LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND COMMUNITY WELLBEING
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Submission Cover Sheet

Inquiry into Abortion and reproductive choice in the ACT

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Abortion and reproductive choice in the ACT

Consultation submission

MSI AUSTRALIA

Acknowledgement

MSI Australia acknowledges the Traditional Owners and Custodians of the land on which we live and work. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present and emerging. We also acknowledge the enduring connection to their Traditional estates across Australia and to the ongoing passion, responsibility and commitment for their lands, waters, seas, flora and fauna as Traditional Owners and Custodians.

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1. Executive Summary

MSI Australia has operated within the ACT for the past two decades, first with a face to face clinic, then expanding to telehealth, and now with a hybrid virtual care model. In this submission we have summarised some key areas of practice knowledge and demographic data, and have provided the following recommendations.

Recommendation 1: Provide universal access to sexual and reproductive healthcare

a) Fund the out of pocket costs that consumers face, to enable free access to medical abortion, surgical abortion and contraceptive methods including LARC, vasectomy and tubal ligation. Ensure access for temporary visa holders.

b) Review and upgrade all facilities that provide surgical abortion care to ensure that all people, including people with diverse health needs, people who need interpreters, people with disability and those who are in prison or institutionalised, can access private, quality and safe abortion care in the ACT.

c) Provide financial support for rituals related to grief and loss, including specific cultural rituals, cremation and other related costs.

d) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, cervical and STI screening, condoms, dental dams and menstrual health products.

Recommendation 2: Strategise for sexual and reproductive health

a) Design and resource a Sexual and Reproductive Health Strategy that can link to the *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)*.

b) Co-design the Sexual and Reproductive Health Strategy with health consumer leaders, community groups, health leaders, GPs, specialists and clinical providers of sexual and reproductive healthcare. Use that process to develop communities of practice on abortion access and care.

c) Continually review clinical guidelines that can renew alongside evolving models of abortion care, and invest in abortion related data collection and academic research partnerships that will increase evidence and understanding of abortion access in the ACT.

d) Enable further abortion law reform to harmonise legislation, deregulate and progress evidence based practice, including nurse led care. Work with other Australian jurisdictions, particularly NSW, in a move towards nationwide and cross-border abortion access and equity.

Recommendation 3: Prevent reproductive coercion and violence

a) Invest in age-appropriate, culturally safe, community centred reproductive coercion prevention activities and programs, including relationships and sexuality education throughout the lifespan.

b) Embed pre-service and in-service healthcare professional training and education on abortion access and care, including identifying and responding to reproductive coercion.

c) Provide training and support for family, domestic and sexual violence services to promote early intervention and response to reproductive coercion.

d) Develop communities of practice on reproductive coercion and fund academic research partnerships to increase evidence and understanding of reproductive coercion in the ACT.

2. Background

The ACT Government's inquiry into abortion and contraceptive choice is timely. In recent years there have been broad social normalisation of reproductive rights, a series of legislative and policy reforms, and a growing evidence base that sexual and reproductive healthcare is evolving.

As an independent, non-profit organisation, MSI Australia (formerly Marie Stopes Australia) is Australia's only national accredited provider of abortion, contraception and vasectomy services, and the country's longest running provider of teleabortion.

For individuals looking to control their sexual and reproductive health and choices safely, we are the fiercely pro-choice, non-judgemental, holistic health provider. Our clinical expertise, supported client journey, and values-led approach combine to deliver safer clinical outcomes and client wellbeing.

The MSI Canberra clinic was established in 2004, following on from another clinical provider that operated in the same space. Since that time, Australian Capital Territory (ACT) Government has been consistently supportive of our presence.

The ACT Government resources high-level facility costs by sponsoring the clinic lease. MSI Australia manages all other operational aspects of service delivery. Our services have outgrown the current service location. Not only are facilities outdated, clinic demand is greater than clinic capacity.

We published a white paper on reproductive coercion in 2018 called 'Hidden Forces: Reproductive Coercion in contexts of domestic violence'.[1] That was reviewed with recommendations updated in a Second Edition published in 2020.

We work alongside MS Health, a non-profit pharmaceutical provider of medical abortion medication that sits within the MSI Reproductive Choices International umbrella. Further information on MS Health is available at www.mshealth.org.au.

Sister services in the region include Winnunga Nimmityjah Aboriginal Health and Community Services (WNAHCS), Sexual Health Family Planning ACT (SHFPACT), Women's Health Matters, and Women With Disabilities ACT. They have a range of reproductive choices services and programs, including relationships and sexuality education, parenting support and advocacy for childcare subsidies. We support their submissions in this inquiry.

