Submission to the Inquiry into abortion and reproductive choice in the ACT

22 August 2022

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About Women's Health Matters

Women's Health Matters (WHM) is an independent, non-partisan think tank that works to improve the health and wellbeing of all women in the ACT and surrounding region. We seek to improve access to health information and enhance knowledge and understanding about the causes of health and illness among anyone who identifies as a woman.

We advocate on behalf of all ACT women, especially those experiencing disadvantage and vulnerability. We want women to feel in control of and understand the determinants of their own health and wellbeing.

We do this through health promotion and by providing evidence-based social research, policy development and advocacy services to governments, the corporate sector, policy makers, service providers and peak bodies.

Our submission

WHM supports and welcomes the Inquiry into Abortion and Reproductive Choice in the ACT. We view the inquiry as a timely opportunity to consider reproductive rights of women and people with uteruses living in Canberra and the surrounding regions following the overturning of Roe v Wade decision in the United States and significant community protest to this decision across Australia.

We note the limited scope of this inquiry and that reproductive choice requires reproductive justice, not only universal access to abortion services.

Reproductive justice

WHM supports and calls for reproductive justice, which acknowledges that reproductive rights include the formal and substantive right not to have a child, through abortion and/or contraception, as well as the right to have a child, and the right to parent children without fear of violence or discrimination.[1] We acknowledge that these reproductive rights have been deliberately and actively denied to many people in the ACT as in Australia more generally, particularly Aboriginal and Torres Strait Islander people, people with disabilities, people living in poverty, and people being subjected to coercion, among others.

Alongside our recommendations here, WHM emphasises our support, in particular, for the full implementation of recommendations from the *Our Booris, Our Way* review as policy reform that embodies reproductive justice. We also support calls for a Royal Commission or Commission of Inquiry into the overrepresentation of Aboriginal and Torres Strait Islander people in the justice system, with its implications for the number of Aboriginal and/or Torres Strait Islander children in care.

Voices of women

This submission is informed by the voices of women and people with uteruses who have accessed or tried to access an abortion, which we have collected via a community survey. WHM's Survey about

[1] See SisterSong, who coined the term reproductive justice: https://www.sistersong.net/reproductive-justice, accessed 4 August 2022, https://msi-australia.medium.com/in-response-to-overturning-roe-v-wade-we-need-reproductive-justice-now-ec7f09f120ce, accessed 4 August 2022.

accessing abortion in the ACT and surrounding regions was open from the 25th of July to the 10th of August 2022 and collected 102 responses.

It is also informed by collaboration and consultation with health care providers, peak bodies and community organizations and services across the sector. Our submission is endorsed by the following organisations and individuals:

- ACT Council of Social Services
- A Gender Agenda
- ANU Students' Association (ANUSA)/ ANUSA Women's Department
- Dr Melanie Dorrington (GP with focus on Women's Health)
- MSI Australia
- Sexual Health and Family Planning ACT
- Women With Disabilities ACT

WHM thanks these organisations and individuals, and all others who participated in our stakeholder consultation, for their input in the development of this submission

New ACT Government funding for free abortion access

We acknowledge and welcome the ACT government's budget commitment of $4.6 million over four years, plus ongoing funding, to remove out-of-pocket costs of abortion services for both medical and surgical abortions, along with a communications package to improve accessibility of abortion services,[2] which was announced while this inquiry has been open.

As detailed in our submission, this commitment will have a significant impact by removing affordability barriers to abortion (particularly for women and people with uteruses on low to middle incomes, and those on temporary visas who lack access to Medicare or pregnancy-related health care coverage). Our comments raise some considerations for implementing this commitment.

However, there is always more to be done to improve access to abortion services in the ACT and this commitment will not address all current barriers. In particular, we highlight issues with workforce capability, conscientious objection and substantive gestational limits that need to be addressed for reproductive choice in the ACT to be fully realised.

We strongly encourage the ACT government to work with abortion providers, Winnunga Nimmityjah Aboriginal Health and Community Services, WHM and other key stakeholders in designing of models of care and communication strategies to implement this commitment.

Summary of recommendations

We recommend:

1. Developing a Sexual and Reproductive Health Strategy for the ACT, which:
    a. Is underpinned by principles of reproductive justice
    b. Is intersectional
    c. Aspires to universal access to sexual and reproductive health care

[2] https://www.treasury.act.gov.au/__data/assets/pdf_file/0003/2051328/Womens-Budget-Statement.pdf, accessed 4 August 2022.

d. Is co-designed with key stakeholders including community organisations, service providers and women and people with uteruses in the ACT
e. Is linked to the National Women's Health Strategy 2020-2030 and the National Men's Health Strategy 2020-2030

Improving **Accessibility of services**, by:

2. Appropriately resourcing the communications package committed to in the 2022-23 Budget to be targeted to, and meet the needs of, different groups, including by:
    a. Developing and implementing tailored resources and health promotion which are safe for and appropriate to different groups of women and people with uteruses, including Aboriginal and Torres Strait Islander women, migrant and refugee women, trans men and nonbinary people, and people with disability
    b. Working with the primary health network to ensure that HealthPathways reflects all medical abortion providers in the ACT, and communicates a clear model of care to GPs
    c. Building capacity of all health practitioners and workers (including nurses, midwives, Aboriginal and Torres Strait Islander health workers, pharmacists, radiographers and phlebotomists) involved in abortion access to provide non-stigmatising, trauma-informed, culturally safe and inclusive care
    d. Raising awareness about medical and surgical abortion options and referral pathways among community services and organisations
    e. Promoting awareness of the different types of available abortion care among the general public, and the importance of early identification and presentation
3. Resourcing an ACT network or community of practice to improve coordination of abortion service provision and provide peer support to GPs and allied health professionals

Improving **Affordability of services**, by:

4. Developing policy for and trialing reproductive health and wellbeing leave in ACT Government workplaces, as best practice for supporting abortion access in workplaces
5. Designing universal, free abortion model of care committed to in 2022-23 Budget in collaboration with existing providers and key stakeholders

Improving **Availability of services**, by:

6. Reforming law and scope of practice to enable nurse-led medical abortion care, including nurse practitioners, nurses, midwives and Aboriginal and Torres Strait Islander health workers
7. Expanding existing clinical infrastructure in the ACT to provide surgical abortion after 16 weeks
8. Resourcing the abortion service system to provide adequate follow-up and post-procedure support, including mental health support and safety resources for women and people with uteruses who may be experiencing social isolation or escalated violence due to their pregnancy choice

Preventing **Reproductive coercion and embedding reproductive justice**, by:

9. Developing a quantitative and qualitative evidence base on reproductive coercion in the ACT, including intersectional experiences of Aboriginal and/ or Torres Strait Islander people and people with disability

10. Embedding response to and prevention of reproductive coercion in the Third Action Plan of the ACT Women's Plan 2016-26 and any future Sexual and Reproductive Health Strategy
11. Embedding reproductive coercion prevention into age-appropriate, culturally safe prevention programs, including relationships and sexuality education
12. Providing training for family, domestic and sexual violence services to respond to reproductive coercion
13. Implementing recommendations of the *Our Booris, Our Way* review in full
14. Funding a Royal Commission or Commission of Inquiry into the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system
15. Considering options for subsidising antenatal care for women and people with uteruses without access to Medicare or pregnancy-related health care, to complement access to free abortion care

Harmonising ACT legislation with other States/ Territories, by:

16. Amending the Health Act (1993) to require health practitioners to make referrals if they have a conscientious objection to providing abortion
17. Collecting and publishing data on medical and surgical abortions provided in the ACT, and invest in local partnerships to further develop an evidence base on abortion
18. Considering options for and implementing the most appropriate mechanisms to eliminate intimidation and harassment against and safety concerns of women and people with uteruses accessing abortion providers, including harmonising exclusion zone legislation with other States/ Territories by increasing the zone distance to 150m.

