National Rural Health Alliance

... healthy and sustainable rural, regional and remote communities

16 January 2023

NATIONAL RURAL HEALTH ALLIANCE

SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS
COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO THE UNIVERSAL ACCESS TO REPRODUCTIVE HEALTHCARE

Terms of reference

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

a. cost and accessibility of contraceptives, including:

i. PBS coverage and TGA approval processes for contraceptives,

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

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

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

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

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

e. sexual and reproductive health literacy;

f. experiences of people with a disability accessing sexual and reproductive healthcare;

g. experiences of transgender people, non-binary people, and people with variations of sex characteristics accessing sexual and reproductive healthcare;

h. availability of reproductive health leave for employees; and

i. any other related matter.

This submission will address the terms of reference highlighted in bold.

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Key Recommendations

Women and girls in rural, regional and remote (rural) Australia have poorer health outcomes than their metropolitan counterparts and experience a multitude of barriers to accessing reproductive healthcare services. Rural women are prioritised within the National Women's Health Strategy 2020-2030, to which this inquiry refers and hence improving their health and wellbeing outcomes, as they relate to reproductive healthcare, is imperative. The Alliance's response aligns with the World Health Organisation's (WHO) view of reproductive health as being inclusive of the spectrum of women's healthcare and hence we present our recommendations regarding contraceptive, termination and maternity services for rural women.

Key to improving access to care and ultimately health outcomes along the spectrum of reproductive healthcare for rural women are:

1.) Workforce interventions that aim to **increase the prevalence of primary health care professionals**, **specifically general practitioners (GPs) (including rural generalists) and midwives (especially endorsed midwives (EMs))**. This includes the model of comprehensive, multidisciplinary primary healthcare for rural Australia proposed by the Alliance that would address the barriers to recruitment and retention of a rural health workforce in order to increase its size and enable improved access to high quality, culturally safe health care in rural Australia. This model requires block funding, enables a flexible employment model, creates a multidisciplinary team and is locally designed and led, ensuring close links between the service and the community it serves.

2.) Workforce interventions that aim to **increase the education and training of the aforementioned health professionals, along with nurse practitioners (NPs), primary healthcare nurses, pharmacists and paramedics** across the range of reproductive healthcare services in order to increase the number of these professionals willing and able to provide care to rural women.

3.) System level interventions that **aim to explore alternative models of care provision** to enable the most efficient and effective use of the existing health workforce by allowing health professionals to work to their full scope of practice, with the aim of increasing access to reproductive healthcare for rural women - for example nurse-led and midwife-led models of care.

4.) Committing to **re-open and maintain rural maternity** units in accordance with local and regional planning mechanisms and ensure all rural hospitals have capacity to manage emergency reproductive health events.

5.) **Addressing cost barriers** to accessing contraceptives and termination services.

6.) **Addressing the specific needs of Aboriginal and Torres Strait Islander women, women from culturally and linguistically diverse backgrounds and women with disabilities**.

7.) Working to **improve the literacy of rural women**, including digital literacy and reproductive health literacy, to ensure their ability to navigate the system and access the services they need.

Background

The National Rural Health Alliance (the Alliance) welcomes the opportunity to make a submission to the Community Affairs References Committee's Inquiry into universal access to reproductive healthcare. The Alliance is the peak body for rural health in Australia. We represent 45 member bodies[i] and our vision is for healthy and sustainable rural communities across Australia. The Alliance is focused on advancing rural health reform to achieve equitable health outcomes for rural communities – the 7 million people residing outside our major cities. Our members include health consumers, health care and medical professionals, service providers, health and medical educators, students, and the Aboriginal and Torres Strait Islander health sector.

The terms of reference for this inquiry refer to the National Women's Health Strategy 2020-2030[1], released by the Australian Government Department of Health in 2018 and outlining a national approach to improving the health status of all women and girls in Australia. *Maternal, sexual and reproductive health* is one of the five key priority areas of the strategy, which is guided by principles including *health equity between women* and *a focus on prevention*. Women and girls from rural and remote areas are listed as a priority population within the strategy, and the interrelationship between priority population groups is acknowledged, highlighting the compounding effect of rurality, socioeconomic disadvantage, the experience of gender-based violence or abuse and identifying as an Aboriginal or Torres Strait Islander, all of which can and often do coexist in rural Australia. Hence this strategy is well-placed to drive advancement of the health of women and girls in rural Australia and the focus of this inquiry on the strategy should similarly place rural women at its core.

