Submission of Family Planning NSW

Inquiry into universal access to reproductive healthcare

Due Date: 15 December 2022

Senate Community Affairs References Committee
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Introduction

Family Planning NSW welcomes the opportunity to make a submission to the Senate Community Affairs References Committee regarding universal access to reproductive healthcare. We have a strong history of consulting with the federal government on policy and legislation and call for government to prioritise improved accessibility and funding to ensure that essential reproductive health care programs and services are available to all.

About Family Planning NSW

Family Planning NSW is the leading provider of reproductive and sexual health services in NSW and Australia. We are experts in clinical service provision, including contraception, pregnancy options, sexually transmissible infections, sexuality and sexual function, menstruation, menopause, common gynaecological and vaginal problems, cervical screening, breast awareness and men's and women's sexual health. Our mission is to enhance the reproductive and sexual health and rights of our communities by supporting all people to have control over and decide freely on all matters related to their reproductive and sexual health throughout their lives. Since 1926 we have provided independent, not for profit clinical services and health information to communities. Our work is underpinned by evidence and a strong commitment to sexual and reproductive health and rights.

Each year we provide more than 30,000 clinical occasions of service to clients, information and health promotion activities to communities, and best practice education and training in reproductive and sexual health for health for doctors, nurses, teachers, disability support workers and other health, education, and welfare professionals. We also have a significant international development program in the Pacific.

Family Planning NSW has substantial experience in the provision of reproductive and sexual health services, including for people of diverse sexualities and genders, people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds, young people and people with disability. We work across the state of NSW, including in regional communities with limited access to reproductive and sexual health care.

Our work is evidence-based, and shaped by our research, published clinical practice handbooks on reproductive and sexual health, nationally recognised data and evaluation unit and validated through extensive clinical practice.

Our work is also framed by a commitment to the United Nations 2030 Agenda for Sustainable Development. Our recommendations for this submission are relevant to making progress towards achieving Sustainable Development Goals (SDGs), in particular SDG3 relating to good health and well-being, SDG5, achieving gender equality and empowering women and girls, and SDG10 on reducing inequalities.

Note on language

Throughout this document, we refer to women where research has been specific to women, and in recognition that the majority of people who are pregnant or seeking contraception identify as women. However, we acknowledge that the content about women also applies to people who are pregnant or seeking contraception who do not identify as women, including trans, gender diverse and non-binary people. Likewise, we acknowledge that contraceptive methods labelled 'male' contraceptives in the Terms of Reference, some research and in the body of this submission are also likely to be relevant to people who do not identify as men, including trans, gender diverse and non-binary people.

Summary of recommendations

Access to reproductive health care is a fundamental human right which contributes to positive health, social and economic outcomes across the community. This right has been reinforced within global commitments, such as the Programme of Action of the International Conference on Population and Development, with one of the overarching goals being to achieve universal access to sexual and reproductive health and rights as a part of universal health coverage.i

Australians do not currently have sufficient or equitable access to reproductive healthcare services, particularly in regional, rural and remote areas. Universal access to reproductive healthcare must become a reality across the entire health sector, not only in specialist private services, or restricted to metropolitan areas for those who can afford it. All people in Australia should be able to access affordable, safe and inclusive reproductive health services.

Family Planning NSW makes the following recommendations addressing the Terms of Reference, based on our expertise in reproductive and sexual health services delivery:

a) Contraception

Oral contraceptives

- Enhanced access or oral contraceptives via pharmacist provision to occur, ensuring:
  - development of a comprehensive credentialed training program and framework for pharmacists
  - requirements for private spaces for assessment to allow safe provision and contraceptive counselling (pharmacist provision should only occur when this space can be guaranteed)
  - clear communication framework in place where pharmacists can inform prescribers when clients have accessed a continuing supply of their prescribed oral contraceptive

Long-acting reversible contraceptives (LARCs)

- Improved access to contraception, including LARCs and emergency contraception
- Increased access to training for doctors, nurses and midwives in assessment, insertion and removal of LARCs
- Nurse-led clinics (registered nurses/midwives), using a collaborative model of care with doctors, to support more widespread provision of LARCs
- Copper IUDs to be listed for subsidy under the PBS as a priority
- Establishment of new Medicare Benefits Schedule (MBS) items for Registered Nurses or other sustainable funding for nurse-led assessment, insertion and removal of LARC, including contraceptive implants, copper IUDs and hormonal IUDs.
- Community and professional education and training about the cost-benefit of LARCs as against traditional methods such as the Pill
- Improve the lengthy timeliness of assessments and approvals of modern methods of contraception under the TGA and PBS
- Implement standard clinical practice, as appropriate, to offer women access to LARCs at the time of, or immediately following, an abortion

Male contraceptive options

- Provide funding for increasing the number of clinicians trained in vasectomy
- Continue to support research into viable contraceptive options for men, including reversible options

b) **Access to abortion care:**

- improved training and support for GPs in primary care to provide access to medical abortion care early in pregnancy
- improved access to affordable abortion care post 9 weeks gestation, including in the public health sector
- training and development for public health sector staff in the delivery of abortion care
- funding to support the additional work for the public sector in delivering abortion care services, including in relation to both medical and surgical abortion clinical care and in supporting women's choices about their pregnancy. This includes training for doctors, nurses, social workers, receptionists and other care providers in abortion service delivery
- provision of appropriate levels of remuneration through the MBS and other sustainable funding mechanisms for abortion care
- increasing capacity of all health care clinicians to provide comprehensive reproductive healthcare, including LARCs, alongside abortion services
- regional planning for abortion services to ensure all Australians have access to services as close to home as possible
- continuance of all telehealth MBS items for medical abortion services post COVID-19 pandemic, including those for blood borne viruses and reproductive and sexual health services
- removal of the requirement for pharmacists to be registered to dispense MS-2step

c) Workforce development:

- Ensure equality of access to reproductive health care for all priority populations
- Ensure access to services focused on prevention and early intervention for priority populations, including CSE
- Support workforce development and other strategies which improve access to reproductive healthcare, particularly in regional, rural and remote areas where there is generally less access to reproductive healthcare services.
- Support the inclusion of reproductive healthcare training in undergraduate and GP training programmes.
- Support development of a recognised training program for surgical abortion
- Support the development of local communities of practice for abortion care providers

d) **Sexual and reproductive health literacy:**

- provide education strategies and health information to improve reproductive health outcomes, including comprehensive sexuality education in schools and community settings, boosting health literacy and continuing to develop and disseminate health information resources, including those relevant to the particular needs of priority population groups
- support consistent delivery of effective comprehensive sexuality education programs in schools and community settings that are age-appropriate, evidence-based, inclusive of diversity, and support learners with the knowledge and skills to access reproductive health services.
- improve the quality and consistency of comprehensive sexuality education in Australian schools. This should take the form of a national framework for CSE developed by recognised experts in the field of CSE, informed by consumer consultation and aligned with the 2018 UNESCO international technical guidance on CSE. The framework should include more specific guidance on content for each stage of development, examples of effective learning strategies and resources to support implementation. Professional learning for pre-service and in-service teachers should accompany the framework in order to build the capacity of schools to delivery consistently high quality CSE programs which are well-resourced and consistently delivered across the country.

e) **Access to reproductive healthcare for people with disability:**

- Support initiatives which are inclusive and target meeting the reproductive health needs of people with disability.
- Promote professional learning for all health professionals, disability and community sector workers, on strategies to support inclusive practice which upholds the sexual and reproductive health and rights of people with disability

f) Experiences of transgender people, non-binary people, and people with variations of sex characteristics:

- Support initiatives which are inclusive and target the reproductive health needs of lesbian, gay, bisexual, transgender, intersex and queer people.
- Ensure that cervical screening, contraception, abortion and other reproductive healthcare services are equitably available, inclusive of people with diverse bodies, gender identities and sexual orientations.
- Support provision of inclusive CSE in schools and community settings.

g) Reproductive health leave for employees:

- Evaluate existing reproductive health leave policies and invest in research to explore the feasibility and impact of reproductive health leave on women's and people with uterus' engagement in the workforce.
- Undertake a public consultation on reproductive health leave to establish public interest and support. This should include consultation with employers, experts, and the general public.

h) Other related matters:

- To address reproductive coercion:
  - implement trauma-informed approaches to recognise and respond to reproductive coercion in relevant health settings by appropriately trained staff
  - implement ongoing domestic, family and sexual violence training, which includes reproductive coercion, in all primary healthcare organisations professional development programs and undergraduate education
  - ensure consistent implementation of evidence based comprehensive sexuality education to address factors driving family, domestic and sexual violence across the lifespan, including through schools, community programs and primary healthcare organisations
  - improve access to contraceptives for women, particularly those in regional, rural and remote areas
- Continue to support access to reproductive health screening, including cervical screening, particularly for under-screened groups. Inclusive strategies are needed to communicate the importance of screening and strategies to access screening services (including self collection where appropriate) in ways targeted to reach priority groups, including people with disability, Aboriginal and Torres Strait Islander communities, people from CALD backgrounds and trans and gender diverse people with a cervix who may not identify as women.
- Continue to offer accessible STI testing and treatment for all, along with CSE and targeted health promotion campaigns to support STI prevention, testing and treatment, particularly amongst priority population groups.

Responses to Terms of Reference:

This section identifies 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', and makes recommendations to address these, with particular reference to elements of reproductive healthcare appearing in the Terms of Reference.

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**
- **iii. options to improve access to contraceptives, including over the counter access, longer prescriptions, and pharmacist interventions**

Despite greater availability of contraception in recent years, there is still an 8% unmet need for contraception among Australian women.[ii]

Oral contraceptives

The contraceptive pill is one of the most commonly used contraceptive methods in Australia. As experts in reproductive and sexual health, Family Planning NSW strongly supports strategies to enhance access to oral contraceptives, provided these strategies take appropriate measures to ensure they do not inadvertently compromise patient safety, quality and contraceptive choice.

We encourage the Therapeutic Goods Administration (TGA) to prioritise exploration of strategies to enhance access to oral contraceptives via pharmacists that will ensure patient safety and quality of service delivery. Issues to be considered include adequate pharmacist training on all contraceptive options, sufficient time allocation for patients to address their clinical needs, including review of the acceptability of the existing contraceptive prescription, and ensuring the privacy of the consultations. Allowing continued access to oral contraceptives through pharmacies would allow greater contraceptive access for those who have difficulties returning to a General Practitioner, and thereby reduce risks associated with unintended pregnancy. There is significant need to address barriers that prevent access to contraceptives in primary healthcare settings, particularly for those in rural and regional areas who have reduced access to doctors and nurse practitioners to obtain prescriptions.

