



CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

New National Women's Health Policy Development

Submission
November 2009

About Children by Choice Association Inc:

Children by Choice provides counselling, information and education services on all options with an unplanned pregnancy, including abortion, adoption and parenting. We provide a Queensland-wide counselling, information and referral service to women experiencing unplanned pregnancy, deliver sexual and reproductive health education sessions in schools, and offer training for GPs and other health professionals on unplanned pregnancy options. Through our active volunteer base, we campaign for the removal of abortion provisions from the Criminal Code of Queensland, and many reproductive health issues such as paid maternity leave.

Children by Choice supports women's access to all options with an unplanned pregnancy, including abortion, and have been involved in helping women access these options since the service began operation in 1972. Children by Choice is the only independent, not-for-profit women's service dedicated to unplanned pregnancy in Australia. Children by Choice is recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to access to reproductive health services with regard to unplanned pregnancy.

Our vision: all women can freely determine their sexual and reproductive health choices.

Key values that underpin our work are:

- pro choice and woman centred
- ethical and evidence based
- non-judgemental and unbiased
- confidential and respectful
- commitment to social justice, diversity and equity, and
- the right to self determination.

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Introduction

Children by Choice welcomes the Commonwealth Government's commitment to promoting health equity among women, and believes a new National Women's Health Policy could be an important step in addressing imbalances. We congratulate the Commonwealth Government on its commitment to developing this policy, and also endorse the recognition of the social determinants of health and the inclusion of this approach in the policy development.

As a member of the WomenSpeak Alliance we have endorsed that submission to this consultation and all the recommendations contained therein. We also acknowledge the Australian Women's Health Network Aboriginal and Torres Strait Islander Women's Talking Circle submission as a key document to inform this policy's development.

Our submission to this policy is based in our specialist field of sexual and reproductive health, in particular unplanned pregnancy and pregnancy options.

This submission is underpinned by the United Nations definition of health as “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”.¹ In addition to this underlying definition of health, our submission is also guided by the definition of sexuality and sexual rights, being that “*The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences*”²

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

² O'Rourke, 2008. Sexual and Reproductive Health Strategy Reference Group, Time for a national sexual and reproductive health strategy for Australia.

Executive Summary and Recommendations

Executive Summary

Children by Choice draws the attention of policy makers to the inequalities experienced by women in the area of Sexual and Reproductive Health, which is the core focus of our submission. Sexual and reproductive health is widely recognised as a major priority area for improving women's health around the world.

Mode of Delivery – A policy which embraces the principles of community development

The formulation, implementation evaluation and review of the National Women's Health Policy needs to allow for community representation, engagement and participation. Various government sectors – including health, housing, education, social welfare and justice – need to work together to address the underlying social determinants of women's health. The Department of Health and Ageing has a central role in making this happen.

Recommendation 1 : The National Women's Health Policy must be adequately resourced and monitored to ensure women are comprehensively engaged in policy development, decision making, and management of all strategies and service delivery directed towards improving women's health including the social determinants of health.

Equity between States and across Australia – A policy which creates equal access to abortion

One of the key gender inequities in sexual and reproductive health is the access of Australian women to abortion. While states such as South Australia and Victoria have a sound legislative framework and service provision within the public hospital system, Queensland and New South Wales retain abortion provisions within the Criminal Codes. All Australian women have the right to access a safe and legal abortion, not determined by where they happen to live. Australian women are also entitled to equity with their international counterparts. The limitations and restrictions imposed against RU486, or mifepristone, mean that medical abortion in Australia is performed using Misoprostol. This is despite the fact that RU486 is considered best practice in medical abortion and has been listed as an essential medicine for developing countries by the World Health Organisation.

Recommendation 2 : The National Women's Health Policy must facilitate the removal of abortion from the criminal codes of all remaining States and Territories.

Recommendation 3 : We recommend the Federal Government liaise with states and territories to increase access to RU486 for all Australian women. We recommend that the Australian Government support applications by pharmaceutical companies to distribute RU486, which would greatly improve women's access to the drug.

Equity between groups of women – A policy which builds culturally appropriate practice

Some groups of women are particularly vulnerable to poor health outcomes. Rather than decreasing, health inequalities between women continue to increase. Women require access to relevant, timely and clear information to take responsibility for the maintenance and improvement of their health, to prevent specific health problems and to seek the most appropriate treatment when necessary. There is a need for special strategies for women who experience difficulty in accessing health information due to language barriers, culture, age, disability or isolation.³ It is important that health service delivery for women is directed towards and/or inclusive of at risk groups.

Recommendation 4 : The National Women's Health Policy must inform, promote and provide frameworks which require the commitment of all generalist and specialist health services to culturally appropriate practices which recognise the woman as the expert in her own life.

³ <http://www.womhealth.org.au>

Equity regardless of geography – A policy which supports equal health outcomes for rural and remote women

Rural women are at a direct disadvantage concerning access to health services compared to urban women. Service access can often require significant travel, and rural women have more difficulty accessing contraception, emergency contraception, ante-natal care, termination of pregnancy and assisted reproductive technologies. In reproductive health, particular concern about privacy is expressed by rural women, particularly young women.

Recommendation 5 : The National Women’s Health Policy should support well resourced women’s centres on the ground and regional provision of ante-natal and termination services. Local services should be assisted by the extended provision role of nurses, specialist fly in/fly out services and telephone based services. Specialist women’s health services provided across great distances must be supported by local health centres, with well resourced physical premises and well trained staff, responsive to the needs of indigenous Australians. Funding for travel is a necessary, budgeted inclusion in health service delivery.

