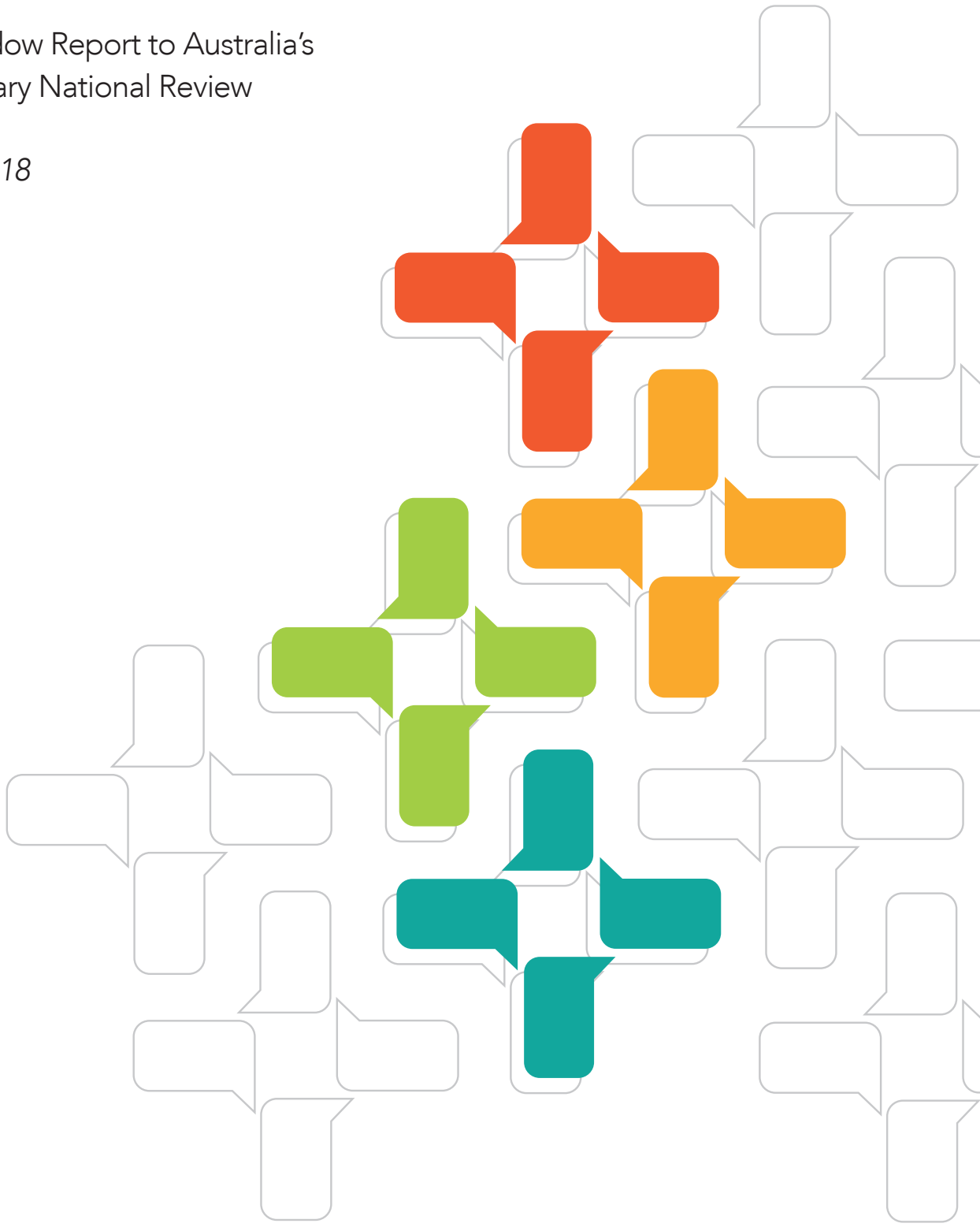
Family Planning NSW

Sexual & Reproductive Health & Rights in the Sustainable Development Goals

A Shadow Report to Australia's Voluntary National Review

July 2018



Introduction

In 2015 the United Nations (UN), in collaboration with member nations, set an agenda of Sustainable Development Goals (SDGs) which aim to transform the world by calling on governments, business and civil society to meet a framework of 17 goals and 169 targets to improve the lives of people everywhere by 2030.

To stimulate governments charged with implementing the SDGs, countries participate in a process of Voluntary National Review (VNR) so they can critically analyse progress, future priorities and areas of high need for attention.

This document is a shadow report to the Australian Government's VNR presented at the High Level Political Forum, at the UN in New York, July 2018.

As a local provider of reproductive and sexual health services, Family Planning NSW works within Australia's federated health system. Our primary focus through our 90-year history has been meeting the reproductive and sexual health needs of clients in New South Wales (NSW), the nation's largest and most populous state, whose community spans the complexity of dense urban areas, urban fringe, large and small regional cities, very remote towns and areas of significant need with high levels of priority populations, including Aboriginal and Torres Strait Islander People. As an international provider of reproductive and sexual health services Family Planning NSW is an accredited International Development provider and chooses to focus our work in the Pacific, an area of very high need in relation to reproductive and sexual health and rights.

As such, Family Planning NSW has a unique insight as to where Australia sits in terms of key reproductive and sexual health goals captured within SDG 3 – Good Health & Well-being and SDG 5 – Gender Equality.

Sexual and reproductive health and rights are fundamental to health and essential for sustainable development. In fact, we know sexual and reproductive health and rights are linked to gender equality and health and wellbeing, and have a significant impact on maternal, newborn, child, and adolescent health.[1]

Today, we see an Australia with strong performance in key areas of sexual and reproductive health. It is widely recognised high performance in this area is necessary to meet overall health and well-being goals.

However, there remain significant gaps in several areas, including meaningful national data collection that would allow health agencies to identify pockets of need, national policy around sexual and reproductive health care services and access – including abortions, comprehensive sexuality and relationships education and cervical cancer screening for the country's most disadvantaged.

Leaving no one behind is intrinsic to the values of the SDGs and closing the gap between 'mainstream' Australia and Aboriginal and Torres Strait Islander communities is essential. Also of critical importance is understanding and supporting the reproductive and sexual health of our Pacific neighbours. This falls in line with SDG 17 – Partnerships for the Goals, which require higher income countries such as Australia to not only perform well against the goals on home soil but to partner with developing countries, so the 2030 agenda can be realised by all.

We know that the test of how Australia fares in meeting the 2030 agenda will lie in the national approaches we can develop to better align reproductive and sexual health services across the nation, how we address the needs of our most vulnerable citizens, the gains that can be made to improve areas of deep need and the partnerships we can establish to support our Pacific neighbours in pursuit of these goals.