For women who find returning to their initial GP prescriber difficult, allowing continuing provision of contraceptive pills by pharmacists may improve contraceptive accessibility and convenience. Pharmacies typically have longer opening hours than GPs, convenient locations and provide a walk-in service without appointment. Rescheduling of select oral contraceptives, with the appropriate safety and quality considerations put in place, ensures women have greater access to oral contraception should their prescribed supply run out. Several studies suggest that oral contraception provided 'over the counter' may increase women's access to contraception, reduce unintended pregnancy and result in higher continuation rates[iii].

Recommendations:

- Enhanced access via pharmacist provision to occur, ensuring the following:

- development of a comprehensive credentialed training program and framework for pharmacists
- requirements for private spaces for assessment to allow safe provision and contraceptive counselling (pharmacist provision should only occur when this space can be guaranteed)
- clear communication framework in place where pharmacists can inform prescribers when clients have accessed a continuing supply of their prescribed oral contraceptive

Long-acting reversible contraceptives (LARCs)

Ensuring equitable access to highly effective contraceptives, particularly LARCs, is a national health priority articulated within Australia's National Women's Health Strategy[iv]. LARCs include copper and hormonal intrauterine devices (IUDs) and contraceptive implants, and are safe and highly effective forms of contraception, each at over 99.5% efficacy[v].

The rates of uptake of LARCs in Australia are well below comparable developed countries across the world,[vi] with only 12-15% of women using long-acting reversible contraception (LARC)[vii]. Increasing access to LARCs is a primary strategy to address unmet need for contraception.[viii]

LARCs are both more effective in preventing pregnancies, and more cost-effective over time, though the up-front initial cost of LARCs is higher than for contraceptive pill options. While a high proportion (66-70%) of women use contraception, the unintended pregnancy rate is high in Australia, with about one in ten women reporting contraceptive failure[ix]. Contraceptive failure results in significant individual and societal costs.

Due to their high efficacy rates, uptake of LARCs results in significantly reduced unintended pregnancy and abortion rates. Offering women provision of LARCs at the time of an abortion, or immediately following an abortion at follow-up appointments, would improve access to comprehensive reproductive healthcare.

Considerations for increasing the use of LARCs include the following[x]:

- A lack of access to General Practitioners and other providers trained in LARC services impedes their uptake, particularly in rural and remote areas. Women's choice of and access to contraception depends on the affordability of accessing contraceptive options and the availability of health providers being adequately skilled to provide a client's preferred option. Provision of LARC services led by registered nurses and midwives could assist in addressing these service and community needs. Additionally, utilising appropriately trained nurses and midwives to undertake LARC procedures would reduce GP workload in this area, allow opportunities for task sharing, and increase Australian women's access to contraception.

- Accredited training programs for LARC assessment, insertion and removal for doctors, nurses and midwives are available in Australia. Doctors, registered nurses (RNs) and midwives complete the same competency-based program. Recent published research demonstrates that RNs who undertake competency-based IUD insertion training have a high rate of successful insertions and a low rate of adverse outcomes. Similarly, Australian domestic research, published in 2021, concludes that registered nurses are well placed to undertake contraceptive implant procedures. Investing in training nurses

to provide LARCs could therefore significantly increase access to this method of contraception for women, especially in areas where doctors are in short supply to the community[xi].

- Evidence shows RN-led LARC service provision is a highly effective, safe and economical strategy for promoting women's access to LARC, with many countries already having integrated RN-led LARC service provision into funded healthcare. Alongside the evidence, there is strong support from key Australian stakeholders around RN-led LARC service provision as a strategy to address unmet need in rural and regional areas[xii].

- There is also strong evidence that supports the cost-effectiveness of RN-led LARC insertions[xiii],[xiv]. This cost benefit is for both women accessing LARC and for Government. Financial modelling commissioned by Family Planning NSW found:
    1. If Australian women using the oral contraceptive pill switched to LARC, in-line with LARC uptake in comparable countries, net savings are estimated at $68 million over five years
    2. For women using no contraception who adopt a LARC, in-line with uptake in comparable countries, the value of avoided abortions and miscarriages is $20 million over five years
    3. If 20% of women who switch to a LARC are provided with services by a RN (compared to a GP), there would be an additional saving to Government of $2.7 million.

- RN-led assessment, insertion and removal of implants and IUDs is already taking place in Australia. However, the lack of access to MBS or other sustainable funding for nurses severely limits the provision of LARCs by nurses and therefore significantly reduces access to LARCs in areas of unmet need. In order to effectively provide this service RNs must have access to MBS or other sustainable funding that fully covers their costs of service provision.

- Australia has not sufficiently invested in professional and community education about the higher comparable effectiveness of LARCs. This means that both health practitioners and women are not clear about the relative efficacy of LARCs and often opt for traditional methods. The impact of this is higher rates of unplanned pregnancy, higher abortion rates and higher costs for contraception.

