AUSTRALIAN SENATE INQUIRY INTO THE UNIVERSAL ACCESS TO REPRODUCTIVE HEALTHCARE

WOMEN'S HEALTH GOULBURN NORTH EAST SUBMISSION
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Acknowledgements

Women's Health Goulburn North East acknowledges the wisdom, living culture and connection of the Traditional Custodians of the unceded lands on which we work, and acknowledge the profound disruption of colonisation and the Stolen Generations on Aboriginal and Torres Strait Islander peoples. We also respect the self-determination of First Nations people.

We are intersectional in our approach and are proud to stand beside generations of great women whose work has brought us closer to equality for all. We believe in shared and just cultural transformation that embraces diversity, and these acknowledgements are part of the ethical principles that guide our work and conduct.

About Women's Health Goulburn North East

Women's Health Goulburn North East (WHGNE) is a proudly feminist organisation supporting the creation of regional and rural Victorian communities that centre intersectional equity, care, wellbeing, and safety. We view the world through a prevention lens and work according to a social determinants framework to address the root causes of gender inequality and gendered discrimination, exclusion, oppression, and violence.

Our vision is that "Rural and regional women of all ages have optimal health and wellbeing."

WHGNE is one of 12 Women's Health Services in Victoria, and collectively, the WHS network has played an essential role in increasing the capacity of evidence-based reproductive health services and building awareness around intersectional reproductive justice information in Victorian communities. On a regional level, we have provided local translation and awareness of the Victorian 2021-2025 Women's Sexual and Reproductive Health plan and, before it, the Women's Sexual and Reproductive Health: Key Priorities 2017-2020. Our work has been based upon building strong partnerships with other local organisations, including organisations whose work is led by and tailored to Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse communities and disabled women, to work towards a reproductive healthcare system characterised by intersectional equity, care, and reproductive justice. It is here that we would like to highlight the importance of principles of reproductive justice, in relation to universal reproductive healthcare access – that is, the "human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[1]

We are pleased to have the opportunity to consider this inquiry in the context of this vision and our past work, and to bring our perspective and experience as a regional gender equity organisation to discussions around achieving universal access to reproductive healthcare in Australia.

[1] SisterSong, Reproductive Justice, *SisterSong*, https://www.sistersong.net/reproductive-justice [Accessed November 23, 2022]

Introduction

As a regionally based gender equity and primary prevention organisation WHGNE will focus this submission specifically upon systemic issues affecting regional people, particularly those in our north-east Victoria and Goulburn Valley region, and specifically women and gender-diverse people, when it comes to universal access to reproductive healthcare.

Many indicators point to poor sexual and reproductive health (SRH) outcomes for people living in rural and regional areas, compared to their metropolitan peers. This is particularly the case for rural/regional women and gender-diverse people, rural/regionally based people of refugee/migrant background and international students, rural/regional Indigenous people, and rural/regional people with disability, who face compounding discriminations and barriers when accessing care. Limited access to services and support, lack of access to bilingual and culturally appropriate services, knowledge gaps, affordability, embarrassment, lack of confidentiality, social stigma, and discrimination such as a racism and ableism, all contribute to these poorer outcomes.

Despite our focus on rural/regional women and gender-diverse people, we acknowledge that universal access to reproductive health requires that *all* people have access to the high quality, culturally appropriate, inclusive, and trauma-informed reproductive education, information and healthcare they need, when, where and how they require it. The practical realisation of universal access necessitates the removal of structural barriers, institutionalised medical biases and discrimination based on gender, sexuality, race, socio-economic status, ability, geographic location, visa status or other identity markers and the unconditional recognition of reproductive healthcare as essential healthcare for all.

In making this submission, WHGNE also acknowledges that the experiences of regional women and gender-diverse people are complex and diverse and cut across layers of identity categories in ways that we may not be able to adequately reflect. We urge the committee to seek out and reflect the lived experience of adolescents/young women, older women, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people living with a disability and gender-diverse people in framing its response to, and actions arising from, this inquiry. The submission by the collective of Victorian Women's Health Services, of which we are part, is informative in this regard.

Our submission will respond specifically to the following points from the inquiry's terms of reference:

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

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

e) sexual and reproductive health literacy

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 reference to:

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

Research and anecdotal evidence demonstrate that access to reproductive healthcare, is limited in regional and rural areas due to factors including:

- lack of local services;
- lack of access to a "familiar" GP or female GP;
- systemic barriers to healthcare access, including discrimination based upon immigration status
- lack of clarity around GP referral pathways and telehealth options and over-reliance on GP-facilitated healthcare, to the detriment of nurse practitioner-led models of care;
- lack of reliable, affordable, and accessible transport options to services (local or metropolitan);
- longer delays and waiting periods;
- affordability and lack of bulk billing;
- strains to social networks;
- fear of stigma and judgement, including due to an individual's sexuality (queerphobia) or gender identity (cis-sexism);
- intergenerational trauma, socio-economic disadvantage, racism, and discrimination experienced by Aboriginal and Torres Strait Islander people;
- limited community support and in-language reproductive health information tailored to needs of rural/regional culturally and linguistically diverse populations;
- concerns over lack of privacy;
- high rates of practitioner conscientious objection to abortion;
- geographic distance to metropolitan services.

