Submission to the

Commonwealth Government Senate Standing Committee on Community Affairs

Inquiry into the universal access to reproductive healthcare

by

Illawarra Women's Health Centre

December 2022

Illawarra Women's Health Centre

Nationally accredited, the Illawarra Women's Health Centre has a focus on mental health, women experiencing domestic and family violence and sexual assault, and sexual and reproductive health. The community-based Centre sees over 5,000 women a year and has an exceptional reputation, providing integrated care and social support to women with complex needs using a social model of health and a community development approach to service delivery.

The Centre is a women's only space, and its doctors, nurses, psychologists, counsellors and social workers are all female, experienced and trauma informed. The Centre offers specialised domestic and family violence programs for girls, boys and young women, and women with intellectual disabilities. It also developed the first in Australia, Mothers and Sons Program which focuses on raising young boys into respectful men.

The Centre also runs a wide range of health and wellbeing programs and group activities.

The Centre is driving the development of and funding for a Women's Trauma Recovery Centre project. This Australian first model of care is informed by survivor advocates, interdisciplinary professional input and groundbreaking research to be adapted and replicated in communities across the state and country.

We welcome the opportunity to contribute to **Senate Standing Committee on Community Affairs, inquiry on universal access to reproductive healthcare** and commend the Commonwealth Government on taking the initiative to deepen understanding of the multitude of cultural, systemic and structural barriers impacting women seeking equitable and accessible reproductive health care.

Illawarra Women's Health Centre is situated on the land of the Dharawal Nation.

We acknowledge the traditional custodians of this land, where the Aboriginal people have performed age-old ceremonies of storytelling, music, dance and celebration.

We acknowledge and pay respect to Elders past and present, for they hold the memories, traditions and hopes of First Nations people.

We must always remember that under the concrete and asphalt, this land is, was, and always will be, traditional Aboriginal land.

We acknowledge that we work in the context of generations of resilient, strengths-based, holistic resistance to violence in First Nations communities.

We commit to actively supporting and promoting the voices of First Nations people and organisations in our work and continue to work on decolonising our views and actions.

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

Executive summary

The responsibility and cost of managing fertility, contraception, pregnancy, abortion and parenting remains overwhelmingly with women. As a feminist organisation we support reproductive justice for all women and believe that women should be supported to make decisions about their own bodies.

We work to dismantle the entrenched inequity in healthcare which places disproportionate social, mental, emotional, and financial cost burdens on women.

For women in the Illawarra, costs are incurred for most contraceptive devices and medications, for most medical and surgical abortions, and for consultations where general practitioners, specialists or clinics charge a fee above Medicare. Additionally, the spend time attending medical and diagnostic appointments can result in time away from work, study, caring responsibilities, and social engagement, and can add child-care or transport costs.

Women in the Illawarra seeking abortion face multiple barriers including difficulty accessing

general practitioner appointments for a medical abortion or to get a referral for surgical abortion in the public system. For women living in a regional area such as ours, availability of bulk-billing general practitioners and free or low-cost abortion services is fast diminishing.

Private medical and surgical abortion services vary in cost across different providers, and it is highly stressful for women trying to find free or affordable abortion. We receive many phone calls per week from women unable to pay the fees associated with medical or surgical abortions.

Legalised abortion is essential for reproductive justice, but fails without safe, accessible, free or low-cost services in place where and when people need them.

We call for free, safe and timely access to contraceptives, and free, safe and timely abortion services close to home or within reasonable reach.

We support models of care where women can book directly for public abortion services without a doctor's referral and have pre and post abortion care in a single setting (such as offered at the Pregnancy Advisory Centre in South Australia). [1]

Action is needed to address the barriers impacting marginalised communities including First Nations women, culturally and linguistically diverse women, women with disabilities, refugee and migrant women, women with intersex variations, and trans and non-binary people.

We also call for ongoing and increased funding to stop domestic and family violence, including sexual and reproductive violence and coercion, and to support women escaping and recovering from violence and coercion, recognising that pregnancy can be a time of added risk for women in or escaping violence.

[1] Pregnancy Advisory Centre SA
https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/health+services+for/womens+health+services/unplanned+pregnancy+services/south+australia+abortion+and+support+services

These are essential components to achieve reproductive justice, health equity and best practice in public health.

Background

On 28 September 2022, the Senate referred an inquiry into the universal access to reproductive healthcare to the Senate Community Affairs References Committee for inquiry and report by 31 March 2023.