Adj Prof. Ann Brassil
Chief Executive Officer
BSc (Psych) Hons, MA (Hons) Clin Psych, MBA, MAICD

Table of Contents

Sustainable Development Goal 3 – **Good Health and Well-Being**

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

Maternal mortality in Australia

The maternal mortality rate in Australia sits among the lowest in the world. In 2017, the Australian Institute of Health and Welfare (AIHW) reported that between 2012 and 2014 there were 6.8 deaths per 100,000 women giving birth in Australia.[2]

However, among Aboriginal and Torres Strait Islander women alone the risk of death is almost three times greater. For these women, the maternal mortality ratio (MMR) was 18.7 per 100,000 women who gave birth between 2012 and 2014[3], compared with 13.8 in 2008-2012.[4] The corresponding figures for non-Indigenous Australian women were 6.3 per 100,000 in 2012–2014[5] and 6.6 in 2008-2012.[6]

Maternal mortality globally

From a global perspective, the Maternal Mortality Estimation Inter-Agency Group (MMEIG) estimated that the MMR in 2015 for developed regions was 12 per 100,000 women giving birth.[7]

However, the MMR for Australia's less developed northern neighbours is at least 10 times greater and highlights a significant gap in maternal health and welfare. In Papua New Guinea and Timor-Leste, the MMR was 215 per 100,000 women giving birth, and 114 per 100,000 women giving birth in the Solomon Islands.[8]

Recommendations

- Reduce the maternal mortality ratio among Australia's Aboriginal and Torres Strait Islander population. By 2030 maternal mortality among Indigenous women should be in line with maternal mortality among Australia's non-Indigenous women.
- By 2030 Australia should be actively supporting our Pacific neighbours and SDG 17 to create partnerships that ensure maternal mortality in the Pacific has significantly declined and their MMR is in line with the SDG of 70 per 100,000 live births.
- Increase meaningful funding commitments and partnership programs focusing on increasing access to family planning and maternal health services in remote Australian communities and the Pacific.

Case Study: Condom Credit Card

Family Planning NSW introduced the Condom Credit Card (CCC) project in 2008. The Family Planning NSW CCC is a friendly and confidential way for young people under the age of 25 to access free condoms, lubricant and sexual health information. In 2016-17, 1043 new young people signed up to the CCC, and a total of 14,304 condoms were distributed through the program.

Since 2008, the project has grown to over 150 registered CCC providers across NSW. The CCC project engages young people in discussions about reproductive and sexual health, providing a condom demonstration and information about sexually transmissible infections and contraception within a safe and supportive environment. It is a friendly, confidential way for young people under 25 years old to get free condoms every time they present their CCC to a registered provider. It also provides an opportunity to discuss STI prevention and screening, and refer to local services where appropriate. Family Planning NSW continues to engage young people with the CCC and supplies free training and resources to other registered providers. Family Planning NSW and registered providers are located across NSW.

Last year, we launched the CCC app. This allows young people to locate free condoms in their area from participating services across NSW. The app also supports content that promotes safe sex and interactive information on how to use condoms, contraception, sexually transmissible infections and testing. The app enabled rollout to remote and rural parts of NSW that may have limited access to reproductive and sexual health services. We have developed and implemented support resources for our partner organisations, consisting of a provider manual, posters, and a sticker which services can display to signal to young people that they are a CCC provider.

We undertook 33 CCC face-to-face training sessions last financial year with a total of 183 participants receiving training (132 female, 51 male). Quantitative data obtained from training evaluations showed that over 90% of participants indicated they were confident in how to use a condom after doing a condom demonstration and had increased knowledge about safe sex practices. The majority of participants were youth workers. Others included administration staff, support workers, nurses, general practitioners and psychologists. We also worked collaboratively with regional health services to train local clinicians and with a Local Health District in planning and delivering CCC training where a total of 9 participants from 3 services received training.

We carried out CCC new and refresher training for headspace mental health staff working in urban, outer urban and regional areas. We also delivered CCC training of Youth Advisory Committee members at two headspace sites.

We developed an online version of the CCC partnership training, with six modules covering the CCC, consent, condom demonstration, STIs, and contraception. Once training is completed, participants receive a certificate of attainment. Online training is primarily designed for services that are located in rural and remote areas of NSW where distance poses a barrier to face-to-face training.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Universal access

In January 2018, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) released updated guidance on quality comprehensive sexuality education. The International Technical Guidance on Sexuality Education is aimed at national authorities which UNESCO charges with developing curricula for young people that will have a positive impact on their overall health and well-being.

Despite this clear direction, Australia continues to lack a national approach to sexuality education. There is no consistency across states and territories regarding their approach to sexuality education and Australia has yet to register a position on the recently released UNESCO Technical Guidance.[9]

Australia lacks a comprehensive, national policy around sexual and reproductive health care and comprehensive sexuality education. In 2014 the Australian Medical Association noted that: "Federal, state and territory governments have a range of policies on individual aspects of sexual and reproductive health, but a coordinated approach is lacking. No policy or strategy has been developed that addresses sexual and reproductive health as a whole, or that attends to interconnections with other relevant areas, such as mental health, education, or drug and alcohol strategies. National policy leadership is imperative in overcoming policy fragmentation, maximising the linkages between interdependent strategies, and to support cooperation across federal, state and territory levels."[10]

The SDGs call for an integration of reproductive health into national strategies and programs, however Australia retains a fragmented approach. This has several implications, including in areas such as comprehensive sexuality education, abortion and contraceptive services.

Abortion

There is no standardised national data collection or overarching policy on abortion in Australia. Each state and territory have different statutes governing abortion, and in some parts of Australia universal access is impossible with abortion still falling under the Crimes Act – as ABC Health and Wellbeing recently noted; *Is Abortion Legal in Australia? – it's complicated.*[11] In many parts of Australia access to abortion is also affected by socioeconomic status with private clinics charging high rates for services (both medical and surgical) and publicly-funded Medicare services scant. Aside from the many access and legislative issues affecting women, those seeking medical abortions may also face large discrepancies between the Pharmaceutical Benefits Scheme (PBS) price of the medication and the varied prices applied by providers. This price gap is an unpublished issue that reproductive and sexual health workers are alerted to in their day to day dealings with health clients. Again, a lack of national data collection hinders meaningful analysis of the issue.

Australia's lack of co-ordinated policy on abortion defies efforts by medical experts to provide leadership and guidance on the issue. The Termination of pregnancy statement and associated recommendations, released in 2005 by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) Australia, has not resulted in a national strategy on this issue.