Despite abortion being legal in Victoria since 2008 and medication abortion being available in Australia since 2012, barriers to abortion persist, particularly in regional and rural areas, which generally experience scarcity in health services. Across Australia, fewer than 10% of GPs are active prescribers of the medication for medical abortions.[2] The maps below demonstrate the particularly stark discrepancy between rates of medication abortion patients by location, and the rates of prescribers and pharmacies offering medication abortion by location. Despite fairly even rates of medication abortion use/need by people across the north-east Victoria and Goulburn Valley region (see figure 1) – much of this rate sitting higher than the state average – rates of both prescribers and pharmacists offering access to medication

[2] Subasinghe, A et al, 2021, Early medical abortion services provided in Australian primary care, The Medical Journal of Australia, https://www.mja.com.au/journal/2021/215/8/early-medical-abortion-services-provided-australian-primary-care [Accessed December 14, 2022]

abortion are particularly low away from regional centres like Wodonga, Wangaratta and Shepparton (see figures 2 and 3).[3]

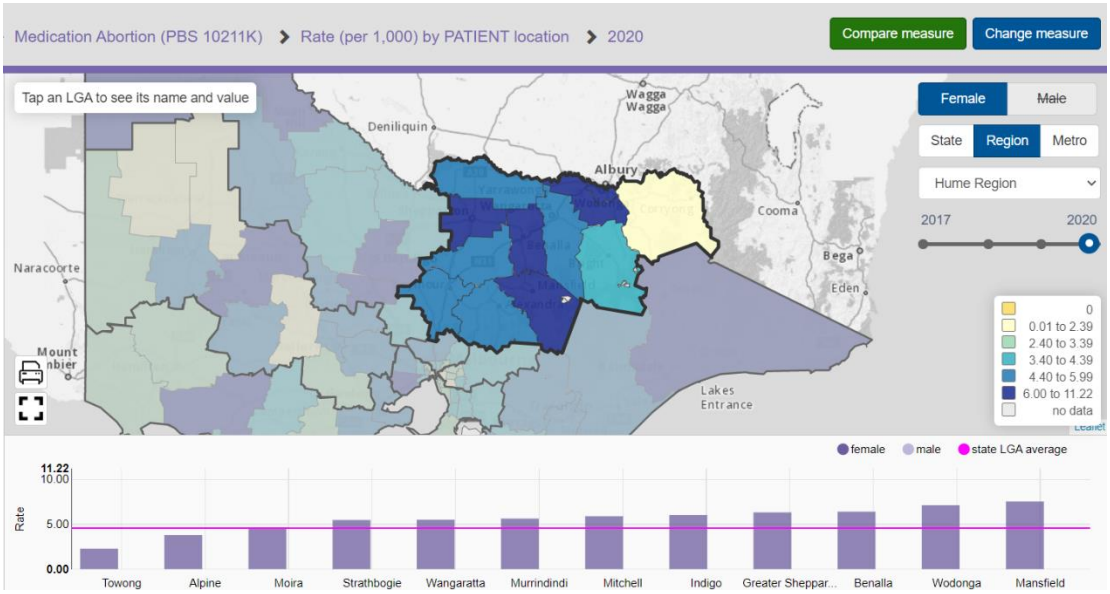

Figure 1. Rate (per 1000) of medication abortion by patient location, Hume region, 2020[4]

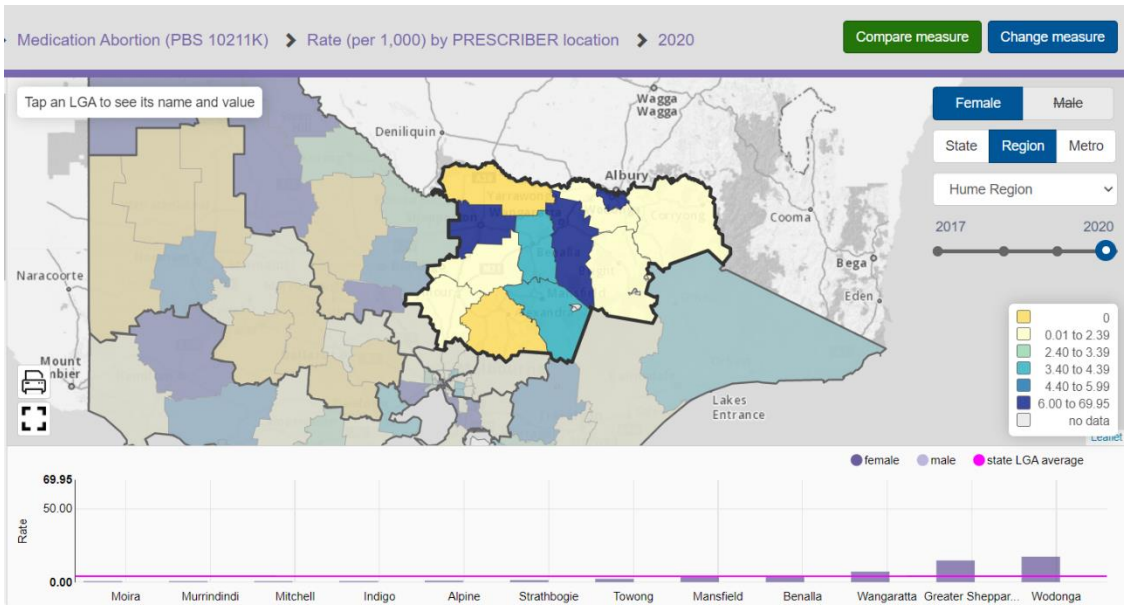

Figure 2. Rate (per 1000) of medication abortion by prescriber location, Hume region, 2020[5]

[3] Women's Health Victoria. 2022. Victorian Women's Health Atlas Medication Abortion (PBS 10211K). https://victorianwomenshealthatlas.net.au/ [Accessed November 23, 2022]
[4] Ibid
[5] Ibid

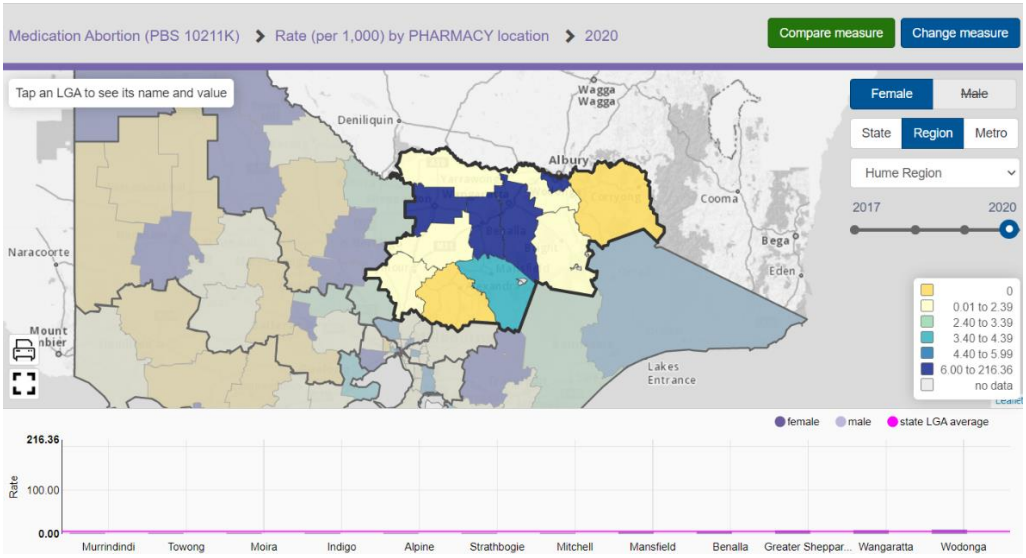

Figure 3. Rate (per 1000) of medication abortion by pharmacy location, Hume region, 2020[6]

