

WOMEN AND SEXUAL AND REPRODUCTIVE HEALTH

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Australian Women's Health Network

Women and Sexual and Reproductive Health

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Executive summary

Women's sexual and reproductive health is recognised worldwide as a priority health issue, and Australia is a signatory to a number of treaties to protect women's sexual and reproductive rights. Australian federal, state and territory governments have a range of policies on individual aspects of sexual and reproductive health, but a coordinated response is lacking. This piecemeal approach to women's health is ineffective and a new, holistic approach is urgently needed.

Most government policy is gender blind, yet gender is one of the most significant determinants of sexual and reproductive health. Women are significantly more likely to experience sexual violence, take the major role in contraceptive decision-making and have sole responsibility for pregnancy.

The challenges for some women are far greater than for others and health inequalities between Australian women continue to increase. Women with disabilities, young women, rural women, Aboriginal and Torres Strait Islander women and other disadvantaged groups are most vulnerable to experiencing sexual and reproductive ill-health.

This paper advocates for a rights-based approach to ensuring all women can access comprehensive sexual and reproductive health care appropriate to their needs, regardless of their location, age, sexuality, financial status and religious and cultural background. It explores seven key areas through which good sexual and reproductive health for Australian women can be achieved. These are:

- promoting positive and respectful attitudes to sex and sexuality;
- developing women's health literacy;
- increasing reproductive choice;
- facilitating women's health throughout pregnancy and birth;
- expanding prevention and treatment of reproductive cancers and menstrual issues;
- improving prevention and treatment of sexually transmitted infections (STIs); and
- equipping the health workforce to better respond to women's health needs.

The Australian Women's Health Network advocates for comprehensive action across these areas, and particularly recommends: a national sexual and reproductive health strategy; a national sexuality education curriculum, including respectful relationships education; the decriminalisation of abortion across all Australian states and territories; and a transformation in the knowledge and capacity of the health workforce to address the full range of women's sexual and reproductive health needs.

Recommendations

AWHN makes the following recommendations for action to improve sexual and reproductive health outcomes for women. Our recommendations have been organised under a Policy development and implementation category, in addition to the seven key areas listed above. However, many actions are relevant to and would positively impact across a number of categories.

Government policy development and implementation

It is recommended that:

- a national sexual and reproductive health strategy for Australia be developed as a priority, to improve the sexual and reproductive health of all by addressing the social determinants of sexual and reproductive ill-health. The Australian Women's Health Network endorses the paper by Public Health Association and Sexual Health & Family Planning Australia *Time for a national sexual and reproductive health strategy* (O'Rourke, 2008) and the objectives, processes and actions it identifies for the formulation of a national strategy. (Action 1: p. 12).
- the entirety of the *National Plan to Reduce Violence Against Women and Their Children* be implemented and that it is adequately funded at both federal and state levels. (Action 3: p. 15).
- the federal government's *Voluntary Industry Code of Conduct on Body Image*, which outlines principles to guide the media, advertising and fashion industries to adopt positive body image practices, is made mandatory. (Action 5: p. 15).
- all Australian governments develop a legislative framework that protects and supports the health and safety of sex industry workers, and ensure consistent implementation throughout Australia. (Action 6: p. 16).
- Australian governments enact laws to regulate health product advertising on the internet and ensure transparency in advertising for pregnancy counselling services. Pregnancy counselling services that are opposed to abortion and that do not provide referrals or information about pregnancy termination services must be required to disclose this clearly when advertising to the public. (Action 7: p. 16).
- more rigorous monitoring of existing Australian laws and regulations on sterilisation procedures performed on girls and women living with disabilities are introduced, to ensure that these procedures are carried out only in cases of medical necessity or where they have been mandated by a court. (Action 11: p. 17).
- abortion be decriminalised through law reform in those states where abortion still forms part of the criminal code. (Action 16: p. 19).
- law reform be undertaken to remove discrimination in accessing fertility treatment in all states and territories. (Action 22: p. 19).

Developing women's health literacy

It is recommended that:

- alternative avenues for the delivery of sexuality education throughout the duration of women's lives are given institutional and policy support, including initiatives in women's health centres and workplaces, and the development of online resources. Programs should incorporate raising women's awareness of evidence-based websites, improving their capacity to assess the reliability of information and building their skills in communicating confidently about private health issues. (Action 9: p. 17).
- critical recognition be given to the availability of low-literacy sexual and reproductive health resources and culturally appropriate materials for specific communities, including CALD and ATSI women. Resources targeting specific groups need to be developed in partnership with these women, an initiative that requires appropriate funding. (Action 10: p. 17).
- preventable infertility be reduced for both men and women through a broad public health campaign to improve awareness of the underlying and gendered risk factors, such as identifying and managing Polycystic Ovarian Syndrome and the prevention and treatment of Sexually Transmissible Infections that can cause infertility. (Action 20: p. 19).
- federal and state governments conduct a targeted sexual health campaign for young women that involves them in its development and focuses on their right to negotiate safe sex, condom use, protection from chlamydia, and its link to infertility. The campaign would focus on high risk groups and incorporate grants for local programs, low-literacy resources and an interactive youth-friendly website and social marketing elements. (Action 33: p. 23).

Promoting positive and respectful attitudes to sex and sexuality

It is recommended that:

- a comprehensive and compulsory national sexuality education program is implemented in all schools. The curriculum must be evidence-based, age-appropriate, and its implementation monitored by the Australian Curriculum Assessment and Reporting Authority. (Action 2: p. 14).
- respectful relationships education be implemented by state and territory governments in all primary and secondary schools to support the reduction of sexual violence against women. The current Respectful Relationships funding program by the federal government should be extended beyond 2013 and expanded to enable more communities to access ongoing funding for anti-violence initiatives. (Action 4: p. 15).

Increasing reproductive choice

It is recommended that:

- all pregnancy counselling services which receive government funding be required to offer evidence-based information on the range of pregnancy options available and be publicly evaluated to ensure their compliance. (Action 8: p. 16).
- increased access be provided to a wide range of safe, affordable contraceptive options, including male and female condoms, advance supply of emergency contraception, and expansion of contraceptive prescribing rights for nurse practitioners. (Action 12: p. 18).
- the affordability of—and access to—all contraceptives be improved through the listing of newly-available hormonal contraceptives, including those used for emergency contraception, on the Pharmaceutical Benefits Scheme. (Action 13: p. 18).
- a review be undertaken by the federal government of restrictions by pharmacists on the supply of emergency contraception to women under 16 years of age. (Action 14: p. 18).

- access to safe and legal abortion be provided to all Australian women through the public health system and through accessible licensed private providers. (Action 17: p. 19).
- medication abortion as a readily available method for all women seeking early termination be made possible through federal government support of applications for the importation and distribution of mifepristone in Australia, including the listing of mifepristone on the Pharmaceutical Benefits Scheme. (Action 19: p. 19).
- the federal government commission a report into the measures required to ensure equity in access to Assisted Reproductive Technology (ART), including some public hospital provision of ART services. (Action 21: p. 19).
- private health facilities that receive government funding to provide public reproductive and sexual health services be required to provide comprehensive contraceptive and all-options pregnancy information and services. (Action 42: p. 25).

Facilitating women's health throughout pregnancy and birth

It is recommended that:

- government funding be provided and policy developed to ensure that the health system provides continuity of care during pregnancy to all women, regardless of where they live. This would include the provision of accurate and timely information and care to women, delivered by skilled and collaborating professionals mindful of women's need to feel safe and in control. Women would receive antenatal care and be attended at birth by known health professionals with whom they have built a trusting relationship. (Action 23: p. 20).
- all public health messages concerning a 'healthy pregnancy and baby' are framed in a sensitive, non-judgemental way that is relevant to the social and economic circumstances of women's daily lives. (Action 24: p. 20).
- women's choices and beliefs regarding pregnancy are respected and supported through systemic change to the health system. Where quality of service delivery is ensured, this includes:
 - » support for women's choices during pregnancy and childbirth;
 - » facilitating birthing close to home, including increased provision of midwifery based care models such as birth centres; and
 - » timely and sensitive support for women experiencing difficult labour, miscarriage or stillbirth. (Action 25: p. 21).

Expanding prevention and treatment of reproductive cancers and menstrual issues

It is recommended that:

- governments concentrate efforts to explore, fund, and implement innovative ways to increase the prevention, detection and treatment of reproductive cancer in communities of high risk women, in particular Aboriginal and Torres Strait Islander women. (Action 26: p. 21).
- governments promote participation by all eligible women in recommended breast and gynaecological cancer screening programs, by consistently and adequately funding and promoting these programs. This should be accompanied by public education campaigns to encourage women's self-monitoring of bodily changes to promote early detection of cancer. (Action 27: p. 22).
- women's awareness and understanding of menstrual health be increased through a menstrual health awareness and education campaign in local health services, including the community health sector. (Action 29: p. 22).
- the federal government remove the GST on menstruation sanitary products to improve affordability. (Action 31: p. 22).

Improving prevention and treatment of sexually transmitted infections (STIs)

It is recommended that:

- research findings from the HPV vaccine implementation program be translated—via awareness campaigns targeted at parents, schools and health centres—to ensure that the uptake is optimal across all schools and youth settings, including among young women living in remote Australia and those disengaged from school. (Action 28: p. 22).
- an STI prevention and treatment education campaign be implemented that increases awareness of the prevalence of STIs, their transmission, treatment, and protective behaviours. The campaign should include targeted approaches for ‘at risk’ groups, and incorporate the key message that anyone who is sexually active is at risk of STIs and should be screened regularly by a General Practitioner or specialised sexual health service. Confidentiality of services should also be emphasised. (Action 32: p. 23).
- coordination of a male and female condom initiative is undertaken to increase the availability of free or low-cost condoms and to normalise condom use. The initiative should include distribution programs and identify access points through youth services; women’s health centres and services; family planning services; community health centres; women’s health nurses; GPs; ATSI health centres; and school-based nurses. (Action 34: p. 23).

Equipping the health workforce to better respond to women’s health needs

It is recommended that:

- education programs for pharmacists and other health practitioners be developed and implemented, along with a public awareness campaign concerning the use and effectiveness of emergency contraception. (Action 15: p. 18).
- federal, state and territory governments address inequities in abortion service delivery to ensure that women living in regional, rural and remote areas have timely access to affordable services. (Action 18: p. 19).
- improvements be sought in health professionals’ understanding of menstrual health issues and diagnosis rates through the establishment of menstrual health as a component of all nursing and medical education. These programs should focus on improving recognition of menstrual problems and addressing the sensitivity and taboo of menstruation for both women and health professionals. (Action 30: p. 22).
- in order to ensure optimal provision of services in the future, the Commonwealth Department of Health and Ageing and/or Health Workforce Australia conduct an analysis of the sexual and reproductive health workforce and recommend actions to rectify gaps. (Action 35: p. 24).
- national sexual and reproductive health accreditation standards for nurses and GPs are developed and implemented to ensure that Australian women have access to high quality care and health information which is evidence-based and non-discriminatory. (Action 36: p. 24).

