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Ensuring Rights: Improving Access to Sexual and Reproductive Health Services for Female International Students in Australia

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Abstract

Drawing on the research and advocacy work being conducted by the Multicultural Centre for Women's Health (MCWH), a national community-based organization in Victoria, Australia, the paper analyzes female international students' experiences with accessing sexual and reproductive health information and services. Accessibility of sexual and reproductive health services is one of a number of areas identified by MCWH in which international students experience unequal treatment. The limitations of international students' mandatory health insurance is of particular concern because it appears to conflict with Australia's human rights obligations to take all appropriate measures to eliminate discrimination and to ensure appropriate services in connection with pregnancy. Given the social, cultural and economic benefits international students bring to the country in which they choose to study, state action on equitable health access for international students is urgently called for.

Keywords: sexual and reproductive health, international students, Australia

Although recent changes to student visa regulations and violent attacks against international students have seen the number of student enrolments decline, Australia continues to be a favoured destination for international students out of all Organization for Economic Co-operation and Development (OECD) countries in 2009 (Australian Human Rights Commission [AHRC], 2011). International education services remain Australia's largest export industry, contributing \$16.3 billion to the Australian economy in 2010-11: approximately \$15.8 billion (or 97%) can be attributed to onshore students' expenditure on fees, goods and services (Australian Education International, 2011). The success of the industry, as with international education discourses, has always been recognized and discussed in monetary terms, which has led advocates to point out that students are not "cash cows" but are right holders (Chau, 2010; Jakubowicz & Monani, 2010;).

Similarly, international students' status as education consumers also obscures the fact that they are, at the same time, deemed "temporary residents"; an immigration status that, compared with permanent residents, further entails fewer entitlements and protections, especially in relation to healthcare. Consequently, international students' health and wellbeing are invisible to policy makers. This invisibility is made evident in recent federal government policy exercises that have failed to acknowledge the inextricable link between improving the international student experience—including maintaining student health—and strengthening the quality of the international education in Australia.

A recent review (Knight, 2011) of the effect of the student visa program on Australia's international education industry made no recommendations for student wellbeing initiatives. Despite receiving 200 submissions, with several submissions highlighting key health and welfare concerns in the international student population, the review sought to recognize the financial benefits of international students to the Australian economy and made recommendations primarily seeking to improve the financial viability of the international education industry. Nor is there any reference to health promotion programs in the Council of Australian Governments *International Students Strategy for Australia*. The only reference in the *Strategy* to improving student health is via student safety initiatives, community engagement and "stronger health cover arrangements" (Council of Australian Governments [COAG], 2010).

Literature Review

The health of female international students in Australia has assumed greater significance recently. There is expressed concern about high rates of unplanned pregnancy and abortion (Babatsikos & Lamoro, 2012; Healy & Bond, 2006; Kalsi, Do, & Gu, 2007; Shepherd, 2009), as well as discrimination and violence in accommodation settings, educational institutions, relationships and workplaces (Burke, 2010; Deumert, Marginson, Nyland, Ramia & Sawir, 2005; Forbes-Mewett & Nyland, 2007; Graycar, 2010; Nyland, et al. 2009; Victorian Immigrant and Refugee Women's Coalition [VIRWC], 2009). Given the high number of unplanned pregnancies in the female international student population, it is reasonable to assume there is also a high rate of unsafe sex practices in this population as sexually transmitted infections (STIs) are also an issue (Rosenthal, Russell, & Thomson, 2006).

International students in Australia are a diverse group and the size of the temporary female immigrant population has contributed significantly to the international education industry in Australia. From 1 January 2008 to 31 December 2010, 320,460 student visas were issued to women aged 16 years and over from non-English speaking countries, with half of these visas for women from three countries: China (27.7%), India (15.6%) and South Korea (6.8%). Other significant countries of origin include Thailand and Vietnam (Department of Immigration and Citizenship [DIAC], 2011).

