Victorian Women's Health Services Network
c/o Women's Health Victoria
GPO Box 1160
Melbourne, Victoria, 3001

Senator Janet Rice
Chair, References Committee
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Submitted online via aph.gov.au

15/12/2022

Dear Senator Rice,

RE: Submission to the Senate Standing Committees on Community Affairs, inquiry on universal access to reproductive healthcare

The Victorian Women's Health Services, with support and insight from GEN VIC and Birth for Humankind, welcome the opportunity to make a submission to the Senate Inquiry into Universal Access to Reproductive Healthcare. As feminist and pro-choice organisations, the Victorian Women's Health Services bring an evidence-based reproductive justice framework to the Sexual and Reproductive Health system, and are dedicated to centring the experiences of women, girls and gender diverse people.

In Australia we enjoy a world-class public health system. Yet, the sexual and reproductive health needs of women, girls and gender diverse people over their lifespans are not consistently met across the country. Access to contraception, abortion, perinatal, pelvic pain, menopause and other sexual and reproductive healthcare services often depends on the postcode, income, language spoken, residency status, ability, or gender identity of the person seeking care. In order to ensure that all people living in Australia can access the SRH services that they need in a timely manner, reform and coordination is needed at a national level.

Key factors exist in Victoria and around Australia relating to access to reproductive healthcare that are highlighted in this submission include:

- Cost of services
- Workforce capacity and sustainability
- Health literacy
- Health Service Cultural Safety

Through decades of direct work with women and communities at local and state-wide levels, the Victorian Women's Health Services have highly developed understandings of sexual and reproductive health (SRH) access issues in Victoria. We welcome the opportunity to contribute to this inquiry, and any further opportunity for input into your work.

Sincerely,

Dianne Hill
On behalf of the Victorian Women's Health Network

Executive Summary

Access to sexual and reproductive health (SRH) services in Australia is limited and highly inequitable, leading to health and social inequities[1] and contributing to gender inequality[2]. Having achieved decriminalisation of abortion and safe access zones in every Australian state and territory, our attention must now turn to addressing the many other barriers to access (particularly for key population groups), as well as reforms to expand contraception access, and improve care for other SRH conditions (e.g., pelvic pain conditions, perinatal care, menopause etc).

In Victoria, the setting with which we are most familiar:

- 12 of 79 LGAs do not have local medical abortion prescribers, and 14 of 79 LGAs do not have local medical abortion dispensing. In addition, in over 50% of Victorian LGAs (42), fewer than half of the medical abortion services received by patients were prescribed from within the LGA.[3]
- 6 of 79 LGAs do not have IUD services, and in 22 LGAs fewer than half of the hormonal IUD services received by patients were provided from within the LGA.[4]

The consequences of delays in access to SRH care are significant. A few examples of these include:

- Increased pain or impacts on future fertility for those with pelvic pain conditions such as endometriosis[5]
- Increased maternal and foetal mortality and morbidity for pregnant people[6]
- Economic hardship and insecurity that can last for years for abortion seekers[7]
- Increased transmission[8] and increased reproductive morbidity[9] for those with STIs,
- Significant economic cost to both the affected individual and the healthcare system[10].

Based on our knowledge and experience of the Victorian context, this submission highlights the following issues for SRH across Australia:

- Access – including cost of services, distance to travel, intake requirements, gestational limits for abortion services, and requirements for referrals and tests;
- Workforce – including workforce capacity to provide services, and the sustainability of a small and centralised workforce;
- Health literacy – people's understanding of the services they need and how to access these services, supported by healthcare professionals who are equipped to provide information in accessible and appropriate ways; and
- Cultural safety for all people accessing SRH services, including but not limited to migrant and refugee women; Aboriginal and Torres Strait Islander women; women with disabilities; and trans and gender diverse people.

The Australian SRH system is inadequate to meet the population health needs of all people living in Australia. There is a need for a coordinated approach to SRH service delivery, incorporating both mainstream and specialist services that can address SRH issues in a safe, timely and efficient manner. In order to enhance our public health system so that it can address sexual and reproductive health needs across the lifespan – from childhood, puberty, reproductive years and post-reproductive years – significant investment is required to ensure that:

- SRH services are accessible – in relation to cost, distance from home, intake requirements, frequency of services, visibility, and referral pathways.
- The SRH workforce is strong, well-equipped, and sustainable – with multiple pathways for learning through pre- and post-qualification training, succession planning, and appropriate remuneration.
- People all across Australia – of different ages, life stages, backgrounds and education levels - understand their own SRH and seek healthcare as and when they need it, with the ability to expect and request high-quality, best practice care.
- All health services in Australia are culturally safe in their service provision, ensuring that people from all backgrounds and life experiences are heard, understood, respected and supported through their sexual and reproductive healthcare journeys.
- The lived experience of service users is respected and supported by the SRH service system, with service users empowered as experts in their own bodies and experiences.

A strong SRH system is integral to good overall health of Australians, and to gender equity. We welcome the opportunity to make this submission to the Senate Inquiry, and to work with all levels of government to achieve optimal sexual and reproductive health experiences and outcomes for all Australians.

