

Sexual and Reproductive Health Data Report

June 2016



MULTICULTURAL
WOMEN'S HEALTH
AUSTRALIA

The MWA Program aims to improve the capacity of immigrant and refugee women to make informed choices about reproductive health through research, health promotion and advocacy.

Introduction

This national data report summarises the latest available data across a range of areas that impact on the sexual and reproductive health (SRH) of immigrant and refugee women.

The data in this report has been obtained from a variety of sources ranging from national, population-based studies to small community-based studies. As a national report, ideally all data reported would be population-based. However, where national, disaggregated data sets are not available, state and territory based research has been used. Where Australian data or research is not available, international research is used. Community-based-studies have also been included to highlight the issues relating to immigrant and refugee women's health.

Available research shows that immigrant and refugee women are:

- at a greater risk of suffering poorer maternal and child health outcomes.
- less likely than Australian-born women to have adequate information and familiarity with modern contraceptive methods.
- at greater risk of contracting a sexually transmitted condition (such as HIV and hepatitis B), especially immigrant women who are from countries where the condition has a high prevalence.
- less likely to use health and social/support services. (It is important to note that low access to prevention programs leads to higher representation among crisis and acute service-users).
- less likely to have access to evidence-based and culturally relevant information which will enable them to make decisions about their health.
- well-placed to improve sexual and reproductive health through preventative health education;
- more likely to establish and/or improve health literacy more effectively through small group, same-sex education delivered by trained bilingual educators in the preferred language of the group.

Sexual and Reproductive Health Data and Research

Significant data gaps exist in Australia in relation to SRH. In 2002 the Australian Institute of Health and Welfare created 44 Reproductive Health Indicators, but found that almost half (21 indicators or 48%) lacked adequate national, state and territory based data. While comprehensive data on fertility rates are available, other indicators such as maternal morbidity, infertility and family planning generally reflect a lack of standardised definitions and data collection tools (Ford et al 2003). For example, there are significant gaps in our knowledge of reproductive health because no data is routinely collected on:

- Abortion: it is currently not possible in Australia to reliably estimate the rate of surgical and medical abortions. Information is also lacking on the extent of induced abortions among population sub-groups; socio-demographic characteristics of women having abortions; measures of out-of-state procedures (i.e. when the state or territory where the procedure was carried out is not the woman's usual state or territory of residence); and reasons for abortion.
- Contraceptive use: understanding of trends and patterns of contraceptive use is fragmented and limited. There is also a lack of social, geographic and demographic data on contraceptive users.
- Unplanned pregnancy: There are currently no processes in place to collect data on unplanned pregnancy, including socio-demographic information and decision-making information.

In 2002 the Australian Institute of Health and Welfare created 44 Reproductive Health Indicators, but found that almost half (21 indicators or 48%) lacked adequate national, state and territory based data.

Moreover, the current evidence base is significantly lacking in specific data about immigrant and refugee women. If data collection does include immigrant and refugee groups, classifications used to measure ethnicity are often ambiguous, potentially misleading or inconsistent across studies and can include region of birth, country of birth and/or language spoken. The lack of available evidence-based information places immigrant and refugee women's sexual and reproductive health at greater risk.

There remains a paucity of SRH surveillance and monitoring data (SHFPA 2013) and this report strongly recommends:

- development of a national conceptual and information framework for reproductive health;
- more accessible data;
- comprehensive and cohesive coordination and analysis of collected data; and
- data disaggregated by gender, sex, ability, ethnicity, place of birth and visa status.

Contraceptive Use

In 2015, 64% of married or in-union women of reproductive age worldwide were using some form of contraception (UN 2015). The rate of contraceptive use around the world may serve as an indicator of the likelihood that a newly-arrived woman will be familiar with a range of available contraceptive methods on arrival in Australia.

The rate of contraceptive use in Australia is nearly 70% (UN 2015) for women of reproductive age. By contrast, the rate is significantly lower in the countries of origin of immigrant women who have the highest birth rates* in Australia (see also 'Fertility').

Contraceptive use in country of origin (%)		
Country of birth of mother	Any method	Modern methods
Australia	68.4	65.4
Samoa*	31.6	30.6
North Africa and Middle East, including Egypt, Sudan	52.7	47.7
Iraq	54.8	37.5
Lebanon*	63	40.4
Syria*	57.7	41.2
SE Asia including Philippines and Vietnam	64.1	56.5
Laos*	53.6	46.2
Southern Asia including Afghanistan, India, Nepal, Pakistan	58.6	50.3
Afghanistan	29.3	24.1
India	59.8	52.4
Pakistan*	38.5	27.9
Sub Saharan Africa, including Eritrea, Ethiopia, Somalia and South Sudan	28.4	23.6
South Sudan	6.8	2.6

Contraceptive Management

According to Australian research:

- Patient factors such as age, ethnicity, Indigenous status and holding a Commonwealth Health Care Card were significantly associated with lower rates of contraceptive consultations (Mazza et al 2012).
- Inadequate access to information was the overwhelming issue cited by African and Middle Eastern immigrant and refugee women regarding knowledge about both the range and side effects of contraceptives (Allotey et al 2004).
- Use of the contraceptive pill was found to be lower among women from non-English speaking backgrounds (Yusuf and Siedlecky 2007).

