Family Planning Tasmania.

Submission to the Senate Community Affairs References Committee Inquiry into universal access to reproductive healthcare

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1. INTRODUCTION

Family Planning Tasmania (FPT) is a member of Family Planning Alliance Australia (FPAA) and has contributed to the submission prepared for the Senate Inquiry by FPAA. Many of the issues and solutions raised in the FPAA submission are applicable to Tasmania. The FPAA submission is appended to this submission for later reference by FPT stakeholders.

In addition, FPT has engaged specifically with stakeholders in Tasmania about the key issues being considered in the Inquiry. This consultation, which invited individuals and organisations to provide comments via an online portal, generated a significant volume of detailed feedback from people across Tasmania, and is summarised in section 2 of this submission.

In response, FPT is proposing ***three practical ideas that could be implemented immediately*** – and at comparatively low cost - to address the most pressing issues raised in the FPAA submission, and arising from FPT's consultations.

Proposal 1: Extend FPT clinic services to regional and remote Tasmanian communities, via a cost-effective 'local hosting' model. Currently, many Tasmanian women are unable to access essential SRH services because they live outside a major centre.

Proposal 2: Provide access to fully funded (no 'out-of-pocket payment') Medication Termination of Pregnancy (MTOP) procedures for all Tasmanian women. Among other things, this will provide a cost-effective alternative to Surgical Termination of Pregnancy (STOP), which is currently fully funded by the Tasmanian Government.

Proposal 3: Direct funding for Tasmanian primary schools to access FPT's relationships, consent, sexuality and protective behaviours education program, with priority for schools in low socio-economic and remote/regional areas of Tasmania. Currently, individual primary schools must 'purchase' FPT's *Growing Up* program ('GUP'). This has resulted in many schools (especially those servicing communities with higher needs) being unable to access FPT's education programs on a regular basis, or at all.

More detail about each of these three proposals is also set out in section 3 of this submission.

Quick Overview of FPT

FPT is a community-based, not for profit organisation providing sexual and reproductive health (SRH) clinical, education and advocacy services. FPT operates clinics in Glenorchy, Launceston and Burnie and provides outreach services across Tasmania.

In the 2021-2022 financial year, FPT:

- delivered clinical services to 14,093 Tasmanian health consumers, including (but not limited to) contraception, gynaecology, treatment of sexually transmitted infections, and termination of pregnancies
- delivered clinic services equitably to consumers across the North-West (21%); (North (29%); and Southern (50%) regions of Tasmania
- delivered 1,263 hours of healthy relationships education sessions with 62 Tasmanian schools, 10 professional development sessions with educators (115 attendees), and 130 one-on-one and small group education sessions for people with additional needs
- delivered to education consumers across the North-West (12%); North (29%); and Southern (59%) regions of Tasmania
- employed a rolling average of 60 staff, including general practitioners, nurses and SRH educators.

In 2021-22, 51% of FPT's annual revenue was provided by the Tasmanian Government in recurrent and project specific funding, and 49% was self-generated.

2. SUMMARY OF FPT CONSULTATION WITH TASMANIAN STAKEHOLDERS ON THE SENATE INQUIRY TERMS OF REFERENCE

2.1 Cost and accessibility of pregnancy care and termination services in Tasmania

In summary, Tasmanians told FPT:

- When women can access sexual and reproductive health services, both through primary care providers such as FPT and in the public system, the services are high quality.
- Cost is a barrier for Tasmanian women to access Medication Termination of Pregnancy (MTOP).
- Cost, access to transport and time away from home/work is a barrier for women in remote and regional Tasmanian to access pregnancy care and termination services.
- Due to Tasmania recently experiencing a situation (now resolved) where there was no access to surgical termination of pregnancy (STOP), there is insufficient awareness of access to termination options.

In their own words, Tasmanians said:

"The cost [of MTOP] is an added worry for women in [an] already very stressful situation. We should follow the UK where the cost of abortion is covered by the NHS."

"[We need] better information and more social knowledge that terminations are available in Tasmania."

"Patients in rural and regional areas of the state must travel a long way for these services. Part time or 'Pop Up' clinics in regional towns may work to improve accessibility, reduce patient costs, improve patient outcomes and reduce teen pregnancy."

"There are problems with the cost and accessibility of pregnancy and termination Services on the North-west coast. Many women travelling to hospitals and clinics which provide these services…have problems with the cost of transport, either petrol or bus/coach especially those from rural areas such as the west coast and Smithton and King Island. By the time they get around to getting appointments with doctors who are trained and sensitive to reproductive and termination services they have few options available to them."

"Medical termination medications and appointments including ultrasound are expensive and outside most people's financial capacity."

"Surgical terminations in Public Hospitals is a great step forward. Ensure GPs know this is available statewide."

"A number of patients are unsure if terminations are available in Tasmania. Also GPs don't seem to be aware of the accessibility within the public system."

2.2 Cost of contraceptives

In summary, Tasmanians told FPT:

- While Tasmanians can access some non-prescription contraceptives at no cost through FPT and other primary and public health providers, there are cost barriers for contraception requiring a prescription, and for LARCs requiring a procedure by a health professional.
- While some low-income Tasmanians can access financial support for contraception through Tasmanian Government funds administered by Women's Health Tasmania and the Link Youth Service, this is not readily available to many Tasmanians.
- There are issues with the cost of Slinda (drospirenone) – a progesterone only oral contraceptive pill – because it is currently not subsidised by the PBS.
- Again, access to contraception can be more difficult in remote and regional Tasmania.