About the Victorian Women's Health Services

A critical part of the SRH service system across Victoria, the Victorian Women's Health Services include nine regional services and three state-wide services.[11] The work of the Women's Health Services (WHS) is based upon the social determinants of health, incorporating a number of interconnected areas of women's health that intersect with SRH including prevention of violence against women, mental health and gender equality.

WHS's play a key leadership and partnership role in their regions around SRH needs assessment, training, and capacity and capability building. They develop regional SRH strategies, integrated health promotion planning, and place-based approaches to ensure that SRH issues are addressed within local contexts. WHS are particularly skilled in navigating complex service systems and building partnerships to improve access to services for women in their local areas, and collaborating on state-wide campaigns, policy, advocacy and promoting pathways to services.

The work of Women with Disabilities Victoria and Multicultural Centre for Women's Health is fundamental to WHS' intersectional approach to feminist practice, as the regional and state-wide WHS work together to address the intersecting and interlinking forms of discrimination and oppression which contribute to inequitable access to SRH care. Women's Health Victoria provides critical state-wide strategic and capacity building policy and advocacy support.

1800 My Options, Victoria's state-government funded phoneline for contraception, pregnancy options including abortion and sexual health, is delivered by Women's Health Victoria. As an impartial service that doesn't provide clinical SRH services, 1800 My Options supports people to access the services that will meet their individual needs, ensuring that they have pathways to affordable, timely and appropriate services. The phoneline currently receives 600+ calls per month from people seeking evidence-based information and pathways to SRH services, most of whom are seeking abortions. Since 2018, 1800 My Options has spoken to over 23,000 people, many of whom identify as experiencing significant barriers to their SRH system access, including:

- Financial insecurity leading to inability to pay for private SRH services, for GP appointments for referrals to public hospitals or private gynaecologists and other specialists, or for ultrasound or counselling services;
- Geographical isolation, requiring them to travel significant distances for services;
- Family violence and reproductive coercion, which can delay help seeking and impact their ability to safely access SRH services;
- Medicare ineligibility, which makes many SRH services financially prohibitive;
- Lack of access to experienced and qualified SRH providers in their local area, or uncertainty around which healthcare providers they can approach to receive evidence based advice around their reproductive choices;
- Delays in seeking care due to lack of appropriately qualified service providers, or lack of appointment availability for ultrasound and other diagnostic services;
- Low levels of SRH literacy which can delay them seeking time-sensitive healthcare services.

The recommendations in this submission are based on the expertise and experience of the Victorian WHS sector in supporting SRH care across our state over the last 30+ years. While it has a focus on the Victorian context, the submission speaks to national issues relating to SRH access and barriers to care.

Please find following:

- Recommendations to the Senate Standing Committee on Community Affairs – Universal Access to Reproductive Healthcare
- Terms of Reference Response
- Endorsers and contributing organisations

Recommendations:
The following overarching recommendations are complemented by additional sub-recommendations, providing detail and context within the body of this submission.

Recommendation	TOR Alignment
1. Invest in a sustainable, coordinated and integrated SRH system to ensure that everyone living in Australia can access the SRH care that suits their needs.	a, b, d
2. Invest in a national workforce industry plan to monitor and increase the capacity of the Australian health workforce to respond to abortion and other SRH issues as part of standard healthcare provision, particularly in regional and rural areas	b, c
3. Invest in evidence-based, culturally appropriate, accessible education initiatives that provide information about SRH across the lifespan to people of all ages and reproductive life stages	e, f, g, i
4. Ensure that underserved communities have their needs appropriately met by the entire SRH service system	c, d, e, f, g, i
5. Create provisions in national legislation for reproductive leave via both modern awards and in National Employment Standards, that enshrine the right to paid gender-inclusive reproductive leave for any conditions relating to menstruation, perimenopause, menopause, miscarriage, pelvic pain, IVF and other forms of ART, vasectomy, hysterectomy, contraception, and abortion. This right includes the right to paid leave in addition to regular personal leave and annual leave, as well as flexible working arrangements.	h

Terms of Reference Response

Recommendation 1: *Invest in a sustainable, coordinated and integrated SRH system to ensure that everyone living in Australia can access the SRH care that suits their needs.*

Key Issues

Lack of a well-planned, integrated SRH service system

The sexual and reproductive health system across Australia lacks integration with mainstream health services, and oversight of SRH is ad hoc and disconnected. Australia's federalised health system means that funding streams, legislative and policy frameworks differ between State and Federal Governments. The co-existence of public and private service provision adds further complexity. As a result, the overall SRH system lacks cohesion and consistency.

A coordinated and consistent approach to SRH across all levels of government – overseen by a national taskforce and informed by the National Advisory Council for Women's Health - would enable better planning, monitoring and development of SRH services to address population health needs, in alignment with federal and state legislative and policy frameworks. This would enable better policy, funding and legislative coordination across the country to address inconsistencies and gaps more efficiently and effectively.

In addition to a lack of system coordination and integration, there is a lack of data collection relating to abortion, contraception, menstrual health, pelvic pain, birth trauma, and other reproductive health conditions. To better support access to SRH services, a greater understanding of demand and service provision across the country is required. Comprehensive data collection relating to SRH service provision and population level need would enable meaningful planning for future efforts to ensure an evidence base for needs-based funding allocation and enable development of best practice models that can be replicated and adapted for different population health needs. A monitoring and evaluation framework – developed with standards and key performance indicators – would both inform future planning and funding as well as monitor progress of equity of access to SRH services across Australia.

