



Legislative Assembly for the Australian Capital Territory

Standing Committee on Health and
Community Wellbeing

Inquiry into Abortion and Reproductive Choice in the ACT

Legislative Assembly for the Australian Capital Territory
Standing Committee on Health and Community Wellbeing

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About the committee

The Assembly established the Standing Committee on Health and Community Wellbeing on 2 December 2020.

The Committee is responsible for the following areas:

- Health and health system
- Prevention of domestic and family violence
- Justice health
- Mental health
- Homelessness and housing services

You can read the full establishing resolution [on our website](#).

Committee members

Mr Johnathan Davis MLA, Chair

Mr James Milligan MLA, Deputy Chair

Dr Marisa Paterson MLA

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About this inquiry

On 1 July 2022, the ACT Legislative Assembly Standing Committee on Health & Community Wellbeing resolved to conduct an inquiry into abortion and reproductive choice in the ACT.

Terms of reference

The Standing Committee on Health and Community Wellbeing resolved on 1 July 2022 to inquire into and report on the following matters:

- 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;
- 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;
- 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
- 4) access to information to support a variety of possible reproductive choices, including choosing to give birth and
- 5) any other related matters.

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Acronyms

Acronym	Long form
ACCHO	Aboriginal community-controlled health organisation
ACTCOSS	ACT Council of Social Services
AMA (ACT)	Australian Medical Association (ACT) Limited
CALD	culturally and linguistically diverse
D&C	dilation and curettage
D&E	dilation and evacuation
HCCA	Health Care Consumers Association
IUD	intrauterine device
LARC	long-acting reversible contraception
LGBTQIA+	lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual.
O&G	obstetrics and gynaecology
SHFPACT	Sexual Health and Family Planning ACT

Glossary

Abortifacient	a medicine, drug or other substance that causes a pregnancy to end prematurely. ¹
Dilatation and curettage ('D&C')	an operation to scrape away tissue from the inside of the womb (uterus). ²
Surgical abortion	<ul style="list-style-type: none"> • Suction abortion: This is the most common method of abortion. This method involves gentle suction to empty the womb (uterus), usually performed at about 14-16 weeks pregnancy gestation. • Dilation and evacuation (D&E): suction and medical tools are used to empty the uterus. This is normally done for pregnancies that are further along in gestation (more than 16 weeks).³
Medical abortion	The prescription, supply or administration of an abortifacient ⁴ . In the ACT MS2-Step is the abortifacient prescribed.

¹ *Health Act 1993*, ss 80 (1)

² Health Direct, Dilatation and Curettage <https://www.healthdirect.gov.au/dilatation-and-curettage>, April 2021 (accessed 22 February 2023).

³ Pregnancy Birth and Baby, Abortion-Surgical and Medical Options, March 2021 (accessed 23 February 2023) <https://www.pregnancybirthbaby.org.au/abortion-surgical-and-medical-options>

⁴ *Health Act 1993* (ACT), ss80(1).

Recommendations

Recommendation 1

The Committee recommends that the ACT Government engage with Universities Australia, the Group of Eight, Regional Universities Network, Australian Technology Network of Universities to include reproductive health care as part of core medical training courses.

Recommendation 2

- a. That the ACT Government identify how many GPs have undertaken medical abortion and LARC training and are applying that training in their practice.
- b. until more than 50 per cent of uptake is identified, then the ACT Government is encouraged to undertake further investigation into the reasons as to why GPs are not completing such training; and
- c. liaise with the Commonwealth and the Australian Medical Association ACT Ltd to facilitate training.

Recommendation 3

That the ACT Government liaise with the Therapeutic Goods Administration with the aim of including nurses on the list of persons able to prescribe MS-2Step.

Recommendation 4

The Committee recommends that the ACT Government engage with Universities Australia, the Group of Eight, Regional Universities Network, Australian Technology Network of Universities to include reproductive health care as part of core nursing and midwifery training courses.

Recommendation 5

That the ACT Government, as a matter of urgency, investigate ways to increase access to ultrasounds for patients seeking abortions, and report back to the Assembly by end-2023.

Recommendation 6

The Committee recommends that the ACT Government invest in the infrastructure and services necessary to provide post-16-week abortions in the ACT and subsidise interstate patient travel to access this service in the interim, including travel for a support person.

Recommendation 7

⁵ Mr Doctor, MS2®-Step Gymiso, published by MIMS November 2022, [MS-2 Step® GyMiso® - MyDr.com.au](https://www.mydr.com.au/MS-2-Step-GyMiso) (accessed 23 February 2023).