- Of particular concern is that the PBS in Australia does not include copper IUDs, therefore the costs of these for patients is high and therefore limits access. This is particularly important when the use of a copper IUD may be assessed as the most effective contraceptive for the patient

- Assessment of new and effective contraceptive options in Australia lags behind assessments and approvals in other countries. This is highly relevant at the present as a new progesterone only pill is available overseas for patients who can't tolerate oestrogen. However, this has not yet been approved by the TGA in Australia and is therefore not covered by the PBS. These processes of approval need to be hastened and ready access to modern methods by available in Australia.

Recommendations:

- Improved access to contraception, including LARCs and emergency contraception
- Increased access to training for doctors, nurses and midwives in assessment, insertion and removal of LARCs
- Nurse-led clinics (registered nurses/midwives), using a collaborative model of care with doctors, to support more widespread provision of LARCs
- Copper IUDs to be listed for subsidy under the PBS as a priority
- Establishment of new Medicare Benefits Schedule (MBS) items for Registered Nurses or other sustainable funding for nurse-led assessment, insertion and removal of LARC, including contraceptive implants, copper IUDs and hormonal IUDs.
- Community and professional education and training about the cost-benefit of LARCs as against traditional methods such as the Pill
- Improve the lengthy timeliness of assessments and approvals of modern methods of contraception under the TGA and PBS
- Implement standard clinical practice, as appropriate, to offer women access to LARCs at the time of, or immediately following, an abortion

Awareness and availability of male contraceptive options

There are currently very limited options for male contraception in Australia, with the focus remaining largely on women to shoulder responsibility for contraception.

Vasectomy is still a viable contraceptive option for men. However, access to vasectomy can be very limited, dependent on availability of trained clinicians.

Recommendations:

- Provide funding for increasing the number of clinicians trained in vasectomy
- Continue to support research into viable contraceptive options for men, including reversible options

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

This is a significant time in Australia for abortion service access, following decriminalisation of abortion services across the country. There is a real opportunity to develop effective systems to support good access to services. This must include developing a well-trained, committed workforce and ensuring accessible facilities and provision of care in all regions. Studies have previously shown[xv] that an estimated 1 in 3 women in Australia will experience an unintended pregnancy, and over 80,000 people access abortion care each year. Improving equity of access to pregnancy termination services is also an objective of the National Women's Health Strategy.

Major barriers to abortion access include high costs for clients and service providers, lack of available services, particularly outside of metropolitan areas, and limited availability of medical abortion medication in pharmacies.

Access to affordable services

Abortion remains expensive and inaccessible for many Australians[xvi]. Affordability of abortion services has a great impact on access to abortion services.

Abortion care is not readily available in public health care settings, so most women need to access private providers and pay large out of pocket costs for access to time-critical care. Costs often range from $500 - $8,000 for abortion care in Australia. This is not withstanding that medications for a medical abortion are listed on the PBS (MS-2Step) and surgical abortion is a rebatable procedure under Medicare. Client costs include the GP visit (or referral), blood test, ultrasound scan, prescription medication, the cost of the procedure for surgical abortion and the cost of after-care. There are significant additional costs to support access to abortions, including transport, childcare and lost wages. For those from rural and remote areas where there are no local services, costs are higher due to factors such as additional travel and accommodation expenses. Costs increase for later gestation abortions, and this is compounded when accessing earlier gestation abortions is complicated and may involve lengthy investigations about options and funding.

The necessary role of the public health system in abortion care is the management of women who have pregnancies under 9 weeks gestation who cannot be managed in primary care due to being complicated cases or where there are complications post medical abortion. In addition, the public health sector is required to provided abortion care for late gestations, usually post 20 weeks gestation, though the gestation varies between states. Whilst some women with gestations post 9 weeks can be managed in the private sector, the high cost of these services means that many women can't afford this private care. However, irrespective of the agreed legality of abortion, and the role of the public sector in the provision of health care for all, there is a significant cohort of health care staff who opt not to provide abortion services to women where they consider the abortion to be for 'social' reasons. These include doctors (GPs and Obstetrics and Gynaecological specialists, anaesthetists and sedationists), nurses, social workers and receptionists. Addressing the engagement of health care staff in delivery of abortion care is of critical importance, including addressing the rights of women to this essential health care. This can be achieved through training in all-options pregnancy choices including the role of counselling for women in making decisions about their pregnancy.

Early medical abortion in a primary care setting is the ideal for most women. Medical abortion care in a primary care-setting is acutely time-sensitive, as a viable pregnancy is typically established at 6 weeks, and medical abortion care is generally approved for up to 9 weeks in Australia. This provides little time to prepare, particularly for those on low incomes unable to bear the cost at short notice, or for those who are unaware they are pregnant at earlier gestations.

Some people have significant difficulty paying for abortions. In 2015, an Australian study of women seeking abortion found two-thirds of women needed financial assistance to obtain an abortion. The median cost for indirect expenses was $150. Another Australian study with rural women found some borrowed funds so they could access an abortion. Women with financial difficulties and/or marginalised groups either proceed with the pregnancy or may more commonly access services at a later gestation, due to access barriers, and abortion becomes progressively more expensive with increasing gestation.

