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AMA submission to the Senate Standing Committee on Community Affairs inquiry into universal access to reproductive healthcare

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Contents

Introduction

The AMA strongly advocates that reproductive health services should be readily accessible throughout Australia. This requires the provision of and access to services to be timely, culturally safe, equitable, affordable and free of political or religious interference. Reproductive health is an essential element of good health and human development and support for the health of all mothers, other people who can get pregnant, and babies should be provided throughout the preconception, pregnancy, birth and the post-natal periods.

The following submission focuses on the perspectives of doctors on reproductive healthcare. Medical professionals play an important role in supporting pregnant women and other pregnant people to make fully informed health care decisions, considering the risks and benefits of various treatment pathways.

The AMA also supports the inquiry consulting patient and consumer groups, to take their perspectives and concerns seriously when considering universal access to reproductive healthcare. We further support consultation with the appropriate medical colleges on best practice approaches to sexual and reproductive healthcare, such as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal Australian College of General Practitioners, and the Australian College of Rural and Remote Medicine.

Reproductive healthcare is broad and complex. In this submission, the AMA has focused on contraception, abortion, collaborative models of reproductive health care, health literacy, and equity of access to reproductive health services. We note that the terms of reference are extremely broad, and some aspects of reproductive health care could warrant their own inquiry.

Cost and accessibility of contraceptives

A range of safe and affordable methods of contraception should be accessible to all people who seek them. In addition to reliable, reversible long-term contraception, emergency hormonal contraception should be affordable and accessible through registered medical practitioners who have the expertise to prescribe safely and provide appropriate follow up.[1]

Around two-thirds of Australian women between the ages of 18 and 44 years use a form of contraception, with 83% of Australian women having used contraception at some point in their lives.[2] Oral contraception and condoms are the most common methods, but a small increase in Long Acting Reversible Contraception (LARC) has been observed. In rural and regional areas in particular, access to this contraceptive modality depends heavily on access to adequately trained GPs, with IUCD insertion not being within scope of practice of nurse practitioners or midwives.

The AMA supports the role of the Therapeutic Goods Administration (TGA) as the regulator of medicines in Australia to ensure that medicines meet appropriate standards for quality, safety

[1] AMA position statement (2014) *Sexual and Reproductive Health*
[2] Family Planning New South Wales (2020) *Contraception in Australia 2005-2018.*

and efficacy. The regulatory framework for the approval of prescription medicines allows medical practitioners to have confidence in the medicine being prescribed.

In the context of this inquiry focusing on universal access - the AMA reiterates that we do not support the down-scheduling of oral contraceptives, nor the proposals by some states to allow pharmacists to prescribe and dispense hormonal contraception. The TGA determined late last year that oral contraceptive substances should remain schedule 4 (prescription only) for important health and safety reasons.

As noted in the interim decision:

"The use of oral contraceptive pills can cause significant adverse effects that are not consistent with over the counter medicines. These effects include weight gain, emotional anxiety, heavy bleeding and thromboembolism, particularly with increasing age. Even oral contraceptive products with the most favourable safety profiles lead to a rate of 5-7 cases of thromboembolism per 10,000 women per year, compared to a baseline of 2 in 10,000."[3]

The AMA is concerned by proposals for pharmacy and nurse practitioners (NPs) to be given access to prescribe contraception, noting this will detract from the ability of women to receive adequate information on other options available and reducing access to information on LARCs. Pharmacies and NPs will not be able to provide other reproductive healthcare including sexually transmitted infections (STI) screening, complex contraceptive consultation, cervical smear and other reproductive care which usually provided by GPs when patients come to consult suitable contraception option for them. In the case of the pharmacy prescribing trials, there is a conflict of interest with a direct financial benefit to the pharmacy regardless of whether or not it is in the best interest of the consumer.

There are issues with cost and access to contraceptives through general practice that are beyond the control of general practices and GPs. First, only certain basic oral contraceptives are available through the PBS. GPs regularly see patients who are better suited to a non-PBS subsidised option however this can be quite expensive and as a result is not accessible to all.

The other issue is access to LARCs in terms of cost and availability. There is an initial cost outlay that GPs or practices must pay to enable them to perform the procedure which includes the cost of training, equipment including an examination bed, and ensuring that the practice has a nurse. Supporting GPs through these steps would increase access to the community. This is particularly important for rural and underserved communities.