The RANZCOG[12] expert statement was reviewed in 2016 and in June 2018 President Prof Steve Robson restated the organisation's commitment to national consistency on equitable access to abortion services based on health care need.[13] In RANZCOG's *O&G Magazine*, Winter 2018, Prof Robson said that women's access to reproductive health services, safe abortion in particular, was of enormous interest and importance to the community.[14]

In the same publication lawyer Julie Hamblin argued that: "The patchwork of different legal regulation across nine different jurisdictions in Australia…is confusing and irrational. Doctors attempting to navigate this terrain could be forgiven for feeling nervous about exposing themselves to the risk of criminal liability if they perform abortions…it is unsatisfactory, in 2018, that one of the most commonly performed procedures should remain subject to complex and uncertain legal regulation, as well as the threat of criminality in some places. Majority public opinion has consistently been shown to favour lawful access to abortion.[15] It is time for the law in Australia and New Zealand to be brought into alignment with public opinion and accepted medical practice, so that abortion can become a full part of mainstream gynaecological care."[16]

The 2016 RANZCOG expert statement is a guide for specialists, as well as hospitals and states, on how their facilities and health staff may manage abortions. The statement supports that:

- Access to abortions should be based on healthcare need and not be limited by age, socioeconomic disadvantage or geography
- Women's physical, social, emotional and psychological needs be considered during decision making
- Pre-and post-abortion counselling by appropriately qualified personnel should be offered to women
- A national sexual and reproductive health strategy which would include termination of pregnancy be established
- Health professionals be aware of the abortion legislation in their state or territory.[17]

Abortion rates

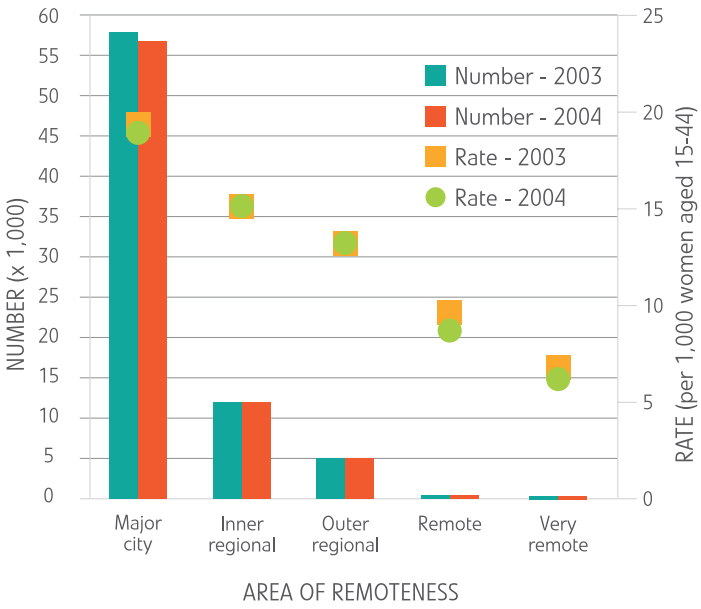
The number of induced abortions in Australia was estimated by the AIHW to be over 80,000 in 2003.[18] This estimation is limited by the acknowledged lack of national data, and there has been no published national estimate since. The 2003 estimate induced abortion rate was calculated using Medicare data and the national hospital morbidity database.

There is a need for routine national abortion data collection to inform policy, workforce and service delivery.

Abortions by area of remoteness

In 2004, most abortions were carried out in major cities with few being carried out in very remote areas of Australia.[19] The number of induced abortions was around 58,000 in major cities and 251 in very remote areas. The induced abortion rate was 19 per 1,000 women in the major cities and 6.2 per 1,000 women in very remote areas (Figure1). The lower abortion rate in remote areas may reflect issues regarding access to abortion services and/or that women from remote areas may be travelling to other centres where facilities are more available.

Figure 1: Induced abortion by areas of remoteness, Australia, 2003 and 2004



Sources: Data for 2003: Grayson N, Hargreaves J, Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. AIHW Cat. No. PER 30. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 17). Data for 2004: Laws PJ, Grayson N & Sullivan EA 2006. Australia's mothers and babies 2004. Perinatal statistics series no. 18. AIHW cat. no. PER 34. Sydney: AIHW National Perinatal Statistics Unit

Abortions by Indigenous status and throughout the Pacific

Data on induced abortion by Indigenous status is only available from Western Australia. The rate of induced abortion for Aboriginal women of reproductive age was 12.2 per 1,000 women in 2010 and 2012. This rate was lower than the rates of 17.6 in 2010 and 19.4 in 2011 for non-Aboriginal women.[20] This lack of data means there is insufficient evidence regarding access and safety issues among Indigenous women seeking an abortion.

Tracking access and safety of abortions in the Pacific is even more problematic than in Australia and among our priority populations. In March 2018 *The Lancet* analysed issues of safety and access to abortions around the globe, based on the broader report by the Guttmacher Institute on the incidence of abortion and unintended pregnancy worldwide. It found that the rate of unintended pregnancy and abortion in high-income countries had fallen significantly over the past decade, likely due in part to increased use of modern contraception. However, low-income and middle-income countries, including the Pacific, continue to have a higher abortion rate coupled with safety issues with less safe and unsafe abortions contributing to 8 to 11% of global maternal deaths.[21, 22]

> "The burden of unintended pregnancies falls hardest on the most vulnerable women. Reducing the stigma, minimising the social and economic consequences of unintended pregnancies, improving access to highly effective modern contraception, and ensuring legal and safe abortions would generate tangible improvements to health."[23]
>
> —The Lancet, March 2018

Recommendations

- There is no recognised national data collection on key reproductive health care indicators, including for family planning, and this should be a priority for governments as we aim to meet the sustainable development agenda by 2030.
- There is no national approach to comprehensive sexuality education. Australia must respond with a position on the UNESCO technical guidance and work toward a meaningful and national curriculum which supports young people.
- Australian governments need to support national consistency in relation to abortion law, access to services, and timely, mandatory, national data collection. This will bring Australia in line with the international goal of integrating reproductive health into national strategies and programs.
- RANZCOG have had a series of expert, clinical abortion guidelines available for more than a decade. Australian governments must engage with medical experts to endorse a national strategy and program in this area.

Prevalence of contraceptive use

There is broad access to sexual and reproductive healthcare across Australia and a wide range of effective contraceptive methods available to women.[24]

Approximately sixty-eight per cent of partnered women in Australia used contraception in 2015 (Table 1). This proportion has remained relatively stable over the past 20 years and is consistent with other more developed countries. There has been a rise in the prevalence of contraceptive use in less developed (44% to 53%) and least developed countries (21% to 63%) over the same period.[25]

Table 1: Estimates of contraceptive prevalence, any method, selected regions

	1994	2015
Australia	68.7	68.4
World	58.7	63.6
More developed	68.1	67.3
Less developed	44.3	53.125
Least developed	20.8	63.5

Note: Data are for women who are married or are in-union, aged 15 to 49. Source: United Nations, Department of Economic and Social Affair, Population Division (2015). *Trends in Contraceptive Use Worldwide 2015* (ST/ESA/SER.A/349).

