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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Standing Committee on Health & Community Wellbeing

Inquiry into abortion and reproductive choice in the ACT

22 August 2022

Acknowledgement

SHFPACT acknowledges the Ngunnawal people, the traditional custodians of country in the region our organisation operates, and the neighbouring Gundagurra, Wiradjuri, Ngarigo, and Yuin nations in the Canberra/Capital region. We pay our respects to elders past, present and emerging, and acknowledge the continuing and enduring connection to the lands, waters, flora and fauna. SHFPACT acknowledges that sovereignty was never ceded.

About SHFPACT

Sexual Health and Family Planning ACT (SHFPACT) is a non-government, not-for-profit organisation and ATO-endorsed Health Promotion Charity working in the Canberra community for 50 years. SHFPACT's purpose is improved sexual and reproductive health for the Canberra community, within a human rights and social justice framework. SHFPACT is a member of Family Planning Alliance Australia (FPAA), and through FPAA affiliated with the International Planned Parenthood Federation (IPPF).

SHFPACT currently provides a suite of clinical services, professional development training programs for the health, education & community services workforces, community education and health promotion, and information services in the areas of reproductive and sexual health.

SHFPACT acknowledges the long-term funding agreements for services it has held with ACT Government Health and Education directorates. SHFPACT also derives revenue from other grant/funding sources, fee-for-service and social enterprise activities.

Sexual Health and Family Planning ACT (SHFPACT) is a leader in sexual and reproductive health workforce development, health promotion and clinical service delivery to reduce barriers to improved sexual and reproductive health. Sexual Health and Family Planning ACT identifies priority populations facing barriers to achieving improved sexual and reproductive health as:

- Young people
- Financially disadvantaged people
- Culturally and linguistically diverse people
- People with disabilities
- Aboriginal and Torres Strait Islanders, and
- Gay, lesbian, bisexual, and queer identifying people, and sex- and gender-diverse people

For many decades, SHFPACT has been at the forefront promoting the sexual and reproductive health, rights, and wellbeing of people in the Australian Capital Territory and region. The organisation has been proud to promote a rights-based and evidence-informed approach to respect for diversity in sexuality, sexual orientation, gender identity and expression through its programs, activities, and advocacy. The organisation contributes directly through its programs and in partnership activities with other community organisations and government agencies to improving understanding of diversity in our community, and promoting the safety, inclusion, health and wellbeing of minority sexuality and gender identities.

Between 1993 and 2004, SHFPACT operated Reproductive Healthcare Services Ltd, a subsidiary company that provided surgical abortion services. This service was transitioned to the current provider MSI Australia in 2004. SHFPACT is not currently a provider of abortion health care, either through surgical termination of pregnancy or medication termination of pregnancy.

SHFPACT currently provides a non-directive, all-options referring, unplanned pregnancy counselling service funded by ACT Health, and provides information/referral services to pregnant people and healthcare workers in the Canberra community about all pregnancy options including birthing and parenting, adoption, kinship care, and abortion.

SHFPACT also maintains a referral list for GP providers of medication termination of pregnancy.

Further information about SHFPACT's services and programs can be found at www.shfpact.org.au.

SHFPACT welcomes the opportunity to provide a response to the ACT Legislative Assembly's Standing Committee on Health and Community Wellbeing inquiry into abortion and reproductive choice in the ACT.

SHFPACT has a longstanding commitment to advocacy and service for sexual and reproductive health and rights in our community and supporting access to all reproductive choices for pregnant people.

We are proud to have cooperated and collaborated over many years with key community organisation partners, health service providers including therapists, general practitioners and specialists in the women's, sexual and reproductive health sphere, and a wide range of civil society actors and organisations across the education, health and community services sectors.

We particularly acknowledge and support the submissions and recommendations from Women's Health Matters, MSI Australia, and Deep End GP Network to this enquiry. We value the diversity in perspective that these submissions reflect, and especially the depth of experience and knowledge of healthcare providers currently providing abortion services.

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Summary and recommendations

1. Access to safe, legal, affordable abortion is an essential part of the continuum of reproductive health care. All pregnant people have the right to the highest attainable standard of reproductive healthcare and information their community is capable of providing and which they can access without impediment, stigma, or discrimination.

