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Article

Inclusive Policy? An Intersectional Analysis of Policy Influencing Women's Reproductive Decision-Making

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Abstract
Policy can be used and experienced as a tool for social inclusion or exclusion; it can empower or disenfranchise. Women's reproductive decision-making and health is impacted by policy, and women's experiences of diverse and intersecting marginalised social locations can influence their experiences of policy. This research aimed to explore how intersectionality is considered within Victorian state government policies that influence and impact women's reproductive decision-making. A systematic search of Victorian (Australia) government policy instruments was undertaken, identifying twenty policy instruments. Policies were analysed using an intersectional policy analysis framework using a two-stage process involving deductive coding into the domains of the framework, followed by inductive thematic analysis within and across domains. Findings reveal inconsistencies within and across policies in how they consider intersecting social relations of power in the representation of problems, women's positionings, policy impacts, and policy solutions. These gaps could exclude and marginalise individuals and groups and contribute to systemic inequities in women's reproductive decision-making and the outcomes of those decisions, particularly among already marginalised groups. The lack of women's voices in policy further excludes and marginalises those impacted by the policy and limits the representation of all women in policy. Policy development needs to meaningfully involve women with diverse and intersecting marginalised social locations, and critical reflexivity of all stakeholders, to ensure policies can better account for the experiences of, and impacts upon, women who are marginalised and effect change to promote social inclusion and equity in women's reproductive decision-making.

Keywords
intersectionality; policy analysis; reproductive decision-making; social inclusion; women

Issue
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1. Introduction

Social exclusion is a multidimensional (political, economic, social, and cultural) process interacting with micro, meso, and macro levels of society. It is both driven by and reinforcing of unequal power relationships, manifesting in inequities in the extent and quality of individuals' and groups' resources and opportunities for participating in society (Levitas et al., 2007; Popay et al., 2008). Women can experience social inclusion or exclusion in the process of, and as an outcome of, their reproductive decision-making (Graham et al., 2020). The policy environment, including policies addressing micro, meso, and macro issues, can influence women's reproductive decision-making (WRDM; Graham et al., 2016, 2022), but little is understood about how those policies consider and accommodate women's experiences of intersecting social locations of marginalisation which may impact their reproductive decision making. Intersectionality (Crenshaw, 1989) examines how factors

such race, class and gender interact to produce multiple states of oppression (Gopaldas, 2013). This lens enables exploration of structural and societal factors that create and perpetuate oppressive social power relationships, and individuals' subjective experiences of those oppressions. As such, the aim of this research is to explore how intersectionality is considered within Victorian state government policies that influence and impact WRDM.

WRDM and health are complex and multifaceted domains, and impacted by intersecting factors at the micro (individual, family, and social), meso (community and services), and macro (societal and structural) levels, which can enhance and/or restrict the extent and quality of women's resources and opportunities to, or not to, participate in reproduction and parenting in preferred ways. This includes self-determining whether and when to have biological or adopted children, the number and spacing of children, and whether to use fertility control, assisted reproduction technology, or pregnancy termination in support of their decisions (Graham et al., 2016, 2018, 2022; Redshaw & Martin, 2011). Inequitable resources and participation across these levels can constitute social exclusion driven by unequal relations of gender, sexuality, class, race, age, and ability. Middle-classed, white, heterosexual, cisgender, married women are constructed interactively by society and through policy as good and desirable procreators and mothers who are enabled, encouraged, and obliged to access resources that enable conformity with pronatalist norms. Conversely, low-income, Indigenous, non-white, queer, single, adolescent, older, and disabled women are constructed as undesirable procreators and mothers who are discouraged or excluded from becoming mothers and experience barriers to accessing the resources and opportunities that would enhance their reproductive health and decision-making (Elliott, 2017; Graham et al., 2016, 2018; Hayman & Wilkes, 2017; Morison & Herbert, 2019; Turnbull et al., 2020).

At the micro level, research suggests women make reproductive decisions in the context of their everyday lives, which are unique and constituted by individual and contextual interactions of circumstances and experiences (Graham et al., 2018). These include women's economic, educational, employment, housing and geographic circumstances, marital status, social support, age, physical and mental health conditions, and reproductive and sexual health knowledge, skills, service use, intentions, beliefs, desires, preferences, and identities. These circumstances and experiences are positioned within social, historical, cultural, religious, and political contexts in families, relationships, communities, services, and societies (Botfield et al., 2015, 2016; Graham et al., 2022; Hawkey et al., 2018; Kirkman et al., 2010; Metusela et al., 2017; Rich et al., 2021; Robards et al., 2019). For example, policies that make reproductive technologies available, but fail to ensure they are affordable, can inhibit low-income women from making decisions to access high-cost assisted reproductive technologies or pregnancy terminations (Graham et al., 2016; Sifris & Belton, 2017; Soucie et al., 2022).

At the meso level, medical and reproductive health professionals' positions of power and authority can influence WRDM and the consequences of their decision. Professionals' knowledge, prejudices, moral, religious, and cultural beliefs, gatekeeping, and dismissal of women's experiences regarding sexual and reproductive health and women's socially constructed identities, can influence women's experiences of access to information and reproductive services and technologies, including the affordability, acceptability, appropriateness, and confidentiality of information and services (as governed by policy positions). This in turn can influence women's reproductive decisions (Botfield et al., 2015, 2016; Carter et al., 2022; Graham et al., 2022; Kapilashrami, 2020; Rich et al., 2021; Sifris, 2016; Soucie et al., 2022). For example, women who live in rural areas with limited services and providers, who are younger, and/or identify as sexually or gender-diverse, and/or from minority cultural or religious backgrounds can experience barriers to accessing sexual and reproductive health services and technologies (Campbell, 2020; Quinn et al., 2021; Robards et al., 2019; Sifris & Belton, 2017; Soucie et al., 2022; Ussher et al., 2012).