Overview

Abortion care is health care. Yet the many hurdles and conditions set up for accessing abortion means that women and pregnant people are forced to accept poorer experiences of healthcare than would be acceptable for other health products, treatments and procedures.

The reasons that women and pregnant people seek abortion are diverse, and framing abortion as only a result of unintended pregnancy blames women for their health in a way that both simplifies a complex issue and is markedly different from other health conditions.[3] For example, one of the people who responded to our survey explained:

> *I had an abortion as a mum of 2 kids already... The pregnancy was planned. I aborted because I could no longer cope with the insane nausea and panic attacks induced by pregnancy which I experienced with both kids for almost the full 40 weeks. I do not regret my decision. In the 8 weeks until my abortion, I'd already been really sick for 4 of those weeks, unable to get out of bed, unable to look after my kids or myself. And unable to work. That made me change my mind about wanting to go through another pregnancy and I know it was the right choice for me at that time.*

The Turnaway Study,[4] conducted at the University of California, included 1,000 women in the United States who either received or were denied an abortion. While their lives were similar prior to seeking abortion, women who were denied abortion experienced an increase in poverty, debt, and publicly recorded bankruptcies and evictions. In cases of physical violence from a man involved in the pregnancy, violence decreased for women who received wanted abortions but not for women who were denied. Women who were denied abortion were also more likely to experience serious adverse health outcomes. Being denied abortion increased women's likelihood of living in poverty, experiencing physical violence, and serious health problems.

Women and pregnant people are best-placed to know what they need in their own lives, and for some, having an abortion may be the best choice for their health and wellbeing regardless of whether it is a decision made easily or with mixed feelings.

Framing abortion as health care raises a need for an overarching strategy for sexual and reproductive health in the ACT, in which access to abortion is one component. Such a strategy should have universal access to sexual and reproductive health care as a goal and be underpinned by principles of reproductive justice and choice.

Abortion in the ACT

There is no way to accurately estimate the number of abortions which currently occur in the ACT, and there are significant differences in existing data sources. It has been estimated that as many as one

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[3] Through our consultation, it became apparent there are gaps in terms of health promotion, affordability and accessibility of contraception which may contribute to unwanted or unplanned pregnancy, however we have treated these as outside the scope of this submission given the diverse reasons women and pregnant people may seek abortion.

[4] https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf, accessed 9 August 2022.

quarter to one third of women and people with uteruses in Australia will have an abortion in their lifetime.[5]

ACT-level data from the Australian Longitudinal Study of Women's Health (ALSWH) sample shows that lifetime prevalence of having had an abortion could be between 11% and 23% of women, depending on their age cohort, but we note that it is reasonable to assume this is an underestimate due to the self-reporting nature of the data and abortion stigma:

ALSWH cohort	Age at latest survey (years)	Ever had a termination (N, %)			
		No	Yes	Missing	Total
Born 1989-95	24-30	291 (85%)	33 (10%)	18 (5%)	342 (100%)
Born 1973-78	40-45	130 (76%)	40 (23%)	1 (1%)	171 (100%)
Born 1946-51	68-73	74 (75%)	11 (11%)	14 (14%)	99 (100%)

Source: Personal communication, Unpublished data from ALSWH

Other figures indicate as many as 1,800 people seek abortion in the ACT each year,[6] but in the course of our consultation this has been indicated to be an underestimation by stakeholders. Further, there is no available on how many people may seek abortion interstate, including after 16 weeks gestation. There is currently no Territory-level data collection and publication on abortion, and the difference in existing data sources demonstrates there is a need for consistency through data sharing and publication.

PBS data indicates that medical abortion processed in the ACT has increased significantly in the ACT in the last five years. We note that this data cannot be taken as an indicator of prevalence, as it does not include all and significantly underrepresents medical abortions in the ACT and. However, it could suggest the number of abortions provided through GPs has increased since legislative change in 2019 which no longer required medical abortion to be provided at an approved medical facility.

Financial year	Number of MS-2 Step PBS Items processed for the ACT
2017/18	3
2018/19	1
2019/20	40
2020/21	63
2021/22	146

Source: Services Australia (2022)[7]

Our own survey received 102 responses, of whom 90 had an abortion in the ACT and 12 had tried but been unable to access an abortion. Of those who reported having had an abortion, most (63%) had it in the last ten years.

[5] https://www.childrenbychoice.org.au/resources-statistics/papers-reports/abortion-rates-in-australia/, accessed 4 August 2022.

[6] https://www.canberratimes.com.au/story/7847439/stephen-smith-urges-federal-counterpart-make-abortions-free-across-country/?cs=19265, accessed 5 August 2022.

[7] http://medicarestatistics.humanservices.gov.au/statistics/do.jsp?_PROGRAM=%2Fstatistics%2Fpbs_item_standard_report&itemlst=%2710211K%27&ITEMCNT=1&LIST=10211K&VAR=SERVICES&RPT_FMT=1&start_dt=201707&end_dt=202206, accessed 4 August 2022.

How long since abortion	%	Number of responses
In the last 3 years	26%	23
More than 3 years but less than 10 years	37%	33
More than 10 years but less than 20 years	23%	21
More than 20 years ago	14%	13
Total		90

Echoing the PBS data above, our survey results show the proportion of medical abortions has been growing over the period covered by our survey responses, to make up just over half of all abortions reported as occurring during the last 3 years. It is important to note, however, that our survey sample is limited and does not enable conclusive findings about prevalence.

	Type of abortion (N, %)			
Years since abortion	Surgical	Medical (appt)	Medical (ph)	Total
Last 3 years	11 (48%)	11 (48%)	1 (4%)	23 (100%)
4-10 years	24 (73%)	9 (27%)	0 (0%)	33 (100%)
11-20 years	20 (95%)	1 (5%)	0 (0%)	21 (100%)
20+ years	12 (92%)	1 (8%)**	0 (0%)	13 (100%)
Totals (all years)	67 (74%)	22 (24%)	1 (1%)	90 (100%)*

*Percentages have been rounded to nearest per cent, so columns may not add to total of 100%

** Medical abortion in the form currently used was not available 20+ years ago. The survey instrument did not enable us to explore the experiences of this respondent further.

As discussed below, a significant proportion of people in our survey would have preferred a different type of abortion than the one they had.