- through effective use of the capacity of the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, a full range of sexual and reproductive health services are provided, including increased prescribing rights for nurse practitioners, 'well women' checks, and support services. (Action 37: p. 24).
- active encouragement and support be provided for women to become health practitioners in the sexual and reproductive health field via incentives and extra support, including specific targeting of women from diverse groups. (Action 38: p. 25).
- research be conducted into gaps in rural sexual and reproductive health service delivery and subsequently formulate appropriate policies. (Action 39: p. 25).
- the Department of Health and Ageing provide leadership in advocating for gender sensitive sexual and reproductive health services in local Health Networks, in Medicare Locals, and in population health plans. (Action 40: p. 25).
- all health facilities and health professionals be mandated to disclose to patients their policies, religious values or personal prejudices concerning sexual and reproductive health in instances in which they will impact on the options, types and extent of health treatment and care provided. (Action 41: p. 25).
- a mandatory requirement be instituted for private tertiary education institutions that provide undergraduate and graduate nursing and medical education programs, and which receive government funding for subsidised student places, to include the teaching of hormonal and barrier contraceptive methods and pregnancy termination procedures. (Action 43: p. 25).

Introduction

While the Australian Government has ratified multiple international conventions enshrining sexual and reproductive health rights, these rights are not fixed in domestic law and policy. Sexual and reproductive health is a priority area of women's health and well-being. A comprehensive, rights-based approach is needed to address current inequities impacting upon women's health.

Australia has a range of policies at state, territory and federal levels in relation to sexual and reproductive health, including the second National Women's Health Policy 2010 (NWHP), which prioritises sexual and reproductive health. Disappointingly, the current policy environment fails to provide a coordinated all-of-government approach or a gendered framework for service delivery. This is exemplified by the absence of a National Sexual and Reproductive Health Strategy.

Evidence strongly indicates that **investing** in women's sexual and reproductive health is cost effective, has the capacity to improve the health of all, and will impact positively on the economy.

Relying on evidence derived from research into the issues surrounding women's health and gender, this paper uses a rights-based approach founded particularly on the international law regimes outlined in the following section, and as specified in Appendix 1, to argue for a nationally led, coordinated approach to women's sexual and reproductive health, and recommends actions within **seven key areas**.

The action areas are:

1. Promoting positive and respectful attitudes to sex and sexuality.
2. Developing women's health literacy.
3. Increasing reproductive choice.
4. Facilitating women's health throughout pregnancy and birth.
5. Expanding prevention and treatment of reproductive cancers and menstrual issues.
6. Improving prevention and treatment of sexually transmissible infections (STIs).
7. Equipping the health workforce to better respond to women's health needs.

Although gender is one of the most significant determinants of sexual and reproductive health, health is also affected by an array of social, economic, genetic, physiological and psychological factors (O'Rourke, 2008). Rather than decreasing, health inequalities between women of differing geographic, cultural, economic and age characteristics have increased in recent years (Walker, 2001). Women who have limited resources and lack the capacity to exert control over their lives are more vulnerable to experiencing sexual and reproductive ill-health. In Australia, vulnerable women include:

- young women;
- Aboriginal and Torres Strait Islander (ATSI) women;
- women living with a disability;
- women living in rural, regional and remote areas (rural women);
- culturally and linguistically diverse (CALD) women;
- same sex attracted women;
- gender diverse women.

Specific issues for vulnerable groups will be raised throughout this position paper.

A rights-based approach

A rights-based approach to health recognises women as the experts in their own lives. It recognises that they have the right to self-determination, to privacy, to consent to sex, and to receive comprehensive and understandable information to enable them to make the best decisions about their health in the context of their own lives. Women's reproductive and sexual rights are enshrined in international treaties (Appendix 1) and law which must be upheld Australia-wide.

A rights-based approach to sexual health underpins the World Health Organisation's (WHO) definitions of sexual health and reproductive health (see page 4).

The *Beijing Declaration and its Platform for Action* (1995) included the recognition of the human rights of women as integral to the achievement of optimal health and well-being.

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (United Nations, Fourth World Conference on Women, Beijing, 1995, p. 36).

The *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), to which Australia is a signatory, includes the rights of women to “freely choose a spouse and only enter into marriage if ‘free and full consent’ is given” and “to decide the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (CEDAW, Article 16).

To support effective rights-based action on women's sexual and reproductive health in Australia, eight major guiding principles have been developed. The actions recommended in this paper require implementation and delivery in accordance with these principles:

1. Health action requires respect for the reproductive rights and sexual rights of Australian women.
2. Services must be accessible, responsive and accountable to their clients.
3. Diversity must be acknowledged and supported in health policy and service provision.
4. Sexual and reproductive health initiatives must address the social determinants of health, especially gender.
5. Strategies must build and enhance the capacity of communities.
6. All governmental and private health and related community sectors must work together to achieve high-quality sexual and reproductive health outcomes.
7. Effective approaches to sexual and reproductive health must consider the whole person, including their social, emotional, physical and spiritual dimensions.
8. Interventions must be safe, effective and evidence-based.

Appendix 2 is a comprehensive guide to these principles.

Policy context and programs

Current Australian policy environment

At state, territory and federal levels, a range of policies exist that deal with particular sexual and reproductive health issues (Appendix 3). The shortcomings of these policies are that: they focus on single issues or diseases; there are no linkages to strategies that address the social determinants of health; links are not made between interdependent strategies; gender is not addressed as a key determinant of health; and gender-disaggregated data is not used to inform the policy (O'Rourke, 2008). Therefore, Australia has an array of policies that have been developed independently of each other in an ad hoc manner. There is no coherent national sexual and reproductive health strategy.

The division of state, territory and federal responsibility impacts upon public health. For example, while federal law and regulations allow doctors to prescribe mifepristone (or RU486), a medication abortifacient, some states retain laws that criminalise the provision of abortion services to women (Calcutt & Marsh, 2011). The resulting confusion discourages the medical profession from providing these services and limits women's access to abortion care (de Costa, 2011).

Similar issues arise in relation to the National Plan to Reduce Violence Against Women and Their Children. Women's advocates welcome the policy, but its effectiveness is reliant upon "the quality of implementation and the seriousness of commitment from respective governments" (McCormack, 2010). A major concern is that current funding for implementation of the whole policy at both state and federal levels is inadequate.

Inadequate funding of existing policies is a major barrier to achieving the stated policy directions and the economic advantages from investing in women's health. For example, the NWHP highlights key health issues facing Australian women, including sexual and reproductive health as a priority issue. However, it contains no new programs, no recognition of the importance of work done by women-specific services, and no funding for implementation.

Emerging issues in the interaction between state, territory and federal authorities include the development of the national school curriculum and its impact on the delivery of sexuality and relationships education; and the effect of the National Health and Hospital Reforms upon the delivery of sexual and reproductive health services.

Improving on current policies

A coordinated national approach to sexual and reproductive health would reduce the isolation of existing strategies from each other, improve the delivery of services, increase the efficacy of existing strategies, and improve public health outcomes (NPHP, 1999).

Despite the disjointed policy environment, some successful programs are making a difference to women's sexual and reproductive health. Examples include the South Australian Pregnancy Advisory Centre, Congress Alukura in Alice Springs, and Melbourne's Multicultural Centre for Women's Health (Appendix 4). These programs exemplify best practice, implementing research findings and advocating a rights-based approach as outlined above. They have been developed cooperatively with target groups and do not operate from within a solely biomedical framework. However, because there is no coordinated national approach, opportunities to learn from best practice and to create coherent and interactive programs are limited.

A national sexual and reproductive health policy is required to address the current gaps in policy provision and provide a coordinated response to improving the sexual and reproductive health of all women.

Action 1: It is recommended that a national sexual and reproductive health strategy for Australia be developed as a priority, to improve the sexual and reproductive health of all by addressing the social determinants of sexual and reproductive ill-health. The Australian Women's Health Network endorses the paper by Public Health Association and Sexual Health & Family Planning Australia *Time for a national sexual and reproductive health strategy* (O'Rourke, 2008) and the objectives, processes and actions it identifies for the formulation of a national strategy.

Investing in women's sexual and reproductive health

The impacts of sexual and reproductive health are both human and economic, and Australia would greatly benefit from increased investment. Direct health impacts are easier to identify, such as the prevention of cancer deaths. Indirect health benefits are more difficult to quantify, with consequences at personal, family and societal levels, including increased economic growth and social equity (Singh et al, 2003).

Evidence suggests that investment in sexual and reproductive health has the capacity to minimise future health system costs. According to a British study, a public health intervention that prevents one new HIV infection would save the public health system £350,000 (A\$559,000) per case (BHIVA et al, 2010). American research estimated that the direct medical costs of unintended pregnancy were US\$5 billion (A\$5b) annually (Trussell, 2007).

Women's sexual and reproductive health should be incorporated within general health initiatives to improve their impact and cost effectiveness. For example, diabetes interacts with pregnancy, carer responsibilities, sexual function and menopause (ARROW, 2012). In Australia, the annual cost of type 2 diabetes alone is estimated at \$10.3 billion (Access Economics, 2006). Yet approaches to prevention and management of diabetes are aimed at individuals aged over 50, with no gendered analysis of programs (Grant, 2009) and no discussion of sexual health.

The lack of responsiveness of the health system to women's issues is another factor adding to the overall cost of addressing women's health, particularly where women may seek help repeatedly for a health condition without receiving effective treatment. For example, to obtain a diagnosis of endometriosis currently takes an average of seven years (Healy et al, 2009), and the disease's estimated cost to the Australian economy is \$6 billion per year (QENDO, 2011).

Reluctance to discuss sexuality openly and honestly increases health costs and limits the effectiveness of health promotion initiatives. Despite substantial evidence that abstinence-only sex education is ineffective, it continues to be provided in many schools. Research suggests that students who exclusively receive abstinence messages are less likely to practice safe sex at first intercourse, exposing them to the risk of disease and unplanned pregnancy (Boonstra, 2009).

Substantial economic gains could be achieved by eliminating sexual violence perpetrated against Australian women. If intimate partner violence were to be eliminated in Australia, potential annual savings are estimated to be in the order of \$207 million in health costs and \$1.8 billion from lost productivity and lost leisure activity spending (Cadilhac et al, 2009).

Women who experience economic and social disadvantage are at far greater risk of sexual and reproductive ill-health. In the study of the consequences of income inequity, *The Spirit Level: Why More Equal Societies Almost Always Do Better* (Wilkinson and Pickett, 2009), the authors illustrate that the best overall health outcomes are achieved in societies with narrow income differentials. Addressing economic inequality—particularly for those who suffer extreme disadvantage, such as ATSI women—will assist in improving the well-being of women and have economic and social benefits for all.

Key areas for action

Key area for action: Promoting positive and respectful attitudes to sex and sexuality

A positive approach to sex and sexuality acknowledges women and men as sexual beings and everyone's equal right to intimacy and pleasure. It encompasses respect for individual diversity regarding sexual orientation, rather than adopting hetero-normative stereotypes.

A healthy sexual relationship involves mutual consent, equality, respect, trust and safety. Women have the right to engage in sexual activity and to find pleasure in doing so. Critical issues requiring action are: sexuality education; sexual violence; body image; and sex work.

Sexuality education

Sexuality education is defined as the lifelong process of acquiring information and forming attitudes, beliefs and values about feelings, relationships, gender roles, body image, sexual development and reproductive health (SIECUS, 2007).

Research indicates that comprehensive sexuality education delays the beginning of sexual activity and can better prepare young people to make safe and responsible decisions about sexual activity. When young people are provided with accurate information and skills in relation to sexual health they are less likely to experience poor sexual and reproductive health outcomes (Wellings & Parker, 2006).