Contraception is a critical element of a population's reproductive and sexual health and individual choice with regard to fertility. However, there are some gaps in knowledge regarding aspects of contraceptive use in Australia, including methods and products used, how contraceptive choices are made and how they may vary by geographic, social and other factors.

Contraceptive use and unmet need for family planning

An unmet need for family planning is when a woman wants to stop or delay childbearing but is not using any method of contraception.[26] In Australia, there is still a 10 per cent unmet need for family planning.[27] This is similar to the unmet need worldwide and among more developed countries (Table 2). A greater unmet need for family planning can be seen among less developed (17%) and least developed countries (22%), which includes many of our Pacific neighbours, where the unmet need for contraception is 22.1%, more than double the rate in Australia.

Table 2: Estimates of contraceptive prevalence for family planning and percentage of unmet need, selected regions, 2015

	Prevalence (any method)	Unmet need
Australia	68.4	10.4
World	63.6	11.9
More developed	70.9	10.75
Less developed	53.125	16.75
Least developed	39.5	22.1

Note: Data are for women who are married or are in-union, aged 15 to 49. Source: United Nations, Department of Economic and Social Affair, Population Division (2015). *Trends in Contraceptive Use Worldwide 2015* (ST/ESA/SER.A/349).

In fact, some of the world's poorest rates of contraceptive prevalence and unmet need for family planning are recorded in the Pacific with correspondingly high rates of adolescent birth and maternal mortality. In Samoa, there is a 42% unmet need for family planning, 38% in Vanuatu, and 28% Tonga and Tuvalu.

Country	Cervical cancer mortality ASR; deaths / 100,000 women per year*	Maternal mortality ratio deaths / 100,000 live births^	Contraceptive prevalence rate (%) women aged 15-49 (modern method)^	Unmet need for family planning^	Adolescent birth rates per 1,000 women, aged 15-19	Women who experience physical or sexual violence (%)#
Australia	1.6	6	65	10	14.1	
Papua New Guinea	21.7	215	29	25	65	67.5
Fiji	20.1	30	44	19	28	64.1
Kiribati		90	23	27	49	67.6
Samoa	7	51	31	42	39	46.1
Solomon Islands	18	114	32	21	62	63.5
Timor-Leste	8.1	215	28	26	54	58.8
Tonga		124	30	28	30	39.6
Tuvalu			28	28	42	36.8
Vanuatu	9.8	78	38	38	78	60

ASR = age standardised rate

*Data source: http://globocan.iarc.fr/Pages/fact_sheets_population.aspx

^Data source: http://www.unfpa.org/world-population-dashboard

#Data source: http://asiapacific.unfpa.org/sites/asiapacific/files/pub-pdf/VAW%20Regional%20Snapshot_1.pdf

Dashboard ratings source: http://www.sdgindex.org/assets/files/sdg_index_and_dashboards_compact.pdf

Contraceptive use by Indigenous status

The National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), conducted by the ABS in 2012, found that 49.4 per cent of Indigenous women reported currently using contraception.[28] This is lower than the national average of 60 per cent who were currently using contraception as reported in the HILDA 2015 survey.[29]

Recommendations

- A consistent, national approach to the collection of data on contraceptive use, either through routine data collection and reporting by Medicare, or through regular, population-based survey research is required to provide the level of information needed to ensure effective health service provision and cost-effective policy in this area.
- Increase contraceptive choice and access for women in the Pacific by working with Governments and NGOs to increase access to reliable supplies of contraceptives, provide training for clinicians in the insertion and removal of long acting reversible contraception (LARC), and community education on the benefits of family planning.

Case study: Aboriginal and Torres Strait Islander communities

Meeting the needs of Aboriginal and Torres Strait Islander communities is a core priority at Family Planning NSW. We do this by bringing our services to rural and remote areas where many of these communities live and embedding culturally respectful and appropriate practices into our five clinic sites and our offsite programs and education sessions to meet reproductive and sexual health needs.

We provide clinical services to clients who identify as Aboriginal or Torres Strait Islander. We also carry out many projects and community outreach services to reach a broader proportion of this community.

Our Aboriginal leadership and mentoring framework, Everybody's Business, identified language and processes that would support our work in a culturally appropriate way. We worked with the NSW Ministry of Health throughout the development of this resource. Most of the content was developed by our working group and the final framework document was submitted to the Ministry of Health in June 2017.

Case study: Culturally and linguistically diverse communities

'Culturally and linguistically diverse' (CALD) communities in NSW have a significant need for accessible and culturally appropriate reproductive and sexual health services and Family Planning NSW is building capacity to reach and respond to all our clients in an acceptable way, culturally and clinically.

In 2016/17, 4,837 of our clients were born overseas. The main languages spoken by them, other than English, were Arabic, Spanish, Vietnamese, Mandarin and Cantonese.

Our outer-urban clinic, in Fairfield, has one of the most diverse cultural communities in Australia and demand for onsite interpreters is high. For some languages, access to female interpreters, which are often requested by clients, remains a challenge. We therefore use a telephone interpreter service for urgent appointments.

We have partnered with NSW Refugee Health to better engage with clients who have not attended reproductive or sexual health services. We launched a nurse-led health screening clinic at Fairfield to extend health care services to newly settled refugees. We also operate an outreach nurse-led clinic at an outer-urban centre run by NSW Refugee Health. The site aims to provide women's health service to refugee women.

In partnership with local Primary Health Networks, we support male general practitioners by providing cervical screening and women's health services to patients in the surrounding regions. We collaborated with South West Sydney Primary Health Network (SWSPHN) to deliver reproductive and sexual health information to GPs working in south west Sydney, leading to a 42% increase in GP referrals to our nearby clinic.

Extending our efforts to improve our reach into the CALD community saw us awarded an additional grant from a Local Health District to provide women's health services to CALD immigrant and refugee women in the local area.

In 2017 we held a forum on reproductive and sexual health needs of Intensive English Course (IEC) students. Following this we developed a comprehensive program for IEC students in high need outer-urban areas. Students came from a diverse range of backgrounds including Assyrian, Chinese, Vietnamese, Iraqi and Cambodian.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Universal health coverage is a core goal within the SDGs and Australia has many outstanding programs, including immunisation, that have penetrated well across society. Another example is the National Cervical Screening Program (NCSP) which has crucial importance to the general health and well-being of Australian women.

The NCSP aims to reduce cervical cancer cases, as well as illness and death from cervical cancer in Australia, through an organised approach to cervical screening aimed at detecting and treating high-grade abnormalities before possible progression to cervical cancer. The target group is women aged 25-74 years and this program has had broad success, however, there are ongoing issues with screening among the most disadvantaged in our community.