We recommend:

1. Developing a Sexual and Reproductive Health Strategy for the ACT, which:
    a. Is underpinned by principles of reproductive justice
    b. Is intersectional
    c. Aspires to universal access to sexual and reproductive health care
    d. Is co-designed with key stakeholders including community organisations, service providers and women and people with uteruses in the ACT
    e. Is linked to the National Women's Health Strategy 2020-2030 and the National Men's Health Strategy 2020-2030

Accessibility of services

Access to abortion in the ACT is facilitated up to 16 weeks gestation by a handful of abortion-specific non-profit private clinics (MSI Australia in Canberra and Gynaecology Centres Australia in Queanbeyan), community and public clinics, an all-options unplanned pregnancy counselling service provided by Sexual Health and Family Planning ACT and a small number of prescribing GPs and

dispensing pharmacies.[8] We note that while medical abortion (until 9 weeks) is provided by the Women's Health Service, and surgical abortion in case of foetal abnormality is provided for at Canberra Hospital, there is a significant gap in the provision of abortion in the public health system.

Through consultation, we have repeatedly heard that accessing abortion requires a high degree of health and computer literacy as information about abortion clinics, let alone available prescribers, suppliers and dispensers of abortion medication (MS-2 Step), are not necessarily well known in the community or easy to find information about. This makes accessing abortion difficult for many women and pregnant people, and especially for those subjected to additional disadvantage or discrimination.

Our survey found that while some people had a straightforward process, for many it is complex and expensive. This explanation by a survey respondent documents the many steps that can be involved, as well as the many appointments with different practitioners:

> *Initial appointment with my GP who sent me for blood tests and an ultrasound - appointment with another GP at my clinic to try and access medication, denied the prescription by GP - follow up appointment with regular GP to confirm pregnancy and prescribe medication - pharmacy to purchase medication - follow [up] ultrasound - follow up GP - second follow up ultrasound - consultation with gynaecologist at public hospital - day surgery for a D&C due to retained product - follow up appointment GP*

Findings on accessibility from our survey

In our survey, the majority of respondents had been able to have an abortion after seeking one (90), while only a comparatively small number had tried but not been able to have an abortion in the ACT/region (12). This may reflect the accessibility of abortion in the ACT, but it might also reflect the sampling process and barriers to reporting. For example, people continued with a pregnancy after not being able to access an abortion might not wish to be reminded of the process by completing a survey. In the relatively short time when the survey was open, it also might not have reached some of the people who are more likely to experience difficulties accessing abortion (for example, we did not have any respondents reporting they were on a temporary visa, despite the fact that people in this category are known to be at risk of lacking access to reproductive healthcare).

Of the 12 people who reported having tried but been unable to access an abortion in the ACT/region, the majority (8) had attempted in the last 10 years (4 in the last 3 years and 4 between 4 and 10 years ago). The most commonly reported reason for being unable to access an abortion was 'Health providers refused or chose not to help me' (42%), followed by 'Medication, tests, procedure and/or appointments were too expensive' (33%) and 'The gestation of my pregnancy limited the services I could access' (33%). Other significant factors reported were judgement or stigma from healthcare providers (25%), being in a violent relationship (25%), appointments being too far away or difficult to get to (25%), and having trouble finding appointments (25%). Some of these issues are explored in more detail below.

Among those people who were able to access an abortion in the ACT or region, the majority were very satisfied or extremely satisfied with their ability to access one (54%), compared with those who were

[8] We note that not all abortion medication may be dispensed from the ACT, for example, if abortion is accessed via telehealth.

dissatisfied or very dissatisfied (14%). This is perhaps to be expected, considering that all of these respondents were ultimately able to have the abortion that they were seeking.

How satisfied with access to abortion	%	n
Very dissatisfied	1%	1
Dissatisfied	13%	11
Quite satisfied	33%	30
Very satisfied	16%	14
Extremely satisfied	38%	34
TOTAL		90

Of the nine Aboriginal women who responded to our survey, one had been unable to access an abortion in the ACT/region and 8 had had an abortion. Those who had an abortion were on the whole less satisfied than respondents overall with their ability to access the procedure, with only 25% very satisfied or extremely satisfied and 25% dissatisfied. (The remainder indicated they were 'quite satisfied'). It is important to note that the number of respondents is small, so results should be interpreted with caution.

Across the respondents as a whole, significant challenges were reported, even among those who were able to access an abortion and who were in general satisfied with their ability to do so. Most notably, 41% reported that 'Medication, tests, procedure and/or appointments were too expensive', while significant numbers had trouble finding appointments (18%), were worried about their privacy (17%), or had trouble taking time off work or study (14%).

It is concerning that even among those who were ultimately able to have an abortion, 13% (or 12 people) had experienced judgement or stigma from healthcare providers. Of these 12 people, 5 had encountered healthcare providers who had refused or chosen not to help them. This suggests that there is still a long way to go in improving systems to enable access to abortion as a basic element of healthcare, rather than one that forces people to navigate barriers and hardship in order to receive the services they need.

Survey findings: When asked what would improve access to abortion in the ACT, the most commonly recommended measures were those to address the cost of abortion, followed by measures to improve information about options, community education and help with navigating services. Many respondents also mentioned the need for dedicated services to be provided at different locations, with greater availability of appointments in a timely way. Many also mentioned the need for professionals to be more non-judgmental and supportive.

Coordination and timing as a barrier to access

Abortion care is time sensitive with a need to coordinate a series of procedures, involving a series of scans, tests, screenings and assessments. The pathway to accessing medical abortion through general practice involves multiple touchpoints (doctors, phlebotomists, radiographers, pharmacists and medical interpreters).[9] Coordination and multiple steps in the pathway are significant barriers for

[9] Private clinics such as MSI Australia provide all services within their clinic.

women or pregnant people who are in insecure housing and employment and/ or may have substance abuse or mental illness and complex trauma, and attending scheduled appointments can be challenging. For young people, late presentations are particularly common, and can mean unintended pregnancies are continued due to being too late in accessing and coordinating the needed services after an initial request.

Being subject to domestic and family violence can also increase the difficulty of coordinating and timing appointments and services, and may put survivors at increased risk. This is particularly the case where a woman or pregnant person's movements, such as leaving the home, accessing funds or changing their regular routine may be controlled and surveilled. Access to timely and discrete services may be critical for this group of women and pregnant people, who may otherwise be forced to continue an unintended pregnancy,[10] and which may increase their risk of being subject to violence longer term. As the Turnaway Study showed, in cases of physical violence from a man involved in the pregnancy, violence decreased for women who received wanted abortions but not for women who were denied.[11] While DVCS has some brokerage available to support costs for this cohort, this is limited.

Case study* - coordination and timing as a barrier to access: A woman who was experiencing intimate partner violence and reproductive coercion presented late with an unwanted pregnancy. A delay with seeking assistance from Victims of Crimes meant the only option was to seek surgical abortion in Sydney with higher expenses. However, the woman was not able to go to Sydney and was not able to proceed with obtaining an abortion and continued with the pregnancy. This patient was not seen again.

*Case study from a health service provider in the ACT

Improved service coordination to and trauma-informed care are important for these women and people navigating additional layers of complexity. As one of the respondents to our survey wrote:

> *I feel like I was rushed. I was also coerced by my partner at the time, and I don't feel there was enough done to find out about my circumstance, or any therapy or after care afterwards. This was extremely traumatic and caused me a lot of grief (mentally, spiritually and emotionally) afterwards.*

Abortion stigma and discrimination as access barriers

Under current legislation, only doctors providing medical abortion or carrying out surgical abortion, a person assisting in carrying out a surgical abortion, pharmacists and pharmacy assistants can conscientiously object[12] to providing abortion and delay access by not providing appropriate referrals or incorrect information. However, in practice any health practitioners involved in the pathway may perpetuate abortion stigma, and our survey results confirm that this is a significant challenge for people attempting to access an abortion. Abortion is time sensitive and barriers at any point in the

[10] Reproductive coercion, in which women and pregnant people may be coerced into keeping or ending a pregnancy, is discussed later in this submission.

