Submission to the
Senate Standing Committees on
Community Affairs Inquiry into

Universal Access to
Reproductive Healthcare

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Contact for recipient:
Senate Standing Committees on Community Affairs
A: PO Box 6100, Parliament House, Canberra
E: community.affairs.sen@aph.gov.au **T:** (02) 6277 3515

Contact for PHAA:
Terry Slevin – Chief Executive Officer
A: 20 Napier Close, Deakin ACT 2600
E: policy@phaa.net.au **T:** (02) 6285 2373

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Introduction

PHAA welcomes the opportunity to provide input to the Committee's inquiry into Universal Access to Reproductive Healthcare.

We also note that reference is continually made to "women" in discussing this subject, and for convenience this submission will do likewise. However, we recognise that not all pregnant people have a female gender identity, or refer to themselves as "women".

The enjoyment by all people of sexual and reproductive health rights is fundamental to population health, inextricably linked to gender equality, essential for sustainable development, and dramatically impacts health and wellbeing outcomes across the life cycle.

PHAA maintains nearly 100 policy position statements developed by our membership on a wide range of public health issues, including on a dozen topics relating to women's health. With reference to this inquiry, key resources are our policy statements covering:

- Abortion (2020)
- Contraception (2020)
- Emergency Contraception (2021)
- Long Acting Reversible Contraception (2021)
- Fertility and Preconception Health (2022)
- The Health of People with Diverse Genders, Sexualities, and Sex Characteristics (2021)

Before turning to your terms of reference, this introductory section sets out key findings and recommendations from our existing policy positions.

Our position on Fertility and Preconception Health

PHAA firmly believes that all people should be empowered with adequate fertility and preconception health-related knowledge to enable informed reproductive decisions.

Health promotion programs and campaigns should include information about the impact of lifestyle factors on fertility and reproductive outcomes. Research should be undertaken to inform fertility and preconception health promotion strategy development, implementation, and evaluation of outcomes.

Fertility and preconception health promotion should be an intrinsic part of sexual and reproductive health and family planning education and services. Family-centred preconception health services should offer tailored, individualised support prior to conception to both healthy couples and those with complex, chronic illnesses.

Fertility and preconception health literacy should be integrated into health education and health promotion programs including those with an impact on chronic disease.

Governments should develop and implement integrated sexual and reproductive health education strategies in teaching and health professionals' education which includes fertility and preconception health optimisation. There should also be expansion of existing national fertility and preconception health promotion programs and services, inclusive of targeted interventions for special populations, and services which increase awareness about the factors that influence fertility, benefits of preconception health optimisation, and limitations of assisted reproductive technology treatment in alleviating age-related infertility.

Research should be undertaken on how to improve the uptake of preconception care guidelines, such as the recent RACGP and RANZCOG guidelines, by health professionals and gauge people's attitudes towards preconception care and their preconception health literacy.

The Australian Government should create an extended Medicare Item Number for reproductive health including fertility management or optimisation and preconception health care including genetic and infectious disease screening and behaviour change counselling.

Our position on Abortion

Abortion is a safe, common medical procedure which should be regulated in the same way as other medical procedures. Both medical and surgical abortions should be included in health service planning. Preventing unintended pregnancy is a public health goal. Improved access to and uptake of contraception is associated with lower rates of unintended pregnancy and abortion.[1]

Abortion is a common gynaecological procedure.[2] When performed by skilled providers using evidence-based medical techniques and medications, induced abortion is a safe medical procedure.[3] Abortion should be regulated in the same way as other health procedures, without additional barriers or conditions. The regulation of abortion should be removed from Australian criminal law.

Most Australians support access to safe, legal abortion.[4] [5] [6]

Universal access to safe abortion is an essential strategy in the provision of high-quality reproductive health in Australia. Comprehensive abortion care and services must be guided by evidence-based strategies and plans at the national and State/Territory level.

Failure of healthcare systems to provide accessible and appropriate sexual and reproductive health care, including the provision of safe abortion services, deprives individuals of their fundamental human rights such as bodily autonomy, dignity, and well-being.[7]

There is no increased risk of mental health issues for women who have an early abortion.[6] However, those who are denied an abortion have higher rates of anxiety than those who can access an abortion if they choose.[8]

Regulatory and service delivery developments relating to the provision of medical abortion present an opportunity to improve geographic and economic access to early medical abortion, recognising there will always be a need for abortion at all gestations and surgical abortion.[9]

There are high quality evidence-based guidelines to support abortion service delivery at the State and Territory level, but no national guidelines such as in the UK.[10] [11] [12]

Comprehensive safe abortion care encompasses the provision of elective abortion services at the request of the woman, along with counselling for contraceptive use, medical after-care, and attention to other issues that are relevant to the woman's health.[13] [14] [15]

While abortion is now generally legal, or at least 'non-criminal', in all Australian States and Territories, different gestational and age limits remain in force, in criminal law rather than in ordinary health care regulation.[16] Restrictions that require the approval of one or two medical practitioners place women and other pregnancy capable people, as well as health professionals, at risk of criminal sanctions for obtaining or delivering health care.

Barriers to safe and timely abortion include legal restrictions, cost, lack of social support, delays in seeking health care, social stigma and negative attitudes of health professionals, poor quality services and a lack of policy and resources to ensure adequate service provision. These barriers disproportionally affect adolescents and people who are from ethno-cultural minorities, low income, rural or remote living and experience violence and/or abuse.[17] [18]

States and Territories should actively work toward equitable access (including geographic and financial access) to abortion services, with a mix of public and private services available.

In Australia, there are limited evidence-based guidelines and training to support the delivery of abortion services by appropriately qualified and skilled health professionals. The efforts to expand abortion guidelines through RANZCOG as well as the development of pathways for medical trainees to pursue a speciality in contraceptive and abortion services without the need for obstetrics training in labour and delivery/maternity care services should be fully funded and supported.[19]

Our position on the Health of People with Diverse Genders, Sexualities, and Sex Characteristics

PHAA recognises the diversity of sex characteristics, sexual orientations, and gender identities represented by lesbian, gay, bisexual, transgender, queer, intersex, asexual, and related people (LGBTQIA+).