The WHO uses a human rights approach in its work in reproductive health and reiterates the importance of reproductive health at the individual, couple and family level, along with its impact on the social and economic functioning of communities.[2] The WHO sees health as spanning the physical, mental and social spheres and striving for wellbeing rather than the absence of disease. Reproductive health and healthcare are defined as everything relating to the reproductive system, spanning a satisfying and safe sex life (including the management of sexually transmitted diseases), choices about when and if to have a family (contraception, termination, fertility) and care prior to, during and after pregnancy and childbirth. **Noting this approach, the interrelated nature of these areas of health and healthcare, and the inclusion of maternal, sexual and reproductive health as a priority under the National Women's Health Strategy, the Alliance will focus this submission on the status of contraception, termination and maternity services in rural Australia.**

People living in rural Australia have, on average, lower rates of employment, lower incomes and lower educational attainment than their metropolitan counterparts.[3] They have higher exposure to health risk factors, reduced access to health services, and ultimately poorer health outcomes as a result.[4] Significantly however, this 30 per cent of the population adds considerable value to the wellbeing of the remainder of Australia's economy, gross domestic product and society more generally.

[i] Please see https://www.ruralhealth.org.au/about/memberbodies for details

The health workforce reduces with geographical remoteness, with many professions in short supply, including GPs, non-GP medical specialists, nurses, midwives, pharmacists and most allied health professions.[4] Government spending on healthcare is also reduced in rural areas – the Alliance has estimated that each year there is a $4 billion deficit of funding for rural health.[4]

While rates of contraceptive use are highest in remote[ii] and very remote Australia and lowest in major cities,[5] rates of unintended pregnancy are higher in rural areas,[6,7] access to surgical termination of pregnancy is very limited and though available in primary healthcare, many areas of rural Australia do not have access to early medical abortion (EMA).[8]

Perinatal mortality rates are higher for babies born to women living in very remote areas[9], as is the rate of maternal death in remote and very remote areas.[9] Women living in remote and very remote areas are less likely to attend the recommended antenatal care[9] and more likely to consume alcohol during pregnancy.[9] Women living outside major cities are more likely to smoke during pregnancy and this trend increases with remoteness and is amplified for Aboriginal and Torres Strait Islander women.[9] Babies born to women living in very remote areas are more likely to be born preterm[9], be small for gestational age at birth[9] and have an extended neonatal hospital stay.[9]

Rural women face many hurdles when it comes to their reproductive health and as has been illustrated, women living in rural Australia are more, not less likely to need access to high quality reproductive healthcare than those living in major cities, yet this is not the case on the ground. **Throughout this submission we will highlight the key areas of inequity, give an appraisal of the factors contributing to this inequity and present policy implications for their rectification.**

[ii] Refers to the Australian Statistical Geographic Standard (ASGS) Remoteness Areas (RAs). Under ASGS, RAs are Major Cities, Inner Regional, Outer Regional, Remote or Very Remote. More information on ASGS is here https://www.abs.gov.au/geography

Statements addressing the terms of reference

a. cost and accessibility of contraceptives, including:

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

The ability to make choices about and plan parenthood is a core component of reproductive healthcare and access to reliable contraception is essential to this. A cross-sectional population level survey of Australian women found the prevalence of unintended pregnancy to be close to 25 per cent in the preceding ten years, with around 25 per cent of these pregnancies reported to be unwanted.[10] About 30 per cent of these unintended pregnancies ended in abortion.[10] **Women living in rural Australia are more likely to have an unintended pregnancy**.[6,7]

There are various forms of contraception available in Australia, both hormonal and non-hormonal in nature, including various oral contraceptive pills, barriers methods such as condoms, long-acting reversible contraceptives (LARC) (intrauterine devices, injectables and implants), natural methods and emergency contraception. The **proportion of women using contraception at the time of unintended pregnancy varies between approximately 25[7] and 50[10] per cent**, with the majority of those using contraception using an oral contraceptive pill and **very few using LARC**.[7]

