Emerging sexual and reproductive health in Australia and New Zealand: gaps, challenges and solutions

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\textbf{ABSTRACT}

This Virtual Special Issue explores emerging topics in reproductive health in the Australian and New Zealand context. The included manuscripts cover pregnancy and termination of pregnancy, priority populations for sexual and reproductive health, digital technology and its impact on reproductive health, and perspectives from clinicians.

\textbf{Introduction}

The World Health Organization defines reproductive health as not simply the absence of disease, but a state of physical, mental and social well-being.\textsuperscript{1} Good reproductive health means that ‘people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do.’ The Australian and New Zealand governments both recognise sexual and reproductive health (SRH) as priority health issues, in large part due to increasing numbers of sexually transmissible infections (STIs) and high levels of unintended pregnancies.\textsuperscript{2,3} In this editorial, we highlight the diversity of reproductive health in these countries; from key challenges in the provision of pregnancy services, to access issues for priority populations, the role of digital technologies and clinical perspectives. We highlight some challenges and solutions to ensuring good SRH for those living in Australia and New Zealand.

\textbf{Pregnancy}

A cornerstone of reproductive health is timely access to the information and healthcare services needed at the commencement of pregnancy, for either antenatal care or termination services. In Australia, an estimated 10\% of people will become pregnant each year.\textsuperscript{4} For those wishing or needing to terminate their pregnancy, for whatever reason, access to timely care is crucial. However, people cannot access care if they do not know what services exist, or where to access them. Although termination of pregnancy is in theory accessible in Australia, in practice many barriers to access exist, including a lack of awareness and knowledge of termination options among those who may wish to use them.\textsuperscript{5} Accordingly, Cashman \textit{et al.}, use qualitative interviews to explore how those needing to access termination services find information about the services available to them, and their experiences of accessing medical termination of pregnancy (MTOP, where the pregnant person takes misoprostol and mifepristone to end their pregnancy).\textsuperscript{6} Cashman \textit{et al.} found a need to increase knowledge about MTOP availability and accessibility, and highlight the need to improve access to MTOP within existing primary care services, particularly in rural areas, findings which echo the recommendations of the recent Australian Senate Inquiry into universal access to reproductive healthcare.\textsuperscript{7}

Continuing with termination of pregnancy, understanding attitudes is also important to understand issues relating to access and use of services. This is particularly the case among adolescents, whose experiences of and attitudes towards termination of pregnancy are not well understood in the Australian context. Hendriks \textit{et al.} utilised a cross-sectional survey with more than 1000 adolescents living in Perth to understand their attitudes towards
termination of pregnancy, and included both female and male participants, a perspective not often taken in research focusing on termination of pregnancy.⁸ For both female and male participants, more supportive attitudes towards termination of pregnancy were found among those who were using, or had sexual partners who were using contraception, and among female participants, those who had previous experience with a termination of pregnancy. The authors emphasise the varied nature of sexual and relationship experience and history among adolescents (from no sexual relationships to multiple sexual partners; no experience of pregnancy to an unintended pregnancy and termination), and the impact these experiences have on views towards termination of pregnancy services. They note that good SRH education must be cognisant of these varied and changing experiences, to ensure the needs of adolescents are being met.

Warzywoda et al. also highlight the importance of knowledge as a facilitator for reproductive health, in their qualitative exploration of barriers to antenatal screening for syphilis in Queensland from healthcare provider’s perspectives.⁹ Infectious syphilis is on the rise in many middle- and high-income countries, including Australia and New Zealand.¹⁰ Worryingly, a large number of infections are among women of reproductive age, increasing the risk of congenital syphilis (that is, where the infection passes from the mother to the baby).¹¹ Congenital syphilis can have catastrophic consequences for the baby, including death. In response, some states and territories in Australia have introduced syphilis testing into their routine antenatal testing schedules. While identifying and treating syphilis as early as possible is vital among pregnant women, as highlighted by Warzywoda et al., there are clear barriers to doing so. While knowledge and awareness of the importance of screening among healthcare providers was identified as a key barrier to address, engaging patients in the importance of screening, and limitations in the current model of healthcare delivery also impeded effective screening. Warzywoda et al. make a strong argument for finding solutions to these barriers, noting the need to improve healthcare provider knowledge and healthcare systems to optimise syphilis screening, and ultimately reduce the incidence of congenital syphilis.

**Priority populations**

The Australian Government has acknowledged the pressing need to improve health among priority populations in Australia by including them as a focus in the current set of Priorities for the Medical Research Future Fund.¹² Reproductive health disparities among priority populations in Australia and New Zealand exist as a result of social determinants of health, discrimination and limited access to sexual healthcare. Recent publications in Sexual Health have highlighted these disparities among several priority populations, including refugee and migrant men, trans and gender diverse individuals, Aboriginal and Torres Strait Islanders, Māori and LGBTQ+ youth.

Refugee and migrant men are a growing priority population for SRH. A scoping review by Menesha et al. synthesises the evidence on men’s SRH health needs in Australia and found there is a focus on STIs and HIV but other areas of reproductive health are poorly understood.¹³ Studies of migrant and refugee men in Australia indicated varying levels of knowledge about SRH but also about where to access SRH services. Cost of services and navigating the healthcare system exacerbate difficulties in accessing care, as do communication barriers (which are often not ameliorated by translation services as privacy concerns impede uptake of these services). Shame and stigma surrounding SRH continues to be a barrier to accessing SRH among many migrant and refugee men.