[11] https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf, accessed 9 August 2022.

[12] Conscientious objection is discussed later in this submission.

pathway can delay or limit access to care, and compound to result in a lower-quality or negative experience of abortion care.

The likelihood and impacts of stigma are greater at the intersections of multiple forms of marginalisation. Aboriginal and/ or Torres Strait Islander people may already be subject to racism, dismissive behaviour or assumptions about the care they may need when accessing sexual and reproductive health or maternity services. During consultation, we have heard examples of women being advised to have tubal ligation, or CYPS being present while women are receiving maternity care in hospital.

Trans men and nonbinary people may be exposed to gender-based discrimination, including assumptions, negative body language or comments about their need for or choice of contraceptive access or abortion care. At present there is little inclusive health promotion information, including about inclusive providers or choices, for this cohort.

As indicated by our previous research, women with disability are also widely subjected to ableism in health care settings, and often lack access to appropriate sexual and reproductive health care, in part due to lack of understanding by health professionals.[13]

For survivors of sexual violence, dismissive or stigmatising encounters with health professionals such as victim blaming or denial of emergency contraception, may increase their trauma from assault.[14] As these experiences accumulate in the course of accessing abortion, they increase the degree to which a woman or pregnant person may have a negative or traumatic experience of care.

Survey findings: Our survey found that objection/refusal by practitioners is the leading reason reported for being unable to access an abortion, with 42% nominating 'health providers refused or chose not to help me' as a main reason for being unable to access an abortion. Even among those who were able to have an abortion, 13% had experienced judgement or stigma from healthcare providers and 6% had encountered health providers who refused or chose not to help them.

Many across both groups reported delays in referrals and getting appointments as key challenges, highlighting the many points at which even subtle forms of stigma or reluctance by practitioners can impede access to the kind of abortion care that is desired and needed.

When we asked people who had an abortion what worked well with the support they received, the most widely cited factor was kind, compassionate, non-judgemental and competent care by medical professionals. As noted above, however, this kind of support is not currently available to all people seeking an abortion, and many still experience stigma and encounter systems that are ill-equipped to meet their needs.

[13] See Women's Health Matters (2022*), 'I have to ask to be included…' The views of ACT women with disabilities about their health and health needs, access to services, supports and information, and barriers to maintaining health*, https://www.womenshealthmatters.org.au/wp-content/uploads/2022/02/Womens-Health-Matters-Women-with-disability-health-and-wellbeing-report-February-2022.pdf

[14] See https://www.womenshealthmatters.org.au/wp-content/uploads/2021/10/Submission-to-the-ACT-Sexual-Assault-Reform.pdf, for discussion of the challenges women may experience in encountering services after sexual assault.

Culturally safe information and services for Aboriginal and Torres Strait Islander people

Through stakeholder consultation, we heard that Aboriginal and Torres Strait Islander women and people need access to holistic, culturally safe and private services and information. Aboriginal and Torres Strait Islander women and people need health promotion providing culturally safe information about sexual and reproductive health and abortion, and holistic, spiritual, emotional and physical abortion care. Aboriginal people should be able to access any available service and receive culturally safe care. This would require mainstream services to have the capability to provide abortion care in a culturally safe manner. This may include working with local elders and the ACT Aboriginal and Torres Strait Islander Elected Body to help shift mainstream services to culturally safe models.

Additionally Aboriginal women are currently travelling from interstate, remote communities to access abortion in the ACT. In order for the design of a universal, free care model to not have the perverse impact of restricting access for these women, it will be important to consider how their travel and accommodation needs may be supported, and for the ACT government to consider how a service model can provide continuity of care for this group of women.

Culturally appropriate information for migrant and refugee people

According to MSI Australia, one in three (31%) of people accessing the MSI Canberra Clinic are born outside of Australia.[15] For women and people from migrant and refugee backgrounds,[16] cultural and religious stigma and privacy may also impact access particularly where communities are small, GPs are often from the local community or where the financial resources a woman or person may need to pay for an abortion may need to be sought from their community.

We have heard that if abortion is not viewed as acceptable or may be illegal in a woman's or person's country of origin, accessing an abortion may not even seem like a possibility, even in instances where violence may be present in the relationship, or where a pregnancy was a result of sexual assault. People may feel that if they were to get pregnant, there would be no choice about whether to keep the pregnancy, because they must be able to continue living in their cultural context that does not allow abortion. Conversely, our consultation also heard stories of migrant and refugee women using herbs or other unsafe abortion methods.

Both these stories highlight a significant need for culturally appropriate and sensitive health promotion, tailored to different communities, to make women and people with uteruses aware of and able to navigate the options available to them in the ACT. This may include using discrete, in-language communication strategies, working with women's groups to increase their awareness and comfort with abortion, and if possible, working with community leaders. In order to be effective, it is critical that messaging is in plain language free of medical jargon and is developed with key stakeholders and communities to be culturally appropriate.[17] Health promotion strategies are also determined in collaboration with key stakeholders and communities.

According to MSI Australia, one in twenty (5%) people accessing their clinic prefer a language other than English, and only one in fifty (2%) had an interpreter present for their abortion (including

[15] See MSI Australia submission to this Inquiry.
[16] Affordability is a major access barrier for women on temporary visas, which we discuss further below.
[17] See, for example https://www.childrenbychoice.org.au/resources-statistics/resources/multicultural-resources/, accessed 12 August 2022.

Auslan).[18] If a woman prefers an interpreter when using health services, access can also be impacted by poor interpretation on the part of interpreters who may either have personal objections to abortion, or who may not have had sufficient training to be able to appropriately interpret for abortion care. Further consideration should be given to the provision of training to improve sexual and reproductive health interpretation in the ACT,[19] and to access to phone interpreters.

Informed choice of abortion type

From our survey, nearly 30% (n=26) of people who had had an abortion said they would have preferred another type of abortion instead of the one they had. The majority of these (n=16) were people who had a surgical abortion but said they would have preferred a medical abortion. People who expanded on why they would have preferred a medical abortion noted factors such as convenience and the procedure being "less intrusive". Most of the respondents who said they would have preferred a medical abortion had their surgical abortion more than 10 years ago, and many of these noted that a medical abortion was not an option at the time.

Five people who had medical abortions said they would have preferred a surgical abortion (four of these took medication at/after a face-to-face consultation with a doctor/health professional, while one had medical abortion after telehealth consultation). Several indicated that they had adverse outcomes and/or negative experiences with the process. For example, some noted:

> *Medical abortion left me in the unknown.*
>
> *I would have elected to have a surgery initially as I had constant heavy bleeding for 8 weeks and still required a D&C for retained product. The surgery option would've been quicker and less traumatic and tiring then medication and multiple follow ups. The side effects of medical abortion were not explained in enough detail to me.*
>
> *The downside of Telehealth medical terminations is that once the call is over you are on your own. I ended up going through the process alone and at times it was quite lonely.*

Three of the four people who had negative experiences with medical abortions said that they were not provided enough information about the process and possible effects of medical abortion.

