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Supported by the NSW Ministry of Health

***ABN** 66 085 654 397*

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Inquiry into the Universal Access to Reproductive Health Care

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and emerging.

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About the AH&MRC

The AH&MRC is a membership-based organisation and the Peak Body for Aboriginal Health in New South Wales. We represent 49 Aboriginal Community Controlled Health Organisations (ACCHOs) across the state.

The AH&MRC assists ACCHOs to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities. The AH&MRC is committed to the delivery of four key priorities:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC welcomes the opportunity to make a submission to this inquiry on behalf of its members.

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AH&MRC response

Reproductive healthcare refers to "a state of physical, mental and social wellbeing in matters relating to the reproductive system".[1] This also includes the right to a safe and satisfying sex life, the freedom and ability to choose to have a child, and the right to have a healthy and safe pregnancy, delivery, and baby. The legacy of colonisation and institutional control has affected reproductive healthcare in Aboriginal and Torres Strait Islander communities. At present, there are significant disparities in reproductive health outcomes between Indigenous and non-Indigenous Australians. This is evidenced by the higher prevalence of sexually transmissible infections (STIs), perinatal and maternal mortality and infant deaths.[2]

Consultation with the ACCHO sector and Aboriginal communities has highlighted a number of issues that the AH&MRC wishes to bring to the Committee's attention regarding the barriers faced by Aboriginal people in accessing contraceptives and those faced by Aboriginal people in accessing reproductive healthcare, including pregnancy care and termination services through their local ACCHOs.

Barriers to accessing contraceptives through ACCHOs

Contraceptive use among Aboriginal communities is reportedly lower than non-Indigenous Australians. There are a number of contributing factors including potential apprehension due to Aboriginal people's historical experience with forced contraceptive use and removal of children; stigmatisation; lack of sexual education; and lack of access to contraceptives.

While Aboriginal people have a range of options of primary healthcare providers, it is widely acknowledged that a large majority prefer to access care through an ACCHO due to locality, cultural safety and holistic service offerings. Within ACCHOs condoms are the most readily available method of contraception, with the majority of services identifying that they have easy access to and adequate supplies of condoms. The primary challenge is instead, access to long-acting reversible contraceptive (LARC) methods such as intrauterine devices (IUD) and insertions.

LARCs are recognised as being more effective in reducing the rate of unintended pregnancies for younger women and those who may experience socioeconomic

[1] Department of Health and Aged Care. 2022. *About Reproductive Health.* https://www.health.gov.au/topics/reproductive-health/about

[2] Hickey, S., Roe, Y., Harvey, C., Kruske, S., Clifford-Motopi, A., Fisher, I., Bernardino, B. & Kildea, S. (2021). Community-based Sexual and Reproductive Health Promotion and Services for First Nations People in Urban Australia. *Int J Womens Health, 18*(13), 467-478. doi: 10.2147/IJWH.S297479.

disadvantage.[3] This method is less dependent on the consumer and can last for several years. LARC methods can be accessed through general practice, family planning, and some sexual health or abortion services. Increased availability and uptake of LARCs, including copper IUDs is a key objective for the *National Women's Health Strategy:* 2020-2030, despite not being subsidised under the Pharmaceutical Benefits Scheme (PBS).[4]

Aboriginal people typically access contraceptives through their local GP. Doctors, eligible nurses, and midwives are able to undertake specific IUD training to offer insertions in their clinical practice. ACCHOs are however limited in their ability to provide these services due to limited access to GPs, gynaecologists and trained nurses and midwives who can perform IUD insertion and removal. Some services can access them through arrangements with LHDs or the Rural Doctors Network, but this is usually on an ad hoc basis, with access varying across the state.

There are also constraints on the reimbursement that services can claim through Medicare when eligible nurses or midwives perform these services. The Federal government has recently increased the MBS schedule fee to $70.90. While this increase is supported, it is less than half of the recommended increase for IUD insertion.[5] ACCHOs require additional preparation, consultation, and staff such as Aboriginal Health Workers and Practitioners, should a patient require. The current MBS schedule fee does not reflect this and is restricting services from offering IUD insertions/removals.

Where ACCHOs are unable to provide these services, patients are often referred to non-community-controlled services. These services are generally culturally unsafe and can attract out-of-pocket costs for Aboriginal patients, discouraging uptake.[6] In improving use of LARCs, it is imperative that the government support the delivery of services through ACCHOs, including through the increasing of Medicare rebates.

The NSW government had previously funded an Aboriginal Sexual and Reproductive Health (SRH) Program, tailored for individual communities. This program was developed in partnership with the ACCHO sector, having employed Aboriginal SRH workers in seven ACCHOs and one LHD. This program has since ceased yet findings

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[3] Black, K., Bateson, D. & Harvey, C. (2013). Australian women need increased access to long-acting reversible contraception. *Med J Aust,* 199(5). doi: 10.5694/mja12.11832

[4] Department of Health. (2020). *National Women's Health Strategy 2020-2030.* https://www.health.gov.au/sites/default/files/documents/2021/05/national-women-s-health-strategy-2020-2030.pdf

[5] Tsirtsakis, A. (2022, March 2). Rebate increase for IUD insertion called out as 'inadequate'. *RACGP.*https://www1.racgp.org.au/newsgp/professional/rebate-increase-for-iud-insertion-called-out-as-in

[6] RANZCOG. (2017). *Consensus Statement: reducing unintended pregnancy for Australian women through increased access to long-acting reversible contraceptive methods.* https://ranzcog.edu.au/wp-content/uploads/2022/05/Long-Acting-Reversible-Contraception-LARC-Consensus-Statement.pdf

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from the 2015 evaluation have identified best practice for SRH programs. The program led to an increase in service attendance and STI testing for Aboriginal youth (15-24 years). There was also an increase in contraceptive use, however this did decline at the 6 month follow up period. Key recommendations of the evaluation identified that an ACCHO-based health promotion approach as central to the success of the program. The risk of short-term funding leading to the loss of Aboriginal SRH workers between funding cycles was also noted.