2. The Australian Capital Territory has been a leading Australian jurisdiction in law reform for abortion access over the least twenty years.

3. Sexual and reproductive health needs, including access to abortion options, are not supported by a strong integrated policy and health needs planning framework in the ACT.
    a. The ACT needs a sexual and reproductive health strategy – linked to national men's and women's health strategies – and co-designed with health consumers, community groups, and specialist, primary care and NGO delivered sexual and reproductive health care providers.
        - *This need for a specific policy and funding focus is becoming urgent, as health service commissioning in the NGO sector by ACT Health is narrowing scope away from currently supported reproductive and sexual health services, including currently funded unplanned pregnancy counselling service. No alternative policy or funding responsibility for NGO sexual and reproductive healthcare services currently funded by ACT Health but not related specifically to STI/BBVs has been identified.*
    b. Improving abortion access must occur alongside investment to reduce unplanned/unintended pregnancy through improved access to more effective forms of contraception, increased community awareness education to reduce stigma and increase understanding of unplanned pregnancy, and continued and expanded support for unbiased, non-directive unplanned pregnancy counselling.

4. The recent ACT Budget 2022 announcement to fund access to abortion for ACT residents is a very welcome commitment to address financial barriers for many people for abortion procedures. There remain additional barriers that affect pregnant people's ability to access abortion care when needed.
    a. The interaction of financial barriers and abortion-stigma produces unique barriers for pregnant people that are not always anticipated when financial means alone are considered.
    b. There is effectively no access to abortion care after 14-16 weeks gestation in the ACT and capital region, except for foetal abnormality or risk to maternal health during high-risk pregnancy through Canberra Hospital Foetal Medicine Unit. This imposes significant additional cost and other burdens to pregnant people requiring abortion care after this time and who do not meet the referral criteria at Canberra Hospital.

5. Conceptually, health care access includes **physical accessibility** (inclusive of: access for people with mobility restriction; reasonable geographical/regional proximity; and, accessible opening hours and waiting periods), **economic accessibility and affordability**, and **information accessibility**. Health care system design should strive for **equality** (all citizens enjoy the same access to care), **equity** (services are responsive and accessible to the needs of relative need and disadvantage within a community), and **dignity** (personal autonomy and positive regard are enhanced by health services access, not diminished by engagement or attempts to access care).
    a. There is still more legal reform, health services policy development, and workforce training needed to ensure conscientious objection to abortion does not impede access to reproductive and sexual health care, including abortion.
    b. Ongoing workforce development initiatives are a parallel investment in future accessibility of abortion services, and GP education is important to ensure that increased in medical abortion in primary care settings are supported by accurate information and advice about symptoms and follow up, to minimise misinformation about complication rates, and ensure timely and appropriate referral for additional care when appropriate.
    c. ACT Government infrastructure and health services planning processes need to attend to the range of facilities and providers needed to serve the health needs of the Canberra community, not just the current scope of publicly-provided health care. Abortion access in the ACT after 16 weeks gestation is inhibited by availability of appropriate clinical facilities.

6. Continuing health consumer and other key stakeholder consultation is needed to identify, understand and address the range of timely information and referral needs of our diverse community for reproductive and sexual health care, including abortion options. Language and information accessibility and cultural safety are critical elements of healthcare access.

    We particularly note the extraordinary work conducted by Women's Health Matters in this arena to provide robust local sociological research to inform public policy and health system design, and the efforts of Women with Disabilities ACT to advocate for the needs of people with disability who are often subject to extreme levels of marginalisation, discrimination and violence in relation to reproductive and sexual health and wellbeing.

7. Continuing access to reproductive health services is significantly affected by an available, trained, and supported workforce. Future workforce capacity and capability may be the greatest single risk to abortion access in the Australian healthcare system.
    a. Abortion stigma continues to impact primary care provision of medication termination of pregnancy, and the willingness of abortion care providers to advertise their service to their patients/community.
    b. Abortion care remains marginalised, optional content in most health professional qualifying programs relevant to reproductive and sexual health care provision. This affects the availability of surgical termination of pregnancy.
    c. The role of nurses, including both Nurse Practitioners and advance practice Registered Nurses, in provision of reproductive and sexual health care including abortion, is poorly structured in the Australian healthcare system. Workforce development and resourcing strategies need to operate consistently and in conjunction to improve cost-effective service delivery and affordable access to healthcare for the community.