Similar discrepancies can be seen when it comes to access to long-acting reversible contraceptive (LARC) methods like the contraceptive inter-uterine device (IUD), with people from the Indigo, Murrindindi and Strathbogie shires facing particular challenges when it comes to gaining access to practitioners providing the contraceptive IUD (see figures 4 and 5).[7]

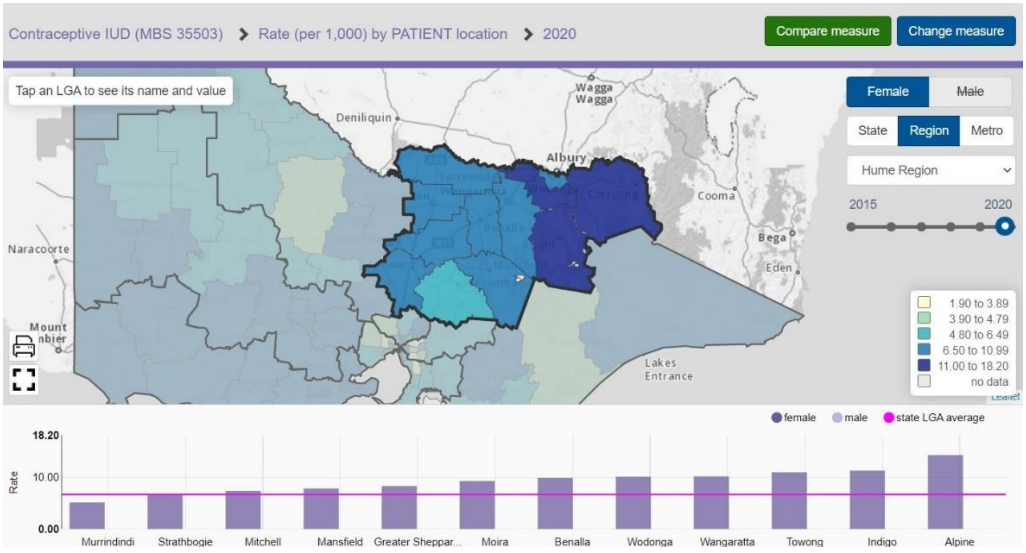

Figure 4. Rate (per 1000) of contraceptive IUD by patient location, Hume region, 2020[8]

[6] Women's Health Victoria. 2022. Victorian Women's Health Atlas Medication Abortion (PBS 10211K). https://victorianwomenshealthatlas.net.au/ [Accessed November 23, 2022]
[7] Women's Health Victoria. 2022. Victorian Women's Health Atlas Contraceptive Impact (IUD) (MBS 35503). https://victorianwomenshealthatlas.net.au/ [Accessed November 23, 2022]
[8] Ibid

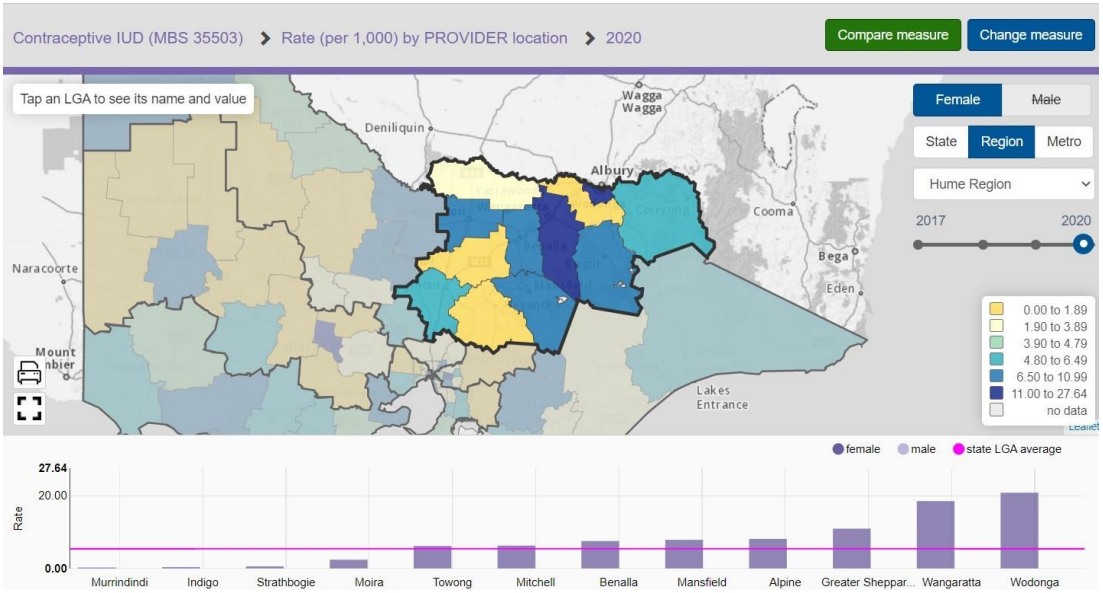

Figure 5. Rate (per 1000) of contraceptive IUD by provider location, Hume region, 2020[9]

Anecdotal evidence contextualises the access difficulties suggested above, with a survey of rural and regional Victorian women, undertaken by the Victorian rural women's health services finding that the lack of availability of general practitioners and specialists in regional areas contributed to "untimely health care and ineffective treatment."[10] Furthermore, lack of consistent access to the same GP, or to a female practitioner, were reported as barriers to women accessing services including contraception information, vaginal examinations and cervical screening.