Accessibility issues

One quarter of Australian women experience an unintended pregnancy. 30% of unintended pregnancies end in abortion[12], and there are higher rates of unintended pregnancy in rural areas.[13] Younger women are more likely to have unintended pregnancies[14] and to use less effective methods of contraception.[15] Only 11% of Australian women aged 15-44 use Long Acting Reversible Contraception (LARC), the most effective contraceptive method.[16] While not all unintended pregnancies are unwanted, these statistics nonetheless highlight significant problems with access to abortion and contraception.

A prohibitive factor impeding access to sexual and reproductive health services in Australia is cost.[17] This reflects the limited role of the public health system in SRH provision in most parts of Australia - the time-sensitive nature of contraception and abortion services pushes those able to afford it into the private system.

In Victoria, most abortions are performed by private providers (GPs, private clinics or specialists) and most abortion-seekers also need to pay for blood tests and ultrasound scans. Surgical abortions under 12 weeks' gestation in the private abortion system range from $500-$700, and medical abortions cost between $100-$600. A small proportion of public hospitals provide bulk billed abortion services, and provision across the hospital system is limited, inconsistent[18], often ad hoc, has strict access criteria (including Medicare eligibility), gestational limits, or has significant wait times - leading to further barriers to abortion access.[19]

For Victorians seeking to prevent pregnancies with the most effective hormonal IUD devices, insertions generally cost $400-$600 in private clinics under sedation, or $100-$400 in general practice. Low-cost LARC services are uncommon, and thus often have significant wait times.

Geographic isolation is another key barrier to SRH access. Compared with Australians living in metropolitan centres, those in rural areas have poorer SRH outcomes including higher rates of unplanned pregnancies[20] and higher rates of STIs[21]. These outcomes are due to a lack of local services, high costs and misinformation[22], exacerbated by the uneven distribution of the healthcare workforce in rural areas.[23] In Victoria, most private surgical abortion options are in metropolitan Melbourne, with few public hospitals providing abortions for large geographical areas – complicating access to this essential service.

Possible solutions

Several interventions could be explored and implemented immediately to improve SRH access:

- Provision of clearer direction and ongoing commitment from the Federal Government to develop a sustainable framework for access to SRH in collaboration with PHNs, the National Advisory Council for Women's Health, RANZCOG, RACGP and other key organisations, and informed by the National Women's Health Strategy and other key state and federal legislative and policy contexts.
- Requirements for public hospital provision of abortion as a part of a full suite of comprehensive sexual and reproductive health care.
- Address higher rates of unintended pregnancy and lower rates of LARC use in young people through provision of free contraceptive devices and services to people aged under 25 years.
- Continuation of MBS telehealth item numbers for SRH consultations beyond June 2023. The time-limited aspect of many SRH services – especially early medical abortion – makes telehealth an essential part of access, with comparable safety, efficacy and accessibility to in-person services.[24]
- Establishment of an emergency fund to address immediate costs of specific SRH care for those ineligible for Medicare or unable to access services in the public system, administered by a service external to the SRH system (such as women's health networks), while an affordable, sustainable, and accessible public health system is established.
- Extend Medicare entitlements to include all migrants (irrespective of visa category), to ensure that they can access SRH services in a safe, timely and appropriate manner.
- Urgent review of MBS and PBS coverage of LARC devices and services, acknowledging their efficacy as well as the time required for appropriate provision.
- Exploration of over-the-counter dispensing of contraceptive methods such as the combined oral contraceptive pill (removing the need to pay for a GP appointment).
- Development of impartial and independent state-wide centralised systems, linked at a national level through a phoneline, that both ensure SRH service seekers can find pathways to appropriate services and that coordinate, monitor and distribute SRH demand throughout the healthcare system (see 1800 My Options in Victoria for an example of such a service).
- Expand practice scope of nurses,[25] and examine evidence to expand scope of midwives, doulas and Aboriginal Health Workers to ensure that their full skill sets are used to ensure efficiency and effectiveness of the SRH system.

TOR	Sub-recommendation	
a, b, d	1. Establish a national SRH taskforce designed to plan and monitor SRH access Australia-wide, with representation from consumers, healthcare providers, academics, and advocacy organisations with a mandate to coordinate and integrate the SRH system with specific aims, performance indicators and outcomes.	i. Implement a monitoring and evaluation framework for SRH in Australia to increase transparency of the number and type of SRH services available, and increase understanding of effective initiatives and key gaps for SRH, in order to establish standards and key performance indicators for regional, state and national monitoring. ii. Review and engage with policy and legislation at state and federal levels to ensure SRH system reform, through collaboration with the National Advisory Council for Women's Health, PHNs, and other leading organisations. iii. Invest in research and evaluation that builds the evidence base for best practice trauma informed, culturally safe SRH services. Explore implementation of best practice SRH initiatives designed to address population health needs, including: a. Free contraception devices and consultations for all people living in Australia under 25 years old; b. Permanent continuation of the availability of telehealth for SRH consultations in primary care; c. Establishment of an emergency fund while an affordable, accessible and sustainable public SRH system is established; d. Extend Medicare to include all migrants (irrespective of visa category) d. Review of MBS and PBS item numbers to ensure access to highly effective LARC methods;