Family Violence and Sexual & Reproductive Coercion

The relationship between family violence and poor reproductive health outcomes is well established in international literature.

The World Health Organization (2010) reports that intimate partner violence (IPV) may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, and pregnancy complications.

International research (PPFA 2012) highlights the link between violence and reproductive health in the following ways:

- IPV is associated with poor sexual and reproductive health outcomes compared to non-abused women. This includes being at a greater risk of unintended pregnancy, repeat abortions, second-trimester abortions, and sexually transmitted infections.
- Reproductive coercion may be one mechanism that helps to explain the known association between IPV and unintended pregnancy.
- Unplanned pregnancies increase women's risk for violence and violence increases women's risk for unplanned pregnancies. Women who experience IPV are more likely to be in relationships with a partner who controls their contraceptive methods.
- There is a strong association between IPV and involvement in three or more abortions.
- Women in abusive relationships are more likely to be coerced into risky behaviours such as inconsistent condom use, which puts them at greater risk of sexually transmitted infections. Additionally, women exposed to IPV are less likely to disclose an STI to a partner due to fear. Studies show that young women who are exposed to IPV are more likely to have partners say that the STI was not from them or accuse them of cheating.

Research conducted in Australia into the impact of domestic violence on women's reproductive health and access to options and services (Cheung et al 2014; Children by Choice 2014) shows:

- Domestic violence impacts on women's reproductive autonomy.
- Unplanned, unintended or unwanted pregnancy is more common among women who identify as experiencing domestic or family violence.
- There is an increased risk of intimate partner violence and/or controlling behaviours towards women during pregnancy.
- For women who choose to terminate a coerced pregnancy, there are many barriers to current abortion provision in Queensland, which are compounded for women experiencing domestic violence.

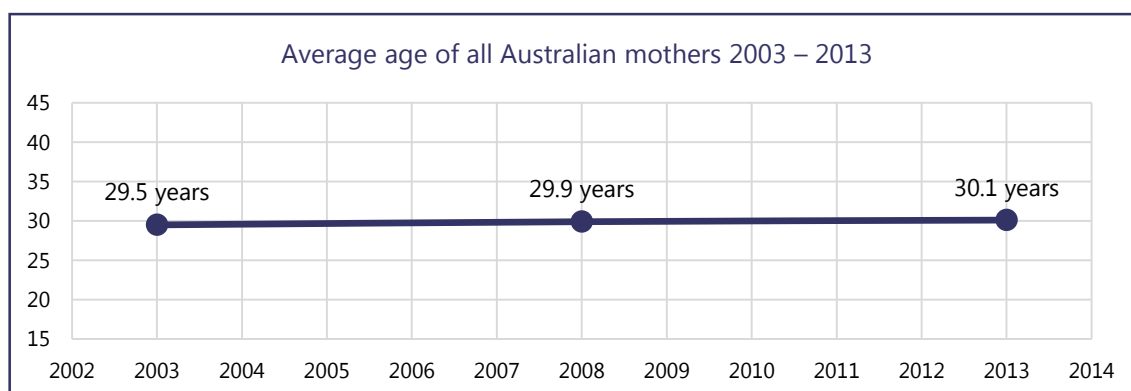
Fertility

According to 2014 data (ABS Births Australia), the fertility rate for Australian-born mothers is 1.93 births per woman.

Among overseas-born women, rates vary widely, with the highest rate at four (for mothers born in Lebanon), more than double the Australian rate. However, the age-specific fertility rate for some overseas-born women aged 15-19 years, is between three to four times higher than that of the Australian rate for the same age category.