In some cases, health services support costs associated with their clients' abortion care, covered by donations, fundraising, grants or savings from elsewhere in the organisation, although these funds are limited and do not represent sustainable models of funding for access to abortion services. ACCHOs, AMSs, Women's Health Centres and other organisations can incur significant costs in providing transport and staff to attend abortion services with the woman. For example, during the 2018-2019 financial year Penrith Women's Health Centre in NSW spent $40,000 in brokerage aiding women to access abortion services (they were managing referrals from across NSW) and these costs are currently likely to be higher. Private and not-for profit abortion providers often refer financially disadvantaged women who cannot afford the listed service fees to Women's Health Centres and Family Planning NSW with the expectation that they will either provide brokerage funds for the service or provide these services to women. Although some abortion providers publicly promote reduced costs for those who cannot afford to pay out-of-pocket fees, this is highly limited and often results in referrals to other providers (such as Family Planning NSW) or other organisations facilitating such access (such as Family Planning NSW social work service or through Women's Health Centres).

Access to services in rural and remote areas

Access to abortion and affordability is highly dependent on postcode, financial status, access to facilities and gestation. Groups who are already experiencing disadvantage are amongst the worst affected, including people with low incomes and those in rural and remote areas, Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds.

There are currently no comprehensive medical and/or surgical abortion services within a publicly funded model for regional, rural and remote NSW, and this exacerbates inequity of access. Access to abortion in rural areas is extremely limited and challenging. Furthermore, a perceived lack of local confidentiality results in women travelling to other areas at significantly higher cost. In these circumstances, there may be a higher likelihood of inadequate post-abortion care. In 2016, a NSW-based study found rural women travelled 1 to 9 hours one way to access an abortion. Another Australian study of 2,326 women aged 16 and over found women who travelled more than 4 hours were more likely to have difficulty paying, were more likely to be Aboriginal and Torres Strait Islander and more likely to present later in the pregnancy.

Access to services delivered by GPs is highly variable. A study in 2017 found that, whilst some GPs are willing to provide a medical abortion, most GPs thought abortion should occur in for-purpose clinic settings rather than general practice. GPs suggested access to abortion could be strengthened by formalised referral pathways to those clinics. Access to medical abortion via telemedicine is limited in rural areas due to the referral criteria, out-of-pocket costs and the lack of availability of registered dispensers in rural pharmacies.

Women in all geographical locations should have equal access to affordable, appropriately located and safe abortions. Women also need access to unbiased and confidential information to enable them to make a choice that is right for them. Having abortion services available closer to home is essential in reducing inequities in access to healthcare experienced by rural women.

Access to medical abortion medications through pharmacies

Medication can be difficult to access as it is not routinely stocked in all pharmacies, particularly outside of metropolitan areas. This may be in part due to some pharmacy operators being opposed to provision of medical abortion. It may also be about business operations, such as low demand not making it viable for them to routinely stock these medications. Having to order medication on demand creates delays, which is problematic when there is a time limit for taking the medication by 9 weeks gestation.

A second impediment to abortion care is the requirement for each pharmacist to be registered to dispense MS-2 Step. This creates an unnecessary bureaucratic barrier for the provision of abortion services.

Establishing MBS item numbers for medical abortion care

Including the cost of providing follow-up appointments, the cost of providing medical abortion is an issue for service providers. Some GPs opt out of providing LARC and medical abortion services due to insufficient remuneration for provision of these services. MBS items for medial abortion care must cover the true costs for the provision of abortion services by GPs. This issue is compounded in rural, regional and remote areas where there are already fewer GPs.

While temporary item numbers that include telehealth medical abortion have been established over the period of the COVID-19 pandemic, there is concern about their permanency.

Establishing MBS item numbers for medical abortion will also generate data about service delivery. This data will contribute to building a broader evidence base on abortion care access in Australia.

Recommendations:

- improved training and support for GPs in primary care to provide access to medical abortion care early in pregnancy
- improved access to affordable abortion care post 9 weeks gestation, including in the public health sector
- training and development for public health sector staff in the delivery of abortion care
- funding to support the additional work for the public sector in delivering abortion care services, including in relation to both medical and surgical abortion clinical care and in supporting women's choices about their pregnancy. This includes training for doctors, nurses, social workers, receptionists and other care providers in abortion service delivery
- provision of appropriate levels of remuneration through the MBS and other sustainable funding mechanisms for abortion care
- increasing capacity of all health care clinicians to provide comprehensive reproductive healthcare, including LARCs, alongside abortion services
- regional planning for abortion services to ensure all Australians have access to services as close to home as possible
- continuance of all telehealth MBS items for medical abortion services post COVID-19 pandemic, including those for blood borne viruses and reproductive and sexual health services
- removal of the requirement for pharmacists to be registered to dispense MS-2step

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

Pre-service education and training for clinicians

Comprehensive reproductive healthcare, including training in LARCs and abortion care, is not included in undergraduate degrees for doctors, nurses and midwives. This means that clinicians need to undertake specialised training after graduation to gain skills in this area. Family Planning NSW provides accredited training for doctors, nurses and midwives in reproductive healthcare, including medical abortion, contraception and provision of LARCs.

Needs of priority populations

Access to health services is a critical issue for priority populations with poorer health status. Whilst some services are targeted to specific priority population groups, access is reduced if priority groups are limited to only attending speciality services.