		e. Review of over-the-counter access to contraceptives, in line with international best practice and evidence; f. Build centralised systems to ensure that people can seek evidence-based advice and pathways to appropriate care providers, and that timely, evidence-based, appropriate referrals are made by all healthcare professionals for those seeking SRH services. iv. Expand the scope of practice of nurses, nurse practitioners, doulas, Aboriginal Health Workers and midwives to ensure that their full skill sets are used and supported, in order to maximise access to SRH services.
a, b, d	2. Require all public hospitals with appropriate maternity capability to provide abortion options, and all publicly funded hospitals without capability, to provide transparent, evidence-based and timely referrals to care.	i) ensure that all Australians are able to access free abortion and contraceptive services in the public hospital system ii) ensure that all public hospitals without appropriate capabilities make timely, appropriate evidence-based referrals for their abortion seeking patients

Recommendation 2: *Invest in a national workforce industry plan to monitor and increase the capacity of the Australian health workforce to respond to abortion and other SRH issues as part of standard healthcare provision, particularly in regional and rural areas.*

Key Issues

There is need for greater investment in and coordination of the national SRH workforce in Australia. Coordinating, accreditation and training bodies including the RACGP, RANZCOG, PHNs, AHPRA, AMA and ANMAC must ensure that critical SRH components are included in standard training and assessed as part of competency measures.

Currently, standard pre-medical[26] and nursing[27] training does not consistently include standardised or structured information or training relating to surgical abortion, medical abortion, LARC, menopause, pelvic pain or other SRH conditions; nor practitioner obligations in relation to conscientious objection laws. Access to training is not consistent across Australia and is particularly problematic for practitioners in non-metropolitan areas and for overseas trained health practitioners. A non-existent or reduced healthcare workforce in rural areas, alongside aforementioned lack of services in public hospitals, limits SRH training opportunities for the entire healthcare workforce. This lack of workplace exposure compounds inconsistencies in formal education, further contributing to a workforce ill-equipped to address the lack of adequate SRH services including surgical abortion .

Financial incentives for practitioners must be available to enable them to attend training, and ongoing support and supervision beyond the training, including online training for rural practitioners. Registration and accreditation bodies must also support and require SRH training as part of their assessments and accreditation requirements.

Currently, in Australia abortion can only be performed by medical doctors. Yet nurse-led models (NLM) increase access to medical abortion, LARC and STI diagnosis and treatment. They support the provision of SRH through 'task-shifting abortion provision from doctors to appropriately trained nurses and midwives"[28] and are an effective and cost-saving approach through reducing time spent in the clinic, waiting times, and cost of treatment.[29] Greater investment is

required to expand current nurse-led models operating around Australia, including into more service systems. Additionally, changes in state and federal level legislation are needed to enable nurses to better support LARC and medical abortion.[30]

It is also important to acknowledge the importance of training the broader associated healthcare workforce that supports and provides services to women and gender diverse people seeking SRH care. This includes pharmacists, physiotherapists, doulas, Aboriginal Healthcare Workers, bilingual health educators and others. To ensure that SRH is treated as part of the mainstream healthcare system, appropriate training must be provided to all healthcare professionals to be able to support their patients to exercise their sexual and reproductive rights.

TOR	Sub-recommendation	
A, b, c, d, e, f, g	2.1 Ensure adequate and accessible SRH training at all levels of practice for healthcare practitioners in Australia to ensure that clinicians and services across the country have capability to manage a variety of reproductive health concerns in a timely manner including abortion, pelvic pain, pregnancy, contraception, menopause, and other reproductive health conditions.	i) Embed SRH training, including practical training relating to abortion and contraception care, into all levels of GP, nursing, midwifery and associated healthcare workforce education. Ensure that this training and relevant competencies are included in accreditation, and that healthcare professionals are appropriately remunerated to gain accreditation.
		ii) Establish training frameworks and standards for newly arrived overseas healthcare practitioners to ensure understanding of legislation and best practice SRH care.
		iii) Invest in nurse led models of care for SRH to increase sector capacity, increase efficiency, and increase cost effectiveness of SRH services – including ensuring that regulatory and legislative environments support this model of practice.
A, b, c, d, e, f, g	2.2 Ensure that non-direct SRH workers in the healthcare system – including doctors, nurses, midwives, doulas, sonographers, Aboriginal Health Workers, midwives, counsellors, physiotherapists, pharmacists and others have competency to respond and refer appropriately for SRH issues.	Address the SRH training needs of the broader healthcare workforce including doctors, nurses, midwives, birth and abortion doulas, ultrasound, Aboriginal Health Workers, midwives, counsellors, pelvic floor physiotherapists, pharmacists, etc.

Recommendation 3: *Ensure that all people in Australia access culturally appropriate, best practice, evidence-based information about Sexual and Reproductive Health, throughout all life stages.*

Key Issues

Good sexual and reproductive health is a priority across the lifespan[31] of all people, but requires up-to-date health literacy and understanding of systems on the part of individuals.