Despite the growth in the international student population, there has been scant consideration given to the health and wellbeing of international students. However, there is a community-based organization that has taken steps to address the gaps in health service provision to international students. Multicultural Centre for Women's Health (MCWH), a women's health organization committed to improving the health of immigrant and refugee women across Australia, has implemented a research and advocacy program with a specific focus on the sexual and reproductive health of female international students. In addition to research and professional training, MCWH provides health education and information, in an outreach capacity, to immigrant and refugee women in workplaces and community settings. The Centre is for all immigrant women, including refugees and asylum seekers, women from emerging and established communities, and

women temporarily settled in Australia. The Centre's health education program, for example, follows a holistic, peer education model known as the woman-to-woman approach, which is participatory in design and respects women's experiences and knowledge. Trained bilingual health educators (BHEs) conduct health education sessions for women in the preferred languages of the participants, covering a range of health issues, with a focus on sexual and reproductive health. While MCWH can be seen to fill a practical need in the delivery of multilingual health education to diverse communities (it delivers health education in 22 languages), MCWH's gendered and rights-based approach to improving health outcomes for immigrant and refugee women has served to highlight health or, more specifically, the inequities in health, as a product of social relations and, in effect, a matter of social justice. From program development to advocacy, the Centre's work is based on the knowledge that women's sexual and reproductive rights are essential to realising a fundamental range of human rights. The Centre's research and advocacy program has consistently called attention to the fact that immigrant and refugee women have poorer health outcomes and are at a greater risk of developing adverse health conditions than Australian-born women (MCWH, 2010). Such inequities in health stem from inequities in access, which cannot be simply or solely attributed to biology and individual behaviour. To pose such a problem as a matter of "rights" provides a framework of accountability, in which state and other actors have a responsibility to ensure, amongst other things, access to healthcare.

The need to ensure sexual and reproductive health services to international students is related to fundamental human rights. The UN International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive clause on the right to health in international human rights law. According to Article 12(1), State Parties recognise: "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR, 1966). The content of this provision has been further clarified by the United Nations Committee on Economic, Social and Cultural Rights (UNESCR, 2000), established to monitor the implementation of the convention: "States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal migrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy...."

To date, MCWH's Female International Student Research and Advocacy (FISRA) Program has involved the implementation of: the "Women's Health Connect" Project in 2010; the "Creating Healthier Pathways" Project in 2011; and qualitative research examining the sexual and reproductive health/care experiences of female international students in Melbourne, Australia (Tran, 2012). The two Projects formed a comprehensive health promotion program, involving research, education and evaluation. Multilingual health information was provided to international students through various means: a MCWH information stall at international student events; a university health service; and group education sessions conducted by BHEs. Approximately 450 female international students from 40 countries participated in the health promotion program over the two-year period, along with eleven agencies, educational institutions and organizations (Poljski, 2011).

The latest research was conducted by a MCWH BHE as part of a professional project and involved in-depth interviews with ten female international students (Latrobe University's Human Research Ethics Committee approved the study). Collectively, all three initiatives aim to improve the health and wellbeing of international students. MCWH continues to consult with key stakeholders in the education services industry and to meet with government representatives to advocate for the health rights of international students.

Research Method

This paper draws on the work of the FISRA Program, with particular analyses focused on female international students' experiences of accessing sexual and reproductive health information and services in Australia. The findings are based on work conducted through the FISRA Program (Tran, 2012; Poljski, 2011): an extensive literature review of sexual and reproductive health issues affecting female students in Australia; 210 student surveys; three focus groups with a total of 36 female international students; 35 key stakeholder consultations from 16 agencies, educational institutions and organizations across Australia; and 10 in-depth interviews with female international students living in metropolitan regions in Victoria. Accessibility of sexual and reproductive health services is one of a number of areas identified by MCWH in which international students experience unequal treatment. The limitations of international students' mandatory health insurance, otherwise known as Overseas Student Health Cover (OSHC), is of particular concern because it appears to conflict with Australia's obligation under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) to take all appropriate measures to eliminate discrimination and to ensure appropriate services in connection with pregnancy.

In using a rights-based approach, we seek to make visible the connections between discrimination, inequality and health. As such, female international students' stories—which emerged during the FISRA Program consultations, focus groups, and interviews—have been quoted extensively to illustrate common issues. In doing so, we argue that many of the individual problems they experienced are, in fact, systemic and require not only health system, but also politico-judicial, responses.