Trans and gender diverse individuals also face disparities in SRH in Australia, often as a result of discrimination and limited access to gender-affirming care. A qualitative study by Del Tufo et al. sought to contribute to the limited body of knowledge about the health outcomes of trans and gender diverse individuals living in rural Australia. These interviews with 21 trans and gender diverse individuals living in two rural areas of New South Wales showed living rurally has both positive and negative impacts on health and wellbeing; for example they reported easy to access, quality gender-affirming care at the recruiting sexual health clinics, but reported a lack of access to respectful and holistic care outside of these clinics.¹⁴ Living in a small community for some added a sense of safety and belonging while for others it led to feeling isolated or even fearful for their safety as a result of their gender identity. There is no one-size-fits-all experience of trans and gender diverse individuals with living rurally in Australia, but it is clear that access to gender affirming care is paramount to their health and wellbeing.

Barriers to SRH access are also heightened for young people. A study of 500 young people aged 15 to 24 years old by Rose et al. highlighted how there are gaps in knowledge about how young people access sexual and reproductive care in New Zealand. This study included 25% of Māori ethnicity, showed a large unmet need for SRH, where nearly half of respondents reported previously needing help for sexual health and not seeking or receiving it. Being a woman, identifying as LGBTQI+, living in the city or being a carer for someone else were all more likely to have faced an unmet sexual health need in the past. Māori and European participants reported similar levels of unmet need, however when investigating reasons why they had not received help in the past a higher proportion of Māori participants indicated they worried about being judged by staff, uncertainty about where to go, or having a previous bad experience. These findings call for improved policies aimed at normalising discussions around sexual health and incorporating young people, particularly Māori and LGBTQI+ youth, in designing services.¹⁵
Young Aboriginal and Torres Strait Islanders in Australia experience higher rates of STIs and teenage pregnancy than their non-indigenous counterparts. In-depth interviews of 35 young Aboriginal women and men aged 16–21 years old by Bell et al. explored how participants reduced sexual health risks, including exploring condom and contraception use. The strategies reported here can support culturally safe and youth-centred SRH promotion programs that reinforce and supplement the existing harm minimising strategies these young people are already using.

Digital reproductive health

Advancing digital technologies brings both complications and opportunities to SRH. Discourse continues about the role of sexting (sending or receiving of sexually explicit text messages, photos, or videos) among adolescents. Falconer’s cross-sectional study of 8263 youth in Australia reports a high prevalence of sexting but also calls into question the appropriateness of framing sexting as an inherently risky practice. More than half of participants (52%) had sexted in the previous 2 months and those engaging in this practice were 3.29 times more likely to have ever engaged in vaginal or anal sex, and 2.88 times more likely to have engaged in sex that resulted in pregnancy than those who did not sext. Sexters also had significantly more sexual partners. However, there were no significant differences in past STI, condom use or the proportion on oral contraception between those who sexted and those who did not. The findings suggest the conversation about sexting needs to place it as part of normal sexual expression for adolescents rather than link it with risky sexual behaviours.

In contrast to sexting as a healthy part of sexual experimentation, sharing sexually explicit imagery can be harmful when it is shared without consent or as a result of coercion. Little is known about the frequency of non-consensual sharing of sexually explicit imagery among young people in Australia. An online survey by Douglass et al. of over 1000 participants (aged 15 to 29 years old) showed 13% had experienced their images being shared without consent and among these the majority did not make an official report. More can be done to ensure young people both know their legal rights and are enabled to seek support.

Advances in digital technologies also hold the promise of making access to sexual and reproductive healthcare easier and potentially more affordable. Stevenson et al. reported a search for online platforms (as of July 2022) for contraception access in Australia found eight websites where contraception could be purchased. These platforms were all offering oral contraception, some offered the vaginal ring and one website offered emergency contraception. Only one of the services offered subsidised medicine, so online platforms may provide a way for people to access contraception if they are willing to pay out of pocket and have barriers to access, but current online platforms do not offer a solution for financial barriers.

Clinician perspectives on SRH in Australia

We would like to end our editorial by highlighting clinician’s perspectives on SRH topics in Australia. Clinicians play a vital role in bridging the gaps in and informing the future of SRH. Cheng et al. evaluates clinicians’ experiences with a program that was implemented in New South Wales to screen for reproductive coercion (including contraceptive sabotage, pregnancy coercion, controlling a pregnancy outcome or forced sterilisation). Clinicians at a family planning service were trained to perform screening and respond to disclosures of reproductive coercion. This evaluation of 28 clinicians’ experiences with this program found that while they considered the information they were collecting vital, there were barriers to this screening, particularly time constraints and limited resources for when coercion was disclosed. Clinicians offered valuable insights into enhancing this program in light of the challenges, such as limiting the screening to those of reproductive age and calling for ongoing education and support, particularly multi-disciplinary collaborations for referral pathways.

Training and supporting clinicians is vital to addressing SRH needs. Another example of this can be seen in the management of pelvic inflammatory disease (PID) which is underdiagnosed in Australia and can lead to significant reproductive health complications, including infertility. An online survey by Bittleston et al. for over 300 Australian general practitioners (GPs) evaluated their experiences with chlamydia management and PID diagnoses. Findings indicate that there is variation in when GPs will perform pelvic examinations to support PID diagnoses, even in light of high rates of GPs asking female patients about STI and PID symptoms. GPs indicated barriers to performing pelvic examinations including a perception that the patient was averse to having one performed or GP reluctance due to lack of experience or confidence. These findings indicate more support is needed to train GPs on performing pelvic examinations and better incorporating these examinations in consultations for those at risk.

Conclusion

There are barriers to SRH access in Australia and New Zealand that disproportionately impact priority populations. Woven throughout the reproductive health challenges we face are the needs to address stigma and discrimination with regards to SRH and gender and sexual identity, as well as key knowledge barriers. Advancements in digital technologies that expand access to care and education for SRH needs as
well as capacity building for clinicians, particularly in primary care, may hold the keys to overcoming many SRH challenges in Australia and New Zealand.

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