At the macro-level, the policy environment is a key influence on women's access to and quality of resources and opportunities for participation, which can influence meso and micro-level contexts surrounding WRDM and health (Graham et al., 2016, 2018, 2022; Rich et al., 2021). Previous research suggests inequitable policy environments can directly constrain WRDM (Rich et al., 2021) by creating unequal access to reproductive rights and resources; for example, excluding single and lesbian women from assisted reproductive technologies (Agénor et al., 2021), and depriving women with disabilities of choice through involuntary sterilisation (Elliott, 2017; Sifris, 2016). Similarly, policies purporting to support groups with intersecting experiences of marginalisation by focusing on, regulating the decisions of, and restricting the autonomy of, at-risk or devalued groups (such as younger, older, Indigenous, disabled, and low-income women) can instead entrench stigmatisation, inequitable access to services and technologies, and social exclusion (Elliott, 2017; Graham et al., 2016, 2018; Morison & Herbert, 2019).

Despite the evidence about intersecting influences on WRDM, and the role of policy influencing WRDM, there is an absence of understanding of policy influencing WRDM through an intersectional lens. The research builds on previous work mapping federal and state/territory policy instruments that govern women's reproductive choices (Graham et al., 2016), analysis of the Australian policy context relating to women's reproductive choices (Graham et al., 2018), and women's lived experience of policy which influenced their reproductive decision-making (Graham et al., 2022). The current research extends on this work by bringing a focus to

Victorian policy and the representation of intersectionality in policy.

2. Methods

A search of Victorian (Australia) policy instruments was undertaken to identify the number and scope of policies governing WRDM. In Australia, the federal policy environment governs the context for policy at the state and territory levels. Victorian state policies were the exclusive focus of this research in order to maintain a manageable data set within the limited scope and practical context of the research. Victoria was specifically chosen because it is the state within which the researchers live and work and therefore have greater knowledge of the context. Further, no research to date has looked specifically at WRMD and intersectionality in the Victorian context.

For this research, a "policy" includes instruments across the four categories of Hood's (1983) typology of policy instruments: nodality instruments which seek to influence behaviour through education and information, including advisory and advocacy instruments (see, for example, Victorian Law Reform Commission, 2008); treasure instruments which use fiscal means to influence and regulate private organisations and the public (for example, the 1965 Maintenance Act); organisation instruments which govern actions and services delivered by government agencies (see, for example, Department of Health and Human Services, 2017); and authority instruments such as parliamentary Acts which are legislative instruments designed to enact new or amended law. It is possible for instruments to be considered as multiple types; for example, the 1965 Maintenance Act is both a treasure instrument and an authority instrument.

A systematic search was undertaken of Victorian government websites including, but not limited to, the Australian Government ComLaw, state parliamentary sites, the Department of Health and Ageing, the Department of Health and Human Services, the Department of Education, Employment and Workplace Relations, and the Department of Social Services. Search terms used were:

> Abortion/termination, act, adoption, adoption rights, agenda, assisted reproductive technologies, bills, child support, child care, cloning, discrimination, equal opportunity, family, family planning, family tax benefit, federal, fertility/infertility, framework, gender, government, health, IVF, legislation, mother, parent, parental leave, parental policy, parenting payment, policy, pregnancy, regulation/s, reproduction, reproductive health, sexual health, social security, strategy, surrogacy, woman/en/female

Policy instruments were included if they influenced WRDM, such as economic support and service provision, were current at the time of the search, and applied to Victoria. Policies were excluded if they related to aspects of reproductive health not specific to decision-making, such as if they affect aspects deemed as post-decision-making. For example, the 2015 Public Health and Wellbeing Amendment "No Jab No Play" Act was identified during the search strategy but was excluded from the data set as it is specific to children and increasing their immunisation rates, which is beyond the reproductive decision-making process. An initial search identified 25 policy instruments; eight were removed as they did not fit the inclusion criteria. An additional three policies were identified through a hand search. This resulted in 20 policies included in the data set (Table 1). There were 15 legislative instruments; 13 Acts (laws that had been passed) and two regulations (delegations of legislation to operationalise the Acts). One instrument was a Bill (a proposed law introduced to parliament but not yet passed). The remaining four policies were non-legally binding instruments (one report, one strategy, one statement and one key priorities document).

In the absence of existing frameworks that encompass gender, intersectionality and women's reproductive health, an intersectional policy analysis framework was developed by the research team to analyse policy impacting women's reproductive decision-making. The framework drew upon the Bacchi (2009, pp. 25–53), Hankivsky et al. (2012), Keleher (2013), and Manning (2014) frameworks. These frameworks contributed to the development of an intersectional policy analysis, whereby intersectionality-informed analysis (Hankivsky et al., 2014) moves beyond looking at singular categories to explore the intersection of two or more axes of oppression (Hankivsky et al., 2010). Further, the framework was applied specifically to examine policies which may influence decision-making among people who identify as women, including trans women, and whose social locations and lived experiences of policy relate to the identity of being a woman. We acknowledge that people with diverse gender identities including agender, gender expansive, and non-binary or pan-gender people also experience social locations of marginalisation which impact sexual and reproductive health and rights, including reproductive decision-making. However, the scope of this analysis was on how policies considered intersections of social oppression with regards to identities and lived experiences of women specifically.

The framework included pre-analysis reflexivity to facilitate users to examine their own conceptualisation of intersectionality and gender for the analysis. The analysis phase set out four key domains to interrogate with regards to intersectionality: the representation of the problem, the history of the representation of the problem, the differential impacts of the representation of the problem, and the policy solutions to the problem. Within each domain there were key questions and prompts to guide the analysis, such as about underlying assumptions, use of evidence and positioning of key stakeholders and/or individuals. A final post-analysis reflection was

Table 1. Victoria policy instruments.