Prevention through education – a policy which supports young women to be well informed and educated concerning their reproductive and sexual health

Sexual & Reproductive Health Sexuality education is defined as the life-long process of acquiring information and forming attitudes, beliefs and values about feelings, relationships, gender roles, body image, sexual development and reproductive health (Sexuality Information and Education Council of the United States (SEICUS)).⁴ Sexuality education can facilitate the capacity of individuals to make informed, safe and healthy decisions in accordance with personal beliefs and values as well as develop respect for the diversity that exists in our community (Blake, 2002).⁵

Children by Choice recognises the importance of sexual & reproductive health for all women but in particular those from disadvantaged groups and young people. There is currently no national sexual and reproductive health curriculum yet providing adolescents with age-appropriate sexual and reproductive health information empowers them to make responsible decisions regarding sexuality, thereby reducing the number of unintended pregnancies and STI incidence.

We recommend the introduction of a comprehensive and evidence-based National Sexual and Reproductive Health strategy to work in conjunction with the new National Women’s and Men’s Health policies.

Recommendation 6 : The new National Women’s Policy should support the introduction of a nationally mandated sexual and reproductive health curriculum which is respectful of differences and recognises the human right of all people to safe and respectful relationships. This National Sexuality Education curriculum must be comprehensive, evidence based, age appropriate and mandated, ensuring that no young Australian is excluded.

⁴ SEICUS. Comprehensive Sexuality Education. Retrieved on 6th March, 2009 from <http://www.siecus.org/index.cfm?fuseaction=Page.viewPage&pageId=515&grandparentID=477&parentID=514>

⁵ Blake, S. (2002). *Sex and relationships education. A step-by-step guide for teachers.* London: David Fulton Publishers Ltd.

Women are safe – a policy which ensures women are safe and able to achieve good health outcomes

Pregnancy is a time of increased risk of domestic violence. Children by Choice believes that all government policy should aspire to stopping violence against women, not merely to reducing violence.

Recommendation 7 : The National Women’s Health Policy should support community solutions, developed with both men and women, to stop violence against women.

Recommendation 8 : Every woman in every Australian community must be able to access a woman safe space. While this policy should work towards all women being safe in their homes and in public, at night and during the day, the need for refuge must be recognised in policy and well resourced in practice.

Building shared knowledge - A policy which supports informed decisions on sound evidence

The social determinants of health approach recognises that many underlying factors, such as housing, employment, education contribute to health outcomes. The Federal Government must work collaboratively across the three tiers of government to ensure that policy, programs and resourcing with the potential to influence underlying causes of health outcomes are analysed by gender.

Recommendation 9 : The National Women’s Health Policy should emphasise the importance of gender analysis tools in the development of all government policy and procedure from portfolios other than health, as well as within the Department of Health and Ageing, to ensure that underlying factors impacting on health are also addressed to produce improved health outcomes for women.

There is no minimum data collection on key sexual and reproductive health issues.

Recommendation 10 : The National Women’s Health Policy should provide for the gender disaggregation of comprehensive statistics on health and welfare, not only between men and women, but between groups of women and groups of men, to allow for analysis of the effectiveness of health policies for women, and identify further areas of need.

Recommendation 11 : A National Sexual and Reproductive Health strategy needs to be introduced and work in conjunction with the new National Women’s and Men’s Health policies. Any sexual and reproductive health strategy should include strategies that address health system delivery of, safe and legal pregnancy termination services in Australia to ensure all women have timely access to services when/if required.

Nature of “evidence” – a policy which recognises diverse experiences and local knowledge

Many communities already have strong client focussed service delivery or have undertaken successful pilot projects which then weren’t funded by government or funding bodies. The evidence from specific community work needs to be collected and social innovation rewarded.

Recommendation 12 : The National Women’s Health Policy should collect stories and examples operating successfully in communities, and not just consider academically researched evidence. The policy should foster collection, collaboration and comparison of both centralised academic and local case study evidence.

Right to independent and sound evidence for decisions - A policy which ensures the provision of appropriate and accessible health information

We recommend that the National Women's Health Policy should support the adoption of standards that protect women from misleading information and promote the rights of individual women to choose what type of service they contact, without barriers and deception.

Recommendation 13 : The National Women's Health Policy should support the adoption of standards that protect women from misleading and false advertising by pregnancy counselling agencies, and promote the rights of individuals to choose what type of service they contact, without barriers and deception.

Healthy lives – a policy which addresses sexual and reproductive health needs across the life cycle

Young women face both education and access barriers in managing their sexual and reproductive health, from a very young age, particularly the risk of unplanned pregnancy.

Recommendation 14 : The National Women's Health Policy should support a National sex education curriculum approach that includes earlier initiatives to address this risk. Youth specific sexual and reproductive health services should be easily accessible in the wide range of communities around Australia. (Note: In the United Kingdom, services that require young people to travel more than 5 miles are regarded as inaccessible.)

Women from puberty to menopause face the possibility of unplanned pregnancy. They also are responsible, to a significant degree more than men, for child-rearing and carer roles. These responsibilities greatly impact on the ability of women to enjoy economic prosperity and limit their capacity to fund their health requirements.

Recommendation 15 : The National Women's Health Policy should ensure that Medicare and the PBS system recognise the lifecourse needs of women and that women have a reduced capacity compared to men to fund their health requirements. We recommend that the Federal Government increases Medicare support for women seeking pregnancy termination, including increasing the Scheduled Fee and Benefit for item number 35643 by 100%. Pregnancy termination must be available at low or no cost for financially disadvantaged women.