In their own words, Tasmanians said:

"[There are] problems with the cost of contraception and cost of attending a GP if living out of area to attend a Family Planning service."

"I feel quite strongly that contraceptive should be free! The cost to the healthcare and social welfare system of unwanted pregnancies is significant."

"The cost of contraceptives in Tasmania is also prohibitive to many women on the North-West coast. Many women at times cannot afford the $6.80 prescription if they have a health care card and if they are on a low income the cost can be prohibitive. Again, the family planning clinic is not always accessible for people who live in regional or remote areas and have difficulty with transport and the cost of petrol. Also other alternative options such as implants etc. may not be possible as the access to doctors and or health professionals who are trained and sensitive to contraceptive services is in many cases limited."

"The cost of contraceptives can be prohibitive, with many having ongoing costs and/or requiring medical services (again possibly ongoing) to continue access to the contraceptive. During the cost-of-living crisis, contraception may be viewed as a luxury item in the household budget. Free contraception for all is a possible solution and would remove associated power and control issues that are sometimes seen in [family violence] situations."

"[The] Youth Health Fund is an option for U/25 if young people are experiencing difficulty but for low income people over 25, Women's Health will only cover the cost of LARC."

2.3 Workforce Development

In summary, Tasmanians told FPT:

- The current shortage of GPs, nurses and other healthcare professionals in Tasmania – particularly in regional and remote communities – is impacting access to sexual and reproductive healthcare.
- Some GPs are not aware of the sexual and reproductive health options provided by FPT and other primary and public health providers.
- Some GPs are not adequately trained in the specific sexual and reproductive health needs of Tasmanian Aboriginal people, culturally diverse Tasmanians, people living with disability, and LGBTQI+ Tasmanians.
- Organisations such as FPT provide practical options for GP training and development in sexual and reproductive healthcare.
- Consideration should be given to models of care that broaden services delivered by nurses and allied health care professionals, particularly to service women in rural and regional areas.

In their own words, Tasmanians said:

"Due to shortages of GPs, nurses and other healthcare professionals in traditional health care settings, expanding funding and focus of existing models of care in allied services (e.g. Family Planning Tasmania, etc.), by allowing them to develop more health professionals in the workforce - using their models, would increase access to and availability of reproductive healthcare state-wide."

"[Tasmania requires] more awareness regarding where services are available and who to link with. Do you have to go through your GP, can you self-refer?

"Upskill GPs and other relevant staff in the process of accessing an abortion and the unique challenges people face."

"Accrediting nurses and midwives to insert implanon would be helpful, but an assessment and prescription from a medical practitioner would still be required. More sexual health drop in opportunities for young people with funding for advertising and setting up these services a priority."

"Something ...anything in remote/country areas!! We will take whatever you give us!"

2.4 Priority Cohorts

In summary, Tasmanians told FPT:

- There are ongoing barriers to Tasmanian Aboriginal people, culturally diverse Tasmanians, people living with disability, and LGBTQI+ Tasmanians accessing appropriate clinical, primary prevention and education services for sexual and reproductive well-being.
- Tasmania has a relatively high proportion of people living with disability, who often have specific needs and barriers in relation to sexual and reproductive health.
- Tasmania would benefit from more effective engagement, co-design and communication with priority cohorts.
- Some Tasmanian health professionals have little exposure to working with culturally diverse people, and little or no specific training in effective engagement with CALD patients and their families.
- Again, Tasmanians living in regional and remote areas of the state face significant barriers to accessing reproductive healthcare. This is compounded when they are also from one or more additional vulnerable cohorts (e.g. Aboriginal Tasmanians).

In their own words, Tasmanians said:

"[Tasmania needs] more support for people from CALD backgrounds with possible cultural sensitivities. GPs who can sign to better support the Deaf community or have access to tele-health interpreters, especially in Hobart where the Deaf community is so small and discussing something as personal as reproductive health with someone in your community interpreting, may be a barrier for accessing support."

"There is a gap for sex and relationship education for PWD particularly those with intellectual disabilities and those with physical disabilities who may need sex therapy to explore what a healthy sexual relationship could look like for them. I would love to see this funded!"

"Financial difficulties are huge drivers for [vulnerable cohorts] - free sexual health service outreach to rural areas would greatly benefit these communities - note FREE not BULK-BILLED."

"[There are currently] issues with interpreters - means longer consults which often increases costs for patients if they are in a non-bulk billing service."

"Unless Tasmanian [vulnerable cohorts] know where to go for professional and funded assisted services like FPT they go without. Promotion and more funding for services by sexual health professionals is required."

"Patients in regional and remote areas of the state must travel a long way for these services. Part time or "Pop Up" clinics in regional towns may work to improve accessibility and outcomes."

2.5 Sexual and reproductive health literacy

In summary, Tasmanians told FPT:

- Too few Tasmanian schools are providing consistent, standardised education in relationships, consent, sexuality and protective behaviours.
- It is not reasonable to expect Tasmanian teachers to take responsibility for education in sexual and reproductive health – including dealing with problematic sexual behaviours – in the absence of structured professional development.
- With current teacher shortages and workload pressures, Tasmanian schools must be externally supported over the medium-term to ensure effective sexual and reproductive health literacy.
- Tasmanian has a rate of teenage pregnancy above the national average, and this is partly a result of poor sexual and reproductive health literacy.
- Support to improve sexual and reproductive health literacy is required across all age groupings, including via delivery in community settings.
- Language, religion, and culturally specific gender norms can impact the sexual and reproductive health literacy of culturally diverse Tasmanians.