Cervical cancer in Australia: Screening, cases and deaths

The Australian Institute of Health Welfare reported that in 2015-16 more than 3.8 million Australian women participated in cervical cancer screening. This was 55% of women aged 20 to 69. In 2016 around 700 women were diagnosed with cervical cancer and in 2015, 143 women aged 20-69 died from cervical cancer.[30]

Both cervical cancer incidence and mortality halved between the introduction of the NCSP in 1991 and the year 2002 and have since remained at 9 to 10 new cases and 2 deaths, per 100,000 women.[31] In 2011-15 the mortality rate from cervical cancer was higher in Indigenous women aged 20 to 69, at 7.0 deaths per 100,000 compared with 1.9 deaths for non-Indigenous women.[32]

Cervical cancer screening participation varies across remoteness areas, ranging from 46% in very remote areas to 54% in inner regional areas. There is a clear trend of increasing participation with different socioeconomic groups, from 49% for women in the lowest socioeconomic group to 61% for those in the highest socioeconomic group.[33]

National participation rates for Aboriginal and Torres Strait Islander women are not available due to Indigenous status information not being collected on pathology forms and cancer screening registries.

The continuing disparity in the cervical cancer mortality rate between Aboriginal and Torres Strait Islander and non-Indigenous women is unacceptable and remains a key barrier to the overall success of the cervical screening program.

The ability to address this issue has been hampered, in part, by incomplete data on Aboriginal and Torres Strait Islander participation in cervical screening.

Cervical cancer mortality in the Pacific

Although cervical cancer deaths have halved in Australia since the introduction of the National Cervical Cancer Screening Program in 1991 this trend has not occurred in developing countries where screening programs have not been implemented or where success has been more limited.

Cervical cancer is the fourth most common cancer in women worldwide. In 2012, 528,000 new cases of cervical cancer were diagnosed, and 266,000 women died of the disease with nearly 90% of deaths occurring in less developed regions. Cervical cancer is one of the most preventable and treatable forms of cancer if it is detected early and managed effectively.

Despite this, screening for cervical cancer is not routinely available in Pacific nations. The estimated age-standardised rate of deaths from cervical cancer in 2012 was 21.7 in Papua New Guinea, 17.9 in the Solomon Islands, and 9.8 in Vanuatu. This can be compared to 1.6 in Australia.[34]

Recommendations

- There is a need to collect additional demographic characteristics of women attending for cervical cancer screening to ensure participation rates by subgroups is monitored.
- Meaningful national data collection that identifies participation rates in cervical screening of Indigenous women is needed.
- More targeted efforts to promote screening in Indigenous and rural/remote communities is required.
- Self-collect options in the Cervical Screening Program and other culturally sensitive efforts are required to meet the screening needs of priority populations.
- Cost and resource-effective methods for prevention, screening and treatment of cervical pre-cancer in the Pacific must be implemented. This will reduce deaths from cervical cancer in the Pacific.

Case study: Cervical cancer screening

While many Australian women have benefited from national initiatives to reduce cervical cancer incidence and mortality, this has not been the case for all women, particularly Aboriginal women, women from culturally and linguistically diverse communities and women experiencing socioeconomic disadvantage.

Studies of health status of disadvantaged populations have found large health disparities that are both unjust and avoidable. In late 2013, Family Planning NSW collaborated with Sydney LHD, a women's health service, and a domestic violence service, to implement a Cancer Institute funded health promotion project based within supported accommodation services.
Project achievements included:

- A working group and an Aboriginal Women's Representative Group established to ensure cultural relevance and appropriateness.
- A suite of resources developed, including a women's resource 'Talking about Pap tests', a support worker tool, a poster and a list of 43 women-friendly no-cost Pap test providers. At follow-up, 100% of participating services were displaying some or all project resourses. Among those who participated in the initiative in the pilot phase of the project (phase 2), 66.7% had used the resource "Talking about Pap tests" in education session/s. All of them (100%) evaluated the 'resource' and the 'tool for accommodation support workers' as "useful/ very useful".
- Education provided to 54 support workers in 12 support services. 69% of participating workers reported an increase in confidence. 100% of workers participating in training during the piloting phase of the project reported an increase in knowledge on where to access no cost women friendly providers. There was also a slight increase in the number of workers overall who reported being likely to have a conversation about preventative screening, in particular Pap tests.
- Clinical services provided at a residential therapeutic service aimed at achieving recovery from drug and alcohol dependency (the new 'pop-up clinic') and at the women's health service (an existing clinic). Between November 2015 and December 2016, 64 individual clinics were provided. This included the provision of 280 occasions of service, with 189 appointments, 93 Pap tests and 97 referrals. The women's health service has since incorporated the 'pop-up clinic' into core business. Overall, the addition of an on-site clinic appeared to increase the success of this initiative.

Sustainable Development Goal 5 – **Gender Equality**

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.

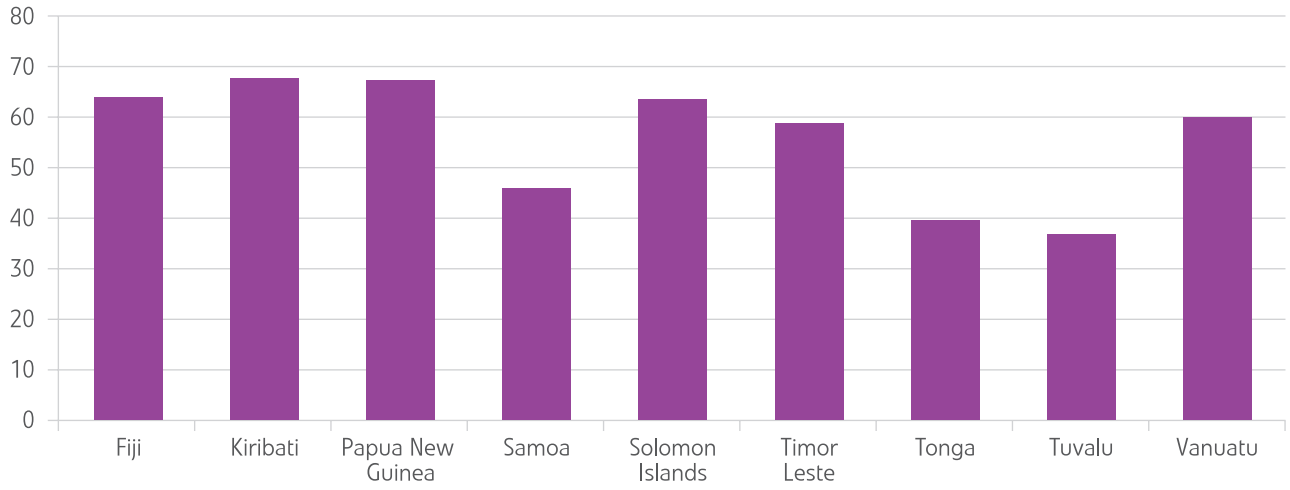
In Australia, two in five people (39 per cent, or 7.2 million) aged 18 years and over have experienced an incident of physical or sexual violence since the age of 15, including 42 per cent of men and 37 per cent of women. Four in 10 men and three in 10 women have experienced physical violence, and one in five women and one in 20 men have experienced sexual violence. Approximately one in four women have experienced violence by an intimate partner.[35]

Domestic violence routine screening was introduced in NSW in 2003 as part of antenatal, child and family health services, mental health services and alcohol and other drug services. In 2012 Family Planning NSW implemented routine screening through its clinics and has achieved an organisational average screening rate of 64%. Similarly, a 2015 Domestic Violence Routine Screening snapshot across NSW Local Health Districts showed a routine screening rate of 63.5%.[36] Across NSW, 6.4% of women screened disclosed domestic violence.

