Leve 1, 70 St Kilda Road, St Kilda 3182

Phone: (03) 9794 8677 • Email: whise@whise.org.au

Web: www.whise.org.au

ABN 90 641 895 966

Submission to the Senate Inquiry into Universal Access to Reproductive Healthcare

Submission prepared by Women's Health in the South East, August 2022

Authors: Laura Riccardi and Tara Kortel
Email (Direct): lriccardi@whise.org.au
Address: Level 1, 70 St Kilda Road, St Kilda 3182
Phone: (03) 9794 8677
Web: www.whise.org.au

Introduction

Women's Health in the South East (WHISE) welcomes the opportunity to provide input into the Senate Inquiry into Universal Access to Reproductive Healthcare. WHISE is the regional women's health service for the Southern Metropolitan Region. WHISE is a not-for-profit organisation that focuses on empowering women. We work to improve the health and well-being of women in our region by providing health information and education to governments, organisations, education providers, and community groups. WHISE is the lead of the regional four-year strategy for sexual and reproductive health (SRH), *Good Health Down South 2021 – 2025*, the associated action plans, and the bimonthly network in the Southern Metropolitan Region comprising representatives from local and state government, youth and maternal and child health services, health promotion agencies, community health organisations and other community and social services.

This submission has been endorsed by Peninsula Health, the South Eastern Melbourne Primary Health Network, and Talking the Talk Healthy Sexuality Education. These agencies have written letters of support which are attached to the end of this submission.

WHISE's submission will apply an intersectional gender lens to the Terms of Reference supplied by the Senate Community Affairs References Committee, outlining identified areas for strengthening in the provision of health services, education, information and resources, policy and legislation, to ensure equitable access to reproductive healthcare. Our response to the Terms of Reference is informed by

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Web: www.whise.org.au
ABN 90 641 895 966

evidence and best practice; and was developed in alignment with our strategic priorities of enhancing gender equality, preventing violence against women and improving SRH outcomes. The submission also includes key recommendations highlighted below, for your convenience.

Executive Summary

Key recommendations

Our recommendations include:

1. Embed system enablers for healthcare providers to complete training to administer and dispense medical abortions, including increased investment in initiatives that provide training and educational opportunities for healthcare providers to provide medical abortion, and expand the health workforce by enabling nurses, midwives, and pharmacists to work to their full scope of practice in contraception and abortion care, with appropriate remuneration and training opportunities.
2. Increase and commit to long-term funding for Sexual and Reproductive Health Hubs to administer staff training and hire new staff to address staff shortage, including investment in staff training to deliver dating scans for timely and affordable reproductive care.
3. Invest in the health workforce to incentivise general practitioners (GPs) and other health professionals to support necessary training to providing reproductive health services including abortion and LARC, as well as mandatory inclusion of SRH in all undergraduate medical curricula, including all obstetrics and gynaecology, general practitioner, practice nurse, nurse practitioner and midwife training programs, with the support and guidance of recognised medical training programs such as RANZCOG and the RACGP, to reduce administrative and structural barriers to accessing appropriate services.
4. Establish and convene a national taskforce on abortion care in Australia, to review the provision of affordable, accessible abortion services across the states and territories, with a view to establishing federal legislation governing abortion provision in Australia.
5. Amend Medicare Item Numbers that prevent adequate reproductive healthcare. This includes Telehealth, cost of consumables such as IUD/Implanon, other contraceptives, and Nurse Led Model of Care and abortion.
6. Extend PBS coverage to include the progesterone-only oral contraceptive pill (also known as the mini-pill), the combined vaginal ring, and new contraceptives.
7. Review current approval processes for the introduction of new medicines, including the provision of over-the-counter access to contraceptives.
8. Introduce a process which enforces the Department of Health and Human Resources to oversee funding to ensure models are being implemented and government spending is being used correctly, for the purposes of universalising access to SRH services across the SRH Hubs and public hospitals.

