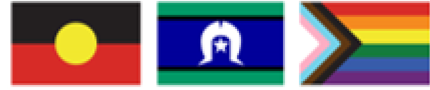
WOMEN'S HEALTH & WELLBEING
Barwon South West



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

Sent via email to community.affairs.sen@aph.gov.au

15/12/2022

Dear Senator Rice,

RE: Submission to the Senate Standing Committees on Community Affairs, inquiry on universal access to reproductive healthcare

Women's Health and Wellbeing Barwon South West welcome the opportunity to make a submission to the Senate Inquiry into Universal Access to Reproductive Healthcare.

The Australian population overall is among the healthiest in the world, yet we have unacceptably high levels of sexual and reproductive ill-health (source). Sexual and reproductive health and rights as a priority area, is lacking the authorising environment and investment that Gender Equality and Prevention of Violence Against Women are currently experiencing. Evidence strongly indicates that investing in women's sexual and reproductive health (SRH) is cost effective, has the capacity to improve the health of all, and will impact positively on the economy (source).

As a rural women's health organisation with over 12 years' experience in the sector, our submission focusses on the ways in which barriers to SRH service access manifest for rural and regional women.

We look forward to receiving the report and welcome any further opportunity for input into your work. We consent to this submission being published on the inquiry website and shared publicly.

Submission to the Senate Standing Committees on Community Affairs, inquiry on universal access to reproductive healthcare

Women's Health and Wellbeing Barwon South West

15/12/2022

Executive Summary

Australia has a world class public health system, yet the sexual and reproductive health (SRH) needs of women, girls and gender diverse people are not being consistently or adequately met across the country. SRH service provision lacks coordination and access to services is often very limited and, as a result, inequitable.

Women living in rural and regional communities are disproportionately impacted by poor SRH health outcomes. As a rural women's health organisation with over 12 years' experience in the sector, our submission focusses on the ways in which barriers to SRH service access manifest for rural and regional women.

The Barwon South West region of Victoria spans 29,146 km2 and has a population of 190,500 women and girls. Despite this, the region has

- Less than 10 GPs listed as IUD providers on 1800 My Options (source) resulting in wait lists of 3-4 months for a private provider and at times over 12 months for a public provider.
- 3 pharmacies publicly listed on 1800 My Options as being able to prescribe medication abortion (these are generally marketed as MS 2 Step providers) (source).
- 7 out of 9 Local Government Areas (LGAs) with greater demand for abortion services than prescribers [when comparing Medication Abortion Rate by patient location to rate by prescriber location (source)].
- Poorer SRH outcomes compared with Australians living in metropolitan centres, including higher rates of unplanned pregnancies (source) and higher rates of STIs (source)
These outcomes are due to a lack of local services, high costs and misinformation (source) exacerbated by the uneven distribution of the healthcare workforce in rural areas (source)
In Victoria, most private surgical abortion options are in metropolitan Melbourne, with few public hospitals providing abortions for large geographical areas – complicating access to this essential service.

This failure to ensure equitable access to sexual and reproductive healthcare has both short- and long-term consequences for women as well as significant implications for the healthcare sector. The negative health outcomes for women include:

- Increased pain or impacts on future fertility for those with pelvic pain conditions such as endometriosis (source)
- Increased maternal and fetal mortality and morbidity for pregnant people (source)
- Economic hardship and insecurity that can last for years for abortion seekers (source)
- Increased transmission (source) and increased reproductive morbidity (source) for those with Sexually Transmitted Infections (STIs)
- Significant economic cost to affected individuals and to the healthcare system (source).

Based on our knowledge and experience of the Barwon South West region, this submission highlights the following issues for SRH across our rural and regional landscape:

- *There are significant barriers to accessing SRH services in a rural and regional context* – these include the cost of services, travel distances, lack of public transport, intake requirements, gestational limits on abortion services, difficulties accessing testing, referral and specialist services, all within a service environment that is limited.

- *Poor SRH Health literacy* – people's understanding of SRH, knowledge of services and how to access them in consistent and commonly poor. In additional there are challenges to accessing healthcare professionals equipped to provide information in accessible and appropriate ways, free of prejudice and discrimination
- *There are barriers to accessing culturally safe SRH healthcare* – for all people accessing SRH services including, but not limited to immigrant and refugee women; Aboriginal and Torres Strait Islander women; women with disabilities; and transgender and gender diverse people. In addition, there are unique cultural safety issues for women in rural and regional communities, these link to broader social norms, stigmatization, discrimination as well as the problems of increased visibility and lack of confidentiality.
- *Social and economic determinants of SRH health*– shape women's ability to make choices and to access support and services. Examples include the importance of living free from violence intimate partner violence and coercion, navigating a respectful relationship and of social connection.
- *Data* – a lack of consistent and comprehensive data across the SRH service landscape underpins an inadequate understanding of the scale of the problems across women's SRH and lives.