Health literacy efforts need to ensure that both health practitioners understand the health needs of priority populations, and that priority populations can easily access required information. This may include embedding health literacy messaging in both school-based education as well as education for health staff. More broadly, health literacy efforts need to be community-led, go beyond targeting key priority populations, and be embedded in systems, policies, and organisations to ensure the health system and policies are accessible and prioritise health literacy actions.[32]

Sexuality and relationships education is an essential contributor to SRH literacy. It can enable people to make informed decisions about sex and relationships, and support the prevention of violence against women.[33] Comprehensive sexuality and relationships education includes education on respectful relationships, violence against women, gender, sexuality, sex (inclusive of pleasure and consent), and SRH rights (inclusive of contraception and abortion).

TOR	Sub-recommendation	
B, d, e, f, g	1. Invest in evidence-based, culturally appropriate, accessible education initiatives that provide information about SRH across the lifespan to people of all ages and reproductive life stages.	i. Ensure that SRH information is tailored to and accessible to all Australians throughout the lifespan, with specific attention to: b. Early childhood; c. All primary and secondary schools in Australia; d. Out of home care; e. People of reproductive age; f. Post-reproductive age.
B, c, d, e, f, g	2. Ensure that all workers responsible for health communications are able to communicate in plain English, with understandings of cultural considerations and best practice use of interpreters.	i) Ensure that workforces are equipped to support SRH literacy, with particular attention to: b. Health workforce including doctors, nurses, allied health and other support workforce; c. Bilingual and bicultural workforce; d. Teaching and education workforce; e. Youth workforce.

Recommendation 4: *Ensure that underserved communities have their needs appropriately met by the entire SRH service system.*

Key Issues

A number of communities are underserved by mainstream SRH services in Australia. In particular:

- Migrant and refugee women are at greater risk of suffering poorer maternal and child health outcomes, are less likely to have information and familiarity with contraceptive methods, and are at greater risk of STIs when compared to non-Indigenous Australians.[34]
- Women with disabilities have minimal to no access to sexual and reproductive health programs, and reduced access to health information, screening, prevention and care services[35], alongside experiencing higher rates of sexual violence,[36] and forced abortion, contraception and sterilisation.[37] Women with disabilities experience inadequate and non-responsive health services including being refused the right to consent to medical treatment including abortion[38], and are more likely to experience reproductive coercion than women without disabilities[39].
- Trans and gender diverse people report experiencing very high rates of marginalisation in sexual health care due to transphobia, resulting in lower STI testing rates, low uptake of PrEP and heightened vulnerability to STIs[40]
- Aboriginal and Torres Strait Islander women identify gaps in appropriate sexual and reproductive health education,[41] as well as higher rates of pregnancy risk factors, adverse perinatal outcomes, and adolescent pregnancy.[42] Data indicates that 22% of Aboriginal and Torres Strait Islanders experienced racial discrimination from healthcare workers in the last 12 months.[43]

Genuine change in health outcomes for underserved communities is facilitated by ensuring that these communities are empowered to lead and manage health interventions, and that they are adequately resourced to do so. For all of the aforementioned groups, evidence supports community-controlled interventions to ensure that the genuine needs of underserved communities are understood and appropriately met. This is due to their understanding of community

need,[44] cultural safety,[45] acceptability of interventions,[46] and community-based collaboration with community organisations.[47] The importance of cultural safety principles such as policy guidelines[48] and training are vital to the safety of underserved communities in healthcare services.[49]

Whilst best practice is recognised in relation to cultural safety and competency within healthcare settings and by healthcare practitioners,[50] essential monitoring and accountability around the many ways in which health service providers may or may not practice cultural safety is lacking.[51] Embedding cultural safety requirements into funding and service agreements, as well as quality assurance mechanisms and accreditation, would provide both incentives and mechanisms to ensure that cultural safety is prioritised and maintained by healthcare services.

TOR	Sub-recommendation	
B, c, d, e, f, g	4.1 Build monitoring and accountability into funding and service agreements to ensure that key performance indicators relating to access and equity are reported on and accountable through quality assurance mechanisms.	i. Link funding agreements to health care organisations' efforts to be culturally safe, such as through obtaining Rainbow Tick and other cultural safety frameworks. ii. Link accreditation to cultural safety achievements.
B, c, d, e, f, g	4.2 Invest in women with disabilities-led organisations to ensure SRH is accessible and culturally appropriate for this population.	i) provide funding to women with disabilities-led organisations to: a. consult with community relating to identified SRH need; b. train healthcare services in accessibility and safety for women with disabilities; c. contribute to the evidence base around best practice SRH services for Women with Disabilities.
B, c, d, e, f, g	4.3 Invest in intersex and trans and gender diverse, -led organisations to ensure SRH is accessible and culturally appropriate for these populations.	i) provide funding to intersex and trans and gender diverse -led organisations to: d. consult with community relating to identified SRH need; e. train healthcare services in accessibility and safety for intersex, trans and gender diverse people; f. contribute to the evidence base around best practice SRH services for intersex, trans and gender diverse people.
B, c, d, e, f, g	4.4 Invest in First Nations women-led organisations to ensure SRH is accessible and culturally appropriate for these populations.	i) provide funding to First Nations women-led organisations to: a. consult with community relating to identified SRH need; b. train healthcare services in accessibility and safety for First Nations women; c. contribute to the evidence base around best practice SRH services for First Nations women.
B, c, d, e, f, g	4.5 Invest in migrant and refugee women-led organisations to ensure that SRH is accessible and culturally appropriate for these populations.	i) provide funding to migrant and refugee women-led organisations to: a. consult with community relating to identified SRH need; b. train healthcare services in accessibility and safety for immigrant and refugee women; c. contribute to the evidence base around best practice SRH services for immigrant and refugee women.