In general, many respondents who would have preferred another type of abortion indicated that information and support to navigate options was sorely lacking, particularly as options become more limited as gestation proceeds, and that this challenge is compounded by delays in accessing appointments. There is a need for health promotion on the types of abortion and how to access them, their risks and benefits, and for abortion providers to adequately communicate these risks and benefits to women and pregnant people.

Communications package commitment in the 2022-23 Budget

WHM welcomes the ACT government Budget 2022-23 commitment to delivering a communications package to improve accessibility of abortion. It is critical that this package goes beyond the development of universal, online information and is instead tailored to and designed with groups of women and people who have different health promotion needs. For example, this may include:

[18] See MSI Australia submission to this Inquiry.

[19] For example, True Relationships and Reproductive Health in Queensland provides face-to-face and online (self-paced) training for interpreters and translators on communicating about reproductive and sexual health.

- Holistic, culturally safe information by and for Aboriginal and Torres Strait Islander women
- Culturally appropriate in-language information by and for migrant and refugee women
- Easy English information, free of medical jargon
- Inclusive information for trans men and nonbinary people
- Trauma-informed approaches to health literacy information, content and communication methods

It is important that navigation and communication is appropriate to the landscape of services in the ACT, in order to avoid 'navigating to nowhere' or to culturally unsafe, inappropriate or inaccessible services. This is particularly relevant to medical abortion, given that there are limited GPs prescribing and pharmacies dispensing medical abortion medication.

Several respondents to our survey mentioned that a number of health facilities run by religious organisations in the ACT do not provide some sexual and reproductive health services on religious grounds. Support for navigation should include transparency about facilities that will refuse to support people's choice to terminate a pregnancy, in order to avoid delay and prevent people having to undergo distressing interactions with service providers.

There will also be value in utilising the communications package to increase knowledge and awareness of abortion pathways among community services and organisations, to provide 'no wrong door' navigation for abortion care. We strongly urge the ACT Government to appropriately resource the communications package to be targeted to and meet the needs of different groups, including GPs, allied health professionals, health workers, community services and organization, and people with uteruses.

Case study – supporting pregnant people to access abortion through Abortion Doula program, Children by Choice:

In 2020, Children by Choice trained a small team of volunteer abortion doulas in partnership with the Australian Doula College. Abortion doulas can provide practical support, including accompanying a pregnant person to and from their appointments, are trained to help a pregnant person monitor the process of medical abortion and know when to seek medical assistance, or provide emotional support by sitting with a pregnant person as they seek care.

Support for health practitioners

Conversely, in the course of our consultation, stakeholders have also described how abortion stigma and fear of harassment (both professionally and from protestors) affects the willingness of GPs to become prescribers and to publicly advertise themselves as providers. Through our consultation, we have heard that health practitioners and workers involved in abortion care, currently experience interpersonal abortion stigma in their personal lives, for example bullying of children at school. Practitioners and workers in all aspects of abortions care (GPs, pharmacists, proceduralists, anesthetists, nurses, managers, radiographers, reception and administrative support staff) need to be appropriately supported, including through psychological support (as vicarious trauma can be experienced in this area of care).

The position of the AMA is that medical practices have an institutional right to conscientious objection provided they make this clear to the public, and which may also discourage some GPs from becoming prescribers.[20] This has dual impacts of creating additional navigational challenges when GPs do not publicly advertise, and availability issues where GPs may not feel supported to become prescribers. Despite the relatively few providers, the ACT does not have a formal network for coordinating abortion service provision. A formal network of health practitioners and services providers would allow for more coordinated and timely services for women and people with uteruses, peer support for GPs or practitioners from experienced colleagues for those who would otherwise be hesitant to become providers, as well as the ability to identify and respond to systemic access issues as they arise.

We recommend:

2. Appropriately resource the communications package committed to in the 2022-23 Budget to be targeted to, and meet the needs of, different groups, including by:
    a. Developing and implementing tailored resources and health promotion which are safe for and appropriate to different groups of women and people with uteruses, including Aboriginal and Torres Strait Islander women, migrant and refugee women, trans men and nonbinary people, and people with disability
    b. Working with the primary health network to ensure that HealthPathways reflects all medical abortion providers in the ACT, and communicates a clear model of care to GPs
    c. Building capacity of all health practitioners and workers (including nurses, midwives, Aboriginal and Torres Strait Islander health workers, pharmacists, radiographers and phlebotomists) involved in abortion access to provide non-stigmatising, trauma-informed, culturally safe and inclusive care
    d. Raising awareness about medical and surgical abortion options and referral pathways among community services and organisations
    e. Promoting awareness of the different types of available abortion care among the general public, and the importance of early identification and presentation
3. Resource an ACT network or community of practice to improve coordination of abortion service provision and provide peer support to GPs and allied health professionals

Affordability of services

Accessing abortion is expensive, and cost constitutes a significant barrier to care for many women and people with uteruses. As noted above, our survey found that of those who had tried but been unable to access an abortion in the ACT/region, a third (33%) reported expenses as a main reason why they were unable to have an abortion. Stakeholders told us how the current economic circumstances and pandemic have created a perfect storm with mortgage stress, cost of living pressure, COVID and increasing domestic and family violence, increasing complexity in women and pregnant people's cases. Women and pregnant people are simultaneously on the brink of becoming homeless and needing to access abortion.

[20] https://www.ama.com.au/position-statement/conscientious-objection-2019, accessed 11 August 2022.

Groups of women and people with uteruses particularly impacted by the cost of abortion include women and people on temporary visas - including international students, young people, women and people experiencing violence - and those on low and middle incomes. Women and people on temporary visas without access to Medicare or pregnancy-related health insurance are particularly disadvantaged. This includes international students, who are subject to a one year waiting period on pregnancy-related health care under the Overseas Student Health Cover (OSHC) arrangements.[21]

Responses to our survey highlight how unaffordability of abortion care is compounded by these kinds of life circumstances:

> *The cost and being a victim of DV made it almost impossible for me to access because I was already in debt from my ex and it was hard to find the money, let alone have the procedure*

Even where people manage to afford the abortion, this is sometimes only achieved by creating financial hardship and insecurity into the future:

> *[It was] financially expensive since I was a full time student at the time, and used up all of my savings.*

Household income or socioeconomic status are not necessarily good indicators of ability to afford abortion care, due to the intersection with abortion stigma, which creates perverse impacts. While at a household level, women and people with uteruses may be financially secure, stigma or coercion from partners or family members may prevent them being able to draw on these resources to access abortion. In the case of migrant and refugee women and people, abortion stigma in their religious and ethnic communities may mean they are unable to draw on local resources and networks to afford abortion care.

Current costs of abortion

MSI Australia is the only non-profit and private abortion clinic in the ACT,[22] and the sole provider of surgical abortion up to 16 weeks. Cost of abortion currently starts at $401.10 for medical abortion at home and $620.00 for surgical abortion for Medicare and Health Care Card holders. Costs can range to up to $1,250.00 for a surgical procedure up to 16 weeks for Medicare Card holders. Without a Medicare card, medical abortion at home costs $795.60 and $1,200.00 for medical abortion in clinic. Before 16 weeks, a surgical abortion can cost between $990.00 and $1,850.00 depending on gestation.