There is a current consultation listed on the Senate Standing Committees on Community Affairs website, which is open until 11.59 pm AEDT on 15 December 2022. We appreciate the opportunity to provide a submission. This submission is written in response to the Committee Terms of Reference.

We consent to this submission being published on the inquiry website and shared publicly online.

Summary of reproductive healthcare services provided

Our clinical team is a nurse practitioner and a registered nurse, with capacity for a medical officer.

Reproductive healthcare we currently provide includes:

- Information and advice on all methods of contraception
- Provision and management of oral and injectable contraceptives
- Insertion and management of contraceptive implant
- Removal of inter-uterine device (IUD)
- Pregnancy testing and pregnancy options counselling
- Information and referral for pregnancy care
- Information and referral for medical and surgical abortion
- Sexually transmitted infections testing, management and advice
- Pre-pregnancy planning
- Postnatal check-ups, parenting support and advice

When we have a medical officer, we are also able to provide

- Medical abortion
- Insertion of IUDs

Terms of Reference response

This section is framed in direct response to the Committee Terms of Reference.

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

a. cost and accessibility of contraceptives, including:

i. Pharmaceutical Benefit Scheme (PBS) coverage and Therapeutic Goods Administration (TGA) approval processes for contraceptives,

We support specific recommendations in the submission by MSI Reproductive Choices, Australia (MSI) to:

- amend the Risk Management Plan and regulatory reforms for medical abortion medications that will improve abortion access and equity;
- extend PBS coverage to include all progesterone only and combined oral contraceptive pills, as some are currently not listed on the PBS; and
- better approval processes for new contraceptives such as the contraceptive patch and self-injectable progesterone which have already been approved in several countries including US and UK.

In addition, we support actions to remove the out-of-pocket costs for contraceptive medications and devices, and for associated consultations.

Barriers such as cost and wait times for practitioners or services can contribute to breaks in contraceptive cover, the risk of unplanned pregnancies, and increased mental stress for women.

ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and

Making informed choices about long-acting reversible contraception (LARC) depends on effective dissemination of information to women and to and by healthcare providers.

Information for women about LARC must be evidence-based, available in multiple languages, accessible in hardcopy and online, and supported by consultations and conversations with informed practitioners and health workers.

Information to clinicians must be evidence based, and free of vested interests, incentives or bias, and delivery of information in consultations should also meet these standards.

Australia has a lower uptake of LARC than income-comparable countries.[2] We support assessing the level of knowledge about LARC in general practice and healthcare settings and among women seeking contraception as well as assessing the level of uptake of LARC in different clinical settings and geographic areas to learn more about awareness, use and barriers for women and practitioners.

[2] Changes in use of hormonal long-acting reversible contraceptive methods in Australia between 2006 and 2018: A population-based study. Grzeskowiak LE, Calabretto H, Amos N, Mazza D, Ilomaki J.

iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;

We support improving access to contraception including exploring the role of the pharmacist where it is safe to do so and benefits women.

An example of this in action is that Scotland now authorises pharmacists to give three months' supply of the progesterone only pill without prescription, with the aim of bridging the gap between receiving the emergency contraceptive pill and seeing a GP or Nurse Practitioner for contraceptive advice, prescription and management. [3]

For pharmacists to take a greater role in contraception we suggest additional training or standards may be indicated to ensure a non-judgemental approach and provision of privacy can be guaranteed.

b. cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas;

Barriers related to accessing GPs, multiple appointments required, and cost.

There is an overall shortage of GPs in the Illawarra, and a rapidly declining number of bulk billing GPs. Wait times to see a bulk-billing GP can be up to two weeks, and at times GPs will close their books to new patients. The gap payment for private billing GPs is increasing. Added to this, there is a low number of GPs offering medical abortion and very few offering this as a bulk-billed service.

Prior to abortion occurring, multiple appointments at different providers are usually required including an initial GP consultation, appointment for ultrasound, appointment for blood tests, return to GP for results, and a prescription for a medical abortion, or referral letter for a surgical abortion at a public hospital.

The cost of medical abortions in the Illawarra ranges from bulk-billed to up to $400 out of pocket, while surgical abortions at private clinics range from $400-$600 out of pocket, including for health care card holders.