These recommendations are discussed more fully in our submission, and informed by the evidence based data we provide in the following snapshot.

The Sexual and Reproductive Health of Australian Women

In Australia, where the overall population is among the healthiest in the world, we have unacceptably high levels of sexual and reproductive ill health⁶. This section provides a snap shot of the Sexual and Reproductive Health of Australia women and the key issues in this area of women's health, to be addressed in the new National Women's Health Policy.

Sexual activity

The age at which sexual activity commences has decreased significantly over the past 50 years⁷. Recent research of students across Australia in Years 10 and 12 shows the majority – 78% - have experienced some form of sexual activity⁸. Over one quarter of year 10 students and just over half of year 12 students had experienced sexual intercourse, with 40% of all students surveyed reporting having sexual intercourse. This showed an increase from the 2002 survey, which found 35% of students reported having sexual intercourse⁹. The Australian Study of Health and Relationships in 2003 stressed that statistics showing the majority of students in their final years of schooling have commenced sexual activity, demonstrates the importance of sexuality education in schools¹⁰.

Sexual activity during adolescence puts adolescents at risk of sexual and reproductive health problems. These include early pregnancy (intended or otherwise), unsafe abortion, sexually transmitted infections (STIs) including HIV, and sexual coercion and violence. In addition, in some cultures, girls face genital mutilation and its consequences. Many sexually active adolescents lack the knowledge needed to avoid STIs and unintended pregnancies. Almost universally, they lack timely access to health-care products (such as condoms and other contraceptives) that they need to protect themselves or to the health-care services they need when they need assistance. Even if they have access to condoms, girls and young women are often unable to negotiate their use with their partners.¹¹

Unplanned Pregnancy

It is estimated that there are almost 200 000 unplanned pregnancies in Australia every year. Unplanned pregnancies occur for a wide variety of individual, social and political reasons. Some of these include:

- misinformation (such as you can't get pregnant the first time you have sex);
- embarrassment of buying contraception (particularly in small towns);
- self esteem issues (lacking confidence to negotiate for safe sex);
- having sex while using drugs or alcohol (reduced judgment and capacity to make safe decisions);
- lack of communication or support within the relationship;
- sexual violence;
- lack of access to contraception due to insufficient sexual and reproductive health education, high cost, unsupportive doctors, religious beliefs and limited knowledge around contraception.

While teenage pregnancy rates in Australia are of concern, unplanned and unwanted pregnancy occurs more frequently in women aged 20–29. It is also important to remember that no contraception method is 100% effective. While some methods may technically be 98-99% effective, the effectiveness of any method is reduced when allowing for human error. Abstinence is usually not a realistic contraception option for most people across their entire life cycle.

About 25% of women find decision making regarding an unplanned pregnancy a straightforward process. Others experience this decision as a difficult choice, raising issues from their past and having the potential to greatly impact their life. Children by Choice assists almost 3000 Queensland women with their concerns each year, ranging from simple information to extensive decision making counselling.

⁶ O'Rourke, 2008. Sexual and Reproductive Health Strategy Reference Group, Time for a national sexual and reproductive health strategy for Australia.

⁷ Smith A, Rissel C, Richters J, Grulich A. 2003. *Australian Study of Health and Relationships*: Australian Research Centre in Sex, Health and Society, La Trobe University.

⁸ Smith A, Agius P, Mitchell A, Barrett C, Pitts M. 2009. *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

⁹ Ibid

¹⁰ Smith A, Rissel C, Richters J, Grulich A. 2003. *Australian Study of Health and Relationships*: Australian Research Centre in Sex, Health and Society, La Trobe University.

¹¹ Implementing the global reproductive health strategy , sexual and reproductive health of adolescents”, www.who.int/reproductive-health www.who.int/child-adolescent-health© World Health Organization, 2006

Abortion

Abortion rates in Australia have fallen and stabilised but are still higher than other comparable OECD countries. The abortion rate in Australia is about 19.7 per 1000 women aged 15-44. Abortion is treated differently in each state and territory in Australia. This has significant outcomes in regards to: cost, access, availability, experience, training of health professionals and accurate statistics.

Accurate data regarding the numbers of abortions in Australia is patchy at best. It is estimated that half of unplanned pregnancies will result in a termination. The following information based on Medicare users and indicates the number of abortions performed in the financial year July 2005 to June 2006¹². Medicare statistics do not include abortions performed in public hospitals, nor do they provide accurate figures on abortion rates for Australia.

Estimates of Terminations of Pregnancy carried out from July 2005 to June 2006

Age Range	NSW/ACT	VIC/TAS	QLD	SA/NT*	WA^	TOTAL
0-19	4183	2117	2261	953	1487	11001
20-24	6853	4081	3496	1434	2263	18127
25-34	11 807	7162	5678	2149	2765	29561
>=35	6852	4637	2920	1169	1313	16891
Unknown	0	1	0	0	0	1
TOTAL	29 695	17 998	14 355	5705	7828	75 581

* SA/NT figures are sourced from Government of South Australia's Pregnancy outcome 2005 and added to NT Medicare figures.

^ WA figures sourced from Department of Health – Government of Western Australia

Approximately 25.9% of all pregnancies are terminated every year in Australia¹³. It has been estimated that almost one third of Australian women will experience an abortion in their lifetime. Studies of Australian and New Zealand women considering abortion have shown that between 40% and 66% women had been using contraception prior to becoming pregnant. Reasons women why women choose abortion can be complex. Issues include financial concerns, relationship problems with the man involved, coping with single parenthood and violence.

