Senate Inquiry on Universal Access to Reproductive Healthcare

Prepared by the Multicultural Centre for Women's Health

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Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

Executive Summary

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), the national voice for migrant and refugee women's health and wellbeing. MCWH is a Victorian women's health service established in 1978 that works both nationally and across Victoria to promote the health and wellbeing of migrant and refugee[1] women and gender diverse people across Australia. We do this through research and publication, participation in advisory groups and committees, written submissions, and training and capacity building (see **MCWH Annual Report 2022**).

MCWH also works directly with women and gender diverse people in the community providing multilingual health education on women's health and wellbeing, across a range of issues and topics, through the use of nationally accredited, trained, community-based health educators. One of MCWH's key areas of education and expertise is sexual and reproductive health. This submission focuses on the barriers and solutions to universal access to reproductive healthcare for migrant and refugee women and gender diverse people. Our key recommendations are:

1. Extend Medicare to include all migrants (irrespective of visa category);

2. Resource primary care providers/practitioners, health organisations, and community-based organisations to provide culturally appropriate and responsive education on contraception;

3. Abolish waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed which is due to expire in June 2024, and within the

[1] The term 'migrant and refugee' refers to people who have migrated from overseas, and their children. It includes people who are part of both newly emerging and longer established communities, and who arrive in Australia on either temporary or permanent visas.

Minister for Health's power to remove (as outlined in Schedule 4d);

4. Offer all pregnant people safe, free or low cost, culturally appropriate and publicly funded pregnancy and abortion care;

5. Establish a National Taskforce on abortion care, to review the complexities of accessing abortion care in Australia. The taskforce should address the nuanced barriers that communities, such as migrants, experience to ensure universality, and should involve all states and territories, health experts including care providers, community-led organisations and people with lived experience;

6. Include migrant and refugee health as a key priority in regional organisational activity and planning (e.g. Primary Health Networks), including collecting information about migrant and refugee groups (e.g. visa/residency status, maternal country of birth, year of arrival in Australia, a request for an interpreter, and people's preferred language) and collaborating with migrant organisations with relevant expertise and knowledge (Ziersch et. al 2020; Khatri and Assefa 2022);

7. Provide ongoing investment and support to develop a bilingual, bicultural health workforce that is professionally recognised, appropriately remunerated and specifically trained to deliver and work with communities on sexual and reproductive health

8. Upskill, resource and embed bilingual workers across sexual and reproductive healthcare services;

9. Enhance the collaboration between primary care and the prevention sector. For example, improve referral pathways between clinical care and health education for migrant and refugee women and gender diverse people;

10. Invest in and strengthen intersectional policy development and analysis to ensure that national policy at all levels impacts positively on migrant and refugee people's capacity to access reproductive healthcare;

11. Provide free, culturally responsive, voluntary, non-biased mental health support as an integral part of reproductive healthcare (including in relation to perinatal anxiety and depression, trauma, abortion counselling);

12. Provide targeted, sustainable funding for migrant and refugee women's health programs, including healthcare provision and access to abortion care;

13. Bring culturally appropriate sexual and reproductive healthcare into the mainstream and into tertiary education settings by collaborating with migrant women's organisations to develop best practice guidelines for culturally responsive service delivery;

14. Support national (including rural, regional and remote), community-led, tailored preventative sexual and reproductive health education run by migrant women's organisations and delivered to migrant women and gender diverse people by trained bilingual workers, on key sexual and reproductive health topics, including in FGM/C and reproductive coercion;

15. Invest in research to better understand the barriers to migrant and refugee women and gender diverse people's access to health literacy, including engagement with digital technologies;

16. Invest in programs to build capacity of migrant and refugee women and gender diverse people to engage with digital technologies.

Background

On 28 September 2022, the Senate referred an **inquiry into the universal access to reproductive healthcare** to the Senate Community Affairs References Committee for inquiry and report by 31 March 2023.

There is a current consultation listed on the Senate Standing Committees on Community Affairs website, which is open until 11.59 pm AEDT on 15 December 2022. MCWH appreciates the opportunity to provide a submission. This submission is written in response to the Committee Terms of Reference.