These up-front costs can delay women booking in while trying to find money and can mean the option for a medical abortion is lost as time passes. We regularly receive requests for financial help and unless we have funds through donations to the Centre, we can rarely help.

Some women travel to larger urban or city areas due to local wait times, incurring extra costs and time which adds mental stress, and disruption to employment, study, childcare or caring duties.

There are barriers related to misinformation or bias from service providers including frontline reception staff, GPs, and other health workers and practitioners. Some recent experiences relayed to us are: being told surgical is 'better' than medical abortion; being given wrong information about gestation related to medical and surgical abortion availability; only being given fee-paying options; being met with value judgements, advice-giving, or anti-abortion views; and being told abortion is illegal and not being provided with timely and accurate referral to another practitioner or service.

Access to pregnancy care:

We support strengthening services in the Illawarra so that all women can receive pregnancy and birthing services close to home, with access to public hospital care. Pregnancy and birthing care should include access to midwifery-led care, shared care, and homebirth options. Interpreter services and culturally aware

[3] https://www.gov.scot/news/supporting-womens-health/#:~:text=Women%20will%20be%20able%20to,pharmacies%20across%20Lothian%20and%20Tayside.

care must be available at all stages of pregnancy and birthing for people across languages (including Auslan), cultures and religions.

First Nations women must have access to cultural safe pregnancy, birthing and parenting services, including access to Aboriginal and Torres Strait Islander midwives and healthcare workers, and access to birthing on county.

The higher rates of maternal deaths for First Nations people (more than three times the maternal death rate than non-Indigenous women) and continuing escalation in children being removed from First Nation's families are just two indicators that there is systemic failure and ongoing injustice for First Nation's people in reproductive health outcomes.[4] [5]

We support First Nations-led pregnancy, birthing and parenting services in the Illawarra being well resourced to continue to provide culturally safe service models in reproductive health care to First Nation's women and families and to determine where strengthening or expansion of services is required.[6]

c. workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals;

Across Australia, less than 10% of GPs are registered to prescribe abortion medication and this drops below 1% in some regional, rural and remote areas.[7]

Workforce development is essential to ensure proper access to contraception and abortion, and in particular, we support nurse-led and midwife-led initiatives:

- Provide specific training to accredit registered nurses and midwives as prescribers for medical abortion medications;
- Authorise Nurse Practitioners to refer for pelvic ultrasounds, and to public hospitals for surgical abortions where GP referral is required;
- Investigate the role of nurses and midwives as providers of surgical abortion considering evidence from countries where this is already occurring;
- Increase the scope of practice for nurses, registered midwives, and Aboriginal and Torres Strait Islander health workers in providing contraceptive services; and
- Consider the role of allied health professionals in contraceptive information and advice.

d. best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery;

Sexual violence and reproductive coercion and control can include actions targeting contraception. This can include a man. Acts of violence, control or coercion include refusing to use condoms or removing condoms during sex, pressuring a partner to start or cease of contraceptives, or to choose certain methods over others, or to continue or discontinue a pregnancy.

[4] https://www.familymatters.org.au/wp-content/uploads/2020/11/FamilyMattersReport2020_LR.pdf

[5] https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-australia

[6] https://waminda.org.au/ and https://www.islhd.health.nsw.gov.au/services-clinics/binji-boori

[7] https://www.msiaustralia.org.au/nurse-led-medical-abortion-care-reforms-proposed-in-victoria//

We recognise that sexual and reproductive violence and coercion and control can form part of domestic and family violence. We use a trauma-informed approach in opening conversations about safety and risk, including whether a woman has autonomy over contraceptive and pregnancy decisions.

Practitioners involved in services for contraception, pregnancy and abortion must include safety planning, whether related to appointments and after care for abortion, or in discussing contraceptive options; for example, the injectable contraceptive or the emergency contraceptive pill may enable a woman to maintain contraception without easy detection.

e. sexual and reproductive health literacy;

Through our work with young people in schools and community settings, we learn there is still taboo and stigma in many areas of sexual and reproductive health, such as menstruation, sex, pleasure, sexuality and gender, different relationship structures, pregnancy, and abortion. Our experience is that it is important for young people to not only receive accurate information but to also have opportunity to talk free of judgments.

In our work with women of all ages we learn that many people received inadequate sex and reproductive health education in their youth and may not have health literacy as adults. As practitioners and health workers we must not assume literacy, especially in relation to anatomy and physiology when seeking informed consent and explaining procedures and processes.