Policies included in the analysis	Orientation (micro, meso, macro)	Intersectionality considered in solutions to the problem representation (comprehensively, limited consideration, not considered)
Abortion Law Reform Act 2008	Micro Meso	Not considered
Adoption Act 1984: Version No. 070	Micro	Not considered
Adoption Amendment Act 2013	Micro	Not considered
Assisted Reproductive Treatment Act 2008: Version No. 021	Micro Meso	Limited consideration
Assisted Reproductive Treatment Amendment Act 2013	Micro Meso	Not considered
Children's Legislation Amendment Act 2008	Meso	Not considered
Children Legislation Amendment (Information Sharing) Bill 2017	Micro Meso	Not considered
Equal Opportunity Act 2010: Version No. 020	Macro	Not considered
Equal Opportunity Amendment Act 2011	Macro	Not considered
Equal Opportunity Amendment (Family Responsibilities) Act 2008	Macro	Not considered
Family Violence Protection Amendment (Safety Notices) Act 2011	Micro	Not considered
Law of Abortion: Final Report 2008	Micro Meso	Limited consideration
Maintenance Act 1965: Version No. 050	Micro	Limited consideration
Public Health and Wellbeing Act 2008	Macro	Not considered
Public Health and Wellbeing Regulations 2009	Macro	Not considered
Public Health and Wellbeing Regulation Amendment 2018	Macro	Not considered
Safe and Strong: A Victorian Gender Equality Strategy 2016	Macro	Limited consideration
State Superannuation Act 1988: Version No. 083	Micro	Not considered
Victorian Families Statement 2011	Macro	Not considered
Women's Sexual and Reproductive Health: Key Priorities 2017–2020	Macro Meso	Limited consideration

included to facilitate users to consider the implications of the analysis.

Policies were deductively coded into each of the four domains of the framework by two researchers, using NVivo™. Due to the number and scope of policies, "bracketing" was used to enable researchers to focus on data relevant to intersectionality. Data were inductively thematically analysed to identify common themes within each domain and then across domains. Post-analysis reflection assisted with writing the themes in each domain, including what the key findings from the analysis in its entirety were; and what the implications of these findings for intersectionality, WRDM and future policy are.

3. Findings and Discussion

3.1. Domain 1: Representation of the Problem

The first domain explores the "problem" that the policies proposed to address, including assumptions and evidence underpinning those representations. The representation of the "problem" related to WRDM with a specific focus on how the representations consider and/or account for intersectionality.

Of the twenty policies included in the analysis, ten were oriented at addressing the micro level. Among these, a common problem representation identified was

that women's reproductive decisions are conceptualised as individual "problems" that sit within a woman's domain to be managed at the individual level. Multiple assumptions, explicit and implicit, embedded in the policies reinforce the problematisation of reproductive decision-making issues as individual. For example, the 2008 Assisted Reproductive Treatment Act requires that "before a woman consents to undergo a treatment procedure, the woman and her partner, if any, must have received counselling (including counselling in relation to the prescribed matters)" (Victorian Government, 2008a, p. 15). This language requires only that counselling must be received, not that the counselling is understood or comprehended. This implies and emphasises individual agency in taking responsibility and control for one's own health and wellbeing. Such assumptions do not consider intersecting social relations of power which may impact individuals' capacity to act with agency, or the broader circumstances and environment in which individuals experience their health and wellbeing. Existing research reveals policies which universalise women's identities and experiences, and that position women as individually responsible for their own health and wellbeing, can serve to create and perpetuate social exclusion of women. Such policies can ignore and reinforce the "multiple and mutually constitutive forms of discrimination…oppression [and privilege]" (Agénor et al., 2021, p. 65) that influence WRDM in the context of various intersecting social locations of marginalisation. Failure to acknowledge that women's intersectional experiences require nuanced and targeted policy responses could reinforce social exclusion, particularly of those already marginalised (Agénor et al., 2021; Botfield et al., 2015; Graham et al., 2016, 2018; Kapilashrami, 2020; Morison & Herbert, 2019).

Seven policies addressed meso-level matters and nine policies addressed the macro level. Policies oriented at the meso and macro levels focused on population health and system inequities, and take somewhat more consideration of social diversity and women's intersectional experiences in these problem representations compared to micro level policies. For example, the *Women's Sexual and Reproductive Health Key Priorities 2017–2020* (Department of Health and Human Services, 2017) highlights inequities that exist in access to health services including sexual and reproductive health and rights, services, information, and support, and subsequent health outcomes for diverse women, particularly in relation to reproductive decisions and choices. The instrument acknowledges the need for more equitable access for women who experience various intersecting social positions of marginalisation such as women living in rural or regional locations, women living with disability, those who are carers of a person living with a disability, women with specific cultural needs, and other marginalised groups in order to have greater impact. The *Safe and Strong: Victorian Gender Equality Strategy* considers gender inequality a structural issue and explicitly recognises intersecting social relations of power in the problem representation, stating: "For many, the impact of gender inequality is compounded by the way that gendered barriers interact with other forms of disadvantage and discrimination" (Department of Premier and Cabinet, 2016, p. 4). It adds:

> The Victorian Government recognises that gender inequality is even more of a problem when it Intersects with other forms of inequality and disadvantage, such as Aboriginality, disability, ethnicity, sexual orientation, gender identity, rurality and socioeconomic status. There is no one size fits all approach to addressing it. (Department of Premier and Cabinet, 2016, p. ii)

However, problematic in several policies at all levels was the construction of "gender" itself. The *Safe and Strong: Victorian Gender Equality Strategy* recognises that gender stereotypes develop early and are entrenched. Notably though, this strategy defines "gender" as "the socially-constructed differences between men and women" (Department of Premier and Cabinet, 2016, p. 36), while trans identity is defined separately. This reinforces entrenched and exclusionary binary gender norms of what it is to identify and live as "man" or "woman," and excludes trans women from consideration within the strategy with regards to problem representations, impacts, and solutions that impact women.

Several other policies make no distinction between genders, using gender-neutral language instead, including the 2011 Family Violence Protection Amendment (Safety Notices) Act (Victorian Government, 2011), the 1984 Adoption Act (version 70; Victorian Government, 2016), the 2008 Children's Legislation Amendment Act (Victorian Government, 2008b), and the *Victorian Families Statement 2011* (Department of Premier and Cabinet, 2011). The 2010 Equal Opportunity Act (Victorian Government, 2015) aims for the realisation of equality for all and so makes no distinction between genders in many clauses, for instance, referring to all "employees" homogenously in support of the notion of equality. However, in doing so, it fails to acknowledge the level of inequality or disadvantage already existing which is compounded for women and marginalised groups such as trans women, much less women with various other intersecting social locations and experiences of marginalisation. This could potentially result in negative impacts for those individuals and groups.