> *"My doctor finished up at the clinic after 11 years and they can't replace him. It's really hard for women to see a female doctor in this town; you have to book weeks in advance for PAP test or issues that you'd prefer to see a woman GP about."*[11]

> *"You can't even get into doctors. Like, we've lost two good doctors, and I'd been seeing this one doctor for years and now I don't have a doctor."*[12]

Similarly, long wait times for appointments with visiting metropolitan specialists have been cited as a barrier to timely access to care:

> *"The problem is that when you have a [health] problem that's a big issue, a specialist comes from Melbourne once a month...it's not enough. You have to wait on the list because [there's*

[9] Women's Health Victoria. 2022. Victorian Women's Health Atlas Contraceptive Impact (IUD) (MBS 35503). https://victorianwomenshealthatlas.net.au/ [Accessed November 23, 2022]
[10] Women's Health Loddon Mallee and Women's Health Goulburn North East, 2018, Women's Sexual and Reproductive Health Needs in the Murray Region: A Final Report Prepared for Murray PHN, p49 https://www.whealth.com.au/wp-content/uploads/2020/08/MPHN-Report-%E2%80%93-Sexual-and-Reproductive-Health-Needs-in-the-Murray-Region.pdf [Accessed November 29, 2022]
[11] Ibid
[12] Ibid

only one specialist] otherwise you've got to see the doctor. [Even] when I was in hospital for two weeks, I had to wait for two doctors to come from Melbourne."[13]

Regional and rural women have also cited inadequacies in the support offered by and consult times with healthcare providers in their local areas as being barriers to access to evidence-based information and options to support their reproductive health. With standard bulk-bill GP consults just 10 minutes long, and no current Medicare line items for contraception consulting, many women lack an opportunity to adequately discuss their contraception options with their medical professional.[14] This can mean GPs favour faster-to-prescribe contraceptive options like the pill, over "set and forget" options like LARCs:

"Just after I turned 18, I went to the GP for contraception. The only thing I was offered was the pill. No discussion around other options or referral to a women's health clinic to discuss."[15]

A lack of practitioner knowledge – particularly about menstruation, endometriosis, and polycystic ovarian syndrome - and gender biases that sometimes see practitioners discount women's own knowledge of their bodies and overlook women's attempts to communicate their needs, hamper regional and rural women's access to reproductive healthcare and support and in many cases, cause years of debilitating pain as women seek an accurate diagnosis.

"As I aged my periods became heavier, more irregular and the pain was so intense, I could be bed ridden for days. At age 40, I asked my gynaecologist if I could have a hysterectomy and was refused. He insisted I was too young and that the Mirena IUD would be the answer to my problems. I left his office so angry… At age 46, [my new doctor] took one look at me and [booked me into surgery]. The operation found that I had not only been suffering with Endometriosis, but that I also had Adenomyosis and fibroids the size of oranges."[16]

"This has not been due to lack of trying but more due to lack of knowledge of symptoms I was describing to doctors/specialist I visited in those years. Unless a General Practitioner knows of endometriosis as such and has dealt with patients it can very easily go misdiagnosed."[17]

Furthermore, women living with disability have reported that ingrained biases, ableism and discrimination, presumptions, stereotypes, and lack of understanding about their disabilities, bodies and

[13] Women's Health Loddon Mallee and Women's Health Goulburn North East, 2018, Women's Sexual and Reproductive Health Needs in the Murray Region: A Final Report Prepared for Murray PHN, p49 https://www.whealth.com.au/wp-content/uploads/2020/08/MPHN-Report-%E2%80%93-Sexual-and-Reproductive-Health-Needs-in-the-Murray-Region.pdf [Accessed November 29, 2022]
[14] Schultz, A., 'At what point does it start to become coercive?' Access to reproductive health still highly inequitable, *Crikey*, https://www.crikey.com.au/2022/06/30/access-reproductive-health-services-australia-highly-inequitable/ [Accessed December 6, 2022]
[15] Women's Health Loddon Mallee and Women's Health Goulburn North East, 2018, Women's Sexual and Reproductive Health Needs in the Murray Region: A Final Report Prepared for Murray PHN, p45 https://www.whealth.com.au/wp-content/uploads/2020/08/MPHN-Report-%E2%80%93-Sexual-and-Reproductive-Health-Needs-in-the-Murray-Region.pdf [Accessed November 29, 2022]
[16] Ibid
[17] Ibid

needs among practitioners and mainstream SRH services have compromised their access to person-centred reproductive healthcare.

> *"My biggest problem was that nobody listened, and nobody heard what I was actually saying. I had had so many doctors who were trying to treat things as a wheelchair issue rather than a women's issue. We're not getting past first base because they only see the wheelchair. I am still a woman. I still function as a woman. So I don't go to the doctors to be told what to do as a paraplegic; I go because there's something wrong with my body… Eventually I was booked in for emergency surgery."*[18]

> *"I went to the doctors a couple of days ago and asked to get a test. They sent me home with the test and I had to do it myself and because of my disability I [didn't] understand. [The Doctor] didn't explain what to do with this test so I went back and I had to get the nurse to do it for me. I couldn't see what to do or how to do it."*[19]

Feelings of a lack of confidentiality and anonymity, and fear of stigma, shame and judgement also pose cultural barriers to rural/regional people's access to reproductive healthcare. A 2012 survey of rural and regional medical practitioners about their, and their patients', experiences of family planning and reproductive healthcare indicated that 72.1% of practitioners saw client anonymity as "an issue" in their area, with much of this attributed to "small town syndrome" - that is, the feeling that everyone knows everything about everyone in a rural or regional community.[20]

[18] Women's Health Loddon Mallee and Women's Health Goulburn North East, 2018, Women's Sexual and Reproductive Health Needs in the Murray Region: A Final Report Prepared for Murray PHN, p49 https://www.whealth.com.au/wp-content/uploads/2020/08/MPHN-Report-%E2%80%93-Sexual-and-Reproductive-Health-Needs-in-the-Murray-Region.pdf [Accessed November 29, 2022]