Recommendation 5: *Create provisions in national legislation for reproductive leave via both modern awards and in National Employment Standards, that enshrine the right to paid gender-inclusive reproductive leave for any conditions relating to menstruation, perimenopause, menopause, miscarriage, pelvic pain, IVF and other forms of ART, vasectomy, hysterectomy, contraception, and abortion. This right includes the right to paid leave in addition to regular personal leave and annual leave, as well as flexible working arrangements.*

Key issues: Reproductive leave is essential to gender equity, and to ensuring that all people can exercise their reproductive rights. Reproductive conditions impact on workplace attendance,[52] productivity[53] when present in the workplace, with substantial direct and indirect costs to women and gender diverse people.[54] Contextualising reproductive health needs and conditions outside of a medical model of "sick leave" as recognised in current employment standards ensures that workers' needs can be met more appropriately than they can within the constraints of sick or personal leave requirements.[55] Reproductive leave has the potential to ensure that all women and gender diverse people can participate actively, productively and creatively in the workforce according to their individual needs.[56]

TOR	Sub-recommendation	
h	5.1 Reduce the gendered-burden of sexual and reproductive conditions in the workplace, as an issue that disproportionately affects women and gender diverse people and contributes to the gender pay gap.	i. Amend the Fair Work Act to allow for paid reproductive leave for all workers in Australia, not just for eligible women who have experienced the spontaneous loss of an embryo or fetus. ii. Reduce stigma around sexual and reproductive health issues in the workplace, such as menopause, by funding the creation of evidence-based resources and training opportunities for Australian employers including managers.

This is a collaborative submission from and endorsed by the Victorian Women's Health Services:

With support and contributions from our colleagues:

[1] Foster DG, Ralph LJ, Biggs MA, Gerdts C, Roberts SCM, Glymour MA (2018) Socioeconomic outcomes of women who receive and women who are denied wanted abortions. *American Journal of Public Health*, 108(3):407-413.
[2] TBC
[3] Women's Health Victoria. 2022. Victorian Women's Health Atlas Medication Abortion (PBS 10211K). Accessed 4/12/2022. [https://victorianwomenshealthatlas.net.au/#!/]
[4] Women's Health Victoria. 2022. Victorian Women's Health Atlas Contraceptive IUD (MBS 35503). Accessed 4/12/2022. [https://victorianwomenshealthatlas.net.au/#!/]
[5] Cromeens MG, Carey ET, Robinson WR, Knafl K, Thoyre S. Timing, delays and pathways to diagnosis of endometriosis: a scoping review protocol. BMJ Open. 2021 Jun 24;11(6):e049390. doi: 10.1136/bmjopen-2021-049390. PMID: 34168034; PMCID: PMC8231065.
[6] Haddrill, R., Jones, G.L., Mitchell, C.A. et al. Understanding delayed access to antenatal care: a qualitative interview study. BMC Pregnancy Childbirth 14, 207 (2014). https://doi.org/10.1186/1471-2393-14-207
[7] Foster DG, Ralph LJ, Biggs MA, Gerdts C, Roberts SCM, Glymour MA. Socioeconomic outcomes of women who receive and women who are denied wanted abortions. March 2018. American Journal of Public Health, 108(3):407-413.
[8] Peter J. White, Helen Ward, Jackie A. Cassell, Catherine H. Mercer, Geoff P. Garnett, Vicious and Virtuous Circles in the Dynamics of Infectious Disease and the Provision of Health Care: Gonorrhea in Britain as an Example, *The Journal of Infectious Diseases*, Volume 192, Issue 5, 1 September 2005, Pages 824–836, https://doi.org/10.1086/432004
[9] Van Gerwen, O.T., Muzny, C.A. & Marrazzo, J.M. Sexually transmitted infections and female reproductive health. *Nat Microbiol* **7**, 1116–1126 (2022). https://doi.org/10.1038/s41564-022-01177-x
[10] HTANALYSTS, 2022. Impact of unintended pregnancy. Report prepared for Organon by HTANALYSTS. Macquarie Park. Accessed 4/12/2022.
[https://www.organon.com/australia/wpcontent/uploads/sites/16/2022/09/ORG01_Report_FINAL_28June2022.pdf]
[11] Regional: Women's Health Grampians, Women's Health and Wellbeing Barwon Southwest, Women's Health Loddon Mallee, Women's Health Goulburn North East, Gippsland Women's Health. Metropolitan: Women's Health in the North, GenWest, Women's Health East, Women's Health South East. Statewide: Multicultural Centre for Women's Health, Women with Disabilities Victoria, Women's Health Victoria.
[12] Taft AJ, Shankar M, Black KI, Mazza D, Hussainy S, Lucke JC. Unintended and unwanted pregnancy in Australia: a cross-sectional, national random telephone survey of prevalence and outcomes. Med J Aust. 2018;209(9):407-8.
[13] Rowe H, Holton S, Kirkman M, Bayly C, Jordan L, McNamee K, et al. Prevalence and distribution of unintended pregnancy: the Understanding Fertility Management in Australia National Survey. Australian and New Zealand Journal of Public Health. 2016;40(2):104-9.
[14] Rassi A, Wattimena J, Black K. Pregnancy intention in an urban Australian antenatal population. Aust N Z J Public Health. 2013;37(6):568-73.
[15] Coombe J, Harris ML, Wigginton B, Loxton D, Lucke J. Contraceptive use at the time of unintended pregnancy: Findings from the Contraceptive Use, Pregnancy Intention and Decisions study. Australian Journal for General Practitioners. 2016;45:842-8.
[16] Grzeskowiak LE, Calabretto H, Amos N, Mazza D, Ilomaki J. Changes in use of hormonal long-acting reversible contraceptive methods in Australia between 2006 and 2018: A population-based study. Aust N Z J Obstet Gynaecol. 2021 Feb;61(1):128-134. doi: 10.1111/ajo.13257. Epub 2020 Oct 23. PMID: 33095452
[17] Shankar, M., Black, K. I., Goldstone, P., Hussainy, S., Mazza, D., Petersen, K., Lucke, J., & Taft, A. (2017). Access, equity and costs of induced abortion services in Australia: A cross-sectional study. Australian and New Zealand Journal of Public Health, 41(3), 309-314. https://doi.org/10.1111/1753-6405.12641
[18] Dawson A, Bateson D, Estoesta J, Sullivan E. Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. BMC Health Services Research. 2016;16(1):612.
[19] Dawson A, Bateson D, Estoesta J, Sullivan E. Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia. BMC Health Services Research. 2016;16(1):612.
[20] Marie Stopes International Australia. Real choices: Women, contraception and unplanned pregnancy. Melbourne: Marie Stopes International Australia, 2008
[21] Newman P, Morell S, Black M, Munot S, Estoesta J, Brassil A. Reproductive and sexual health in New South Wales and Australia: differentials, trends and assessment of data sources. Sydney; 2011
[22] Moulton JE, Mazza D, Tomnay J, Bateson D, Norman WV, Black KI, et al. Co- design of a nurse- led model of care to increase access to medical abortion and contraception in rural and regional general practice: A protocol. Aust J Rural Health. 2022;00:1–8. doi: 10.1111/ajr.12937
[23] Australian Institute of Health and Welfare (2018) Survey of Health Care: selected findings for rural and remote Australians, AIHW, Australian Government, accessed 02 August 2022.
[24] SPHERE (2020) Women's Sexual and Reproductive Health COVID-19 Coalition: Using telehealth to provide early medical abortion during the COVID-19 pandemic and beyond: a consensus statement. NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care, Melbourne. Available from: URL
[25] Women's Sexual and Reproductive Health COVID-19 Coalition. Nurse and midwife-led provision of SPHERE Coalition submission to the Senate inquiry into universal access to reproductive healthcare December 2022 Page 15 of 18 mifepristone and misoprostol for the purposes of early medical abortion: A consensus statement. Victoria, Australia: SPHERE NHMRC Centre