PHAA is committed to a respectful and adaptable approach to employing inclusive language. Australian research and evidence relating to LGBTQIA+ experiences is limited. Definitions and understandings of sex characteristics, gender, and sexuality vary across available studies, contributing to the ongoing invisibility of many experiences of discrimination.

PHAA acknowledges that the collective term "LGBTQIA+" is not all-encompassing and does not capture the complexities of everyone's experiences, and will therefore resonate with people differently. This term is used in this policy in the absence of a national consensus, and has been consulted on with LGBTIQ+ Health Australia, Intersex Human Rights Australia, and other key stakeholders across several states.

In relation to the needs of intersex people, PHAA acknowledges the importance of the priorities set out in the *Darlington Statement* - a joint consensus statement by Australian and Aotearoa/New Zealand intersex organisations and independent advocates.[20]

Governments and other stakeholders should:

- work with key LGBTQIA+ peoples, communities, groups, organisations and peak bodies to develop best practice guidance for the provision of inclusive, safe, appropriate, and high quality health information, care, services, programs, education and training that meet the needs of LGBTQIA+ people.
- ensure that sexual and reproductive health services planning processes provide an inclusive and supportive environment for LGBTQIA+ people.
- ensure that the sexual and reproductive health and wellbeing of LGBTQIA+ peoples is included in all health professional education and training, and in general sexual and reproductive health programmes.
- support the development and implementation of workplace anti-discrimination policies in sexual and reproductive health care and beyond, which include specific references to harassment and discrimination based on sexual orientation, sex characteristics and gender identity.

Key recommendations for the Senate Committee

PHAA urges the Committee to recommend the following actions:

Strategy, planning and policy

- The Government create a comprehensive national sexual and reproductive health strategy addressing the domains identified in the 2014 Melbourne Proclamation that honours Australia's commitment to the SDGs and reports against agreed indicators.
- Abortion services should be included in service planning for all State and Territory health authorities and delivered in accordance with evidence-base standards of best practice and informed consent.
- Medicare rebates for abortion should be sufficient to prevent cost presenting a barrier to access, as well as made universally free regardless of Medicare and/or immigration status.

Regulation

- The regulation of abortion should be fully removed from criminal laws and codes of the states and territories and regulated under existing health care legislation.
- Barriers and restrictions to access, such as requirements for multiple opinions, gestational limits or mandated counselling should not be applied through legislation, regulation or policy.

Services

- Health care organisations should ensure attention to fertility control and person-centred decision making that includes pregnancy options counselling, information about access to abortion services and choice of methods, contraception counselling and referral without judgement or coercion.
- Service development and funding arrangements should increase access to medical abortion.
- A mix of private and public services should be available in all jurisdictions, including the availability of universally accessible comprehensive contraception and abortion care within public health services and international aid.
- The Australian Government should review the relationship between public funding and health care organisations, and ensure that all hospitals and other health care institutions which utilise Commonwealth public funding are required to offer non-judgemental, all-options contraception and abortion care.
- Abortion service providers should offer optional, comprehensive pre- and post-abortion counselling and contraceptive decision support and provision.

Workforce issues

- Health professionals with a conscientious objection to abortion care should inform their patients and refer patients to another health professional without such objection in a timely manner. Registration, professional and educational bodies should reinforce this responsibility.
- Legal protection should safeguard clients and staff of legal abortion services from harassment. This should include the provision of exclusion zones.

Research

- Abortion related research, training and workforce planning and development should be adequately funded, promote evidence-based quality care, and ensure equitable access to services and continuous quality improvement.
- National routine, complete and systematic data collection on abortion should be implemented and reported on annually in Australia.

Responses to the Inquiry Terms of Reference

ToR (a): Cost and accessibility of contraceptives

"(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"

Preventing unintended pregnancies through increasing access to effective contraceptive use is a public health goal. Advice and provision of effective contraception is an essential health service and is cost-effective in reducing the impact of unintended pregnancies on individuals, the health system and society.

All people across the life course, and in particular of reproductive age, should receive health education that is age-appropriate, evidence-informed and free of discrimination, enabling the choice of contraceptive options that are safe, reliable, accessible, and affordable. Service planners should focus attention on improving information about and access to Long-Acting Reversible Contraception (LARC) and Emergency Contraception (EC), as well as being aware to avoid any potential for perceived coercion or discriminatory practices.

Evidence-based and transparent approval processes, which enable access to the most up to date contraceptives and technologies, for all genders, should be prioritized and supported. This support could be in the form of financial incentives, or policies that enhance access to their products, by all in need, regardless of the person's economic status, or geographical location.

Limited knowledge of the different forms of male contraceptives, and their access, remains a concern, creating a knowledge gap in the prevention of unintended pregnancies. Resources should be readily available for all particularly for those in communities where patriarchal structures see pregnancy and contraception use as a female only issue. Modern modes of communication, including the use of mobile phone technologies, should be drawn upon, and should become an opportunity for information dissemination across marginalized population groups.

Pharmacists remain a group of healthcare providers whose potential outside of medication distribution is least untapped. The role of pharmacist in population health was evident during the Covid19 pandemic where they had responsibility in vaccination administration, was well received by the community. Proving pharmacists with the opportunity, and with the tools required to prescribe and dispense over counter contraceptives, will enhance access in the community.

We draw the Committee's attention to the recently updated (2022) WHO handbook *Family Planning - global handbook for providers*.[21] In relation to this handbook Pascale Allotey, WHO Director for Sexual and Reproductive Health and Rights, commented that:

> "family planning promotes self-actualization, empowerment, as well as health and wellbeing, and reduces maternal and infant deaths through the prevention of unintended pregnancy and unsafe abortion".[22]

Regarding family planning and contraceptives generally, we recommend a number of policy changes:

- the removal of the Medical Benefits Scheme (MBS) restrictions on nurse practitioners (NPs) and eligible midwives requesting pelvic ultrasounds with private Imaging providers (there is no item

number for these providers). Nurse practitioners, nurses and midwives need to be able to have access to timely pelvic USS before and after IUS/IUD insertions.
- Allow for contraceptives available in other countries to have a quick review and approval through the Therapeutic Goods Administration (TGA) – e.g. self-injectable contraception, different Intrauterine devices, patches, and implants.
- Include all contraception in the Pharmaceutical Benefits Scheme (PBS), e.g the third and fourth generation oral contraceptive pills, the combination vaginal ring contraception and increase the script repeats to 12 months for all non long-acting reversible contraceptives (e.g. it is currently only 6 months for injectable contraception and menopause hormonal therapy).
- improve access by increasing the range of approved prescribers to include nurse practitioners, eligible midwives and Advanced Aboriginal and Torres Strait Islander Health Workers. This will mean improved education regarding prescribing and access to abortion care, and will increase the opportunities for prescribers in regional, rural, remote, and very remote communities.
- Remove the MBS barriers for nurse practitioners and eligible midwife requests for pelvic ultrasound scans to determine pregnancy gestation and if it is intrauterine before a medical termination of pregnancy (nurses/midwives can only order third trimester ultrasound scans with an MBS item number).
- Remove the requirement of pharmacists to be registered providers of medical termination medicines.
- Incentivise pharmacies to supply medical termination medicines, and provide education the roles of pharmacists and legal obligations with respect to conscientious objection.
- Change the authority for prescribing medical termination medicines to a streamlined authority

Regarding emergency contraception, we recommend the following:

- Emergency contraception methods should be made available free to all, including the copper IUD.
- Implementation of national pharmacy guidelines should be supported by government and pharmacy professional groups to ensure consistent, best-practice emergency contraception care.
- A national information, referral support and advice service should be resourced to allow people of all genders to access information as to the locations of pro-choice pharmacies, IUD insertion, vasectomy and abortion providers.
- Cu-IUD provision should be publicly funded at no cost to the woman and available through a variety of services in the community.[23]

PHAA also supports the recent (2020) *Women's Sexual and Reproductive Health COVID-19 Coalition - Provision of emergency contraception: a consensus statement* from the NHMRC Centre for Research Excellence in Sexual Health for Women in Primary Care (SPHERE), which calls for remuneration of staff and service providers be strengthened as follows:

- Provide appropriate remuneration for 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.
- Ensure appropriate remuneration and reimbursement for GPs providing LARC insertion and removal services, including through increased MBS rebates and subsidised costs for related equipment.
- Fund Primary Health Networks to develop an integrated regional approach to contraception care that identifies gaps in service provision at a local level (with consideration of the needs of remote, rural and regional patients), commissions health services to fill those gaps, and maps the availability of services.

- Incentivise GPs and other health practitioners to undertake abortion and LARC insertion/removal training in areas of need, as identified by regional reporting.[24]

In line with a gender balanced approach, contraceptive services for males should also be expanded through community awareness campaigns about vasectomy, an underused, safe and cost-effective family planning methods, and universal access to the procedure.[25]

Investment in contraception research, both female and male controlled, should be prioritised, as should be effective translation of research into practice.[26 27]

Lack of affordability is one of the most widely reported and distressing aspects of abortion care. People who are seeking abortion care need greater financial support to avoid delays, which cause distress and affect our communities. In the longer term, there are several possible solutions to consider, including looking at Medicare's abortion care subsidies, PBS funding and private health reform agreements.

But action is needed now. This could include creating a national fund to provide financial support for pregnant people who want contraception or abortion but cannot afford their choice of health care and associated costs, including travel and childcare. Such a fund must be accessible, discreet and provide funding upfront in order to support all people who wish to access an abortion, including people on visas, and women in violent or financial abuse situations.

ToR (b): Cost and accessibility of reproductive healthcare

> *"(b) cost and accessibility of reproductive healthcare, including pregnancy care and termination services across Australia, particularly in regional and remote areas"*

Women carry the greatest burden for mistimed, and/or unplanned, pregnancies. Women are also financially disadvantaged in Australia compared to men. Costs associated with contraceptives disproportionately affects the most disadvantaged people, forming an equity barrier to contraceptive use. Providing low cost – or even free – access to all forms of contraception, particularly to young women, will not only reduce a gender inequity, but also ensure better health outcomes for the affected infants, the mothers, and future children born to these mothers.

It is also very important to highlight the need to achieve universal sexual and reproductive health care support for men. In respect of reproductive health issues, men:

- have their own needs that deserve attention
- can support their partners to achieve joint reproductive outcomes
- should be engaged to change harmful gender roles that undermine women's bodily autonomy.

Ensuring that men's sexual and reproductive health care needs are supported will have positive flow on effects on the health of their partners, children and the whole family. Men should therefore be supported by our health systems to use all forms of contraceptives available to them, though contraception use and unplanned pregnancies as a result remains a gender issue that disproportionately affects women.

The goal of ensuring access to reproductive health should include the full continuum of measures, including:

- family-planning counselling, information, education, communication and services
- education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care
- prevention and appropriate treatment of infertility

- management of unintended/unwanted pregnancies, including abortion
- treatment of reproductive tract infections
- sexually transmitted diseases and other reproductive health conditions
- information, education and counselling, as appropriate, on human sexuality, reproductive health and contemporary parenthood.[28]

Governments, and in particular their public health systems, should address – equitably to all Australians – the following needs:

- Contraception for all those wanting it including LARC procedural cost [29]
- free and easier access to condoms and lubricant – especially to young people and school aged people
- Free access to menstrual products in schools, public buildings, libraries, and other places, reducing stigma through community-wide education.[30]
- Access to emergency contraception in high schools by school based youth nurses
- Services for termination of pregnancy (TOP) – either medical or surgical depending on their circumstances, personal preferences and health history
- Bring about a consistent and standardised approach to TOP services in all states and territories. This would include clinical guidelines for the provision of TOP services and undergraduate education
- Bring about an integrated approach to TOP care in other reproductive health services (public and private) so surgical TOP is always an option
- Mainstream abortion care – e.g. second trimester abortion care is the same as second trimester miscarriage care, hospitals already care for people having third trimester miscarriages and still births, translating this health care into termination care should not need to be a sub-specialty in obstetric education.
- Where people must travel to a termination provider, they should be supported for travel expenses and the expenses of a support person if requested.

Government services should be working toward an intersectoral collaborative approach, with joined-up responsibilities across community, regulators, health services, CALD sectors, and disability support providers to improve access to TOP services.