Mainstream health services should be able to cater for the needs of clients of all ages, cultural backgrounds and sexuality and gender diverse people. Workforce development initiatives therefore need to embed strategies to support clinicians and other health workers to develop the knowledge and skills to appropriately communicate with and provide appropriate client-centred care for diverse communities. This is particularly significant for reproductive healthcare for priority populations to increase their access to services.

Examples of such training include:

- Family Planning NSW's *The Nitty Gritty* Specialised reproductive and sexual health training for those working in health, youth work and the community sector. This course provides strategies and resources for engaging with young people from priority groups including LGBTIQA+, Aboriginal and Torres Strait Islander, culturally and linguistically diverse communities and young people with disability around reproductive and sexual health and consent and to support reproductive and sexual health literacy.
- ACON's suite of courses, available via Pride Training, provides information on inclusive practice for working with sexuality and gender diverse people.
- The Aboriginal Health and Medical Research Council's *Doin It Right* course for Aboriginal Health Workers and others working with Aboriginal and Torres Strait Islander youth provides content and resources needed to communicate appropriately around reproductive and sexual health issues.

Focusing on prevention and early intervention in reproductive health care is also paramount. Many priority populations have not had access to comprehensive sexuality education and this impacts on the choices they make about their own health care and those in their family. Supporting the training and development of professionals in comprehensive sexuality education is critical so that they can appropriately support these communities in improving their reproductive health status.

Recommendations:

- Ensure equality of access to reproductive health care for all priority populations

- Ensure access to services focused on prevention and early intervention for priority populations, including CSE

Abortion training for clinicians

Training for GPs, nurses and specialists in abortion care is required in order to increase access to medical and surgical abortion. Training in abortion care is generally not included in undergraduate programs for doctors and nurses and is not a standard inclusion in GP training programs. While some training is available for doctors, nurses and midwives (as detailed below), clinical training alone may not increase their provision of abortion services, given stigma and contentious objection may also play roles in limiting abortion care, particularly in regional, rural and remote areas where access to multiple clinicians is less.

For medical abortion:

- Doctors must register with MS Health (the company that sponsors the medical abortion drugs in Australia) and either complete the MS-2-Step 3 hour online education program, be a Fellow of the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) OR have an advanced diploma from RANZCOG. This allows them to provide medical abortion up to 9 weeks gestation. There is no published data available on uptake of this training by GPs, but anecdotally the uptake of this training among GPs is very low.
- RANZCOG has developed educational programs in abortion, including an online learning module since December 2019 for O&G trainees. For O& G trainees in the final years of the RANZCOG fellowship there is an Advanced Training Module on Contraception, Abortion and Sexual Health that provides an opportunity to develop advanced skills in medical and surgical abortion, however, this is optional.
- Registered Nurses, who can be involved in abortion care assessment and follow-up, do not have access to the MS-2Step online training as they do not prescribe medications for abortion.
- To meet the training needs of GPs, nurses and midwives, Family Planning NSW has developed a comprehensive online training course for medical abortion that goes beyond the MS-2Step training requirements. This provides practical support to assist clinicians in establishing and delivering medical abortion services, from prescribing through to follow up, with a focus on clinical scenarios and addressing complications. 104 participants have completed the course since it was launched in 2020.

For surgical abortion:

- There is currently no recognised training program for surgical abortion in Australia, with the exception of the advanced training module for RANZCOG trainees in the RANZCOG O&G program.
- Training in community abortion clinics has generally been provided by experienced medical practitioners to peers, but there is no formal credentialing process.
- The lack of training impacts on access to abortions for women as there are insufficient numbers of trained and credentialed clinicians skilled in providing abortion care.

Communities of practice

Communities of practice are useful for supporting the development of new skills and gaining support from clinical peers, especially when offering new services, which supports uptake of provision amongst clinicians. Ideally these groups should be relatively small and assist in developing local pathways of care for reproductive health care service provision. There are a

number of existing models for supporting abortion service providers through communities of practice, however, these need to be funded and resourced locally to operate effectively.

Recommendations:

- Support workforce development and other strategies which improve access to reproductive healthcare, particularly in regional, rural and remote areas where there is generally less access to reproductive healthcare services.
- Support the inclusion of reproductive healthcare training in undergraduate and GP training programmes.
- Support development of a recognised training program for surgical abortion
- Support the development of local communities of practice for abortion care providers

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

Adopting a trauma-informed approach for all reproductive healthcare clients, not just those who have a history of sexual or other trauma, ensures that reproductive healthcare is always person-centred and sensitive to the individual.

All clinicians and health service staff must develop knowledge and skills to provide safe and inclusive care for clients, including those from priority populations. Negative experiences, including where the language or approach of health service staff was perceived as inappropriate or discriminatory by clients, create feelings of discomfort, mistrust and sometimes trauma, which can serve as a disincentive to attend follow-up appointments and/or to seek healthcare in the future[xvii]. This in turn exacerbates reproductive health problems, where issues may not be addressed, or not addressed until they are more advanced and complicated than they would have been if health care was sought earlier.

People from priority groups often find it difficult to access services that are affirming or able to provide accurate reproductive health information. For example, the practice of accessing reproductive care for sexuality and gender diverse people can include experiencing ignorance, stigma, or having assumptions made about them or their partners that delay or prevent care. If services are not affirming and universally accessible, this contributes to poorer health outcomes in the patient and a barrier to accessing further care[xviii].