Interestingly, **rates of contraceptive use are highest in remote and very remote Australia and lowest in major cities**.[5] Oral contraceptive pills and condoms are the most common form of contraception used in all geographical areas except remote and very remote areas, where use of LARC is more prevalent.[5] The use of LARC in Australia has been increasing over time, but its uptake remains low by world standards.[5] **There is an association between rural residence and the use of LARC or permanent methods of contraception** and women with poorer access to GPs have been found to be significantly more likely to utilise permanent methods of contraception (tubal ligation and vasectomy in a partner), independent of their location of residence. [11]

As illustrated above, a proportion of unintended pregnancy is related to contraceptive failure. LARC is a highly effective form of contraception.[12] While the use of LARC requires specific knowledge and skills on behalf of the health professional, it requires less frequent interaction with health services over time. **Reducing the prevalence of unintended pregnancy via prevention requires not only an increase in the uptake of contraception in those not using it, but specifically an increase in the uptake of more reliable forms of contraception such as LARC. This should be a priority for women in rural Australia who have reduced access to primary health care.**

Inadequate education and training in healthcare professionals creates a barrier to the uptake of LARC, including the misconception that LARC are unsuitable for young and/or nulliparous women.[13] Accessing forms of contraception that require a prescription needs timely and affordable access to authorised prescribers, for example GPs, eligible NPs and EMs and dispensers (for example community pharmacies). This is a challenge in rural Australia. The lack of access to Pharmaceutical Benefits Schedule (PBS) funding for all forms of LARC by all health professionals for whom their prescription is within scope (for example EMs) creates barriers to uptake based on cost which require regulatory changes to ameliorate.

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

Improving access to contraceptives for women and girls in rural Australia must focus on **improving access to primary healthcare services, especially GPs** and considering **models of care** that enable NP, midwives (especially EMs), primary healthcare nurses and pharmacists to work to their full scope of practice in this area.

The **GP workforce** is in very short supply in Modified Monash Model[iii] areas MM5-7 (small rural towns, remote areas and very remote areas).[14] Barriers to the recruitment and retention of GPs (and other health professionals) in rural Australia straddle three key groupings:
• Professional – limited networking opportunities, clinical experiences and supervision; professional isolation and lack of support from peers; and work–life balance issues.
• Financial – financial viability of rural practices; the need to work across multiple settings; multiple sources of both government and private funding; administrative burden; and business acumen requirements.
• Social – lack of family and friendship networks; social isolation; cultural and recreational limitations; and partner concerns, including their career and children's education. Interventions to attract and retain rural GPs need to address each of these barriers.

The Alliance has proposed a **new model of comprehensive, multidisciplinary primary healthcare for rural Australia** that would address these barriers to increase the size of the health workforce and enable improved access to high quality, culturally safe health care, with the aim of equalising the inequities in health outcomes experienced by rural people. This model requires block funding in recognition of the market failure in many rural areas that makes private practice unsustainable, enables an employment model to ensure attractive pay and conditions and remove the need for clinicians to run a business, creates a multidisciplinary team to ensure high-quality care that is coordinated, integrated and continuous, where health professionals can support and learn from each other, and is locally designed and led, ensuring close links between the service and the community it serves.

This model of care has the potential to include various health professionals, including NPs, midwives, primary healthcare nurses and pharmacists, who could support GPs in the provision of primary healthcare – in this case the provision of reproductive healthcare. The inclusion of block funding in the model would enable a funding stream to allow nurses and midwives to be remunerated in innovative models that allowed them to work to their full scope of practice in this area (as current fee-for-service provisions and incentive-based programs are inadequate to make this sustainable).

The **ORIENT study**, led by Professor Danielle Mazza, Director of the SPHERE Centre of Research Excellence in Women's Health in Primary Care is currently investigating the "effectiveness of a collaborative nurse-led model of care in general practice, involving optimal use of clinical upskilling, GP-nurse task sharing and telehealth services to increase access to LARC" and it is open to general practices located in regional and rural Australia.[iv] The intervention involves **online or virtual education and training** in LARC and EMA for nurses and GPs and enrolment in a **national virtual community of practice** to enable professional support. Key outcomes of the study include the impact on LARC and EMA uptake, along with feasibility and economic viability of the **nurse-led**

[iii] Refers to the Modified Monash Model (MMM) geographical classification system. Under MMM, major cities are MM1, regional centres are MM2, rural towns are MM3–5 and remote communities are MM6–7 (more information available at www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm).
[iv] For more information see https://www.spherecre.org/the-orient-study

model. We note that EMs are also able to prescribe LARC and non-endorsed midwives also have a role in this area.