Access to safe, legal, affordable abortion is an essential part of the continuum of reproductive health care.

When pregnancy occurs, all pregnant people have the right to the highest attainable standard of reproductive healthcare and information their community is capable of providing and which they can access without impediment, stigma, or discrimination. This includes early pregnancy care for a continuing pregnancy, access to information about birthing, parenting support and/or adoption options, and legal, safe, affordable abortion.

Unplanned pregnancies may not be unwanted, and when critical circumstances change, sometimes planned pregnancies can become unwanted. All pregnancy options must be available to account for the diversity of needs, especially those that arise from the dynamic interaction of health status, financial means, abortion-stigma, and reproductive coercion.

Unplanned pregnancy occurs for many reasons. It is estimated that half of all pregnancies in Australia are unplanned, and that half of these will end in abortion. While efforts to improve community awareness of and access to effective contraception options that reduce unplanned pregnancy rates remain a key focus and goal of sexual and reproductive health promotion.

National peak body for the network of family planning organisations working in every Australian State/Territory in the reproductive and sexual health field states:

- *Abortion must be legal, safe and accessible to all women[1] in Australia.*
- *Better access to abortion services will reduce maternal mortality and morbidity because of unsafe and illegal abortion.*
- *Women must have access to accurate, unbiased information needed to exercise self-determination, enable informed decision making and management of their health.*
- *Abortion provision needs to be a visible and required component of health professional undergraduate education.*
- *A National database needs to be established to provide evidence and inform policy directions.*
- *Where a health practitioner conscientiously objects to abortion, they must refer the client to another health professional or doctor who does not conscientiously object so that the woman's needs are met.*

Family Planning Alliance Australia, Position Statement on Abortion Access[2]

The national registration and professional body for gynaecology and obstetrics in Australia and New Zealand states:

"Access to termination of pregnancy should be on the basis of health care need and should not be limited by age, socioeconomic disadvantage, or geographic isolation."

RANZCOG Statement on Termination of Pregnancy (2016)

[1] SHFPACT:
- acknowledges that not all women and girls have reproductive systems for pregnancy;
- affirms the specific rights and needs of all gender diverse, transgender, nonbinary and intersex people in accessing healthcare, including care related to pregnancy and abortion;
- recognises the burden of reproductive and other health impacts related to pregnancy and abortion falls heavily on people with female reproductive systems who identify as women and girls;
- The use of any gendered language throughout this document reflects these understandings as a whole.

[2] https://www.familyplanningallianceaustralia.org.au/wp-content/uploads/2018/11/FPAA-Abortion-Position-Statement-August-2018-FINAL.pdf

Definition of abortion

Abortion is the termination of an established pregnancy. An abortion may be induced or spontaneous (also called miscarriage). An induced abortion may be via medication (M-TOP), a surgical procedure (S-TOP), or an induction of labour at a later gestation.

A rights-based approach to healthcare access

The World Health Organization (WHO) Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being."

Understanding health as a human right creates a legal obligation on states parties to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.

A States' obligation to support the right to health – including through the allocation of "maximum available resources" to progressively realise this goal - is reviewed through various international human rights mechanisms, such as the Universal Periodic Review, or the Committee on Economic, Social and Cultural Rights. In many cases, the right to health has been adopted into domestic law or Constitutional law.

A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage.[3]

The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality require states to take steps to redress any discriminatory law, practice or policy.

Conceptually, access to healthcare is understood by the World Health Organization to include **physical accessibility** (inclusive of: access for people with mobility restriction; reasonable geographical/regional proximity; and, accessible opening hours and waiting periods), **economic accessibility and affordability**, and **information accessibility**.

Reproductive health needs, especially abortion, can be highly stigmatised, leading to prejudice and discrimination that undermine equality, equity, and dignity in health care access.