3. Response to Terms of Reference

3.1 Accessibility of abortion and reproductive choice for people in the ACT, including abortion medication, and taking into consideration barriers for:

a. ***non-English speakers;***
b. ***victims of domestic and family violence, including coercive control;***
c. ***people with a disability;***
d. ***young people and minors; and***
e. ***other vulnerable demographics;***

Services

At MSI Australia we provide the following services to ACT residents:

- Contraceptive options counselling, including vasectomy counselling
- Pregnancy options counselling, including: abortion, adoption, care, kinship care and parenting
- Various aspects of nurse care including blood tests, ultrasounds and safety planning
- STI tests and cervical screening
- Contraceptive care, including Long Acting Reversible Contraception (LARC)
- Vasectomy care
- Medical abortion care (in clinic)
- Medical abortion care (via telehealth)
- Surgical abortion care up to 14 or 16 weeks pregnancy gestation, depending on clinic capacity and clinician availability
- Surgical abortion care beyond 16 weeks pregnancy gestation, travelling interstate, predominantly to MSI Sydney and Brisbane clinics, or depending on location, support to access other abortion providers in NSW
- Aftercare, including low-sensitivity urine pregnancy tests where relevant
- Australian Choice Fund bursaries, philanthropic bursaries to subsidise part of or all of a contraception or abortion funding gap

Some of these services are face to face, others are online and some are a hybrid depending on the needs of clients and availability of clinical staff.

Medical abortion

Medical abortion is a safe and effective method of terminating a pregnancy up to 9 weeks (63 days) gestation using medication rather than a procedure. Overall, medical abortion is a low risk non-surgical option for early termination with a high success rate, up to 98%.

Medical abortion is a two-stage process. The first stage involves taking a tablet that blocks the hormone necessary for the pregnancy to continue and prepares the uterus for the second stage of the procedure. This is followed 24-48 hours later by a second medication that causes the contents of the uterus to be expelled.

Medical abortion care can be accessed face to face at the MSI Canberra Clinic and a number of local GP prescriber sites. There are currently 54 active prescribers (doctors) and 154 dispensers (pharmacists) across the Territory.[1]

Medical abortion via telehealth is a safe, quality and private method of abortion access.[2] During the course of the COVID-19 pandemic, client preferences in the ACTshifted and are now trending towards medical termination via telehealth.

MSI Australia's national teleabortion service is partially staffed from the MSI Canberra Clinic, servicing thousands of people each year with online bookings, nurse and doctor consults, medication courier system and a 24 hour aftercare phone line.[3] Alongside MSI's teleabortion service, GP providers of medical abortion are increasingly offering telehealth options as part of their everyday services.

Surgical abortion

Surgical abortion is a safe and straightforward day-surgery procedure that is most commonly performed in the first trimester (up to 12–14 weeks' gestation). Termination of pregnancy after 14 weeks gestation, is legal however is less accessible due to clinical complexity and often requires travelling to interstate clinics.

Surgical abortion in the first trimester is a low-risk procedure with a high success rate of greater than 98%. A doctor uses gentle suction to remove the pregnancy from the uterus. The procedure takes between 5–15 minutes and is usually performed under intravenous sedation. Local anaesthetic can be used if preferred and/or when intravenous sedation is not clinically suitable.

Surgical abortion can be accessed at the MSI Canberra Clinic or at the Canberra Hospital in specific circumstances, usually if the pregnancy involves a fetal anomaly. Gynaecological Centres Australia (in Queanbeyan) also offers surgical abortion care.

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[1] MS Health (2022), July Update, Melbourne, Australia: MSI Reproductive Choices at https://www.mshealth.com.au/publications/

[2] Fix, L., Seymour, J. W., Sandhu, M. V., Melville, C., Mazza, D., & Thompson, T. A. (2020). At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations. *BMJ Sexual & Reproductive Health*, *46*(3), 172-176.

[3] MSI Australia (2022), Teleabortion, at https://www.mariestopes.org.au/abortion/home-abortion/

People in the ACT will travel as far as Sydney or Brisbane for surgical abortion care beyond 16 weeks pregnancy gestation.

For people who wish to prevent or delay pregnancy following their abortion, a surgical abortion is an opportune time to have a LARC fitted. For example an IUD can be inserted within the same episode of twilight medication or local anaesthetic. We offer surgical abortion clients free insertion of a LARC providing they cover the device cost. At the MSI Canberra Clinic almost 2 in 3 (60%) people choose to have a LARC inserted following a surgical abortion.

LARC is also available as a standalone service, either at our clinics or from SHFPACT, from most gynaecology specialists, the Canberra Hospital Gynaecological clinic and some GPs.