The findings of this study will be highly valuable in determining future activities to improve access to contraceptives (and EMA) for women and girls in rural Australia as this research addresses both education and training of health professionals, alternative models of care and the provision of professional support.

The **ALLIANCE trial**[v] will assess whether **expanding community pharmacist's scope of practice** to deliver a billable consultation involving high quality, structured, patient-centred, contraceptive counselling and a referral to a contraceptive provider result in increased use of subsequent effective contraception amongst women at high risk of an unintended pregnancy and provides another potential avenue to enable access to contraceptives in rural women.

Access to **emergency contraception as Pharmacist Only medicines** via community pharmacies is also a crucial component of the spectrum of care, given the medicine must be taken within a strict timeframe following unprotected sexual intercourse. Research suggests that there is scope to improve consumer awareness and knowledge regarding emergency contraception availability, effectiveness window and safety in vulnerable groups.[15]

Addressing barriers related to the **cost of both contraceptives themselves and any associated consultations** with medical and health professionals, is important to improving access, particularly for rural populations where incomes are generally lower than average and there are additional costs associated with travel. Consideration could be given to implementing arrangements that would allow for emergency contraception to be provided at low or no out-of-pocket cost, especially for vulnerable populations, such as via PBS subsidisation of emergency contraceptive medicines when supplied as a Pharmacist Only medicine.

[v] For more information see https://www.spherecre.org/the-alliance-trial

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

TERMINATION SERVICES

Termination of pregnancy or abortion is regulated by different laws in each state and territory but is legal in all jurisdictions, generally with a gestational limit that requires additional considerations which vary by state or territory.[16] Abortion can be performed either medically or surgically. Both are considered safe and straightforward procedures with low complication rates.[17] In Australia, early medical abortion (EMA) can be performed up to nine weeks gestation, the medications used are subsided by the PBS and can be prescribed by GPs who have completed a training module or fellows/diplomates of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).[18]

There is no national data collection on rates of abortion in Australia, nor an analysis by geographic location.[19] A recently published estimate of the rate of abortion shows a reduction in surgical and an increase in medical abortions over time, with an overall rate in 2017-18 of 17.3 abortions per 1,000 women aged 15-44 years, which is lower than the estimate published in 2005 (for 2003) of 19.7 abortions per 1,000 women aged 15-44 years.[20]

Access

In Australia surgical termination of pregnancy (STOP) is generally provided in private clinics (and some public hospitals), but they are commonly located in major cities.[16] Hence, **access for rural women close to home is limited**.

Medical abortion can be provided in primary care, either in person or via telehealth.[21] A 2020 study reported that only 2,850 of the 41,000 GPs in Australia were registered to prescribe EMA medications at that time.[18] Another study analysed the rate of prescription and dispensation of EMA medications across Australia in 2019 and found they were highest in outer regional and remote areas and lowest in major cities, at 6.53 prescriptions per 1,000 women aged 15-54 years in outer regional areas, 6.02 per 1,000 in remote areas and 3.30 per 1,000 in major cities.[8] Despite the higher rate of EMA in rural areas when analysed by geography at the national level, these authors also found that 30 per cent of all women and 50 per cent of women in remote Australia lived in smaller local areas (SA3s) where EMA medications had not been prescribed or dispensed at all in 2019, illustrating a **lack of access in large sections of rural Australia**.