In their own words, Tasmanians said:

"[Tasmania needs] more information about non binary and/or transgender issues. Mandatory sex education for highschoolers - including but not limited to: respectful conduct, sexual coercion, contraceptives."

"Consistent and standardised approach to SRH education across all schools state-wide. Also, more education to a wider variety of cultural groups and organisations."

"Peer facilitation is paramount…encourage and educate people to be leaders for their communities…better overall RSE in schools would benefit the community greatly as well - especially for those [identifying as] LGBTIQ+."

"Teachers are not health professionals and therefore can teach incorrect information or that smattered with their own biases. Increase access for underage who are wishing to receive reproductive health services against their guardians wishes."

"Have [more, better targeted] information about sexual and reproductive health literacy in different languages in multi-cultural community centres, in high schools for female students and in areas where young people access health care like Pulse."

"[Education initiatives should focus on] normalising periods, tapping into Neighbourhood Houses and other less clinical-feeling spaces for sexual health education."

"The Link Youth Health Service is a great pathway to further healthcare services for young people, more funding and advertising would support them."

"Family Planning services are excellent. School health nurses are a great resource. The Pulse Youth health service is another agency which could have greater availability for sexual health services."

3. THREE PRACTICAL, LOW-COST INITIATIVES PROPOSED BY FPT

FPT has developed three proposed initiatives that address many of the issues raised by stakeholders during consultations for this submission. These initiatives are being considered by the Tasmanian Government as part of its 2023-24 budget processes, and could also be supported by modest investments of Australian Government funding. These three initiatives are:

3.1 Extension of FPT clinic services to regional and remote Tasmanian community health centres and GP practices, via a cost-effective 'local hosting' model.

The current problem

Women living in most remote and regional communities of Tasmania have little or no direct access to women's sexual and reproductive health services. Tasmania has 87 population centres with an Accessibility/Remoteness Index of Australia (ARIA+)[1] score of over 2.40. Analysis undertaken by FPT has found that women in all these localities (with the exception of the Derwent Valley) have highly restricted or no access to specialised women's health.

The *Tasmanian Health and Wellbeing for Women Action Plan 2020-23* acknowledges that Tasmanian women "continue to face barriers in health care access, particularly in relation to reproductive and sexual health" and that "specific issues in relation to maternal, sexual and reproductive health exist for…women living in rural and remote areas".

The *National Women's Health Strategy 2020-2030* acknowledges that women and girls from rural and remote backgrounds experience compounding disadvantage: for example, by being more likely to have a lower socio-economic status, and more likely to have experienced gendered violence and/or abuse, which singularly and collectively impacts their health needs.

One of four goals in the *Tasmanian Women's Strategy 2022-27* is that "women and girls have equal opportunities for good health and wellbeing". The current lack of access to women's health services in regional and remote areas of Tasmania prevents this goal being achieved, and places additional pressure on over-stretched rural GPs.

Lack of effective access to basic sexual and reproductive health services for women in remote and regional areas of Tasmania leads to greater costs for the Tasmanian health system, including:

- More referrals to public hospitals, instead of sexual and reproductive health issues being dealt with in the primary care system
- Increased referrals for more costly surgical terminations, resulting from limited access to contraception and medication termination
- Increased demand and pressure on GPs in regional and remote locations, contributing to burnout, turnover and service disruption.

The solution

FPT currently employs doctors with the qualifications, expertise and motivation to provide women's sexual and reproductive health services to regional and remote parts of Tasmania. FPT can provide quarterly, bulk-billed (no 'out of pocket expenses') outreach clinics in regional and remote communities, in partnership with local services that have existing facilities, and strong engagement with local women.

The cost to government of FPT providing quarterly clinics in each remote/regional community is less than $10,000 per year.

[1] The Accessibility/Remoteness Index of Australia (ARIA+) is an index of the accessibility of places to service centres, or remoteness of places. Geographical areas are given a score between 0 to 15. An ARIA+ score of 2.40-5.92 indicates that a place has 'significantly restricted accessibility' to goods, services and opportunities for social interaction. A score from 5.92 to 10.50 indicates 'very restricted accessibility'; and over 10.50 indicates 'very little accessibility'.

3.2 Fully funded (no 'out-of-pocket payment') Medication Termination of Pregnancy (MTOP) procedures for all Tasmanian women

The current problem

There are cost barriers to Tasmanian women accessing Medication Termination of Pregnancy (MTOP). Perversely, it is now more affordable for many Tasmanian women to access Surgical Termination of Pregnancy (STOP), than MTOP.

Access to STOP in Tasmania has improved greatly since the service was introduced in Tasmania's public hospitals in October 2021. STOP is now free for all women, including non-Medicare card holders. This approach is strongly supported by FPT.

Nonetheless, non-invasive MTOP is the preferred abortion alternative for many Tasmanian women. FPT provides approximately 400 MTOPs per year in a primary care setting. MTOP is also provided by some GPs.

FPT is not specifically funded to provide MTOP, and therefore currently needs to charge 'out of pocket' costs for women who are not eligible for State Government funding. Out of pocket costs for health consumers of MTOP are required because the service requires significant patient preparation, monitoring and follow up.