Recommendations:

- support initiatives which are inclusive and target the reproductive health needs of priority groups with poorer reproductive health care outcomes, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people with disability, young people and lesbian, gay, bisexual, transgender, intersex and queer people.

- ensure education and service design for reproductive health includes a trauma-informed approach

e) sexual and reproductive health literacy

Comprehensive Sexuality Education (CSE) is vital to ensuring positive reproductive health outcomes. CSE incorporates the development of sexual and reproductive health literacy. CSE has been proven to support positive reproductive health outcomes, including reduced rates of unintended pregnancy and STIs, improved communication about reproductive and sexual health and improved health literacy[xix].

Effective CSE includes information about contraceptive options so that learners can make informed decisions about the best options for their circumstances, along with information about puberty, conception and pregnancy, STIs, consent and relationships. It also provides knowledge and skills supporting sexual and reproductive health literacy to enable learner to access health services and reliable health information.

Providing effective CSE includes:

- ensuring high quality and consistent CSE delivered by appropriately trained educators in schools
- availability of CSE outside of school settings in the community for young people, particularly those disengaged from or no longer attending school, and others of all ages
- education delivered in clinical settings
- availability of high quality information resources, including online resources, suitable to meet community education needs.

Whilst health literacy and CSE content are included in Australia's national curriculum for Health and Physical Education[xx] and state syllabus documents, the quality and quantity of CSE implementation varies widely between schools.

Ensuring education is appropriate and accessible to all in the community includes education and resources tailored to the learning needs of people with intellectual disability and low literacy, people from culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander people, and LGBTIQ people.

Recommendations:

- provide education strategies and health information to improve reproductive health outcomes, including comprehensive sexuality education in schools and community settings, boosting health literacy and continuing to develop and disseminate health information resources, including those relevant to the particular needs of priority population groups
- support consistent delivery of effective comprehensive sexuality education programs in schools and community settings that are age-appropriate, evidence-based, inclusive of diversity, and support learners with the knowledge and skills to access reproductive health services.
- improve the quality and consistency of comprehensive sexuality education in Australian schools. This should take the form of a national framework for CSE developed by recognised experts in the field of CSE, informed by consumer consultation and aligned with the 2018 UNESCO International Technical Guidance on CSE. The framework should include more specific guidance on content for each stage of development, examples of effective learning strategies and resources to support implementation. Professional learning for pre-service and in-service

teachers should accompany the framework in order to build the capacity of schools to delivery consistently high quality CSE programs which are well-resourced and consistently delivered across the country.

f) experiences of people with a disability accessing sexual and reproductive healthcare

Family Planning NSW respects and upholds the right of people with disability to have autonomy to control and decide feely on all matters related to their reproductive and sexual health, free from coercion, discrimination, and violence. Women with disability are particularly vulnerable to having their reproductive and sexual health rights abused and to experience exploitation and violence. Young people with disability and people with disability who are also Aboriginal and Torres Strait Islander, from culturally and linguistically diverse backgrounds and/or sexuality and gender diverse may face additional barriers to achieving their rights.

People with disability must have access to comprehensive sexuality education to gain the knowledge and skills to make decisions about their own reproductive health, or actively participate in supported decision making if they do not have the capacity to do this independently. This education should be delivered in schools, but also be available in later adolescence and adulthood as relationships develop and their reproductive healthcare needs change.

Recommendations:

- Support initiatives which are inclusive and target meeting the reproductive health needs of people with disability.
- Promote professional learning for all health professionals, disability and community sector workers, on strategies to support inclusive practice which upholds the sexual and reproductive health and rights of people with disability

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

Transgender people, non-binary people and people with variations in sex characteristics experience barriers and discrimination in relation to reproductive healthcare, which is reflected in health indicators, such as higher rates of STIs, lower rates of cervical screening, and higher rates of mental health issues than the general population [xxi], [xxii].

Reproductive health care clinicians require training in CSE, trauma informed care and inclusive practice to ensure that care is inclusive and appropriate to their clients' needs, preferences and personal circumstances.

Schools and community services also have a role to play as key settings to provide CSE information and access to sexual and reproductive healthcare which is inclusive and appropriate to the needs of these communities. Appropriate CSE provision has been

demonstrated to support better reproductive and sexual health outcomes, along with other benefits such as improved resilience and mental health outcomes[xxiii],[xxiv].

Recommendations:

- Support initiatives which are inclusive and target the reproductive health needs of lesbian, gay, bisexual, transgender, intersex and queer people.
- Ensure that cervical screening, contraception, abortion and other reproductive healthcare services are equitably available, inclusive of people with diverse bodies, gender identities and sexual orientations.
- Support provision of inclusive CSE in schools and community settings.

h) availability of reproductive health leave for employees

Family Planning NSW recognises the impact of reproductive health on capacity to work, particularly for women.

Recommendations:

- Evaluate existing reproductive health leave policies and invest in research to explore the feasibility and impact of reproductive health leave on women's and people with uterus' engagement in the workforce.
- Undertake a public consultation on reproductive health leave to establish public interest and support. This should include consultation with employers, experts, and the general public.

i) any other related matter

Reproductive Coercion

Reproductive coercion includes behaviours which interfere with a woman's autonomous decision-making with regard to her reproductive and sexual health. It may include behaviours such as controlling or limiting access to contraception, sabotaging contraception use and/or using violent or threatening behaviours in response to pregnancy options, including limiting access to abortion services or forcing someone to terminate their pregnancy.[xxv],[xxvi].