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9. Remove barriers to contraceptive access by providing free contraception to women under 25 years and incentivising primary care health practitioner training in contraceptive service provision.
10. Invest in services that provide antenatal care to prevent birth trauma and trauma-informed sexual and reproductive healthcare services for victim-survivors of gender-based violence including sexual violence.
11. Extend Medicare coverage of pregnancy care and abortion services to include all migrants and refugees, regardless of their visa status, and to amend the current agreements with insurance companies that require a 12-month waiting period for international students before they are eligible to make a pregnancy-related claim.
12. Establish a national inquiry into reproductive violence for people with disabilities, including the removal of babies and children from parents with disabilities and forced sterilisation; and work with relevant bodies, including National Health Boards and specialist medical colleges to review the findings of the Senate Inquiry into involuntary or coerced sterilisation of people with disabilities in Australia, and implement the recommendations including medical workforce training with respect to SRH, including content on supporting sexual relationships and SRH needs for people with a disability.
13. Invest in sexual health literacy through the embedding of evidence-based, inclusive, and sex-positive SRH literacy, including age-appropriate content on contraceptive options, in the *Resilience, Rights and Respectful Relationships* program.
14. Embed flexible working arrangements to provide support to employees to manage and/or alleviate symptoms relating to reproductive health, including menopause and perimenopause, endometriosis, and polycystic ovary syndrome (PCOS).
15. Introduce the availability of reproductive health leave for employees, with the aim of supporting access to abortion, assisted reproductive technology and other fertility treatment, and gender-affirming healthcare.

A note on inclusive language

This submission uses the term "women" throughout, inclusive of all people who identify as women. WHISE recognises that trans men, non-binary, agender, intersex and other gender diverse people or people assigned female at birth who do not identify as women also use and need abortion, contraception and other sexual health services. We acknowledge the need for the Senate Standing Committees on Community Affairs to consult with organisations that represent those communities, to ensure services are inclusive, equitable and appropriate for all.

Response to the Terms of Reference

Summarised below are a list of key issues identified by WHISE in response to the Terms of Reference listed by the Senate Standing Committees on Community Affairs. The rationale for our response to the Terms of Reference is based on our detailed consideration of existing literature and evidence, our work

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with key stakeholders in the SRH sector through our regional partnership, *Good Health Down South*, and our health promotion work in the Southern Metropolitan Region.

Cost and accessibility of contraceptives, including: 1)PBS coverage and TGA approval processes for contraceptives, 2) awareness and availability of long-acting reversible contraceptive and male contraceptive options, and 3) options to improve access to contraceptives, including over-the-counter access, longer prescriptions, and pharmacist interventions

Cost is a major barrier to the uptake of contraceptives, particularly long-acting reversible contraception methods (LARC) (Eisenberg, et al., 2013; Garrett, et al., 2015; Mazza, et al., 2020)

LARC contraceptives[1] are widely known to be the most efficacious methods of preventing unwanted pregnancy, as well as the most cost-effective in the long-term. However, the upfront costs and ongoing appointments required for the insertion and management of these methods limit the affordability and uptake of LARC (Mazza, et al., 2017). WHISE recommends that the Australian government adopt the approach taken by governments such as France, Sweden, New Zealand and the United Kingdom, and offer no-cost contraception for all women and people with a uterus, at a minimum until the age of 25 years.

WHISE also recommendations PBS coverage be extended to include the progesterone-only oral contraceptive pill (also known as the mini-pill), to ensure affordable access to oral contraceptive options for people who cannot use the combined oral contraceptive pill due to contraindications[2] or those who do not want to use the combined oral contraceptive pill. PBS coverage should also be extended to include the combined vaginal ring, to provide women and people with a uterus with multiple options to prevent unwanted pregnancy.

In addition to cost, there are administrative barriers that limit the accessibility of contraceptive options for women. WHISE notes that the Therapeutic Goods Administration (TGA) has historically taken a very conservative and cautious approach to the approval of new contraceptives. While this has been with a view to protecting the interest of the public, Australia now lags comparable settings such as the United States and the United Kingdom, where new contraceptive methods, such as the combined contraceptive patch, and self-administered progesterone injection, have been introduced. To remedy this, the government should streamline the approval process for the introduction of new contraceptives.

WHISE also recommends that the TGA revisit its rejection of the proposal to down-schedule the oral contraceptive pill to allow over-the-counter access, on the condition that the pill has been prescribed by a doctor during a consultation in the preceding two years. This recommendation is in response to the

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[1] Including the copper (non-hormonal) intrauterine device, the hormonal intrauterine device, known in Australia as Mirena, and the contraceptive implant known in Australia as Implanon.
[2] Contraindications can include a history of heart disease, breast cancer, experiencing migraines, or smoking.

