Inquiry into universal access to reproductive healthcare

Melbourne Hearing – 28 April 2023
Questions on Notice from Senator Tammy Tyrrell
Answers due COB 5 May 2023

Multicultural Centre for Women's Health

QUESTION ONE

You've discussed barriers to accessing reproductive healthcare for migrant and refugee women and gender diverse people in your submission. I'd like to learn about access to reproductive healthcare for migrant and refugee women in rural, regional and remote areas. Can you tell me a bit about what you are hearing and how we can make improvements for this cohort?

Migrant and refugee women in rural, regional and remote areas tend to have lower levels of access to the broad range of reproductive health services that are available in more populated areas. In addition, in rural areas there tend to be fewer in-language, multicultural and ethno-specific support services, which can increase social and cultural isolation and reduce engagement with the health and social support system, as only mainstream services are available and they may not provide a culturally safe or linguistically appropriate service.

Findings from MCWH's rural SRH project

In 2019, MCWH conducted a sexual and reproductive health research project in two rural regions of Victoria in 2019. The project conducted focus groups with women from two small ethnic communities. I will not name the ethnicity of these groups because the communities are small and we do not want to breach the privacy of the women.

MCWH partnered with local services to recruit participants for the focus groups, which were conducted with migrant and refugee women aged between 21 and 60 years. Each focus group was conducted in the women's preferred language and facilitated by trained and accredited MCWH Bilingual Health Educators.

Focus groups were held over weekly sessions to build rapport and trust within the groups. There were between 10 to 20 women in each group. Participants were a mix of people who were newly-arrived and those who has lived in Australia and in the region for a number of years, Many had spent time in refugee camps prior to settlement in Australia and have limited English language proficiency.

MCWH Bilingual Health Educators used discussion points and key words to prompt discussions and conversations about women's experiences accessing reproductive health services in their local area. The discussion points centred around three main themes in relation to accessing information and services related to contraception, abortion, stillbirth support, perinatal mental health services and antenatal care:

- Challenges and barriers experienced by women;
- Facilitators and supports for access women received; and
- Women's recommendations to improve access to reproductive health services.

The final phase of the information gathering was conducting interviews with stakeholders working in women's health in rural and regional areas. Stakeholders ranged from community health nurses, refugee health nurses, settlement services workers and project workers.

Challenges and barriers

The findings we gathered from speaking to migrant and refugee women in regional and rural areas show that the barriers and challenges they experience in accessing reproductive health services can be grouped into three categories:

1. Language and communication barriers
2. Social and community barriers
3. Systemic barriers (health system and transport)

1. Language and communication barriers

Migrant and refugee women interviewed overwhelmingly identified communication barriers as a major challenge in accessing health services. Women spoke of not knowing what to do when it came to using contraception prescribed for them, some spoke of feeling uninformed about caring for themselves during pregnancy:

> *"I do not speak English and it's hard to discuss with someone the nutrients I need to build up [during antenatal care]"*

(Woman aged 40)

Stakeholders we interviewed reported their concern that doctors, whether in public hospitals or private practice, were often hesitant or refuse to use telephone interpreters. Stakeholders working in the hospital system stated that while there are posters placed around the clinics with information on how to access phone interpreting that *"there are a lot of language barriers but some GPs just refuse to use an interpreter"* (Community Health Nurse). As another Community Health Nurse in the region stated:

> *"Using interpreters, the importance of using interpreters and translated materials need to be best practice and PHNs [Primary Health Networks] need to communicate this."* (Community Health Nurse)

2. Social and community barriers

Women reported experiencing stigma and embarrassment in accessing reproductive health services, in particular when seeking information about contraception options. In combination with language and communication barriers noted above, women reported not receiving adequate information about contraception options and side effects to make informed choices about their contraceptive use. For some women, this has led to reluctance to seek further medical advice when experiencing side effects.

Women who experienced perinatal mental health conditions also cited social isolation as a barrier to accessing services. The majority of women we spoke to had little to no prior knowledge that depression, anxiety or other mental health conditions can develop or be exacerbated during the perinatal period. Women also reported not knowing where to seek medical or professional help for perinatal mental health conditions.