There is currently no standardised national sexual and reproductive health curriculum, nor are there best practice guidelines for individuals delivering sexuality education. This generates large differences in the provision of information to—and its reception by—young people. Many teenagers who have received school sex education report that they were given no information about topics such as sexual decision making, emotional aspects of sex, and non-consensual sex (MSI, 2008).

In the absence of open conversations with educators or parents regarding sex, some young people report that they turn to pornography for sexual information. Increasing ease of access to the internet makes it difficult to avoid exposure to online pornography. For adults, high exposure to violent sexually explicit material can lead to men engaging in aggressive and abusive sexual practices against women (Guy et al, 2012). There is increasing evidence that young men's understanding and experience of sex can be negatively influenced by what they observe in pornography (Flood, 2010). Given that pornography often depicts the debasement of women and sexualised violence against women, it is having a considerable negative impact on relationships and men's attitudes and behaviours towards women and sex (Dines, 2010). Sexuality education must incorporate discussions about gender and power in society, emphasise mutual enjoyment and consent, and assist young people to think critically about the way sexuality and relationships are depicted in the media.

Action 2: It is recommended that a comprehensive and compulsory national sexuality education program is implemented in all schools. The curriculum must be evidence-based, age-appropriate, and its implementation monitored by the Australian Curriculum Assessment and Reporting Authority.

Sexual violence

Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009–2021, sets out a zero tolerance position, arguing that no woman should be a victim of sexual assault or domestic and family violence, and that no woman should fear for her safety at home, at work, or in her community.

However, in Australia, women in cohabitating, heterosexual relationships are more likely to be sexually assaulted by their intimate partners than by any other man. Almost one in five women experience sexual violence over their lifetime and one in three women are survivors of child sexual abuse (Australian Bureau of Statistics [ABS], 2005). Young women, Indigenous women, and women with a disability are far more likely to suffer sexual violence than the general female population (Young et al, 2000; ABS, 2004; Australian Law Reform Commission, 2010).

Disturbingly, the number of young women who report having had unwanted sex increased from 28% to 38% between 2002 and 2008. They cited being drunk (17%) or pressure from their partners (18%) as the most common reasons for experiencing unwanted sex (Smith et al, 2008).

Another life stage where women experience increased risk of violence is during pregnancy. ABS data (2007) shows that around 16% of women experience violence from a partner for the first time while pregnant. Statistics from Victoria's Pregnancy Advisory Service at the Royal Women's Hospital show that 16% of pregnant women reported experiencing violence (Rosenthal, 2008).

Action 3: It is recommended that the entirety of the National Plan to Reduce Violence Against Women and Their Children be implemented and that it is adequately funded at both federal and territory and state levels.

Action 4: It is recommended that respectful relationships education be implemented by state and territory governments in all primary and secondary schools to support the reduction of sexual violence against women. The current Respectful Relationships funding program by the federal government should be extended beyond 2013 and expanded to enable more communities to access ongoing funding for anti-violence initiatives.

Body image

Women learn vicariously from an early age that their most important characteristic is their appearance; this message is perpetuated by sexualised advertising, undersized actresses and models, and airbrushed photographs. Women with poor body image and lower self-esteem are less likely to be able to negotiate safe or pleasurable sex, and may make unhealthy sexual choices or engage in riskier sexual behaviours (Eisenberg et al, 2005).

According to the Australian Medical Association (AMA), poor body image can affect lifestyle choices and produces negative mental and physical health outcomes. It can lead to "unhealthy dieting, eating disorders, excessive exercise or under-exercise, substance

use, and the desire for unnecessary surgical intervention" (AMA, 2009, p. 1). Enquiries about genital cosmetic surgery (labiaplasty) are increasing (WHQW, 2009).

Action 5: It is recommended that the federal government's Voluntary Industry Code of Conduct on Body Image, which outlines principles to guide the media, advertising and fashion industries to adopt positive body image practices, is made mandatory.

Sex work

Legal frameworks and health care for women engaged in sex work require a non-discriminatory approach. Legislation differs throughout Australia and discrimination, assault and harassment are experienced by a majority of sex workers (Bridgett & Robinson, 1999). Women who enter sex work should not be criminalised (Crofts & Summerfield, 2006) or marginalised, and have the right to work in safe and healthy conditions.

In the context of the sex industry, sexual health becomes an occupational health and safety issue, as well as a public health issue. The social stigma attached to working in the industry can mean that workers are discriminated against in all aspects of society if they are open about what they do. The stigma attached to sex work means that sex workers' experiences of sexual assault, both in work and in their private lives, are questioned, minimised or silenced. They are often disbelieved and perceived as undeserving of support or legal justice because of their work. Underage sex workers in particular are vulnerable to sexual assault and other disadvantage, and are reluctant to go to the police (Women's Health Victoria, p. 11).

Research also points to links between childhood sexual abuse and sex work. It suggests that women who work in the sex industry are much more likely to have histories of sexual abuse.

In a Sydney based study, 75 percent of sex workers reported having experienced sexual abuse before the age of 16 years. Almost half of the Sydney sample of sex workers met the criteria for lifetime diagnosis of post-traumatic stress disorder, while 87 percent reported some depressive symptoms (Women's Health Victoria, p. 11).

Sex industry workers use both general practitioners (GPs) and sexual health clinics for their sexual health checks. However, research suggests that they do not disclose their work or access screening at the recommended intervals. Further research and workforce development is needed to ensure health professionals can respond to the specialised needs of this group (Esler et al, 2008).

Action 6: It is recommended that all Australian governments develop a legislative framework that protects and supports the health and safety of sex industry workers, and ensure consistent implementation throughout Australia.

Key area for action: Developing women's health literacy

Women require comprehensive and reliable sexual and reproductive health information to make their own informed choices and decisions. Information needs to be transparent and accessible, particularly for disadvantaged women.

Acting to ensure information transparency

Women seek health information from a wide range of sources, including GPs, health centres, the internet, books, mass media, and informally from friends and family. Internet use is increasing, yet some women do not or are unable to check the reliability of the information source (Warner and Drew Procaccino, 2004).

Regulatory action needs to be taken where information is inaccurate or misleading. One example is the commercially driven online sale of antidepressants to women, many of whom have not been diagnosed with depression (Carroll and McCarthy, 2010). Another example is unplanned pregnancy counselling organisations, which are not covered by the Competition and Consumer Act and are not subject to advertising regulations. They are able to advertise as providing 'all-options' counselling even if they are opposed to

abortion. These organisations have the potential to provide misleading and false information, such as the capacity of abortion to cause breast cancer, mental health problems, or infertility, despite this being repeatedly shown to be false by reputable medical research (Appendix 5). Women who receive this misinformation report experiencing increased distress at an already difficult time.

Action 7: It is recommended that Australian governments enact laws to regulate health product advertising on the internet and ensure transparency in advertising for pregnancy counselling services. Pregnancy counselling services that are opposed to abortion and that do not provide referrals or information about pregnancy termination services must be required to disclose this clearly when advertising to the public.

Action 8: It is recommended that all pregnancy counselling services which receive government funding be required to offer evidence-based information on the range of pregnancy options available and be publicly evaluated to ensure their compliance.

Acting to ensure reliable and accessible information

The information needs of women and girls vary throughout the duration of their lives. Sexuality education is targeted at school attendees, excluding disengaged youth and women who have finished education. Women in their twenties are the highest demographic presenting for pregnancy termination. However, they are unlikely to have received any sexuality education after leaving school. Women who are over 40 are still at risk of unplanned pregnancy and STIs, but some mistakenly think that their age is a protective factor.

Increasing numbers of women seek online health information about managing illness, staying healthy, and treatment pathways (Dart and Gallois, 2010). When women search for specific topics, such as menopause, they can strategically gather and sift through a great deal of data (Sillence et al, 2007). However, women express frustration about being

unable to find credible health information. Women's Centre for Health Matters has developed the ASSURED (Appendix 6) tool to assist women to identify evidenced-based health information and advice online. This enabling approach could be more widely adopted.

Action 9: It is recommended that alternative avenues for the delivery of sexuality education throughout the duration of women's lives are given institutional and policy support, including initiatives in women's health centres and workplaces, and the development of online resources. Programs should incorporate raising women's awareness of evidence-based websites, improving their capacity to assess the reliability of information and building their skills in communicating confidently about private health issues.

Acting to ensure information is accessible for disadvantaged women

Access to, and understanding of, health information can be very difficult for disadvantaged women. Women from CALD backgrounds and ATSI women are likely to experience a myriad of barriers when seeking health information. Cultural barriers exist for women who have experienced female genital mutilation. Interpretation and translation services are not always able to communicate conversations between health professionals and non-English speaking women appropriately around sexual and reproductive health concerns. This may result in frustration, misinterpretation of health information, and concerns about informed consent and the quality of services provided (MCWH, 2010; Carnovale and Carr, 2010). More specialised support services for vulnerable women with complex needs and low English literacy are needed, along with improved cultural competency in mainstream health services.

Action 10: It is recommended that critical recognition be given to the availability of low-literacy sexual and reproductive health resources and culturally appropriate materials for specific communities, including CALD and ATSI women. Resources targeting specific groups need to be developed in partnership with these women, an initiative that requires appropriate funding.

Key area for action: Increasing reproductive choice

Reproductive choice encompasses women's right to choose when and whether to become a parent. It includes women's ability to control their fertility, to prevent pregnancy through contraception, to respond in the way they choose to an unplanned pregnancy, and to access assistance to become a parent. Pregnancy and birthing are discussed in key action area 4.

Some groups of women experience considerable barriers to control over their own bodies. Women With Disabilities Australia (WWDA) reports that forced sterilisation, contraception and menstrual suppression are key issues facing women living with a disability (Frohman, 2011). Despite regulations restricting the sterilisation of young women with a disability in Australia, anecdotal accounts suggest that some individual doctors are bypassing these requirements and sterilising female children living with a disability without the child's knowledge or consent, for reasons of convenience rather than medical necessity.

Action 11: It is recommended that more rigorous monitoring of existing Australian laws and regulations on sterilisation procedures performed on girls and women living with disabilities are introduced, to ensure that these procedures are carried out only in cases of medical necessity or where they have been mandated by a court.

Contraception

The most commonly used contraceptives in Australia are the oral contraceptive pill and male condoms (Loxton & Lucke, 2009). Despite the introduction of different forms of contraception in the past 15 years, there remains a distinct lack of contraceptive knowledge about methods other than male condoms and the pill, and their appropriateness for individual women across their lives. Other methods include female condoms (see page 22) and long-acting reversible contraceptives (LARCs), which are very effective at preventing repeat, unplanned, and unwanted pregnancy.

Emergency contraception (EC) is available over the counter through Australian pharmacies, but women's knowledge of EC is poor. Many believe it must be taken the morning after unprotected sex, whereas it remains effective for up to 120 hours (Hussainy, 2011). EC is not listed on the Pharmaceutical Benefits Scheme, resulting in decreased affordability. Furthermore, some pharmacists refuse to supply EC to women due to religious beliefs and the mistaken view that EC causes abortion. Currently some states and territories also prohibit pharmacists supplying to women under 16 years of age. Increased awareness, affordability, and advance supply of EC, along with improved training of pharmacists and medical practitioners, have the potential to significantly lower unplanned pregnancy rates in Australia.

It is estimated that half of all pregnancies in Australia are unplanned (Marie Stopes International, 2006). Studies of Australian women considering abortion have shown that around two thirds of women were using contraception prior to becoming pregnant (Abigail et al, 2008). Increasing women's access to and knowledge of all contraception methods available would contribute to lowering the rate of unplanned pregnancy and women's need to seek abortion services. Comprehensive sexuality and respectful relationships education throughout the duration of women's lives and targeted health promotion are also effective.