Demographics of abortion access

In order to provide insight into abortion access, we have analysed a range of client data to look at key demographic information. Given patterns changing during the pandemic, we analysed clinic data and produced average values from January 2018 to June 2022.

The average age of a person accessing abortion in the MSI Canberra Clinic during that time is 29.5 years old. The youngest person in the past five years has been 15 years of age, and the oldest person has been 55 years of age.

Most (95%) of people living in the ACT who contact MSI Australia will access an abortion in the Canberra Clinic. For the 5% who travel interstate, the majority travel to Sydney and a minority travel to Melbourne or Brisbane. Of people who access surgical or medical abortion at the MSI Canberra Clinic:

- At least 2% of people are First Nations people, which is lower than the average of 4% in MSI clinics nationally.
- The majority (92%) of people live in metropolitan areas, with the remaining (8%) living in regional areas.
- Of those who travel from interstate, the majority (97%) travel from NSW.
- Unfortunately, data regarding a range of disability is only available in hardcopy clinic files. They cannot be analysed without further resources.
- One in three (31%) people are born outside of Australia.
- Just over one in ten (13%) people do not have access to Medicare.
- One in twenty (5%) people prefer a language other than English.
- One in fifty (2%) people had an interpreter present for their abortion related consultations, including Auslan.

It is particularly hard to find interpreters in Canberra for abortion and contraceptive care, and near impossible for any minority or emerging language groups.

Clinic access

Sexual and reproductive health service infrastructure is long overdue for an upgrade. MSI Canberra services have outgrown the current clinic location, which means that clinic demand is often greater than clinic capacity. The clinic is not fit for purpose for:

- **Complex abortion and contraceptive care:** the current clinic cannot meet emerging standards or accreditation requirements for either tubal ligation or abortion beyond 16 weeks
- **Care for people with disability:** the current clinic is lacking accessible design features such as appropriate clearances in the hallway and door functionality. It is overdue for an upgrade to improve functionality for a range of disability needs to support disabled clients and clinic staff.
- **Care for people with diverse bodies:** the procedure room requires an upgrade to lighting and to other equipment that would better service people who need a different bed weight capacity or who have specialised manual handling requirements.
- **Care for people who are criminalised or institutionalised:** there is not the space or functionality to enable holistic care for women and pregnant people who are escorted to the clinic under custody. Subsequently personnel, such as prison guards, share space with numerous clients, in addition to the client they are escorting.
- **Care for people with diverse cultural needs:** there is no space in the clinic for prayer or ritual. Some people choose to bury fetal remains, others choose cremation, which rely upon the client having access to funds and resources.

To address these issues, the clinic requires an upgrade including a discreet space for situations where additional client privacy is required, for example, a larger surgery room, upgraded beds and other equipment, all of which are essential for quality and safety in care.

Reproductive coercion

Abortion access is not an indicator of agency. Agency to choose to have abortion or contraception, depends on risk of reproductive coercion.

Reproductive coercion is behaviour that interferes with the autonomy of a person to make decisions about their reproductive health and is a form of violence[4]. It includes:

[4] MSI Australia (2020), Hidden Forces: a white paper on reproductive coercion in contexts of family and domestic violence, at https://www.mariestopes.org.au/advocacy-policy/reproductive-coercion/

- sabotage of another person's contraception
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy
- forcing someone into sterilisation, or preventing them from accessing their choice of vasectomy or tubal ligation; and
- any other behaviour that interferes with the autonomy of a person to make decisions about their sexual and reproductive health.

Reproductive coercion can be experienced by trans and non-binary people, and people of all genders. Women experience intimate partner violence at higher rates than men, including reproductive coercion. Women and pregnant people attempting to access abortion can be at higher risk of violence than the general population.[5]

Reproductive coercion can be particularly complex for First Nations women, migrant and refugee women, women with disability, sex workers and people who are incarcerated. The violence they endure may be more severe and prolonged and they often experience structural and interpersonal barriers to accessing support services.[6]

Recent research using pregnancy choices counselling data demonstrates that in Australia, 15% of people experience reproductive coercion and abuse when considering their pregnancy options.[7]

Reproductive coercion includes preventing someone from accessing their choice of contraception or abortion. A child or an additional child, to an abusive partner creates yet another link with lifelong risk and other implications. Sexual and reproductive healthcare not only prevents the risk of harm; it is a point of early intervention and prevention.
It is often the case that reproductive coercion co-occurs with other forms of interpersonal violence, resulting in women and pregnant people and their children seeking a range of support services. Many of these services including housing, trauma counselling and specialised education are struggling to meet demand.