Cost and accessibility of abortion

All women and other pregnant people should have access to legal and safe abortion and counselling services. In addition to ensuring access to safe and legal abortion services, women and other pregnant people should have access to appropriate support to maintain a pregnancy

[3] TGA (2021) *Notice of interim decisions to amend (or not amend) the current Poisons Standard (oral contraceptive substances).*

to term but not to raise (or care) for the child.[4] The non-availability of abortion of pregnancy services has been shown to increase maternal morbidity and mortality in population studies.[5] Access to such services should be on the basis of healthcare need and not be limited by age, socioeconomic disadvantage or geographical location.

In most state jurisdictions, access to abortion services is not provided by rural public hospitals. While in some areas, private GPs or other specialists may provide that service, where that is not the case, the state/territory health department has a responsibility to provide the service at least on a regional basis.

The AMA recognises that unwanted pregnancies can have significant health, social and financial costs and we support measures to reduce unwanted pregnancies, including enhanced access to affordable and effective contraception.

Access to other reproductive healthcare services under the MBS

As with all Medicare Benefits Schedule (MBS items), years of frozen or poor indexation have created a situation where Medicare benefits do not match the cost of providing the service.[6] As a result, there are often out-of-pocket costs associated with loss of pregnancy and abortions. The AMA recognises the fundamental importance of the following MBS items to support patients who have experienced pregnancy loss or are seeking an abortion:

- 35643 'Evacuation of the contents of the gravid uterus by curettage or suction curettage'
- 16530 'Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation',
- 16531 'Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation',
- 16522 'The management of foetal loss from 23 weeks'.

The AMA supports equitable access to these items for all patients who have experienced pregnancy loss or are seeking an abortion and appropriate indexation of benefits for patients.

General practice and maternity care

Optimal maternity care is provided by a multi-disciplinary team of health professionals led by an obstetrician or GP-obstetrician (GPO) in partnership with a patient's usual GP, and includes midwives, nurses, physicians, allied health professionals and Aboriginal health workers.[7]

GPs have the most comprehensive training of all maternity care providers when addressing whole person health needs. GPs provide almost all pre-conception care, maternity care – for most women and other pregnant people – until about 20 weeks, and almost all postnatal care. However current MBS funding arrangements for GP care are increasingly leaving patients out of pocket with a gap payment, impacting access to care.

[4] AMA position statement (2014) *Women's health*
[5] *Ibid.*
[6] AMA (2022) *Why is there a Gap?*
[7] AMA Position Statement (2021) *General Practitioners in Maternity Care*

Strengthening and supporting the role and ability of GPs to be involved in the entire continuum of maternity care:

- increases the ability of women and other people who can get pregnant to have accessible, continuous whole person care;[8]
- increases the ability for women and other people who can get pregnant to be cared for in their community; and
- improves equity for women and other people who can get pregnant who are marginalised and/or live in rural and regional areas and for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

The AMA supports a shared model of collaborative care and is concerned by a growing trend across rural and remote Australia where obstetricians and GPOs are being relegated to secondary positions within the maternity care team or wholly excluded in favour of midwifery-led care. Reemphasising the shared model of care with GPs would help provide better care to rural maternity patients and their newborns.

Government policy must prioritise increased support, training and skills maintenance for GP obstetricians and rural generalists with accredited advanced obstetrics skills. All women and other pregnant people must have care led by a doctor with obstetric training. This is critical, noting the closure of maternity units in some rural areas in Australia due to the lack of an appropriate skill set.[9,10]

Reproductive health services in rural and remote areas

The AMA Queensland submission to the Rural Maternity Taskforce (2019) emphasised it is important that women and other pregnant people in rural and remote locations be able to access services as close as possible to where they live. This is especially relevant for Aboriginal and Torres Strait Islander women and other pregnant people for whom birthing on country can be very important.