I consent to this submission being published on the inquiry website and shared publicly online.

Consultation response

MCWH welcomes the opportunity to make a submission to comment on the Senate inquiry into the universal access to reproductive healthcare as it relates to migrant and refugee women and gender diverse people in Australia. MCWH recognises the enormous challenges and gendered inequities that exist in the community and health system and acknowledges the leadership that has been demonstrated in calling for this inquiry. MCWH also welcomes the opportunity to present our recommendations at a public hearing and/or future consultations.

In this submission, 'women and gender diverse people' is used to include cisgender women, transgender women and non-binary and gender diverse people who may use sexual and reproductive services including abortion, maternity, contraception and assisted reproductive technology. Unless specified, where research is cited, we have used term 'women' as the majority of research does not clarify their understanding of gender. MCWH recognises that this approach is limiting and not always inclusive of non-binary and gender diverse people, who may experience significant barriers to accessing reproductive healthcare and support. Additionally, when data references Australian-born populations, it does not necessarily include Aboriginal and Torres Strait Islander communities, who face poorer sexual and reproductive health outcomes, and health disparity.

Terms of Reference response

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

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

a) cost and accessibility of contraceptives, including:

i. Pharmaceutical Benefit Scheme (PBS) coverage and Therapeutic Goods Administration (TGA) approval processes for contraceptives,

ii. awareness and availability of long-acting reversible contraceptive and male contraceptive options, and

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

While there is a lack of social, geographical and demographic data on contraceptive users, according to Family Planning NSW (FPNSW), those born in non-English speaking countries reported lowest rates of contraceptive use (60%), compared to those born in Australia (69%), with condoms being the most used method (32%) among this cohort. The same report by FPNSW found that withdrawal and safe period methods were highest among people from mainly non-English speaking countries. This is similar to other studies which indicate that migrants and refugees may have inadequate information and familiarity with modern contraceptive methods, as well and services in Australia (FPNSW 2020).

In terms of awareness and availability of long-acting reversible contraceptive options (LARC), FPNSW suggests that several barriers exist to the wider use of LARC uptake, such as lack of information, access and lack of confidence among healthcare providers in providing LARC insertions (FPNSW 2020). For migrant and refugee women and gender diverse people, these barriers may be exacerbated by the lack of culturally appropriate information and education, cost, lack of continuity of care in the healthcare setting and lack of clear guidelines regarding culturally responsive practice.

When it comes to cost and accessibility of contraceptives, some migrant women and gender diverse people experience additional barriers. As the Pharmaceutical Benefit Scheme (PBS) is only available to Australian residents who hold a Medicare card, temporary migrants, including international students and temporary workers, are not eligible to receive subsidised medication. According to O'Brien and Phillips (2015), the impacts of this policy are wide-reaching, and can include:

1. Basic health care needs of workers and their families not being met,
2. Cost of private health insurance and out-of-pocket expenses is a major financial burden on families,
3. Psychosocial aspects of their settlement in Australia affected adversely.

For temporary migrants and those who are not eligible for Medicare, simply including contraceptives on the PBS will not improve access. Instead, it serves to widen health inequity between groups of

people in Australia. Access to free or lower cost contraception, and a wider range of contraceptive options should be widely available to everyone, regardless of visa category. Extending Medicare should not be regarded as a radical or innovative solution but should be seen as a necessary requirement for universal access for all people living in Australia.

Recommendations:

- Extend Medicare to include all migrants (irrespective of visa category)
- Resource primary care providers/practitioners, health organisations, and community-based organisations to provide culturally appropriate and responsive education on contraception

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

Like access to contraception, access to safe, affordable and culturally appropriate reproductive healthcare, including pregnancy care and termination services are not available to everyone in Australia. Research shows that migrant and refugee women access health services at a later point and at lower levels than the rest of the population. In terms of antenatal care, 70% of women born in mainly non-English speaking countries access antenatal care in the first trimester, compared with 76% of women born in Australia (AIHW 2020).

