WOMEN'S HEALTH & WELLBEING
Barwon South West

Case Study:

Factors impacting Sexual and Reproductive Health and Rights in Barwon South West

Unintended pregnancy and abortion are among the most controversial and stigmatised topics in our society today. This is particularly so when the pregnant woman is in her teenage years.

This case study focusses on the story of a young woman in the Barwon South West region of Victoria, who became pregnant at a young age and is seeking an abortion. Rather than focus on one young woman's experience, this case study is built from interviews with Sexual and Reproductive Health Nurses. The case study is presented through a Socioecological lens, identifying the contextual factors that contribute to this experience, for young women in Barwon South West.

Case presentation:

A young woman aged 16 presented to a GP clinic at 10 weeks pregnant, seeking an abortion.

The young woman reported that she was in a relationship with a young man aged 19, and that while this was her first sexual partner, it was not her first sexual experience with him.

When asked if contraception was used in the sexual experience, she reported that she had ordered the pill online over 12 months ago but had taken "a break" as advised by a trusted teacher during sex ed that year. Her partner did not like condoms, so their usual method was withdrawal. While she knew that this put her at risk of pregnancy, she did not feel that she had any power to change this.

When asked why she didn't seek help earlier, the young woman stated that she didn't track her periods so didn't realise that she was in fact "late". By the time she had realised she was pregnant, she faced significant barriers being able to seek help independently. The young woman did not know what her options were, or who to go to in her small town. There was a wait list for the provider once she found one.

Ultimately, it was the involvement of the young woman's mother that ensured that she was able to see a GP. The mother's involvement was facilitated by the mother of a friend, as close friends were the young woman's first source of information and support.

The young woman was advised that she had missed the window for a medical abortion and that surgical abortion was now the only option. Surgical abortion was limited in the region and Ballarat (a 2 hour drive 172km), Geelong (a 2.5 hour drive 196.8km) or Melbourne (a 3 hour drive 257km) were the best options to be seen within the 14 week window.

When the potential cost of abortion was discussed (at minimum of $620 if they were to be seen by ta private metropolitan provider) the mother of the young woman explained that this cost, plus the cost of travel and accommodation was not something they could afford.

Choice, Knowledge, Access, and Focus – the broader influences on this case presentation

The following part of this case study will look at the social and political determinants that drive poor sexual and reproductive health. The following information will shape the direction for a proposed model of action for the Barwon South West.

Choice

When we speak about choice, we are referring to three key factors that influence women's sexual and reproductive health and rights: social norms, power, and policy.

Social norms

Social norms related to sexual behaviour can expose women, girls, men, and boys to risks and vulnerabilities. Norms that emphasise women's submissiveness can limit girls' decision-making about sex, shape fertility choices and influence access to SRH services.

Puberty is a formative period of rapid physical, cognitive, social, emotional, and sexual development, when differences in gender roles and gender inequalities become ingrained (source). These inequalities are particularly harmful to the sexual and reproductive health of adolescent girls and reverberate with lifelong effects.

Power

When we have the power and agency to make choices over our bodies and futures, without violence or coercion, we have bodily autonomy. This includes when, whether, or with whom, to have sex. It includes when, whether, or with whom, you want to become pregnant. It means the freedom to go to a doctor whenever you need one (source). Yet women and girls continue to face constraints in realising their right to bodily autonomy, including obstacles to access health services, information, and education.

Differences between women and men's access to power can influence interpersonal decisions about sex, including the type and frequency of sexual practices. 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). However, researchers examining condom use have found that gender-based power imbalances constrain women's ability to negotiate safer sex (source).

> There is a significant gender inequality among the students, with many boys refusing the wear condoms. Female students are coming to the Secondary School Nurse asking for STI checks, as they are engaging in sexual activities without protection against STI's

Policy

Women's bodies are political (source). Political decisions at national, state, and/or local level, on sexual and reproductive health and rights can shape community views on sexuality, and affect the delivery of SRH services, information, and education. While the reproductive needs and concerns of men and women are different, the fact that half of the population is subject to a disproportionate array of potential legislation surrounding their bodies and related personal choices is a human rights issue (source).

When seeking sexual and reproductive healthcare, women are often faced with the need for professional and legislative approval. Abortion for instance is particularly significant, because it embeds moral values. These values violate ethical requirements of treating patients with respect and choice. They can also result in violations of human rights laws that prohibit discrimination against women (source).

Knowledge

Education can be a powerful tool to drive progress for bodily autonomy and sexual and reproductive health and rights. Comprehensive sexuality education is key to promoting healthy behaviours and relationships, while empowering children and young people to make informed choices about their lives (source).

Comprehensive Sexuality Education

Positioned at the crossroads of education and health, comprehensive sexuality education (CSE) is vital to advancing health outcomes and gender equality. It gives young people the tools they need to have healthy lives and relationships. It helps them navigate lifechanging decisions about their sexual and reproductive health. Yet, many young people receive a range of scientifically incorrect, conflicting, and confusing messages about sexuality and gender daily. This can lead to serious risks for their health, wellbeing, and dignity. As a result, young women are left vulnerable to coercion, sexually transmitted infections, and unintended pregnancy (source). This points to the urgent need for effective CSE on a large scale (source).