There can be multiple barriers to access to safe, legal and affordable abortion. These include:

- legal barriers;
- the availability of services in local area and the gestational limits imposed by laws and/or practitioners for those services;
- the availability of a local workforce trained and willing to provide abortion services needed in the local community;
- stigma about abortion as a reproductive health option;
    - *We note that the ACT has not yet legislated a requirement that healthcare providers who conscientiously object to abortion must refer to another healthcare provider that does not object.*

[3] http://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

- difficulty accessing accurate and timely information about available services;
- transport;
- employment (obtaining time off work, and services being available outside standard business hours);
- reproductive coercion and control by others (e.g., partner, partner in pregnancy, parents, alternative decision-makers/guardians for people with disabilities) and harassment of people accessing abortion services;
- disability,
- disadvantage; and significantly,
- financial barriers, which can compound and exacerbate all other barriers.

The Australian Capital Territory is among the leading jurisdictions in Australia in terms of legislation and in protections to access abortion services. Other barriers remain a complex and challenging set of obstacles to equitable and accessible healthcare for the Canberra community.

Health service workforce availability, including continuing limitations on the role nurses can effectively play in the Australian healthcare system, remains a primary barrier to abortion access in Australia and in the ACT.

The recent announcement by ACT Government that it will fund access to abortion up to 16 weeks' gestation to ACT residents from mid-2023 is a very welcome and long overdue complement to leading legislative support in addressing financial barriers to abortion care.

The budget funding announcement offers an opportunity for stakeholders and healthcare consumers to come together to co-design a service system that addresses the information and referral barriers that many pregnant people face in obtaining timely, relevant and current information and referral about pregnancy options and services. We note that other submissions address some of these issues in greater detail and point the Committee members' attention to these.

Unfortunately, the ACT's leading legislative and now funding commitments to abortion access are not matched by a policy environment for reproductive and sexual health. Civil society organisations with a focus on sexual and reproductive health and rights have called for a such strategy in the ACT that addresses issues beyond a narrow STI/BBV disease focus. In fact, current NGO health service planning and commissioning processes are narrowing the scope of eligible services away from integrated approaches to reproductive and sexual health – contrary to the international evidence base - that recognise the closely connected nature of these issues as people live their lives, and the linked drivers of sexual health literacy and sexual wellbeing with varied additional positive social and health outcomes including violence prevention, health service access, inclusion, equity and enhanced dignity.

A continuum of options to remove or reduce barriers to abortion access

Health service access is a result of the physical and timely availability of health services, affordable cost and available financial resources, and accurate information to inform decision-making. A rights-based and just approach to improved access to abortion considers and aims for **equality** (all citizens enjoy the same access to care), **equity** (services are responsive and accessible to the needs of relative disadvantage within a community), and **dignity** (personal autonomy and positive regard are enhanced by health services, not diminished by engagement or attempts to access care).

While recognising that different societies find different resolutions to the balance of these factors, the Australian community tends to value universal access to critical health care in a system that combines government, private and individual funding and contribution sources for the health system overall.

Improving abortion access must occur alongside investment to reduce unplanned/unintended pregnancy through improved access to more effective forms of contraception, increased community awareness education to reduce stigma and increase understanding of unplanned pregnancy, and continued and expanded support for unbiased, non-directive unplanned pregnancy counselling. Ongoing workforce development initiatives are a parallel investment in future accessibility of abortion services, and GP education is important to ensure that increased in medical abortion in primary care settings are supported by accurate information and advice about symptoms and follow up, to minimise misinformation about complication rates, and ensure timely and appropriate referral for additional care when appropriate.

Regardless of the specific funding and eligibility models selected, SHFPACT advocates for the following principles and needs to be addressed:

a) Financial supports/eligibility must always include both medical and surgical abortion options. The interaction of gestational time limits and personal circumstances can delay identification of an unplanned pregnancy and pregnancy decision making. The effects of these delays fall most heavily on people with complex needs, who experience the greatest disadvantage.
b) Access to more than one service provider gives people more choice and control, especially in relation to privacy when accessing a highly stigmatised service.
c) Consideration of how local access to surgical abortion over 14-16 weeks gestation can be achieved and improved in the ACT, noting:
    i. There is currently no service in the ACT which provides abortion after 16 weeks other than for foetal abnormality in the public hospital system, and this very rarely.
    ii. At present, there is no surgical option available for later-term abortion in the ACT public hospital system as it is in other jurisdictions. The only option offered and provided is induction of labour.
    iii. The absence of legal gestational limits for provision of abortion in the ACT, but the continued lack of a private provider of late-term abortions despite the absence of legal constraints, suggests that a public provider is necessary to address this gap.