The limited and limiting socio-normative gender constructions perpetuate the hidden nature of intersecting experiences of marginalisation in the representation of the problem in policies. Graham et al. (2016) previously argued that the state contributes to creating and perpetuating gender norms through policies that relate to reproductive decision-making. Thus, the representation of the problem in policies relevant to WRDM is critical to challenging essentialising stereotypes of women and acknowledging women's intersectional experiences.

Details about policy consultation and development processes, including how policy decisions were made, and whose voices were considered and/or absent in the processes (including any recognition of stakeholders with intersectional experiences), are largely lacking across all instruments. Only three instruments provide any details about these processes, namely, the *Law of Abortion: Final Report 2008* (Victorian Law Reform Commission, 2008), *Women's Sexual and Reproductive Health: Key Priorities 2017–2020* (Department of Health and Human Services, 2017), and *Safe and Strong: Victorian Gender Equality Strategy 2016* (Department of Premier and Cabinet, 2016). Each provides details of processes including community consultations with women of diverse and intersectional experiences. Popay (2006) developed a widely-accepted and utilised model for community engagement to achieve health improvement. The typology shows activities like consultation as low-level on the continuum of engagement activities and having no real effect on changing social and material conditions which influence health outcomes. Rather, activities like co-production and power sharing are more effective in effecting equitable change, and thus should be considered for policy development relevant to populations with diverse and intersecting experiences of marginalisation. Hankivsky et al. (2010) supports this argument, stating those involved in intersectional policy development should be committed to understanding and shifting power relations to challenge oppressive social systems and bring about social change. However, this analysis reveals there is a greater capacity to extend community engagement in policy development processes concerning WRDM. The *Victorian Families Statement 2011* and the *Safe and Strong: Victorian Gender Equality Strategy 2016* also allude to future collaborations but are not explicit about the processes. For instance, the *Victorian Families Statement* suggests "a genuine and ongoing discussion between the government and Victorian families about what is important, what is needed and how we are progressing is going to be essential" (Department of Premier and Cabinet, 2011, p. 3). The *Safe and Strong: Victorian Gender Equality Strategy* makes several references to "recognis[ing] women's leadership," "continu[ing] to support and grow" women's leadership, and creating "strategic alliances…to identify and respond to the challenges of gender inequality and how they affect their communities" (Department of Premier and Cabinet, 2016, p. 20). While these statements hold some promise, there is a gap in firm commitment and action to meaningful community engagement in policy development influencing WRDM.

Notably, the instruments that did evidence some community engagement are all policy guidelines and strategies rather than legislative instruments, suggesting a gap in consultation and a lack of intersectional voices in policy processes to develop legislation influencing WRDM, particularly that which is proximal to women's experiences of reproductive decision-making.

3.2. Domain 2: History of the Representation of the Problem

This domain explores the history of the representation of the problem, including how the context of the representation of the problem has changed over time, and whether or how the positioning of women in the representation has changed over time.

There exists limited data indicating changes in representation of the problem over time as few policy instruments explicitly discussed this. The *Law of Abortion: Final Report 2008* is an exception. It recognises the influence of medical professional dominance in determining women's access to abortion historically, but that this context has changed. There is now a greater focus on consumers' autonomy, with the report explaining that "the ethical principles underlying doctor–patient relationships have moved on considerably in the past few decades….Personal autonomy is one of the guiding principles of medical law" and, further, "community attitudes [have] further shifted towards reproductive autonomy. It is likely that this in turn meant that reproductive autonomy became more institutionalised within the medical profession" (Victorian Law Reform Commission, 2008, p. 147). The report states laws governing abortion in Victoria were "strongly criticised" (p. 16) for being out of date with these shifting medical and community attitudes, but Victorian laws have since changed, removing abortion from the Criminal Act to bring laws more in line with community and medical profession expectations.

However, in the context of debates about abortion law reform, while this report did acknowledge that recognition of social diversities had advanced, consideration of intersectionality in the problem representation is not explicit and so was underrepresented in key evidence used to inform the subsequent law reform. The amended law, the 2008 Victoria Abortion Law Reform Act, shows no evidence of considering women's intersecting experiences and locations of marginalisation in amendments to, or application of, the law. Further, the Act makes no reference to women's diverse identities, experiences or needs, defining any woman simply as "a female person of any age" (Victorian Government, 2008c, p. 3).

Evidence of changes in the positionings of women in the problem representation was also limited. Again, the *Law of Abortion: Final Report* (2008) is the exception. This report describes that, "historically, medical discourse has treated women as biologically unstable, psychologically or socially vulnerable, and therefore in need of protection and control" (Victorian Law Reform Commission, 2008, p. 147), with women essentialised in those historical discourses. This positioning is particularly evident in policies which represent women's reproductive issues as a medical problem at an individual level, as discussed in Domain 1. Such positionings contribute to reinforcing "power over women…at the individual level, and destructive discourses at the institutional level" (Bourgeois, 2014, p. 31) which limit

women's reproductive autonomy and rights. The report claims the contemporary positioning of women in the policy as one of increased self-determination and autonomy in medical contexts generally, but that women's reproductive autonomy remains constrained and subject to continue institutional medicalisation of women's reproductive decisions, particularly concerning abortion. However, recognition of intersectionality in the changing positionings of women is again absent. Previous research contends women's health and reproductive issues have become politicised whereby women's private reproductive choices have become public (Charles, 2000), and the "personal is political" (Campbell & Wasco, 2000, p. 788). The politicisation of women's health and reproductive issues could "contribute to disregarding intersectionality in questions regarding reproductive health" (Sommer & Forman-Rabinovici, 2020, p. 2), and pose a barrier to achieving developments in women's health including progress toward achieving several of the United Nations SDGs (Sommer & Forman-Rabinovici, 2020). Conversely, policy that considers reproductive rights and health as a broader public policy issue beyond the public health domain, and considers intersecting social relations of power in that broader context which may influence WRDM, could contribute to more effective, equitable, and socially inclusive policy influencing WRDM.