The AMA supports the retention of existing services in rural and remote locations wherever possible and urges closer collaboration between state and territory health departments and private services to support a workforce (Obstetrics and Gynaecology, resident doctors, registrars, GP Obstetricians, anaesthetists, GP anaesthetists and paediatricians) that can provide access to maternity services outside of metropolitan centres. The closure of rural maternity services not only reduces access to safe and effective maternity care for the almost 30 per cent of Australians who live outside of major cities,[11] but also undermines skills of GP obstetricians and rural

[8] Arabin B and Baschat AA (2017) *Pregnancy: An Underutilized Window of Opportunity to Improve Long-term Maternal and Infant Health—An Appeal for Continuous Family Care and Interdisciplinary Communication*. Front. Pediatr., 13 April

[9] Kruske S, et al (2016) *Primary Maternity Units in rural and remote Australia: results of a national survey.* Midwifery 40: 1-9.

[10] Kildea S, et al (2015) *Babies born before arrival to hospital and maternity unit closures in Queensland and Australia.* Women Birth 28: 236-245.

[11] Rolfe, M.I.et al (2017) *The distribution of maternity services across rural and remote Australia: does it reflect population need?. BMC Health Serv Res*.

generalists, nurses and midwives. There is evidence that closing maternity and birthing services can result in poorer health outcomes. For example, extended travel time to access maternity services has been shown to lead to increased rates of mortality and adverse outcomes, underscoring the need for local services to deal with obstetric emergencies.[12]

To help re-enable greater retention of private rural GPs, rural and regional hospital and health services need to ensure that doctors working in rural communities are supported to be upskilled in sexual and reproductive health care and are actively encouraged to be credentialed and to have admitting rights in rural and regional hospitals, where they exist. Birthing services also require well-trained and credentialed rural generalist anaesthetists, with back up support from Obstetricians and Gynaecologists.

Access to pregnancy care under private health insurance

The AMA has been continually disappointed with the restriction of pregnancy care remaining at the top level of cover – making private maternity care unaffordable and inaccessible for the majority of Australian women and other pregnant people. The AMA continues to call for pregnancy cover to be included from Bronze policies upwards – matching it alongside coverage for other reproductive policies.

Failing this, the AMA supports having pregnancy cover treated in a similar way to mental health cover. For example – insurance policy holders can upgrade their hospital cover for psychiatric care without a further waiting period (but only once in their lifetime), once they have finished a 2-month waiting period for limited psychiatric benefits.

The challenge that unaffordable private obstetric cover poses for the health system and for reproductive healthcare is that many obstetricians work across the private and public systems. When there is no private market, it is financially challenging for an obstetrician to remain in practice. When the obstetrician leaves the private health service, they also leave the public. We have seen this occur recently in Queensland where public maternity services have had to close due to a lack of obstetricians.[13]

Conscientious objection

The AMA recognises that there are those within the medical profession as well as the wider community who are morally opposed to certain aspects of reproductive health care, particularly services such as abortion and contraception.

As outlined in the AMA's *Position Statement on Ethical Issues in Reproductive Medicine 2019,* access to any form of reproductive health services should be free from political or religious

[12] Ravelli A, et al (2010) *Travel time from home to hospital and adverse perinatal outcomes in women at term in the Netherlands*. BJOG 118:457-465.
[13] Janelle Miles (1 Oct 2022) *Provision of maternity services to be hit across Australia after damning Mackay Base Hospital report findings*, ABC News; Holly Payne (30 Nov 2022) *Private maternity closures put screws on insurance*, Medical Republic.

interference. No one seeking reproductive services should be subject to any form of harassment, discrimination or stigmatisation or be forced or coerced into undertaking (or not undertaking) any form of reproductive health care. Doctors and other health care professionals who choose to provide clinical services, or conduct research, in reproductive health care should not be subject to harassment, discrimination or stigmatisation either.

Consistent with good medical practice, patients have the right to make their own decisions about reproduction and the use of available reproductive health care services. As outlined in the AMA's *Code of Ethics 2016* some patients may have limited, impaired or fluctuating decision-making capacity, however, they should be supported to participate in decision-making related to their own reproductive health care consistent with their level of capacity at the time a decision needs to be made.

Doctors must treat patients with respect and dignity, providing care impartially and without discrimination. While the AMA believes it is acceptable for a doctor to refuse to provide or to participate in certain medical treatments or procedures based on a conscientious objection, a right to conscientious objection comes with responsibilities to patients, colleagues and the wider community.