While the costs of MTOP in Tasmania may be reimbursed for people who can demonstrate financial hardship (with government funding administered via Women's Health Tasmania and The Link) this creates a further barrier for MTOP compared to STOP. Medical practices such as FPT must still 'advertise' the cost of MTOP, and consumers have to declare they can't pay in order to access financial hardship support. There is evidence that some clients are unable or unwilling to make this declaration to FPT, including due to feelings of shame and embarrassment. Some of these women unfairly incur the financial hardship of MTOP 'out of pocket' expenses. Others do not proceed with the MTOP at all, and instead access STOP. An unknown number of women may proceed with an unwanted pregnancy.

Women who would prefer to choose MTOP, but cannot due to out of pocket costs, can instead access free STOP in public hospitals at an approximate cost to the health system of $3,000 per procedure. Conversely, every woman who chooses to access MTOP in a primary health setting, instead of STOP in a public hospital, reduces pressure on the public health system. MTOP also provides options for tele-health delivery that are not possible with STOP, which can be particularly beneficial for women in regional and remote Tasmanian communities.

The solution

FPT proposes to provide equitable access to MTOP for all Tasmanian women by fully funding MTOP through FPT clinics in Glenorchy, Launceston and Burnie, and via FPT outreach to remote and regional parts of Tasmania.

FPT is a proven, high-quality provider of MTOP in Tasmania. FPT has systems, processes, facilities and equipment in place – including nursing support and specialised GP training – to expand on its current provision of 400 MTOP services per year. FPT now provides in-house ultrasound (required prior to some MTOP procedures) and has a focus on providing reliable contraception and support to all MTOP patients to prevent future unplanned pregnancy.

FPT estimates that it could meet current demand for free MTOP in Tasmania for less than $250,000 per year.

3.3 Direct funding for primary schools to access FPT's relationships, sexuality and protective behaviours education program, with priority for schools in low socio-economic and remote/regional areas of Tasmania.

The current problem

Too few Tasmanian primary schools are providing relationships, sexuality and protective behaviours education for students in a consistent, up-to-date and structured annual program.

This is despite such programs being a priority across a range of state and national plans, including the:

- *Tasmanian Sexual and Reproductive Health Strategic Framework* - "support the provision of comprehensive relationships and sexuality education for young people in schools and alternative educational settings."
- *National Action Plan for the Health of Children and Young People 2020 – 2030* - "Support respectful relationships and good sexual health" including: "Develop and implement healthy relationship programs appropriate for each life stage [including in] in ECEC (3-5) [and] primary education settings"
- Tasmanian Government's *'Safe Home, Safe Families' Action Plan for Family and Sexual Violence 2019-2022* - "Embed respectful relationship education in all Tasmanian Government schools [to] support students and school communities to build healthy, respectful and equal relationships and address the attitudes and behaviours that lead to violence".

Family Planning Tasmania has a well-established, proven education program for primary schools, called the *Growing Up Program* (GUP). Approximately 60 Tasmanian schools purchase this program each year. GUP incorporates three critical areas of age-appropriate education:

- Respectful relationships and consent
- Protective behaviours
- Sexuality.

The Tasmanian Government currently partly funds FPT to provide GUP for Tasmanian primary schools. This funding is used to administer and continuously improve GUP educators and resources. However, currently, each Tasmanian state school must utilise its local discretionary funds to purchase delivery of GUP. This results in many schools with high needs and competing priorities accessing GUP intermittingly, or not at all.

The solution

It is proposed that FPT Is directly funded to provide consistent, structured respectful relationships, protective behaviours and sexuality education in Tasmanian schools via an annual program. Importantly, FPT is the only known provider in Tasmania that can deliver combined relationships, consent, sexuality, and protective behaviours education across all primary school years.

Currently, FPT delivers GUP to approximately 60 schools per annum. It is proposed that with direct funding, this would be scaled-up annually as follows:

- 80 schools in 2024 (for a three-year program 2024-2026)
- 100 schools in 2025 (80 schools 2024-26 and 20 additional schools 2025-2027)
- 120 school in 2026 (80 schools on 2024-26; 20 schools on 2025-27; 20 schools 2026-28).

FPT could provide this program for approximately $4000 per school, per year.

For further information about this submission please contact:

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Appendix: FPAA Submission – FPT CEO is Deputy Chair of FPAA.

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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100,
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12 December 2022

To Whom It May Concern,

RE: FPAA submission to Senate Standing Committees on Community Affairs in response to inquiry on universal access to reproductive healthcare

I write to you on behalf of Family Planning Alliance Australia (FPAA), the nation's peak body for reproductive and sexual health services. The primary members of FPAA are not-for-profit Family Planning Organisations (FPO) from each State and Territory of Australia, including:

- Sexual Health Quarters (WA)
- Sexual Health Victoria
- True Relationships & Reproductive Health (QLD)
- Sexual Health and Family Planning ACT
- SHINE SA
- Family Planning NSW
- Family Planning Welfare NT
- Family Planning Tasmania

We appreciate the opportunity to provide a submission in response to the inquiry on universal access to reproductive healthcare. The attached submission is written by the FPAA in response to the Committee Terms of Reference. We consent to this submission being published on the inquiry website and shared publicly online.