In Australia domestic and sexual violence is recognised as a significant public health concern. There are known links between domestic violence and sexual and reproductive ill health. Routine screening for these issues in appropriate settings including antenatal and sexual and reproductive health settings is an important intervention.[37]

In the Pacific, based on data from 2000 – 2015, it has been estimated that between 60% and 70% of women experience physical or sexual violence during their lifetime.

Percentage of women who experience physical or sexual violence in their lifetime



Source: UNFPA http://asiapacific.unfpa.org/sites/default/files/pub-pdf/VAW%20Regional%20Snapshot_2.pdf

Recommendations

- Governments should act now to establish and implement a comprehensive national domestic violence screening process. The screening model could be similar to the NSW Health model which has been shown to produce high rates of screening. Domestic violence screening, which should take place in appropriate settings, would allow women and girls greater access to support services, strengthen referral pathways, improve support for women and provide a basis for meaningful public reporting of the issue annually.
- Through Australia and the Pacific integrate response mechanisms and strong referral pathways for gender-based violence in reproductive and sexual health services.
- Establish comprehensive reproductive and sexual health education that incorporates a gender equality approach and addresses violence against women.
- Engage men and boys in community education programs as a partner in change to prevent violence against women.

"Gender-based violence against women is a human rights violation and both a cause and a consequence of unequal power relationships between men and women. It is a public health issue with serious consequences on women's physical, sexual, reproductive and mental health."[39]

—United Nations Population Fund

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

There is no national information or reporting on the number of women who have experienced female genital mutilation and cutting in Australia or the psychosocial, health or workforce impact for these women and their families. It is estimated that at least 125 million women and girls have undergone genital mutilation in more than 30 countries where this practice is prevalent.[40]

Through migration and humanitarian programs, women and girls who have experienced female genital mutilation have resettled in western countries, including in Australia[41] however, there is no data collection or reporting mechanisms. This lack of data means there is no understanding of localities where the issue may be concentrated and where related health needs exist.

Such information is essential for community engagement, policy development, health system planning for primary prevention of the issue and the management and support of women living with female genital mutilation.

Recommendations

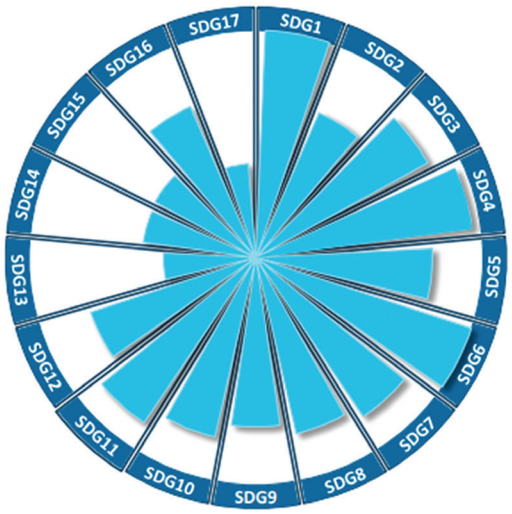
- Health professionals should undertake continuing professional development around female genital mutilation and cutting, to be more effective in communicating with women. Education will allow health workers to understand the health consequences and management of female genital mutilation, and to accurately collect information.
- Appropriately skilled and confident health professionals should contribute to mandatory collection of robust and reliable national and state-based data on female genital mutilation and cutting.
- Funding bodies should support the institution of mandatory collection and reporting of female genital mutilation data to Territory and State health departments. This information is relevant for government and policy makers to establish and maintain the services required to support women who are affected by, or are at risk of, mutilation or cutting.
- General practitioners, nurses, midwives and allied health workers should be informed about appropriate referral pathways for the variety of physical and psychological health implications of female genital mutilation. A network of expert health professionals, appropriately skilled in the particularities of the issue, should be easily accessible, and adequately publicised.

Sustainable Development Goal 17 – **Partnerships for the Goals**

In July 2016 the *SDG Index & Dashboards – A GLOBAL REPORT* found Australia performed worst for its performance against those goals in relation to international collaboration and action, specifically SDG 17- partnership, and SDG 13- climate change.

Australia[42]: Bertelsmann Stiftung Sustainable Development Solutions Network (SDSN), 2016 SDG Index & Dashboards Report, p.69.

AVERAGE PERFORMANCE BY SDG



The SDGs openly require Organization for Economic Cooperation and Development (OECD) countries such as Australia to support and work in partnership with less developed countries, and this includes Australia's Pacific neighbours.

In 2016 the *SDG Index Dashboards Report* noted that; ''... even many high-income countries fall far short of achieving the SDGs. This is not surprising. Sustainable development includes three pillars – economic development, social inclusion, and environmental sustainability – supported by good governance. It is possible to be rich (high income) but with significant inequality and unsustainable environmental practices (Osberg and Sharpe, 2002). These results merely underscore the point that the SDGs are universal stretch goals, applicable to every country in the world…. A major global commitment…is for the richer countries to help the poorer countries to meet all of the SDGs."[43]

To address issues outlined in this shadow report, such as high maternal mortality, poor access to contraception and reproductive health services, and high cervical cancer death rates, Family Planning NSW works in the Pacific, building partnerships with family planning organisations at national and international levels, and with local NGOs and government health services to improve access to comprehensive reproductive and sexual health services with funding from the Australian Department of Foreign Affairs and Trade (DFAT), and private donors.

Access to family planning so women can control their fertility has been estimated to result in up to a 40% increase in women's monthly wages, increasing women's control and agency over finances and property, and enabling greater long-term savings (Canning and Shultz, 2012).

Our approach is to develop collaborative partnerships at local, national and international levels. We are committed to long term capacity building with government and non-government organisations to address reproductive and sexual health needs of the community. We achieve this by training in-country providers in best practice services, enhancing the knowledge and skills of service providers, improving the body of knowledge about reproductive and sexual health through rigorous research and evaluation, and leading international development projects to promote the rights of marginalised people in developing countries.