At the macro level, the *Safe and Strong: Victorian Gender Equality Strategy* (Department of Premier and Cabinet, 2016) recognises the improved social status and participation of women in leadership over time, particularly regarding issues of gender equality, women's health and the reduction of gender-based violence. The strategy bases this recognition on evidence of effectiveness of women-led health organisations and advocacy networks driving change in these areas. Thus, the strategy positions women both individually and collectively as contemporary organisational and community leaders and change-makers, and with an enhanced agency now compared to historically. However, "women" in this positioning are still largely essentialised, with an absence of recognition of the multiple intersectional experiences of women. Overall, the problem representations and women's positionings in those problem representations have evolved, but policy is not progressing in alignment with those changes as an intersectional lens is still largely absent. Further development in this regard is needed to increase reproductive equity, autonomy and rights for all women.

3.3. Domain 3: Differential Impacts of the Representation of the Problem

This domain sought to interrogate how and in what ways women were impacted by the representation of the problem, and particularly, whether differential impacts for women with intersecting social locations of marginalisation were recognised. The domain also considered whether problem representations perpetuate essentialised gender stereotypes and dominant systems of oppression, or challenge these.

Impacts of the problem representations are identified as falling disproportionately on women, including economic inequities, disproportionate burdens of caregiving, experiences of violence, negative mental and physical health and wellbeing impacts, and negative social impacts. Consideration of differential impacts for women with intersectional lived experiences varied. Generally, micro-level policies considered more proximal to WRDM, while tending not to recognise intersectionality in the problem representation (as discussed in Domain 1), did recognise and acknowledge the differential impacts of the problem for women who experience multiple intersecting positions of marginalisation. For example, the 2008 Assisted Reproductive Treatment Act (Victorian Government, 2008a) acknowledges generally that increasing medicalisation of reproduction and decision-making can impact women differentially due to women's diverse socio-demographic characteristics, but does not elaborate on the nature of those impacts or provide examples. The *Law of Abortion: Final Report* (Victorian Law Reform Commission, 2008) recognises many inequities in access to abortion services disproportionately impact women already marginalised due to low socio-economic status, rural and remote location, lower education status, and with compromised health of mother and/or foetus. However, the report is not legislative so it does not have the capacity to redress this in law, highlighting systemic and structural limitations, and gaps that remain for promoting intersectional equity, rights, and social inclusion.

In contrast, recognition of differential impacts for women with intersectional experiences is generally lacking in meso- and macro-oriented policies which are more distal to WRDM. For example, the 2010 Equal Opportunity Act (Victorian Government, 2015) recognises systemic discrepancies that perpetuate gender inequalities, such as gender-based pay gaps and leadership gaps. However, the Act does not consider or account for how the impacts of these discrepancies may impact women of diverse identities differently and perpetuate inequities for women with intersecting social positions and experiences of marginalisation. Graham et al. (2022) argued there is a gap in understanding the impacts of policy on women's reproductive decisions and experiences of those decisions. This need is compounded for women with intersectional lived experiences as current policy appears to inconsistently acknowledge differential impacts, and this needs to be addressed in future policy. The exception among the meso- and macro-level policies is the *Safe and Strong: A Victorian Gender Equality Strategy* (Department of Premier and Cabinet, 2016). This strategy recognises compounding inequities in various domains including education and training; work and economic security; health, wellbeing and safety; leadership and participation; sport and recreation; and media, arts, and culture

for a range of women including pregnant women, single mothers, Aboriginal women, women with disabilities, migrant women, women from culturally and linguistically diverse backgrounds or refugee backgrounds, and those living in rural and regional areas.

Many systems of oppression operating at multiple levels including institutions, society and systemically are implicitly suggested or alluded to across policies, but scarcely explicated. These systems included sexism, ageism, racism, colonialism, ableism, heterosexism, transphobia, classism, and carceralism. Only racism and sexism are explicitly referred to in *Safe and Strong: A Victorian Gender Equality Strategy*, and racism is discussed concerning experiences of Aboriginal Australians but not other diverse cultural or ethnic groups, and not specifically about intersections with gender.

Recognition of intersections of systems of oppression is largely absent across the instruments, and therefore not addressed or challenged in the policy documents. This further entrenches the hidden nature of intersecting social relations of power and the differential impacts for diverse women of representations of problems in policy. The exception to this is again the *Safe and Strong: A Victorian Gender Equality Strategy*, which provides several examples suggesting intersecting systems of oppression. One example discusses how women living with disability "are less likely to be in paid employment and are paid comparatively less than men with a disability or women without a disability" (Department of Premier and Cabinet, 2016, p. 4). This suggests interactive influences of sexism and ableism influencing experiences of employment for women living with a disability. However, the strategy stops short of explicitly identifying these systems of oppression and their intersections; rather, it is up to the reader to be able to identify and interpret these.

Embedded systems of oppression are created and perpetuated by macro-level socio-cultural and institutional values and practices. There is a pressing need for explicit articulation and recognition of the systems, their intersections, and the impacts of these in policies influencing WRDM. Reproductive health policy is often framed through either a socio-normative morality lens or a feminist lens that reflects and reinforces dominant systems of inclusion/exclusion but fails to account for women's diverse intersecting locations and experiences of marginalisation (Sommer & Forman-Rabinovici, 2020). Further, Manuel (2006, pp. 194–195) argues:

> Public policy scholars tend to propose policy solutions that are "politically" feasible. That typically means solutions that appeal to the mainstream are simple, and work within the existing institutional framework. This kind of reductionism and incrementalism has the impact of narrowing our ability to see and respond to the more multifaceted ways that identity markers shape our experiences.