Faith-based challenges and objections to contraception and abortion were also identified with women reporting travelling to another town for these services due to fear of family and community finding out. While not limited to migrant and refugee communities, abortion and contraception stigma can create and reinforce negative attitudes towards women seeking these services. These barriers are often magnified in regional and rural areas.

3. Systemic barriers (health system and transport)

While the migrant and refugee women we spoke to identified access barriers related to language and communication (e.g., medical professionals not using interpreters during appointments) and social and community barriers from stigma and gendered assumptions – they also identified systemic or structural barriers such as a lack of transport options to attend medical appointments, cost of services and the complexity of the medical referral system as

challenges in accessing health services. Addressing these systemic barriers – barriers that impact on regional and rural populations in general – will mean improving access for all women.

Migrant and refugee women we spoke to identified cost as a barrier to accessing reproductive health services. The lack of availability of bulk-billing GP services in regional and rural areas means that women will almost always pay an out-of-pocket cost, even for routine appointments to request prescriptions for oral contraceptives.

Additionally, costs associated with specialist medical services can make attending obstetrics and gynaecology appointments prohibitively costly, especially so for migrant and refugee women experiencing socioeconomic disadvantage.

The referral system for specialist services has also been described as complex and confusing by the women we spoke to and stakeholders working within the health sector. A number of stakeholders have noted this as a factor in women delaying or not proceeding with referrals to specialist appointments.

The availability of reproductive health services in regional and rural areas was also noted as a systemic barrier for all women. Waiting lists for specialist and GP appointments were cited by migrant and refugee women and stakeholders. Stakeholders also identified a shortage of GPs who provided pregnancy options counselling and Medication Termination of Pregnancy (MToP). While oral contraceptives were readily available, there was a shortage of GPs who were trained and able to provide the more reliable Long-Acting Reversible Contraception (LARC) options such as IUDs.

One particular issue of concern is the situation of pregnant asylum seekers with no Medicare eligibility. There is a cohort of asylum seekers who are not eligible for healthcare under Medicare. The Victorian State Government has made special access arrangements for asylum seekers which means that all asylum seekers residing in Victoria, regardless of Medicare eligibility, are entitled to free public hospital service.

MCWH would like to commend the Victorian State Government for enacting special access arrangements to ensure that all asylum seekers receive State-funded medical care, regardless of visa status or Medicare eligibility. However, women and health service providers are not always aware of this entitlement. As one nurse at a Victorian rural area hospital reported instances of Medicare-ineligible asylum seekers receiving invoices for hospital care or not being triaged when presenting at hospital.

"There is a duty of care but it's really hard for [Medicare-ineligible] asylum seekers to access services" (Nurse, rural hospital)

The nurse reported instances of pregnant asylum seekers presenting to their midwifery department in labour having had no previous antenatal care. With antenatal care being associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes, there needs to be increased awareness within the public health system of the health entitlements of Medicare-ineligible asylum seekers in order to prevent adverse health risks for both mother and infant.

Supports and facilitators

Despite the barriers that emerged from the focus group discussions, migrant and refugee women reported receiving a range of supports and facilitators that enabled greater access to a range of health and community services.

In one regional area, transport to and from a range of community initiatives were provided by a local community organisation – this provided practical support to get to and from multicultural playgroups and 'Mums and Bubs' English-language classes. Some women also reported receiving support from other community members for transport, and childminding to attend antenatal care and other medical appointments.

The importance of social and community networks was highlighted with a number women reporting receiving support from their family and community members rather than from health professionals. This was particularly the case during the perinatal period:

"My husband is supporting me who has been working full-time. I have a new baby and I feel isolated from society. I can socialise only once a week in this group"

(Focus group participant, age 26 about support she receives from weekly multicultural Mums and Bubs English classes)

In some instances, informal interpreting assistance was provided by community members and family. As one Settlement Support Worker noted, rather than use interpreters, some doctors will often request that a patient bring a friend or family member to a medical appointment. The use of informal interpreting which concerns about potential ethical and privacy breaches, and inaccurate communication of medical issues.