The recommendations within this submission are based on our knowledge and experience of the regional and rural Victorian context but have relevance nationally.

No	**Recommendation**	**TOR alignment**
1	That the Australian Government establish a National Taskforce to conduct a legislative scan across Australia to harmonise and update legislation across jurisdictions on sexual and reproductive rights.	a,b,e,h
2	That the Australian Government invest in expanding the sexual and reproductive healthcare model so that it is culturally safe, accessible and can be delivered by a range of healthcare practitioners.	b,c,d,f,g
3	That mainstream SRH services consider and meet the needs of underserved communities with poor SRH outcomes, key among them Aboriginal and Torres Strait Islander communities.	f,g
4	That investment is made into standardised and comprehensive national sexuality education that is culturally appropriate and adequately resourced across the lifespan.	e,f,g
5	That national legislation includes provisions for reproductive leave via both modern awards and in National Employment Standards, enshrining the right to paid gender-inclusive reproductive leave, including the right to paid leave in addition to regular personal leave and annual leave, as well as flexible working arrangements.	h

About Women's Health and Wellbeing Barwon South West

Women's Health and Wellbeing Barwon South West is an independent, feminist organisation committed to gender equality and great practice health promotion. We strive towards an ambitious vision for change where women are healthy, safe and can access all of life's opportunities. Our work is built on a foundation of evidence and a commitment to excellence, and we drive change by shifting public discussion, translating evidence into action, and pushing for policy changes in businesses, organisations, and all levels of government.

The Barwon South West region spans the lands of three Traditional Owner groups – Gunditjmara, Eastern Marr and Wadawurrung – and the clans that reside within them. It includes nine LGAs: Borough of Queenscliffe, City of Greater Geelong, Colac Otway Shire, Corangamite Shire, Glenelg Shire, Moyne Shire, Southern Grampians Shire, Surf Coast Shire and Warrnambool City Council.

Established in 2011, we are the only organisation in our region that has SRH as a funded priority area and we and lead the Knowledge, Choice and Access strategy that aims to drive regional and collective action on women's sexual and reproductive health and right.

Terms of Reference Response

Recommendation 1: **That the Australian Government establishes a National Taskforce to conduct a legislative scan across Australia to harmonise and update legislation across jurisdictions on sexual and reproductive rights.**

Australian states and territories currently have inconsistent legislation regarding reproductive rights and access to care. This inconsistency is potentially harmful to women and gender diverse people, and it can make service access confusing, difficult and daunting. Harmonised legislation is critical for ensuring that women in Australia can access a consistent level of care, rights and education.

The most progressive components of state and territory legislation (e.g., no-cost abortions including transport and support person, removal of gestational limits on abortion services) need to be considered the minimum standard and, critically, it is essential that steps to harmonise and update legislation does not jeopardise the progressive SRH-related legislation in place in Victoria. Interestingly while Victoria has the most progressive abortion policy and practice there is still work to be done to ensure access abortion care extends beyond those living in Metropolitan areas, with a Medicare card and money for several medical appointments.

Sub-recommendation	TOR alignment
That a national sexual and reproductive health and rights (SRHR) strategy for Australia be developed and funded as a priority. The strategy should have a particular focus on women and address the social determinants of sexual and reproductive ill-health and align to *Advancing sexual and reproductive wellbeing in Australia: the Melbourne proclamation* (2012) for sexual and reproductive rights to be integrated into policy and program planning.	a,b,e,h
That the strategy be supported by strong data collection and evaluation. Robust data is essential for addressing the significant gaps that exist at federal, state, and regional level and to better understand trends and patterns in community need as well as to measure progress (source).	a,b,e,g,f,h

Recommendation 2: **That the Australian Government invests in expanding the sexual and reproductive healthcare model so that it is culturally safe, accessible and can be delivered by a range of healthcare practitioners.**

SRH information and services must be accessible and affordable to everyone who needs them regardless of location, age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity.

Rural women and girls face significant barriers in accessing essential SRH services including distance from healthcare facilities; limited transport options; restricted service operating hours; the high cost of some services; medical staff with limited SRH training; confidentiality issues and the risk of stigmatisation and discrimination (source).