Migrant and refugee women have higher rates of pre-eclampsia, and gestational diabetes, which if undetected and untreated can result in serious complications during birth (MCWH 2021). The rate of perinatal deaths for overseas-born mothers (10.2) is higher than for mothers born in Australia (9.2) and it is highest for mothers born in North Africa (19.2), Polynesia (excludes Hawaii) (15.4) and Melanesia (14.8). The rate of stillbirths for overseas born mothers (7.5) is higher than for mothers born in Australia (7) and is highest for mothers born in North Africa (15.3), Melanesia (12.3) and Central and West Africa (11.6). The rate of neonatal deaths for overseas born mothers (2.7) is higher than for mothers born in Australia (2.2) and is highest for mothers born in Central America (10) (AIHW 2019).

Migrant and refugee women and gender diverse people experience a range of systemic barriers to accessing sexual and reproductive healthcare, as well as lower levels of health literacy. For example, temporary visa holders who do not have access to Medicare face restrictions when accessing services due to various factors including being subject to restrictive waiting periods, as well as hefty upfront costs (Shannon 2021). For migrant and refugee women and gender diverse people living in regional and remote areas, these barriers may be exacerbated by transport difficulties and lack of infrastructure, including issues related to accessing interpreters and culturally appropriate, in-language information.

While it is currently not possible in Australia to reliably estimate the rate of surgical and medical abortions, migrant and refugee women are among the highest population group who access MSI Australia's Choice Fund, a bursary service set up for women and pregnant people in Australia who are experiencing financial hardship, in addition to other healthcare barriers.

International students or partners of international students do not currently have access to pregnancy-related care if they fall pregnant within the first 12-months of migration. This is because international students are not entitled to Medicare and must have Overseas Student Health Cover

(OSHC) for the duration of their stay in Australia. This has been the case since July 2011, when the Commonwealth Government included Schedule 4d. in the deed for the provision of OSHC, allowing OSHC providers to introduce a 12 month waiting period for pregnancy related claims. It is concerning that evidence suggests that more than 70% of all claims for pregnancy-related treatment for all international students occur within the first 12 months of cover (WHIN 2020). This means that if an international student, or the partner of an international student experiences an unintended pregnancy within the first 12 months of arrival in Australia, they may be faced with limited reproductive choices and feel coerced into making a decision, whilst experiencing financial and settlement difficulties at the same time. This is an example of how migration related policies impact reproductive choice and 'universal' access to care in Australia. The complexities of accessing pregnancy and abortion care need to be further reviewed, in order to address the structural and systemic barriers that communities, such as migrants and refugees, face in Australia.

Research shows that state policy has enabled various forms of reproductive coercion to occur for some groups of marginalised people, including people living with disabilities, incarcerated people and people living in immigration detention, and people 'released into community' after detention (Kevin and Agutter 2018). It is clear that many people continue to be made vulnerable by inequitable health and migration-related policies.

Any person who is pregnant should be able to access safe, free or low cost, culturally appropriate, publicly funded pregnancy and abortion care.

Recommendations:

- Abolish waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed which is due to expire in June 2024; and within the Minister for Health's power to remove (as outlined in Schedule 4d)
- Offer all pregnant people safe, free or low cost, culturally appropriate publicly funded pregnancy and abortion care
- Establish a National Taskforce on abortion care, to review the complexities of accessing abortion care in Australia. The taskforce should address the nuanced barriers that communities, such as migrants experience to ensure universality, and should involve all states and territories, health experts including care providers, community-led organisations and people with lived experience

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

Workforce development is essential for increasing access to reproductive healthcare services. The reproductive healthcare workforce in Australia is large and diverse. It not only includes GPs, specialists, and nurses but also allied health practitioners, community workers, health promotion practitioners, bilingual and bicultural workers, and interpreters. All of these roles need to be considered in workforce planning and development to ensure that migrant and refugee women and

gender diverse people can access the reproductive healthcare they need. In this way, the notion of 'the workforce' needs to be more broadly conceptualised to include all of these roles, and the workforce needs to reflect the population that it serves.