Health Care for International Students

The exclusion of vulnerable groups from health care brings along major risks like individual suffering and exploitation, a risk for public health in general, demand for emergency services which are far more expensive, the creation of backstreet services, ethical dilemmas, problems for the administration and discrimination against the concerned migrants. Migrants. [PICUM], 2007, p.5)

It has been noted that national health-care plans around the world often discriminate against temporary migrants by making only emergency care available for non-citizens (PICUM, 2007). In Australia, a key underlying principle is universal access to good quality of health care regardless of ability to pay and this premise would appear in keeping with the government's legal obligations in relation to the health of every person within its jurisdiction. However, the practical implementation of such a principle has proved otherwise in the case of international students. Recent media reports of international students being refused non-obstetric emergency care because they were deemed "ineligible patients" (Lion, 2011; Ross, 2011a, 2011c) have highlighted the shortcomings in Australia's health and hospital system. In one instance, an international student's wife gave birth in a car after being turned away from five different public hospitals (Hare, 2012; Henriques-Gomes, 2012). In all cases, the international students had the necessary, compulsory health coverage, but were, nevertheless, refused care because of hospital administrators' concerns over mounting costs incurred through bad debts.

While the degree of vulnerability in which international students find themselves depends on a wide range of environmental factors, a major part of the problem is associated with their migrant status. Laws and policies which prevent "temporary" migrants from accessing the same level of health care as their permanent counterparts are based primarily on the notion that it would otherwise be burdensome to the domestic taxpayer. In the case of Australia, where the health care

system is mainly tax-funded, with medical services subsidised through “Medicare,” a national, public health insurance scheme, this view of citizen entitlement is significant. Internationals students in Australia are ineligible for Medicare and—as a visa condition—are required to purchase OSHC for themselves and their dependants to cover medical costs for the duration of their stay in Australia. Under the OSHC, international students are covered for basic medical treatment similar to that which Australian citizens and permanent residents are covered for under Medicare. This is not to imply, however, that international students are guaranteed unqualified and equal health protection once OSHC is purchased (Ross 2011b).

Affordability

While Medicare provides free hospital treatment as a public patient, care for private patients in public and private hospitals is only partially covered by Medicare. There is a strong reliance on out-of-pocket payments within the health system, which has led commentators to suggest that the claimed benefits of private insurance, particularly as it operates in Australia, are “overstated” and “essentially subsidizes queue jumping” (Menadue & McAuley, 2012, p.12). Although an extended critique of private health insurance arrangement falls outside the scope of this paper, the separation of public and private health care, as it currently operates in Australia, brings attention to issues of equity and social inclusion. Within a rights-based approach, private health insurance arrangements can be seen to violate principles of equity. As Menadue and McAuley (2012) point out, there is a high correlation between high income (above AUD\$100,000) and having private health insurance. Any discussion of accessibility in health care cannot therefore be made without consideration of affordability.

International students in Australia experience significant financial pressures. Tuition fees and living costs are expensive. In many cases, these costs are higher than anticipated. International students interviewed as part of the FISRA Program have been unequivocal about the high cost of living and studying in Australia:

When you come as a student, your income is from India. You're not earning any Australian dollars. You know, like Indian rupees, and that's a lot in Indian money. So when you compare Australia to India, it is very expensive, but if you're earning Australian dollars, I think it's OK for the Australian standard. But compared to our country it's very expensive.

Female international student (Tran, 2012)

I'm paying \$13,000 per semester and I study for three semesters. The health cover I get is \$700...and the health cover is limited to only some diseases or health diagnoses, which is really bad. People coming from overseas aren't rich. They are coming to get a living.

Female international student (Tran, 2012)

From this financial perspective alone, the “strengthened” health coverage arrangements put forward in the federal government’s *International Students Strategy for Australia* is problematic. It should be noted that the proposed health coverage arrangements do not refer to more comprehensive cover for students, but rather is intended to “help” international students eliminate “risk”.

Currently, an insured international student could be personally liable for considerable medical expenses in the event of sickness or injury. The stronger health coverage arrangements will eliminate this risk and will ensure that students do not breach this visa condition, which puts

them at additional risk of visa cancellation and deportation. (Council of Australian Governments [COAG] 2010).