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current crisis in general practice, and the limited availability of bulk-billed general practitioner appointments (Australian Government Department of Health, 2021; Deloitte, 2022). Over-the-counter contraceptives may support women, particularly those in regional and rural communities, to access critical medicines (The Pharmacy Guild of Australia, 2018). While we acknowledge the risks associated with the use of the oral contraceptive pill, and the importance of clinical expertise and examination, we believe that down-scheduling the oral contraceptive pill may provide an opportunity to reduce the burden on primary care while providing women with increased access to contraception. Oral contraceptives are already available over the counter in more than 100 countries around the world (Grindlay , et al., 2013), and recent studies show that women can use a simple checklist via clear labelling to accurately identify health conditions and risk in accordance to taking birth control pills, and employ their own decision-making as to whether to consult with a pharmacist or another healthcare provider (Grossman , et al., 2008; Grindlay, et al., 2022).

Almost half of women who initiate use of oral contraceptives discontinue the method during the first year of use and access issues have been found to contribute to this (Potter, et al., 2013). Several studies in Mexico have found that women who received oral contraceptives over-the-counter were more likely to stay on the pill longer compared to women who purchased contraceptives by prescription at a clinic (Grindlay, et al., 2022; Hopkins, et al., 2012). Therefore, reducing limits on the prescribing and dispensing of oral contraceptive pills will enhance access to contraception and reduce unwanted or unintended pregnancies.

In addition to reducing the cost and administrative barriers to contraceptives, it is necessary to increase practitioner and community knowledge of contraceptive methods, including the efficacy and suitability of LARC. To increase community health literacy regarding the availability of varied contraceptive methods, including emergency contraception, we recommend embedding evidence-based, inclusive, and sex-positive SRH literacy, including age-appropriate content on contraceptive options, in the *Resilience, Rights and Respectful Relationships* program.

WHISE also recommends the government mandate contraceptive counselling and insertion and removal of all LARC options in medical curricula, including all obstetrics and gynaecology, general practitioner, practice nurse, nurse practitioner and midwife training programs, with the support and guidance of recognised medical training programs such as RANZCOG and the RACGP. Additionally, we recommend the government ensure appropriate remuneration for GPs, nurses, nurse practitioners and midwives providing contraceptive services, LARC insertion and removal procedures, and medical abortion care, as well as subsidised costs for related equipment. This will support the embedding of nurse-led models of care, supported by GPs, to deliver services such as LARC and medical abortion, rather than relying on costly gynaecological services. For example, the Victorian Sexual and Reproductive Health Hubs have almost universally implemented nurse-led models of care for the provision of SRH services with success. Doing so would support practitioners to address the underutilisation of LARC in the Southern Metropolitan Region. Data on LARC utilisation can be accessed from two key pages within the Victorian Women's Health Atlas:

1. Contraceptive implant use
2. Contraceptive IUD use

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Cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas

The cost of abortion and limited number of abortion providers in Australia are major barriers to accessible abortion services. There are relatively few abortion providers in the primary care setting and hospital system in Australia and even fewer who can manage complex medical and gynaecological cases. Only a minority of specialist and trainee obstetricians and gynaecologists perform surgical abortions, due in part to institutional barriers and public stigma.

Inconsistent provision of abortion in public hospitals, including sparse availability in many parts of Australia, further contributes to inequitable access. The low numbers, or in some cases, complete lack of public and private hospital abortion providers in some regional areas, mean few referral pathways exist particularly for surgical abortion, as most providers are located in metropolitan areas. WHISE recommends the government provide free transport for rural and regional abortion-seekers who cannot access abortion locally.

Many hospitals do not perform abortions as it may not be an explicit expectation under their service agreement, and some faith-based public and private hospitals prohibit provision of abortion and contraception. WHISE recommends that the government ensures that no-cost surgical abortion is available for any pregnant person when requested at any indication (not only foetal abnormality) in all hospitals in receipt of public funds.

The cost of reproductive healthcare, specifically abortion, is a major barrier to accessing vital services for women in the Southern Metropolitan Region. Abortion costs are substantial, increase at later gestations, and are a financial strain for many women. Surgical abortion fees can start from $400-$700, with medical abortion fees ranging between $100-$600.