We also recognise that health literacy plus the confidence to discuss sexual and reproductive health topics should not be assumed in practitioners and health workers, particularly where taboo, stigma and discomfort may be factors.

It is essential to maintain the presence of specialised sexual and reproductive health services including women's health centres across rural, remote, regional and metropolitan settings.

f. experiences of people with a disability accessing sexual and reproductive healthcare;

Women and girls with disabilities have equal right to information about and services for sexual and reproductive health yet often experience barriers to access. A recent Women with Disabilities Australia report found that most young women and girls didn't make their own decisions on menstruation and contraception. Instead, parents guardians and doctors are making these decisions on their behalf. [8]

In our work with women and girls with disability we encounter complexity for the clients related to the presence of parents, carers, support workers or significant others in individual consultations and group programs. There can be tension from parents or carers about whether giving information will lead to sexual behavior and risk, wanting to gatekeep or filter information, rather than supporting the right to information and informed choice. There can be conflicts of values and expectations including religious and ethical differences such as sex before marriage, using contraception, abortion, or parenting. While this can arise for many young people it is heightened for people with disabilities who may rely on another person to be in the room for care or communication, or for transport to activities, or for managing care. Privacy can be difficult to achieve in many situations.

We support the right for people with disabilities to have equal access to information and services, to give informed consent, to make decisions about sex, relationships, contraception, pregnancy, parenting and abortion free of judgement or coercion.

[8] https://wwda.org.au/publication/youth-sexual-health-and-reproductive-rights-report-and-resources/

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

We recognise that trans, non-binary and gender diverse people need reproductive healthcare, including contraception and abortion, and are navigating services often based on binary-gender models and not yet providing inclusive care.

There is evidence that many trans, non-binary and gender diverse people have experienced discrimination in the health system including being refused services, misgendered, outed, vilified or abused.[9]

We support actions that raise awareness, increase access, and reduce discrimination and harm.

We support the recommendations in the submission made by Dr Ruth McNair, General Practitioner and Associate Professor at University of Melbourne, about access to healthcare for trans, non-binary and gender diverse people:

1) ensure access to public funded free healthcare services

2) recognise and address past and current discriminatory practices in healthcare settings

3) increase education about trans, non-binary and gender diverse people's health needs and include education about healthcare workers responsibilities.

h. availability of reproductive health leave for employees; and

Abortion and contraceptive-related procedures and are not illnesses. They form part of healthcare episodes required for many women and people with uteruses across their reproductive lives.

Taking time off work for reproductive healthcare adds burden when women are already disproportionately on lower incomes, more likely to be in insecure work, and have higher rates of sex discrimination and sexual harassment at work.

We support the submission made by Women's Health Matters in calling for research into the impact of reproductive leave on women's health, and community consultation about reproductive health leave for employees.

i. any other related matter. No comment

[9] https://www.liebertpub.com/doi/10.1089/lgbt.2020.0178

Recommendations

Universal access to reproductive healthcare is essential. We support this important Inquiry, with the following recommendations:

1. Establish one or more community clinics in the Illawarra to provide free medical and surgical abortions, contraception, and support and information, via self-referral;
2. Provide immediate brokerage money to be utilised for women who are unable to afford private medical and surgical abortion, including provision for travel and accommodation costs where services are not available within their area;
3. Remove the requirement for referrals from general practitioners to public abortion services; and in the interim authorise other practitioners to make referrals such as nurses, midwives, and Aboriginal healthcare workers;
4. Amend PBS coverage to provide free access to LARC and other contraceptives;
5. Implement strategies to increase uptake of training by general practitioners to prescribe medical abortion medications
6. Expand training to include nurses and midwives as prescribers of medical abortion medications;
7. Authorise nurse practitioners to refer for ultrasound in pregnancy;
8. Mandate curriculum on sexual and reproductive health including abortion in medical, nursing and midwifery undergraduate degrees and post graduate training programs including general practice, obstetrics and gynaecology;
9. Implement strategies to change structural and cultural barriers in public hospitals where there is a high level of reluctance, refusal and conscientious objection by staff that prevents effective service delivery and compromises duty of care to women requesting abortion; and
10. Tighten conscientious objection laws and develop policy directives for public and private health settings to ensure individuals and institutions are aware of their rights and obligations including to not disadvantage their clients, and that employers provide education and ensure compliance of staff and the institution.