A small percentage of women will terminate a pregnancy due to diagnosis of a severe foetal abnormality. Women experiencing a difficult diagnosis may require additional mental and emotional support from health professionals, counselling agencies and peer support.

The provision of abortion services has been left to the private health sector in most Australian states with little involvement from the public health sector (Vic and SA exception). This has led to unaffordable and inaccessible services for women living in rural and regional areas and for women on low and no incomes.

While more focus is required on services to support women and men to reduce unplanned and unwanted pregnancy, it must be accepted that unwanted pregnancy and abortion will remain a reality for women. Australian law, health policy and service delivery needs to recognise and include access to abortion in any women's health strategies.

¹² Health Commission. Medicare Item No. <http://www.hic.gov.au> (<http://www.hic.gov.au>).

¹³ www.mja.com.au/public/issues/182_09_020505/cha10829_fm.html

Teenage pregnancy

Research shows that around 90% of pregnancies for young women aged 15 to 19 years old are unintended. More than half of these unplanned pregnancies will end in a termination. There is currently no accurate national or Queensland specific data on termination rates, therefore numbers are misrepresentative. Medicare data shows that Australia wide there are approximately 11 000 rebates for gynaecological procedures for young women under 19 years of age each year. It is estimated that the vast majority of these were for termination of pregnancy.

A small but nonetheless significant proportion (5%) of surveyed sexually active students report that they had experienced sex that resulted in pregnancy¹⁴. Students in year 10 (8%) were more likely than those in year 12 (2%) to report having sex that resulted in pregnancy. Students also expressed a degree of uncertainty regarding pregnancy, with 4% of sexually active students unsure if they had had sex that resulted in pregnancy¹⁵.

A different study showed that the number of women who experienced their first pregnancy as a teenager has declined in the last 50 years from 22.8% to 16.9%¹⁶. Whilst this rate has declined, it is higher than many developed nations.

Contraception

The reality is that no contraception is 100% effective and contraception can fail when not used accurately, when used with other prescribed medications, or if not used every time penetrative vaginal intercourse occurs. Many unplanned pregnancies are thought to occur due to contraceptive method failure or inconsistent method use. Even when used correctly and consistently, all contraceptive methods can fail.

Many women may not be in a position to negotiate contraceptive use, due to the effects of alcohol or other drugs, lack of power in relationship decision-making, or being forced or coerced into having sex. Other barriers to women accessing contraception include lack of information about options, geographic location (particularly women living in rural areas), cost, privacy concerns, or medical practitioners refusing to prescribe due to their *personal* beliefs and values.

Condoms are the contraceptive most commonly used by teenagers, however, like all contraception; condoms can fail, resulting in pregnancies in between 2-15 per 100 women per year. Condoms often fail because they are not used correctly, e.g. incorrect application or removal, or not used in assistance with lubricant, resulting in the condom splitting. Research shows that condom use among high school students has remained stable between 2002 and 2008 surveys.

In 2008 most students (69%) reported using a condom the last time they had sex and half the sample of sexually active students always used a condom when they had sex in the previous year. A considerable proportion (43%) of sexually active students reported they only used condoms sometimes when they had sex, and a small (7%) but nonetheless notable proportion never used condoms when they had sex in the previous year¹⁷.

The same study also reported that students who reported three or more sexual partners were significantly less likely to report always using a condom when they had sex¹⁸.

Another comprehensive study of 19,307 respondents between the ages of 16 and 59 years in 2001/2002 found that of those at risk of experiencing pregnancy, 95% were using contraception¹⁹. Oral contraception (33.6%) was the most popular with tubal ligation/hysterectomy (22.5%), condoms (21.4%) and vasectomy (19.3%) also widely used. Condom breakage was experienced by 23.8% of the men in the sample and condom slippage by 18.1%. The study states that:

breakage appears to be associated with how experienced the user is, rather than the quality of condoms and lubricant.

¹⁴ Smith A, Agius P, Mitchell A, Barrett C, Pitts M. 2009. *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

¹⁵ Ibid

¹⁶ Smith A, Rissel C, Richters J, Grulich A. 2003. *Australian Study of Health and Relationships*: Australian Research Centre in Sex, Health and Society, La Trobe University.

¹⁷ Smith A, Agius P, Mitchell A, Barrett C, Pitts M. 2009. *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University

¹⁸ Ibid

¹⁹ Ibid

As this study illustrates the combined oral contraceptive pill (“the pill”) is a very popular method of contraception. When the pill is used correctly it has a failure rate of less than 1%, however, other factors limit its practical effectiveness to between 94% and 95%. Many women are given inadequate advice about the use of the contraceptive pill. Vomiting, diarrhoea, the use of antibiotics and other drugs, such as some types of anti-depressants, as well as inconsistent doses or Vitamin C can all limit effective absorption of the pill. As well, many women are not made aware of the length of time a ‘backup’ contraceptive method must be used due to missed pills, extracted/eliminated pills or initial contraceptive use.

All of this research highlights the high level of need for comprehensive education about contraception and how to use it safely and effectively, starting well before young people engage in sexual activity, targeting high risk groups and continuing across the reproductive years.

Sexually Transmissible Diseases

Sexually Transmitted Infection rates are increasing in Australia, including a 43% increase in the number of new HIV diagnoses between 2001 and 2007, as mentioned in the Australian Government CEDAW report. Gonorrhoea, syphilis and Chlamydia are also rising sharply in infection rates, particularly among young sexually-active people. The increased incidence of Chlamydia in young women is of particular concern given the disease can cause infertility if left untreated. Young Aboriginal women are particularly at risk, being five times more likely to experience teenage pregnancy and more at risk of contracting an STI.