Abortion and the law in the ACT

The provision of abortion in the ACT is governed by the *Health Act 1993* (ACT), which requires that:

- Only a registered medical practitioner may carry out abortion.
- No person is required to assist or perform in the carrying out of abortion.

A 2015 amendment to the *Health Act 1993* allows for the ACT Health Minister to declare exclusion zones around approved abortion facilities where protest, photography and video, harassing, threatening or intimidating behaviour are prohibited.

In March 2018, the ACT Magistrates Court decision *in Bluett v Popplewell & Ors* upheld the laws providing for exclusion zones around abortion services in the ACT[4]. The magistrate found that the particular one in question at the ACT Health building in Moore Street was not unlawfully established, and does not overreach in achieving the purpose of limiting or removing impediments (in the form of protest and the presence of protesters) to access a health service. The decision does find the inclusion of [adjacent] Rudd Street within the proclaimed zone unnecessary, and helpfully clarifies the distinction between the outside of surrounding buildings included in the zone from activity inside them which would not be in the view of a person outside (such as nearby apartments or offices).

Law reform in 2018 amended a requirement that abortion is to be carried out in a medical facility approved by the Minister for Health to recognise and facilitate medication termination of pregnancy in general practice settings, which were unintentionally limited by 2002 laws established when only surgical termination of pregnancy option was available.

Since passage of the *Medical Practitioners (Maternal Health) Amendment Act 2002*, there are no laws making specific reference to abortion within the ACT *Crimes Act 1900*.

While there is no legal limit on the gestation at which an abortion can be carried out in the ACT, in practice there is currently no abortion service in the ACT region for pregnant people over 14 weeks' gestation (occasionally up to 16 weeks' gestation), except due to foetal abnormality or genetic condition, or risk to the pregnant person's health in a high risk pregnancy, in which case abortion is performed in the public hospital system.

The 2018 amendments enabling accessible GP medication abortion declined to address the issue of referral by a conscientiously objecting healthcare provider to another provider they know not to object. This remains an outstanding law reform need in the ACT.

It is SHFPACT's view that while there is no immediate threat to legal protections for abortion and reproductive choice in the ACT (or Australia more widely), the Canberra community has taken note of recent changes on the constitutional right to privacy that removed a long-standing legal precedent supporting abortion access in the United States Supreme Court. Anti-choice advocates do not enjoy support for their position from most of the Australian community, but neither do they in the United States. Most Australians, regardless of their view about abortion for themselves, support that the right to make this decision rests appropriately and exclusively with the pregnant person in consultation with their healthcare providers[5].

Many community advocates believe abortion access in Australia can never be assumed to be established and invulnerable.

[4] https://www.shfpact.org.au/news-and-updates/353-act-s-laws-about-abortion-clinic-exclusion-zones-tested
[5] https://www.childrenbychoice.org.au/resources-statistics/papers-reports/attitudes-to-abortion/

Abortion services in the ACT region

Public hospital:

There is currently very limited access to abortion in the public hospital system in the ACT and this is generally only available for severe foetal abnormality or genetic condition inconsistent with life. Only Canberra Hospital, of two publicly funded hospitals in the ACT, will provide this service.

During the public health community lockdown response to the COVID-19 pandemic, Canberra Hospital provided limited access to surgical termination of pregnancy due to disrupted access to private abortion clinic providers. This arrangement ended in late 2021.

Private abortion clinics:

There are two providers of abortion services in the ACT region.

- MSI Australia, based in Canberra city which provide medication abortion up until 63 days (9 weeks) gestation, and surgical abortion up to 14 weeks gestation. MSI Australia offers medication abortion via both an in-clinic and telehealth access option.
- Gynaecology Centres Australia (GCA), located in Queanbeyan which provides surgical termination of pregnancy up to 12 weeks gestation. This clinic no longer provides medication abortion.
- A previous telehealth medicine service for medication abortion operating from interstate ceased operations in 2019.

SHFPACT understands that the gestational limits in abortion service availability are due to several factors, including the background and training of the individual proceduralist involved, medical indemnity insurance factors, and individual organisational decisions of the abortion service.

widely, and the availability of appropriate clinical facilities in the ACT for abortion in later gestation.

