Submission to the Senate Community Affairs References Committee
Inquiry into Universal Access to Reproductive Healthcare

from the Fay Gale Centre for Research on Gender, The University of Adelaide
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The Fay Gale Centre for Research on Gender at the University of Adelaide welcomes the opportunity to make a submission to the Senate Inquiry into universal access to reproductive healthcare.

The Fay Gale Centre brings together academics from across the University (in anthropology, economics, history, law, politics, psychology, public health, and other disciplines) to develop, promote and expand research excellence in the field of gender. One of the themes of the Centre is gender and health, seeking to highlight the ways in which gender-based social injustice contributes to poor health and scoping the possibilities for change.

In this submission we focus on items a, b and e in the terms of reference.

We acknowledge that not all people who have the ability to become pregnant will identify as women and not all women have the ability to become pregnant. However, we use the words woman and women for readability, and in preference to terms such as patient or consumer.

Professor Megan Warin, Director

On behalf of members of the Fay Gale Centre for Research on Gender, University of Adelaide

a. cost and accessibility of contraceptives, including:

- **i. PBS coverage and TGA approval processes for contraceptives,**
- **ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and**
- **iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions;**

Safe, affordable and timely access to contraception is key to preventing unintended pregnancy and facilitating reproductive autonomy (Dixon et al. 2014).

Long acting reversible forms of contraception

Long acting reversible forms of contraception (known as LARCs) are the most effective contraceptives, but these entail the greatest out-of-pocket costs for users and greater engagement with health services to establish. This can serve as a deterrent to optimal contraception, especially for women who are disadvantaged and/or otherwise marginalized (for example, Aboriginal or Torres Strait Islander, rural, remote and migrant groups and women with disability or experiencing homelessness).

The Pharmaceutical Benefits Scheme (PBS) subsidizes the cost of most LARCs (injections, implants or intrauterine devices (IUDs); the exception is the copper IUD, considered a device rather than a medication, an anomaly that should be addressed). However, women are still left with high out-of-pocket costs for medical consultations to have a LARC inserted (Callander, Corscadden & Levesque 2017).

An important consideration (entailing costs) is the acceptability of IUD insertion procedures. This can be extremely painful, especially for nulliparous women (those who have not given birth). It is common practice for IUDs to be inserted in a clinic setting with the recipient awake, with no sedation or analgesia. Some private clinics offer sedation services for this procedure, but at considerable cost to the recipient. Some women seek private gynecology services and pay for a hospital admission and a full general anesthetic. For those who cannot afford it, the insertion process and associated pain may strongly discourage use of an IUD. We advocate for accessible public services that insert IUDs with appropriate amounts of sedation and analgesia.

Australia has low uptake of LARCs (with an estimated prevalence of 11% among women aged 15-44 years, Grzeskowiak et al. 2020) yet these forms of contraception are more effective than any others (with low likelihood of failure, because LARCs do not require daily consumption of pills or proactivity before a specific sexual encounter). As well as the above, commonly reported barriers to LARC uptake include lack of awareness, and misconceptions about user suitability, among both potential users and providers (Mazza et al. 2017). There is thus a need for increased education and health promotion.

Access to LARCs, in particular, could be increased through nurse-led models of care provision. Such models are supported in Sweden and the UK (Botfield et al. 2021). In Australia, this is particularly relevant to improving access in rural and remote areas, as well as reducing costs. Research has demonstrated that procedural outcomes and complication rates in nurse-led provision programs are comparable to traditional medical practitioner led provision (Botfield et al. 2020).

Other forms of contraception

Despite existing PBS rebates on a range of contraceptives, there is no subsidy for some of them

(e.g. the vaginal ring, the contraceptive patch and some types of the oral contraceptive pill). This means that women are left to cover out-of-pocket costs for these. Yet these options may be the most suitable for some people and cost should not be a barrier.

Furthermore, access to contraceptives would be improved with over-the-counter availability and pharmacist provision. These models have been implemented successfully in the UK and parts of the US, for example (Mitchell et al. 2020, Burns 2021). Such flexible models of provision of contraceptives are associated with an increase in adherence to regimens and continuity of contraception use. Evidence shows that providing these services in the pharmacy setting is comparably as safe and acceptable to doing so through general practice (Rafie et al. 2014, Rodriguez et al. 2020).