Reproductive coercion extends to all pregnancy outcomes. For example, adoption requires consent from all parents on the birth certificate. In an abusive relationship, this can result in child safety services involvement or a residency or access dispute. Care in the context of the current pandemic may involve extended periods of out-of-home care. Kinship care has complexities in contexts of isolation, movement

[5] Hall, M., Chappell, L.C., Parnell, B.L., Seed, P.T., & Bewley, S. (2014). Associations between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis. PLoS Medicine, 11 (1), e1001581.
[6] https://www.anrows.org.au/publication/promoting-community-led-responses-to-violence-against-immigrant-and-refugee-women-in-metropolitan-and-regional-australia-the-aspire-project-state-of-knowledge-paper/
[7] Sheeran, N., et al (2022). Reproductive coercion and abuse among pregnancy counselling clients in Australia: trends and directions. *Reproductive health*, *19*(1), 1-10.

restrictions and physical distancing. In contexts of adoption, care and kinship care, additional Legal Aid may be required.

Informed consent and person-centred care are central to our service provision. We use sensitive enquiry to identify points in someone's abortion care journey where we can enquire about harm, including coercion, abuse and violence. The way that questions are phrased, asked and expanded will be responsive to the unique social, cultural and emotional needs of the person in front of us on the day.

Sensitive enquiry enables us to prevent and respond to reproductive coercion in clinical settings. It supports us to tailor personalised care for each unique person. Only when care is holistically seen as physical, mental, cultural, environmental and social can we properly embed sensitive enquiry.

For people who present with experience of coercion and violence, our administrative, counselling, nursing and clinical staff move through stages of identification, risk analysis, support, safety planning, documentation and referral.

Clinic staff have access to a national psychosocial support team that can assist with pathways. Qualified social workers and psychologists with specialist skills in sexual and reproductive health staff this psychosocial support team. All MSI Australia clients have access to this service for counselling support, which operates without any government funding.

Any moves to criminalise reproductive coercion should be mindful of the risk of creating additional barriers for disclosure between a client and their healthcare professional. This includes disruptions to sensitive enquiry and informed consent. Ideally reproductive coercion would be addressed through prevention and early intervention, including relationships and sexuality education throughout the lifespan.

3.2 Affordability of abortion and reproductive choice in the ACT, including:

a. ***access to bulk billing general practitioners;***
b. ***indirect costs such as transport, leave from work, childcare; and***
c. ***options for low-income patients;***

The Choice Fund

As a non-profit healthcare provider, we provide bursaries to clients who are experiencing financial hardship. We do this by combining philanthropic donations together with any surplus from other sexual and reproductive health services where clients have paid the full-fee. Known as the 'Safe Abortion and Contraception Choice Fund', the Choice Fund is for women and pregnant people in Australia who are experiencing financial hardship in addition to other barriers.

Every week we receive 1 to 3 Choice Fund requests for the MSI Canberra Clinic. People's situations are complex. Their pregnancies are planned and unplanned. They are First Nations women and pregnant people, migrants and refugees, many of whom are on temporary visas, they are women with disabilities, they are survivors of violence, they are LGBTIQ+ and experiencing or at risk of homelessness.

They are all people who are experiencing hardship, who:

- meet stringent financial hardship criteria
- can't access abortion at the public hospital
- don't have private health insurance or there is a waiting period on claims
- have approached friends and family for financial support but still have a fee gap
- want a healthcare procedure that increases in price and clinical complexity with every week that passes.

In every one of these cases, it is philanthropists who donate to the Australian Choice Fund who fill the gap.

In the past three years, the Choice Fund has funded in excess of $1 million worth of contraception and abortion services nationally, for women and pregnant people experiencing financial hardship. During the pandemic, the number of regular Choice Fund donors, philanthropists and the size of their donations has dramatically reduced. For the first time in many years, MSI Australia has had to turn away women experiencing financial hardship who cannot afford to access their choice of healthcare.

Abortion service gaps are particularly high for people who hold temporary visas. For example international students are not entitled to Medicare and must have Overseas Student Health Cover (OSHC) for the duration of their stay in Australia. OSHC does not cover pregnancy-related conditions in the first 12 months of arrival in Australia unless the pregnancy is linked to an emergency situation. This means that if an international student, or the partner of an international student, experiences an unplanned pregnancy within the first 12 months of arrival in Australia, they may be faced with limited reproductive choices while simultaneously experiencing financial and resettlement difficulties. There are also cultural considerations that preclude some groups from seeking emotional support from family. In turn this can lead to poorer health outcomes due to ongoing isolation and disengagement.