Action 12: It is recommended that increased access be provided to a wide range of safe, affordable contraceptive options, including male and female condoms, advance supply of emergency contraception, and expansion of contraceptive prescribing rights for nurse practitioners.

Action 13: It is recommended that the affordability of—and access to—all contraceptives be improved through the listing of newly-available hormonal contraceptives, including those used for emergency contraception, on the Pharmaceutical Benefits Scheme.

Action 14: It is recommended that a review be undertaken by the federal government of restrictions by pharmacists on the supply of emergency contraception to women under 16 years of age.

Action 15: It is recommended that education programs for pharmacists and other health practitioners be developed and implemented, along with a public awareness campaign concerning the use and effectiveness of emergency contraception.

Termination of pregnancy (abortion)

Approximately 80,000 Australian women access pregnancy termination services per year (Pratt et al, 2001). Almost one in three women will have an abortion during their lifetime (Chan et al, 2005). Available statistics show that 90-95% of terminations are performed within the first trimester and less than 1% of terminations are performed later than 20 weeks' gestation (Grayson et al, 2005; Straton et al, 2006; Chan et al, 2011).

Australian states differ in terms of legality and access to abortion (Appendix 7). In some states abortion is lawful and publicly available with a woman's informed consent; in others, abortion is still a crime for women and their doctors. Differing laws and regulations have created a 'postcode lottery', leading to extreme differences in women's capacity to access safe, legal and affordable abortion services in Australia. Private pregnancy termination services are often unaffordable and inaccessible for rural women and for women on lower incomes.

Lack of clarity about state laws causes confusion within the medical profession. A national survey of GPs found that almost 40% are not confident in their knowledge of their state's or territory's abortion law (MSI, 2004). This uncertainty also inhibits the public hospital provision of abortion, particularly in Queensland, where women who seek to terminate a pregnancy that was caused by a sexual assault are turned away.

Access to mifepristone (medication abortion) is still restricted in Australia, unlike most developed countries where women have had access to this medication for more than twenty years. Australian doctors must apply to the federal Therapeutic Goods Administration to become individual 'authorised prescribers' and to import the drug from overseas. There is no Medicare item number for a rebate on medication abortion, while one is specified for surgical abortion. This creates

an artificially high price for a relatively inexpensive medication. Wider use of medication abortion would offer public hospitals greater opportunity and flexibility to provide early pregnancy termination services.

Action 16: It is recommended that abortion be decriminalised through law reform in those States where abortion still forms part of the criminal code.

Action 17: It is recommended that access to safe and legal abortion be provided to all Australian women through the public health system and through accessible licensed private providers.

Action 18: It is recommended that federal, state and territory governments address inequities in abortion service delivery to ensure women living in regional, rural and remote areas have timely access to affordable services.

Action 19: It is recommended that medication abortion as a readily available method for all women seeking early termination be made possible through federal government support of applications for the importation and distribution of mifepristone in Australia, including the listing of mifepristone on the Pharmaceutical Benefits Scheme.

Infertility

It is estimated that 9% of couples experience infertility (Wang et al, 2009). For heterosexual couples, problems with the woman's fertility are the sole cause of infertility in less than 50% of cases. Women experience infertility for a range of reasons, including polycystic ovarian syndrome, chlamydia, and endometriosis. Lifestyle factors such as smoking, alcohol intake, stress, and depression impact upon fertility for both men and women. Given this, doctors should work in a non-judgemental and supportive way with women to develop an understanding regarding the link between these issues and infertility as part of the referral process for Assisted Reproductive Technology (ART) services.

The availability of ART services is mostly limited to capital cities; rural women therefore face far greater access issues. Some states retain laws which limit access to ART, making it illegal for single women or those in same sex relationships to pursue fertility treatment.

Action 20: It is recommended that preventable infertility be reduced for both men and women through a broad public health campaign to improve awareness of the underlying and gendered risk factors, such as identifying and managing Polycystic Ovarian Syndrome and the prevention and treatment of Sexually Transmissible Infections that can cause infertility.

Action 21: It is recommended that the federal government commission a report into the measures required to ensure equity in access to Assisted Reproductive Technology (ART), including some public hospital provision of ART services.

Action 22: It is recommended that law reform be undertaken to remove discrimination in accessing fertility treatment in all states and territories.

Key area for action: Facilitating women's health throughout pregnancy and birth

Almost 300,000 Australian women give birth annually. While maternal mortality and morbidity rates are low and have improved, these gains are not shared equally across the population.

Maternal mortality rates are almost three times higher for Indigenous women than for non-Indigenous women (Sullivan et al, 2008). Women from non-English speaking backgrounds are also over-represented in maternal death statistics (MCWH, 2010). Both groups are less likely than the general population to access antenatal care in the first trimester of pregnancy (DoHA, 2009b; Alcalá, 2006).

While the rate of teenage pregnancies has declined, numbers are higher in Australia than in many developed nations (Smith et al, 2003). Indigenous teenage women are five times more likely to give birth as non-Indigenous teenage women (DoHA, 2009b). Teenage pregnancy can lead to poorer health, financial insecurity and compromised educational outcomes for both mother and child (Burns et al, 2010).

Health care during pregnancy

Recommended schedules for antenatal visits vary (Dowswell, 2010). Women's experiences of antenatal care include long waiting times for short consultations, conflicting information given by different health professionals, and a birth supervised by strangers. Rural and Indigenous women are highly likely to have these experiences, compounded by birthing far from home. Urban women may experience difficulty accessing birth centres and midwifery-led care, poorly designed hospital spaces, and care provided by a different team of health professionals for each stage of pregnancy (Hirst, 2008).

Women living in rural Australia are more likely to have difficulties accessing health services due to geographic isolation and lack of available services (Warner-Smith & Lee, 2003). The National Rural Women's Coalition reports a steady decrease in maternity care units in rural hospitals, and the Rural Doctors Association of Australia (RDAA) reported in 2006 that over 130 small rural maternity units had closed across Australia in the previous ten years (DoHA, 2009b, p. 23).

The Indigenous Perspectives Forum, held as part of the consultation process for the federal government's Maternity Services Review in 2009, stressed the need for culturally safe and community centred models of care in partnership with Indigenous communities. Submissions raised the importance of understanding the preference of Indigenous women to give birth in their own community (DOHA, 2009b). The Canadian Nunavik service (Wagner, 2007) and Congress Alukura (Appendix 4) are outstanding models of remote midwifery-led care that can be emulated to provide appropriate care in nations such as Australia.

Emergency obstetric care is required to maintain low levels of maternal and infant mortality. In Australia this will involve emergency treatment and retrieval over substantial distances, including ongoing support to maintain the high standard of perinatal evacuation by the Royal Flying Doctor Service (Akl, 2010). Strong collaboration between regionally based services, ambulatory services and tertiary facilities will be required for sensitive and effective care of women who must travel for medical treatment during pregnancy.

Action 23: It is recommended that government funding be provided and policy developed to ensure that the health system provides continuity of care during pregnancy to all women, regardless of where they live. This would include the provision of accurate and timely information and care to women, delivered by skilled and collaborating professionals mindful of women's need to feel safe and in control. Women would receive antenatal care and be attended at birth by known health professionals with whom they have built a trusting relationship.

Broader health interventions during pregnancy

With directed and improved intervention, pregnancy is a point in a woman's life where she might have both more opportunity to engage with health providers and more incentive to improve her health than is currently the case. The effectiveness of an opportunistic health intervention will also depend upon her trust in the maternity carer, the ongoing continuity of her care, and the capacity of the maternity carer to support broad health interventions. Effective approaches use motivational strategies rather than tactics of shaming to support individual behavioural change.

Health promotion strategies targeted at individuals that have no connection with broader community initiatives are particularly ineffective (Jackson et al, 2005). It is clear that factors such as smoking, drug use, alcohol consumption, and poor nutrition have negative health impacts for everyone, not just pregnant women and their babies. Many conditions identified during pregnancy are pre-existing and in most cases continue after the pregnancy and birth; for example, gestational diabetes can be an indicator of risk of developing diabetes in later life. Addressing these underlying factors requires ongoing holistic action in relation to women's health, not only transitory intervention.

Action 24: It is recommended that all public health messages regarding a 'healthy pregnancy and baby' be framed in a sensitive, non-judgemental way that is relevant to the social and economic circumstances of women's daily lives.

Action 25: It is recommended that women's choices and beliefs regarding pregnancy are respected and supported through systemic change to the health system. Where quality of service delivery is ensured, this includes:

- support for women's choices during pregnancy and childbirth;
- facilitating birthing close to home, including increased provision of midwifery based care models such as birth centres; and
- timely and sensitive support for women experiencing difficult labour, miscarriage or stillbirth.

Key area for action: Expanding prevention and treatment of reproductive cancers and menstrual issues

Expanding prevention and treatment of reproductive cancers

Reproductive cancers include breast cancer and gynaecological cancers: uterine (comprising 43% of gynaecological cancers diagnosed); ovarian (30%); cervical (17.5%); and vulval (8.5%) (Cancer Australia, 2011). Breast cancer is the second most common cause of cancer mortality behind lung cancer (AIHW, 2011). Cervical cancer is one of the most preventable and curable of all cancers (AIHW, 2002). Ovarian cancer is identified later than other forms and therefore has a higher mortality rate.

The general Australian female population is well informed about breast and cervical screening (Glasziou & Irwig, 1997). The National Cervical Screening Program reports that 3,652,181 women had Pap smears in 2007-08 (AIHW, 2010); the lifetime screening participation rate is estimated at 88% of the eligible population (Canfell et al, 2006).

However, a disproportionate number of deaths from reproductive cancers occur among women of minority groups (Thierry, 2000). Indigenous women are 2.4 times more likely than non-Indigenous women to develop cervical cancer and are less likely to survive (Shannon et al, 2011). A vulval cancer cluster has been identified in young Aboriginal women in remote Northern Territory communities (Condon, 2009).

Population research indicates that women with disabilities do not receive the same level of preventative care as the general female population (Cancer Institute NSW, 2004), and are under-represented in cancer screenings (Bridge-Wright, 2004).

For women from CALD backgrounds, language barriers and lack of access to culturally appropriate services can severely limit access to screening (Mullins, 2006). Women born in Asia show lower rates of Pap smear testing and higher rates of hospitalisation for cervical cancer (ABS, 2004).

Non-heterosexual women are less likely to have a regular doctor and access screening less frequently than heterosexual women. Cervical human papilloma virus (HPV) has been reported to occur in 21% of lesbians with no sexual contact with men, dispelling the widespread myth that lesbians do not contract HPV (McNair, 2003).

Women aged 60 to 69 are less likely to access screening services than younger women, for reasons ranging from embarrassment to being too busy or feeling 'too well' to need screening (Anderson, 2007).

Women in rural areas can face significant geographical barriers in accessing testing, reflected in poorer cancer outcomes for women in rural communities (Youl et al, 2011).

Action 26: It is recommended that governments concentrate efforts to explore, fund, and implement innovative ways to increase the prevention, detection and treatment of reproductive cancer in communities of high risk women, in particular Aboriginal and Torres Strait Islander women.

Action 27: It is recommended that governments promote participation by all eligible women in recommended breast and gynaecological cancer screening programs, by consistently and adequately funding and promoting these programs. This should be accompanied by public education campaigns to encourage women's self-monitoring of bodily changes to promote early detection of cancer.