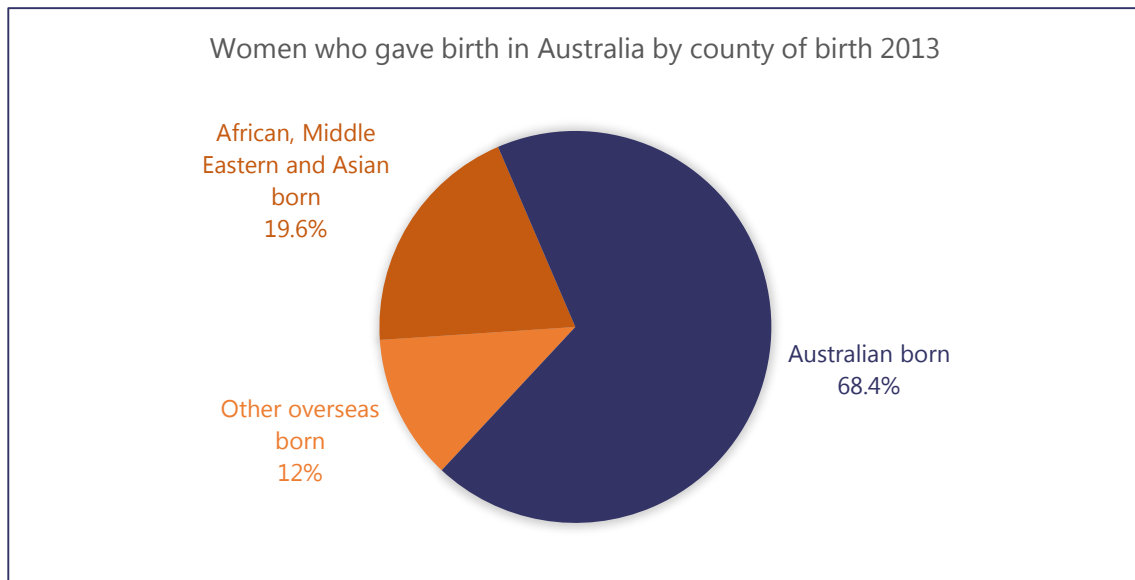
Australian fertility rates 2014 (of mothers giving birth in Australia)		
Country of birth of mother (selected)	Total rate	Age-specific rate: (15-19 years)
Australia	1.8	15.4
Samoa	3.2	30.2
North Africa and Middle East, including Egypt, Iran, Iraq, Israel, Lebanon, Syria, Turkey and Other	2.8	23.4
Lebanon	4.0	60.3
Syria	3.3	31.9
SE Asia, including Burma (Republic of the Union of Myanmar), Cambodia, Indonesia, Laos, Malaysia, Philippines, Singapore, Thailand Viet Nam, and Other	1.6	5.8
Burma	2.5	24.9
Laos	3.4	62.5
Southern & Central Asia including India, Pakistan, Sri Lanka and Other	2.0	5.4
India	2.0	2.5
Pakistan	3.02	9.6
Sub Saharan Africa, including Kenya, Mauritius, South Africa, Zimbabwe and Other	2.1	11.2
Other (sub Saharan)	3.3	26.1

(Source: AIHW 2015)



Maternal country of birth

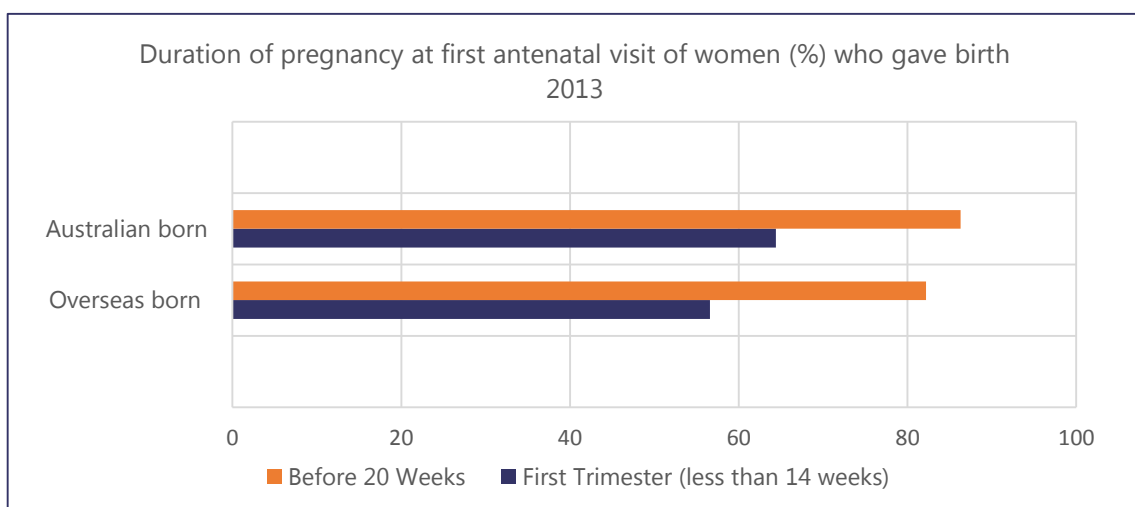
Maternal country of birth can be an important risk factor for obstetric and perinatal outcomes such as low birth weight and perinatal mortality. Among the 31.6% of overseas born women who gave birth in Australia in 2013, women born in Africa, the Middle East and Asia together accounted for 19.6% of all mothers (AIHW 2015).



(Source: AIHW 2015)

First antenatal visit

Antenatal care is associated with better maternal health, fewer interventions in late pregnancy and positive child health outcomes. The World Health Organization recommends receiving antenatal care at least four times during pregnancy and the Australian Antenatal Guidelines recommend that the first antenatal visit occur within the first ten weeks of pregnancy. Women born overseas who gave birth in Australia in 2013 were found to have attended their first antenatal visit at later gestational ages than Australian born mothers.