Abortion cost

In Australia the cost of abortion can be free, or ranging up to $8,000 depending on funding structures. Every abortion provider has different prices, and some outsource parts of the service. MSI Australia delivers a holistic service and as many costs as possible are included in the one fee, including ultrasound (if relevant), counselling

sessions, nurse consultation, doctor consultation, anaesthetist (if relevant), and 24 hour aftercare following. Prices at the MSI Canberra Clinic are publicly available at the online 'cost estimate checker'.[8]

Abortion cost varies greatly depending on personal situation:

- Pregnancy gestation: care changes significantly by pregnancy gestation, increasing in complexity as the pregnancy progresses. For example some abortions can be at home, while others need to be in a day hospital. Some abortions can be without any anaesthetic, while others need to be under twilight medication.
- Abortion care method: In Canberra, there are two methods of abortion, medical abortion with tablets, and surgical abortion using electrical or manual vacuum aspiration. Some people have a choice between methods, others do not because of factors that relate to disability, chronic health issues or other personal health circumstances.
- Mental health needs: some people want pregnancy options counselling prior to making a decision about or continuing one of their five pregnancy options - abortion, adoption, care, kinship care and parenting. They may also need general counselling support, particularly for those seeking abortion care they can feel disenfranchised about the lack of community respect or support for their choice.
- Any complex health needs: for example if the person has a disability or a chronic illness, or if their body is a particular weight, they may need a different form of anaesthetic, procedure or recovery set up.

Abortion provision can be diverse, just like people's bodies and lives. There is no standard cost for surgical abortion, because how, why and where abortion is provided will change depending on the client's personal needs and situation.

Indirect costs that contribute to abortion inequity

Indirect costs that we see abortion clients in the ACT experience include:

- identifying a support person, which in the case of abortion requires disclosing a very personal choice and responding to any reactions or judgement
- taking time off work, for the person seeking care and their support person
- finding child care for existing children in order to travel, attend counselling and clinic appointments, and have appropriate rest in the recovery period
- sourcing carer support to assist with other carer roles including people with disability and elders

[8] Visit: https://www.mariestopes.org.au/bookings/find-a-service/

- travel regionally or interstate, long drives or flights, with a support person
- if someone cannot stay at home following the procedure, for example they need to travel, or are at risk of violence, they may need to source a hotel or stay with a family or friend during the recovery period
- costs of other related health needs such as contraceptive devices or products, menstrual pads, wheat hot packs, plastic sheets, paracetamol and various other pain relief needs
- psychosocial costs of a potentially challenging life choice, or the circumstances around the clinical health provision such as cost of living, housing or work instability, risk of violence and reproductive coercion
- impact on the health and wellbeing of children and partners when a parent/spouse is experiencing traumatic loss, has trouble coping, financial stress
- during the COVID-19 pandemic, there have been additional psychosocial costs linked to lockdowns particularly when people needed permits to travel interstate and were required to quarantine/ receive healthcare in isolation.
- cultural or religious practices; during their time in the health system and beyond, when accessing abortion a person may also need to participate in grief and loss rituals, including ceremony and cremation
- potential implications for long term employment, visas status, educational rankings and other lifelong considerations

The common thread of all of these points is abortion stigma. It is why people do not often disclose their experience with their employers, education institutions, families or broader communities. The presence of abortion stigma can lead to hesitation in seeking a support person, asking for help, booking a counselling appointment or asking for time off work – delaying access to care while the abortion service required increases in cost and clinical complexity.

3.3 Legal protections for abortion rights in the ACT; including:

a. comparison with other Australian jurisdictions;

b. interactions with non-ACT legislative instruments (e.g.: with Commonwealth law);

c. potential implications for IVF providers; and

d. effectiveness of exclusion zones around abortion facilities;

Policy context

The United Nations Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women (CEDAW) have enshrined sexual and reproductive care within women's right to health. [9] As a signatory to CEDAW, the Australian Government is therefore obliged to respect, protect and fulfil sexual and reproductive health and rights.

Australia has a patchwork of health laws and health policies across federal, state, territory and local governments. Observations on Australia's periodic CEDAW report recommends that Australia harmonise abortion-related legislation across jurisdictions to increase health access and equity.[10] Until abortion law is harmonised, women and pregnant people will continue to travel between jurisdictions in order to access healthcare and Australia's human rights record in abortion care will remain opaque.

The National Women's Health Strategy commits to equitable access to pregnancy termination services and strives for universal access by 2030. Alongside the National Preventative Health Strategy, we have a sound national policy model to support further policy development and implementation in the ACT.

Legislative context

Key areas

Health Act 1993, Division 6.1

Who is authorised to access abortions?

Abortion access is legal at any pregnancy gestation.

Who is authorised to provide abortions?

It is legal for one doctor \to provide abortion care.

Who is authorised to assist in providing abortions?