Prevention Issue: Expanding the HPV Vaccine Program for protection against cervical and vulval cancer

Australia's National HPV vaccination program was introduced in 2007. If undertaken before the onset of sexual activity, it can protect women from the two viral strains that cause 75% of cervical cancers and also protect against vulval cancer. It is delivered to teenage girls, free of charge, in schools. Almost all Australian schools have chosen to participate in the program and over 6 million doses of the cervical cancer vaccine have been provided. However, research suggests that uptake of the vaccine is not optimal, with some parents and schools harbouring misgivings about the vaccine and its perceived impact of encouraging sexual activity (Agius et al, 2010).

Action 28: It is recommended that research findings from the HPV vaccine implementation program be translated—via awareness campaigns targeted at parents, schools and health centres—to ensure that the uptake is optimal across all schools and youth settings, including among young women living in remote Australia and those disengaged from school.

Expanding prevention and treatment of menstrual issues

Menstruation is normal, individual, and diverse, changing across a woman's lifetime. This affects its meaning and management. Based on international estimates, the average age at menarche, or first period, is 12.5 years, and has not changed in the past 50 years (Steingraber, 2007). Menopause occurs at the average age of 51.

Menstrual health conditions include menopause transition, absence of periods, painful periods, heavy bleeding, bleeding between periods and premenstrual

syndrome (PMS). These conditions can be influenced by a range of factors, including lifestyle changes, pregnancy, stress, or contraception. They may also be key indicators of other conditions. For example, heavy or painful bleeding and bleeding between periods may indicate fibroids, polyps, endometriosis, pelvic inflammatory disease, sexually transmitted infections, or gynaecological cancer (WHQW, 2011).

Endometriosis is estimated to affect up to one in eight Australian women (QENDO, 2011), but there are problems with timely diagnosis (Healy, Rogers & Farrell, 2009). Delays in diagnosing menstrual problems can be caused by several factors. Gaps in the evidence base mean that understanding of a 'normal' cycle differs greatly. This creates difficulties for both women and doctors in differentiating between short-term changes in bleeding and symptoms of more serious conditions (Harlow & Ehpross, 1995).

Action 29: It is recommended that women's awareness and understanding of menstrual health be increased through a menstrual health awareness and education campaign in local health services, including the community health sector.

Action 30: It is recommended that improvements be sought in health professionals' understanding of menstrual health issues and diagnosis rates through the establishment of menstrual health as a component of all nursing and medical education. These programs should focus on improving recognition of menstrual problems and addressing the sensitivity and taboo of menstruation for both women and health professionals.

When the Goods and Services Tax was introduced in 1996, it was with the aim of taxing non-essential items. Despite protests by the health sector and women's advocates, the GST was applied to sanitary products such as pads and tampons, resulting in increased costs for these items. AWHN opposes the view that these are luxury items and argues strongly for the removal of the GST on these products, to make them as affordable as possible for Australian women.

Action 31: It is recommended that the federal government remove the GST on menstruation sanitary products to improve affordability.

Key area for action: Improving prevention and treatment of sexually transmitted infections (STIs)

STIs and Blood Borne Viruses (BBVs) include chlamydia, syphilis, gonorrhoea, hepatitis B, hepatitis C and HIV/AIDS. STI rates are increasing in Australia and “contribute to a significant level of ill health and long term complications, especially chronic pain and infertility” (O’Rourke, 2008, p. 9). Recent years have seen a spike in notifications of gonorrhoea, syphilis and chlamydia, particularly among young people, and a 43% increase in the number of new HIV diagnoses between 2001 and 2007 (FAHCSIA, 2008). The increased incidence of chlamydia is of particular concern, given that the disease can manifest with no symptoms and may cause infertility if untreated.

The annual report of the National Notifiable Diseases Surveillance System states:

Chlamydial infection continued to be the most commonly notified disease in 2009. Since chlamydial infection became a nationally notifiable disease ... the rate has increased in each consecutive year. In 2009, there were a total of 62,660 notifications ... Between 2004 and 2009, chlamydial infection notification rates increased by 61% ... (NNDSS, 2011, p. 1).

Stancombe (2008, p. 5) found that “awareness of STIs is low and knowledge is poor or incomplete. More myths and misconceptions tend to prevail than fact,” and that within the heterosexual community “safe sex is usually practiced as a pregnancy prevention mechanism rather than to protect oneself and one’s partner from STIs.” Young people’s knowledge of STIs and HIV is improving; however some areas are generally poor, including knowledge of HPV and cervical cancer (Smith et al, 2009).

Action 32: It is recommended that an STI prevention and treatment education campaign be implemented that increases awareness of the prevalence of STIs, their transmission, treatment, and protective

behaviours. The campaign should include targeted approaches for ‘at risk’ groups, and incorporate the key message that anyone who is sexually active is at risk of STIs and should be screened regularly by a General Practitioner or specialised sexual health service. Confidentiality of services should also be emphasised.

Rates of chlamydia are significantly higher among young females aged between 15 and 29 than for older women (UNSW, 2009). Young Aboriginal women are particularly at risk; they experience high rates of chlamydia and hepatitis C (BBV) in the 15-35 year age groups (AIHW, 2008).

Negotiating safe sex and contraceptive use can be difficult for young women (WHO, 2006) even when they can access contraception. Power differentials in relationships mean they are not always in a position to insist on condom use. Young women with poor body image or those in violent relationships are more at risk. Barriers to male condom use include men not wanting to wear a condom and not having condoms available.

Action 33: It is recommended that federal and state governments conduct a targeted sexual health campaign for young women that involves them in its development and focuses on their right to negotiate safe sex, condom use, protection from chlamydia, and its link to infertility. The campaign would focus on high risk groups and incorporate grants for local programs, low-literacy resources and an interactive youth-friendly website and social marketing elements.

Female condoms are a barrier method of contraception entirely under women’s control. If used correctly they provide protection for both partners against STIs and unplanned pregnancy. However, knowledge of the female condom is still limited in Australia (BHC, 2011). Female condoms are expensive—over \$3 each, compared to male condoms—under \$1 each, and are only available online or at selected sexual health clinics. Expanding knowledge of, and access to, female condoms should form an important part of any strategy aimed at lowering STI rates in Australia.

Action 34: It is recommended that coordination of a male and female condom initiative is undertaken to increase the availability of free or low-cost condoms

and to normalise condom use. The initiative should include distribution programs and identify access points through youth services; women's health centres and services; family planning services; community health centres; women's health nurses; GPs; ATSI health centres; and school-based nurses.

Key area for action: Equipping the health workforce to better respond to women's health needs

For all women to achieve and maintain good sexual and reproductive health, they must have access to—and be supported by—publicly funded and skilled health professionals. Services should be holistic, gender sensitive, evidence-based, and financially affordable. Women-specific services should be recognised as an essential part of health service delivery. Women's access to quality care is dependent upon ongoing investment in the workforce.

Workforce development

Data concerning availability of providers across the full range of services in sexual and reproductive health is difficult to obtain. Service provision can be compromised because of a shortage of skilled practitioners. For example, the lack of medical practitioners with training in surgical abortion provision is becoming acute in some states (*Abortion in Queensland*, 2008).

Lack of knowledge in sexual and reproductive health can directly impact on the level of care that health providers are able to offer to women. For example, women with disabilities who choose to parent often face barriers in seeking health care, including prejudice on the part of health care providers (Frohman, 2009). Lack of provider knowledge leads to same sex attracted women being given inaccurate information about their need for pap smears and STI screening (National LGBT Health Alliance, 2009; Hyde, 2007). Women who have experienced Female Genital Mutilation [FGM] or sexual violence are also groups requiring improved sensitivity in their care.

Action 35: It is recommended that in order to ensure optimal provision of services in the future, the Commonwealth Department of Health and Ageing and/or Health Workforce Australia conduct an analysis of the sexual and reproductive health workforce and recommend actions to rectify gaps.

Action 36: It is recommended that national sexual and reproductive health accreditation standards for nurses and GPs are developed and implemented to ensure that Australian women have access to high quality care and health information which is evidence-based and non-discriminatory.

Holistic care: not just treatment of disease

The composition and location of the health workforce is a contributing factor to women's access to effective reproductive health care provision.

There is a need to increase the availability of female doctors, particularly those specialising in sexual and reproductive health. A recent report found that 57.3% of all women felt that a female doctor was important when choosing a health care provider (Le, 2011). The reluctance to obtain sexual and reproductive health care and information from a male medical professional is common, particularly in cases of sexual assault. Women's preference for treatment by women must be recognised.

While it is projected that women will comprise 42% of the medical workforce by 2025, women remain under-represented among specialists, accounting for only one-quarter of all specialists in 2009. Female practitioners do not generally work the extended hours undertaken by male practitioners and this affects their availability; female doctors' average weekly working hours in 2009 were 37.5, less than male doctors' 44.9 hours (Health Workforce Australia, 2012).

A concerted effort to increase the number of nurse practitioners specialising in sexual and reproductive health or women's health, and to expand the prescribing rights of nurse practitioners (particularly for contraceptives), could significantly increase access to appropriate health services, especially for rural women.

Action 37: It is recommended that through effective use of the capacity of the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme, a full range of sexual and reproductive health services are provided,

including increased prescribing rights for nurse practitioners, 'well women' checks, and support services.

Action 38: It is recommended that active encouragement and support be provided for women to become health practitioners in the sexual and reproductive health field via incentives and extra support, including specific targeting of women from diverse groups.

The distribution of medical professionals in rural Australia is a key barrier to overall health and well-being; access to trained sexual and reproductive health professionals in these areas is complicated due to issues relating to confidentiality and geography. A study into young rural women's sexual health found that over half believed they could not visit a doctor without everyone knowing, and that over a fifth did not trust a doctor to maintain their confidentiality (Hillier, 1999).

The gaps in adequate sexual and reproductive health services in rural areas are well documented and some have been outlined in this paper, particularly in regards to maternity and abortion services for rural women.

Action 39: It is recommended that research be conducted into gaps in rural sexual and reproductive health service delivery and subsequently formulate appropriate policies.

Action 40: It is recommended that the Department of Health and Ageing provide leadership in advocating for gender sensitive sexual and reproductive health services in local Health Networks, in Medicare Locals, and in population health plans.

Consumer rights to evidence-based care

Effective intervention into sexual and reproductive health needs to be evidence-based and unbiased. It should not be proscribed by stereotypes or by the personal moral values or religious beliefs of health service providers. Information and service provision on reproductive health, including contraception and abortion, is particularly sensitive to value judgements.