of Research Excellence in Sexual and Reproductive Health for Women in Primary Care; 2020 [Available from: https://3fe3eaf7-296b-470f-809af8eebaec315a.filesusr.com/ugd/410f2f_b90e75bf10784fedb7f3f6b2de9e6f48.pdf]
[26] Cheng Hc, de Costa C. Abortion Education in Australian Medical Schools. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2021. doi: 10.1111/ajo.13368
[27] Desai A, Maier B, James-McAlpie J, Prentice D, de Costa C. Views and practice of abortion among Queensland midwives and sexual health nurses. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2022. doi: 10.1111/ajo.13489
[28] SPHERE (2020) Women's Sexual and Reproductive Health COVID-19 Coalition: Using telehealth to provide early medical abortion during the COVID-19 pandemic and beyond: a consensus statement. NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care, Melbourne. Available from: URL
[29] SPHERE (2020) Women's Sexual and Reproductive Health COVID-19 Coalition: Using telehealth to provide early medical abortion during the COVID-19 pandemic and beyond: a consensus statement. NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care, Melbourne. Available from: URL
[30] SPHERE (2020) Women's Sexual and Reproductive Health COVID-19 Coalition: Using telehealth to provide early medical abortion during the COVID-19 pandemic and beyond: a consensus statement. NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care, Melbourne. Available from: URL
[31] Tim Sladden, Anne Philpott, Doortje Braeken, Antón Castellanos-Usigli, Vithika Yadav, Emily Christie, Lianne Gonsalves & Tlaleng Mofokeng (2021) Sexual Health and Wellbeing through the Life Course: Ensuring Sexual Health, Rights and Pleasure for All, International Journal of Sexual Health, 33:4, 565-571, DOI: 10.1080/19317611.2021.1991071
[32] Australian Commission on Safety and Quality in Health Care, 2014, Health literacy: Taking action to improve safety and quality. ACSQHC. Sydney.
[33] Holden, J., Bell, E. & Schauerhammer, V. (2015). We Want to Learn About Good Love: Findings from a Qualitative Study Assessing the Links Between Comprehensive Sexuality Education and Violence Against Women and Girls. London: Plan International UK and Social Development Direct
[34] Multicultural Centre for Women's Health (2021), Data Report: Sexual and Reproductive Health 2021. Melbourne. ISBN: 978-0-6451608-2-6
[35] Women with Disabilities Victoria, 2019, Fact Sheet 04 Health, Melbourne
[36] Frohmader, C., Dowse, L., and Didi, A. (2015) 'Preventing Violence against Women and Girls with Disabilities: Integrating A Human Rights Perspective'. Women With Disabilities Australia (WWDA), Hobart, Tasmania. ISBN: 978-0-9585268-4-5.
[37] Frohmader, C. (2013) 'Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia'. WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia. Prepared for Women with Disabilities Australia (WWDA), Tasmania.ISBN: 978-0-9876035-0-0
[38] Women with Disabilities Victoria, 2012. Access to health services for women with disabilities. Accessed 4/12/2022. [https://www.wdv.org.au/documents/Access%20to%20health%20services%20-%20the%20issues%20for%20women%20with%20disabilities.pdf]
[39] Horner-Johnson, Willi, Esther L. Moe, Ryan C. Stoner, Krystal A. Klein, Alison B. Edelman, Karen B. Eden, Elena M. Andresen, Aaron B. Caughey, and Jeanne-Marie Guise. 2019. "Contraceptive knowledge and use among women with intellectual, physical, or sensory disabilities: A systematic review."Disability and health journal12, no. 2: 139-154
[40] Callander D, Wiggins J, Rosenberg S, Cornelisse VJ, Duck-Chong E, Holt M, Pony M, Vlahakis E, MacGibbon J, Cook T. 2019. The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings. Sydney, NSW: The Kirby Institute, UNSW Sydney.
[41] Australian Human Rights Commission. Wiyi Yani U Thangani (Women's voices): Securing Our Rights, Securing Our Future Report. 2020. Australian Human Rights Commission. Sydney.
[42] Botfield J, Griffiths E, McMillan F, Mazza D. Letters: Unintended pregnancy among Aboriginal and Torres Strait Islander women: where are the data? Medical Journal of Australia. 2022. doi: 10.5694/mja2.51605
[43] Reconciliation Australia. 2020 Australian Reconciliation Barometer, Full Report. 2020, Polity Research and Consulting, Sydney.
[44] Panaretto K, Wenitong M, Button S, Ring I. Aboriginal Community Controlled Health Services: leading the way in primary care. MJA, 2014. Doi: 10.5694/mja13.00005
[45] Campbell Megan Ann, Hunt Jennifer, Scrimgeour David J., Davey Maureen, Jones Victoria (2018) Contribution of Aboriginal Community-Controlled Health Services to improving Aboriginal health: an evidence review. Australian Health Review 42, 218-226. Doi: 10.1071/AH16149
[46] Reilly, R., Evans, K., Gomersall, J. et al. Effectiveness, cost effectiveness, acceptability and implementation barriers/enablers of chronic kidney disease management programs for Indigenous people in Australia, New Zealand and Canada: a systematic review of mixed evidence. BMC Health Serv Res 16, 119 (2016). https://doi.org/10.1186/s12913-016-1363-0
[47] Seedat F, Hargreaves S, Friedland JS (2014) Engaging New Migrants in Infectious Disease Screening: A Qualitative Semi-Structured Interview Study of UK Migrant Community Health-Care Leads. PLoS ONE 9(10): e108261. https://doi.org/10.1371/journal.pone.0108261
[48] Maria Pallotta-Chiarolli & Erik Martin (2009) "Which Sexuality? Which Service?": Bisexual Young People's Experiences with Youth, Queer and Mental Health Services in Australia, Journal of LGBT Youth, 6:2-3, 199-222, DOI: 10.1080/19361650902927719