As outlined in the AMA's *Position Statement on Conscientious Objection 2019*, a doctor's refusal to participate or provide a certain medical treatment or procedure based on a conscientious objection directly affects patients. Doctors have an ethical obligation to minimise disruption to patient care and take whatever steps are necessary to ensure the patient's access to care is not impeded, with particular consideration of the impact of a delay in access to services such as abortion, which are time critical.

The AMA recognises that some health care facilities may not provide certain services due to institutional conscientious objection (for example, contraceptive or abortion services). The AMA believes that such facilities have a responsibility in such cases to inform the public of their conscientious objection and what services they will not provide so that potential patients seeking those services can obtain care elsewhere. In cases where a patient admitted to an institution requests a treatment or procedure that the institution does not provide due to conscientious objection, doctors should be allowed to refer patients seeking such a service to another doctor outside the facility.

Sexual and reproductive health literacy

It is imperative that all Australians have access to accurate sexual and reproductive health information, provided in a culturally safe way, that is suitable for the diverse needs of the population. The AMA's position statement relating to *Health Literacy (2021)*, outlines actions that would assist in improving health literacy outcomes across Australia. Our position acknowledges that targeted education programs, continued funding for research, and easily accessible, up-to-date health information, through resources like *Health Direct,*[14] for all Australians is the way forward, in a health literacy approach that acknowledges the diverse needs of Australians.

[14] Health Direct (2022) *Health Direct*.

Medical misinformation is problematic from a sexual and reproductive health literacy perspective as it has the potential to harm health and obstruct well-informed decision making about seeking health care. The AMA maintains that all forms of media have the potential to distribute helpful and constructive information around health and wellbeing. However, this is not always the case and comes with the risk of false information being perpetuated and targeted at vulnerable populations with poor health literacy skills.

From a sexual and reproductive health literacy perspective, self-autonomy must be the focus of ensuring there is accessibility of relevant and easily understood health information. Young people are most likely to receive their sexual knowledge through peers, media, family and community, and formal education.[15] Discrepancy of information amongst these sources means that often competing ideologies impact knowledge around sexual and reproductive health, and not actual health and safety information.[16]

Health professionals should feel well equipped to deal with the complexities of situations surrounding sexuality, sexual health and reproduction information. Medical colleges and employers in the health sector should be supporting doctors, helping to implement evidence-based communication techniques to improve health literacy in their patients. This should include time and funding for professional development and training in sexual and reproductive health literacy.

Equity of access for diverse population groups

The AMA supports looking at sexual and reproductive health literacy through an equity lens, noting that not all communities and individuals are able to access and understand health care at the same rate – for a range of reasons. A person's health is shaped by the social, economic, cultural and environmental conditions they live in. All Australians, regardless of their individualities, should have the right to feel safe and empowered when seeking out health advice and knowledge from trusted sources.

The AMA notes that Article 16 of the UN Convention on the Elimination of All Forms of Discrimination against Women sets out the obligation for states to allow women to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".[17] This does, in a sense, obligate the state to provide safe and equitable access to fertility and reproductive health services. This is not consistently accessible across Australia and is often prohibitively expensive, and the AMA strongly advises this inequity is addressed by this inquiry.

As per our 2020 position statement on *Social Determinants of Health*, the AMA notes that health inequities typically arise because of inequalities within society, they are avoidable and can be associated with forms of disadvantage such as poverty, discrimination, and access to goods and

[15] Waling, A. et al (2019). *Young People, Sexual Literacy, and Sources of Knowledge: A Review (ARCSHS Monograph series No. 119).* Bundoora, VIC: Australian Research Centre in Sex, Health and Society, La Trobe University.
[16] *Ibid.*
[17] United Nations (2014) *Reproductive rights are human rights: a handbook for national human rights institutions.*

services. To combat the impact of the social determinants on health inequality, investment must be made through collaboration of the Commonwealth, State and Territory governments to improve the sexual and reproductive health literacy of all Australians.