Nurses and midwives are the largest cohort within the health workforce and often represent a stable workforce in rural and remote communities. Nurse-led models of care must be included in sexual and reproductive healthcare. In relation to abortion specifically, evidence shows that adequately prepared nurses and midwives are as safe as doctors at providing medical and surgical abortion care (source).

Further women's ability to negotiate the conditions and timing of sex with their partners is key to controlling several health outcomes including family planning and prevention of sexually transmitted infections (source). Rigid and traditional gender roles shape intimate relationship, sexual activity and

reproduction (source) So, women's sexual and reproductive health outcomes will not improve without structural changes in gender equality, social norms, government policy, legislation and investment, workplace practices and education (source)

Sub-recommendation	TOR alignment
Introduce amendments to the Risk Management Plan (RMP) and regulatory reforms for medical abortion medications that improve abortion access and equity. The revised RMP proposes allowing medical and other healthcare practitioners to prescribe medical abortion. This will remove the Therapeutic Goods Administration (TGA) restrictions on who can prescribe medical abortions (MS-2 Step), allowing states and territories to decide. This could include nurses, midwives and Aboriginal and Torres Strait Islander healthcare workers. The safety and efficacy of medical abortion is well established and reducing the TGA risk profile of RU486-Mifepristone will increase access to this service and improve health outcomes for women. Anecdotally, the greatest access barrier is the requirement for pharmacists to be registered to dispense MS-2 Step, particularly as registration sits with the individual pharmacist and not the pharmacy. The revised RMP proposes removal of the registration requirement, meaning that any pharmacist could order the product, as is the case with other medicines.	b
Access to a more comprehensive choice of effective contraceptive options in Australia by increasing Pharmaceutical Benefits Scheme (PBS) access, streamlining TGA approval processes and increasing Medicare Benefits Scheme (MBS) rebates for long-acting reversible contraception. The current MBS rebates for primary care providers are insufficient for these procedures and need to be increased to ensure our population can access these without paying a gap.	a
Standardised, evidence-based SRH and abortion education needs to be mandatory in every Australian medicine, midwifery, nursing, general practice, obstetrics and gynaecology and Aboriginal and Torres Strait Islander health worker undergraduate degree and postgraduate training program. This includes for people who don't want to become abortion providers themselves but who need to understand the information to correctly advise patients of their pregnancy options and to be able to refer to abortion providers.	c
Investment in clinical guidelines and medical publications that normalise abortion and reduce abortion stigma. Abortion is healthcare and it is both legal and safe in Australia. Despite this, it is often framed as an ethical issue in medical and nursing degrees. Changes to clinical guidelines and other medical texts will help normalise abortion care within healthcare.	c
That all public hospitals provide abortions Public hospitals already manage miscarriages, stillbirths and abortions in specific circumstances. Public hospitals providing these services already have the staff and resources to provide abortions for any indication until at least 22 weeks.	b
That public hospitals provide no-cost abortions Public funding should be used to provide no-cost abortions in primary care and public hospitals when requested, with a choice of all available abortion methods. Public funding should also cover the cost of travel and accommodation to access abortions	b

when they are not available locally. This is vital for people living in rural and remote areas.	

Recommendation 3: **That mainstream SRH services consider and meet the needs of underserved communities with poor SRH outcomes, key among them Aboriginal and Torres Strait Islander communities.**

Aboriginal and Torres Strait Islander women, immigrants and refugees including women on temporary visas, the LGBTIQA+ community, women with disability, sex workers and incarcerated women are often vulnerable to poor SRH outcomes. As echoed through this submission and WHWBSW work rural and regional women do not have adequate access to SRH healthcare.

- Aboriginal and Torres Strait Islander women's SRH is impacted by the trauma of colonisation, forced removal, racism and socio-economic disadvantage (source). They identify gaps in appropriate SRH education (source) and higher rates of pregnancy risk factors, adverse perinatal outcomes and adolescent pregnancy (source). 22% of Aboriginal and Torres Strait Islanders were racially discriminated against by healthcare workers in the last 12 months (source).
- Women with disabilities often have minimal to no access to SRH programs, and reduced access to health information, screening, prevention and care services (source). They experience higher rates of sexual violence (source), and forced abortion, contraception and sterilisation (source). They also experience inadequate and non-responsive health services including being refused the right to consent to medical treatment including abortion (source), and are more likely to experience reproductive coercion, where others attempt to dictate a women's reproductive choices. (source).
- Immigrant and refugee women are at greater risk of suffering poorer maternal and child health outcomes, are less likely to have information and familiarity with contraceptive methods, and are at greater risk of STIs (source).
- Transgender and gender diverse people report experiencing very high rates of marginalisation in sexual health care because of their gender, resulting in lower testing rates, low uptake of pre-exposure prophylaxis (PrEP) and heightened vulnerability to STIs (source)
- Rural and regional women shared the same gendered inequality and experience the same layers of sexism and discrimination as the broader community of women, while they additionally experience poorer SRH outcomes, reduced access to accurate and independent information and services, and can be living in communities where some social norms, for example more traditional gendered stereotypes, are more prevalent and shape their ability to learn about, navigate and seek good SRH outcomes and care.