Young people’s knowledge of STIs and HIV prevention, risks and identification is improving; however some areas are generally poor including knowledge of HPV and cervical cancer²⁰. Despite showing slight improvements in the level of knowledge of diseases including Chlamydia and hepatitis, general rates of knowledge among students are poor²¹.

Despite research showing an increasing awareness of STI risks and prevention strategies, rates of infection continue to rise. The most striking example of this is Chlamydia:

Chlamydial infection continues to be the most commonly notified disease in 2007. A total of 51,859 notifications of Chlamydia infection were received; a notification rate of 246.8 cases per 100,000 population. This represents an increase of 8% on the rate reported in 2006 (229.2 cases per 100,000 populations)...Between 2002 and 2007, Chlamydia infection notification rates increased from 124.5 to 246.8 cases per 100,000 population, an increase of 97%²².

Lack of sexuality education in schools in most states of Australia contribute to this recent rise in STI rates, and should be remedied immediately. A national sexuality education curriculum could also help address the relatively high rate of teenage pregnancy and abortion in Australia.

Unwanted sex and sexual violence

Unfortunately, new research shows that young women’s experience of unwanted sex has increased significantly between 2002 and 2008 surveys. In 2002, 28% of young women reported ever having unwanted sex and in 2008 this figure had increased to 38%. In terms of ever having unwanted sex, for young women the rate has increased significantly from 28% to 38% since the 2002 survey, but remained relatively unchanged for young men²³. Just under one third of the sample reported ever having experienced unwanted sex. Young women were more likely than young men to have experienced sex when they did not want to (38% vs.19%). Students cited being too drunk (17%) or pressure from their partner (18%) as the most common reasons for having sex when they did not want to.

This again highlights the need for comprehensive sexuality education and robust curriculum incorporating issues such as sexual decision making, relationships, emotional issues and negotiate of safe sex.

²⁰ Smith A, Agius P, Mitchell A, Barrett C, Pitts M. 2009. *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

²¹ Ibid

²² Commonwealth Department of Health and Ageing. *Australia’s notifiable diseases status, 2007: Annual report of the National Notifiable Diseases Surveillance System*

²³ Smith A, Agius P, Mitchell A, Barrett C, Pitts M. 2009. *Secondary Students and Sexual Health 2008*, Monograph Series No. 70, Melbourne: Australian Research Centre in Sex, Health & Society, La Trobe University.

Guiding Principles

Children by Choice believes a new National Women's Health Policy can adopt the following guiding principles:

- Gender Equity
- Health Equity Between Women
- Focus on Prevention
- Strong and Emerging Evidence Base
- Lifecourse Approach

Gender Equity

As recognised by the Department of Health and Ageing in the National Women's Health Policy consultation briefing paper, gender is a major determinant of health, in particular sexual and reproductive health. Women are at significantly higher risk of poor sexual and reproductive health than men, with many conditions or issues only affecting women, or affecting women at a considerably higher rate or having a more serious impact than on men. Some of these include unwanted sex and sexual violence, STI rates, child sex abuse, and infertility. As noted in DoHA's National Women's Health Policy consultation discussion paper, antenatal and postnatal depression, cervical cancer, ovarian cancer and polycystic ovary syndrome also fall into this category and can have a severe negative impact on women's sexual and reproductive health.

This policy needs to actively ensure the participation of women not just in health policy and decision making, but also control of resources allocated towards improving their health. As recognised by the National Sexually Transmissible Infections Strategy 2005-2008, the participation of affected people and communities is essential in developing and implementing health policy. According to the strategy:

'This participation ensures that policies and programs are responsive to needs, are informed by the experiences of people affected by [the policy] and are designed for maximum positive effect'.

In recognising the social determinants of health, the policy must direct resources to the "causes of the causes", not merely concentrate on medical models of responding to disease.

Recommendation 1: The National Women's Health Policy must be adequately resourced and monitored to ensure women are comprehensively engaged in policy development, decision making, and management of all strategies and service delivery directed towards improving women's health including the social determinant of health.

One of key gender inequities in sexual and reproductive health is the access of Australian women to abortion. Children by Choice welcomes the Victorian Government's decriminalisation of abortion. Abortion law is determined by state and territory governments and is therefore patchy and provides different levels of access to terminations for women across the country, depending on geographical location. Restrictions on the legality of the procedure in different states create confusion both in the medical sector and the wider community as to the status of abortion. It impacts on where services are available - in states like Queensland, where it is still embedded in the Criminal Code, there is no public access, meaning women have to travel to private facilities to access a termination. This can often mean travelling to the capital or to major regional centres, incurring extra costs. The legality of medical abortion is another grey area and is yet to be clearly defined, putting practitioners at risk of prosecution and making others less likely to become involved in the area of pregnancy termination. Unclear legal status also leads to problems in training and recruitment of health staff, the lack of public acceptance of abortion as a women's health issue, and a lack of access to services and information.

Unfortunately these problems are often exacerbated for women living in rural, regional and remote areas, and Aboriginal and Torres Strait Islander women, who continue to be the most disadvantaged by these issues. All Australian women have the right to access a safe and legal abortion, not determined by where they happen to live.

There are negative consequences for a woman and her family if she is unable to access abortion services. A woman denied termination of pregnancy is likely to suffer psychological and social problems, and her children are likely to carry such problems into adulthood. Under suitable conditions, abortion is a very safe procedure. Yet the present legal situation makes it difficult to ensure best practice delivery of this critical health service.