Women's access to reproductive health services is impacted by the role of faith-based organisations in training health professionals and providing health services. There are 21 public hospitals administered by Catholic Health Australia (CHA), whose Code of

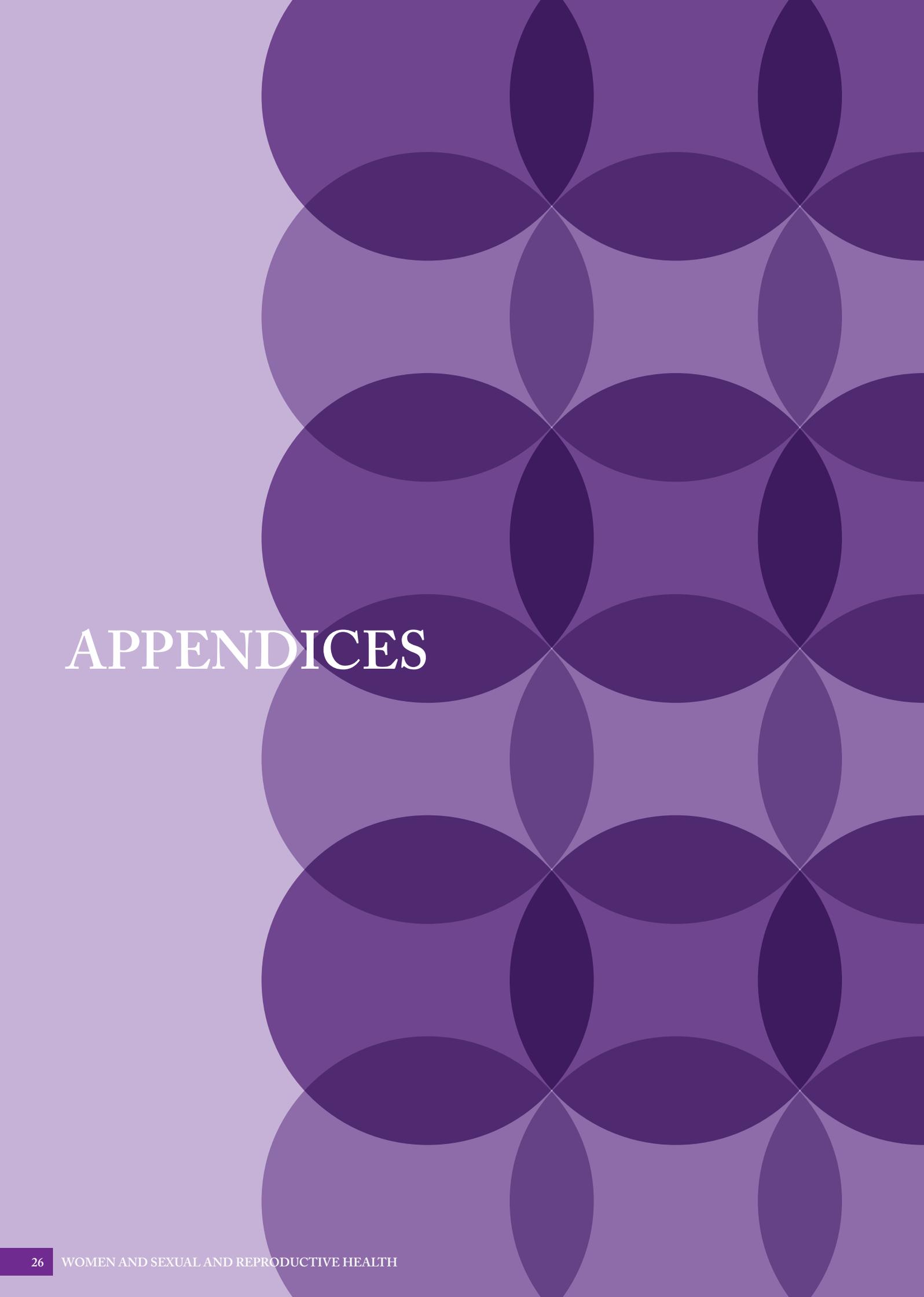
Ethical Standards restricts the provision of reproductive health care. The guidelines ban offering advice or information on hormonal or barrier methods of contraception, including for married couples or where a woman's life would be at risk from a further pregnancy. They prevent women who present following a sexual assault from being offered emergency contraception, or being referred to another service which may offer EC. The guidelines state that "Catholic facilities should not provide, or refer for, abortions" under any circumstances (CHA, 2001, p. 24). A report into the CHA guidelines found that the "practices of Catholic hospitals in Australia may lead to some violations that rise to the level of torture and cruel, inhuman or degrading treatment" (Poole, 2011, p. 2), despite Australia being a signatory to the international convention against such treatment (Appendix 1).

Many students obtain their qualifications through Catholic tertiary education institutions, such as Australian Catholic University and Notre Dame, institutions that receive government funding for student places in medicine, nursing and midwifery courses. The Australian Catholic University advertises itself as the largest provider of graduate nurses in Australia (ACU website, 2012). Both institutions provide anti-abortion information on campus and restrict teaching concerning pregnancy termination (Cowie, 2011).

Action 41: It is recommended that all health facilities and health professionals be mandated to disclose to patients their policies, religious values or personal prejudices concerning sexual and reproductive health in instances in which they will impact on the options, types and extent of health treatment and care provided.

Action 42: It is recommended that private health facilities that receive government funding to provide public reproductive and sexual health services be required to provide comprehensive contraceptive and all-options pregnancy information and services.

Action 43: It is recommended that a mandatory requirement be instituted for private tertiary education institutions that provide undergraduate and graduate nursing and medical education programs, and which receive government funding for subsidised student places, to include the teaching of hormonal and barrier contraceptive methods and pregnancy termination procedures.



APPENDICES

Appendix 1

International human rights conventions

The right to health

Australia is a signatory to the following human rights conventions with clauses relating to sexual and reproductive health, health more broadly, and human rights, including:

- *International Covenant on Civil and Political Rights*
- *International Covenant on Economic, Social and Cultural Rights*
- *Convention on the Political Rights of Women*
- *International Convention on the Elimination of all forms of Racial Discrimination*
- *Convention on the Elimination of all forms of Discrimination Against Women**
- *Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment*
- *Convention on the Rights of the Child*
- *Convention on the Rights of Persons with Disabilities.*

The rights of women

In addition, the United Nations' Fourth Conference on Women in 1995 recognised the human rights of women as integral to the achievement of health and well-being:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (UN, 1995).

* The Convention on the Elimination of all forms of Discrimination Against Women contains specific references to women's right to sexual and reproductive health. Article 12 of CEDAW bids all signatories to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."

Article 16 of CEDAW refers to "matters relating to marriage and family relations". Rights enshrined in Article 16 include: the right to freely choose a spouse and only enter into marriage if "free and full consent" is given; and the right to decide "the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".

Appendix 2

Principles underpinning effective action on sexual and reproductive health

1. Health action requires respect for the reproductive rights and sexual rights of Australian women.

Respect recognises the woman as the expert in her own life. Each woman has the right to self-determination, to privacy, to consent to sex, and to be given full information about her options to make the best decision possible in the context of her own life. Her reproductive and sexual rights are enshrined in international treaties and law which must be upheld Australia-wide.

2. Services must be accessible, responsive and accountable to their clients.

Women must be engaged at all levels within the health system as leaders, providers, consumers, and carers. Services that women enter should feel safe; this will involve dedicated women's spaces, community controlled and responsive mainstream health services. Women must be involved in every stage of the design and implementation of services. Services must communicate openly and effectively with clients, including supporting languages other than English. Services should be provided locally wherever possible.

3. Diversity must be acknowledged and supported in health policy and service provision.

For too long, women have been subjected to the 'one size fits all' approach. Health interventions that have been researched and tested on men are applied to women, and extrapolated to all women regardless of ethnicity, socio-economic status or age. Women are not a homogeneous group. Health disparities between groups of women are significant; the challenges for some women are far greater than for others. All health interactions require cultural competence, including active listening to the patient's perception of their health, careful exploration of differences in understanding, and recommendations for care sensitive to the patient's individual circumstances.

4. Sexual and reproductive health initiatives must address the social determinants of health.

Good health cannot be achieved through action just within the health portfolio. Poverty, housing, geography, transport, culture, race, age and education are major contributors to health. All sectors must consider the health impact of their policies. If we were serious about improving population health, examination of health implications would be mandatory in all sectors and between all sectors and levels. Only collaborative action has the capacity to reduce the burden of disease upon individuals and upon the public health system.

5. Strategies must build and enhance the capacity of communities.

While the workforce can be strengthened through skills development and incentives, one key strategy is the empowerment of workers, communities and individuals to act to improve their health. Issues of privacy and confidentiality can have a significant impact on sexual and reproductive health, and an understanding of this and sensitivity towards women's needs are required, including, for example, the need for service delivery provided by female practitioners, and the inclusion of 'safe spaces' when developing infrastructure and programs.

6. All sectors must work together to achieve high-quality sexual and reproductive health outcomes.

A collaborative approach is required to advance women's health. Between levels of government we need more commitment, information sharing, and consistency of approach. Between government and the community sector, we require more understanding, respect, and open communication. Between specialists and generalists, we need clear communication and transfer of health care records. Between women and men, we need to place more value upon 'women's work', in both the private and public spheres, and on the women's experience and input.

7. Effective approaches to sexual and reproductive health must consider the whole person, including their social, emotional, physical and spiritual dimensions.

Health involves social, emotional, physical and spiritual dimensions. Women's experience of sexual and reproductive life can include feelings of love, pleasure and achievement, but also shame, embarrassment and anxiety. Policies must consider more than the prevention and treatment of disease.

8. Interventions must be based on evidence, and be safe and effective.

Women need detailed and accurate information that is directly relevant to their individual circumstances and their family responsibilities. Health providers should be obligated to provide services beyond scripted answers and rushed referrals. This requires a health workforce committed to gender equity, to continuous improvement of its knowledge base, and to providing services based on evidence, rather than on personal values.

Appendix 3

The current sexual and reproductive health policy environment

At state, territory and federal levels, a range of policies exist that deal with particular sexual and reproductive health issues.

Federally, these policies and strategies include:

- National Women's Health Policy 2010 (NWHPP)
- National Maternity Services Plan 2010-2015
- National Plan to Reduce Violence Against Women and Their Children
- The First National Hepatitis B Strategy
- The Second National Sexually Transmissible Infections (STI) Strategy
- The Third National Hepatitis C Virus (HCV) Strategy
- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and STI Strategy
- The Sixth National HIV Strategy
- National Blood-borne Virus and STI Surveillance and Monitoring Plan: 2010-2013
- Provision of a Medicare item number for pregnancy counselling by GPs and allied health professionals
- National Pregnancy, Baby and Birth Helpline

Policies and strategies at state and territory level differ greatly across the country. Some states, including Victoria and South Australia, have specific Women's Health Plans in place, while most do not. Most states and territories have some level of STI prevention strategies in place, but target populations may differ. Strategies in relation to violence prevention also vary across state and territory lines, and not all priorities align with the National Strategy to Reduce Violence Against Women and their Children.

Appendix 4

The current sexual and reproductive health program environment: Successful programs

Programs such as these are a useful guide to effective service models, and common features contribute to their success.

Pregnancy Advisory Centre, Adelaide

PAC is funded by the South Australian Government, providing women across the state with pregnancy testing, pregnancy counselling, termination, contraceptive supply, sexual health services and emergency contraception. Counselling and abortion services are free, provided by qualified professionals in an integrated setting.

Congress Alukura Maternity Service and Women's Health Clinic, Alice Springs

Alukura is run in conjunction with the Central Australian Aboriginal Congress. It provides culturally appropriate antenatal and birthing care, home visits from birth until the child is two years old, contraceptive supply, sexual health services, mammograms, cervical screening, and well women's checks. Sexual health education is also provided to young women aged 12 to 20 in schools, youth organisations, town camps and remote communities.

Multicultural Centre for Women's Health, Melbourne

MCWH provides multilingual health education for women from immigrant and refugee communities, specialising in sexual and reproductive health promotion. Programs include professional development for workers in the health and community sectors to build their capacity to respond to the sexual and reproductive health needs of immigrant and refugee women.