If you have any questions about this submission, please contact me at Debra.Barnes@shq.org.au or 08 9227 6177. Thank you for your consideration of our submission.

Sincerely,

Debra Barnes
Chairperson, Family Planning Alliance Australia
CEO, Sexual Health Quarters

Submission to the Senate Standing Committees on Community Affairs in response to the inquiry on universal access to reproductive healthcare.

Statement on universal access to reproductive healthcare

> *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. – UN Sustainable Development Goal 3.7.*

Bodily autonomy is a basic human right. FPAA regard universal access to reproductive healthcare as fundamental to bodily autonomy; enabling all people to make reproductive choices and decisions without geographical, social, cultural, legal, religious, economic or political barriers. Enabling universal access to reproductive healthcare has the profound capacity to improve:

- Community health and well-being
- Community cultures of inclusion and safety
- Workforce participation, economic output and strengthened economy

Prioritisation of universal access to reproductive healthcare, including contraception and abortion, is particularly pertinent during the current economic climate, and with communities continuing to experience the health, social and economic impacts of the COVID-19 pandemic and associated restrictions[1-4].

Universal access requires the Federal and State governments' commitment to recognise:

- Contraception and abortion as essential health care for all.
- Contraception and abortion as essential preventive health measures and services that must be appropriately funded.
- The intersecting structural barriers to safe, inclusive reproductive healthcare that are underpinned by pervasive gender inequity. Some of the key systemic barriers relate to geographic location[5-8]; country of origin, citizenship, length of residency or visa[9-11]; gender, sex characteristics or sexual identity[12]; ability/disability; occupation; socioeconomic status[8]; and English and health literacy.

Federal government policy and funding actions to meet the goal of universal access need to be fundamentally guided by reproductive justice so that women and people with a uterus have: (1) the right to have a child; (2) the right to not have a child; and (3) the right to parent a child/children in a safe and healthy environment. This means that throughout a person's lifespan, they are empowered to make decisions about their body, sexuality, sexual health and reproduction without socio-cultural, economic, legal or political barriers. This includes a person's unimpeded access, if and when needed, to safe and inclusive:

- Health education and comprehensive relationships and sexuality education
- Period products, information and support; including early management of period pain and diagnosis and management of endometriosis
- Gender affirming care
- Contraception
- Abortion care and support
- Pre-natal, peri-natal and post-natal care and support
- Infertility and miscarriage care and support
- Menopause care and support
- Health, educational, work and community environments that accommodate, without bias, needs associated with the above.

FPAA recommendations

Universal access to reproductive healthcare is essential. The FPAA support this important Inquiry with a series of recommendations that are summarised below and discussed in further detail throughout this submission.

1. **Establish a national taskforce** to develop and monitor a comprehensive plan to deliver the National Women's Health Strategy's commitment to universal access to sexual and reproductive health care. This national taskforce must include representation from all States and Territories, and consultation with service providers and people with lived experience across metropolitan, regional, rural and remote locations. This taskforce should be inclusive of Aboriginal and Torres Strait Islander people, people with disability, migrant and refugee communities and gender and sexually diverse people. A comprehensive plan with specific and achievable targets is essential for progress, accountability and visibility that instills confidence among the community and health workforce.

2. **Ensure *affordability* of reproductive health services, including abortion and contraception:**
   - Contraception (including long acting reversible contraceptives; LARC) free of cost to all people under the age of 25.
   - Abortion services free of cost to all individuals.
   - Comprehensive review of Medicare items and rebates, and PBS coverage for contraception.

3. **Ensure *availability* of essential reproductive services**
   - Appropriate remuneration and reimbursement for GPs providing LARC and medical abortion care.
   - Appropriate remuneration and reimbursement for nurse-led contraceptive and medical abortion care.
   - Amendment to the medical abortion Risk Management Plan and regulatory reforms for medical abortion medications that will improve abortion access and equity.
   - Streamlining TGA approval processes to enable a broader choice of contraceptive options.
   - Greater inclusion of reproductive healthcare in pre-service medical education.
   - Strong investment in reproductive health training for the current health workforce.
   - A focus on workplace retention strategies; particularly in regional and remote locations.

4. **Ensure *safety and equity of access* to reproductive services**
   - Harmonisation of abortion laws across Australia.
   - Medicare funding for telehealth delivery of medical abortion.
   - Funding for fly-in fly-out abortion and LARC services for regional and remote communities.
   - Review of Medicare rebates and item numbers for transgender and gender diverse people.
   - Further funding for comprehensive sexuality education in-schools and community settings to improve sexual health literacy.
   - Further funding for clinical guidelines and professional development opportunities in providing safe, inclusive and culturally appropriate reproductive healthcare.
   - Comprehensive review and public consultation on the introduction of reproductive health leave.

FPAA response to Senate inquiry Terms of Reference (ToR)

This section is framed in direct response to the Committee Terms of Reference.