The right to bodily and psychological integrity is one of the most fundamental. We recognise that control over reproduction is an issue on which people hold strong opinions, and that those opinions can differ. However, on the issue of abortion, credible polling consistently shows more than 80% of Australians to support a woman's right to choose. The right to safe legal abortion has been recognised as a human right by many bodies, including Amnesty International which has urged all countries to repeal laws which allow women to be persecuted or criminally charged for seeking abortion. The abortion decision should be left to women and their partners and doctors, not parliamentarians or police. This policy must recognise that women have the right to make this decision without coercion or pressure, or threat of prosecution.

Recommendation 2 : The National Women's Health Policy must facilitate the removal of abortion from the criminal codes of all remaining States and Territories.

Although RU486, or mifepristone, has been authorised for use by the Federal Government, there are severe limitations on its use, and it is still not an option for many women who choose to access pregnancy termination. For example, in Queensland, doctors who have applied and been granted the right to prescribe RU486 may only do so in 'life-threatening or otherwise serious situations'. Australian women who do have access to medical abortion are currently being treated with the drug misoprostol, which is safe and effective but inferior to mifepristone. State Governments are able to sponsor doctors to apply to use RU486 in public hospitals for public patients, but have not done so. This is despite the fact that RU486 is considered best practice in medical abortion and has been listed as an essential medicine for developing countries by the World Health Organisation.

Recommendation 3 : : We recommend the Federal Government liaise with states and territories to increase access to RU486 for all Australian women. We recommend that the Australian Government support applications by pharmaceutical companies to distribute RU486, which would greatly improve women's access to the drug.

Health Equity Between Women

Research into the social determinants of health has found that factors including housing, income and distribution, education and literacy, unemployment and job security, Indigenous status, social exclusion and lack of access to health care services, can all impact negatively on health outcomes²⁴. These factors cause gross inequalities in health outcomes and access to services for Australian women, with some groups at far greater risk of poor sexual and reproductive health because of these.

Women disproportionately at risk of poor sexual and reproductive health in Australia include the following groups:

- Young women
- Aboriginal and Torres Strait Islander women
- Women with disabilities
- Women living in rural, regional and remote areas
- Immigrant and refugee women
- Homeless women
- Women experiencing family or partner violence
- Women in prison

Rather than decreasing, research shows that health inequalities between women continue to increase²⁵. These groups need better access to inclusive health services which recognise individual rights to self-determination, target women most at risk of poor health and enable women to make informed decision about their health and wellbeing.

²⁴ Marmot M and Wilkinson R, eds, *Social Determinants of Health* Oxford University Press, 2006.

²⁵ Walker A, *Health Inequalities and Income Distribution, Australia: 1977 to 1995* Centre for Social and Economic Modelling, 2001

For example, Children by Choice recently received a referral from a large religious based service operating several women's shelters. We immediately booked an interpreter once it was evident that the woman had very little English. When this client met with our counsellor and the interpreter, she had been in a shelter for three days without any access to her own language. Our counsellor provided an extensive three hour session centred around domestic violence, which was the key issue for this woman and not the unplanned pregnancy. This client was provided with an opportunity to access not only support but the invaluable assistance of an interpreter, to allow her to make an informed decision about her health.

Recommendation 4 : The National Women's Health Policy must inform, promote and provide frameworks which require the commitment of all generalist and specialist health services to culturally appropriate practices which recognise the woman as the expert in her own life.

As a Queensland state-wide telephone counselling service, Children by Choice regularly encounters gaps in the geographic location of services available on the ground for women. GPs cannot be viewed as the complete answer in reproductive health, as young people are often embarrassed to talk to their GPs around sexual and reproductive health issues. More professional development is needed to ensure all doctors have a solid grounding in sexual and reproductive health issues and that their care extends beyond diagnosis and treatment of existing STIs to include patient education, risk monitoring and mental health issues.

Academic courses and training must also address the severe shortage in aboriginal workers trained in health service delivery, as well as the knowledge of health professionals around indigenous health issues. Provision of confidential services is particularly important in reproductive health issues, especially in rural and remote settings.

Children by Choice acknowledges the success of Queensland's School Based Youth Health Nurses, the mobile health units in operation for breast screening and the funding of Queensland Health for women's health centres. Increasing the prescribing rights of nurses would also improve conditions for rural women, particularly in the area of contraception and medical abortion.

Women in rural, regional or remote areas are often faced with large amounts of travel to access services, and this situation is particularly apparent in relation to family planning services. A recent study in Victoria found that 10% of women in that state will have to travel over 100km to access a pregnancy termination, meaning they also face increased costs for travel on top of the procedure cost. In a state like Queensland which is much larger and has more geographically-isolated communities, the situation is dire for many women. With only three clinics outside the southeast corner of the state offering pregnancy termination services, women in regional or remote areas face large distances and increased costs for accessing the same procedure as their urban sisters. This is exacerbated by the reluctance of patient travel assistance schemes to help cover the costs of women travelling for an abortion, as well as the fact that many have to also pay for accommodation costs on top of the higher out-of-pocket cost for the procedure in regional centres. The following is a true case story from a recent client of Children by Choice. Her name has been altered to protect her privacy.

Sara was a young single mother who recently contacted Children by Choice. Sara lived in a remote Indigenous community in northern Queensland, and was nearing the end of her first trimester before discovering she was pregnant. Children by Choice and three other women's services were able to provide some monies to assist with the cost of a termination, but as the minimum out-of-pocket cost outside Brisbane is \$550, an exceptional fee reduction was needed by the clinic in question to make the procedure affordable for Sara. On top of the procedure cost, Sara needed a private car to get from her remote community to the clinic hundreds of kilometres away, and the car was an extra expense she was unable to afford. Significant time and energy was devoted to her case by workers, but sufficient funds to cover the termination procedure and the travel expenses could not be found in time to meet the gestational limit. She had no choice but to continue with an unwanted pregnancy.*

Women in rural and remote areas also have more trouble accessing contraception, particularly emergency contraception. Similar access difficulties apply to antenatal care. Rural women are at a direct disadvantage when compared to women in metropolitan areas, for no other reason than their geographic isolation.