Navigating the System

In addition to cost, other barriers related to OSHC can affect student utilization of health services in Australia. Many international students do not understand their OSHC policies, nor are they aware of any additional health care costs they may be required to pay (Smith & Kay, 2010). Health insurance funds provide information about their OSHC policies, including claims processes and gap payments, on their websites; however inconsistencies in the administration and communication of OSHC conditions mean that students will invariably miss out on vital information that could facilitate their access to health services. Although some OSHC insurance representatives visit educational institutions during orientation and study periods to inform students—in English—about OSHC policies, until they require urgent health care, students' capacity to actively understand what is covered under OSHC is impeded by study obligations, work commitments and settlement issues. As one student recounted,

I used to work at this place where a girl lost her virginity to an Australian who said that he would marry her, and she got pregnant. She's Asian and she just arrived in the country recently, and she was totally devastated when the guy disappeared in thin air. She didn't know what to do and she just talked to me, she said, "I'm pregnant, and I don't know where this guy is, what do I do?" I asked her if she had Medicare, she said no, because she just came here recently. She had overseas student health cover, but she didn't actually activate her account, so she just asked me what to do. Because I wasn't very aware of the health policies they had in Australia, all I said was you could get your overseas health cover activated, and then go to a public hospital and look for abortion. She could not go to hospital immediately and get advice there because [without] Medicare, you have to spend a lot of money. I tried to follow her progress for one month but I don't know what happened. It's very hard, because she's here with no family. She was totally devastated.

Female international student (Tran, 2012)

Differing processes for the payment of health care costs also have an impact on student utilization of health services. While some health insurance funds have direct-billing arrangements with health services, others may require students to make a gap payment at the time of access. In other instances, where there are no direct-billing arrangements, students are required to pay for health care costs upfront and then claim on their OSHC policy. This arrangement is not possible for students experiencing financial pressures, thereby affecting their health service access.

When I enrolled in my studies, I paid \$650 for the health cover card for 12 months, and now I'm thinking it's of no use. Because if you have to use it: first you have to click on their website and find the doctors who have their link with that company; then you have to contact those doctors; then you see them. After your treatment, I think they give you a slip with the fee and medication, and then you have to access the site login, find the doctor's name, and put in all the data. And maybe then you get the reimbursement, I think.

Female international student (Tran, 2012)

Difficulty navigating OSHC arrangements is perhaps symptomatic of students' low utilization of health services in Australia. The majority of student participants (85.7%) who participated in the MCWH health promotion program reported accessing health services in their country of origin, while only 34.3% had done so in Australia (Poljski, 2011).

International students possess limited understanding of the Australian health system. For instance, many students come from countries with specialized health systems, where there is less emphasis on primary care, direct access to specialised care, and more focus on treatment than prevention. As a result, students believe only specialists provide high-quality health care, and so doubt the capacity of general practitioners (GP) to fulfill their health needs:

I went to a GP and explained my problem and she tried to solve my problem with herself and her knowledge. I was a little wondered because when I was in (country of origin) I go directly to the specialist to solve my problem. I was not sure about her recognition, so she sent me to the hospital to see a specialist, but still in the hospital I think I didn't visit a real specialist—it was kind of maybe a GP again.

Female international student (Poljski, 2011)

A limited understanding, or poor awareness, of the GP role may affect student access to GPs and result in student dissatisfaction with health care provided by GPs. Similarly, the availability of health and community services for international students is variable. Some students have better access to services than other students. Generally, public educational institutions, such as universities, are better equipped to cater to student health needs via university medical or nursing clinics and counselling services. While some private educational institutions are able to provide welfare assistance to students, many do not, leaving students on their own to navigate services in the health and community sectors. Government-funded services specifically for international students are available, but staff members in these services are not qualified to fully address complex health and welfare issues, such as unplanned pregnancy or domestic violence. In these cases, referral to other services may be necessary, but is problematic due to fragmentation in the network of international student-friendly services.

Additionally, health and community services outside of educational institutions create their own access rules. While some services are bound by funding body rules, which may preclude access by people on temporary visas, other services create their own rules, which may allow access by anybody, regardless of their visa status. This situation creates further confusion for students who are navigating services on their own, as well as for referring service providers, all of whom may relinquish the search for assistance.