It is a crime if a person besides a doctor supplies or administers an abortion drug to another person; and the abortion drug is supplied or administered by the person for the purpose of ending a pregnancy. A pharmacist or person assisting a pharmacist can dispense or deliver medication in accordance with a prescription.

It is also a crime if a person besides a doctor carries out a surgical abortion.

[9] Office of the United Nations High Commissioner (2020), Sexual and Reproductive Health and Rights, viewed on 27 July 2020 at <https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.asp>
[10] Committee on the Elimination of Discrimination against Women (2018), CEDAW/C/AUS/CO/8: Concluding observations on the 8th periodic report of Australia viewed on 27 July 2020 at < https://digitallibrary.un.org/record/1641944?ln=en>.

Safe Access Zones

There are 50 metre safe access zones set around the protected facility (an approved medical facility or place where an abortion medication is prescribed, supplied or administered).

If/when surgical abortion facilities need approval

The ACT Health Minister must approve any facility where surgical abortions are provided.

The ACT Health Minister declares protected areas around approved medical facilities which prohibits photography, video etc.

Conscientious objection

Health practitioners with a conscientious objection are legally required to inform the person requesting an abortion.

Counselling referrals

Counselling referrals for pregnancy and abortion related issues are available, however they are not mandatory nor legislated.

Data Mapping

There is no territory level data collection or publication on abortions provided in the ACT.

Legislative background

In 2019 the ACT Government commenced the *Health (Improving Abortion Access) Amendment Act 2018*, which expanded abortion access in the ACT. Until then, abortions could only be provided at an approved medical facility. The changes meant additional models of abortion care were available to Canberrans, including medical abortion via telehealth and prescription via general practice. At that time MSI Australia supported MS Health in the delivery of face to face training for medical abortion providers in the ACT.

The original *Health (Improving Abortion Access) Amendment Bill 2018* had initially proposed the scope of medical abortion prescribing be expanded to GPs and nurse practitioners. This was retracted through an amendment that removed nurse practitioners. Following law reform in 2019, MS Health has had numerous requests from Nurse Practitioners in the ACT interested in becoming prescribers, however this requires further legislative and regulatory reform.

In early 2022 MSI Australia published the second edition of a paper which conducted a legislative scan of nurse-led abortion care in Australia, which contains further detail

on the shift towards nurse led care.[11] The ACT Parliament would need to change the Health Act to enable nurse led prescribing. MS Health would need to amend the risk management plan for medical abortion medication, with approval from the Therapeutics Goods Administrator (TGA). Nurse practitioner, nursing and midwifery colleges and professional bodies would need to be involved in expanding pre-service and in-service training, clinical guidance, governance and regulation.

Comparison with other Australian Jurisdictions

In 2022 MSI Australia released an Abortion Access Scorecard which outlined and simplified legislative barriers across jurisdictions.[12] Each legislative area of abortion is ranked according to most accessible legislative framework (green tick), somewhat accessible legislative framework (orange tick) or least accessible legislative framework (red cross). Green points to no remaining legislative barriers.

Importantly, legislative barriers are only one piece of the abortion access puzzle – alongside regulations, resourcing, health literacy and community empowerment.

[11] MSI Australia (2022), Nurse Led Medical Termination of Pregnancy In Australia, available at https://www.mariestopes.org.au/advocacy-policy/nurse-led-care/
[12] MSI Australia (2022), Abortion Access Scorecard, available at https://www.mariestopes.org.au/advocacy-policy/abortion-access-scorecard-australia/

When abortion was criminalised, a high level of regulation was understandable. Now that abortion is recognised as healthcare, governance of abortion care must be led by clinicians rather than politicians.

All areas of healthcare, including abortion care, changes rapidly alongside new and emerging evidence, health system structures, and workforce capacity development. For these reasons, it is clinical guidelines and standards that must provide guidance for abortion care, rather than legislation. Clinical guidelines are led by relevant colleges, informed by current evidence, and considered at length by clinical leaders and other health sector experts. Likewise clinical standards are set by healthcare agencies, such as the Australian Commission on Safety and Quality in Care.

Abortion care can be provided with a red, or red and orange scorecard. However, complexities and contradictions across jurisdictions create significant administrative and clinical care obstacles for our clinics and for people who are required to physically travel between them. Ideally, as a long term goal, there would be harmonisation of law across Australia to enable consistent provision of this essential healthcare.

