missed, threatened and recurrent miscarriage (as defined by RANZCOG 2025).
MS-2 Step	The marketed name of the combined regimen of (TGA approved) misoprostol and mifepristone.
Perimenopause	Perimenopause refers to the time from the onset of a change in menstrual cycle pattern or onset of menopausal symptoms, through to one year after the last menstrual period. The average duration is 4–6 years with onset in the fifth decade of life (40's) (AMS 2022). It is also referred to as the menopause transition (AMS 2023).
Polycystic ovary syndrome (PCOS)	A multi-system condition that has metabolic, reproductive, psychological and dermatological features (Teede et al. 2023).
Pregnancy loss	The unplanned loss of a pregnancy before 20 weeks' gestation, including miscarriage, ectopic and molar pregnancies.
Premature Ovarian Insufficiency (POI)	Loss of ovarian function in women younger than 40 years of age affecting approximately 4% of women. In most women, POI occurs spontaneously, and the cause is unknown. POI was previously referred to as premature ovarian failure; however, the preferred term is now premature (or primary) ovarian insufficiency (AMS 2022).
Prevalence	The number or proportion (of cases, instances, and so forth) in a population at a given time.
Priority populations	Different groups within society who experience a disproportionate burden of disease, leading to differences in health outcomes and life expectancy (DoHAC 2021).
Procedural/ surgical termination of pregnancy (STOP)	A procedure, performed by a trained health professional, to remove pregnancy tissue from the uterus. Can be done using a suction (up until about 14 weeks gestation) or a dilation and evaluation (D & E) (often used after 14 weeks gestation) (Healthdirect 2025).
Recurrent miscarriage	Two or more miscarriages in pregnancies up to 20 weeks' gestation (whether or not a gestational sac is present and whether or not the miscarriages are consecutive) (RANZCOG 2025).

Term	Meaning
Self-managed abortion	‘Self-managed abortion involves any action that is taken to end a pregnancy outside of the formal healthcare system’. Someone self-managing abortion may be supported by health professionals at different stages. Self-managed abortion can include, but is not always, unsafe abortion (Verma & Grossman 2023).
Sexual and reproductive health	Experiencing sexual and reproductive health means that a person has complete physical, mental and social well-being in all matters relating to their reproductive system and its functions. In everyday life, this means that people are able to have satisfying and safer sex lives, to have healthy pregnancies and births, and decide if, when and how often to have children (WHO 2025b).
Socio-ecological model	The socio-ecological model of health “states that health is affected by the interaction between the characteristics of the individual, the community, and the environment that includes the physical, social, and political components.” It is often characterised by nesting circles placing the individual at the centre and aspects of the environment around them (Kilanowski 2017).
Termination of pregnancy (TOP)	Commonly called ‘abortion’, involves intentionally ending a pregnancy by removal or expulsion of the embryo or foetus and placenta from the uterus.
Unsafe abortion	Self-management or attempted self-induction of abortion using unsafe or invasive methods, including healthcare avoidance for complications of self-managed abortion and visiting untrained abortion providers (Verma & Grossman 2023). Unsafe abortion is a leading cause of maternal mortality and morbidity in contexts where abortion access is highly restricted (WHO 2024).

Appendices