Recommendations

- Increase access to and uptake of LARCs through:
  - concerted education and health promotion for potential users and health care providers;
  - reducing out-of-pocket costs associated with consultations and procedures;
  - increasing public provision of relevant health services;
  - expanding the health care workforce through nurse-led models of care.

- Increase access to other forms of contraception by:
  - applying PBS rebates to all types of contraception;
  - allowing flexibility in provision, including over-the-counter and pharmacist prescribing.

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

In Australia, 1 in 5 women will have an abortion in their lifetime. In many cases, this reflects lack of reproductive health education and literacy (addressed below) as well as lack of access to effective contraception and related health services (see above) (Mazza et al. 2020).

Access to abortion care in Australia is uneven, inequitable and highly dependent on a person's location (de Moel-Mansel & Shelley 2017). Heavy reliance on the private sector for service provision means that the out-of-pocket costs to clients are often considerable (Dawson et al. 2016, Shankar et al. 2017).

While it is lawful in all states and territories to terminate a pregnancy, the circumstances under which this may occur vary by jurisdiction. Consequently, there is considerable confusion among those seeking abortion and also among providers. This is also partly a result of the fraught history of abortion access prior to decriminalization (Dawson et al. 2016, de Moel-Mansel & Shelley 2017).

The World Health Organization (WHO 2022) has compiled and endorsed comprehensive, evidence-based guidelines for the provision of gold standard abortion care. Currently, provision in Australia does not meet these standards.

Medical abortion

Up to 9 weeks of gestation, a pregnancy can be terminated through taking medication. (This comprises mifepristone, followed after 24 to 48 hours by misoprostol, referred to as MS-2 Step

in Australia.) In 95-99% of cases, this approach is successful and no further medical intervention is required (Mazza et al. 2020). The latest World Health Organization guidelines (WHO 2022) state that a woman can self-manage this process. Thus medical abortion is, in theory, convenient and private as well as effective and safe.

However, in Australia accessing medical abortion is currently more onerous than the World Health Organization considers necessary. It is important to reduce current barriers because abortion is safest when performed early.

Barriers, in general, include:
- Tight regulations that mean general practitioners must undertake specific training and be registered to provide prescriptions for MS-2 Step; this leads to many being unable or unwilling to provide access to medical abortions (de Moel-Mandel & Graham 2021).
- The requirement for ultrasound dating (and blood tests, prior to Covid-19) before medical abortion, despite acknowledgment by the World Health Organization and the UK Royal College of Obstetricians and Gynecologists that omitting this does not compromise safety or lead to increased complication rates (Meurice et al. 2021).
- Regulatory restrictions that prohibit health care providers such as nurses or midwives from prescribing medical abortions.

Additional barriers to access in rural and remote locations:
- Most providers of medical abortion are in private clinics in metropolitan locations.
- Currently only private services are providing telehealth access, meaning that women are required to pay hundreds of dollars for care.

Access to medical abortion would be improved by enabling nurse-led models for this aspect of health care as well as publicly funded telehealth services. Of note, medical abortion through telehealth services was used during Covid-19 in the UK and considered appropriate and safe, with proposals to continue this form of access (Meurice et al. 2021, Romanis et al. 2021, Parsons & Romanis 2022).

There is evidence that medical abortion is safe beyond 9 weeks (WHO 2022). Extending the period in which medication abortions could be provided, and removing the need for in person consultation prior to or following provision, would substantially increase access.

Surgical Abortion

Public provision of surgical abortion health services is uncommon in Australia, with South Australia and the Northern Territory notable exceptions. Thus most women have no option but to use private clinics, where they are met with high out-of-pocket costs. These clinics tend to be located in metropolitan settings, so women from rural and remote areas also face considerable additional costs in terms of time and travel.