(Source: AIHW 2015)

Maternal Health and Pregnancy Outcomes

Preeclampsia and eclampsia

Preeclampsia is a major pregnancy complication leading to substantial maternal morbidity and mortality. It is associated with various pregnancy complications including pre-term birth, fetal growth restriction, perinatal death and adult long-term health problems in offspring.

A cross-country comparative study of six industrialised countries (including Australia) shows that immigrants from Sub-Saharan Africa, Latin America and the Caribbean were at higher risk of preeclampsia (Urquia et al 2014).

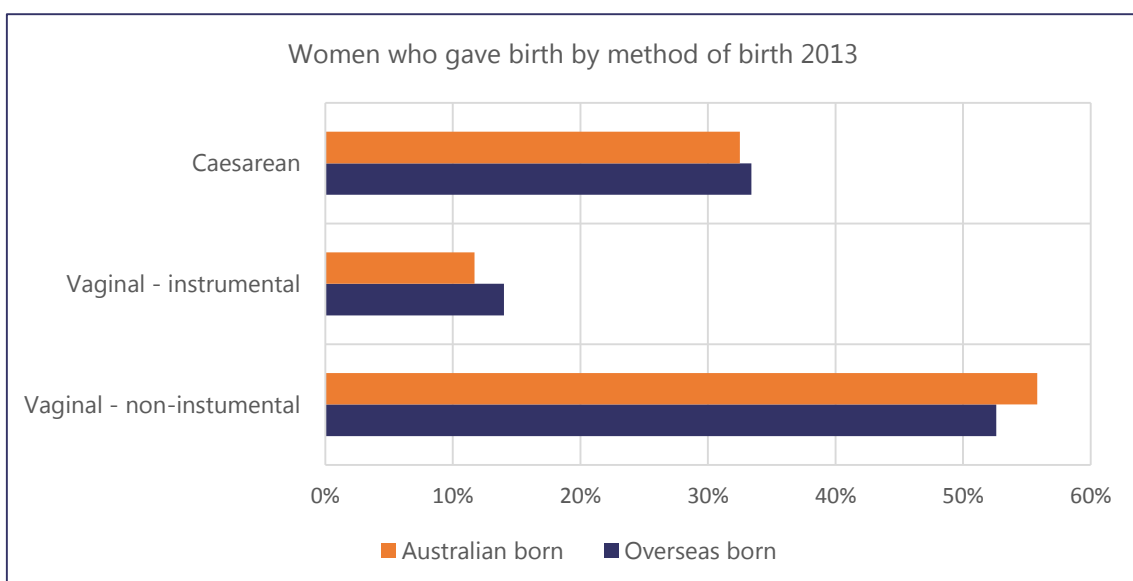
Gestational Diabetes Mellitus (GDM)

In 2013, mothers born overseas reported higher proportions of pre-existing diabetes (1.2%) than mothers born in Australia (0.9%) (AIHW 2015). In addition, mothers born in high-diabetes-risk regions, such as Polynesia, Asia and the Middle East, were slightly more likely to have Type 2 diabetes, and three times as likely to have GDM, as mothers born in Australia (AIHW 2010).

An Australian study of immigrant South Asian women who were recently diagnosed with GDM found that before diagnosis, women's knowledge and awareness of any diabetes was low. (Bandyopadhyay et al 2011).

A study comparing migrant women of refugee background from African countries with women who migrated for non-humanitarian reasons, found that mothers giving birth from humanitarian source countries in Middle and East Africa were more likely to experience GDM (Gibson-Helm 2014).

Birth type, including caesarean section



(Source: AIHW 2015)

Of the mothers who gave birth in 2013, those born overseas were less likely to have a non-instrumental vaginal birth than mothers born in Australia (52.6% compared to 55.8%). Mothers born overseas were more likely to have instrumental vaginal births (14%) or a caesarean section (33.4%) compared with Australian born mothers (11.7% and 32.5% respectively) (AIHW 2015).

A NSW population-based study found that compared with low risk women born in Australia and women born overseas, Indian-born women had the highest caesarean section (31%), instrumental birth rates (16%) and episiotomy rates (32%) (Dahlen et al 2013).

A 2016 study of caesarean rates for African immigrants in Australia found that both first-time mothers and mothers who had previously given birth from Eastern African countries (Eritrea, Ethiopia, Somalia and Sudan) had elevated odds of unplanned caesarean in labour. The study further found that the odds of any first-time caesarean (planned or unplanned) were elevated for first-time mothers from Eritrea, Ethiopia and Somalia, and were elevated for mothers who had previously given birth from Ethiopia and Somalia (Belihu et al 2016).

The caesarean rate recommended by The World Health Organisation is between 10-15%.