General practitioners:

Since amendments to the *Health Act 2003* came into effect in 2019, provision of medication abortion by general practitioners and medical specialists up to 63 days (9 weeks) has been possible provided:

- Prescribing GPs have completed an online training program; and,
- Dispensing pharmacists have undertaken an online training program, and the pharmacy has available stock, and a trained pharmacist is available to dispense at the time a prescription is presented.

Continuing abortion stigma in the community and healthcare professions limits the accessibility of GP/community-based medication abortion. This is observable in the difference between the numbers of general practitioners based in the ACT who have completed the relevant online training to prescribe, and the number known to SHFPACT and via GP networks as willing to accept referrals for M-TOP.

Anecdotally, GPs reluctance to broadcast the availability of medication abortion is cited in relation to:

- potentially adverse response from existing patients/clients who are anti-choice;
- professional stigma from colleagues, or having their internal practice referrals dominated by colleagues referring for a service they don't want to provide themselves; and,
- concern about professional backlash or safety if they are identified widely in the community as an abortion provider.

The effects and sequelae of abortion denied: *The Turnaway Study*[6]

While very few (and limited) studies have been conducted on the effects when abortion is sought but denied in Australia, there is some robust evidence internationally.

The *'Turnaway Study'* is a longitudinal study that conducted in the USA from 2008-2013, involving 30 abortion facilities across the USA. 1000 women were recruited to the study and followed up every 6 months for 5 years. This study compared women just over gestational limit for abortion (in the jurisdiction they sought care) and who were therefore denied abortion, with a control group of women just under legal gestational limit who received abortion.

The results of the study found that women who were denied abortion were more likely to:

- Live in poverty;
- Remain in a violent relationship;
- Experience ill health (complications of pregnancy/birth);
- Report psychological stress;
- Experience negative effects on the development of existing children;
- Be recipients of welfare assistance, and with lower rates of full-time employment in this group.

Locally, it is the experience of SHFPACT's provision of unplanned pregnancy counselling services confirms that there is an important intersection of financial means and other factors that significantly affect people with reduced financial resources and complex health needs and/or chaotic lives. These people disproportionately wear the brunt of financial, social, and psychological impacts of unplanned pregnancy and abortion.

The intersection of barriers to abortion:
case studies from SHFPACT's unplanned pregnancy counselling service

SHFPACT has used real case studies, with names and certain details changed to protect individual's identities and privacy, to illustrate the range and intersection of needs that create very different patterns of affordability, accessibility and support for people contemplating or seeking abortion services in the Canberra community.

Broadly, SHFPACT has identified 6 categories of relative need, based on the interaction of:

1. the availability of financial resources (critically, available funds at the time abortion is required); WITH
2. the effects of stigma or perceived stigma about abortion; AND
3. other life circumstances pre-existing an unplanned or unwanted pregnancy.

There will be some people who can afford the cost of an abortion or can manage the cost without too much difficulty at the time need arises. With cost-of-living pressures and inflation impacting negatively on real wages and discretionary funds for many individuals and households, this category now likely represents a minority of Canberra residents. The recent commitment in the 2022 ACT Budget to

[6] Foster, DG, Biggs, MA, Ralph, L., Gerdts, C., Roberts, S., & Glymour, MM. (2018). Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. American Journal of Public Health, 108(3), 407-413. http://dx.doi.org/10.2105/AJPH.2017.304247

financially support access to abortion is a significant step towards addressing financial barriers for most people who seek abortion care.

The six case studies are:

1. People who meet recognised low-income concession criteria (e.g., Health Care Card Holders, Disability Support Pension).

   Case example: *Kim is a woman with a chronic health condition who is on a disability support pension exclusively and is a Health Care Card holder. She uses all her income to pay for essentials: housing, utilities, and food, and is anticipating a rent increase in a few months that will be more than she can afford. She is 8 weeks pregnant and does not want to continue the pregnancy. She recently broke up with and is no longer in contact with the father of the pregnancy. She has no money for an abortion and has already exhausted available Centrelink loan options. Her extended family live interstate and are also low income. Even though they would probably try to assist her, she does not wish to tell them about the pregnancy because she knows her mother wants to be a grandparent and will likely pressure her to continue the pregnancy.*

2. People who may appear to be able to afford the cost of an abortion (regular income, housing etc.) but do not have available cash or other access to funds (or sufficient asset liquidity) to pay for an abortion at the time it is required. The time required to save for the cost adds delays that lengthen the period of gestation which may continue to put costs out of reach, or they may meet gestational limits for an abortion in the ACT region.