Barriers to access (woman's perspective)

Due to the concentration of facilities providing STOP in metropolitan areas, the low rate of registration of GPs as prescribers of EMA medications and the large swathes of the country without GPs prescribing and/or pharmacists dispensing these medications, rural women have limited local options for access to abortion services. This results in the need to travel large distances to receive the care they need. **Travel** requires management of **logistics** such as limited public transport options, especially for young women or those experiencing socioeconomic disadvantage. It might require time off work, childcare, overnight accommodation and the support of a family member or friend, all of which can be difficult to negotiate and have associated financial **costs**. The treatments themselves also have associated financial costs – the median out-of-pocket cost of EMA in primary care is reported to be $560[8] and the cost of STOP in a private clinic is also likely to be substantial. Financial costs are also associated with the GP consultations, ultrasound scans and blood tests required in primary care and depend on the ability of the provider to bulk bill these services. These costs must be placed within the context of the lower average levels of socioeconomic advantage in rural Australia, and therefore reduced ability to pay.

The **time** limited nature of EMA (only up to nine weeks gestation) can reduce rural women's access, given that women's knowledge of treatment options may be limited[17], there may be waiting times for appointments to see a GP (especially one who bulk bills) and any other necessary investigations and referral pathways to health professionals who are willing and able to provide the treatment may not be clear and streamlined.[17] Rural women have reported having to **jump "through hoops"**[(17,p4)] to get the information and/or referrals required from their GP.

Following on from this is the issue of **stigma**, which continues to be reported by rural women as a hindrance to abortion care and is particularly acute in small rural towns.[17] This stigma may be at the community level, the institutional level or the level of individual care providers who have a conscientious objection to the provision of abortion.[22] It is linked with concerns about confidentiality and privacy which are also acute in small rural towns where there are often limited choices of provider and "everyone knows one another".

Barriers to provision (provider perspective)

There are several concerns reported by rural GPs as reasons for not providing EMA. Some doctors **conscientiously object** to performing abortion and refuse to refer women for the procedure despite having a legal responsibility to do so.[8] Many do not have the **knowledge and training** required to provide the care, they have concerns about **inadequate support from local hospital services** in the event of complications and the **lack of access to associated investigations** such as ultrasound scans, along with **uncertainly regarding the applicable legal restrictions**.[23] The **remuneration** available under the Medicare Benefits Schedule (MBS) to patients for abortion services is inadequate given the complexity and time consuming nature of the intervention, making it unviable for many GPs.[22]

Policy implications

In order to achieve universal access to reproductive healthcare (abortion care being a core component) inequities in access between women must be addressed and hence rural women's ability to access abortion care must be improved. Women need to be able to access affordable services, closer to home. Key strategies to achieve this include:

- Increasing **community level knowledge** about abortion to improve women's understanding and reduce community and institutional level stigma.[23]
- Increasing **knowledge and training of GPs/NPs/EMs/primary healthcare nurses and pharmacists** regarding abortion generally and EMA specifically, both at the entry-to-practice and post-graduate levels, to increase the number of GPs providing and pharmacists dispensing EMA in rural Australia
    - Specific issues to address include the most up-to-date evidence regarding necessary investigations (for example anti-D, ultrasound scans)[8]
    - Processes and requirements for the management of complications (including the availability of a 24-hr after-care telephone service, the ability for women to self-screen for serious EMA complications, and the severity of complications aligning with those post childbirth or spontaneous termination).[23]
- Explore **enhancement of the role of nurses and midwives** in abortion care in both primary care and hospital settings.[19] This would enlarge the health workforce available to deliver care. Research has found nurse-led models to be safe, effective[8] and well received by women[22] and also cost-effective.[19]
- Creating a **specific MBS item number** for the provision of abortion care to enable adequate reimbursement to women for the time spent, increasing the likelihood of bulk-billing by GPs/NP and EM and making the service more viable for them and cost-effective for women.
- Increase the provision of **telehealth** EMA services.[19]

- Increase the **size of the GP workforce** in rural Australia so that rural women have improved access to primary healthcare practitioners closer to home.
- Explore the possibility of **dedicated provision of abortion care within state and territory run public hospital services** where care is provided free-of-charge, ensuring tailoring of services for all population groups (for example, equitable distribution of services in rural areas).[19]
- Generate **standards of abortion care** for the Australian context that guide a consistently high quality, accessible approach to service delivery.[19]
- Fund and create a **national data collection** for abortion services in Australia, with reporting on geographic access included as part of this collection.[19]
- Fund **research** into abortion care, including for women in rural Australia.[19]

MATERNITY CARE

Access

Most Australian mothers give birth in a public hospital, utilising various models of care.[24] Australian public hospitals are managed and run by jurisdictional governments. Some models of maternity care which interface with the public hospital system are funded by the Australian government - GPs working in primary care, Aboriginal Community Controlled Health Organisations (ACCHOs) and endorsed privately practicing midwives. Therefore, state and territory governments have significant influence when it comes to the provision of maternity services, but any major change to the system and/or awareness raising and education, requires concurrent work with the Australian Government to integrate models of care across primary healthcare and the acute hospital sector.