These costs can be prohibitive, particularly for women experiencing socioeconomic disadvantage, including those living in local government areas within the Southern Metropolitan Region. For example, Greater Dandenong is one of the most disadvantaged areas in Victoria with a weekly personal income at $619, lower than the Victorian level of $803. Medicare rebates and pharmaceutical benefits should be sufficient to prevent cost being a barrier to seeking an abortion, and to avoid financial disincentives for health professionals or those seeking contraception.

WHISE recommends the government establishes and convenes a national taskforce on abortion care in Australia, to review the provision of affordable, accessible abortion services across the states and territories, with a view to establishing federal legislation governing abortion provision in Australia (Children by Choice, 2022). This will ensure abortion-seekers across Australia have equitable access to vital reproductive services.

WHISE also recommends that the government invest in significant expansion of medical abortion service provision, to increase the accessibility of abortion and reduce demand for surgical abortion where feasible. Increasing the accessibility of medical abortion could be achieved through (1) amendments to

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the risk management plan to reduce over-regulation of medical abortion prescribing, (2) removing the individual pharmacist registration requirement for dispensing medical abortion medication, (3) increasing the current approval requirement for use up to 70 days as is consistent with prescribing internationally, and (4) increasing the capacity and capability of the primary care workforce to provide medical abortions. Only 3,018 out of approximately 29,017 registered GPs are active prescribers of medical abortion drugs. This is evident in the Southern Metropolitan Region, where significant gaps in some local government areas exist.

The establishment of Sexual and Reproductive Health Hubs in community health organisations throughout Victoria, as well as the 1800 My Options telephone pregnancy and sexual health information service, has been instrumental in increasing abortion access. However, there are inconsistencies in how the funding is being used to provide services to the community, and local abortion providers continue to be difficult for people to locate and access. WHISE recommends that as part of efforts to establish a national taskforce on abortion care in Australia, to ensure universal and equitable provision of abortion services across the states and territories, that key performance indicators are established and rigorously monitored to ensure that services are accountable.

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

Workforce knowledge and capacity to provide reproductive healthcare services can be a significant enabler or barrier to comprehensive, high-quality, and affordable SRH services.

According to the World Health Organization (WHO), both vacuum aspiration and medical abortion can be provided at the primary-care level on an outpatient basis and do not require advanced technical knowledge or skills, expensive equipment such as ultrasound, or a full complement of hospital staff such as an anaesthesiologist. In this context, primary health-care staff include nurses, midwives, health-care assistants and, in some contexts, GPs. In Victoria, the best practice of medical abortion provision has been established as nurse-led models of care, with prescriptions provided by GPs and consultation with gynaecologists only if needed. This has been implemented almost universally through the Sexual and Reproductive Health Hubs.

Yet, there is a noted lack of financial incentives or support for GPs and other health practitioners to undergo necessary training to become providers of medical abortion or LARC. For instance, current IUD insertion training can cost approximately $2,000, excluding travel and other associated costs. While registered nurses, nurse practitioners and registered midwives are well-placed to provide LARC insertion and removal services, there is no remuneration available to support this model of task-shifting or to encourage nurses and midwives to undertake the training or provide this service.

WHISE recommends increased and ongoing investment into the health workforce to incentivise GPs and other health professionals to support necessary training to providing reproductive health services including abortion and LARC.

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In addition to increased investment in the SRH workforce, WHISE recommends mandatory inclusion of SRH in all undergraduate medical curricula, including all obstetrics and gynaecology, GP, practice nurse, nurse practitioner and midwife training programs, with the support and guidance of recognised medical training programs such as RANZCOG and the RACGP, to reduce administrative and structural barriers to accessing appropriate services.

WHISE also recommends the introduction of post-graduate education pathways accredited by peak bodies for practitioners already in the health workforce, to enable practitioners to expand their competencies in SRH, particularly for medical abortion.

Best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery

Trauma-informed service delivery

Trauma-informed care and practice is critical for accessible sexual and reproductive healthcare, particularly in supporting victim-survivors of sexual violence to access sexual and reproductive healthcare. WHISE supports measures to provide an environment for safe and supported disclosure of sexual violence in clinical settings, as well as the provision of services where victim-survivors are (1) heard and believed by all services involved in the reporting and recovery journey, (2) have control over support and service options, (3) have access to supportive counselling and group therapy as desired, and (4) feel their needs are met in a timely and respectful manner (Queensland Centre For Domestic and Family Violence Research, 2020).