Aboriginal and Torres Strait Islander peoples

The AMA asserts, as per our 2021 position statement on Cultural Safety, that Aboriginal and Torres Strait Islander peoples have a right to access appropriate, affordable, evidence based, accessible and responsive health care, where they feel respected and culturally safe. Culturally safe medical practise requires genuine efforts to understand the impacts of colonisation and systemic racism on health access and health outcomes for Aboriginal and Torres Strait Islander patients.[18]

We also note the importance of engaging Aboriginal and Torres Strait Islander service providers and communities through engagement with a broad range of reproductive health and other community-controlled organisations. It is essential that health literacy objectives are informed by community needs, culturally appropriate and understood by the community to empower individuals and families to advocate for their own health and wellbeing needs.

People living with a disability

While estimates suggest that 9% of women of childbearing age have a disability, there is limited qualitative and quantitative data in this area and efforts to address this would be beneficial to patients and healthcare providers. [19]

Recently, a survey of public maternity services in Australia called for national guidelines on disability identification for women accessing maternity services to be developed and the routine collection of disability identification data. The same survey reported that while most women were asked about disability status, "… most (63%) did not have standardised documentation processes and two thirds (65%) were unable to estimate the number of women with a disability seen at their hospital. Most (68%) did not offer specialised services, with only 13% having specialised training for staff in disability identification, documentation and referral pathways. Only a quarter of respondents felt that there were adequate services for women with a disability related to maternity care."[20]

The Women with Individual Needs (WIN) Clinic within the Royal Women's Hospital in Melbourne Victoria, provides individualised, disability-informed antenatal, birth, and postnatal care to women with disability. It is the only centre of its kind in Australia and options to replicate this service in other states and territories should be explored to provide equity of access to maternity care for people with disability. In a personal communication with the WIN clinic, issues identified as areas for action to support people with disability include (but are not limited to) providing early

[18] Australian Medical Association (2021) *Cultural Safety*
[19] Benzie C, et al. (2022*) How are women with a disability identified in maternity services in Australia? A cross-sectional survey of maternity managers* Women Birth
[20] *Ibid.*

identification of having a disability, addressing birthing options by giving proper consideration of reasonable adjustments, recognising higher unemployment rates for people with disability impacts on access (particularly in respect of access to private services), the difficulties many guardians face in accessing comprehensive information and advice on medical and administrative guardianships and appropriate care options for pregnant people.

More needs to be done to ensure people with disabilities have the same access to reproductive healthcare as they are often stereotyped as being asexual or their sexual health is less likely to be considered as important in their care. Recent work also suggests that more needs to be done to support access to general practice for people with intellectual disability with a range of supply and demand factors identified to support "patient-focused care and interventions aimed at improving access to not only the availability of general practice, but also the level of awareness and ability to access these services in the intellectual disability community".[21]

Health literacy for people with a disability and ensuring a clear understanding of reproductive information at all stages is important. Research also suggests that school-based sexual health and consent education tailored to the level of understanding needed to attain the requisite knowledge to form healthy relationships, understand sexual and romantic relationships, practice safe sex when they choose this option and understand their right to access sexual and reproductive healthcare is important.[22]

LGBTQIA+ community

It is imperative that the LGBTQIA+ community have equitable and safe access to sexual and reproductive health care. A high proportion of LGBTQIA+ Australians report experiencing discrimination, both generally and in health care settings. Just 43.4% of LGBTIQ respondents to the Private Lives 3 survey felt accepted a lot or always when accessing health services.[23] 25.2% of LGBTIQ+ respondents to the Victorian Population Health survey reported experiencing discrimination by doctors, nurses or other staff at hospitals or surgeries.[24] Previous experience or fear of being treated negatively in healthcare settings may discourage people who are LGBTQIA+ from seeking health services. 66% of LGBTIQ[25] adults report having a regular GP, compared to 81% of females and 73% of males in the general population.[26]

Trans and gender diverse people face systemic and cultural bias when seeking sexual and reproductive healthcare. Cisgender women are not the only people who can give birth and referring exclusively to cisgender women in sexual and reproductive healthcare ignores the