Price includes ultrasound, medication, follow-up appointments and treatment undertaken at MSI Australia's clinic. After 16 weeks, a procedure may cost $2,850.00 in an interstate clinic, or $3,850.00 without Medicare, and which doesn't include travel costs to another state or Territory.[23]

The Australian Choice Fund administered by MSI Australia provides financial assistance for women and people with uteruses in accessing abortion, to either partially or fully subsidise the cost of abortion and/or contraception. Due to high demand, assistance under the fund is limited to women and people

[21] Carolyn Poljski, Regina Quiazon, and Chau Tran, "Ensuring Rights: Improving Access to Sexual and Reproductive Health Services for Female International Students in Australia," *Journal of International Students* 4, no. 2 (April 1, 2014): 150–63, https://doi.org/10.32674/jis.v4i2.475.

[22] Gynaecology Centres Australia is based in Queanbeyan but services women from the ACT.

[23] See https://www.mariestopes.org.au/bookings/find-a-service/ for cost calculations, accessed 8 August 2022.

with uteruses who meet financial hardship assessment requirements and demonstrate intersections of vulnerability.

For women and people with uteruses who access abortion through a GP, under the Pharmaceutical Benefit Scheme, medical abortion medication costs $42.50 for Medicare Card Holders, but the multiple doctors appointments, imaging appointments and blood tests required increase actual costs for women and people with uteruses. Cost of appointments is frequently raised in WHM's research as a barrier for women accessing health care.[24]

In the 2020 Cost of Living in the ACT report, ACTCOSS reported the ACT has among the lowest rates of bulk billing and that cost is a more common barrier to people accessing services in the ACT than in any other metropolitan region of Australia. Recent commentary indicates the proportion of people in the ACT who have all their general practice visits bulk-billed is the lowest in the nation, at 40.6%, in comparison with 67.6% nationally.[25] In this context, it is unsurprising that in 2016-17, 10.8% of people in the ACT aged over 15 years said cost was the reason that they delayed or did not seek care, compared to 7.6% nationally.[26] The impacts of delays are particularly troubling and significant for time-sensitive care such as abortion, in which costs generally increase with delaying of care.

Our survey confirmed that GP consultations are part of the process for many people, with 46% of people who had a medical or surgical abortion in the ACT/region having consulted a GP in order to have an abortion.

Indirect costs

Beyond direct costs, indirect costs of accessing an abortion include leave from employment, child care and travel costs to and from appointments. These costs become increasingly significant when women and people with uteruses need to attend a series of appointments, require follow up, and/or when interstate travel is required. Aside from the ACT Interstate Patient Travel Assistance Scheme - which is not well-known, reimburses in arrears, does not cover meals or taxis, and is unavailable to women and people with uteruses on temporary visas without access to Medicare - at present, little is available to support women and people with uteruses with these costs.

The introduction of reproductive health and well-being leave policies[27] could constitute a step toward alleviating indirect costs. There is an opportunity for the ACT Government, as a major employer, to develop and pilot a reproductive health and well-being policy or model clause to cover ACT employees and set a best practice standard for workplace conditions in the Territory.

WHM is currently developing and piloting a Reproductive Health Policy for staff and can provide this as an example on request.

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[24] See for example, https://www.womenshealthmatters.org.au/wp-content/uploads/2020/10/ACT-Womens-Health-Matters.pdf, accessed 8 August 2022.
[25] https://www.theguardian.com/australia-news/2022/aug/10/not-honest-new-health-minister-dismisses-coalition-election-claim-that-bulk-billing-had-hit-88?CMP=Share_iOSApp_Other&fbclid=IwAR3-v665DVE-JqgYJo9X9XaxQwJ8v2dcTdH37BDPBPNjg-nY-kUosYIP5Xo&mibextid=Irg8HP, accessed 10 August 2022.
[26] https://www.actcoss.org.au/sites/default/files/public/publications/2020-report-ACT-Cost-of-Living-Sep2020.pdf, accessed 8 August 2022, see also https://www.womenshealthmatters.org.au/wp-content/uploads/2020/10/ACT-Womens-Health-Matters.pdf, accessed 8 August 2022.
[27] https://theconversation.com/balancing-work-and-fertility-demands-is-not-easy-but-reproductive-leave-can-help-171497, accessed 8 August 2022.

Universal, free access to medical and surgical abortion

In this context, WHM welcomes the ACT Budget 2022-23 commitment to universal, free access to abortion, and including for women and people with uteruses without access to Medicare. Universal, free access should not determine women and people and uteruses' choice of abortion type, and it is positive to see both medical and surgical abortion will be covered by this commitment. An appropriate model of care for free, universal access should be designed in collaboration with key ACT stakeholders and service providers.

Case study – facilitating free access to care through the Women's Health Fund, Tasmania: A brokerage model such as the Women's Health Fund delivered by Women's Health Tasmania may be one option for delivering universal free access to abortion in the ACT. The Women's Health Fund is delivered with Tasmanian government funds, by Women's Health Tasmania, and operated in partnership with Tasmanian abortion providers.

The fund is provided to women seeking medical abortion, and in exceptional cases, surgical abortion (surgical abortion is provided publicly in Tasmania), on application, with support provided by a referring GP. Exemptions for funding support for surgical abortion is also provided for people without access to Medicare. A strength of the Fund is that because it is administered alongside all-options pregnancy choices counselling, it provides a holistic model of care with initial information, navigation and support for people accessing abortion through a primary care in a system under significant time pressure.

We recommend:

4. Develop policy for and trial reproductive health and wellbeing leave in ACT Government workplaces, as best practice for supporting abortion access in workplaces
5. Design universal, free abortion model of care committed to in 2022-23 Budget in collaboration with existing providers and key stakeholders

Availability of services

Pre-16 weeks

Availability of appointments at any stage of seeking care, and the availability of medical abortion medication in pharmacies, are additional barriers to accessing abortion through both private clinics and general practice. The pressures and loss of workforce capacity resulting from COVID has put additional pressure on clinic capacity and an already strained primary care system.

According to MS Health, there 54 actively certified prescribers in the ACT, which is the lowest number of prescribers to women of childbearing age in Australia.[28] Further (and in spite of there being a total of 54 prescribers) for pregnant people accessing abortion through their GP, there are only 4 GPs listed on HealthPathways as a referral pathway. This means that women and people with uteruses need to be referred on before they are able to access a prescribing GP, delaying access to care (noting medical

[28] There is no data for the Northern Territory and Tasmania. See https://www.mshealth.com.au/wp-content/uploads/06072022-MS-Health-July-2022-Update-1.pdf, accessed 15 August 2022.

abortion is only available up to 9 weeks gestation). Accessing ultrasound can be particularly difficult to limited services and appointments, and often requires advocacy on the part of GPs and women and people with uteruses to access in the necessary timeframes.