'Is Your Period Making You See Red?' campaign, Queensland

Women's Health Queensland Wide is a state-wide health promotion and education service. In 2009 it conducted an eight-week menstrual awareness campaign, encouraging women to seek help for painful menstruation or any period concerns. The campaign included bathroom advertising in shopping centres around Brisbane and the distribution of 90,000 contact cards. During the campaign, their Health Information Line underwent a 41% increase in calls regarding period-related concerns, and an 11% rise in calls across all issues (WHQW, 2012).

Community Midwifery Western Australia

CMWA offers team midwifery services to women with low risk pregnancies within 50 km of Perth CBD. About 250 births are supported each year. Support includes arrangements for a backup obstetrician and hospital care if required. This community based not-for-profit organisation also offers group antenatal and postnatal classes.

Women's Health Centres across Australia, such as the Leichhardt Women's Community Health Centre, Sydney

The Leichhardt Women's Community Health Centre was established in 1974 and, like all women's centres, targets the most disadvantaged women in the local community. The centre's programs comprise sexual and reproductive health services, including HIV/AIDS awareness for women, pregnancy counselling, and Pap smears provided by regular clinics.

Family planning organisations

A combination of state, territory and federal government funding supports a national network of state/territory-based family planning organisations. These organisations provide low-cost clinical services and broader community education and health promotion activities aimed at improving sexual and reproductive health. Clinical services include contraceptive advice and provision, pregnancy testing, STI screenings and referrals, while broader health promotion includes evidence-based sexuality education and professional development training for health professionals.

Appendix 5

Safety of abortion: The evidence

The World Health Organisation (2003b) reports that in developed countries such as Australia, where abortions are performed by highly qualified health care professionals in very hygienic conditions, a pregnancy termination is one of the safest medical procedures, and complications are rare.

Anti-choice counselling services and lobby groups distort research and often make false claims regarding abortion. The three assertions most often used in misinformation campaigns are that an abortion will affect a woman's future fertility, that it causes breast cancer, and that there are long-lasting psychological impacts of abortion (VLRC, 2008).

Infertility

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG, 2005) states that serious complications after abortions are rare, and that mortality and serious morbidity occur less commonly with abortions than with pregnancies carried to term. While minor surgery or the administration of medication does carry some risks, neither surgical nor medication abortion should have any adverse effect on future fertility.

The Royal College of Obstetricians and Gynaecologists in the UK identifies that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility, a view supported by RANZCOG, which states that "women who have an uncomplicated termination are not at an increased risk of being infertile in the future" (2005, p. 26).

Breast cancer

Around the world, reproductive health and anti-cancer organisations have rejected any association between abortion and an increased risk of breast cancer. This rejection is based on reliable scientific investigation, documented in reputable medical publications, and has been endorsed by the World Health Organisation (WHO, 2000).

One publication in the *Lancet* medical journal (Beral et al, 2004) analysed 53 studies involving 83,000 women with breast cancer from 16 countries, and found that spontaneous or induced abortion does not increase the risk of breast cancer.

In 2003 the National Cancer Institute in the United States examined in great detail the research on abortion and breast cancer, finding that abortion or miscarriage "does not increase a woman's subsequent risk of developing breast cancer" (NCI, 2011).

The Australian Cancer Council (2011) does not recognise induced or spontaneous abortion as a risk for breast cancer, nor does the National Breast and Ovarian Cancer Centre (2009).

Long-term emotional trauma or mental ill-health

The American Psychological Association's Taskforce on Mental Health and Abortion reviewed 20 years of research and studies into the psychological effects of abortion and released its final report in 2008. It found no difference in the psychological effect of terminating an unplanned pregnancy and carrying that pregnancy to term (APA, 2008).

Reviews of studies into the issue have found a number of consistent trends:

- The legal and voluntary termination of a pregnancy rarely causes immediate or long-lasting negative psychological consequences in healthy women (APA, 2008);
- Greater partner or parental support improves the psychological outcomes for the woman, and having an abortion results in few negative outcomes to the relationship (Bonevski & Adams, 2001); and
- Some studies have reported positive psychological outcomes for women, such as feelings of relief (Bonevski & Adams, 2001).

In 2005, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) reviewed the evidence concerning the psychological impact of abortion and concluded that:

Psychological studies suggest:

- there is mainly improvement in psychological well-being in the short term after termination of pregnancy;
- there are rarely immediate or lasting negative consequences (RANZCOG, 2005 p. 4).

Risk factors for adverse psychological effects are consistently identified as:

- perceptions of stigma, need for secrecy, and/or low levels of anticipated social support for the abortion decision;
- a prior history of mental health problems; and
- characteristics of the pregnancy, including the extent to which the woman wanted and felt committed to it (APA, 2008).

Appendix 6

Guide to internet searching for health and well-being information

Reprinted with permission from the Women's Centre for Health Matters Inc., Canberra, ACT.

Accessed online 1 June 2012 <www.wchm.org.au>.

WCHM ASSURED can help you to access more credible and reliable health and well-being information on the Internet, but it is important that you always consult a health professional rather than using web-based information for diagnosis or treatment of health issues.

WCHM ASSURED is designed to be used as a checklist. Each letter of the ASSURED acronym stands for a step in assessing the quality of health and well-being information found on the Internet. Each step for you to follow is outlined in detail below.

A – Author and funding bodies

- Are the author and funding bodies named and are they reputable, i.e., government or recognised not-for-profit organisations?
- Are their contact details available?
- Are their objectives for creating the website clear?
- Does the site have a policy for content assessment?
- Does the site state clearly its terms of use?

S – Seal of approval

- Has the website been approved by a reputable source, i.e., government or recognised not-for-profit organisations?
- Does the website have the HONcode seal of approval?
- Has the site been peer reviewed and quality assessed by health professionals and experts?

S – Safe

- Does the website respect your privacy? For example, if you are asked to enter personal details, does the website acknowledge how it intends to use these?

- If you are asked to pay a fee to use the website, does it tell you why?

U – Up-to-date

- How current is the website? For example, a website published ten years ago is probably not as up-to-date as one published in more recent times.
- When was the site last updated? A good website will provide details about when it was last updated.

R – Representative

- Who is the website aimed at, e.g., the elderly, children, men or women?
- Is it appropriate and relevant for you?
- Is the site easy to use and understand?

E – Explains and justifies symptoms, causes, prevention and treatment options

- If the website contains information about specific health issues, are the symptoms, causes and preventative measures it lists based on reputable research and sources?
- If the website contains information about treatment options, are the risks and benefits of each option explained clearly, and is this based on reputable research and sources?
- Does the website have a bias for a particular treatment or product; if so, does it explain why?
- Is advertising separate, or incorporated into this section?
- Be cautious of sites that push treatments and products that seem 'too good to be true' (World Health Organization, 2009).

D – Discuss and discern

- Does the website encourage discussion with relevant health professionals and acknowledge that it should not be a replacement for their advice and treatment?
- Don't be afraid to be a discerning cyberskeptic (Women's Health Canada, 2007) and compare the information provided by multiple sites.

Appendix 7

Australian abortion law and practice

Reprinted with permission from Children by Choice, Brisbane, www.childrenbychoice.org.au/.

Summary

State/Territory	Abortion law
ACT	Legal, must be provided by medical doctor.
VIC	Legal to 24 weeks' gestation. Legal post 24 weeks' gestation with two doctors' approval.
NSW & QLD	Abortion a crime for women and doctors. Legal when doctor believes a woman's physical and/or mental health is in serious danger. In NSW social, economic and medical factors may be taken into account.
SA & TAS	Legal if two doctors agree that a woman's physical and/or mental health is endangered by pregnancy, or for serious fetal abnormality. Counselling compulsory in Tasmania. Unlawful abortion is a crime.
WA	Legal up to 20 weeks' gestation; some restrictions, particularly for women under 16. Very restricted after 20 weeks.
NT	Legal to 14 weeks' gestation if 2 doctors agree that woman's physical and/or mental health endangered by pregnancy, or for serious fetal abnormality. Up to 23 weeks in an emergency.

Queensland

Legislation: *Criminal Code 1899 (Qld)*, sections 224, 225 and 226.

Section 224. *Any person who, with intent to procure the miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a crime, and is liable to imprisonment for 14 years.*

Section 225. *Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a crime, and is liable to imprisonment for 7 years.*

Section 226. Section 282 of the Criminal Code attempts to define a lawful medical procedure and, while not relating specifically to abortion, would be used as a defence for doctors were they to be charged with unlawful abortion.

Case law: *R v Bayliss and Cullen, R v Leach and Brennan*

R v Bayliss and Cullen: A doctor and an anaesthetist from Brisbane's Greenslopes clinic were charged with providing unlawful abortion in 1985, following police raids on the clinic. They were both acquitted when the case came to trial in early 1986. Due to the ruling by Justice Maguire in the case, an abortion is considered lawful in Queensland if carried out to prevent serious danger to the woman's physical and mental health from the continuance of the pregnancy. Unlike the 1971 NSW ruling by Justice Levine, economic and social issues are not able to be considered when determining legality.

R v Leach and Brennan: The only other court case in recent times regarding Queensland's abortion law was that involving a couple in Cairns who were tried and acquitted of procuring an abortion in 2010. The result has increased uncertainty over the legality of abortion for both women and doctors.

Legislative Amendments: Changes to s282 of the *Criminal Code* (Qld)

As stated above, section 282 of the Code does not relate specifically to abortion, but is the defence on which doctors would rely, were they charged over providing abortion services. The old text of s282 is as follows:

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

Doctors' concerns were that 'surgical operation' was specified, and that medical abortion could not accurately be defined as a surgical operation.

To resolve this issue, the Government amended s282 of the Code in September 2009 to allow for the provision of medication. The revised section now reads:

A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill a surgical operation on or medical treatment of:

- a) a person or unborn child for the patient's benefit; or*
- b) a person or unborn child to preserve the mother's life;*

if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

New South Wales

In NSW, abortion is generally regarded as lawful if performed to prevent serious danger to the woman's mental and physical health, which includes economic and social pressures.

Legislation: *Crimes Act 1900* (NSW), sections 82, 83, 84.

Section 82. *Whosoever, being a woman with child, unlawfully administers to herself any drug or noxious thing; or unlawfully uses any instrument to procure her miscarriage, shall be liable to penal servitude for ten years.*

Section 83. *Whosoever unlawfully administers to, or causes to be taken by, any woman, whether with child or not, any drug or noxious thing; or unlawfully uses any instrument or other means, with intent in such cases to procure her miscarriage, shall be liable to penal servitude for ten years.*

Section 84. *Whosoever unlawfully supplies or procures any drug or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used with intent to procure the miscarriage of any woman whether with child or not, shall be liable to penal servitude for life.*

The Crimes Act (NSW) specifies that abortion is a crime only if it is performed unlawfully. However, it does not define when an abortion would be considered lawful or unlawful.

Case law: *R v Wald*, *CES v Superclinics*

Justice Levine established a legal precedent on the definition of lawful in his ruling on the case of *R v Wald* in 1971. He allowed that an abortion should be considered to be lawful if the doctor honestly believed on reasonable grounds that "the operation was necessary to preserve the woman involved from serious danger to her life or physical or mental health which the continuance of the pregnancy would entail" and that in regard to mental health the doctor may take into account "the effects of economic or social stress that may be pertaining to the time" (Drabsch, 2005, p. 20). Levine also specified that two doctors' opinions are not necessary and that the abortion does not have to be performed in a public hospital.