The ACT fares better than others, particularly in regard to the omission of gestational limits for abortion care.[13]

Area of abortion law	**ACT**	**Ideal situation to enable abortion access, equity and agency**
Abortion provided by one doctor	✓	In the ACT it is up to person seeking abortion in partnership with their clinical provider.
Doctors can provide abortions without risk of criminalisation	✓	Doctors can provide abortion care, within clinical standards and guidelines, overseen by colleges and regulating bodies.
Nurses, Midwives and Aboriginal and Torres Strait Islander workers can provide medical abortions without risk of criminalisation	✗	All references to abortion be removed from criminal codes. This includes someone being coerced towards an abortion. Reproductive coercion instead needs to be addressed through prevention mechanisms such as: - relationships and sexuality education throughout the lifespan, - parenting programs and support,
Support people can assist someone to access abortion without risk of criminalisation	✗	

[13] MSI Australia (2022), Abortion Law in Australia, ACT section at https://www.mariestopes.org.au/advocacy-policy/abortion-law-in-australia/

		- community based prevention programs to end gender-based violence, - data collection, research investment and the building evidence base, - monitoring and review of clinical standards to be evidence informed, and - clinical governance to prevent and mitigate risk of adverse events.
Safe Access Zones are legislated	✓	Safe access zones are legislated at 50 metres. Ideally safe access zones would be at least 150 metres around clinics in the ACT.
Counselling referrals are optional and not mandated	✓	Pregnancy options counselling should be funded and provided as part of clinical care. As with other healthcare services, psychosocial care should be considered as integral to long term health outcomes for all individuals. Women and pregnant people should be able to choose to speak with a counsellor to discuss all options (abortion, adoption, care, kinship care and parenting), at any point in their pregnancy.
Abortion access free from judgement and justification	✓	Abortion access should be free from judgement, including the need to provide justification for a very personal choice.
Abortion evidence base is supported with data collection and publication	✗	We need a national evidence base on abortion, supported by resourcing to enable data collection, analysis and publication. National data on abortion access, which does not require any publication of client names, address, or any other identifying factors.
Conscientious objection is legislated with a referral	✗	Where someone does contentiously object, we suggest mandating a referral to an actual abortion provider who can and will provide the service. Enacting this

	concept in practice means that abortion care needs to be funded, so that a doctor has at least one service to refer onto.

Safe access to abortion care

The *Health (Patient Privacy) Amendment Act 2015* (ACT) amended the *Health Act 1993* (ACT) by inserting division 6.2 'Patient privacy in protected areas'. This amendment gave the Minister power to establish 'protected areas' around medical facilities. The Minister must declare a protected area around approved medical facilities; however, the Minister may declare a protected area around where an abortifacient (a drug causing abortion) is prescribed, supplied or administered.

The ACT legislation differs from other safe access zone legislation in Australia because it does not stipulate an automatic zone around clinics or medical facilities.[14] The Minister must declare a 'protected area' (the equivalent of a safe access zone) and specify the size of the protected area. The protected area may include area 50 metres from the premises, while other jurisdictions stipulate that the protected area or zone must include area within 150 metres of the premises. With a supportive Minister, in practice safe access zones may simply be similar to other jurisdictions.

The Act also makes it an offence to engage in prohibited behaviour in the protected area and an offence to publish captured visual data of a person in a protected area with the intention of stopping a person from having an abortion or providing abortion services. The ACT legislation differs from other similar cases in that it requires a person to act with the intention to stop a person from entering or leaving an abortion clinic or receiving abortion services.

Legislation	***Health Act 1993* (ACT) Part 6 Div 6.2 ss 85-87**
Creation	Ministerial declaration
Size	>50m
Measured from	'The approved medical facility'
Hours of effect	7am-6pm on days of operation
Prohibited Behaviours	Harassment, hindering, intimidation, interference with, threatening, obstruction, capturing visual data, or any act that can be seen or heard by a person, designed to stop a person from entering the facility or having or providing an abortion. Protest relating to abortion.

[14] MSI Australia (2020), Safe Access Zones in Australia, at https://www.mariestopes.org.au/advocacy-policy/safe-access-zones/

This legislation has protected safe abortion access for our staff and clients. Prior to the legislative change, anti-choice picketers did on occasion harass and intimidate clinic staff or their clients. Clinic staff would walk in pairs to and from their cars.

The front area of the MSI Canberra Clinic was built to enable high security against picketers, but this is no longer required. Since law reform, access has been safe and seamless. Future clinic upgrades will be able to change the way the front doors work to reduce security measures, which will not only make it easier for administrative staff but will help to reduce perceptions of abortion stigma that high security can create.

3.4 Access to information to support a variety of possible reproductive choices, including choosing to give birth

Reproductive choices are much more complex than having an abortion or 'choosing to give birth'. Many pregnancies may have all five pregnancy options: abortion, adoption, care, kinship care or parenting. Other pregnancies have fewer options, which depend on the woman or pregnant persons, health, relationships and personal circumstances. Some pregnancies will end with miscarriage.