Addressing reproductive coercion is an important component in ensuring universal access to reproductive healthcare because reproductive coercion is associated with limited reproductive control, unintended pregnancy, sexually transmissible infections, poorer mental health, and psychological distress for those who experience it. Additionally, reproductive coercion is associated with increased difficulty in accessing healthcare services and an increased risk to safety for women and children, as well as an increased risk of experiencing other reproductive health issues including pelvic inflammatory disease, urinary tract infections and sexual dysfunction. Evidence shows that some women are more likely to disclose experiences of family, domestic and sexual violence, including reproductive coercion, to primary healthcare providers rather than to domestic, family and sexual violence specific services[xxvii].

The Australian National Women's Health Strategy (2020-2030) acknowledges that a "reduction in the rate of reproductive coercion" is a key measure of success in improving health outcomes for Australian women. Family Planning NSW respects and promotes the rights of women to have the autonomy to control and decide freely on all matters related to their reproductive and sexual health. The increasing recognition and prevalence of family, domestic and sexual violence in Australia threatens these rights and is a significant public health concern.[xxviii] We welcome the development of the National Principles to Address Coercive Control, which include reproductive coercion as a form of coercive control, and have recently contributed to the federal Attorney-General's Department's consultation on the draft national principles. These principles will contribute to the much needed evidence-based guidelines for health practitioners around the recognising and responding to reproductive coercion.

HPV and cervical cancer

The success of the National Human Papillomavirus (HPV) Vaccination Program has led to a rapid and significant decline in genital warts, especially for young people under 30 years, and it is expected to reduce the rates of HPV-related cancers in the coming years, including cervical cancer. The detection of high-grade abnormalities in women undergoing cervical cancer screening (Pap screening) has declined significantly over the past decade, reflecting the success of the national HPV vaccination program for young people.

However, there are still significant differences in the rates of screening, diagnosis and treatment success, which highlight inequalities in access to screening and treatment. Aboriginal and Torres Strait Islanders, people with disability, people outside of metropolitan areas and LGBTIQ people with a cervix are under screened in comparison to the general population. Lack of screening at recommended regular intervals leads to diagnoses at later stages when the disease is more advanced, resulting in the need for more complex treatment and higher morbidity rates. As with the strategies required to address other reproductive health issues, more training is needed to ensure more trained doctors, nurses and midwives are available to provide screening, early detection of HPV and identification and treatment of abnormal cells to prevent cervical cancer developing. This training must also include skills to provide this care in inclusive and culturally safe ways to support access and follow-up by priority groups.

We welcome the development of the National Strategy for the Elimination of Cervical Cancer in Australia to provide guidance and accountability to support achieving the goal of elimination. We will provide feedback on the draft which is currently open for consultation until January 2023.

STIs

Failure to detect and treat sexually transmissible infections (STIs) can affect fertility later in life, which can impact on reproductive healthcare. Chlamydia is the most commonly diagnosed STI in Australia. It is one of the main causes of infertility in women, because chlamydia often goes undetected and can spread to other parts of the body causing damage to the reproductive system, in particular the uterus and fallopian tubes[xxix]. The notification rates of STIs, especially chlamydia and gonorrhoea, continue to rise in Australia over the last decade, in particular among young people aged under 30 years, Aboriginal and Torres Strait Islander people, and people living in rural and remote areas. Over the past decade, the rate of newly diagnosed HIV has been decreasing, although people recently arrived from overseas and men who have sex with men continue to have higher rates of new notifications[xxx].

Australia therefore needs to continue to be vigilant in offering accessible STI testing and treatment for all. This includes STI testing on request from clients and also clinicians offering STI testing opportunistically to clients where appropriate. Ongoing comprehensive sexuality

education in schools and community settings and targeted health promotion campaigns to support prevention, testing and treatment, particularly amongst priority population groups, are also essential activities to reduce STI rates and avoid the associated risks to reproductive health. COVID-19 disruptions have resulted in a reduction in STI testing since 2020, so the coming years of COVID recovery will also be crucial to manage anticipated increased notifications.

Recommendations:

- To address reproductive coercion:
  - implement trauma-informed approaches to recognise and respond to reproductive coercion in relevant health settings by appropriately trained staff
  - implement ongoing domestic, family and sexual violence training, which includes reproductive coercion, in all primary healthcare organisations professional development programs and undergraduate education
  - ensure consistent implementation of evidence based comprehensive sexuality education to address factors driving family, domestic and sexual violence across the lifespan, including through schools, community programs and primary healthcare organisations
  - improve access to contraceptives for women, particularly those in regional, rural and remote areas
- Continue to support access to reproductive health screening, including cervical screening, particularly for under-screened groups. Inclusive strategies are needed to communicate the importance of screening and strategies to access screening services (including self collection where appropriate) in ways targeted to reach priority groups, including people with disability, Aboriginal and Torres Strait Islander communities, people from CALD backgrounds and trans and gender diverse people with a cervix who may not identify as women.
- Continue to offer accessible STI testing and treatment for all, along with CSE and targeted health promotion campaigns to support STI prevention, testing and treatment, particularly amongst priority population groups.

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