The absence of government funding for preconception health services limits the time and attention health professionals can dedicate to effective preconception care, inclusive of family planning, health behaviour change, and genetic screening. Equally, there is a need for health promotion campaigns - starting with school-aged children - focused on educating the community of the critical importance of both reproductive partners being healthy prior to conception. The lack of awareness about preconception and reproductive health planning impacts on the frequency with which the public access health professional advice and support in the preconception period, thereby placing all responsibility for identifying the appropriate timing for raising preconception clinical conversations on the health professional amidst other busy clinical interactions.

Maternity care

While early access to antenatal care is paramount for optimal maternal and child health outcomes, substantial inequities in coverage exist, particularly for culturally and linguistically diverse people.[31] There is a need for increased early access to high quality culturally sensitive antenatal services by culturally and linguistically diverse people.[32]

Continuity of midwifery *carer* is internationally recognised as the gold standard of maternity care.[33] However, only 31% of models of maternity care in Australia emphasise the value of continuity of carer across the antenatal, intrapartum, and postnatal periods.[34]

There is significant variation in carer continuity availability around the country.[35] Only a minority of people in Australia have access to continuity of midwifery care, only 8% of women actually do obtain it, and the majority of hospitals report that the demand exceeds capacity.[36] Access is mostly restricted to low-risk pregnancy, and women can lose access to care continuity during pregnancy if complications arise, even though there is evidence that continuity of midwifery carer results in better outcomes, improved experiences for women and midwives and costs less.[37] [38] [39] [40] [41] [42] Australia's health system should commit to increasing the number of women who have access to continuity of midwifery carer.

The number of rural and remote birthing services is declining, forcing women to travel long distances in labour, resulting in increased rates of babies born before arrival to hospital.[43] Over 50% of small units having fewer than 100 births per year were closed between 1992 to 2011. This disproportionately affects Indigenous people as 26% of Indigenous births occur in remote or very remote areas compared to 2% on non-Indigenous births.[44] This has resulted in a higher proportion of babies unintentionally born out of hospital (0.7%) than the number of intended home births (0.4%). There is a reluctance to maintain birthing services without caesarean section capability, despite international evidence that having a non-caesarean service is safer than no service; indeed the perinatal death rate for babies born to mothers who live in *very remote* areas is double that of those who live in other areas.[45] Australia's governments should commit to revitalising rural and remote birth services to improve access to timely care.

Home birth services in Australia have excellent outcomes for mums and babies, including reduced intervention rates and very high satisfaction with birth experience, but are only accessible to a small numbers; 0.4% of babies were born at home in 2021.[46] [47] [48] There are only a few public programs, and these have very restrictive criteria. Some people can access home births by hiring a private midwife, but this is financially impossible for most. The number of private midwives is small, in part due to structural barriers including lack of an indemnity insurance. Australia's health system should commit to facilitating access to care options that support the right to choose a preferred place of birth.

Australia's maternity health system does not prioritises mothers' and babies' long-term health, but instead focuses predominantly on short-term outcomes for babies, with high rates of intervention to attempt to eliminate even the smallest risk factor for the baby during the current pregnancy. This focus results in under-emphasis on women's long term health, the health of any future children they might conceive, and long-term children's health.

Our caesarean rate is very high at 37% (39% for first time mums), and it has increased from 31% (32% for first time mothers) in 2010; in contrast to the WHO's statement that rates above 10-15% do not improve population health.[49] [50] Overuse of caesarean section is expensive to the health system and has negative implications for women's and children's health, including increased rates of asthma, obesity and poorer development for children born by caesarean; and women having children after a caesarean experience increased rates of infertility, miscarriage, stillbirth, uterine rupture, and abnormal placental development.[51]

Our episiotomy rate is unacceptably high: 25% of women (46% of first-time mothers) giving birth vaginally are having their perineum cut, an increase from 21% (37% for first time mothers) in 2010.[52] Episiotomy is painful and may sever nerves and anatomy important to sexual health.[53] [54] When combined with our caesarean rates, half of all mothers (52%), and two thirds (67%) of first time mothers, receive surgery of some kind when giving birth.

Our induction of labour rate is unacceptably high at 35.5% (43% of first time mothers); an increase from 25% (30% for first-time mothers) in 2010, and a further 16% (29% of women experiencing spontaneous

labour; 41% for first-time mothers) receive labour-inducing drugs to speed up their labour.[55] This means that only 25% labour without receiving drugs to start or speed up labour. Induced labour is more painful and increases their chance of having a caesarean, perineal tearing, and an episiotomy. Induction of labour results in increased rates of poor outcomes for babies, including a long-term increase in hospitalisation for infections.[56]

Despite unprecedented rates of surgical birth and medically induced labour, short-term baby outcomes are not improving. The proportion of babies admitted to the SCN/NICU has increased slightly from 16% to 18% since 2010; the perinatal death rate is unchanged.[57] Preterm birth rates have not changed, including for Indigenous mothers, who continue to experience preterm birth at 1.7 times the rate of non-Indigenous mothers.

Increasing rates of intervention in labour and birth has consistently been associated with poorer mental health outcomes, including postpartum anxiety and depression, and birth-related post-traumatic stress disorder. Poor postpartum mental health is estimated to cost the economy around $7.3 billion each year.[58] [59] [60] [61] [62] [63]

Australia's health system should commit to reviewing its policies and procedures with an eye towards supporting the right to be free from unnecessary medical intervention during labour and birth, including increasing access to models of care that result in lower intervention rates.

Many of Australia's mothers do not have access to respectful maternity care. Women experience high rates of psychological trauma during childbirth, with estimated 1 in 3 experiencing a traumatic birth, and 1 in 10 resulting in PTSD, and the number rises for those who have assisted or caesarean births.[64] Poor care provider treatment is a particular risk for women experiencing psychological trauma during birth.[65]

Many women report that they do not receive enough information to make informed decisions during labour and birth, or receive information biased towards their care provider's preference, resulting in them agreeing to interventions that do not align with their preferences.[66] Some of these stories are quite alarming, including mothers being manipulated, punished, badgered and/or assaulted when they did not consent to a recommended intervention in their births. Informed consent to procedures is an essential element of respectful maternity care, yet a study in 2010 revealed that only 27% of women provided informed consent for induction of labour, 52% for planned caesarean, and 12% for unplanned caesarean.[67] Yet another study showed that maternity care providers had poor understanding of their legal responsibilities and women's rights to informed consent during childbirth, and many policies and guidelines contain coercive language that precludes informed consent.[68] [69]

To increase access to respectful maternity care, Australia's health system should commit to ensuring that all clinicians have a working understanding of informed consent to procedures during childbirth, and review policies and procedures to ensure structural support for women's consent.