Reluctance to discuss sexuality openly and honestly increases health costs and limits the effectiveness of health promotion initiatives (source). There is strong evidence that CSE delays the beginning of sexual activity and can better prepare young people to make safe and responsible decisions about sexual activity. When young people are provided with accurate information and skills in relation to sexual health they are less likely to experience poor sexual and reproductive health outcomes, including reducing teen pregnancy and abortion (source). However, there is currently no standardised national sexual and reproductive health curriculum in Australia, nor are there best practice guidelines for individuals delivering sexuality education. In the absence of open conversations with educators or parents regarding sex, some young people report that they turn to pornography for sexual information. Increasing ease of access to the internet makes it difficult to avoid exposure to online pornography (source).

> Conscientious objectors are still an issue – GP's are refusing to give a referral for a termination

Education outside of the school system

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. However, there is an opportunity for CSE to be embedded through integrated health services including medical officers, registered nurses, nurse practitioners, social workers, psychologists and health promotion officers (source).

Education may include information on healthy relationships, consent, and domestic violence screening and counselling. Shared decision making discussion around contraceptive choices or pregnancy options, changing sexual and reproductive health needs over the life course and STI protective behaviours, including the use of condoms and regular STI screening are also important areas to cover (source).

Access

SRHR information and services should be accessible and affordable to all individuals who need them regardless of their location, age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity. The key focus areas for this pillar are the impacts of rurality, structural issues, and stigma.

Rurality

Young rural women and girls face significant barriers in accessing the essential sexual and reproductive health services and commodities they need. Barriers are formed by various factors, such as: transport/distance from the health facilities, restricted operating hours, high costs of service, limited training in SRHR for medical staff, confidentiality issues, long waiting hours, and the constant fear of stigmatisation and discrimination (source). These barriers are strongest for young rural women and girls when obtaining safe abortion services, even in areas where legislative barriers are absent (source).

> Young people are not automatically bulk billed and they do not have the skills to negotiate this with a GP while at the appointment. Even if they do get bulk billed, the cost associated with accessing medication can be a significant barrier to obtaining it.

Structural issues

While Victoria is considered to have some of the most progressive abortion policy and practice, benefits are still limited to those within metropolitan areas, who have Medicare cards, and can afford the multiple doctors' appointments and tests that are required for abortion care. Access to mifepristone (medical abortion) is still restricted in Australia, unlike most developed countries where women have had access to this medication for more than twenty years. There is no Medicare item number for a rebate on medication abortion, while one is specified for surgical abortion. This creates an artificially high price for a relatively inexpensive medication. Wider use of medical abortion would offer public hospitals greater opportunity and flexibility to provide early pregnancy termination services (source).

Stigma and discrimination

To fulfil their SRHR, everyone needs information and services at multiple points during their lives (source). Entrenched social norms and gender inequality around young people and girls' sexuality mean young people's behaviours are controlled and they may be stigmatised for being sexually active. Due to their age, young people's ability to make decisions or express an opinion may not be respected. All these make it difficult, and often prevent young people from accessing sexual and reproductive health services (source). Access to service provision and information is further limited for vulnerable groups including:

- Aboriginal and Torres Strait Islander women and girls,
- Women and girls with a disability,
- Women and girls from CALD communities

Individuals who seek specific kinds of sexual and reproductive health care or services, such as for HIV, sexually transmitted infections, abortion, contraception, sexual dysfunction or transgender health, are particularly affected (source).

Focus

Ensuring access to comprehensive sex and relationship education, reproductive health services, contraception and tackling underlying issues of social determinants requires partnership and collaboration. Strong policy coherence, between the education, social and health sectors is vital. Intersectoral approaches with a strong emphasis on public health interventions is crucial to effectively improve the sexual and reproductive health and rights (SRHR) – as well as overall health and well-being – of women (source).

In Australia, where the overall population is among the healthiest in the world, we have unacceptably high levels of sexual and reproductive ill health (source). SRHR 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 is cost effective, has the capacity to improve the health of all and will impact positively on the economy (source).

Prioritisation

While the Australian Government has ratified multiple international conventions enshrining SRHR, these rights are not fixed in domestic law and policy. This is exemplified by the absence of a National SRHR Strategy (source). Although Australia has two national gendered health strategies, the National Women's Health Strategy (2020-2030) and a National Men's Health Strategy (2020-2030), neither strategy is adequately resourced, nor do they address sexual and reproductive health disparity (source).

This lack of prioritisation at a federal level is also reflected locally with SRHR not prioritised in health and/or strategic plans, despite being identified as a priority area in the Victorian Public health and wellbeing plan 2019-2023.

At a state level, there is an opportunity to leverage the soon to be released Victorian Women's Sexual and Reproductive Health Plan as part of broader prioritisation and collaboration, however at this stage any resourcing linked to the plan is unknown.

Data

At all levels (federal, state, and regional) there is limited data available for SRHR. This not only limits our true understanding of trends, patterns, and needs, but also limits the ability to track and measure progress (source).

Collaboration

Collaboration within SRHR initiatives and services across the region is limited.

The service system itself lacks connection between service providers, affecting referrals, information provision regarding medication stockist/providers, and systems for support and coordination of services. Many contributing factors include a lack of a coordinated approach to, and resourcing of, sexual and reproductive health, a lack of service providers in the region, including minimal EFT associated with these roles and, perhaps most importantly, the stigma attached to sexual and reproductive health.

> Everyone is working in silos and there is little collaboration.

Contact

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