Health Coverage Restrictions

Apart from these common and practical obstacles to accessing health care, international students' access to health care is, from the outset, restricted through the current OSHC arrangements. As we pointed out earlier, the "strengthened cover" acts as a proxy for tighter immigration control policy. The new OSHC Deed spells out the terms of these restrictions.

The OSHC Deed is a legal agreement between the Federal Department of Health and Ageing (DOHA) and registered health insurance funds that provide OSHC (DOHA, 2011a, 2011b). The OSHC Deed sets minimum coverage requirements that OSHC providers are required to meet for all kinds of OSHC policies. A recent change to the OSHC Deed has serious implications for the sexual and reproductive health of female international students and the partners of male international students. This change, effective from 1 July 2011, precludes OSHC providers from paying benefits to overseas students or their dependants for the treatment of pregnancy-related conditions in the first 12 months after arrival in Australia, except when emergency treatment is

required (DOHA, 2011a). More worryingly, the change was instituted despite evidence being provided to the government that up to 73% of all claims for pregnancy-related treatment for all international students and dependants occur within the first 12 months of OSHC membership (N. Roxon, personal communication, 6 December 2011). In the context of such irrefutable evidence, the exclusion in the Deed not only poses grave risks to the sexual and reproductive health of female international students and the partners of male international students, but also limits students' reproductive rights.

The overwhelming majority of international students are young people primarily aged in their late teens and twenties, a population that is typically, or likely to become, sexually active. Given that students are adjusting to a new life in Australia without their traditional social supports, the risk of unprotected sex and the probability of an unplanned pregnancy—especially during the first 12 months after arrival in Australia—are heightened.

The immigration dynamics of freedom and isolation typically characterises the settlement experience of most international students. It is these dynamics, combined with limited sexual health literacy and poor access to health services, which increase female students' susceptibility to poor sexual and reproductive health outcomes. For some international students, the immigration experience is liberating. The distance between students and family members, removing scrutiny of students' behaviour, allows for sexual experimentation that may not be possible in their country of origin and can lead to unintended consequences:

From where I come from, we don't have much of the health education provided to students and it's a kind of shy thing to talk about sex in public. So I have some friends with very poor sexual health knowledge, and once they come over, it's like a bird out of a cage...they start dating people and they have to know what they're doing before they get engaged in some unsafe sex, which leads to complications in future.

Female international student (Tran, 2012)

Conversely, the distance between international students, their families and other traditional social supports results in an immigration experience that is isolating and lonely, particularly during the early months after arrival in Australia (Sawir, Marginson, Deumert, Nyland & Ramia, 2007; Smith & Kay, 2010). Limited capacity and few opportunities to practice English language skills through interaction with locals, including domestic students, exacerbates feelings of loneliness, and can contribute to anxiety and depression:

Our first language is not English, and as a newcomer, we have no chance to speak to others. If we have some feelings, we cannot express us, so I think it's not a good thing.

Female international student (Poljski, 2011)

They are lonely. A lot of them chose the international education concept to come and meet Australians and know about their culture, but what they find when they get here is that the Australian community don't want to interact with them.

Key stakeholder (Poljski, 2011)

The isolation and loneliness inherent in the immigration experience of many international students is contributing to the ghettoization of the international student community in Australia. The lack of interaction between international and domestic students, either due to limited English proficiency, poor social skills in international students, or disinterest or reluctance on the part of domestic students, frequently means that international students only interact with other students

from the same cultural group (Sawir et al., 2007). While these groups provide students with the support they need to adapt to life in Australia, they also extend the distance between students and locals, further limiting opportunities for students to practice their English language skills and to develop connections with locals. In this regard, female students are more vulnerable to the sexual advances of male students from their own cultural group. Far-removed from the scrutiny of family members and friends abroad, and exploiting their perceived freedom in Australia to disrespect women, some male students target their female counterparts, especially those who are newly-arrived, and pressure them to engage in sexual relationships (Gloz & Smith, 2004). This pressure also exists for female students who willingly enter into relationships with male students. However, for many of these female students, these relationships—the kind of which many would never consider in their country of origin—are more of a necessity to ease their isolation and loneliness. Thus, these female students may succumb to pressure to engage in sexual activity—usually unprotected—whether they want to or not, so increasing their susceptibility to unplanned pregnancy and STIs. In some instances, female students are also targeted by landlords, employers and local men (Forbes-Mewett & Nyland, 2007; Gloz & Smith, 2004; Graycar, 2010).