Pregnancy options counselling is a model of non-directive decision-making counselling. This model supports women and pregnant people as they make a decision about their pregnancy. It's a conversation where all pregnancy outcomes are discussed including abortion, adoption, care, kinship care or parenting.

The counsellor supports and listens to concerns without encouraging one option over another. While some people choose to seek advice from their partner, friends or family, others might feel that they can't do so for a variety of reasons. These could include conflict over the decision, fear of abuse and violence, a lack of friends and family close by, or fear of being judged or shamed.

Anecdotally, counsellors who provide support for MSI Canberra clients speak to the need for increased general counselling services in the ACT. Counsellors hear about other aspects of people's lives for which mental health care and wellbeing support is urgently needed.

They described the perception of clients in Canberra that there is a lack of community respect for their choice. This also points to the need to promote reproductive autonomy and address abortion stigma across populations.
At MSI Canberra we also offer contraceptive choices counselling, which may be part of abortion care or part of a separate contraceptive service provision. This is a particularly important service for people considering tubal ligation or vasectomy, given they are making a permanent choice.

SHFPACT has historically provided pregnancy options counselling services throughout the region, and other organisations provide various aspects of community support such as Women With Disabilities ACT, Winnunga Nimmityjah and Women's Health Matters. Rather than speak to their models of care, we support their submissions to this inquiry.

3.5 Any other related matters.

We would welcome an invitation to speak at a hearing, or any further information that may be required to support reproductive health reforms.

4. Recommendations

Legislative reforms in recent years have recognised the importance of healthcare access, bodily autonomy, and diversity within relationships and families. It is now time for the ACT to invest in abortion access. We suggest the following:

Recommendation 1: Provide universal access to sexual and reproductive healthcare

a) Fund the out of pocket costs that consumers face, to enable free access to medical abortion, surgical abortion and contraceptive methods including LARC, vasectomy and tubal ligation. Ensure access for temporary visa holders.

b) Review and upgrade all facilities that provide surgical abortion care to ensure that all people, including people with diverse health needs, people who need interpreters, people with disability and those who are in prison or institutionalised, can access private, quality and safe abortion care. Consider how this can align with opportunities for strategic infrastructure expansion to improve sexual and reproductive health outcomes for all.

c) Provide financial support for rituals related to grief and loss, including specific cultural rituals, cremation and other related costs.

d) Boost public health initiatives that will reduce abortion related costs, such as discreet and free public access to pregnancy tests, cervical and STI screening, condoms, dental dams and menstrual health products.

Recommendation 2: Strategise for sexual and reproductive health

a) Design and resource a Sexual and Reproductive Health Strategy that can link to the *National Women's Health Strategy (2020-2030)* and the *National Men's Health Strategy (2020-2030)*.

b) Co-design the Sexual and Reproductive Health Strategy with health consumer leaders, community groups, health leaders, GPs, specialists and clinical providers of sexual and reproductive healthcare. Use that process to develop communities of practice on abortion access and care.

c) Continually review clinical guidelines that can renew alongside evolving models of abortion care, and invest in abortion related data collection and academic research partnerships that will increase evidence and understanding of abortion access in the ACT.

d) Enable further abortion law reform to harmonise legislation, deregulate and progress evidence based practice, including nurse led care. Work with other Australian jurisdictions, particularly NSW, in a move towards nationwide and cross-border abortion access and equity.

Recommendation 3: Prevent reproductive coercion and violence

a) Invest in age-appropriate, culturally safe, community centred reproductive coercion prevention activities and programs, including relationships and sexuality education throughout the lifespan.

b) Embed pre-service and in-service healthcare professional training and education on abortion access and care, including identifying and responding to reproductive coercion.

c) Provide training and support for family, domestic and sexual violence services to promote early intervention and response to reproductive coercion.

d) Develop communities of practice on reproductive coercion and fund academic research partnerships to increase evidence and understanding of reproductive coercion in the ACT.

When left untreated, sexual and reproductive health concerns can have chronic physical, mental, and social health impacts.[2] ACT Government investment in sexual and reproductive health will have immediate and intergenerational benefits.

We look forward to working with the ACT Government and other key stakeholders to reshape sexual and reproductive health access to enable bodily autonomy for all.

Further information and feedback

If you would like to know more about the work that we do at MSI Australia (formerly Marie Stopes Australia), you can follow us on social media or get in touch via the following channels.

Twitter: @MSI_Australia

Facebook: @AustraliaMSI

Instagram: MSIAustralia_

Website: msiaustralia.org.au

You can also support access to sexual and reproductive healthcare by making a tax deductible donation @ https://www.msiaustralia.org.au/donate/