The use of bicultural support workers and onsite interpreters was highlighted by some service providers as a means of ensuring culturally and linguistically appropriate health services deliver. A

nurse in a regional hospital reported that they employed bilingual support workers and onsite interpreters in their clinics. While these services in this particular hospital were limited to one language and phone interpreters would still be required for other languages, MCWH commends this initiative.

Service providers working in regional areas also identified the importance of health education programs for migrant and refugee women, in particular for young women and girls about contraception. These health education programs are important to build the capacity of women to feel empowered to make informed choices about their health and wellbeing. One service provider noted an effective way to deliver reproductive health education to young people was to work with Secondary Schools English as an Additional Language (EAL) classes to deliver health education sessions about contraception, another service provider noted the importance of involving young people in the community to facilitate peer-based health education sessions.

These findings demonstrate the importance of supports and facilitators such as:

- Social and community networks.
- The provision of interpreters and bilingual health workers and professionals.
- The availability of multilingual resources, including information on how to reach healthcare facilities.
- The option of flexible service delivery models such as home visits by health care professionals.

Recommendations

While care should be taken not to generalise across populations, there are also are a number of common threads in the stories told to us by women and the service providers we spoke to. These common threads cannot be taken in isolation and are the result of migrant and refugee women's intersecting experiences of racism, discrimination, gendered assumptions, geographic and social isolation and levels of socioeconomic disadvantage.

To conclude, we make the following recommendations based on the experiences of migrant and refugee women accessing reproductive health services in regional and rural areas:

1. *Strengthen intersectional policy analysis*

   Embed a gendered, intersectional framework to examine the impact of policy approaches to migrant and refugee women and families. Analysis and evaluation

of reproductive health services and delivery options should address the multiple disadvantages and barriers to accessing services experienced by migrant and refugee families (these barriers include racism, discrimination, ethnocentrism in service delivery, and language barriers).

2. *Strengthen the capacity of hospitals and clinics to provide culturally and linguistically appropriate services*

The use of interpreters should be standard practice for medical appointments for people with low English language proficiency. MCWH recommends increasing the capacity of State-funded hospitals and clinics to employ bilingual support workers and onsite interpreters and increasing the use of telephone interpreting services by health professionals where onsite interpreting is not available.

3. *Strengthen the capacity of hospitals to provide continuity of antenatal care model to address the increased risk of stillbirth and other adverse birth outcomes for some groups of migrant and refugee women*

We note that for some women there are often systemic and cultural barriers to receiving antenatal care and these women may 'fall through the cracks' of antenatal care statistics – e.g., homeless or transient women, socially isolated women, women in certain visa categories. A culturally and linguistically diverse hospital-based care model should therefore be enhanced with considerations of how to reduce systemic barriers. Further, the model of care should be an integrated one, which coordinates hospital-based care with community-based care and peer bilingual education, in order to reach women who may not be able to attend public hospital care.

4. *Increase investment in community-based initiatives to promote the development of social networks within migrant and refugee communities*

Our findings highlighted the importance of social and community networks for women's mental health, particularly during the perinatal period. Initiatives run by community organisations, such as multicultural playgroups and 'mums and bubs' English classes, that are accessible to migrant and refugee women and responsive to their needs have been shown to reduce the risk of social isolation and developing or exacerbating mental health conditions.

5. *Develop culturally-responsive health education and peer support*

Our findings highlighted the importance of peer-to-peer education, particularly for young migrant and refugee women. In addition to social and community networks, ongoing peer-

support that is co-designed and led by migrant and refugee communities should be resourced and promoted.

6. *Conduct further participatory action research to increase the evidence-base and increase collaboration for migrant and refugee health and wellbeing in rural and regional areas*

There is a need for further research into the health and wellbeing of migrant and refugee women who may be experiencing both social and geographic isolation. It is important that partnerships and networks be strengthened between community organisations in rural and regional areas and State-wide and national organisations to share knowledge and resources and to better identify the common threads across regions that can be addressed at a State or national level.