For a population that is of childbearing age, with many female students and the partners of male students wanting to have children, the pregnancy-related exclusion restricts family planning choices and the right to decide the number and spacing of children. For women who wish to have a baby (or another baby), while in Australia, such as the partners of male international students, simply because motherhood has always been on their agenda irrespective of their residence base, access to antenatal care options is likely to be seriously impeded where there are financial pressures.

I have two friends who fell pregnant, one—she was happy to keep the baby, but for another one it was a problem because she didn't expect the pregnancy, so she went for an abortion. Because she was married it wasn't a problem, but as a student [it was a problem] because she was studying.

Female international student (Tran, 2012)

With limited choices, female students and the partners of male students who experience an unplanned pregnancy within their first 12 months in Australia are forced to pay for their own abortion. The cost of a first trimester abortion ranges from AUD\$ 1,000 to AUD\$ 1,700, but increases for terminations performed beyond the first three months of pregnancy. Financial pressures, cultural beliefs, or limited sexual health literacy will prevent some women from procuring a termination, forcing them to either cease their studies to return to their country of origin to proceed with their pregnancy—possibly affecting their capacity to resume studies in Australia at a later stage—or to proceed with their pregnancy while studying or living in Australia, most likely with insufficient or no antenatal care because of their inability to pay for full maternity services required. One student spoke of her concern for her pregnant cousin, also an international student,

I don't think she knows [where to go for help], and I don't know either of any services that can help her, but as far the journey goes, we spend a lot of money for going to see GP, because the Medicare doesn't cover us. Our insurance doesn't cover us for pregnancy. So every time we go to see a GP or to the doctor at the hospital, it costs a fortune... So unless there is something she has to go and see a doctor for, I don't think she's going to a doctor as often as she should be.

Female international student (Tran, 2012)

Many female international students who have a baby in Australia experience great difficulty combining studies with motherhood, so they return to their country of origin with their newborn infant and leave their baby with family members before returning to Australia to resume their studies. Subsequently, these students experience separation anxiety and depression, which in turn affects their ability to study.

For some female students, going through with a pregnancy is not an option, and, as such, may take undesirable—if not drastic—measures to end an unplanned pregnancy if they require and are not able to fund a surgical abortion. For others, the lack of choice is considered a tragedy in itself,

One of my friends had an unwanted pregnancy and she didn't know where to get help and because she can't let her parents know, she took abortion medicine. Maybe it was the wrong thing to do. If she knew where to get help, she maybe would have taken more care. She'd have more options. Maybe taking medicine was not the best way for her. But she had no choice.

Female international student (Tran, 2012)

The federal government has defended the change in the OSHC Deed in terms of market flexibility, arguing that the minimum requirements “are aligned to the minimum requirements set for private health insurance products for Australian citizens...and visa health insurance requirements for 457 long stay working visa holders” (N. Roxon, personal communication, 6 December 2011). Claiming health as an issue of rights, calls into question such reflexive pronouncements of the abstract “market”, an abstraction which is inevitably divorced from the wider conditions of women’s lives. Pregnancy and pregnancy-related conditions do not, after all, occur in a vacuum. Nowhere is this disjuncture more pronounced than in the specific sexual and reproductive health information needs of international students (Burchard, Laurence, & Stocks 2011).

Limited sexual health literacy is universal in the general community (Grulich, de Visser, Smith, Rissel, & Richters, 2003), but compared to Australian-born students, international students know less about sexual health issues such as STIs (Song, Richters, Crawford, & Kippax, 2005). Female international students possess little knowledge about reproductive anatomy, contraception, safe sex (including consensual sex), STIs, menstruation (particularly the most fertile time in the menstrual cycle), menstrual disorders (amenorrhoea and its relationship with mental health, dysmenorrhoea), pregnancy, abortion, Pap tests (rationale, when to commence), etc. Perhaps due to the rising incidence of breast cancer globally, female students are generally aware of this condition, but do not know how to perform breast self-examinations. Also, some female students do not possess the skills required to participate in the sexual decision-making process, such as the discussion of safe sex and contraception options, and so are powerless or reluctant to reject pressure to engage in sexual activity.