Many women do not have access to vaginal breech birth, vaginal birth for twins, or vaginal birth after caesarean; many services and clinicians are only willing to do caesareans in these scenarios, despite evidence that caesarean delivery is of no benefit, or even results in increased risks, to mother and baby. This constitutes mandatory surgery for women who find themselves in these scenarios, which is a violation of their right to bodily integrity.[70] [71] The result of this policy is that the vast majority of clinicians no longer have the skills to manage vaginal birth for breech babies or twins. This is a problem because occasionally women will labour too quickly to perform a caesarean, and if clinicians lack the skills to manage these births, women and babies face additional risks. Australia's health system should review these policies and ensure that all midwives and obstetricians obtain and maintain the skills necessary to give women adequate care in the context of all kinds of vaginal birth.

Indigenous women are 3 times more likely to die from causes related to pregnancy than non-Indigenous women, and the perinatal death rate for babies born to Indigenous mothers is 1.5 times higher than for non-Indigenous mothers.[72 73] In addition, babies born to mothers born in Africa, Central America and the Pacific Islands were also more likely to die. This reflects a serious disparity in access to culturally appropriate care. Increasing access to bilingual trained childbirth companions (doulas) could be a way to bridge cultural gaps, improving women's experiences, including for Indigenous women, low-income women, and migrant women.[74 75 76]

Services should work towards giving women access to models of care that have better outcomes, especially including midwifery continuity of care and out of hospital birth. Scaling up continuity of midwifery care among public hospitals is an important public health strategy to address equitable access to maternity services.[77]

Another priority is non-stigmatising support services for women living with HIV who want to become pregnant, or are pregnant, including supportive breastfeeding with appropriate access to specialists to advise on appropriate antiretroviral care, regardless of Medicare entitlement or migration status.[78]

Maternal health services should be provided in a way that incorporates an understanding of the role and experiences of fathers, in addition to addressing the needs of women and children. Health service organisations should design and implement interventions that promote "father inclusive practices" in maternity care while maintaining women's autonomy.[79]

Fathers should be supported, included, and prepared so they can support their partner effectively in achieving the ideal of transition to a successful pregnancy, joyful birth and positive parenthood experience.[80]

PHAA endorses the 12 competency standards developed by the Migrant and Refugee Women's Health Partnership for clinicians in providing culturally responsive clinical care for people from refugee and migrant backgrounds.[81]

ToR (c): workforce development options

> *"(c) workforce development options for increasing access to reproductive healthcare services, including GP training, credentialing and models of care led by nurses and allied health professionals"*

The skills and human resources shortage within the health workforce is a major challenge affecting the entire healthcare industry. This problem is greatly exacerbated in regional and rural areas. A sexual and reproductive healthcare workforce with specialists' skills pose an even bigger challenge.

Governments should organise an effective response to this challenge by investing in the training of nurses, doctors, maternal and child health nurses, nurse practitioners, and community 'doulas', will enhance and build the knowledge in this specialist area. Further, the workforce should reflect the people and community it serves. This should be reflected at all levels from the community support workers, through to the senior leadership roles.

Preconception health literacy and preconception counselling training is needed for all health professionals likely to provide care to people during their reproductive life. This commonly includes general practitioners, midwives, pharmacists and community health nurses, but may also include allied health practitioners such as dieticians, physiotherapists, chiropractors, naturopaths, and acupuncturists.[82 83]

Increasing the use of models of care that are led by midwives, especially when there is continuity of care between individual midwives and families, could enhance service provision.

Barriers to the accreditation of nurse practitioners to provide medication abortion car, as well as to provision of contraception (including LARC), should be removed from law and policy in all jurisdictions. Additional positions for nurse practitioners in sexual and reproductive health care should be established, with a focus on rural and remote areas and services for vulnerable populations.

Educational providers should embed training in contraceptive counselling, insertion/removal of LARC, abortion care, preconception care, etc. in all obstetrics and gynaecology, GP, practice nurse, nurse practitioner and midwife training programs (including a focus on sensitive enquiry for identifying reproductive coercion and abuse).[84]

Governments and other stakeholders should ensure that literacy on the health and wellbeing of LGBTQIA+ peoples is included in all health professional education and training, and also in general sexual and reproductive health programmes.

Governments should invest in building the health workforce of historically marginalised groups including Aboriginal and Torres Strait Islander people, culturally & linguistically diverse communities, and people with disabilities.

Healthcare organisations should engage the sexual and reproductive health workforce in ongoing cultural competency improvement programs to satisfy the need of people seeking care.[85]

ToR (d): best practice approaches

> *"(d) best practice approaches to sexual and reproductive healthcare, including trauma-informed and culturally appropriate service delivery"*

The *WHO statement on Sexual and Reproductive Health and Research* (2022),[86] provides an excellent starting point for best practice approaches in reproductive health service provision. This statement emphasises principles which should be present in any best practice approach, including the following:

> "**Key conceptual elements of sexual health**
>
> When viewed holistically and positively:
>
> - Sexual health is about well-being, not merely the absence of disease.
> - Sexual health involves respect, safety and freedom from discrimination and violence.
> - Sexual health depends on the fulfilment of certain human rights.
> - Sexual health is relevant throughout the individual's lifespan, not only to those in the reproductive years, but also to both the young and the elderly.
> - Sexual health is expressed through diverse sexualities and forms of sexual expression.
> - Sexual health is critically influenced by gender norms, roles, expectations and power dynamics.
>
> Sexual health needs to be understood within specific social, economic and political contexts."