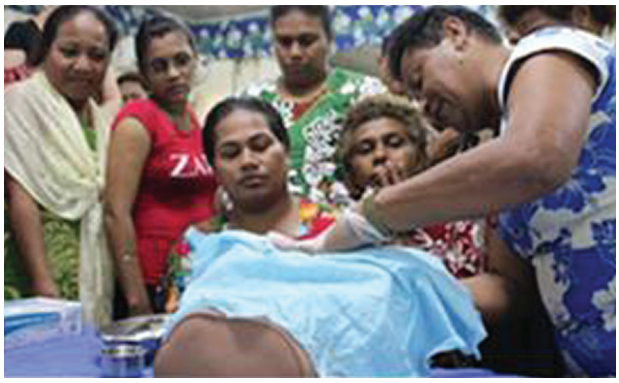
However, capacity for the NGO sector to partner with the Pacific is being crippled by severe funding shortages and this is blocking women's access to family planning and costing lives.

Case Study: Our cervical cancer screening program

Our cervical cancer program aims to reduce deaths from cervical cancer by working with national governments, non-government organisations and key stakeholders to strengthen national health systems and increase cervical cancer screening and treatment appropriate to the local context using visual inspection with acetic acid (VIA) and treatment with cryotherapy, Pap tests or HPV DNA testing. All of this work is supported by funding from the Australian DFAT.

Since 2010, we have worked in Fiji, Cook Islands, Solomon Islands and Vanuatu supporting government and NGOs to deliver sustainable cervical cancer screening and treatment programs. 160 clinicians have been trained and 10,000 women screened, promotional resources developed to raise community awareness and a customised cervical screening training program for the Pacific.

We supported the Fiji Ministry of Health and Medical Services to develop the Cervical Cancer Screening Policy 2015, implementing VIA and cryotherapy as part of the cervical cancer screening pathway. This was the first national cervical cancer screening policy in the Pacific.



Case Study: Credentialing of Solomon Island midwives and nurses in cryotherapy of the cervix

In November 2016, as part of a FPNSW international development project funded through DFAT, three clinicians were credentialed by the Solomon Islands Nursing Council to provide cryotherapy of the cervix for women with pre-cancerous changes on their cervix. These women are the first clinicians in the Solomon Islands to be credentialed to provide this type of treatment to women with pre-cancerous changes on the cervix. The clinicians include one nurse and one midwife from the Solomon Islands Planned Parenthood Association (SIPPA) and one midwife from Honiara City Council Kukum clinic.

Verlyn Gagahe, the Solomon Island Cervical Screening Project Nurse provides support to clinicians and takes a lead role in monitoring the project. Here is an example of the impact of this screening and treatment program for one woman in Guadalcanal Province:

"A patient was seen in Guadalcanal Province by the cervical screening midwives. The patient had a positive lesion and was referred to Honiara for cryotherapy. The woman returned after three months to have her cervix reviewed by clinic staff. She was very happy to hear that her cervix no longer had a lesion. When she left the clinic room she said "I will tell other women to check and I will tell my husband".

Case Study: The Post Basic Certificate Course in Sexual and Reproductive Health for Nurses and Health Extension Officers in Papua New Guinea

The *Post Basic Sexual and Reproductive Health Course* was designed in response to a request to Family Planning NSW from PNG's National Department of Health (NDoH) that registered nurses and health extension officers should have the opportunity to develop knowledge, skills and the desired attitudes for promoting the reproductive and sexual health of people of PNG. DFAT supported this through funding as part of its international development programme.

In developing the content of this course particular importance was given to ensuring that it was highly relevant to the PNG context, that it was informed by national policies and strategies as well as international research, and applied international best practice principles as described by the World Health Organization.

Two pilot courses have been run in Lae District in Morobe Province PNG, resulting in 21 health staff graduating from the 10 month course. This is the only post basic course in reproductive and sexual health of its kind in PNG.

The impact on the graduates in their level of confidence and skills is reflected in their comments in the 18 month evaluation post-training:

"It's how we approach patients and how we talk to them and how we receive them. When one or two come they go back and tell others. My attitude and approach is different now. Partners also come now for treatment, it was there before but now we really encourage them".

"Before the course we use to see less than five STI cases a month, now we get 20-30 a month, especially since we have separated the sexes".

"To be recognised as a Sexual and Reproductive Health nurse, people see me as a specialist, my colleagues and superiors etc. Staffs come and watch what I am doing and patients return when they say they will. They have trust in me. They refer others to me".

Recommendations

- To meet the 2030 Agenda, Australia must work in partnership with our Pacific neighbours.
- Funding must increase if we are to meet our own SDG Partnership Goals and effect significant change across the Pacific.
- The Australian Government needs to increase funding for family planning services through the Pacific, to meet the need for modern contraception and cervical cancer prevention, screening and treatment, and provide quality services which will result in a decline in unintended pregnancies and unsafe abortions and save women's lives.