Foregrounding reproductive issues as public health and broader social issues in policy, rather than morality, feminist or politico-legal issues, may enable greater consideration of the health contexts and needs of diverse and intersecting identity groups (Sommer & Forman-Rabinovici, 2020).

3.4. Domain 4: Policy Solutions to the "Problem"

The final domain considers solutions to the representations of the problem in the policies, including whether or not solutions consider women's intersecting social locations and experiences of marginalisation, and how these are positioned. It also explores whether proposed policy solutions reinforce or challenge gender-based inequities for diverse women, and inconsistencies or incongruences in proposed policy solutions.

In the majority of policy instruments, proposed policy solutions reinforce the representation of the problem as being at the individual level. Policy solutions oriented at the micro level with individualised problem representations are often stringently defined and inflexible, or applied universally to a defined population without considering women's multiple and intersecting locations of marginalisation, or are restrictive and conditional. This is also the case for some legislative Acts with meso and macro level problem representations, but which have regulatory policy solutions oriented at addressing problems through individual operationalisation and accountabilities. For instance, the 2008 Public Health and Wellbeing Act (Victorian Government, 2008d) and the 2010 Equal Opportunity Act (Victorian Government, 2015) acknowledge and support diversity in policy solutions, for example making provisions for people living with disability, but not intersectionality with gender or other intersections. Rather, these Acts are applied universally, referring to all people or persons, or other homogenising terms (for example, "employee," in the case of the 2010 Equal Opportunity Act).

Some instruments propose solutions which seek to challenge the representation of the problem as being individual by proposing solutions which either fully or partially focus on addressing organisational, social, cultural, and systemic problem representations. However, consideration of women's intersectional experiences in these policy solutions is variable, or sometimes unclear or inconsistent. For instance, The *Women's Sexual and Reproductive Health: Key Priorities 2017–2020* takes a systems-based approach with the "aim to create an effective system to…support optimal sexual and reproductive health for Victorian women" (Department of Health and Human Services, 2017, p. 11). The strategy identifies structural and systemic barriers to women attaining optimal sexual and reproductive health and rights and proposes solutions to address those barriers through actions including collaborations, advocacy, and service and systems change rather than placing the onus on women's individual health-seeking behaviours. Examples

of solutions include, "foster sexual health services free from stigma and discrimination" (Department of Health and Human Services, 2017, p. 12) and "develop innovative models to improve confidential and safe access to contraception in primary care for all Victorians, particularly in regional and rural areas, including via innovative technologies such as phone apps for young people" (Department of Health and Human Services, 2017, p. 14). The latter example also demonstrates that policy solutions do consider some intersectional experiences, in this case for women in rural and regional areas and females of young age. Aboriginal women and women from culturally and linguistically diverse backgrounds are also considered in the policy solutions of the strategy. Notably, though, the language used sometimes refers to "Victorians" and "young people" rather than women, young women, or females. It may be implied that this includes women and female young people as the strategy is specifically addressing women's sexual and reproductive health and rights priorities. However, it is unclear whether this is a purposeful use of language in order to be inclusive of diverse and marginalised gender identities (for instance, trans) and intersections with those gender identities, or conversely, whether this language represents a failure to capture the complexity of gender identities and intersectionality.

The *Victorian Families Statement 2011* also focuses on creating physical and social conditions to promote health and wellbeing, in the context of families; including addressing public transport, community safety, education and training opportunities, and services. It explicitly recognises the diversity of Victorian families, stating:

> There is no typical Victorian family. Victorians live in single-parent households, blended, step and extended families. Some of us are starting a family while others have seen their children grow up and move out to live independent lives. Some couples choose not to have children, some people choose to live alone or in group households and some include same-sex relationships. Some families have recently arrived in Victoria from different parts of Australia and the world while aboriginal families have called this place home for many thousands of years. Amongst us, there are families who are struggling and families who are enjoying success. Regardless, they all make up the fabric of Victorian society. (Department of Premier and Cabinet, 2011, p. 4)

Diversity is subsequently recognised in several proposed macro-level problem solutions; for example, the varying needs of families in diverse locations are recognised in the commitment that the government will "develop a population strategy that covers all our regions. Rural and regional families will benefit from better infrastructure, better services, and a more inclusive, connected approach" (Department of Premier and Cabinet, 2011, p. 12). However while diversity is recognised, the intersection(s) of diverse social locations or experiences of marginalisation are not articulated, nor specifically for women. So, while there is promise in some instruments which seek to challenge individualised problem representations and solutions, there is scope for the problem solutions to go further in more fully and explicitly considering and addressing intersectional social locations and experiences of marginalisation of women.

4. Conclusions

The analysis highlights widespread limitations and incongruence across policies and within policies concerning how intersectionality is recognised in problem representations, impacts of the problems, and policy solutions. Meso- and macro-level policies are somewhat distal to WRDM but have a role in creating the conditions and environment to effect equity regarding reproductive decision-making. The policies examined at this level tend to somewhat recognise diverse and intersectional experiences of women in the representation of problems but fail to articulate the impacts and policy solutions in ways that enhance equity and inclusion for women with intersectional lived experiences. Policies oriented at micro-level contexts which are more proximal to WRDM generally fail to acknowledge women's intersecting social locations of marginalisation in the overall problem representation. The policies examined mostly acknowledge differential impacts of problems for women with intersectional experiences, but the representation of the problem and policy solutions to address those problem representations are often incongruent with this. These inconsistencies and gaps within policies limit the potential for real and effective operationalisation, hindering the ability to be socially inclusive for all.

The importance and benefits of applying an intersectional lens to policy analysis are now widely recognised and advocated for (Hankivsky et al., 2010). However, this is the first intersectional analysis of policies influencing WRDM. This is important given the centrality of reproductive decisions to reproductive health and rights, and overall population health equity and advancement. As shown in this analysis, policy is lagging in terms of being inclusive for all through an intersectional lens. While this analysis has provided important insights, limitations to the generalisability of the research findings are that it focuses on the policy context of one state (Victoria) in a high-income country (Australia) and examines policies at a point in time with limited historical comparative data or capacity to respond to any dynamic changes that may occur in policies.