Bilingual educators and translators need to be recognised as an integral part of the provision of healthcare, and supported to develop and upgrade their skills on an ongoing basis. We should be working towards a fully integrated system that facilitates referral pathways between clinical care and health education for migrant and refugee women and gender diverse people in order to increase migrant women and gender diverse people's access to a broad range of contraceptive options, and to exercise their reproductive choice.

Models of care that utilise bilingual health educators to work alongside the clinical health system show increased engagement with, and easier navigation of, the system among migrant and refugee women and gender diverse people. Such programs reduce access barriers for migrant and refugee communities, improve the healthcare experience, and improve perinatal outcomes (MCWH 2021). Research and evidence-based policy, training and health service capacity building, along with support to utilise good practice models of care, is required in order to improve health outcomes for migrant and refugee women and gender diverse people in Australia.

Recommendations:

- Include migrant and refugee health as a key priority in regional organisational activity and planning (e.g. Primary Health Networks), including collecting information about migrant and refugee groups (e.g. visa/residency status, maternal country of birth, year of arrival in Australia, a request for an interpreter, and people's preferred language) and collaborating with migrant organisations with relevant expertise and knowledge (Ziersch et. al 2020; Khatri and Assefa 2022)
- Provide ongoing investment and support to develop a bilingual, bicultural health workforce that is professionally recognised, appropriately remunerated and specifically trained to deliver and work with communities on sexual and reproductive health
- Upskill, resource and embed bilingual workers across sexual and reproductive healthcare services
- Enhance the collaboration between primary care and the prevention sector. For example, improve referral pathways between clinical care and health education for migrant and refugee women and gender diverse people

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

Culturally responsive, best practice approaches to equitable sexual and reproductive healthcare, including abortion care is bigger than one's ability to interact with various people from different cultural backgrounds. It is about analysing and understanding how migrant and refugee women and gender diverse people's reproductive health is influenced by intersecting social, economic and political factors, including experiences of trauma, and working towards removing all barriers to access.

It is well known by now that some barriers to access include lack of information provided in languages other than English, unaffordable cost of healthcare, restrictions on visas and residency conditions, stigma and discrimination both within and imposed on communities, and a lack of culturally appropriate service provision.

Additionally, best practice approaches and culturally responsive care is also about broader organisational and societal change. We need to challenge the ways in which racism, xenophobia, ableism, and other types of discrimination prevent universal access for those most impacted. In particular, we need to consider those who have been made even more marginalised by our systems such as migrants and refugees who are also part of the LGBTIQA+ community, migrant and refugee women with disabilities, migrant women with low-income, migrant women who are incarcerated and migrant women who are sex workers.

Recommendations:

- Invest in and strengthen intersectional policy development and analysis to ensure that national policy at all levels impacts positively on migrant and refugee people's capacity to access reproductive healthcare
- Provide free, culturally responsive, voluntary, non-biased mental health support as an integral part of reproductive healthcare (including in relation to perinatal anxiety and depression, trauma, abortion counselling)
- Provide targeted, sustainable funding for migrant and refugee women's health programs, including healthcare provision and access to abortion care
- Bring culturally appropriate sexual and reproductive healthcare into the mainstream and into tertiary education settings by collaborating with migrant women's organisations to develop best practice guidelines for culturally responsive service delivery

e) sexual and reproductive health literacy;

Health literacy, which relates to how people understand, access, and use health information to promote and maintain good health, is key to advancing health equity. There is evidence to suggest that people who speak a language other than English at home participate less in health services (ABS 2017). The concept of health literacy needs to extend beyond the practice of just providing in-language resources and culturally appropriate service provision, including working with interpreters. For migrant and refugee women and gender diverse people, trust, continuity of care, prevention and education are essential elements of health literacy. There is a need to ensure that migrant and refugee communities can navigate the health system and feel informed and empowered to make decisions for their sexual and reproductive health without judgement and stigma.

A key factor related to sexual and reproductive health literacy is equity in accessing information and services. The COVID-19 pandemic has demonstrated that access to digital technologies has become essential to information, education and participation in healthcare. However, some migrant and refugee women and communities have not been in a position to engage via digital platforms. While some migrants are well connected, there are subgroups such as newly arrived refugees, older

women, people who are unemployed or socio-economically disadvantaged, and rural people who have lower digital inclusion scores than the rest of the population.