From a pharmacy perspectivemedical abortion medication requires training to be registered as a dispenser, has an expiry date and may not be cost-effective for pharmacies to stock if demand is low (particularly for small pharmacies). According to MS Health, there are currently 157 actively certified pharmacists trained to dispense medical abortion medication in the ACT, and which is the highest number of dispensers to women of childbearing age in the country.[29]We have heard through stakeholder consultation that at present, only a small number of pharmacies in the ACT dispense medical abortion medication and may only hold one or two in stock. Even if a pharmacy stocks medical abortion medication, it may not always be available or a pharmacist may have a conscientious objection to dispensing.

Availability of medication is therefore also a barrier to access. Further, it is a failure to provide a supportive, trauma-informed model of care that women and people with uteruses who navigate a series of touchpoints to access medical abortion may be knocked back due to lack of stock or conscientious objection or subjected to stigma at the stage of filling their prescription.

In our survey, the availability of medication was noted as a barrier, but the efforts of individual providers to facilitate access were also appreciated:

> *[I got support from an] awesome pharmacist who took the time to ask other pharmac[ies] for the meds.*

MSI Australia notes that a shortage of trained providers is a significant barrier to accessing abortion care in Australia,[30] and stakeholder feedback confirms it is a major restriction on availability of care in the ACT. Destigmatising abortion and encouraging services across the health pathway to provide abortion-related care will contribute to increasing availability of services.

Nurse-led medical abortion care

In this context, evidence shows that nurse-led abortion care is clinically safe and effective. Nurse-led care is a step toward greater availability and accessibility of abortion care. Implementing nurse-led care would require amending the Health Act so that nurses, midwives and Aboriginal and Torres Strait Islander health workers can lawfully prescribe medical abortion medication. Nurses are also currently restricted from requesting imaging for ultrasound under the Medicare Benefits Scheme, which is an additional barrier to nurse-led medical abortion care, and which could be overcome by employing prescribing nurses in salaried positions in Canberra Health Services.

Post-16 weeks

There are no legal gestational limits on abortion in the ACT, but in clinics it is only available until 16 weeks gestation,[31] after which women and pregnant people are required to travel interstate to obtain

[29] https://www.mshealth.com.au/wp-content/uploads/06072022-MS-Health-July-2022-Update-1.pdf, accessed 15 August 2022.
[30] https://www.mariestopes.org.au/wp-content/uploads/Nurse-led-MToP-in-Australia-legislative-scan.pdf, accessed 5 August 2022.
[31] We have heard through stakeholder consultation that abortion is often only available to 14 weeks gestation.

a surgical abortion.[32] This restriction is a result of a lack of infrastructure within the ACT to deliver surgical abortion after 16 weeks. It constitutes a significant barrier to access care, and creates additional time, travel, accommodation and child care costs for women and people with uteruses. These costs and the practicalities of travelling interstate can be an insurmountable barrier, as described in the case study provided earlier in this submission.

We note that the role of a public provider of last resort is not fully addressed in the ACT, as abortion is provided after 16 weeks in the ACT public hospital system in the case of foetal abnormality or medical emergency, but is not available for all pregnant people.

In general, our survey findings confirm that gestation of pregnancy limits the services people can access in the ACT/region, being reported as a main reason for inability to access an abortion by a third of people who tried but were unable to have one. This supports our recommendations for expanding the availability of different service options in the ACT.

After-care and follow-up

Our survey identified after-care and follow-up as an area of concern for many people who had an abortion in the ACT/region. While most aspects of the care provided were rated fairly highly, this aspect was significantly less highly-rated, with 31% of people reporting poor or very poor experiences. A number commented that better checking-in and follow-up/after-care could have improved their physical recovery and mental health:

> *A follow up appointment would have been beneficial for myself and my mental health*
>
> *I think women have different reason for having a termination and knowing there is a little more support actually makes a difference. A few follow up phones calls or access to a counsellor.*
>
> *No aftercare follow up No warnings of the physical and hormonal side affects of a termination*
>
> *No follow up, minimal post procedure planning. In hindsight given my age at the time (18) and presenting issues I should have received a referral for some community services support, also support for my partner.*
>
> *I called twice given the level of pain and cramping I was experiencing. The first phone call wasn't fantastic. When I followed the up the second time the lady I talked to was amazing and put my concerns at bay as the experience I was experiencing was 'normal however she was clear about when I should access immediate medical attention for x y or z. There didn't appear to be a record of my first follow up call though.*
>
> *I couldn't even afford my follow up appointment and haven't had it still because the only GP I could find who did medical terminations does not bulk bill*
>
> *[T]hey didnt come and see me when I came through, until they came to tell me to leave, and I was just walked out onto the street. No follow up, no comfort, no nothing.*

When we asked people what did not work well with the support they received when having an abortion, the issue most commonly mentioned was the lack of follow-up and checking in on wellbeing,

[32] We note that in the case of medical emergency, abortion is provided after 16 weeks in the public hospital system.

together with experiences of practitioners and systems being cold, impersonal and uncompassionate. While it is important to stress that these experiences are not universal, the fact that a significant proportion of survey respondents recounted them means they are worth addressing.

Alongside measures to provide free access to abortion, there is an important gap to address by resourcing providers to build adequate follow-up and post-procedure support into service provision.

We recommend:

6. Reform law and scope of practice to enable nurse-led medical abortion care, including nurse practitioners, nurses, midwives and Aboriginal and Torres Strait Islander health workers
7. Expand existing clinical infrastructure in the ACT to provide surgical abortion after 16 weeks
8. Resource the abortion service system to provide adequate follow-up and post-procedure support, including mental health support and safety resources for women and people with uteruses who may be experiencing social isolation or escalated violence due to their pregnancy choice

Addressing reproductive coercion and embedding reproductive justice

In the course of our consultation, we heard multiple stories of reproductive coercion in the ACT from community organizations and services providers. According to MSI Australia, reproductive coercion is "behaviour that interferes with the autonomy of a person to make decision about their reproductive health", and can include:

- Sabotage of another person's contraception
- Pressuring another person into pregnancy
- Controlling the outcomes of a woman or person with a uterus's pregnancy. For example, forced continuation of a pregnancy or forced abortion
- Forcing a person into sterilization

Reproductive coercion can be structural, arising from social, political or environmental factors which create an enabling environment for the control of reproductive choice and health, or interpersonal, intentional, controlling behaviours from another person (for example, resulting from domestic and family or sexual violence).

There is very little data on reproductive coercion in Australia, which precludes the development of practice guidelines for health practitioners to respond effectively.[33] Recent research with all options unplanned pregnancy counselling services Children By Choice (QLD) and MSI Australia (national) has indicated that prevalence of interpersonal reproductive coercion among women and people seeking abortion is 15.4%.[34] Women and people with uteruses are equally as likely to be coerced toward

[33] https://www.mariestopes.org.au/wp-content/uploads/Hidden-Forces-Second-Edition-.pdf, accessed 10 August 2022, Nicola Sheeran et al., "Reproductive Coercion and Abuse among Pregnancy Counselling Clients in Australia: Trends and Directions," *Reproductive Health* 19, no. 1 (July 30, 2022): 170, https://doi.org/10.1186/s12978-022-01479-7.
[34] Sheeran et al.

abortion and ending a pregnancy, as they are toward continuing a pregnancy, with a small number of people experiencing both.

Women and people who identified as Aboriginal and Torres Strait Islander were proportionally more likely to experience pregnancy promoting reproductive coercion. More work is needed to understand and to respond to this finding in a culturally safe way.