7. *Address systemic barriers that affect all Australians in regional and rural areas such as lengthy waiting lists for GP and specialist appointments and the complexity of referral pathways*

A lack of public transport options to access medical appointments, waiting lists for specialist appointments, costs and a shortage of available reproductive health service providers were reported as systemic barriers. Addressing these systemic barriers will mean improving access to health services, not just for migrant and refugee women but for regional and rural populations.

8. *Increase equitable access to health services for Medicare-ineligible asylum seekers*

Our findings highlighted an urgent gap in health services for Medicare-ineligible asylum seekers, particularly pregnant asylum seekers. While Medicare-ineligible asylum seekers are entitled to receive State-funded health care in Victorian public hospitals, our findings indicate that this policy is not always followed, resulting in pregnant asylum seekers not presenting for antenatal care in the belief that they would incur prohibitive medical costs.

QUESTION TWO

I'm interested to know about any data you can share on access to reproductive healthcare for migrant and refugee women in Tasmania. Can you also share with me how access to reproductive healthcare in Tasmania compares to access for this cohort on the mainland?

Many of the issue discussed above in our response to question one apply in the Tasmanian context as well.

Talking to women on temporary visas

In addition, MCWH collaborated with Women's Health Tasmania last year to present a specific webinar on Tasmanian migrant and refugee women's barriers to accessing reproductive services. The webinar was based on the research conducted by Lucinda Shannon, published in the report, Talking to Women on Temporary Visas, which has more comprehensive information about barriers to care for women in Tasmania on temporary visas.

The barriers discussed at the webinar facing migrant and refugee women accessing reproductive services in Tasmania are:

1. *A confusing health system*. Women reported that they found the health system different to what they were used to, complex and confusing. In some cases, the women did not see the benefits of going to GPs.

2. *Isolation*. Women reported high levels of social isolation and found it hard to find friends and networks, especially during COVID-19. Women working on farms spoke particularly about the lack of transport which further isolated them.

3. *Racism and mistrust of institutions*. Women talked about their negative experience with health professionals including misunderstandings about their traditional knowledge and medicine, which made the women feel judged and disrespected.

4. *The cost of reproductive healthcare* was a significant barrier preventing migrant and refugee women from having good care during pregnancy and birth. The cost of antenatal care in Tasmania is $346 per appointment with a health care professional. Taking up the option of GP shared care can reduce the cost but is not always available. If the women do not have Medicare or private insurance, they have to accrue debts, go onto payment plans or apply for a fee waiver. Services were concerned that women would delay or avoid key pre and postnatal care due to fears about cost.

   If the women have private insurance, the scope of what is covered by private health insurance is variable. Pregnancy is not covered in the first 12 months. Depending on the level of cover, only hospital expenses (inpatient care) may be included, and this means

women are out of pocket for all the expenses associated with prenatal and ante-natal health care (outpatient care).

5. *The temporary visa system creates extreme vulnerability for migrant and refugee women.* Some examples of the impacts of the temporary visa system are:
    - Private Health Cover left many women who had babies to cover their own antenatal and maternal health care costs;
    - Women incurred large debts as a result of taking up antenatal and birth care in Tasmania;
    - Services were concerned that pregnant women were "rationing" or delaying regular maternity check-ups as a way of managing cost;
    - Women were likely to incur more costs because of their pregnancy if they lived in the North West of Tasmania.

Promoting community-led responses to violence against immigrant and refugee women in metropolitan and regional Australia. The ASPIRE Project: Research report

Between 2014-16 MCWH worked in partnership with the University of Tasmania and the University of Melbourne to research violence against migrant and refugee women in metropolitan and rural Australia, resulting in the above project report.

Tasmania was one of the research sites for the research and research participants were drawn from across Tasmania, as well as metropolitan rural areas of Victoria.

The research found that migrant and refugee women's experiences of violence included reproductive coercion and control, which included forced pregnancy; forced abortion; physical violence with the intention of terminating a pregnancy; and withholding access to, or sabotaging, contraception. We recommend that any family and domestic violence programs, including response, early intervention and prevention, include components that acknowledge the specific forms of reproductive control and coercion that migrant and refugee women experience.