Barriers to achieving priorities under the National Women's Health Strategy for 'universal access to sexual and reproductive health information, treatment and services that offer options to women to empower choice and control in decision-making about their bodies', with particular reference to:

a. cost and accessibility of contraceptives, including:
- **i. Pharmaceutical Benefit Scheme (PBS) coverage and Therapeutic Goods Administration (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;**

Barriers

- TGA processes are lengthy and expensive. This significantly delays community access to new contraceptive options. For example, the 12-month vaginal ring and desogestral mini pill are readily available in parts of Europe Asia and US. The desogestrel mini pill has low-cost generic versions that are available world-wide. However, it is not accessible within Australia.
- Australia has a low uptake of LARCs compared to other countries[13-15]. The cost of LARCs are prohibitive for many people[8], particularly those without Medicare access. Lower cost versions of Mirena IUD are available in other countries, but not within Australia. In addition, Mirena IUDs are licensed for 5 years in Australia, compared to 8 years in the US[16], creating increased cost for Australian consumers.
- Health providers are not adequately remunerated and reimbursed for LARC procedures and are out of pocket when providing bulk-billed services. This is not sustainable.
- Nurses, midwives and nurse practitioners are not funded by Medicare to provide and/or support contraceptive services despite having capacity to do so.

Enablers

- Enable a more comprehensive and affordable **choice** of effective contraceptive options in Australia by:
  - Streamlining TGA approval processes for new contraceptives.
  - Increasing PBS coverage to include the new progestogen-only pill with 24-hour window and copper IUD (including copper IUD use as emergency contraception).
- Enable community **access** to safe and reliable contraceptive options by:
  - Providing contraception (incl. LARC procedures) free of cost to all people under the age of 25.
  - Increasing Medicare rebates for LARC procedures and equipment across the board.
  - Approving Medicare funding for nurse-led services and support.
  - Approving lower-cost generic versions of Levonorgestrel-releasing IUDs.
  - Enabling pharmacists to prescribe oral contraceptives within a framework supported by doctors and nurse practitioners.
- Draw on evidence regarding safety and efficacy of extended scripts of the oral contraceptive pill for people without contraindications; and educate practitioners that people without contraindications can be prescribed the oral contraceptive pill or vaginal ring without need to review for 12 months.
- Invest more resources into LARC accessibility rather than emergency contraceptive pills. LARC has a much higher efficacy rate in preventing pregnancy at a community level than emergency contraception.

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

Access to termination of pregnancy should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation[17].

The inequities in reproductive healthcare access, particularly in regional, rural and remote areas, are well recognised. Access to abortion services, in particular, is described by medical professionals as "A huge lottery" and reliant on local champions. In Australia, around one quarter of all pregnancies are unplanned, and one-third of these pregnancies end in abortion.[18] Unplanned pregnancy occurs more frequently in non-urban areas[19], yet access to abortion services in regional, rural and remote Australia is disproportionately limited by fewer abortion providers and longer distances required to access services[20].

Unintended pregnancies are correlated with a range of negative physical and mental health, economic and social outcomes[21]. When an abortion is sought but denied, individuals are more likely to experience ill health, psychological stress, poverty and negative impacts on development of existing children[22].

Abortion is a time-critical procedure that increases in complexity and risk with gestation[23]. Despite this, abortion access in Australia is limited and inequitable, with many individuals facing significant and intersecting financial, social, geographical and health provider hurdles to access necessary information, support and medical care[24]. Addressing these barriers to abortion care is critical in enabling universal access.

Barriers

- Legal: people around Australia are currently unable to access the same abortion care, rights, or education due to State-based legislative variations that determine the settings and circumstances by which abortion can be performed, and the information that is required to be recorded. These legislative variations are inequitable and confusing, making access to abortion services more difficult and daunting.
- Medical:
  - An ultrasound prior to medical abortion is mandated by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and recommended in TGA-approved MS 2-Step abortion medication product information[25]. This requirement was removed during the COVID pandemic and is not an essential prerequisite in many international guidelines[25]. Ultrasound requirements can delay or prohibit access to a medical abortion due to out-of-pocket costs or difficulties accessing a service, particularly in regional and remote locations.
  - In Australia, a gestational limit of 63 days is applied to use of MS 2-Step, despite its known safety and efficacy of up to 70 days gestation, and approval for use up to 70 days gestation in the US and UK[25].
- Workforce:
  - Low number of abortion providers in Australian primary care and hospital settings; and disproportionately low numbers in regional, rural and remote locations.
  - Low proportion of pharmacists dispensing abortion medication.
  - Very limited inclusion of abortion in undergraduate and postgraduate medical training; resulting in a large proportion of doctors not being competent or confident in providing abortion care[24].
  - Existing models of nurse and midwife led care do not include authority to provide abortion medication.
  - Absence of reliable and accurate national abortion data; limiting workforce planning.
  - Professional stigma and conscientious objection: an Australian study estimated 15% of health professionals conscientiously object to abortion[26] and therefore do not offer it to patients.

- Financial: limited availability of publicly funded abortion services, particularly in regional and remote locations, and significant out-of-pocket costs for private care[24].
- Geographical: lack of abortion services within reasonable geographical proximity necessitates longer-distance travel and can delay or prohibit abortion access.
- Service accessibility: limited supports available to facilitate abortion access for those with additional needs, e.g., relating to low English literacy, restricted mobility or young age.
- Religious barriers: reluctance of faith-based hospitals to provide abortions unless medically indicated.
- Social barriers: stigma and prejudice associated with abortion that can inhibit individuals from seeking care; and deter health professionals from seeking training to provide abortions[24].