To this end, WHISE welcomes the release of new guidelines for cervical screening in 2022 by the Australian National Cervical Screening Program, which outline self-collection for a human papilloma virus (HPV) sample is now available for all women and people with a cervix, not only under-screened populations. The new guidelines will ensure that women and people with a cervix who have experienced trauma, including sexual assault, or for whom a traditional speculum-based examination may induce gender dysphoria, can access preventative screening with reduced risk of re-traumatisation.

WHISE recommends that trauma-informed care and practice is embedded in pre-service training and education for healthcare professionals and social services. We also recommend further consultation with key stakeholders and knowledge experts, including victim-survivors, Australia's National Research Organisation for Women's Safety Limited (ANROWS), 1800RESPECT, the Victorian Centres Against Sexual Assault and others, to ensure that best-practice is implemented in sexual and reproductive healthcare.

WHISE also recommends that sexual and reproductive healthcare providers are equipped to identify, triage and support women experiencing gender-based violence. Violence against women can start or worsen during pregnancy, and can cause complications such as miscarriage, foetal injury and foetal death (State of Victoria, 2018). Intimate partner violence is also associated with poorer health outcomes such as unintended and unwanted pregnancy, pregnancy complications, and abortion and unsafe abortions. According to the WHO, intimate partner violence is associated with a two-fold increase in

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induced abortion (World Health Organisation, 2019). For migrant and refugee women, there is evidence that prevalence rates are even higher for family violence and reproductive violence, and that violence is more severe and prolonged (Segrave, et al., 2021; Suha, et al., 2022).

Research also highlights that a significant number of women experience birth-related trauma. As many as one in three women describe their experience of giving birth as traumatic. Yet, until relatively recently, childbirth was not considered an event that could cause post-traumatic stress disorder (Reed, et al., 2017). While increasingly recognised as a major issue for women's mental health and wellbeing, childbirth is still not explicitly listed as a potential stressor. WHISE recommends investment in services that provide antenatal care to prevent birth trauma and consultation with key stakeholders and knowledge experts, including the Australasian Birth Trauma Association, Perinatal Anxiety & Depression Australia (PANDA) and others, to ensure that women are supported through pregnancy, birth, and parenting.

Culturally appropriate service delivery

The Southern Metropolitan Region comprises a wide range of culturally diverse populations. On average, 31% of residents living in the region were born overseas, slightly lower than the Victorian level of 32%. However, the percentage of residents born overseas living in these regions varies significantly across the region from Greater Dandenong with 58% of residents born overseas to Mornington Peninsula with 18%. Research demonstrates that culturally and linguistically diverse (CALD), migrant and refugee women experience a range of barriers to accessing culturally appropriate information and services for reproductive health and abortion (Hawkey, et al., 2021). The research points to a range of interpersonal and structural factors that can impede reproductive autonomy for migrant and refugee women, such as family and sexual violence, visa status, socio economic status, and language barriers (Multicultural Centre for Women's Health, 2021). These barriers limit the ability to manage their own reproductive and contraceptive choices resulting in high risks for poor health outcomes. A new report by the WHO has found that globally, migrants and refugees experience poorer health outcomes than those in their host communities due to strenuous barriers that compromise access and affordability to healthcare (World Health Organisation, 2022).

Women who are asylum seekers may be ineligible for Medicare or Centrelink Health Care Cards. Women on temporary visas, such as international students, may not have Medicare entitlements. Although international students need to have Overseas Student Health Cover (OSHC) while they are in Australia, pregnancy related services may not be covered in the first 12 months of membership.

We therefore recommend that the government extend Medicare coverage of pregnancy care and abortion services to include all migrants and refugees, regardless of their visa status, and to amend the current agreements with insurance companies that require a 12-month waiting period for international students before they are eligible to make a pregnancy-related claim (Multicultural Centre for Women's Health, 2021; Poljski, et al., 2014).