Best practice in trauma informed care

Domestic, family and sexual violence prevalence rates in Australia are profound and widespread across society. Intimate partner violence is the greatest health risk factor, more than smoking or obesity of women of reproductive age between 25 – 44.[87] Those at greatest risk are young women, pregnant women, women separating from their partners, women with disability, women experiencing financial hardship and Indigenous women. [88]

The *Australian Longitudinal Study on Women's Health* found 51% of women in their twenties, 34% of women in their forties, and 26% of women aged 68 to 73 have experienced sexual violence. The study also showed women who experienced childhood sexual violence were twice as likely to have experienced violence as an adult. Child physical and/or sexual abuse is common, 1 in 6 women and 1 in 6 women before the age of 15, which is likely an underreport.

The most common mental health problem for women survivors of domestic and family violence is post-traumatic stress syndrome, with prevalence ranging from >30% to as high as >80% and there is increasing knowledge about the impact of complex post-traumatic stress disorder in this population.[89]

The above statistics demonstrate the need for the following recommendations:

- Fully fund and implement without delay the 2022 *National Plan to End Violence against Women and Children 2022–2032*.[90]
- Recognise the role of domestic, family and sexual violence and its intersection with sexual and reproductive health, especially among high risk groups – such as those of reproductive age and who are pregnant – by ensuring adequate training on trauma informed approaches and violence prevention.
- Improve the responsiveness of the whole health system, from patient support services, such as front facing administration, and all health care trainees and providers, and in the key areas of general practice, and emergency services.
- Fully fund health care organisations to have social workers and other specialised domestic and family violence support workers as well as capacity within consultations by doctors and nurses to offer warm referrals and case management where there is a disclosure of violence by providers
- Collect data and revisit policies on mandatory reporting and its impact; in general, mandatory reporting has not been shown to be effective, but does hamper disclosure and women's empowerment. Mandatory training of providers to identify and respond to violence should be prioritised instead.[91]
- Expand domestic and family leave entitlements, and emergency payments.

Best practice in services for indigenous women

Specific best practice issues arise in regard to Aboriginal and Torres Strait Islander women. Birthing on Country services have shown excellent improvements in the provision of culturally competent maternity care for Aboriginal and Torres Strait Islander women, including one service which has seen large reductions (40-50%) in preterm birth in women using the service. These programs are leading the way in best practice for improving Aboriginal and Torres Strait Islander maternal health.[92] [93]

Other programs have seen similar improvements in outcomes yet have had trouble sustaining a funding source. A permanent source of funding should be established so that trust in these programs is not compromised.

Examples such as the Bagarok program have found success through "co-design of the study and programme implementation with First Nations people, staff cultural competency training, identification of First Nations women (and babies), and regular engagement between caseload midwives and First Nations hospital and community teams. Further work should include a focus on addressing cultural and workforce barriers to implementation of culturally responsive caseload midwifery in regional areas." [94]

Best practices in regard to recognising diversity

Australia is a country that prides itself in its diversity and multiculturalism. Diversity can present an opportunity. However, diversity can also pose challenges.

Migrants in Australia come from diverse backgrounds, with refugees and asylum seekers constituting an essential demographical group. Other Australian born persons have experienced family violence or other forms of trauma. Acknowledging the diverse needs of the population groups, understanding the intersectionality, understanding the previous experiences of trauma, understanding diverse groups' ways of knowing and living, will all help to enhance contraception acceptance, uptake, and use. Community led approaches to contraception education by people with shared backgrounds and experiences will also enhance acceptance.

Several factors need to be taken into consideration when implementing sexual and reproductive healthcare services for culturally and linguistically diverse individuals. These include:

- addressing the broader economic, geographical and social factors that affect their accessibility to services
- provision of respectful, person-centred and culturally appropriate services
- ongoing community engagement to understand the barriers and potential solutions from their perspectives
- Availability of and access to providers and care in first language, as well as availability of translation and interpretation.[95] [96]

Centres of excellence in the provision of abortion care should be established in the public sector (where they do not already exist), and funding for diversity relevant research, policy-development, and teaching in health professional education should be provided by jurisdictions.

ToR (e): Sexual and reproductive health literacy

In line with the *WHO statement on Sexual and Reproductive Health and Research* (2022),[97] PHAA recognises that sexual health is "a state of physical, emotional, mental, and social wellbeing related to sexuality".[98] Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. Sexuality is a key part of each person's identity and includes "sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction [within] the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors".

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled. There is growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of certain human rights enshrined in existing laws. Educating children and young people about their rights to access health care, Medicare, health service provision, navigating the healthcare system, access to contraception and vaccinations should be supported and promoted.

There is evidence of significant gaps in preconception health literacy and confidence among health professionals and the public. This can be overcome through a coordinated effort across public health, health promotion, policy setting and clinical practice. Expert consensus among Australian preconception health researchers and clinicians has found health and social care professionals need to access to adequate training to address their knowledge gaps. Similarly community education is necessary to improve broader public health literacy with regards to preconception health.[99]

Health literacy programs should address all the eight components of sexual and reproductive health stated in the WHO Framework.[100]

PHAA also supports the recent (2021) *Consensus Statement on Reproductive Coercion* from the NHMRC Centre for Research Excellence in Sexual Health for Women in Primary Care (SPHERE) Women's Sexual and Reproductive Health COVID-19 Coalition recommendations, which includes these recommendations:

- Ensure relationships, sexuality and reproductive health education within schools, age appropriate, sex-positive, non-judgmental and intersectional lens
- Access to community campaigns, translated resources and interpreters
- Embed sexual and reproductive health in clinical education and competence standards for doctors, nurses, aboriginal health practitioners, pharmacists, physiotherapy etc. not as a sub-speciality. [101]

It should also be recognised that there are gender differences in sexual and reproductive health literacy and programs need to be independently designed to be culturally safe and age appropriate. In some cases communities may prefer separate approaches for women, men and LGBTIQ+ people.[102, 103]

Finally, the specific challenges facing refugee arrivals should also be acknowledged. Sexual and reproductive health education should be part of refugee resettlement programs in Australia.[104]

ToR (f): Experiences of people with a disability

"(f) experiences of people with a disability accessing sexual and reproductive healthcare" [105]

PHAA's positions on this topic are articulated in our *Policy position statement on Disability and Health* (2022).[106]

People with disability have poorer health than the general population. They experience health inequities that are linked to discrimination, barriers to accessing services, barriers to inclusion, and are disadvantaged with respect to almost all social determinants of health. We urge the Committee to adopt recommendations in our policy statements including:

- Make health services and equipment accessible and affordable for all people with disability, particularly Aboriginal and Torres Strait Islander people with disability, people with disability in remote areas, people with psychosocial or intellectual disability, people with disability living in institutions, and women and children with disability.
- Amend the NDIS accessibility and assessment process to provide equal opportunities for marginalised groups, adopt the human rights model of disability, and make more resources available and accessible.
- Harmonise Australia's legal framework with the *UN Convention on the Rights of Persons with Disabilities*, including but not limited to protecting people with disability from multiple and intersectional discrimination, amending migration laws and policies to ensure people with disability do not face any form of discrimination related to migration and asylum seeking, and amending laws to enable independent monitoring of the implementation of the Convention on the Rights of Persons with Disabilities.
- Increase training on disability, including hidden forms of disability like intellectual disability and autism, for health care trainees and staff in all areas, addressing ableism and providing appropriate care.
- Abolish practices that violate the autonomy, independence and dignity of people with disability, including the involuntary detention of people with disability in psychiatric hospitals and the use of medical interventions and restrictive practices, and implement a nationally consistent supported decision-making framework.

Young people with intellectual disability

When specifically considering access to sexual and reproductive healthcare, research suggests that sexual education programs in schools may be inadequate for young people with intellectual disability.[107]

Young people with intellectual disability do not have adequate opportunities to give consent, or even voice matters, affecting their sexual health and wellbeing. Anti-ableist policies in sexual and reproductive health, for example, in education curriculum is key to achieving equitable health outcomes. There is a need for well designed, disability inclusive education programs that prioritise safety, assertiveness, and self-determination to support positive outcomes.[108] [109] Sexual education programs should be developed with and for young people with disability, and be accessible.

Women with a disability

It is estimated that 9% of women of childbearing age have a disability. Women with disabilities have higher rates of poor perinatal outcomes, and report poorer experiences during episodes of maternity care. However, women with disabilities are not consistently identified in Australia's maternity care system; there is no systematic data collection, and two thirds of services are unable to estimate the number of women with disabilities seen at their hospital. Most service providers do not offer specialised services or training for staff in disability identification, documentation and referral pathways.[110]

The very recent report by Women With Disabilities Australia (WWDA), *Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD) - Report from the YWGwD National Survey*,[111] identified a range of barriers to access to services, including:

- negative and hostile attitudes among service providers
- an absence of physical accessibility with regard to buildings and equipment (e.g., exam tables and diagnostic equipment)
- a lack of information in accessible formats (e.g., in Braille or Easy English) Towards Reproductive Justice for YWGwD
- communication barriers (e.g., the lack of training for service providers on communicating with young women and girls with intellectual disabilities or a lack of access to Auslan interpreters)
- relatives and caregivers acting as gatekeepers to information and services
- a lack of accessible transportation to or from services
- affordability of services
- the isolation of girls and young women with disabilities living in institutional settings such as disability group homes or youth detention centres.

There is an urgent need for the development of disability identification, data collection and assistance services to ensure that women with disabilities receive adequate maternity care. The WWDA report also proposed a range of solutions to these challenges, including:

- Comprehensive information about contraception use
- Accessible and disability-specific information
- Include SRHR goals as "reasonable and necessary" under NDIS to ensure supports
- Assistance to manage Menstruation and pelvic pain for people with disability
- ensure protected right to be pregnant and parent
- Fund specific supports to address gendered disability violence
- Information about contraception for young women, girls, men, boys & gender diverse people with disability
- ensure and raise community awareness of Privacy and rights when accessing sexual and reproductive healthcare
- Utilise a sex-positive disability lens
- trauma informed health services. [112]

ToR (g): experiences of transgender, non-binary and other people

> *"(g) experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare"*

This subject is addressed in some detail in PHAA's recent (2022) *Policy position statement on The Health of People with Diverse Genders, Sexualities, and Sex Characteristics*.[113] LGBTQIA+ women and people with a uterus have distinct sexual and reproductive health needs.[114] [115]

Evidence from indicates that there may be a lack of knowledge in both healthcare providers and young transgender or non-binary people assigned a female gender at birth regarding contraceptive healthcare needs.[114]

A survey of Australian adults who identify as trans found that "Better training for doctors in trans health issues was the top priority for government funding".

In response, one policy option could be to ensure that in all medical and allied health training, the health and wellbeing of LGBTIQA+ people, including the contraceptive healthcare needs of all people with a uterus, is recommended to be included.[116]

LGBTQIA+ people also experience high levels of discrimination across society, including in healthcare. Evidence has shown that LGBTQIA+ people may not access health services as much as the general population, and when they do they may not disclose their gender identity or sexuality.[117] Therefore, it is vital that LGBTQIA+ inclusive and sensitive training is given to medical professionals, to ensure this is a safer environment for LGBTQIA+ individuals. This is particularly key due to the nature of sexual and reproductive healthcare discussions.

Governments and other stakeholders should support the development and implementation of workplace anti-discrimination policies in health care and beyond, which include specific references to harassment and discrimination based on sexual orientation, sex characteristics and gender identity.

Transgender and gender diverse individuals have varying access to fertility-preserving services, according to ability to afford it and depending on healthcare provider knowledge.[118] In some states, those who wish to change the record of sex on their birth certificate are required to have undergone an 'affirmation procedure', some of which result in sterility. Fertility preservation is seen as a medical necessity for cancer patients, but not for transgender and gender diverse people, and is thus not covered by Medicare. The cost of fertility-preserving services can run to thousands of dollars when not covered by Medicare or private health insurance, and can be viewed as a barrier towards official gender affirmation for those who wish to have genetically related children.