A study examining the distribution of maternity services in rural Australia according to measures of population need, found that the number of births within a catchment of one-hour road travel time from the facility was the strongest predictor of the presence or absence of a birthing service or caesarean section (C-section) capable service, and the only factor consistently associated with the distribution of services.[25] Other measures of population need - geographical isolation and measures of population perinatal vulnerability (socioeconomic status and proportion of Aboriginal and Torres Strait Islander peoples within the catchment) - were either not associated with service distribution, or inconsistently associated. Very remote communities were less likely to have any type of birthing service than less remote areas. There was a notable overlap regarding the number of births in facilities providing different services (birthing versus no-birthing and C-section versus no C-section), and considerable difference by jurisdiction regarding C-section capable services, suggesting inconsistencies in service planning. Rolfe, Donoghue and Longman et al. concluded that **rural maternity services were not distributed according to population need and given the ongoing closure of services since the study, it is unlikely the situation has significantly improved but rather likely worsened.**

Implications of poor access (costs)

When women don't have access to maternity care that meets their needs within a reasonable travel time, there are consequences. International research links **travel time** of more than one hour to a birthing service, with **poorer outcomes** for women and babies and increased interventions.[26] Australian studies have shown a correlation between rates of being born before arrival (BBA) and distance from a maternity unit[27] or the closure of rural maternity services.[28]

When there is inadequate local access to a birthing service, women are often advised to **relocate** up to four weeks prior to their due date and give birth away from home.[29] Relocation removes women from their support structures, with possible impact on their ability to care for other family members and undertake paid work (care which must then be provided by someone else, who might also have to take time off paid work), disrupts continuity of care and may present a culturally unsafe

environment for Aboriginal and Torres Strait Islander women. There is a body of evidence suggesting the lack of access to maternity care close to home results in increased levels of **stress and psychological distress and financial costs** to birthing families.[30]

The lack of locally accessible antenatal and postnatal services is also likely to **reduce the comprehensive nature of care**, including input from multi-disciplinary team members, such as lactation consultants and physiotherapists.

While the implications of poor access to maternity care for rural women and their families are significant, the closure of rural maternity units has **broader repercussions for rural communities**. When units are closed, maternity care providers are either lost from the community, or deskill as a result of reduced access to training opportunities.[28] This might reduce the ability of local health services to deal with unplanned births[30] and has an impact on additional professions, such as anaesthetists or GP anaesthetists, paediatricians, theatre staff and more broadly on the economic activity in the region. The lack of maternity services in a particular community might also become a disincentive for young families moving to, or staying in, the area.

Barriers to access and policy implications

Despite enthusiastic support by major stakeholders for improving access to maternity services for rural women,[31,29,32] strategic national policy which stipulates the provision of high-quality care close to home, and an evidence base highlighting heightened need and the detrimental impact on women, babies, families and communities when access is poor, there has not been nationally consistent action to change policy and practice in recent years.[29] Successive state governments have failed to implement one employer models and/or support rural generalists with advanced skills in obstetrics and gynaecology to work across general practice and hospital settings, resulting in expensive, inaccessible maternity care, and ultimately the loss of access to local services. This has resulted in economic and societal losses within the hospital, general practice and community settings.

A group of authors has articulated the barriers to operationalising national policy as including:[33]

- poor leadership
- lack of understanding of the evidence-base for different models of maternity care and mechanisms of clinical governance
- misperceptions of risk that prioritise clinical risk over social risk
- inadequate planning for workforce and resource allocation and
- inadequate community consultation.

The same authors have re-designed an international tool for rural maternity service planning for the Australian context – the **Australian Rural Birthing Index (ARBI)**, tested it with rural stakeholders and integrated it into a toolkit for use by rural and remote maternity service planners. The toolkit[34] facilitates a systematic three-stage planning process utilising measures of population level need to determine the optimal level of service provision for a given site, followed by an assessment of feasibility considering pragmatic issues that impact on sustainable service delivery and completed with a prioritising stage.