Data on the rate of surgical and medical abortions is limited in Australia. Therefore, there is a lack of information on the extent of induced abortions among population sub-groups and socio-demographic characteristics. WHISE strongly urges the government to mandate data reporting as current legislation

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fails to report abortion rates and the reasons for abortions in some states. With tangible data demonstrating demand exceeding availability, health providers and services can operate within an evidence-based framework to help women from culturally diverse to access culturally safe services and care.

SRH literacy

Relationships and sexuality education that is evidence-based, inclusive and sex-positive is fundamental to ensuring people have consensual, respectful, and fulfilling sexual experiences and relationships, as well as the ability to exercise their SRH rights and access critical services. The *Resilience, Rights and Respectful Relationships* program is an effective primary prevention initiative that provides young people in schools with information regarding their rights and responsibilities in relation to consent and sex.

However, while mandatory, the implementation of the program is varied and relies heavily on the capacity and capability of educators to deliver the program. Additionally, while the program does address components of sexuality, including gender, diversity, interpersonal power and the importance of consent, the program could be expanded to incorporate a systematic and evidence-based SRH curriculum to address identified gaps in young people's knowledge. The *National Survey of Australian Secondary Students and Sexual Health* from La Trobe University, for instance, consistently demonstrates that there is an ongoing need to improve young peoples' sexual health knowledge; that there is room to increase risk reduction practices; and that SRH education programs both in and out of schools could be enhanced to increase knowledge of disease and infection, screening and vaccination (Fisher, et al., 2019). Young people who are disengaged from the mainstream education system also require access to evidence-based, inclusive, and sex-positive SRH information. Youth services, as well as other social and community services, are ideally positioned to deliver this information to young people. Investment to build the knowledge, skills, and confidence of professionals in youth and community services to deliver SRH information is critical.

Consultation with key stakeholders and knowledge experts, including Sexual Health Victoria, Body Safety Australia, Thorne Harbour Health, the Victorian Women's Health Services and others, in partnership with the Department of Education and Training, is vital to embedding SRH literacy in the *Resilience, Rights and Respectful Relationships* program.

The coordinated response to the COVID-19 pandemic, involving the upskilling and embedding of bicultural and bilingual workers in the health promotion workforce to reduce vaccine hesitancy among CALD communities in Victoria, provides a model for delivering effective, culturally safe, and inclusive relationships and sexuality education. Targeted and sustainable investment in bicultural and bilingual workforce, particularly migrant and refugee women's organisations such as the Multicultural Centre for Women's Health, is required to ensure that women and people who may experience barriers to health information, are not disadvantaged.

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Experiences of people with a disability accessing sexual and reproductive healthcare

People with disabilities are subject to discriminatory attitudes and biases regarding their sexuality, which limit their access to SRH information and education, as well as services that are appropriate, inclusive, and accessible. Society often treats people with disabilities as asexual, when in fact people with disabilities can and do experience the same variety of sexual thoughts, feelings, and desires as people without disabilities. Consequently, people with disabilities require access to information and education that enable them to have safe, consensual, and pleasurable sexual experiences. The WHO states that sexuality is a basic need and aspect of being human that cannot be separated from other aspects of life (World Health Organisation, 2022).

As such, WHISE recommend that specific funding and a targeted strategy for the SRH and rights of people with disabilities is required to facilitate the delivery of age and developmentally appropriate relationships and sexuality education; as well as providing accessible and safe SRH services in primary care.

People with disabilities also experience dehumanising and discriminatory prejudices regarding their ability to conceive and raise children. In fact, coerced or involuntary sterilisation is often performed on people with disabilities to prevent pregnancy. (Carter, 2013; Lamont & Bromfield, 2009).

Though the exact rate and incidence of coerced or involuntary sterilisation of people with disabilities is unknown, it is still legal in Australian states and territories (Disabled Poeple's Organisations Australia, 2018). Although forced sterilisation breaches every international human rights treaty to which Australia is a party, and is a practice that constitutes torture, successive Australian governments have consistently taken the view that there are instances in which forced sterilisation can and should be authorised (Frohmader, 2013). This is a grievous violation of the reproductive and human rights of people with disabilities and has been identified as an act of violence, a form of social control and a form of torture by the UN Special Rapporteur on Torture and the UN Committee on the Rights of the Child (CRC) (United Nations Convention on the Rights of the Child , 2011) .