It is crucial that the Commonwealth government address the impacts of the digital divide on migrant and refugee communities in terms of access to health literacy and healthcare more broadly. Research is needed to better understand the barriers and best ways to bridge gaps and investment must be made in tailored outreach programs that build capacity among migrant and refugee women and communities to actively participate in healthcare, including via digital technologies.

Recommendations:

- Support national (including rural, regional and remote), community-led, tailored preventative sexual and reproductive health education run by migrant women's organisations and delivered to migrant women and gender diverse people by trained bilingual workers, on key sexual and reproductive health topics, including in FGM/C and reproductive coercion
- Invest in research to better understand the barriers to migrant and refugee women and gender diverse people's access to health literacy, including engagement with digital technologies
- Invest in programs to build capacity of migrant and refugee women and gender diverse people to engage with digital technologies

f) any other related matter.

MCWH supports the submissions and recommendations outlined in the joint submission by the Victorian Women's Health Services, and individual submissions by MSI Australia, and Birth for Humankind.

Recommendations

Universal access to healthcare is essential. MCWH supports this important Inquiry with the following recommendations:

1. Extend Medicare to include all migrants (irrespective of visa category);

2. Resource primary care providers/practitioners, health organisations, and community-based organisations to provide culturally appropriate and responsive education on contraception;

3. Abolish waiting periods and visa restrictions for all migrants, including in relation to temporary migrants on the Pacific Australia Labour Mobility (PALM) scheme, and overseas student health cover (OSHC) deed which is due to expire in June 2024, and within the Minister for Health's power to remove (as outlined in Schedule 4d);

4. Offer all pregnant people safe, free or low cost, culturally appropriate and publicly funded pregnancy and abortion care;

5. Establish a National Taskforce on abortion care, to review the complexities of accessing abortion care in Australia. The taskforce should address the nuanced barriers that communities, such as migrants, experience to ensure universality, and should involve all states and territories, health experts including care providers, community-led organisations and people with lived experience;

6. Include migrant and refugee health as a key priority in regional organisational activity and planning (e.g. Primary Health Networks), including collecting information about migrant and refugee groups (e.g. visa/residency status, maternal country of birth, year of arrival in Australia, a request for an interpreter, and people's preferred language) and collaborating with migrant organisations with relevant expertise and knowledge (Ziersch et. al 2020; Khatri and Assefa 2022);

7. Provide ongoing investment and support to develop a bilingual, bicultural health workforce that is professionally recognised, appropriately remunerated and specifically trained to deliver and work with communities on sexual and reproductive health
8. Upskill, resource and embed bilingual workers across sexual and reproductive healthcare services;

9. Enhance the collaboration between primary care and the prevention sector. For example, improve referral pathways between clinical care and health education for migrant and refugee women and gender diverse people;

10. Invest in and strengthen intersectional policy development and analysis to ensure that national policy at all levels impacts positively on migrant and refugee people's capacity to access reproductive healthcare;

11. Provide free, culturally responsive, voluntary, non-biased mental health support as an integral part of reproductive healthcare (including in relation to perinatal anxiety and depression, trauma, abortion counselling);

12. Provide targeted, sustainable funding for migrant and refugee women's health programs, including healthcare provision and access to abortion care;

13. Bring culturally appropriate sexual and reproductive healthcare into the mainstream and into tertiary education settings by collaborating with migrant women's organisations to develop best practice guidelines for culturally responsive service delivery;

14. Support national (including rural, regional and remote), community-led, tailored preventative sexual and reproductive health education run by migrant women's organisations and delivered to migrant women and gender diverse people by trained bilingual workers, on key sexual and reproductive health topics, including in FGM/C and

reproductive coercion;

15. Invest in research to better understand the barriers to migrant and refugee women and gender diverse people's access to health literacy, including engagement with digital technologies;

16. Invest in programs to build capacity of migrant and refugee women and gender diverse people to engage with digital technologies.

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