[19] Ibid

[20] Women's Health and Wellbeing Barwon South West et al., Victorian Rural Women's Access to Family Planning Services Survey Report 2012, p9, https://admin.womenshealthbsw.org.au/wp-content/uploads/2021/09/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf [Accessed November 30, 2022]

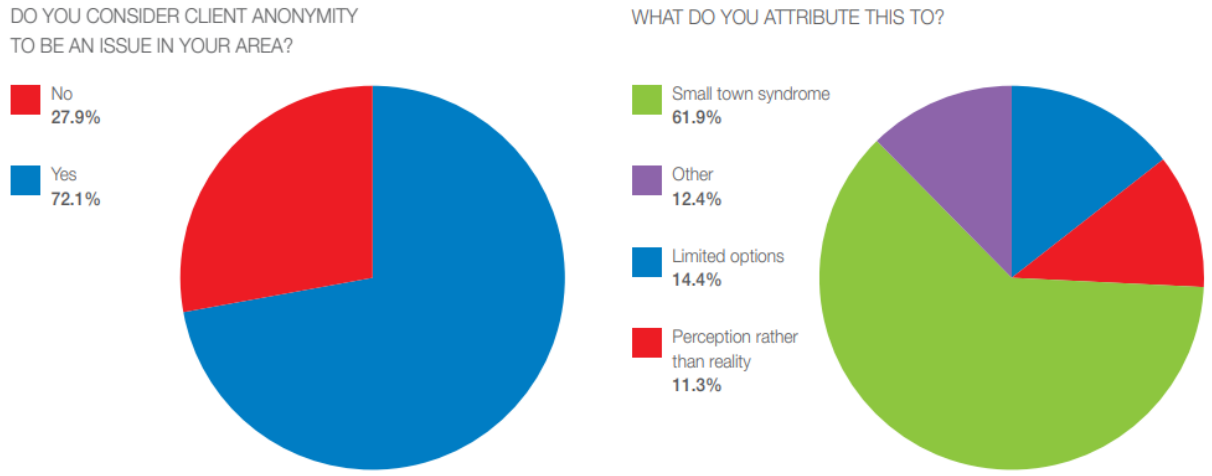

Figure 6. Women's feelings of privacy, anonymity in procuring family planning services in rural/regional Victoria[21]

> *"I live in a small country town. When by boyfriend and I started having sex we used condoms because I couldn't go talk about contraception to the GP as everyone at the clinic knew me. That is the thing about small towns, I had a relative who worked in the clinic and it would always get back to my family. I really didn't want my parents to find out I was sexually active because I knew they wouldn't approve."[22]*

> *"In some towns they are only available at local shops. I had a young person tell me that the shop keeper refused to serve them and threatened to tell their mum (who was a friend)."[23]*

> *"Sitting in a GP clinic with a room full of people you know can be hard to be anonymous."[24]*

These barriers to local services see many regional and rural people often having to resort to travelling to metropolitan areas – namely Melbourne - to access the sexual and reproductive healthcare they need. This is particularly the case for rural/regional people seeking abortion services up to 24 weeks, with only a small proportion of public hospitals in Victoria providing bulk-billed abortion services and most private surgical abortion providers being in Melbourne.

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[21] Women's Health and Wellbeing Barwon South West et al., Victorian Rural Women's Access to Family Planning Services Survey Report 2012, p9, https://admin.womenshealthbsw.org.au/wp-content/uploads/2021/09/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf [Accessed November 30, 2022]

[22] Anonymous, 2018, Small Town, Limited Choices, *Storylines: Her Voice Matters* https://www.hervoicematters.org/post/small-town-limited-choices [Accessed November 30, 2022]

[23] Women's Health and Wellbeing Barwon South West et al., Victorian Rural Women's Access to Family Planning Services Survey Report 2012, p9, https://admin.womenshealthbsw.org.au/wp-content/uploads/2021/09/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf [Accessed November 30, 2022]

[24] Ibid

For those rural/regional people referred to Melbourne for surgical abortions, travel (access to personal transport, linked-up and reliable public transport and distance to services), cost and availability become major barriers to access (see figure 8), particularly when considered alongside other forms of disadvantage such as financial disadvantage, experiences of intimate partner violence and disproportionate gendered sharing of unpaid caring duties.[25] The cost of abortion becomes a "postcode lottery" for rural and regional people, with costs ranging from $500 to $8000, depending on where one lives – people who are on visas and/or do not have access to Medicare often end up paying costs at the higher end of this range.[26] With close to 50% of women in the Murray Public Health Network catchment (which includes north-east Victorian and the Goulburn Valley) earning below the weekly minimum wage,[27] rural/regional women feel a disproportionate financial burden when it comes to the transport costs and time away from work for the purposes of accessing essential healthcare in Melbourne.

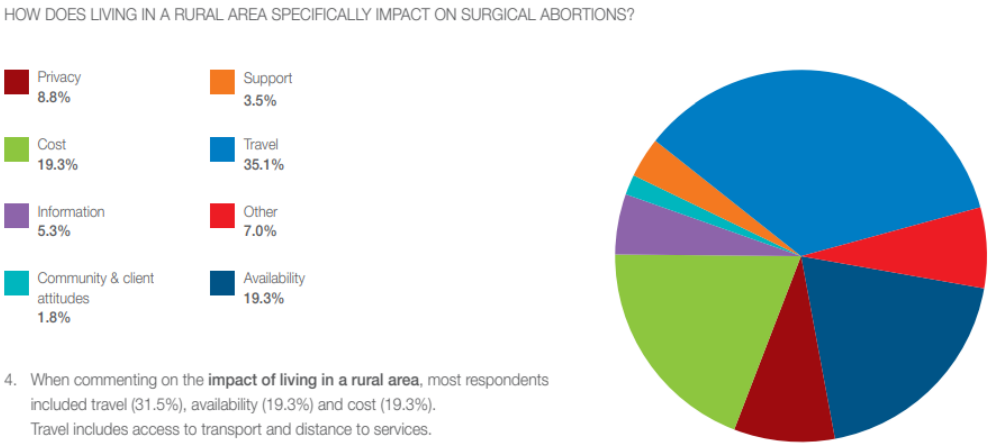

Figure 8. Rural impacts on surgical abortion access.[28]