References

1. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission
2. Maternal death in Australia 2012-2014, Australian Institute of Health and Welfare, https://www.aihw.gov.au/reports/mothers-babies/maternal-deaths-in-australia-2012-2014/contents/table-of-contents, retrieved May 25, 2018
3. Australian Institute for Health and Welfare https://www.aihw.gov.au/getmedia/a8ff4563-b8f6-43b4-826e-a861522d825a/aihw-per-92.pdf.aspx?inline=true retrieved May 30, 2018
4. Australian Institute for Health and Welfare, https://www.aihw.gov.au/getmedia/07bba8de-0413-4980-b553-7592089c4c8c/18796.pdf.aspx?inline=true retrieved May 30, 2018
5. Australian Institute for Health and Welfare https://www.aihw.gov.au/getmedia/a8ff4563-b8f6-43b4-826e-a861522d825a/aihw-per-92.pdf.aspx?inline=true, retrieved May 30, 2018
6. Australian Institute for Health and Welfare, https://www.aihw.gov.au/getmedia/07bba8de-0413-4980-b553-7592089c4c8c/18796.pdf.aspx?inline=true retrieved May 30, 2018
7. United Nations Children's Fund, Trends in Maternal Mortality 1990 to 2015, https://data.unicef.org/wp-content/uploads/2015/12/Trends-in-MMR-1990-2015_Full-report_243.pdf, retrieved May 30, 2018
8. United Nations Children's Fund, Trend in Maternal Mortality 1990 to 2015, https://data.unicef.org/wp-content/uploads/2015/12/Trends-in-MMR-1990-2015_Full-report_243.pdf. Retrieved May 30, 2018
9. UNESCO, International technical guidance on sexuality education http://unesdoc.unesco.org/images/0026/002607/260770e.pdf retrieved June 12, 2018
10. Australian Medical Association, Position Statement, Sexual and Reproductive Health, 2014. https://ama.com.au/position-statement/sexual-and-reproductive-health-2014 retrieved May 25, 2018
11. ABC Health & Wellbeing, Is Abortion Legal In Australia http://www.abc.net.au/news/health/2018-05-26/is-abortion-legal-in-australia/9795188 retrieved May 30 2018
12. https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Termination-of-pregnancy-(C-Gyn-17)-Review-July-2016.pdf?ext=.pdf
13. RANZCOG, OG Magazine Winter 2018, https://www.ogmagazine.org.au/wp-content/uploads/2018/06/OG-Magazine-Winter-2018-Abortion-Web.pdf Retrieved June 4, 2018
14. RANZCOC, OG Magazine Winter 2018, https://www.ogmagazine.org.au/wp-content/uploads/2018/06/OG-Magazine-Winter-2018-Abortion-Web.pdf pg 4 retrieved June 4, 2018
15. RANZCOG OG Magazine – Winter 2018, https://www.ogmagazine.org.au/wp-content/uploads/2018/06/OG-Magazine-Winter-2018-Abortion-Web.pdf pg, 17 ref. 9, For a summary of recent surveys of community attitudes to abortion, see the Queensland Law Reform Commission Consultation Paper Review of Termination of Pregnancy Laws, December 2017, pp27-28., retrieved June 4, 2018
16. RANZCOG, OG Magazine Winter 2018, https://www.ogmagazine.org.au/wp-content/uploads/2018/06/OG-Magazine-Winter-2018-Abortion-Web.pdf pg 17, Retrieved June 4, 2018
17. RANZCOG, Termination of Pregnancy 2016, https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Termination-of-pregnancy-(C-Gyn-17)-Review-July-2016.pdf?ext=.pdf, p3 retrieved June 4, 2018
18. AIHW, Use of Routinely collected national data sets for reporting on induced abortion in Australia, https://www.aihw.gov.au/getmedia/7f961837-d79f-44d2-9b70-5e66facd3678/10206.pdf.aspx?inline=true Retrieved May 26, 2018
19. Data for 2003: Grayson N, Hargreaves J, Sullivan EA 2005. Use of routinely collected national data sets for reporting on induced abortion in Australia. AIHW Cat. No. PER 30. Sydney: AIHW National Perinatal Statistics Unit (Perinatal Statistics Series No. 17).
20. Data for 2004: Laws PJ, Grayson N & Sullivan EA 2006. Australia's mothers and babies 2004. Perinatal statistics series no. 18. AIHW cat. no. PER 34. Sydney: AIHW National Perinatal Statistics Unit
21. Hutchinson M, Joyce A, Cheong M. Induced Abortions in Western Australia 2010–2012. 4th Report of the Western Australian Abortion Notification System, Department of Health, Western Australia, 2013
22. The Lancet, Abortion: Access and safety worldwide https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30624-X/fulltext retrieved June 12, 2018
23. The Guttmacher Institute, Abortion Worldwide 2017, https://www.guttmacher.org/report/abortion-worldwide-2017 Retrieved June 13, 2018.
24. The Lancet, Abortion Access and safety Worldwide https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30624-X/fulltext Retrieved June 13 2018
25. Contraceptive practices among women: the second Australian study of health and Relationships, https://www.contraceptionjournal.org/article/S0010-7824(15)30201-8/fulltext retrieved May 31, 2015
26. United Nations, Department of Economic and Social Affair, Population Division (2015). Trends in Contraceptive Use Worldwide 2015 (ST/ESA/SER.A/349).
27. United Nations, Department of Economic and Social Affair, Population Division (2015). Trends in Contraceptive Use Worldwide 2015 (ST/ESA/SER.A/349)

28. United Nations, Department of Economic and Social Affair, Population Division (2015). Trends in Contraceptive Use Worldwide 2015 (ST/ESA/SER.A/349).

29. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Survey 2012, customized report. 2017

30. Melbourne Institute of Applied Economic and Social Research. Household, Income and Labour Dynamics in Australia Survey. Melbourne, Australia 2015

31. Australian Institute of Health and Welfare, Cervical Cancer Screening in Australia, 2018, https://www.aihw.gov.au/reports/cancer-screening/cervical-screening-in-australia-2018/contents/table-of-contents retrieved May 31, 2018

32. AIHW Cervical Screening in Australia 2014-15 https://www.aihw.gov.au/getmedia/adc621ce-a54a-4680-8b37-2a70d897964a/20434.pdf.aspx?inline=true retrieved May 30, 2015

33. AIHW Cervical screening in Australia, 2018, p. 44, https://www.aihw.gov.au/getmedia/8a26b34d-a912-4f01-b646-dc5d0ca54f03/aihw-can-111.pdf.aspx?inline=true retrieved May 31, 2015

34. AIHW Cervical Screening in Australia, 2018, p58-60 https://www.aihw.gov.au/getmedia/8a26b34d-a912-4f01-b646-dc5d0ca54f03/aihw-can-111.pdf.aspx?inline=true retrieved May 31, 2015

35. World Health Organization, International Agency for Research on Cancer, http://gco.iarc.fr/today/fact-sheets-cancers?cancer=16&type=0&sex=2 Sourced via: Globocan, Retrieved May 30, 2015

36. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0

37. NSW Health Domestic Violence Routine Screening Snapshot p.11, http://www.health.nsw.gov.au/kidsfamilies/protection/Documents/dvrs-snapshot-report-13-2015.pdf Retrieved May 31, 2015,

38. NSW Health http://www.health.nsw.gov.au/kidsfamilies/protection/Documents/dvrs-snapshot-report-13-2015.pdf Retrieved May 31, 2015

39. United Nations Secretary-General. Secretary-General's message on the International Day for the Elimination of Violence against Women. [Online, accessed 17 February 2017]. 2014. Available from: https://www.un.org/sg/en/ content/sg/statement/2014-11-25/secretary-generals-message-international-day-elimination-violence.

40. UNFPA Regional Office for Eastern Europe and Central Asia, WAVE Network and European Info Centre Against Violence. Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia: A Resource Package. UNFPA and WAVE, 2014. https://eeca.unfpa.org/sites/default/files/pub-pdf/WAVE-UNFPA-Report-EN.pdf p. 17,retrieved June 12, 2018.

41. Joint evaluation: UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change 2008-2012. Retrieved from New York: Costello, S., Quinn, M., Tatchell, A., Jordan, L., Neophytou, K., & James, C. (2014). A Tradition in Transition: Female genital mutilation/cutting.

42. Bertelsmann Stiftung Sustainable Development Solutions Network (SDSN), 2016 SDG Index & Dashboards Report, p.69 http://www.sdgindex.org/reports/, accessed May 23, 2018

43. Bertelsmann Stiftung Sustainable Development Solutions Network (SDSN), 2016 SDG Index & Dashboards Report – Compact, p.15 http://www.sdgindex.org/assets/files/sdg_index_and_dashboards_compact.pdf, accessed May 24, 2018