When medically justified, a caesarean section can prevent maternal and perinatal mortality and morbidity. However, there is no evidence showing the benefits of caesarean delivery for women or infants who do not require the procedure. As with any surgery, caesarean sections are associated with short and long term risk which can extend many years beyond the current delivery and affect the health of the woman, her child, and future pregnancies (WHO 2015).

Stillbirth (perinatal or fetal deaths)

The Australian perinatal mortality rate in 2013 was ten per 1000 births.

In Victoria, the perinatal mortality rate in 2013 (9.9 per 1000 births) was lower than the rate for 2009 (10.7 per 1,000 births). Despite this, perinatal mortality rates remain high for specific migrant groups including babies of women born in North Africa, the Middle East or southern and central Asia (the risk of perinatal death is one and half times higher) (CCOPMM 2016).

Australian state-based studies have also shown that:

- Compared with other refugee groups, women from West African humanitarian source countries were found to have the highest stillbirth incidence (4.4% compared to 1.2% and 1.6% from other regions) (Gibson-Helm et al 2014).
- South Asian born women were more than twice as likely to have a late pregnancy antepartum (i.e. not long before birth) stillbirth than either Australian-born or South-East Asian born women (Drysdale et al 2012).

- Lebanese born women had the highest rates of stillbirth (7.2 per 1000 births) compared with low risk women born in Australia and other women born overseas (Dahlen et al 2013).
- According to a Victorian population based study women born in East African countries experienced increased perinatal deaths and other adverse perinatal outcomes compared with Australian-born women. Women from Eritrea and Sudan are particularly at increased risk of adverse outcomes (Belihu et al 2016).

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Other Perinatal Outcomes

Several studies suggest that immigrant and refugee women may be at greater risk of adverse perinatal outcomes:

- Compared to African migrant women without a refugee background, African women of refugee background appear to be at greater risk of specific adverse pregnancy outcomes (Gibson-Helm et al 2014).
- Compared to low risk women born in Australia and women from New Zealand, England, China, Vietnam, Lebanon and Philippines (the most common migrant groups at the time of the study), Indian women were found to have the lowest normal birth rate and high rates of low birth weight babies (Dahlen et al 2013).

Maternal death

- In 2008-2012, there were a total of 105 maternal deaths that occurred within 42 days of the end of pregnancy. The majority (64 or 71.5%) of women who died were born in Australia. Twenty-six (or 25% where country of birth was known) were women born overseas. Nine of the women not born in Australia (whose country of birth was known) were born in New Zealand and 12 were born in the Asia-Pacific region (AIHW 2015).
- It is important to note that information on ethnicity is not routinely collected in perinatal data collections and therefore, no information on whether women were recent immigrants or refugees was available.
- International research (Ronsmans and Graham 2006) suggests that inequalities in the risk of maternal death exist globally and developed health systems such as Australia's need to target

and tailor interventions towards the most vulnerable groups.

- Victoria's Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) has identified immigrants, refugees and asylum seekers as being at risk of maternal death:

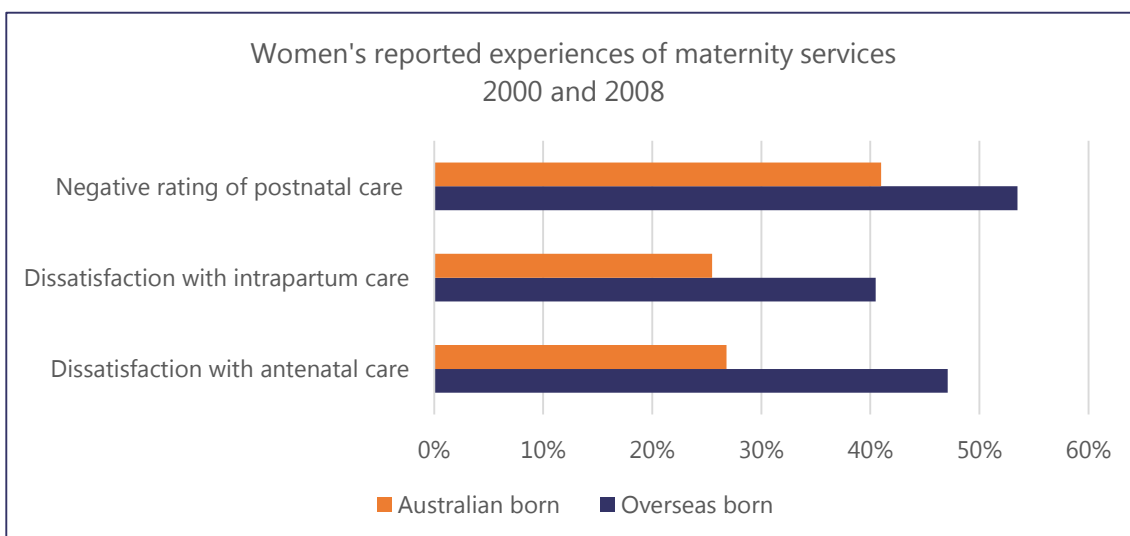
An emerging theme from the review of recent maternal deaths is the barriers to accessing care that recent immigrants, refugees and asylum seekers may face. As well as these challenges, these women may face social isolation and negative psychological impacts from experiencing pregnancy and motherhood in an unfamiliar environment. Information about these maternal factors is not comprehensively collected and further research is needed to fully understand this issue.