Recommendations

[25] Women's Health and Wellbeing Barwon South West et al., Victorian Rural Women's Access to Family Planning Services Survey Report 2012, p19, https://admin.womenshealthbsw.org.au/wp-content/uploads/2021/09/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf [Accessed November 30, 2022]

[26] Australian Women's Health Network, 2022, Achieving Equal Access: Abortion care in Australia, p3 https://assets.nationbuilder.com/fairagenda/pages/5143/attachments/original/1669862318/Achieving_Equal_Access_-_Abortion_care_in_Australia.pdf?1669862318 [Accessed December 14, 2022]

[27] Women's Health Loddon Mallee and Women's Health Goulburn North East, 2018, Women's Sexual and Reproductive Health Needs in the Murray Region: A Final Report Prepared for Murray PHN, p38 https://www.whealth.com.au/wp-content/uploads/2020/08/MPHN-Report-%E2%80%93-Sexual-and-Reproductive-Health-Needs-in-the-Murray-Region.pdf [Accessed November 29, 2022]

[28] Women's Health and Wellbeing Barwon South West et al., Victorian Rural Women's Access to Family Planning Services Survey Report 2012, p19, https://admin.womenshealthbsw.org.au/wp-content/uploads/2021/09/Victorian-rural-womens-access-to-family-planning-services-survey-report-August-2012.pdf [Accessed November 30, 2022]

- Create and implement a national rights-based sexual and reproductive health strategy that addresses the social determinants of health.
- Create a national taskforce on abortion care - a comprehensive plan to deliver the National Women's Health Strategy's commitment to universal access to sexual and reproductive health care, including abortion care. Without this, reforms will likely be piecemeal and maintain the undesirable postcode lottery that characterises abortion care in Australia. The Federal Government should convene this national taskforce with all states and territories and involve experts including service providers and people with lived experience.[29]
- Invest in and facilitate a comprehensive sexual and reproductive health data collection system to ensure prevention efforts are evidence-based.
- Guarantee a bipartisan commitment to publicly funded and public hospital provision of sexual and reproductive health services, including free, non-means-tested access to contraception; free provision of surgical and medication termination of pregnancy services to all who need it, including visa holders.
- Include a full range of sexual and reproductive health services under the Medicare Benefits Schedule and/or Pharmaceutical Benefits Scheme.
- In instances where local access to reproductive healthcare is not available, provide patients with free transport and accommodation to enable them to access such services elsewhere, in order to address the perpetuation of financial burdens associated with accessing equitable reproductive healthcare.
- Resource innovative models of reproductive healthcare in all communities, including nurse-practitioner models of care.
- Promote cervical screening, including self-testing, more effectively and more widely among both rural/regional practitioners and community members, with a focus on local government areas with a comparatively low uptake.
- Embed clear anti-discrimination policy into practice guidelines for all staff working in reproductive health services: reception, admin, practice manager, security, support staff and health practitioners.
- Invest in Aboriginal and Torres Strait Islander led organisations to ensure SRH is accessible and culturally appropriate for this population.[30]

[29]Australian Women's Health Network, 2022, Achieving Equal Access: Abortion care in Australia, p16 https://assets.nationbuilder.com/fairagenda/pages/5143/attachments/original/1669862318/Achieving_Equal_Access_-_Abortion_care_in_Australia.pdf?1669862318 [Accessed December 14, 2022]

[30] Women's Health Victoria, 2021, Delivering optimal sexual and reproductive health outcomes for Victorian women: Priorities for the next women's sexual and reproductive health plan 2021-2025, https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2021.01.11_Priorities-for-the-next-womens-sexual-and-reproductive-health-plan-2021-2025_single-page_(Fulltext-PDF).pdf [Accessed December 7, 2022]

- Invest in Women with Disability led organisations to ensure SRH is accessible and culturally appropriate for this population.[31]
- Invest in migrant and refugee women led organisations to ensure SRH is accessible and culturally appropriate for this population.[32]
- Invest in organisations led by those with diverse sexual orientation and gender diversity to ensure SRH is accessible and culturally appropriate for this population.[33]
- Guarantee ongoing MBS telehealth item numbers for SRH consultations beyond June 2023 to ensure timely, safe, and universal access to reproductive healthcare services, particularly early medical abortion. This must not replace timely and safe access to in-person reproductive health services in regional and rural areas but can serve as a worthy complement to such in-person services.

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

Given the above-mentioned barriers to access experienced by rural and regional people, particularly women, in our catchment, alternative accessible, culturally appropriate and confidential pathways are critical to ensuring universal access to reproductive health. We wish to highlight three best practice approaches, which have proven effective at increasing access to reproductive health for women in our rural and regional Victorian communities and which are worthy of greater resourcing and expansion beyond Victorian settings: the 1800 My Options service, telehealth services and nurse-led SRH Hubs.

The 1800 My Options service, which lists approximately 300 reproductive health service providers – from nurse practitioners and GPs to hospitals, pharmacists, pregnancy options counsellors and imaging specialists - has been impactful and effective at delivering evidence-based and accessible sexual and reproductive health information to both practitioners and clients across Victoria, particularly in rural and regional areas. A Women's Health Victoria survey of health sector professionals highlighted that the phone line was particularly effective in providing support to women who identified as Aboriginal and Torres Strait Islander, who make up 2.16% of callers.[34] The cultural safety training undertaken by phone workers was cited as a core reason for this effectiveness.[35]

[31] Women's Health Victoria, 2021, Delivering optimal sexual and reproductive health outcomes for Victorian women: Priorities for the next women's sexual and reproductive health plan 2021-2025, https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2021.01.11_Priorities-for-the-next-womens-sexual-and-reproductive-health-plan-2021-2025_single-page_(Fulltext-PDF).pdf [Accessed December 7, 2022]
[32] Ibid
[33] Ibid
[34] Ibid
[35] Ibid