Enablers

Access to abortion can be facilitated through the following actions:

- Legal: harmonisation of abortion laws across Australia to create service and access consistency and transparency for healthcare providers and consumers of reproductive health care. We applaud recent discussions between State/Territory Ministers for Women regarding a national approach to abortion law.
- Medical: amending risk management plans and regulatory reforms for medical abortion medications to improve access to abortion services. This includes:
  - TGA approval to extend MS-2 Step use from 63 to 70 days gestation, in line with international practice[25].
  - Review of RANZCOG requirements for ultrasound prior to medical abortions, such that people experiencing significant barriers can proceed without ultrasound unless clinically indicated[25].
- Workforce: refer to item C below.
- Financial: free-of-cost abortion services for all individuals, including those without Medicare access, via primary care and public hospitals. Pregnancy miscarriage care is free of cost via public hospitals; abortion care needs to be the same.
- Faith-based hospitals that receive public funding must be expected to provide a full suite of sexual and reproductive services, including abortion.
- Geographical:
  - Medicare-funded telehealth delivery of medical abortion services.
  - Fly-in fly-out services for regional and remote communities.
- Service awareness and accessibility:
  - Funding abortion information and support services, such as 1800 My Options in Victoria and the Pregnancy Choices helpline and website in NSW, Australia-wide.
  - A 24-hour government funded national help line for those undergoing medical abortion.
  - Progressing with plans to remove requirements for pharmacists to undertake additional training and registration to dispense MS-2 Step.

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;

Barriers

The workforce-related barriers to timely, inclusive and high-quality reproductive care are described in the sections above. Reproductive health services are well-recognised to be under-resourced and fragmented, particularly in regional, rural and remote Australia. This under-resourcing perpetuates access inequities, increases risks to patient safety, and feeds back into the exhaustion experienced by health professionals.

Enablers

Critical services including abortion and contraceptive care can be safely provided by a range of health care practitioners. However, significant investment is needed in capacity building for both pre-service and active health professionals. We propose the following recommendations for building and retaining a strong multidisciplinary reproductive healthcare workforce:

- Increasing the scope of practice for nurse practitioners, nurses and midwives; and recognising this through Medicare funding. This will require standardised, evidence- and competency-based reproductive health training across all pre-registration nursing and midwifery courses, equipping nurses to support and provide reproductive health services including abortion and contraception.
- Investment in pre-service medical education through greater inclusion of reproductive health in undergraduate degrees and postgraduate training programs, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology. Education providers may benefit from partnering with community-based providers of reproductive health care in addition to hospitals.
- Investment in clinical guidelines and medical publications that normalise abortion as health care and reduce abortion stigma. Abortion continues to be framed in medical education as an ethical issue.
- Investment in subsidised education pathways accredited by reproductive health peak bodies to upskill the current health workforce.
- RACGP development of a GP sub-specialty in sexual and reproductive health that recognises specialist skills developed by doctors undertaking the FPAA Sexual and Reproductive Health Certificate.
- Greater collaboration between hospital gynaecology departments and FPAA agencies to minimise wait times for critical services.
- Financial incentive for primary care practitioners to provide LARC services, to address long wait times in some areas for services such as IUD or Implanon insertions. Current Medicare rebates do not sufficiently cover the costs associated with LARC services and equipment, and some health service providers are out of pocket when providing bulk-billed services for clients in need.
- Greater financial incentive, training opportunities and workplace flexibility options to address challenges of healthcare recruitment and retention in regional, rural and remote locations.
- Establish specific Medicare numbers for abortion care, to enable accurate tracking of services provided, and workforce planning.

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

Barriers

Best practice models address the systemic barriers to healthcare access. Barriers include the prohibitive costs of healthcare, restrictions on access to Medicare, lack of services provided in languages other than English, and lack of culturally safe and appropriate services.

Enablers

A best practice approach to reproductive healthcare is culturally responsive, inclusive, safe and accessible for at-risk and marginalised communities. This includes:

- Medicare access for all individuals.
- Using a critical intersectional lens to identify and address barriers to reproductive healthcare access. The following questions need to be asked: Are people able to navigate and access our health care systems? Do they feel safe accessing services? Are they informed and empowered to make choices for their health without coercion, judgement or shame?
- Bringing culturally appropriate reproductive health care into mainstream programs by collaborating with migrant and refugee women's organisations to develop best practice guidelines for culturally responsive service delivery. This must include cohesive models of collaboration between primary and secondary care to facilitate a safe, supported care pathways.

- Sustainable funding for refugee and migrant women's reproductive health programs, in recognition that 51.5% of Australia's population have migrated or sought refuge from another country.
- Ongoing investment to support and develop a professionally recognised and appropriately remunerated bilingual, bicultural health workforce to meet the needs of our multicultural Australian population.
- Further engagement with Aboriginal and Torres Strait Islander communities to establish sustainable culturally appropriate and safe healthcare models that facilitate access.
- Prioritisation of workforce retention initiatives, particularly in regional and remote locations, to enable longer-term therapeutic relationships to be established between healthcare providers and Aboriginal and Torres Strait Islander communities.
- Inclusion of cultural sensitivity training in undergraduate, postgraduate and current workforce education programs; to actively address pervasive stigma and shame associated with reproductive health services.

e. sexual and reproductive health literacy;

Sexual and reproductive health literacy begins in early childhood and continues throughout the lifespan. Comprehensive sexuality education (CSE) provided through schools, community and families offers a foundation from which young people develop sexual and reproductive health literacy.