(CCOPMM 2016)

Maternity Care and Postnatal Experiences

A systematic and comparative review of studies in five countries (including Australia) of immigrant and non-immigrant's women's experiences of maternity care has shown that all women – both immigrant and non-immigrant – want maternity care that is safe, high-quality, attentive and individualised, with adequate information and support (Small et al 2014). However, the same study has also shown that:

- immigrant women were less positive about their care than non-immigrant women.
- communication problems and lack of familiarity with care systems impacted negatively on immigrant women's experiences.
- immigrant women reported problems with discrimination or prejudice.



(Yelland et al 2015)

Other Australian studies (Hennegan et al 2015; Yelland et al 2015; Lansakara et al 2010; Bandyopahyay et al 2010) have also shown that compared with Australian-born mothers, immigrant mothers were:

- less likely to rate overall postnatal physical health positively
- more likely to report relationship problems and to report lower emotional satisfaction with their relationship with the partner
- less likely to be asked about relationship problems by maternal and child health nurses
- less likely to be asked about feeling low or depressed by GPs
- more likely to say that health professionals did not always remember them between visits, make an effort to get to know the issues that were important to them
- less likely to feel involved in decisions
- less likely to understand their options of care
- more likely to have no 'time out' from baby care
- more likely to report feeling lonely and isolated
- more likely to report wanting practical and emotional support

In one study women also more frequently reported having distressing flashbacks and feeling depressed in the postnatal period (Hennegan et al 2015).

Maternal Depression and Postnatal Depression

A comparative study of the post-childbirth experiences of Australian born and immigrant mothers from non-English speaking backgrounds found that compared with Australian born women, immigrant mothers less proficient in English had a higher prevalence of depression (28.8% vs 15%) and were more likely to report wanting more practical (65.2% vs 55.4%) and emotional (65.2% vs 44.1%) support. They were also more likely to have no 'time out' from baby care (47% vs 28%) and to report feeling lonely and isolated (39% vs 17%) (Bandyopadhyay et al 2010).

The Mothers in a New Country (MINC) study (Small et al 2003) of Vietnamese, Turkish and Filipino women's experiences of maternity care and physical and psychological health found the issues most commonly identified by women as contributing to depression were:

- isolation (including homesickness);
- lack of support and marital issues;
- physical ill-health and exhaustion;
- family related issues; and
- baby-related issues.

Significant associations with depression were seen on at least two of the above measures for mothers who: were under 25 years; had a shorter residence in Australia; spoke little or no English; migrated for marriage; had no relatives in Melbourne. Similar themes and issues were also identified among immigrant Afghan mothers in a further study of immigrant Afghan women's emotional well-being after birth (Shafiei et al 2015). This study also found that some women were reluctant to discuss their emotional difficulties with health professionals and did not expect that health professionals could necessarily provide assistance.

Female Genital Mutilation/Cutting (FGM/C)

Due to lack of data, it is impossible to speculate on either the incidence or prevalence of FGM/C in Australia. In Australia, prevalence estimates are obtained from Demographic and Health Surveys and Multiple Indicator Cluster Surveys from African countries and extrapolated to the number of female migrants from FGM/C practising countries residing in Australia. This estimation is inadequate as prevalence depends on various other factors including ethnicity, socio-economic status and education.

There is no research evidence to suggest that FGM/C is practised in Australia. There is, however, research conducted by the University of Melbourne (Vaughan et al 2014a; Vaughan et al 2014b) that indicates the practice has declining support among communities in both rural areas and in the inner metropolitan areas of Victoria (MCWH 2016).

To ensure that women who have experienced FGM/C are properly supported and that the practice is not being continued in communities once they migrate to Australia, it is essential that effective and comprehensive health promotion programs and community education initiatives are in place (Chen and Quiazon 2014).

HIV

The number of HIV infections newly diagnosed in Australia has remained stable for the past three years (1,081 cases in 2014; 1,028 in 2013 and 1,064 in 2012). Based on newly diagnosed cases, the main route of HIV transmission in Australia continues to be sexual contact between men, which accounted for 70% of the cases in 2014.

Among cases attributed to heterosexual sex, 23% were of people born in countries recognised by the UNAIDS as having a national HIV prevalence above 1%, and 16% of people with sexual partners of people born in these countries. In addition, the proportion with late diagnosis was highest in people born in South East Asia (42%) and sub-Saharan Africa (38%) (The Kirby Institute 2015).