COVID-19 also demonstrated the effectiveness of telehealth supports, for providing both non-contact consultation and increased access to essential healthcare for regional and rural Victorians, with reports that by April 2020, more than one-third of GP consultations were telehealth consults, compared with 1% in 2019.[36] When it comes to telehealth consultations for sexual and reproductive healthcare, survey respondents reported using the services for:

- Contraception prescriptions;
- Receiving/discussing test results;
- Uncomplicated/ongoing issues including urinary tract infections and routine STI testing; and
- Organising referral and face-to-face appointments.[37]

Survey respondents reported that it was convenient and fast, with benefits including:

- Being able to access an appointment from home;
- The feeling of being able to create a safe space for the appointment; and
- Being able to continue working up until an appointment.[38]

Generally speaking, telehealth is considered "comparable in safety, efficacy, and acceptability to in-person early medical abortion (EMA) and can significantly improve accessibility of EMA for women."[39]

Despite these benefits, telehealth was not found to be "universally accessible" due to some long wait times, patient inability to speak with a preferred practitioner, the frustrations and costs of having to follow a telehealth appointment with a face-to-face appointment, and technical issues, such as poor internet connection.[40] This latter issue is particularly relevant for regional and rural Victorian communities such as the north-east Victoria and Goulburn Valley region, which has one of the lowest levels of digital inclusion in Victoria in terms of digital access, affordability and ability.[41] This demonstrates the importance of addressing the broader structural barriers to telehealth accessibility, and investing in digital equity measures, in order to ensure that telehealth can take its place as a vital tool in the "universal access to reproductive care" toolkit, providing increased access to medication

[36] Bittleston H et al., 2022, Telehealth for sexual and reproductive health issues: a qualitative study of experiences of accessing care during COVID-19, *Sexual Health*, 19(5), 473–478. doi:10.1071/SH22098 https://www.publish.csiro.au/SH/pdf/SH22098 [Accessed December 12, 2022]
[37] Ibid
[38] Ibid
[39] Women's Health Victoria, 2021, Delivering optimal sexual and reproductive health outcomes for Victorian women: Priorities for the next women's sexual and reproductive health plan 2021-2025, p18, https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2021.01.11_Priorities-for-the-next-womens-sexual-and-reproductive-health-plan-2021-2025_single-page_(Fulltext-PDF).pdf [Accessed December 7, 2022]
[40] Bittleston H et al., 2022, Telehealth for sexual and reproductive health issues: a qualitative study of experiences of accessing care during COVID-19, *Sexual Health*, 19(5), 473–478. doi:10.1071/SH22098 https://www.publish.csiro.au/SH/pdf/SH22098 [Accessed December 12, 2022]
[41] Regional Partnerships Ovens Murray, Ovens Murray Digital Plan: Part 1 - Regional Context and Priorities, p5, https://www.rdv.vic.gov.au/__data/assets/pdf_file/0010/1875070/Ovens-Murray-Digital-Plan-Part-1-web.pdf [Accessed December 12, 2022]

abortion, STI diagnoses and treatment and LARC, particularly for regional and rural Victorian communities.

Finally, the Victorian Sexual and Reproductive Health Hubs program, implemented across 11 regions of Victoria, have supported greater awareness of and access to contraception and abortion via their use of nurse-led models of care.[42] The Gateway Health SRH Hubs, in our own regional centres of Wodonga and Wangaratta, have been effective examples of this model, however, demand for these services often exceeds their capacity to meet it, indicating a need for greater workforce capacity building and resourcing of these hubs.[43]

Such nurse-led models of care can not only reduce the health provision costs of reproductive care via more cost-efficient workforces, but also address some of the barriers to access cited above by increasing reach of service and thus, access to reproductive care - such as medication abortion - in regional and rural areas, reducing client wait times for appointments and reducing client costs.[44] However, federal, state and territorial legislation, regulation and jurisdictional guidelines can limit the scope of these nurse-led models and nurses' authority to obtain, supply or prescribe early medical abortion medications, which serves as a barrier to the broader provision and accessibility of these services.

Recommendations:

- Ongoing and increased investment in 1800 My Options (and other state/territory sexual and reproductive health information services) to ensure women have evidence-based information, and know where to access affordable abortion, contraception and sexual health services.
- Permanent continuation of the availability of telehealth for SRH consultations in primary care.
- National policy/programs to ensure equitable access to and reliability of digital services across Australia, particularly for regional and rural communities.
- Investment in building the capacity of Australia's reproductive healthcare workforce, including across mainstream and specialised services, regional and rural areas, and among Indigenous and culturally and linguistically diverse communities.
- Invest in the "universalisation" of the successful Victorian SRH Hubs program, to increase reproductive health access and awareness.
- Expand the legislative/regulatory/jurisdictional scope of nurse-practitioners to maximise access to reproductive healthcare services, particularly for regional and rural communities.

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[42] Women's Health Victoria, 2021, Delivering optimal sexual and reproductive health outcomes for Victorian women: Priorities for the next women's sexual and reproductive health plan 2021-2025, p16, https://womenshealthvic.com.au/resources/WHV_Publications/Position-Paper_2021.01.11_Priorities-for-the-next-womens-sexual-and-reproductive-health-plan-2021-2025_single-page_(Fulltext-PDF).pdf [Accessed December 7, 2022]

[43] Ibid

[44] NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care (SPHERE), 2020, Nurse and midwife-led provision of mifepristone and misoprostol for the purposes of early medical abortion: a consensus statement, https://3fe3eaf7-296b-470f-809a-f8eebaec315a.filesusr.com/ugd/410f2f_b90e75bf10784fedb7f3f6b2de9e6f48.pdf [Accessed December 7, 2022]

E. Sexual and reproductive health literacy

Education around sexual and reproductive health is not only core to embedding in our communities an awareness of the right to personal bodily autonomy and to experience "physical, emotional, mental and social well-being in relation to sexuality,"[45] but is also a core pillar of the primary prevention of gender-based violence – it is about defending the "right to live free of sexual violence before [that right] can be violated".[46] With 18% of women in Australia experiencing sexual violence since the age of 15,[47] and our individuals, families and communities struggling with the health, social and economic costs of this violence, it is clear that comprehensive, evidence-based, sex positive and age-appropriate education must be mandated and prioritised by governments at all levels, communities, schools, parents, carers and families.