Decisions to close rural maternity services have been attributed to inadequate birth numbers[29], workforce challenges, concerns about safety, cost and tendency to centralise services.[33] Addressing the challenge of providing woman-centred maternity care to rural women will require a **political imperative**; **coordinated action** between stakeholders - including women and communities at the local level[35] - in each jurisdiction and from the national level; the **development and use of planning tools, frameworks and guidance**[29] (such as the ARBI toolkit); and a **specific, rurally-focussed**

national action plan.[29] The previously highlighted **barriers to operationalising national policy must be addressed**, as must **workforce** development, recruitment and retention issues.

Rural women have a right to high quality maternity care that meets their needs and is provided as close to home as possible. National policy, the evidence-base and key stakeholders, all support increased access to maternity services in rural Australia. It is time for coordinated action.

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

The key workforce considerations for improving the reproductive healthcare (specifically contraception, termination and maternity services) available to rural women include:

- **Increasing the number of GPs** in rural Australia, including **rural generalist GPs** with advanced skills in obstetrics, anaesthetics and paediatrics, as these workforces are core to provision of reproductive healthcare services.
    - The rural generalist pathway is an important strategy for building the rural generalist workforce
    - Single-employer models are a positive mechanism for enabling continuity of rural generalist training in rural areas by ensuring pay and conditions are in line with vocational trainees working solely in the hospital sector
    - Increasing opportunities for medical graduates from a rural background and/or those who have a rural interest and have participated in the Rural Health Multidisciplinary Training Program during their entry-to-practice qualification, to continue their pre-vocational training in rural areas, are essential to ensuring potential rural doctors can go rural and stay rural, without being drawn unnecessarily back to major cities
    - Programs such as the Remote Vocational Training Program enable GPs to stay and complete their training in rural areas when the supervision and mentoring required is not available on site
    - The Alliance's comprehensive, multi-disciplinary model of primary health care that addresses the barriers to recruitment and retention of rural health professionals, as discussed in section a.iii above, is another important strategy to improve the number and distribution of GPs in rural areas
    - Enhancing opportunities for rural students in primary, secondary school and tertiary education to consider and/or gain entry to and complete medical degrees is also an important part of the training pipeline to address, especially for Aboriginal and Torres Strait Islander students
    - Research suggests that medical graduates of rural origin, and those who undertake rural training are more likely to work rurally upon completion of their entry-to-practice training and that the length of rural placement positively correlates with rural practice.[36,37] Hence, these strategies for medical training should be prioritised and enhanced.
- **Increasing numbers of midwives (and EMs in particular)** in rural Australia, including Aboriginal and Torres Strait Islander midwives, is also essential to the provision of high quality, culturally safe primary maternity care close to women's homes.
- As discussed under section b above regarding termination services, **improving the education and training** of GPs, NPs, midwives (including EMs), primary healthcare nurses, pharmacists and obstetricians and gynaecologists in abortion care is essential. This enhanced training should also include contraceptive options, especially LARC and should include training in cultural safety.
    - Training should be enhanced at the entry-to-practice level
    - If abortion care were to be incorporated more consistently into the state and territory run hospital system, opportunities for training health professionals would be enhanced
    - A post-graduate training program is currently being developed by RANZCOG in sexual and reproductive health[38]

    - Opportunities for support and mentoring related to reproductive health, including via networks such as the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCCAPPS Community of Practice) are an important strategy to reduce isolation of rural professionals providing these services.
- It is also important to develop **new models of care** that enable other members of the healthcare team (especially nurses, NPs, midwives (especially EMs) and pharmacists) to work to their full scope of practice in reproductive health to most efficiently utilise the existing workforce, provide care that is cost effective and most acceptable to women. This includes access to clinical pharmacists in the hospital setting to ensure safe and effective use of relevant medications.
- **Local and regional planning** is essential to the development of appropriate solutions for the local context in maternity services, ensuring prioritisation of team-based care and continuity of care in alignment with local population need and utilising decision tools such as the ARBI mentioned in b above. High level commitment to the re-establishment and maintenance of rural maternity services is required. Concurrent access to associated services such as pathology, diagnostic imaging, mental health care and support in the context of gender based and family violence is also imperative for women and their families.
- The importance of all rural hospital facilities and paramedic emergency responders having the capability (equipment and training) to **manage emergency pregnancy and birth scenarios**[29] (eg. miscarriage, complications of a termination, unplanned birth) and have an awareness of culturally safe and sensitive care of women seeking pregnancy termination is also key to the reproductive health of rural women.