There is a need to develop an evidence base on reproductive coercion in the ACT and begin to embed responses into policy frameworks.

As stated in our opening comments, WHM calls for a broader framing of abortion as one part of reproductive justice, alongside the right to be a parent, and to parent free from violence. We acknowledge that these rights have been deliberately and actively denied to many people in the ACT as in Australia more generally, and which constitutes reproductive coercion. Aboriginal and Torres Strait Islander people have been subject to forced sterilization and contraception, and child removals at higher rates than the general population, infringing on their right to have children and be parents and constituting reproductive coercion. Responses to reproductive injustice led by and for Aboriginal and/ or Torres Strait Islander communities should be supported and resourced.

Women, girls and people with uteruses with disability in Australia are subject to forced sterilization, forced contraception, reproductive coercion and forced child removal, and which is legal and sanctioned by Australian governments.[35] These practices are often framed as legitimate medical care or consented to by others in their name. Forced and coerced abortions are reported by women and people with uteruses with disability.[36] These practices are a violation of the rights of people with disability.

A potential perverse outcome of this Budget measure is that women and people with uteruses without access to pregnancy-related health care (for example, who are on temporary visas and Medicare ineligible, and/or serving a waiting period for pregnancy-related care under Overseas Student Health Cover)[37] will have a free pathway to abortion in comparison with a complex and costly pathway to continuing their pregnancy. This arrangement is not consistent with reproductive choice and justice. WHM calls on the ACT Government to consider how to subsidise antenatal care for women and people with uteruses without access to pregnancy-related health care in conjunction with providing universal care.

We recommend:

9. Develop a quantitative and qualitative evidence base on reproductive coercion in the ACT, including intersectional experiences of Aboriginal and/ or Torres Strait Islander people and people with disability
10. Embedding response to and prevention of reproductive coercion in the Third Action Plan of the ACT Women's Plan 2016-26 and any future Sexual and Reproductive Health Strategy

[35] See: https://d35ohva3c1yycw.cloudfront.net/wp-content/uploads/2021/11/09123201/WWDACT-Position-Statement-2-Sexual-and-Reproductive-Health-Rights-2.pdf, accessed 9 August 2022, https://wwda.org.au/wp-content/uploads/2020/05/5ea654fbfc3264166cbe2ffe_Position_Statement_4_-_Sexual_and_Reproductive_Rights_FINAL_WEB.pdf, accessed 9 August 2022.

[36] https://wwda.org.au/wp-content/uploads/2020/05/5ea654fbfc3264166cbe2ffe_Position_Statement_4_-_Sexual_and_Reproductive_Rights_FINAL_WEB.pdf, accessed 9 August 2022.

[37] Poljski, Quiazon, and Tran, "Ensuring Rights."

Embed reproductive coercion prevention in age-appropriate, culturally safe prevention programs, including sexual and relationships education

11. Provide training for family, domestic and sexual violence services to respond to reproductive coercion
12. Implement recommendations of the *Our Booris, Our Way* review in full
13. Fund a Royal Commission or Commission of Inquiry into the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system
14. Consider options for subsidising antenatal care for women and people with uteruses without access to Medicare or pregnancy-related health care, to complement access to free abortion care

Harmonisation of ACT legislation with other States/ Territories

Conscientious objection

In ACT legislation, doctors, nurses and pharmacists with a conscientious objection must only inform the woman or pregnant person seeking an abortion on, with no requirement to refer them to a health practitioner or service provider who the referring practitioner believes to not have an objection. Legislation in States/ Territories including Victoria, Queensland and the Northern Territory[38] all include a clause requiring referral and is considered best practice. Amending ACT legislation to include such a clause would further protect abortion access and contribute to harmonizing the ACT with best practice States/ Territories. An amendment would also be an opportunity to improve abortion navigation by increasing knowledge among health practitioners of their obligations and referral options for abortion and is aligned to the Budget commitment to a communications package.

We also note the limited scope of existing conscientious objection legislation, and that accessing abortion involves a wider range of health workers who may also delay access to care due to objection. At any stage of the abortion care pathway, a pregnant person should reasonably expect to be appropriately referred from a health worker with a conscientious objection to a health care professional who can provide the care required.

Data collection

At present, there is no Territory level data collection or publication on abortions provided in the ACT, and as demonstrated in the submission, this makes it difficult to understand the current provision of abortion, as well as the experiences of people with uteruses in accessing care. Without data collection, understanding trends and evidence-based service planning is difficult and may result in lower quality of care or insufficient services. Data is currently collected and published in the Northern Territory, South Australia and Western Australia.[39] WHM supports anonymous data collection and publication on abortions provided in the ACT. There is also an opportunity for investment in data sharing and research on abortion in the ACT, through partnerships with local services and universities, to further

[38] https://www.mariestopes.org.au/advocacy-policy/abortion-law-in-australia/#The_Australian_Capital_Territory_ACT, accessed 9 August 2022.
[39] https://www.mariestopes.org.au/advocacy-policy/abortion-law-in-australia/, accessed 12 August 2022.

develop an evidence base about high quality care. WHM is well-placed to develop and coordinate local partnerships for this purpose.

Exclusion zones

The ACT has legislated exclusion zones of no less than 50m around protected facilities (approved medical facilities or places where surgical abortion is provided, or medical abortion is prescribed, supplied or administered), with the actual distance determined by the discretion of the Minister. To some degree, the effectiveness of ACT exclusion zones is determined by the willingness of the Minister.

It is notable that every State/ Territory aside from the ACT has legislated exclusion zones of 150m. There is evidence to indicate that 150m exclusion zones in Victoria have been effective in protecting women and people with uteruses from harassment and stigma, which has been shown to have negative health impacts.[40] They also protect abortion providers from harassment and stigma.

While most respondents to our survey reported feeling safe around abortion facilities (regardless of how long ago they had an abortion), several reported this as a concern or had experienced harassment from people protesting outside clinics, highlighting the continued importance of measures to eliminate this harassment. For example, one woman who had an abortion 4-10 years ago noted:

> *Having clinics where protesters can't access well, that would help a lot of women feel more at ease I know it would have helped me. Its already an overwhelming situation and when you are emotional due to pregnancy hormones and about to have a procedure done that is scary, having the judgemental people yelling at you outside makes you feel so much worse.*

These findings suggest that there is a need to consider additional measures to eliminate harassment of people accessing abortion. We recommend investigation of the most appropriate mechanism to eliminate harassment, including harmonizing exclusion zone legislation with other States/ Territories by increasing the zone distance to 150m.

We recommend:

15. Amend the Health Act (1993) to require health practitioners to make referrals if they have a conscientious objection to provide abortion
16. Collect and publish data on medical and surgical abortions provided in the ACT, and invest in local partnerships to further develop an evidence base on abortion
17. Consider options for and implement the most appropriate mechanism to eliminate intimidation and harassment against and safety concerns of women and people with uteruses accessing abortion providers, including harmonizing exclusion zone legislation with other States/ Territories by increasing the zone distance to 150m.

[40] Ronli Sifris and Tania Penovic, "Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis," *Monash University Law Review* 44, no. 2 (January 2018): 317–40, https://doi.org/10.3316/informit.605968563104509.

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