Hepatitis B

Hepatitis B leads to chronic liver conditions, including liver cancer. The estimated prevalence of chronic Hepatitis B infection among people born in Australia is 1%. Research has identified that:

- People from the Asia-Pacific (including Taiwan, Vietnam, China, and Cambodia), who represent 9.6% of the Australian population, accounted for an estimated 38% of those living with hepatitis B infection in 2013; and
- People from Sub-Saharan Africa, who represent 1.4% of the Australian population, accounted for an estimated 4% of those living with hepatitis B infection (The Kirby Institute 2015).

Primary prevention strategies to protect people from acquiring Hepatitis B infection include vaccination, use of clean needles and condom use. Testing and treatment are secondary prevention strategies.

Women should be targeted for education because Hepatitis B can be transmitted via sexual contact. Women are particularly vulnerable in this context due to violence and limited information about sexually transmitted infections.

Experiences of accessing sexual and reproductive healthcare

A systematic review of studies that focused on the views and experiences of immigrant and refugee women in accessing sexual and reproductive health care in Australia (Mengesha et al 2016) found the following barriers and facilitators:

Barriers

- Both spoken and written language, including issues relating to interpreters
- Health professionals' lack of knowledge regarding cultural norms
- Systemic barriers relating to the health care system and difficulty navigating the system
- Transport difficulties
- Cost of services

Facilitators

- Provision of interpreters and bilingual health professionals
- Multilingual resources, including information on how to reach healthcare facilities
- Appointment reminding services
- Home visits
- Provision of female health professionals
- Health professionals using their time to listen to concerns, answer questions and explain treatment options

Overall, the study found that interactions with health care professionals were critical to immigrant and refugee women's access to healthcare.

International Students

Research conducted by MCWH (Poljski et al 2014) has highlighted:

- the high rates of unplanned and unintended pregnancy in the international student population
- concerns about international students' rights in relation to informed choice in sexual and reproductive health
- factors that impact upon international students' lack of access to culturally appropriate health information and services, which include socio-economic status, intimate partner or other forms of violence, isolation and visa status entitlements.

International students on student (temporary) visas are not entitled to Medicare and must purchase Overseas Students Health Cover (OSHC) for the duration of their stay in Australia, to cover medical costs for themselves and their families.

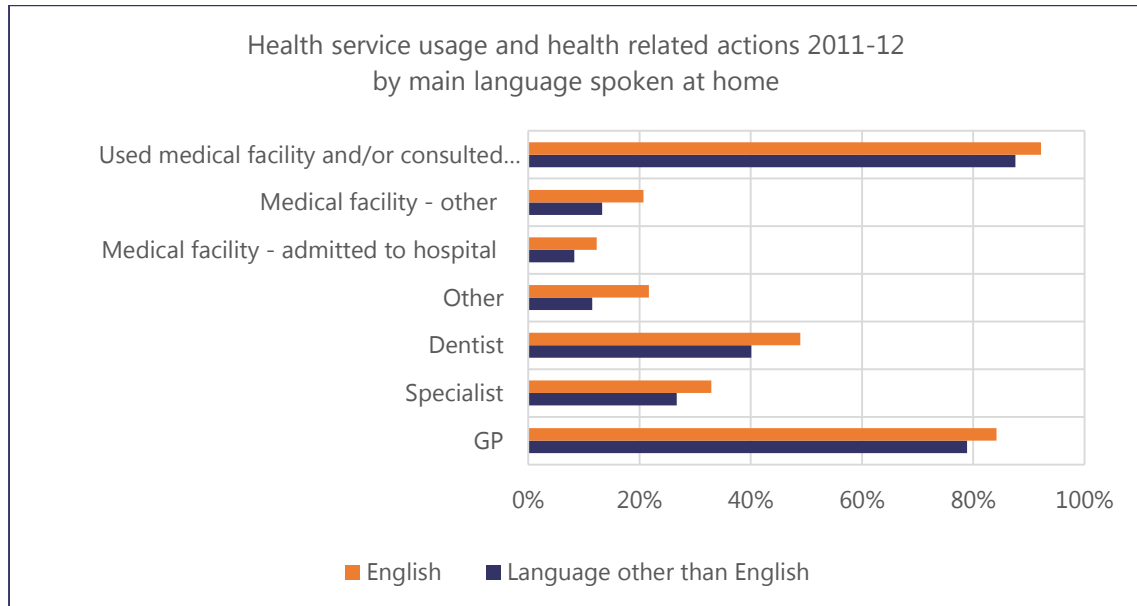
The minimum requirements and arrangements of OSHC are stipulated in the OSHC Deed. This Deed is a legal agreement between the Commonwealth of Australia represented by the Department of Health and Ageing and a registered private health insurer that provides OSHC.