Barriers to accessing reproductive health services including pregnancy care and termination services through ACCHOs

Aboriginal women also face challenges in accessing reproductive health services, both in terms of pregnancy care and termination. In most cases, patients are required to navigate across various systems including community-controlled services and non-Aboriginal community or NGO services and mainstream services, which can, of itself be difficult. This is exacerbated by the lack of integration between systems and by remoteness.

Access to abortion services in Australia is recognised as a systemic issue, with varying laws and costs across jurisdictions. At present, only ten per cent of Australian Doctors (one per cent in regional areas) are registered to prescribe the RU486 pill which is prescription-only and licensed up to 9 weeks (63 days) gestation. There are also a limited number of surgical abortion providers, many of whom are located in urban areas and can charge amounts within the thousands. It is estimated that between one quarter and one third of all Australian women experience an abortion in their lifetime.[8] Further to this, Aboriginal people are more likely to suffer poor health outcomes when prevented from accessing a safe termination.[9]

As previously noted, ACCHOs face significant challenges in accessing GPs and gynaecologists. This limits their ability to prescribe the RU486 pill to eligible patients. Notwithstanding, as many women find out they are pregnant approximately six weeks into their pregnancy, the window for accessing medical abortion is very slim. There are no known ACCHOs in New South Wales that provide surgical abortion services, and therefore, Aboriginal women who present to their ACCHOs seeking surgical termination must be referred to other providers. It is generally the case that these non-community-controlled services are culturally unsafe. Further, as they are clustered in urban areas while the majority of the state's Aboriginal communities live in rural and remote areas, patients are required to travel (sometimes significant distances) to find a service. In addition to the high costs of surgical abortion and any necessary aftercare, these patients may incur costs associated with travel and accommodation. Some ACCHOs have reported instances where they have supported patients with out-of-pocket costs through their core funding.

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ACCHOs must be funded and staffed to provide these services where possible to ensure that Aboriginal people seeking termination can do so within their communities. Where this is not feasible, Aboriginal people should be funded to support patients to access these services as the current model that requires them to draw from their core funding is unsustainable. Moreover, work should be done to support partnership and integration with non-community-controlled service providers to ensure that Aboriginal people have support when navigating across systems and support cultural safety in non-Aboriginal mainstream, private and community services.

For Aboriginal people who choose to go ahead with their pregnancies, access to pregnancy care is also challenging. Evidence indicates that Aboriginal mothers and babies experience poorer perinatal outcomes than their non-Aboriginal counterparts. Despite being at higher risk due to underlying health issues and social complexities, Aboriginal mothers have lower uptake of antenatal and postnatal services. This can be attributed to a number of factors including cost, lack of trust, geographic isolation and culturally unsafe practices.

In 2021, the AH&MRC undertook some mapping of maternal health models of care in ACCHOs and found that many were providing high-quality, holistic services for Aboriginal women and their families. Services with capacity were able to provide women with obstetric GPs, Aboriginal midwives and Aboriginal Health Workers as well as other specialists including dieticians, pediatricians, diabetes educators and AOD support workers within community. These comprehensive programs included individually tailored care and birth plans, home visitation, parenting education classes, tours of LHD birthing suites where partnerships existed and birthing on country where feasible.

It was concluded that the success of these programs was due to the ACCHOs':

- Leveraging their strong connections to communities to develop place-based approaches that are adaptive to the unique needs of different communities.

- Providing wraparound support to women and families who access maternal services, with a specific focus on addressing the underlying social complexities that have historically led to poor perinatal outcomes for Aboriginal women and babies.

- Embedding flexibility and self-determination within their service delivery models to allow women to decide how they wish to engage with services.

This exercise highlighted that Aboriginal mothers' pregnancy care experiences differ vastly within ACCHOs, when compared to non-Aboriginal services due to the focus on holistic, culturally safe care. Further, that where women are required to transition across

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different settings, whether LHD, private or community, they have better experiences when strong partnerships exist with ACCHOs to facilitate culturally appropriate, integrated care.

Notwithstanding, in New South Wales, ACCHOs receive very limited funding for the provision of pregnancy care, with the bulk of funding going to mainstream or non-Aboriginal community services. There is a need for government in ACCHO -based programs and support partnerships across the system to improve outcomes for Aboriginal mothers and their babies.

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Recommendations

The ACCHO sector is well positioned to develop and deliver holistic, culturally safe programs and services for Aboriginal people. It is clear from the issues highlighted in this submission that they are hampered by workforce shortages, limited funding and lack of partnership with external service providers.

The AH&MRC recommends that the government:

1. Invest in the growth of the Aboriginal community-controlled health workforce. This should include exploring mechanisms to increase access to GPs and gynaecologists in ACCHOs and support for the upskilling of nurses and midwives.

2. Invest more broadly in regional and remote reproductive health services (including termination services), with a particular emphasis on facilitating the provision of these services in ACCHOs where possible. Where this is not feasible, ACCHOs should receive dedicated funding to facilitate patient referrals.

3. Increase funding for ACCHO based maternal and infant health services and explore opportunities to support better service integration for mother navigating across the system



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