Transgender men who decide to get pregnant face many barriers to care, including being rejected from reproductive health services and dealing with ignorance from healthcare providers. There is a need for inclusive and specialised services for transgender parents in Australia.[119]

ToR (h): Availability of reproductive health leave for employees

To achieve gender equality and best outcomes for parents and children, paid parental leave for parents of any gender should urgently be expanded to 6 months, regardless of primary or secondary caregiver status, number of children and/or how children enter families. This will assist to significantly increase exclusive breastfeeding and well as shared domestic duties and gender equality.[120]

PHAA supports the Victoria Women's Trust recommendations for menstrual and menopause leave from their 2021 report *Ourselves at Work: Creating positive menstrual culture in your workplace*, suggestions for policies in these terms:

> *"The policy is designed to be flexible depending on the employee's needs, providing for the following options:*
>
> 1. *The possibility of working from home*,*
> 2. *The opportunity to stay in the workplace under circumstances which encourage the comfort of the employee E.g. resting in a quiet area; or*
> 3. *The possibility of taking a day's paid leave.*
>
> *In the case of paid leave, employees are entitled to a maximum of 12 paid days per calendar year (pro-rata, non-cumulative) in the event of inability to perform work duties because of menstruation and menopause, and their associated symptoms. A medical certificate is not required*." [121]

We further support the recent Health and Communities Service Union draft clause for reproductive health and wellbeing leave, which refers to:

> *"any condition relating to:*
>
> - *menstruation,*
> - *perimenopause,*
> - *menopause,*
> - *poly-cystic ovarian syndrome and endometriosis,*
> - *In Vitro Fertilisation (IVF) and*
> - *other forms of assisted reproductive health services,*
> - *vasectomy,*
> - *hysterectomy and*
> - *Terminations [of pregnancy]*." [122]

Recommended leave for the above is that:

> *"An Employee, including a casual Employee, experiencing reproductive health issues is entitled to up to 5 days per year of paid reproductive health leave for the purpose of treatment and management of ill health/symptoms, in addition to any personal leave". In addition to*
>
> - *The right to work from home*
> - *flexible working hours*
> - *Reasonable changes to work environment to provide comfortable working environment to alleviate symptoms or facilitate treatment*
> - *the right to access reasonable unpaid leave*."

The above recommendations should also include expanded domestic and family leave entitlements, and emergency payments as mentioned above.

ToR (i): Any other related matter

Access to genetic health services

We urge the Committee to note the need to address disparities in access to genetic services, especially in regard to Aboriginal and Torres Strait islander people, while also ensuring that services are provided in a culturally safe manner and respectful of patient and family choices and worldviews.[123]

Reproductive Coercion

We also wish to raise the issue of reproductive coercion, which forms a part of the wider problem of sexual, domestic, and family violence (SDFV).

PHAA's positions are set out in our policy position statement on Gender-Based Violence (2019). Other important resources are the 2020 paper *Hidden forces: A white paper on reproductive coercion in contexts of family and domestic violence* (Marie Stopes Australia, 2020),[124] and the recent (2021) NHMRC Centre for Research Excellence in Sexual Health for Women in Primary Care (SPHERE) Women's Sexual and Reproductive Health COVID-19 Coalition *Consensus Statement on Reproductive Coercion*.[125]

Initiatives which we recommend include the following:

- Universal access to quality, confidential contraception care (with free access to all methods), abortion care without a limit on gestation, and pro-choice pregnancy counselling services. recognising the role of coercion, violence and abuse that can occur in reproductive decisions towards pregnancy, abortion, or both and the need for a person-centred approach.[126] [127]
- Embed and invest in appropriate training for providers and community support services in matters of sexual, domestic, family violence, including reproductive coercion and abuse.
- Primary care organisations and others involved in DFV response should integrate mandatory DFV (including reproductive coercion) training. For health professionals, training should commence in undergraduate education, continue across accreditation, and be included in continuing professional education. Training should consider the following: the need to safely speak alone with the woman, legal obligations, and safeguarding issues for staff.
- Best practices in dealing with diverse (such as Aboriginal and Torres Strait Islander, migrant, refugee and LGBTQI+) communities should include standards for identity affirmation and cultural safety and competency, as understanding of coercion differs greatly across cultures and contexts. For example, access to appropriately trained first-language interpreters and/or cultural liaisons should be ensured where applicable.
- Survivors of domestic and family violence community awareness campaigns should be undertaken, including a focus on reproductive coercion.
- Criminal law should omit any reference to sexual and reproductive health, as this can significantly hamper disclosure, and reduce women's agency.
- Governments should review mandatory reporting for Health Care Providers where evidence shows it not to be effective.

Conclusion

The issues raised by this inquiry are of profound importance for the health and wellbeing of all Australians. We look to the Committee to examine the issues and make clear recommendations for action

However, this issue must not end with a Senate Committee report, however strong its conclusions. There is a vital need for *governments* to take coordinated action to change policies and services in the area of sexual and reproductive health care, including abortion care.

The *National Women's Health Strategy 2020-30* makes a commitment to universal access to sexual and reproductive health care.[128] But a coherent plan of implementation has been lacking, and urgently needs to be produced by the Australian Government. Without this, reforms will likely be piecemeal and maintain the undesirable postcode lottery that characterises abortion care in Australia.

Affordability is one of the most widely reported and distressing aspects of abortion care. People seeking abortion care need financial support to avoid delays, which cause distress and affect our communities. In the longer term, there are several possible solutions to consider, including looking at Medicare's abortion care subsidies, PBS funding and private health reform agreements. But action is needed now.

PHAA therefore supports calls for some form of national taskforce, located presumably within the Department of Health, to deliver reforms to sexual and reproductive health care, including abortion care and services. The exercise should be led by the Australian Government, but given the shared jurisdictional responsibilities, it must also involve the states and territories, and involve experts including service providers and people with lived experience.

Such a taskforce should have a wide scope and consider medical and surgical abortion, and address intersecting issues, including:

- Embedding abortion and contraception access in public health systems
- Expanding access to all pregnancy options counselling services
- Evaluating and resource universal abortion and contraception access
- Addressing workforce needs and training, including stigma reduction
- Providing innovative models of care, including culturally safe abortion care
- Resolving the lack of national data collection
- Improving community health literacy, including education on relationships and sexuality
- Creating Australian abortion care guidelines for medical professionals
- Harmonising legislation across states and territories
- Ensuring Australia meets its sexual and reproductive rights obligations, such as those under the Committee on the Elimination of Discrimination against Women (CEDAW).

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

Adj Professor Terry Slevin,
Chief Executive Officer
13 January 2023

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T: (02) 6285 2373 **E:** phaa@phaa.net.au **W:** www.phaa.net.au