Recommendation 5 : The National Women’s Health Policy should support well resourced women’s centres on the ground and regional provision of ante-natal and termination services. Local services should be assisted by the extended provision role of nurses, specialist fly in/fly out services and telephone based services. Specialist women’s health services provided across great distances must be supported by local health centres, with well resourced physical premises and well trained staff, responsive to the needs of indigenous Australians. Funding for travel is a necessary, budgeted inclusion in health service delivery.

Focus on Prevention

The instances of unplanned pregnancy, STI rates, unwanted sex and sexual violence all have the capacity to be reduced through a focus on preventative measures and education. Sexuality and reproductive health education needs to be made uniform and compulsory across all states, and include not only biological aspects but non-biological factors such as healthy relationships, negotiating sex and contraception with a partner, risk-taking behaviour. Education in this field needs to be gender sensitive and inclusive of differences, such as children considering same sex attraction. The curriculum should focus on the characteristics of respectful, safe, healthy relationships which are above religious and culturally prescriptive views on the nature of a family. Children by Choice undertakes both formal classroom work and small group work with at risk groups. We would note the stereotyping of women’s reproductive roles and sexuality, the need to address self-esteem and risk taking behaviour as well as biology, the lack of recognition of extended kinship relationships of aboriginal people and many diverse immigrant groups, detailed information about the experiences of sexual violence by women and some men, and the issue of same sex attraction, as being particularly important to address in inclusive and respectful sex education.

Recommendation 6 : The new National Women’s Policy should support the introduction of a nationally mandated sexual and reproductive health curriculum which is respectful of differences and recognises the human right of all people to safe and respectful relationships. This National Sexuality Education curriculum must be comprehensive, evidence based, age appropriate and mandated, ensuring that no young Australian is excluded.

Pregnancy is a time of increased risk of domestic violence and can also be a time when women make large decisions about their relationships, including choosing abortion or leaving a violent partner. One telephone call can lead to assisting a woman to leave safely and quietly, and these situations can take many hours and complicated networking with police, shelters and domestic violence services to resolve successfully.

Recommendation 7 : The National Women’s Health Policy should support community solutions, developed with both men and women, to stop violence against women.

Recommendation 8 : Every woman in every Australian community must be able to access a woman safe space. While this policy should work towards all women being safe at home and in public, at night and in the day, the need for refuge must be recognised in policy and well resourced in practice.

Strong and Emerging Evidence Base

In sexual and reproductive health, there is currently a plethora of Federal and State strategies, individual policies and projects aimed at just one aspect of women’s health or a particular disease. The social determinants of health approach recognises that many underlying factors, such as housing, employment, education contribute to health outcomes.

Recommendation 9 : The National Women’s Health Policy should emphasise the importance of gender analysis tools in the development of all government policy and procedure from portfolios other than health, as well as within the Department of Health and Ageing, to ensure that underlying factors impacting on health are also addressed to produce improved health outcomes for women.

There is no minimum data collection on key sexual and reproductive health issues, including abortion. One exception is the South Australian Pregnancy Outcomes report. As recognised by the NWHP consultation discussion paper, data on cervical cancer rates in different geographic areas and populations is not known, therefore it is hard to target services to where they are needed most.

Recommendation 10 : The National Women’s Health Policy should provide for the gender disaggregation of comprehensive statistics on health and welfare, not only between men and women, but between groups of women and groups of men, to allow for analysis of the effectiveness of health policies for women, and identify further areas of need.

Recommendation 11 : A National Sexual and Reproductive Health strategy needs to be introduced and work in conjunction with the new National Women’s and Men’s Health policies. Any sexual and reproductive health strategy should include strategies that address health system delivery of, safe and legal pregnancy termination services in Australia to ensure all women have timely access to services when/if required.

Many communities already have strong client focussed service delivery or have undertaken successful pilot projects which then weren’t funded by government or funding bodies. The evidence from specific community work needs to be collected. Whilst there may be opportunities to extend existing service models to other geographical areas, a “one size fits all” approach to health service delivery does not necessarily deliver the best outcomes to diverse communities and far flung regions. Some projects are initiated and continued even though there is already a strong evidence base that they don’t work, such as abstinence only sex education.

Recommendation 12 : The National Women’s Health Policy should collect stories and examples operating successfully in communities, and not just consider academically researched evidence. The policy should foster collection, collaboration and comparison of both centralised academic and local case study evidence.

Pregnancy counselling telephone services in Australia are not currently subject to the same misleading advertising regulations as trading organisations. This essentially means that counselling groups can advertise themselves as a ‘pregnancy crisis helpline’ or something similar which infers a non-directive service, but which are anti-choice in nature. These helplines, of which the federally-funded National Pregnancy Support Helpline is one, often not only deny women information about abortion, but actively spread misinformation and fear about the supposed ‘risks’ of abortion. Women have called Children by Choice in some distress following calls to these helplines, including the case below. The woman’s name has been changed to protect her privacy.

Cathy has a 15 year old daughter who recently discovered she was pregnant. Cathy discussed the pregnancy with her daughter, who had made the decision to terminate the pregnancy. Cathy supported this decision and called the National Pregnancy Counselling Helpline. Cathy explained the circumstances of the pregnancy to the counsellor at the Helpline and asked for some information how to access an abortion. The counsellor asked Cathy several times if her daughter had considered adoption, before telling her she could not assist her with the information she sought.