   Case example*: Sam lives with their partner and three young children in rental accommodation. They are currently in paid employment, and their partner is in low earning casual employment. All household income goes to housing, utilities, and essentials. Sam has recently identified that they are 8 weeks' pregnant. They have no savings to draw on and are not confident of any emergency support from family due to the fear of judgment and stigma about being pregnant again. Sam feels that trying to save for an abortion would take too long, pushing the gestation up higher and therefore increasing costs further.*

3. People who, due to intimate partner violence and/or control and reproductive coercion within a relationship, are not able to access money or support for an abortion.

   Case example: *Jodie is in a de-facto relationship with a very controlling partner. She already has a young child and does not want another. It was very difficult for her to get to the clinic to ask about access to abortion because she does not drive, and her partner does not like her to go out without him. He monitors her mobile telephone calls, so she wanted to attend in person. Her partner controls money in the relationship, giving her small amounts at a time for specific purchases, and she has no way to access money for an abortion. She has no other support from her own extended family and has been very isolated from them since the birth of her child. Her partner's family visit regularly, but she believes they will tell him if she mentions anything about the pregnancy or needing money. Her partner has strong, traditional views about family, and she knows that he would not support her having an abortion – he wants to have at least four children.*

4. People who do not meet usual health concession criteria but who have a low or very low income, and very limited access to funds to pay for an abortion.

   Case example: *Alison is a single woman who works full time and is on a modest income. On discovering that she was pregnant Alison decided that she does not wish to continue the pregnancy and parent. However, she is struggling to find the funds to cover the cost of an abortion. She has recently managed to purchase an apartment and almost all her income is now taken up by the mortgage repayments. She struggles with the costs of daily living and has no reserve funds. Her ability to buy her own place has been very important to her sense of independence and security. She is not in a relationship with the father of the pregnancy.*

5. Young people (especially under 18 years) who are financially dependent on their parents and are unable to ask family support due to genuine belief or strong perception/fear that the family would not support their decision to have an abortion. This includes young people whose cultural or religious background makes them genuinely fearful about the reaction if they tell their family about the pregnancy and wanting to access abortion.

   Case example: *Irina is a high school student and lives at home. She is financially dependent on her parents. Although she has a casual job, she earns very little and has no savings. She is 11 weeks pregnant, and while she noticed her missed period was scared to get a pregnancy test until very recently. She does not want to tell her parents about the pregnancy because she knows they have very strong beliefs about not having sex before marriage and are opposed abortion. She feels they will force her to continue the pregnancy if she tells them. The father of the pregnancy is also a school student who lives at home with his mother. He knows about the pregnancy, is supportive and has offered to try and help but has no funds available to do this.*

6. People with complex needs who may be experiencing homelessness, mental illness, drug use, intimate partner violence, or more than one of these simultaneously. Often experiencing chaotic lives, diagnosis of a pregnancy, recognition of a pregnancy and/or care seeking may occur at a later gestation in turn making access more difficult (especially if the gestational limit for access to abortion in the ACT region is reached) and further escalating the cost of accessing abortion.

   Case example: *Amber is 18 weeks pregnant. She has a mental illness diagnosis and a substance use disorder. She has previously had children removed and placed in foster care by child and youth protection services. Amber entered a new relationship some time ago and moved to northern NSW with her new partner where they planned this current pregnancy. The relationship became abusive and recently ended. Finding herself alone Amber then returned to the ACT. She is very clear that she does not want to continue the pregnancy. As the pregnancy progresses in the second trimester, Amber's mental wellbeing has deteriorated significantly. She is currently homeless with insecure sleep arrangements. She is waiting for an available place in a residential rehabilitation program, the only option for secure accommodation that she can identify. She has limited contact with her family and has no access to any money to pay for an abortion procedure, or the associated travel costs interstate.*