Since July 2011, under the OSHC Deed, insurers have been allowed to set a 12-month waiting period for nonemergency pregnancy-related services. On these terms, an OSHC insurer is not required to pay benefits for the treatment of pregnancy-related conditions to international students and their dependants in the first 12 months of their arrival in Australia, unless emergency care is required. Birth is not explicitly listed in the OSHC Deed as a health condition which constitutes 'emergency care'

An international student, or the female partner of an international student, who experiences an unintended pregnancy within the first 12 months of arrival in Australia is faced with limited reproductive choices while simultaneously experiencing financial and/or settlement difficulties. (MCWH 2013)

Health Service Usage

There is evidence to suggest that people who speak a language other than English at home participate less in health services than those who speak English (ABS 2013).

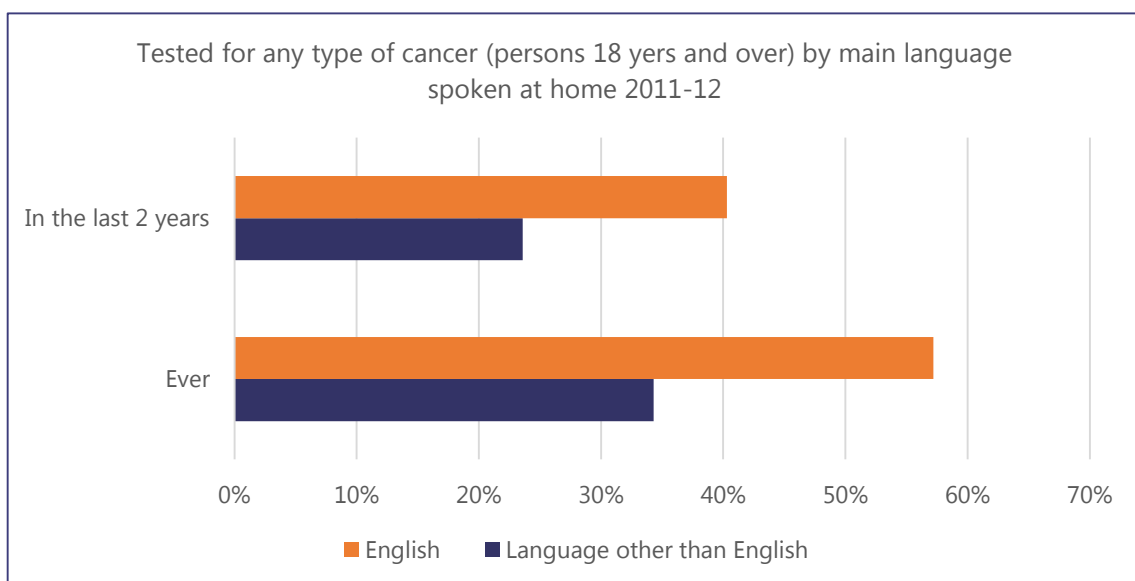


(ABS 2013)

Cancer Screening, including cervical screening

Australia's cervical screening program currently recommends two-yearly screening for women aged 18-69 years.

Australian research shows that migrant women from Asian and Middle-eastern countries are less likely than Australian born women to participate in cervical screening at the recommended level (Aminisani et al 2012).



(ABS 2013)

Breast Screening

In Australia, population-based breast cancer screening is available through BreastScreen Australia, which targets women aged 50–74 for two-yearly screening mammograms (women aged 40–49 and 75 years and over are also eligible).

In 2012-2013, participation of women who report that they speak a language other than English at home was 55.0% compared with the English-speaking rate of 48.8%. (AIHW BreastScreen Australia 2015).

Health Education Preference

Research suggests that verbal, same-sex, group-based, peer education sessions are the preferred mode of health education for immigrant and refugee women:

- A UK based study (Greenhalgh 2009) of a peer model of health education found that positive outcomes can be achieved through group participation (in addition to knowledge acquisition), as participants are able to negotiate meanings and make information meaningful for themselves.
- A Victorian study (McMichael 2008) conducted with resettled youth with refugee backgrounds in relation to the promotion of sexual health, found that gender-matched educators were the preferred method for learning about sexual health issues.
- Research conducted in Perth, Western Australia (Lee et al 2013), into the topic preferences and means of access to health information among newly-arrived women, found that women's health ranked a top priority along with employment advice and mental health issues. Preferred methods for receiving information were interactive talks with written materials. In addition, it was found that non-threatening, participatory processes encouraged women to prioritise sensitive topics such as family violence and highlighted the need for such topics to be incorporated within general health information.
- An evaluation (Hurwirth et al 2003) of MCWH's group-based health education program found that the majority (70%) of immigrant and refugee women who participated in the study expressed a preference for verbal delivery of information. The top three features and benefits cited by participants were: 'are offered only to women'; are offered in a preferred language'; and 'enabled learning'.

Suggested Citation: Multicultural Centre for Women's Health (MCWH), Sexual and Reproductive Health Data Report, June 2016, Australia.

For more information contact info@mcwh.com.au, visit mcwh.com.au or (free) call 1800 656 421.

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