WHISE recommends that the Senate establish a national inquiry into reproductive violence for people with disabilities, including the removal of babies and children from parents with disabilities and forced sterilisation. WHISE also recommends the government work with relevant bodies, including National Health Boards and specialist medical colleges, to review the findings of the Senate Inquiry into involuntary or coerced sterilisation of people with disabilities in Australia, and implement the recommendations including medical workforce training with respect to SRH, and including content on supporting sexual relationships and SRH needs for people with a disability.

People with disabilities experience a disproportionate rate of sexual violence. One in four (25%) women with disability have experienced sexual violence after the age of 15, compared with 15% without disability (Australian Institute of Health and Welfare, 2022). In the last 12 months, people with a disability were at 1.8 times the risk of all types of violence in comparison to people without disability (Royal Commission, 2021). WHISE recommends that the government implement a national redress scheme for

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victim-survivors of various forms of sexual and reproductive violence, particularly among women with disabilities, Aboriginal and Torres Strait Islander women, and other women who experience a disproportionate burden of violence.

WHISE also recommends that the government develop a national strategy in consultation with people with a disability and their organisations to improve access and availability of comprehensive and disability-inclusive SRH information particularly for young women and girls.

People with disabilities are more likely to experience socioeconomic disadvantage (Australian Institute of Health and Welfare, 2022). As such, expanding the provision of no-cost reproductive services, including contraception, abortion and assisted reproductive technology, is critical to ensuring equitable healthcare for people with disabilities.

Experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare

Transgender, non-binary and intersex people require access to mainstream SRH services, such as contraceptives, obstetrics and gynaecological care, abortion and post-abortion services, access to cervical screening, mammography, hysterectomy, and transvaginal ultrasound procedures and assisted reproductive technology, comprehensive and evidence-based sexual education, and testing and treatment for sexually transmissible infections. Transgender, non-binary and intersex people may also require access to healthcare to address specific needs such as consultations with endocrinologists and gender-affirming care, including hormone therapy or surgery.

Transgender, non-binary and intersex people experience specific barriers to accessing sexual and reproductive healthcare related to discrimination, vilification, and abuse, including denial of care. WHISE recommends the government invest in publicly funded SRH services for transgender, non-binary and intersex people, and sensitivity and competency training for practitioners to ensure services are inclusive, appropriate and safe for transgender, non-binary and intersex people.

One of the major barriers to appropriate and accessible sexual and reproductive healthcare for trans, non-binary and gender diverse people is limited knowledge, competency, and confidence among healthcare providers. As such, WHISE recommends that the government work with relevant bodies, including National Health Boards and specialist medical colleges to review all medical curricula, including all obstetrics and gynaecology, GP, practice nurse, nurse practitioner and midwife training programs, with the support and guidance of recognised medical training programs such as RANZCOG and the RACGP, to embed inclusive sexual and reproductive healthcare for trans, non-binary and gender diverse people.

Availability of reproductive health leave for employees

Reproductive health leave for employees would improve SRH outcomes, access to vital SRH services such as abortion, assisted reproductive technology, and gender-affirming care, and gender equality. A

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research project conducted by the Victorian Women's Trust in 2013 identified that 58% of women said that a day off to rest would make their period a better experience every month. Similarly, 26% of those who had gone through menopause said that being able to take time off when needed would have helped their transition (Victorian Women's Trust, 2013).

Ultimately, WHISE recommends that reproductive health leave be legislated in the National Employment Standards as a universal, protected entitlement. Noting that this may be a lengthy process, WHISE recommends that in the interim, the government commissions research into the impact of reproductive health on women's participation in the labour force, to evaluate existing reproductive health leave policies, and conduct public consultation around reproductive health leave to establish and socialise community interest and support. We note that any action to implement these recommendations must be conducted in such a way as to minimise the risk of reinforcing discriminatory employment practices against women.

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whise
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Leve 1, 70 St Kilda Road, St Kilda 3182

Phone: (03) 9794 8677 • Email: whise@whise.org.au

Web: www.whise.org.au

ABN 90 641 895 966

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Leve 1, 70 St Kilda Road, St Kilda 3182
Phone: (03) 9794 8677 • Email: whise@whise.org.au
Web: www.whise.org.au
ABN 90 641 895 966

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