Policy can serve as a strategic platform for effective systemic change by redressing inequities through both the policy instrument and the process of policy development. Policy-makers should consider and apply an intersectional policy analysis framework during policy development to ensure gender and intersectionality are

accounted for and avoid inequitable and incongruent policy outcomes.

Similarly, greater attention to the collection and critique of relevant data is needed to enable an intersectional approach to problem representation, impact recognition and policy solutions. This includes disaggregated data about populations and health issues, and the diversity and intersectional experiences of those involved in policy-making.

Crucially, people need to be at the centre of policy. An intersectional approach to policy development involves the creation of strategic alliances to redress social exclusion and empower marginalised groups (Hankivsky et al., 2010). In particular, a focus on community participation, partnerships and reflexivity of all stakeholders involved is needed (Hankivsky et al., 2010). Greater representation of women with intersecting social locations of marginalisation is crucial for the development of meaningful and inclusive health and social policy influencing WRDM and thus reproductive health and rights. Further, the critical reflexivity of all partners involved in the policy-making process and their subjectivities in relation to the policy should be central to any policy-making process.

This analysis has highlighted vast gaps in how policies related to WRDM consider intersectionality. Policy that essentialises women can exacerbate inequities and social exclusion particularly for marginalised individuals and groups. Moving forward, policy needs to recognise and be inclusive of all individuals, embracing the diversity that exists. Specific to this work, this is needed to benefit all women and their reproductive health and rights. However, more broadly, the concept of an intersectionality lens for all policy warrants further exploration. Applying an intersectional lens to this policy analysis has highlighted the refinement and redressing of policies that are needed to promote women's health for all, and for future informed policy development and social inclusion through policy processes, implementation, and impacts.

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Conflict of Interests

The authors declare no conflict of interests.

References

Agénor, M., Murchison, G. R., Najarro, J., Grimshaw, A., Cottrill, A., Janiak, E., Gordon, A. R., & Charlton, B. M. (2021). Mapping the scientific literature on reproductive health among transgender and gender diverse people: a scoping review. *Sexual and Reproductive Health Matters*, *29*(1), 57–74.

Bacchi, C. (2009).*Analysing policy: What's the problem represented to be?* Frenchs Forest NSW.

Botfield, J. R., Newman, C. E., & Zwi, A. B. (2015). Young people from culturally diverse backgrounds and their use of services for sexual and reproductive health needs: A structured scoping review. *Sexual Health*, *13*(1), 1–9.

Botfield, J. R., Zwi, A. B., & Newman, C. E. (2016). Young migrants and sexual and reproductive healthcare. In F. Thomas (Ed.), *Handbook of migration and health* (pp. 438–458). Edward Elgar.

Bourgeois, S. (2014). Our bodies are our own: Connecting abortion and social policy. *Canadian Review of Social Policy*, *70*. https://crsp.journals.yorku.ca/index.php/crsp/article/view/38700

Campbell, M. (2020). The distance between us: Sexual and reproductive health rights of rural women and girls. In S. Atrey & P. Dunne (Eds.), *Intersectionality and human rights law* (pp. 147–166). Hart Publishing.

Campbell, R., & Wasco, S. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology*, *28*(6), 773–791.

Carter, A., Strnadová, I., Watfern, C., Pebdani, R., Bateson, D., Loblinzk, J., Guy, R., & Newman, C. (2022). The sexual and reproductive health and rights of young people with intellectual disability: A scoping review. *Sexuality Research and Social Policy*, *9*(1), 372–390. https://doi.org/10.1007/s13178-021-00549-y

Charles, N. (2000). *Feminism, the state and social policy*. Macmillian Press.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1*, 139–167.

Department of Health and Human Services. (2017). *Women's sexual and reproductive health. Key priorities 2017—2020.* Victoria State Government.

Department of Premier and Cabinet. (2011). *2011 Victorian families statement*. Victoria State Government.

Department of Premier and Cabinet. (2016). *Safe and strong: A Victorian gender equality strategy*. Victoria State Government.

Elliott, L. (2017). Victims of violence: The forced sterilisation of women and girls with disabilities in Australia. *Laws*, *6*(3). https://doi.org/10.3390/laws6030008

Gopaldas, A. (2013). Intersectionality 101. *Journal of Public Policy and Marketing*, *32*, 90–94.

Graham, M., Lamaro Haintz, G., McKenzie, H., Lippi, K., & Bugden, M. (2022). "That's a woman's body, that's a woman's choice": The influence of policy on women's reproductive choices. *Women's Studies International Forum*, *90*. https://doi.org/10.1016/j.wsif.2021.102559

Graham, M. M., McKenzie, H., & Lamaro Haintz, G. (2020). Social policy to support women's reproduc-

tive decision-making and access to economic participation and resources: An Australian case study. In B. R. Crisp & A. Taket (Eds.), *Sustaining social inclusion* (pp. 65–76). Routledge.

Graham, M., McKenzie, H., & Lamaro Haintz, G. (2018). Exploring the Australian policy context relating to women's reproductive choices. *Policy Studies*, *39*(2), 145–164.

Graham, M., McKenzie, H., Lamaro, G., & Klein, R. (2016). Women's reproductive choices in Australia: Mapping federal and state/territory policy instruments governing choice. *Gender Issues*, *33*(4), 335–349. https://doi.org/10.1007/s12147-016-9159-4

Hankivsky, O., Grace, D., Hunting, G., Ferlatte, O., Clark, N., Fridkin, A., Giesbrecht, M., Rudrum, S., & Laviolette, T. (2012). Intersectionality based policy analysis. In O. Hankivsky (Ed.), *An intersectionality-based policy analysis framework* (pp. 33–45). Institute for Intersectionality Research and Policy, Simon Fraser University.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecth, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clarke, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, *13*. https://doi.org/10.1186/s12939-014-0119-x

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health*, *9*(5). https://doi.org/10.1186/1475-9276-9-5

Hawkey, A. J., Ussher, J. M., & Perz, J. (2018). "If you don't have a baby, you can't be in our culture": Migrant and refugee women's experiences and constructions of fertility and fertility control. *Women's Reproductive Health*, *5*(2), 75–98.