Women have also been told by helplines that if they have an abortion they will get develop breast cancer; that abortion causes severe and ongoing mental health problems; that women who have an abortion early in life have trouble conceiving again later. All of these statements have been disproved by medical bodies and researchers. If a group does not refer for abortion, this should be clearly stated in their advertising. This would protect the rights of these groups to counsel as they choose, while at the same time respecting the rights of individuals to choose what type of service they contact, and ensure informed decision-making.

As another example, Catholic hospitals are exempt from regulations which enforce other institutions to offer emergency contraception to victims of rape and sexual assault. Where government contracts with religious agencies to provide emergency health services or sexual and reproductive health services to women, it must ensure that women’s access to contraception and information is not compromised. People have the right to make their own decisions about their health and should not be coerced into making choices due to the choice by a service provider to selectively supply information. Information provision about contraception and abortion is particularly sensitive to value judgements.

Recommendation 13 : The National Women’s Health Policy should support the adoption of standards that protect women from misleading and false advertising by pregnancy counselling agencies and promote the rights of individuals to choose what type of service they contact, without barriers and deception.

Lifecourse approach

A National Women’s Health Policy must recognise that women face differing health challenges at different stages of their lives.

The earlier onset of puberty has led to young women being exposed to a risk of unplanned pregnancy from an earlier age. Children by Choice has several clients aged twelve and thirteen every year.

Recommendation 14 : The National Women’s Health Policy should support a National sex education curriculum approach that includes earlier initiatives to address this risk. Youth specific sexual and reproductive health services should be easily accessible in the wide range of communities around Australia. (Note: In the United Kingdom, services that require young people to travel more than 5 miles are regarded as inaccessible.)

In managing their reproductive health, women require equitable access to all forms of contraception appropriate for use over extended periods of time and equitable access to assisted reproductive technologies. Termination of pregnancy is a reality of women’s lives and an experience which can impact on women from 12 to 52. Strategies and projects that aim to reduce unplanned pregnancy with the objective of reducing the abortion rate must use disaggregated data sets that recognise particular points of vulnerability in the life cycle – including self esteem issues around negotiating safe sex amongst teenagers, risk taking as single women, beginning and ending of relationships experienced by women, and the onset of menopause.

Other major impacts upon women’s health are child-rearing and carer responsibilities which most women have for an extended period of their life. Women need flexible and responsive family/work arrangements that facilitate childbearing and carer responsibilities, including the childcare and raising of children undertaken by grandmothers. These responsibilities greatly impact on the ability of women to enjoy economic prosperity, and the inequality between women and men’s wages is well documented.

In Australia more than 80,000 women a year will access health care services for the purpose of pregnancy termination. It is estimated that one in three Australian women will experience abortion in their lifetime, with over 80% of abortion procedures carried out in private day facilities where the out of pocket fee is significant. Pregnancy termination services are only available on a very limited basis in major public women’s hospitals in Australian capital cities and rarely in public hospitals in regional and rural areas. The recommended fee for the Medicare item number most utilised for pregnancy termination procedures – Item 35643 – does not meet doctors/providers costs for provision of service, including meeting licensing, accreditation, quality and nursing staff costs. Therefore, women accessing termination of pregnancy in the first trimester of pregnancy (14 weeks since last menstrual period) face significant out of pocket costs. For women in south-east Queensland out of pocket costs are a minimum of \$300 while in regional Queensland the minimum is \$500.

Women on low fixed incomes find meeting these costs within the short time frame is becoming increasingly difficult. Many women who are dependant on Centrelink and family assistance payments already struggle to financially provide for existing children and family members. Some women are in transient housing due to domestic violence. Many of these women who contact Children by Choice for assistance already have children who have been removed by state child protection agencies.

Children by Choice and a handful of agencies can offer limited financial assistance to these women, however often the amount we are able to provide falls short of the cost of procedure (as well as travel and accommodation for rural and remote women) and the timeframe for accessing services closes. This means very low income women will be forced to continue with an unwanted pregnancy which is likely to lead to a continued cycle of poorer health outcomes for the woman and her family.

Recommendation 15 : The National Women’s Health Policy should ensure that Medicare and the PBS system recognise the lifecourse needs of women and that women have a reduced capacity compared to men to fund their health requirements. We recommend that the Federal Government increases Medicare support for women seeking pregnancy termination, including increasing the Scheduled Fee and Benefit for item number 35643 by 100%. Pregnancy termination must be available at low or no cost for financially disadvantaged women.

Conclusion

Children by Choice sincerely hopes that the new National Women’s Health Policy can lead to a healthier future for Australian women. In sexual and reproductive health, our fifteen recommendations envision a future where:

- Women are involved in and collaborate with government to control, develop and implement strategies to improve their own health outcomes,
- Equity across state boundaries and compliance with the best international standards are a way of life,
- An acceptance of cultural diversity recognises the woman as the expert in her own life,
- Rural women can easily access comprehensive reproductive health services,
- Young people are well informed about their sexual and reproductive health choices,
- All women are safe,
- Policy and practice in women’s health are well supported by a wide range of evidence, and
- Women are well resourced financially to achieve good health outcomes.

It is acknowledged that there may be costs involved in making the appropriate changes in legislation, health policy and practice. However, there are high financial and social costs involved in allowing many of these reproductive health inequities to continue. Investment in women’s health has the potential to benefit all Australian women and their families.