The Levine judgment has been affirmed in other NSW court cases, and expanded by the Kirby decision in *CES v Superclinics* to include a threat to the woman's health that may occur following birth if the pregnancy continues.

Australian Capital Territory

There are no laws making specific reference to abortion within the Crimes Act (ACT).

Legislation: *The Medical Practitioners (Maternal Health) Amendment Act 2002 (ACT)*

- Only a registered medical practitioner may carry out abortion (maximum penalty: 5 years imprisonment).
- Abortion is to be carried out in a medical facility (maximum penalty: 50 penalty points, 6 months' imprisonment or both).
- Ministerial approval is required for abortions to be performed at the medical facility.
- No person is required to carry out or assist in carrying out an abortion.

Victoria

Legislation: *Abortion Law Reform Act 2008 (Vic)*.

The Abortion Law Reform Act 2008 allows for the provision of abortion on request by a qualified medical practitioner, nurse or pharmacist if a woman is less than 24 weeks pregnant; after 24 weeks, for an abortion to be lawfully performed a second practitioner must agree that the termination is in the patient's best interest. Abortion by an unqualified person remains a crime.

South Australia

South Australia was the first Australian state to liberalise access to abortion through legislation. Abortion is legally available under some circumstances in South Australia, although restrictions remain and there are still penalties prescribed by law for unlawful abortion.

Legislation: *Criminal Law Consolidation Act 1935 (SA), (amended 1969), sections 81(1), 81(2) and 82.*

Section 82 (A) outlines the circumstances in which a lawful abortion may be obtained. For an abortion to be legal, it must be carried out within 28 weeks of conception in a prescribed hospital by a legally qualified medical practitioner, provided he or she is of the opinion, formed in good faith, that either the 'maternal health' ground or the 'fetal disability' ground is satisfied.

The 'maternal health' ground permits abortion if more risk to the pregnant woman's life, or to her physical or mental health (taking into account her actual or reasonably foreseeable environment), would be posed by continuing rather than terminating the pregnancy. The 'fetal disability' ground permits abortion if there is a substantial risk that the child would be seriously physically or mentally handicapped.

A second qualified medical practitioner must share the medical practitioner's opinion that either of these grounds is satisfied.

The wording of the 'maternal health' ground suggests a liberality of access to abortion in early pregnancy. A conscience clause enables medical practitioners to elect not to participate in an abortion.

The pregnant woman must have been resident in South Australia for at least two months before the abortion.

Tasmania

Laws relating to abortion are contained within the Tasmanian Criminal Code. The sections relating to abortion were amended in December 2001.

Legislation: *Criminal Code Act 1924 (Tas), sections 134, 135, 164 and 165.*

Under sections 134 and 135, women and doctors are liable for criminal charges for unlawful abortion.

Section 164 defines a lawful abortion as one where:

1. two registered medical practitioners have certified, in writing, that the continuation of the pregnancy would involve greater risk of injury to the physical or mental health of the pregnant woman than if the pregnancy were terminated; and
2. the woman has given informed consent, unless it is impracticable for her to do so.

The act further stipulates that ‘informed consent’ means consent given by a woman where:

1. a registered medical practitioner has provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term; and
2. a registered medical practitioner has referred her to counselling about other matters relating to termination of pregnancy and carrying a pregnancy to term;

Further conditions contained in the legislation include that:

- one of the medical practitioners must be an obstetrics and gynaecology specialist;
- the termination must be performed by a registered medical practitioner;
- no person is under a duty to participate in abortion, referring for abortion, or providing counselling for abortion. This clause is invalid if an abortion is medically necessary as a matter of immediacy to save a pregnant woman’s life or to prevent serious immediate injury.

Western Australia

In Western Australia, provisions relating to abortion are found in the Criminal Code 1913 (WA), and the *Health Act*.

Abortion is legal if performed before 20 weeks gestation, with further limitations for women under 16 years of age.

Legislation: *Acts Amendment (Abortion) Act 1998 (WA)*, section 119; *Health Act 1911 (WA)*, sections 334 and 335.

The *Acts Amendment (Abortion) Act 1998* repealed four sections of the Criminal Code and enacted a new section 199, as well as placing regulations in the *Health Act*.

Criminal Code s199 stipulates:

- abortion must be performed by a medical practitioner in good faith and with reasonable care and skill;
- abortion must be justified under section 334 of the *Health Act 1911 (WA)*;
- where an abortion is unlawfully performed by a medical practitioner, he or she is liable to a fine of \$50,000; and
- where an abortion is unlawfully performed by someone other than a medical practitioner, the penalty is a maximum of five years’ imprisonment.

The offence of ‘unlawful’ abortion may only be committed by the persons involved in performing the abortion. The patient herself is not subject to any legal sanction in Western Australia.

Section 259 is a defence for unlawful abortion:

A person is not criminally responsible for administering, in good faith and with reasonable care and skill, surgical or medical treatment:

1. *to another person for that other person’s benefit; or*
2. *to an unborn child for the preservation of the mother’s life, if the administration of the treatment is reasonable, having regards to the patient’s state at the time and to all the circumstances of the case.*

The *Acts (Abortion) Amendment Act 1998 (WA)* specifies that the performance of abortion is justified, under Section 334 (3), in circumstances in which:

1. *the woman concerned has given informed consent; or*
2. *the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or*

3. *serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or*
4. *the pregnancy of the woman concerned is causing serious danger to her physical or mental health.*

Informed consent is defined under the WA legislation as provision by a medical practitioner other than that performing or assisting with the abortion of counselling to the woman concerning medical risk of continuing the pregnancy, and offering the opportunity of referral for counselling prior to and following a pregnancy termination or carrying a pregnancy to term.

After 20 weeks of pregnancy, two medical practitioners from a panel of six appointed by the Minister have to agree that the mother or unborn baby has a severe medical condition. These abortions can only be performed at a facility approved by the Minister.

No person, hospital, health institution, or other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of an abortion.

A parental notification clause requires that women under 16 years of age need to have one parent informed, and be given the opportunity to participate in counselling before an abortion can be performed. However, young women may apply to the Children's Court for an order to proceed with an abortion if it is not considered suitable to involve her parent(s).

Section 335 of the *Health Act* was amended to ensure that data would be collected on abortion procedures, and further to ensure patients' identities cannot be ascertained from that data.

Northern Territory

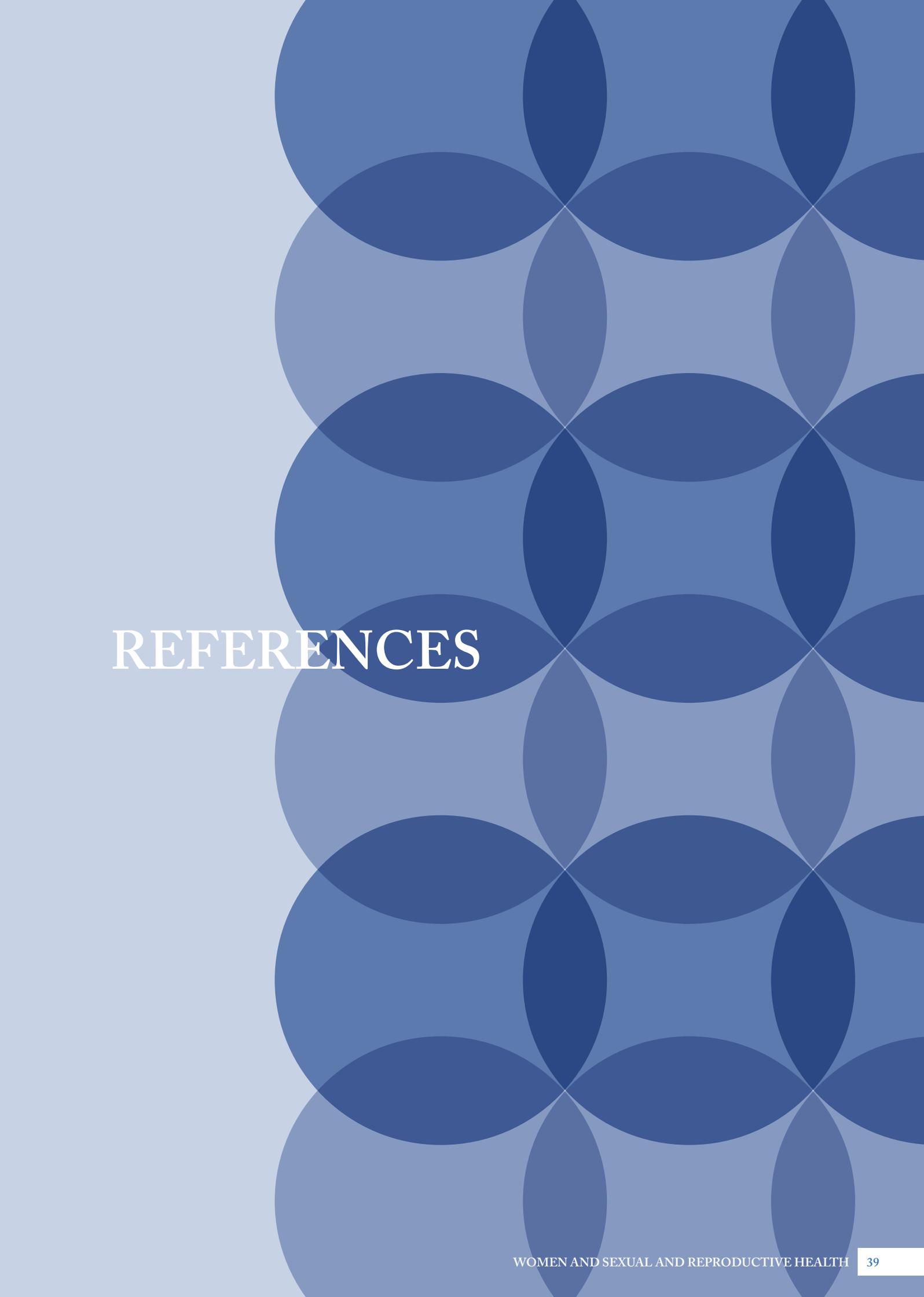
Services for termination of pregnancy are legally available in the Northern Territory for up to 14 weeks' gestation if either the 'maternal health ground' or the 'fetal disability ground' is satisfied.

Legislation: *Medical Services Act 1982 (NT)*.

The Northern Territory's Medical Services Act (section 11) states that abortion is lawful:

1. prior to 14 weeks' gestation, when performed in a hospital by an obstetrician or gynaecologist, where that practitioner and another practitioner are both of the opinion that:
 - i) the continuance of the pregnancy would involve greater risk to a woman's life or greater risk of injury to her physical or mental health than if the pregnancy were terminated; or
 - ii) there is a substantial risk that, if the pregnancy were not terminated and the child were to be born, the child would have or suffer from such physical or mental abnormalities as to be seriously handicapped;
2. prior to 23 weeks' gestation, when a medical practitioner is of the opinion that termination of the pregnancy is immediately necessary to prevent grave injury to a woman's physical or mental health; or
3. at any stage of a pregnancy if the treatment is given in good faith for the purpose only of preserving her life.

The Act also stipulates that any person with a conscientious objection to abortion is not under a duty to assist in the operation or disposal of an aborted foetus; that a medical practitioner has a duty to obtain the consent of the person undergoing the abortion operation, which must be undertaken with professional care and in accordance with the law; and that where a patient is under 16 years old, consent must be obtained from "each person having authority in law ... to give the consent." (s11(5)(b)).



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