Barriers

The Australian Curriculum includes components of CSE; however, these guidelines are ambiguous, open to interpretation and omit key topics. Australian research shows that young people perceive school based CSE as valuable; however the inclusion, quality and relevance of CSE teaching is inconsistent. This may be attributed in part to lack of specific CSE guidelines within Curriculum. Other contributing factors include teacher skills and confidence to teach CSE, absence of school policies and a non-supportive school culture.

Enablers

FPAA advocate for the inclusion of CSE within the Australian Curriculum and community-based educational programs, based on the following principles[27]:

- Explicit and specific inclusion of CSE across the Australian Curriculum from F-12 supports young people to develop the life-long knowledge, skills and attitudes needed to experience positive, respectful and healthy relationships and optimal reproductive health.
- CSE should be accessible to all young people irrespective of their age, ability, socio-cultural context and/or engagement with mainstream schooling; including young people with disability, and those disengaged from mainstream schooling. Parallel community based CSE programs are vital, to ensure young people outside of mainstream schooling are afforded the same opportunities for learning and support.
- High quality professional development programs for school leaders, teachers, health and welfare professionals are critical, to ensure they are equipped with the knowledge, skills and confidence to provide CSE in accurate, responsive and supportive ways both in and out of the classroom.
- CSE training should be included in all pre-service teacher tertiary education.
- Government funding is essential to enable effective integration, implementation and evaluation of CSE within schools and the broader community.

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

The inclusion, safety and protection of human rights of people with disability is fundamental to any strategies designed to enable universal access to reproductive healthcare.

> *YWGwD [young women, girls, feminine identifying and non-binary people with disability] across Australia and the world face severe barriers to fulfilling their sexual and reproductive health and rights (SRHR).[11] SRHR encompass the ability to make free and informed choices about ones' own body, sexual and reproductive health, intimate relationships, and parenting.[12] This includes the right to sexual pleasure, expression of sexual identity, association, equity, privacy, freedom, autonomy and self determination*
> - Women With Disabilities Australia, 2022, p.15[28].

Barriers

People with disability experience severely restricted access to safe, inclusive, accessible reproductive health care due to numerous systemic barriers including:

- Medical ableism and dominance of the medical model that positions disability as a deficit that need to be fixed, and a justification for restriction or denial of human rights[28]. Women with Disabilities in Australia's recently released report revealed that most young women and girls do not make their own decisions about menstruation and contraception. Parents, guardians and doctors are making these decisions on behalf of women with disability, with no strategies in place to improve their understanding of their reproductive choices and rights[28].
- Insufficient reproductive health information, resources and services that meet the needs of people with disability and enable them to make informed choices about their health and wellbeing.
- Lack of health professional skills in providing safe, inclusive care for people with disability, including communicating with people with cognitive and intellectual disability.
- Difficulties associated with having a carer or family member assist with help seeking, making decisions, and/or having assessments or procedures that are sensitive in nature.
- Prohibitive out of pocket costs for reproductive health services.

Enablers

- Investment in disability-inclusive reproductive health education in undergraduate and postgraduate training, including medicine, general practice, nursing, midwifery, obstetrics and gynaecology.
- Investment in clinical guidelines and professional development on safe, inclusive care for people with disability, including legal aspects of care, human rights approaches and supported decision making.
- Development of a national strategy in consultation with people with disability to improve access to safe, inclusive and comprehensive reproductive healthcare and information.

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

Transgender and gender diverse (TGD) people report great difficulty accessing safe, supportive, quality care from clinicians, and long wait times for gender affirming hormone therapy. In the *Australian Trans and Gender Diverse Sexual Health Survey,* 56% of participants described their access to medical gender affirming care as 'OK', 'poor' or 'non-existent'[29].

Barriers

- Stigma and prejudice within medical professions. In the Australian *TRANScending Discrimination in Health and Cancer Care* survey, 69% of TGD respondents had not sought medical care due to

inability to find a doctor they are comfortable with; and 1 in 5 had been refused general healthcare[30].

- Lack of professional training in TGD reproductive healthcare. Australia is experiencing an exponential demand for TGD healthcare across primary and specialty services, and capacity building is urgently needed[29-32].
- Prohibitive costs of reproductive care, including hormonal and surgical gender affirming care, fertility preservation, contraception and abortion.

Enablers

- Inclusion of gender-neutral Medicare item numbers to increase access to reproductive health services.
- Publicly funded reproductive health services, including contraception, abortion and gender affirmation.
- Appropriate use of gender language in government and medical policy and resources.
- Inclusion of gender diversity in all levels of health care education, enabling healthcare providers to develop competency and confidence to provide safe, inclusive and unbiased care.
- Investment in gender-inclusive clinical guidelines and resources for health professionals that normalise gender diversity and provide guidance on inclusive care.

h. availability of reproductive health leave for employees

It is increasingly recognised that women and people with uteruses wear disproportionate costs of reproduction. Reproductive health-related needs, in most circumstances, do not reflect illness that justifies use of allocated personal leave. Menstruation, contraceptive care, fertility care, pregnancy, miscarriage, abortion and post-natal care are a part of daily living for many women and people with a uterus and are highly valuable for our community. However, the burden of reproduction and its impact on workforce participation is largely unrecognised in health and workplace policies. Lack of access to paid leave for reproductive health increases the already high cost of care.

FPAA supports the view that reproductive health leave has the capacity to improve women's well-being and address barriers to workforce participation. We recommend that the federal government:

- 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's engagement in the workforce
- Undertake a public consultation on reproductive health leave to establish community interest and support.

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