[21] Shea, B et al (2022).*Access to general practice for people with intellectual disability in Australia: a systematic scoping review*. BMC Prim. Care
[22]Matin B.K et al. (2021*). Sexual health concerns in women with intellectual disabilities: a systematic review in qualitative studies*. BMC Public Health. Volume 21. DOI: 10.1186/s12889-021-12027-6
[23] Hill, A et al (2020) *Private lives 3: the health and wellbeing of LGBTIQ people in Australia.* La Trobe University.
[24] Victorian Agency for Health Information (2017) *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex, and queer population in Victoria – findings from the Victorian population health survey 2017.*
[25] The AMA uses the term 'LGBTQIA+', however the term used changes throughout this submission to ensure it reflects what was used in the reference document.
[26] Hill, A et al (2020) *Private lives 3: the health and wellbeing of LGBTIQ people in Australia.* La Trobe University.

experiences and needs for these services for transgender and gender diverse people. This may lead to a reluctance to seek reproductive healthcare services.[27] Research and guidance on transitioning in relation to fertility and pregnancy and supporting trans and gender-diverse people during pregnancy, is limited.[28,29]

The lack of nationally representative data on LGBTQIA+ populations make it difficult for governments to plan and design appropriate health services for these communities. As a result, health groups and community organisations advocated in 2019 for the inclusion of questions about sexual orientation, gender identity and intersex status in the 2021 Australian Census.[30] The Australian Bureau of Statistics has now released a Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variable.[31] Full implementation of this standard across federal and state data collection activities, as well as investment in rigorous academic and clinical research, should enhance understanding of the LGBTQIA+ population in Australia. This research should inform LGBTQIA+ community-led health services to provide targeted, informed, and appropriate support.

In our 2021 position statement on *LGBTQIA+ Health*, the AMA calls on state and territory governments to facilitate LGBTQIA+ inclusive practice within their health systems, including by ensuring systems and electronic medical records are set up to acknowledge patient-directed names and pronouns.

The provision of appropriate, respectful and culturally safe healthcare is vital for the health and wellbeing of people who are LGBTQIA+. The AMA calls on the Australian Medical Council (AMC) to include LGBTQIA+ health knowledge as a graduate outcome for students undertaking medical programs of study in Australia. This call has been reiterated in the AMA's submission to the *AMC Review of the Accreditation Standards for Primary Medical Programs*.[32]

The AMA calls on the Australian Government to prioritise support for mainstream health services to increase cultural safety in their practices, including by funding training, education, and accreditation programs. Those accessing LGBTI-specific and LGBTI-friendly services were significantly more likely to feel that their sexual orientation or gender identity was very respected than those accessing mainstream clinics and hospitals.[33]

[27] Moseson, H et al (2020) *The imperative for transgender and gender nonbinary inclusion*. Obstetrics and Gynecology.
[28] Kukura, E (2022) *Reconceiving reproductive health systems: caring for trans, nonbinary, and gender-expansive people during pregnancy and childbirth*. Journal of Law, Medicine and Ethics.
[29] Pfeffer, C (2022) *Transgender men and nonbinary people are asked to stop testosterone therapy during pregnancy – bit the evidence for this guidance is still murky.* The Conversation.
[30] LGBTIQ+ Health Australia (2019) *Joint statement in support of LGBTI inclusion in the 2021 census.*
[31] Australian Bureau of Statistics (2021) *Standard for sex, gender, variations of sex characteristics and sexual orientation variables.*
[32] Australian Medical Council Limited (2022) *Review of accreditation standards for Primary Medical Programs (medical schools).*
[33] Hill, A et al (2020) *Private lives 3: the health and wellbeing of LGBTIQ people in Australia.* La Trobe University.

Health services run by LGBTQIA+ communities are available in some metropolitan areas but are generally difficult to access in rural and remote areas. The AMA calls on the government to take specific steps to improve access to LGBTQIA+ inclusive care for people living in rural and remote areas, particularly young people. For Aboriginal and Torres Strait Islander people who live in rural and remote areas, leaving country to access inclusive care is an added barrier. Prominent organisations include ACON, a NSW based community-led organisation that provides free mental health support, HIV prevention and support, a sexual health clinic, and alcohol and other drugs support for people who identify as LGBTQIA+ and people with HIV.

Conclusion

The AMA strongly advocates that reproductive health services should be universally accessible to the diverse base of peoples seeking these services throughout Australia. This requires the provision of and access to services to be timely, culturally safe, equitable, affordable and free of political or religious interference.

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