Public hospitals that provide gynaecology and obstetrics services could provide surgical abortion care within their scope of practice. Mainstreaming abortion services would increase access and normalize this procedure as part of reproductive health care, thus reducing stigma. Appropriate workforce development would need to occur in order to facilitate this.

Nurse-led models of abortion care would overcome the lack of providers that currently impedes access in Australia (Mainey et al. 2022). Research has demonstrated such models of care are safe, effective and acceptable to clients (e.g. Kopp Kallner et al. 2015). Addressing accessibility in this manner is likely to decrease waiting times, an important consideration (Mainey et al.

2020). Nurses and midwives already have substantial roles in the provision of abortion care, so many are already well placed to be upskilled to provide independent care, following necessary regulatory reform.

Recommendations

- Increase access to medical abortion through:
  - extending the gestational age at which MS-2 Step can be taken;
  - removing the requirement for prior ultrasound;
  - providing publicly funded telehealth services;
  - expanding the health care workforce through nurse-led models of care.

- Increase access to surgical abortion through:
  - increasing publicly funded services in mainstream health care settings;
  - covering the costs of accommodation and transport for rural and remote women who are required to travel to access care;
  - expanding the health care workforce through nurse-led models of care.

e. sexual and reproductive health literacy;

It is widely acknowledged that a lack of comprehensive sex education is a contributor to poor reproductive health outcomes, including unintended pregnancy. Whilst Australia has an existing national curriculum that endorses sexuality and relationships education through a positive strengths-based approach (drawing on the World Health Organization's definition of sexuality), how this is implemented and the content that students have access to varies greatly.

Comprehensive Sexuality and Relationships Education (CSRE) is *"a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality"* with the specific objective of equipping all young people with the knowledge, skills, attitudes and values that will enable them to make considered and adaptive choices concerning their relationships, behaviors, and sexual health and wellbeing (UNESCO, 2018). This curriculum is age-appropriate and emphasizes autonomy, safety and respect.

Currently, Australian students do not necessarily have access to all components of CSRE. Consistently, the biological aspects of reproduction and the health risks of sexual activity are foregrounded in sex education while social and relational aspects are neglected. Thus Australian young people continue to be dissatisfied with the depth of learning available to them through school-based programs and report difficulties in navigating healthy and equitable relationships (with consent being just one aspect of this) (Johnson et al. 2016, Pound et al. 2016).

As well as inconsistent implementation, current sex education is often heteronormative, and excludes LGBTQI and gender diverse people. This is concerning because of the well documented harms of not accepting gender and sexual diversity, notably the poor mental health and elevated risk of suicide among these young people (Wilson & Cariola 2020).

Access to CSRE is a fundamental human right in relation to sexual health and wellbeing. The knowledge and understanding that comes from this education is the foundation of reproductive health literacy which is essential for preventing a range of health problems, including coercive sexual encounters, sexually transmitted infections and unplanned pregnancy.

CSRE is endorsed by the United Nations (2018) *as "an indispensable tool to promote gender equality, because the lack of access to that wealth of information is particularly damaging to girls, as they are the group most at risk of suffering serious or lifelong setbacks, including unplanned pregnancies …".*

The United Nations Independent Expert on Protection Against Violence and Discrimination Based on Sexual Orientation and Gender Identity (IESOGI, Reports on Gender 2021) states that *"Comprehensive gender and sexuality education is the main tool to deconstruct stigma that lies as a powerful root cause for violence and discrimination based on sex, gender, sexual orientation and gender identity".* All students should have access to CSRE that is inclusive of LGBTI people to prevent harms and to promote gender equity in schools, communities and wider society (Gegenfurtner & Gebhardt 2017; O'Farrell et al. 2021).

From 2023, education on consent is to be mandatory in all Australian schools. This is welcome. However, we advocate for this to be achieved through CSRE that is available to all students through all schools, with appropriate training of teachers and provision of resources, including external support staff.

Recommendations

- Comprehensive sexuality and relationships education:
  - should be available to all young people as a human right;
  - should include content that acknowledges gender and sexual diversity;
  - should be provided by teachers with appropriate training, resources and external supports;
  - is the appropriate context in which education on consent should be provided to young people.

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