Sub-recommendation	TOR alignment
That women are equally and diversly represented and influence decision making at every level International evidence suggests that when women are involved in setting healthcare agendas, there is greater attention given to issues that concern women including SRH. A rights-based approach to health recognises women as the experts in their own lives. Principles underpinning effective action on SRH note women must be engaged at all levels within the health system as leaders, providers and consumers (source).	f,g
That women's diverse voices are reflected in policy and program design and implementation. Policy and program design and implementation need to be guided by evidence informed frameworks. Consultation must include women's diverse voices and needs,	f,g

including a balance of heard, unheard, and marginalised women as well as those at greater risk of experiencing sexual and reproductive ill-health including young women, Aboriginal and Torres Strait Islander women, women living with a disability, women living in rural, regional and remote areas, culturally and linguistically diverse women, same sex attracted women, sex workers, women who are incarcerated as well as sex and gender diverse people (source).	

Recommendation 4: **That investment is made into standardised national comprehensive sexuality education that is culturally appropriate and adequately resourced across the lifespan.**

Comprehensive sexuality education (CSE) is vital to advancing health outcomes and gender equality. It provides the tools people need to have healthy lives and relationships and to navigate lifechanging decisions about their sexual and reproductive health.

Australia doesn't have a standardised national sexual and reproductive health curriculum and there are no best practice guidelines for those delivering sexuality education. Outside of the school system, there is limited to no comprehensive sexuality education, leaving disengaged youth and women who have finished school without a formal method of education and information provision. Engagement with Aboriginal women and girls in our region revealed that a lack of culturally appropriate and safe sexuality education resulted in them seeking education from Aboriginal youth and health workers who felt ill-equipped to provide that education.

Many people receive a range of scientifically incorrect, conflicting, and confusing messages about sexuality and gender. This can lead to serious risks for their health, wellbeing, and dignity and women and girls are left vulnerable to coercion, STIs and unintended pregnancy (source). In the absence of open conversations with educators or parents regarding sex, some young people report that they turn to pornography for sexual information (source).

There is strong evidence that CSE delays the beginning of sexual activity and can better prepare people to make safe and responsible decisions about sexual activity. When provided with accurate information and skills in relation to sexual health, people are less likely to experience poor sexual and reproductive health outcomes, and rates of teen pregnancy and abortion are reduced (source).

CSE could be embedded in integrated health services including medical officers, registered nurses, nurse practitioners, social workers, psychologists and health promotion officers (source). Education may include healthy relationships; consent; changing sexual and reproductive health needs over time; domestic violence screening and counselling; contraceptive choices; pregnancy option; and STI protective behaviours, including the use of condoms and STI screening (source). CSE must be culturally safe and accessible to all individuals regardless of their location, age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity.

Sub-recommendation	TOR alignment
A standardised, evidence-based sexual and reproductive health be mandatory within every Australian teaching undergraduate and post graduate degree. Competent and confident teachers are the backbone of a successful Comprehensive Sexuality Education (CSE) program and it is essential that they are adequately equipped and prepared to effectively deliver CSE material (source).	e

Recommendation 5: **That national legislation includes provisions for reproductive leave via both modern awards and in National Employment Standards.**

Reproductive health leave is a paid leave entitlement for employees to address their reproductive needs, sexual health and wellbeing. It recognises that reproductive health needs can be complex, change over time and vary significantly between individuals. They do not, in most circumstances, reflect ill-health, but are part of day-to-day life for a significant proportion of the workforce.

While reproductive health issues can affect everyone, women and transgender people who are disproportionally adversely affected by the status quo. Reproductive health leave is an important part of tackling systemic gender inequality in our workplaces, addressing inequity in access to leave and alleviating the gender pay gap and it has the potential to revolutionise our workplaces by giving greater social value to reproduction generally (source).

It also supports those in rural, regional and remote areas who will likely have to travel to metropolitan areas to access reproductive health services.