[49] Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

[50] Australian Health Practitioner Regulation Agency. 2020. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. Accessed 14/12/2022 [https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx]

[51] Laverty M, McDermott D, Calma T. Embedding cultural safety in Australia's main health care standards. Med J Aust 2017; 207 (1): 15-16. || doi: 10.5694/mja17.00328

[52] Sperschneider ML, Hengartner MP, Kohl-Schwartz A, et al Does endometriosis affect professional life? A matched case-control study in Switzerland, Germany and Austria BMJ Open 2019;9:e019570. doi: 10.1136/bmjopen-2017-019570

[53] Schoep ME, Adang EMM, Maas JWM, et al. Productivity loss due to menstruation-related symptoms: a nationwide cross-sectional survey among 32 748 women. BMJ Open 2019;9:e026186. doi: 10.1136/bmjopen-2018-026186

[54] Klein S, D'Hooghe T, Meuleman C, Dirksen C, Dunselman G, Simoens S. What is the societal burden of endometriosis-associated symptoms? a prospective Belgian study. Reprod Biomed Online. 2014 Jan;28(1):116-24. doi: 10.1016/j.rbmo.2013.09.020. Epub 2013 Sep 27. PMID: 24268732.

[55] Hvala T. In vital need of reform: Providing Certainty for Working Women Undergoing IVF Treatment. 2018. 41(3) UNSWLJ 901: https://doi.org/10.53637/UQZR3499

[56] Bennett J, Melican C, Crooks M. Ourselves at work: creating positive menstrual culture in your workplace. 2021. Victorian Women's Trust. Melbourne.