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

The provision of high-quality reproductive healthcare to Aboriginal and Torres Strait Islander women, who make up a higher proportion of the population with geographical remoteness[39], requires access to a **comprehensive primary healthcare system** that provides **culturally safe care** and support encompassing the spectrum of sexual, reproductive and maternal healthcare, including the ability to address the **broader social determinants of health**.[40] **Aboriginal and Torres Strait Islander health practitioners and health workers** have a key role in the provision of this care, as does the **ACCHO sector**. Care that is provided outside of the ACCHO sector must also be culturally safe and free from discrimination and racism. The provision of **cultural safety training** to staff who work in these settings is imperative.

There is high quality evidence and further research underway that illustrates the effectiveness of **Birthing on Country models** of care in improving the engagement of Aboriginal and Torres Strait Islander women with antenatal care and significantly improves the birth outcomes of Aboriginal and Torres Strait Islander babies.[41,42] Birthing on Country models are community designed and led, with a focus on holistic maternity care that prioritises continuity of midwifery care and aims to build the Aboriginal and Torres Strait Islander midwifery workforce. Further **funding** to continue this research, particularly in rural and remote areas of the country, is essential, as is funding to enable similar services that are ready to launch to get off the ground.

The development of resources and models of care to address the needs of women and girls from culturally and linguistically diverse (CALD) groups living in rural Australia is also important.

e. sexual and reproductive health literacy

Ensuring greater access to services and supporting women's health will require an increased level of general health literacy across the population and for women specifically, health literacy about sexual and reproductive health issues and services. It is important that women can access health information that is easy to understand, is trustworthy and culturally appropriate. What works in one rural community may not work in another and what works in metropolitan areas may not be always be appropriate in rural areas.

As part of this, reliable data and voice services are vital to achieving health equity for rural Australians, including for improving health literacy, digital literacy and more generally bolstering community driven preventative health activities. The Australian Digital Inclusion Index (ADII)[43] demonstrates that geography still plays a critical role in digital inclusion in Australia. It reveals substantial differences between Australians living in rural and urban areas. The divide between metropolitan and regional areas has narrowed but remains marked. Regional areas record an Index score in 2021 of 67.4. This is 3.6 points less than the national average (71.1), and 5.5 points less than metropolitan Australia (72.9). Further improvements will be needed to ensure rural women can access the information and services they need to maximise their reproductive health and wellbeing.

Health literacy initiatives should be grounded in co-design, support a placed-based focus within rural localities and encourage multidisciplinary approaches. The Alliance strongly supports tailored and co-designed health literacy and communication activities, including place-specific measures that draw on the health workforce available in rural areas and the needs of local populations.

f. experiences of people with a disability accessing sexual and reproductive healthcare;

People with a disability experience numerous barriers to accessing healthcare services generally – sociocultural, financial and structural in nature.[44] When combined with the aforementioned challenges to accessing reproductive healthcare in rural Australia – lack of existence of local services, the need for travel, financial costs, the need to manage logistics involved in travel, the lack of streamlined referral pathways and accessible information and stigma associated with the provision of care for some of these services, barriers for people with a disability are likely to be magnified.

Women with disabilities have a right to reproductive healthcare, including the right to informed decision-making, health education and access to services.[45] These services should be disability inclusive and designed with lived experience at their core. Given the complex nature of reproductive health and health services, women with disabilities in rural Australia would benefit from a program of care navigators (or similar) to assist them in finding and utilising the care and support they need.

Any plan to improve access to reproductive healthcare in rural Australia (or for people with a disability more generally), should address the specific needs of this combined cohort of women with a disability living outside of major cities, to ensure equity of access and therefore opportunity for improved health and wellbeing outcomes.

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