Hayman, B., & Wilkes, L. (2017). De novo families: Lesbian motherhood. *Journal of Homosexuality*, *64*(5), 577–591.

Hood, C. (1983). Using bureaucracy sparingly. *Public Administration*, *61*(2), 197–208.

Kapilashrami, A. (2020). What is intersectionality and what promise does it hold for advancing a rights-based sexual and reproductive health agenda? *BMJ Sexual and Reproductive Health*, *46*(1), 4–7.

Keleher, H. (2013). Policy scorecard for gender mainstreaming: Gender equity in health policy. *Australian and New Zealand Journal of Public Health*, *13*(2), 111–117.

Kirkman, M., Rosenthal, D., Mallett, S., Rowe, H., & Hardiman, A. (2010). Reasons women give for contemplating or undergoing abortion: A qualitative investigation in Victoria, Australia. *Sexual & Reproductive Healthcare*, *1*(4), 149–155.

Levitas, R., Pantazis, C., Fahmy, E., Gordon, D., Lloyd, E., & Patsios, D. (2007). *The multi-dimensional analysis of social exclusion*. Cabinet Office.

Manning, S. (2014). *Feminist intersectional policy analysis: resource development and extraction framework*. FemNorthNet; The Canadian Research Institute for the Advancement of Women.

Manuel, T. (2006). Envisioning the possibilities for a good life: Exploring the public policy implications of intersectionality theory. *Journal of Women, Politics & Policy*, *28*(3/4), 173–203.

Metusela, C., Ussher, J., Perz, J., Hawkey, A., Morrow, M., Narchal, R., Estoesta, J., & Monteiro, M. (2017). "In my culture, we don't know anything about that": Sexual and reproductive health of migrant and refugee women. *International Journal of Behavioral Medicine*, *24*(6), 836–845.

Morison, T., & Herbert, S. (2019). Rethinking "risk" in sexual and reproductive health policy: The value of the reproductive justice framework. *Sexuality Research and Social Policy*, *16*(4), 434–445.

Popay, J. (2006). *Community engagement for health improvement: Questions of definition, outcomes and evaluation. A background paper prepared for NICE*. National Institute for Clinical Excellence.

Popay, J., Escorel, S., Hernández, M., Johnston, H., Mathieson, J., & Rispel, L. (2008). *Understanding and tackling social exclusion: Final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network.* WHO Social Exclusion Knowledge Network.

Quinn, G. P., Tishelman, A. C., Chen, D., & Nahata, L. (2021). Reproductive health risks and clinician practices with gender diverse adolescents and young adults. *Andrology*, *9*(6), 1689–1697.

Redshaw, M., & Martin, C. R. (2011). Reproductive decision-making, prenatal attachment and early parenting. *Journal of Reproductive and Infant Psychology*, *29*(3), 195–196.

Rich, S., Lamaro Haintz, G., McKenzie, H., & Graham, M. (2021). Factors that shape women's reproductive decision-making: A scoping review. *Journal of Research in Gender Studies*, *11*(2), 9–31. https://doi.org/10.22381/JRGS11220211

Robards, F., Kang, M., Steinbeck, K., Hawke, C., Jan, S., Sanci, L., Liew, Y. Y., Kong, M., & Usherwood, T. (2019). Health care equity and access for marginalised young people: A longitudinal qualitative study exploring health system navigation in Australia. *International Journal for Equity in Health*, *18*(1), 1–14.

Sifris, R. (2016). The involuntary sterilisation of marginalised women: Power, discrimination, and intersectionality. *Griffith Law Review*, *25*(1), 45-70.

Sifris, R., & Belton, S. (2017). Australia: Abortion and human rights. *Health and Human Rights*, *19*(1). https://www.hhrjournal.org/2017/06/australia-abortion-and-human-rights

Sommer, U., & Forman-Rabinovici, A. (2020). The politicization of women's health and wellbeing. *Sustainability*, *12*(9). https://doi.org/10.3390/su12093593

Soucie, K., Tapp, K., Kobrosli, J., Rakus, M., Katzman, R., Schramer, K., Samardzic, T., Citron, N., & Cao, P. (2022). "It wasn't until i took the reins and said…" Power and advocacy in Canadian women's narratives of polycystic ovary syndrome diagnosis and treatment. *Women's Reproductive Health*. Advance online publication. https://doi.org/10.1080/23293691.2022.2054671

Turnbull, B., Graham, M., & Taket, A. (2020). Hierarchical femininities and masculinities in Australia based on parenting and employment: A multidimensional, multilevel, relational and intersectional perspective. *Journal of Research in Gender Studies*, *10*(2), 9–62.

Ussher, J. M., Rhyder-Obid, M., Perz, J., Rae, M., Wong, T. W., & Newman, P. (2012). Purity, privacy and procreation: Constructions and experiences of sexual and reproductive health in Assyrian and Karen women living in Australia. *Sexuality & Culture*, *16*(4), 467–485.

Victorian Government. (2008a). *Assisted reproductive treatment act 2008* (No. 76 of 2008. Authorised Version No. 021). Victoria State Government.

Victorian Government. (2008b). *Children's legislation amendment act* (No. 22 of 2008). Victoria State Government.

Victorian Government. (2008c). *Abortion law reform act* (No. 58 of 2008). Victoria State Government.

Victorian Government. (2008d). *Victorian public health and wellbeing act* (No. 46 of 2008). Victoria State Government.

Victorian Government. (2011). *Family violence protection amendment (safety notices) act 2011* (No. 16 of 2011). Victoria State Government.

Victorian Government. (2015). *Equal opportunity act 2010* (No. 16 of 2010. Version No. 020). Victoria State Government.

Victorian Government. (2016). *Adoption act 1984* (No. 10150 of 1984. Authorised Version No. 070). Victoria State Government.

Victorian Law Reform Commission. (2008). *Law of abortion: Final report*. Victorian Law Reform Commission.

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