Sexual health is taboo in many cultures. While health education is available in other countries—74.5% of student participants of the MCWH health education sessions had received health education in their country of origin—sexual health is not comprehensively covered, thereby contributing to low levels of sexual health literacy. Where sexual health education is provided, the level and quality is variable. In some countries, structured family planning education is available, as in China where, as part of the one-child policy, such education is compulsorily provided to couples registered to marry. In other countries, education about reproductive anatomy and physiological processes, such as menstruation, is usually provided in biology classes in schools and universities. This education is rarely gender-specific, with male teachers providing information in a didactic and

rigid manner to female and male students collectively. These conditions affect the ability of female students to engage with the information presented (Poljski, 2011). For female international students who have not participated in sexual health education in their country of origin, their only source of sexual health information has been their mother or another close family relation (Tran, 2012; Poljski, 2011)

Female international students also demonstrate limited understanding of, and reluctance to participate in, sexual health promotion initiatives. For students who come from countries with health systems focused on treatment rather than prevention, disease-specific health promotion campaigns are perceived as only being relevant to people affected by the highlighted condition. In the context of sexual health promotion, female students view sexual health as simply being relevant to married women. For female students from countries where a woman's reputation is largely determined by her sexuality, they are aware their "good girl" reputation hinges on not engaging in, or being seen to engage in, sexual activity before marriage. Participation in sexual health promotion programs publicly reveals an interest in or concern with sexual health, which suggests engagement in premarital sexual activity or willingness to do so. Accordingly, some female students are reticent to participate in sexual health promotion programs as this is inconsistent with the "good girl" image. Reluctance to partake in these initiatives only serves to maintain students' poor knowledge of sexual health issues.

In light of these findings, culturally-appropriate and gender-specific health promotion programs are not only critical factors, but also essential in considerations of a rights-based approach to health. Female international students who participated in the MCWH health education sessions reported an increased awareness of, and an interest in learning more about, health issues, as well as willingness to undergo screening procedures. In other words, the education sessions helped to create the conditions in which students could claim their right to health.

Conclusion

Improving access to sexual and reproductive health care for international students should be made a priority. Due to current public policy and immigration controls, international students experience inequities in access to care. In asserting that health is a matter of rights, the state and other actors bear some responsibility for ensuring availability and access to health care, including the protection and promotion of women's rights to sexual and reproductive health.

The recent change to the OSHC Deed that precludes OSHC providers from paying benefits for the treatment of pregnancy-related conditions in the first 12 months after arrival in Australia can be construed as a breach of women's rights. An immediate revision of the OSHC Deed—specifically clause 8.1(g)—is essential to improving sexual and reproductive health of female international students. According to one clinician, it may be worthwhile including a compulsory premium in OSHC policies for all international students to cover costs related to sexual and reproductive health:

I don't think female students should bear the cost of contraception and pregnancy-related things. Essentially, the students that are coming in are of the childbearing age group and so with that insurance, maybe we actually need to be considering that it needs to cover for contraception and termination and pregnancy care and spread that across males and females and have that as a compulsory component. This is where a lot of women bear the cost, but they don't get pregnant by themselves. It's a team effort.

Key stakeholder (Poljski, 2011)

The Australian Human Rights Commission (AHRC, 2012) recently released, *Principles to promote and protect the human rights of international students*, which aims to enhance students' health, safety and wellbeing. Following increasing calls for educational institutions to better exercise a duty of care towards international students (Trounson, 2012; Ethnic Communities' Council of Victoria, 2010), the document is long overdue; however, to be truly effective, the principles need to be incorporated into legislation.

Given the social, cultural and economic benefits international students bring to any country in which they choose to reside, the state needs to take action on equitable health access for international students. There is a need for all key players in the industry—local, state and federal governments, educational institutions, OSHC providers, landlords, employers, etc.—to better exercise their duty of care to international students and to recognize students' human rights.

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