Lifelong learning about sexual and reproductive health education begins in childhood, and "increases the health and wellbeing of children and young people...and enable[s] them to expand their knowledge of sexual and reproductive health and rights, develop communication, decision-making and risk-education skills, and adopt positive and responsible attitudes to sexuality and relationships."[48] We highlight Victoria's Respectful Relationships whole-of-school approach as an example of best practice when it comes to the promotion of respectful relationships, gender equity and the prevention of gender-based violence. Based on the socioecological model, the approach includes key elements that sit beyond the curriculum-based teaching and learning, dealing with the social, physical, cultural and spiritual environment of the school, the school's policies and procedures, and the way a school connects with supportive community partners and organisations.[49] This is consistent with the primary prevention approach that we promote, which sees respectful relationships, consent and sexuality education as sitting outside the scope of a single, stand-alone "subject" and being embedded in the cultural "fabric" of an institution, and indeed, a community.[50]

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[45] World Health Organisation, Sexual and Reproductive Health Research, https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health, [Accessed November 9, 2022]

[46] Marson, K., 2021, Ignorance is not Innocence: Implementing Relationships and Sex Education to safeguard sexual wellbeing, *The University of Queensland*, https://stories.uq.edu.au/policy-futures/2021/implementing-relationships-and-sex-education-in-schools/index.html [Accessed December 7, 2022]

[47] Our Watch, 2021, Quick Facts, https://www.ourwatch.org.au/quick-facts/ [Accessed December 7, 2022]

[48] Marson, K., 2021, Ignorance is not Innocence: Implementing Relationships and Sex Education to safeguard sexual wellbeing, *The University of Queensland*, https://stories.uq.edu.au/policy-futures/2021/implementing-relationships-and-sex-education-in-schools/index.html [Accessed December 7, 2022]

[49] Victorian State Government, 2018, Respectful Relationships: a resource kit for Victorian schools, *Department of Education and Training*, https://fuse.education.vic.gov.au/Resource/Download?objectId=cfee82ef-67f8-488c-a167- 52759afda882&SearchScope=All [Accessed December 7, 2022]

[50] Women's Health Goulburn North East, 2021, WHGNE submission to the ACARA Curriculumn Review, https://www.whealth.com.au/wp-content/uploads/2021/07/WHGNE-ACARA-submission-health-and-physical-education.pdf [Accessed December 7, 2022]

While all Victorian government schools have been mandated to implement whole-of-school, age-appropriate evidence-based sexuality and relationships education, via the Respectful Relationships Education in Schools program, this program is not consistently available at non-government schools, which may contribute to poor SRH literacy among young people and the perpetuation of feelings of stigma and shame around reproductive healthcare.

Where school-based SRH education *is* available, some students have reported that it fails to meet their needs, with young people identifying the following topics as things they wish to learn more about:

- healthy relationships;
- how to access services;
- HIV / AIDS;
- emergency contraception;
- body image;
- sexual pleasure;
- the impacts of pornography;
- sexual diversity; and
- cultural considerations.[51]

Student surveys have also shown the effectiveness of school-based SRH education is dependent upon it being inclusive of the needs of LGBTIQA+ young people, and it taking into consideration cultural preferences among Indigenous and CALD students for single-gender classes.[52] This highlights the need for recognition of young people as experts in their own lives, and for SRH education and literacy initiatives to be created, implemented and evaluated in consultation with young people to ensure such programs are impactful.

In saying that, school-based sexuality education, alone, is inadequate for supporting young people to live healthy, sex positive lives, particularly for young people who do not attend formal education. International research demonstrates that education has the most impact when it is linked with "non-school based youth friendly services, including condom distribution."[53] With young people in our north-east Victoria and Goulburn Valley region citing concerns about the availability of free condoms and their (perceived or actual) lack of privacy and confidentiality to explore contraceptive options with their healthcare providers,[54] it is clear that SRH education and literacy is just one part of an integrated, whole-of-school and community approach to promoting and upholding young people's - and all people's - sexual and reproductive health rights.

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[51] Youth Affairs Council of Victoria, 2013, Young people and sexual health in rural and regional Victoria, p21 https://www.yacvic.org.au/assets/Documents/Young-people-and-sexual-health-in-rural-Victoria-VRYS-June-2013.pdf [Accessed December 7, 2022]

[52] Ibid

[53] UNESCO, 2018, International technical guidance on sexuality education: an evidence-informed approach, p28 https://unesdoc.unesco.org/ark:/48223/pf0000260770 [Accessed December 7, 2022]

[54] Youth Affairs Council of Victoria, 2013, Young people and sexual health in rural and regional Victoria, https://www.yacvic.org.au/assets/Documents/Young-people-and-sexual-health-in-rural-Victoria-VRYS-June-2013.pdf [Accessed December 7, 2022]

Recommendations:

- Consult with young people to formulate age-appropriate, relevant, integrated, and tailored sex and reproductive health education curriculum.
- Gender-transformative, sex positive and inclusive sexual and reproductive health education and literacy programs delivered by appropriately skilled and confident staff in schools and community that include consideration of consent, respectful relationships, sex, sexuality, and reproductive knowledge.
- Skill development of health professionals and youth workers to deliver holistic, evidence-based sexuality education and information about where to access contraception and SRH services locally.
- Universal access to accurate and timely information, counselling and referral to services that provide abortion.
- Comprehensive primary prevention whole-of-school sexuality and respectful relationships education programs.
- Sexual and reproductive health information tailored to meet the diverse format (ie. digital, hardcopy), life stage, accessibility, language and geographic needs of all women, men, gender-diverse people, non-binary people and trans people.
- Adequate funding for research and treatment of women's sexual and reproductive health conditions.
- Comprehensive and evidence-based sexual health and reproductive rights education available.