The ACT Government's commitment to free access to abortion services include resources for post-procedural support, including mental health support and safety resources for people who may be experiencing social isolation, reproductive coercion or domestic or family violence.

Recommendation 8

That the communications package committed to in the 2022-2023 Budget:

- include an audit of current Government-provided information to measure whether it is appropriately trauma-led and meets the needs of people of culturally and linguistically diverse backgrounds
- works with the primary health care network to ensure that HealthPathways reflects all abortion providers in the ACT and communicates a clear model of care to GPs
- builds capacity of all health practitioners and workers to provide non-stigmatising, trauma-informed, culturally safe and inclusive care
- raises awareness about medical and surgical abortion options and referral pathways among community services and organisations
- promotes awareness of the different types of abortion care amongst the general public, including in regard to the importance of early identification and presentation.

Recommendation 9

The Committee recommends that the ACT collect and publish anonymised data on medical and surgical abortions and on reproductive coercion in the ACT and invest in local partnerships (including with service providers and community organisations) to further develop a quantitative and qualitative evidence base on these topics.

Recommendation 10

The Committee recommends that the ACT Government amend the Third Action plan of the ACT Women's Plan 2016-2026 to include the threats posed to women from reproductive coercion.

Recommendation 11

That the ACT Government provide:

- training for family, domestic, and sexual violence services to respond to reproductive coercion; and
- reproductive coercion into age-appropriate, culturally-safe education programs for the general community.

Recommendation 12

That the ACT Legislative Assembly amend the *Health Act 1993* part 86(3)(a) 'not less than 50 m at any point from the protected facility' to 'not less than 150 m at any point from the protected facility'.

Recommendation 13

The Committee recommends that the ACT Legislative Assembly amend the Health Act 1993 part 84A 'Conscientious objection' to insert a requirement for conscientious objectors to provide a referral to an equivalent service.

Recommendation 14

That the ACT Government advocate Calvary Hospital to provide full reproductive health services in accordance with human rights.

Recommendation 15

That the ACT government fund services and information for patients who choose to bring their pregnancy to full term and do not have access to Medicare.

Recommendation 16

That the ACT Government invest in reducing unintended pregnancy by subsidising access to long-acting reversible contraception, alongside a trial of subsidised vasectomies in collaboration with local health providers.

Recommendation 17

The Committee recommends that the ACT Government develop and trial a policy for reproductive health and wellbeing leave in ACT Government workplaces.

Recommendation 18

The Committee recommends that the ACT Government develop a sexual and reproductive health strategy that:

- addresses the needs of vulnerable people
- is informed by an intersectional approach (overlaps in the categories of races, class, gender, disability)
- is co-designed with key stakeholders including community organisations, service providers, specialists, women, and people with uteruses
- is linked to appropriate national health strategies, and
- addresses the issue of reproductive coercion.

1. Introduction

Conduct of the inquiry

- 1.1. On 1 July 2022, the Standing Committee on Health and Community Wellbeing resolved to conduct an inquiry into abortion and reproductive choice in the ACT. The Committee issued a media release inviting written submissions.
- 1.2. The terms of reference for the inquiry included the accessibility and affordability of abortion services and the protection of abortion rights in ACT legislation.
- 1.3. 52 submissions were received from a range of organisations and individuals. These are listed in **Appendix A**.
- 1.4. On 28 October 2022, the Committee conducted a public hearing into the inquiry. Witnesses who appeared at the hearing are listed in **Appendix B**.

Premise

- 1.5. This report is predicated on an affirmation of reproductive rights and justice and is informed by the shock waves that emanated internationally following the 2022 U.S. Supreme Court ruling which overturned Roe v Wade, the 1973 ruling that had established the constitutional right to abortion in the United States.⁶
- 1.6. The outrageous Roe v Wade decision from the USA has prompted Australian women to reflect on the various states of legality applicable across all jurisdictions in Australia and importantly to start a loud conversation about the actual access to services.⁷
- 1.7. The reversal of Roe v Wade epitomises the need for ongoing protection of reproductive rights. The inquiry and this report stand as a concerted initiative as part of this overarching and necessary vigilance.
- 1.8. The Committee heard that reproductive justice encompasses the following:

There is the right not to have children, if a person does not want to have children, the right to be able to parent, if a person wants to parent, and to be able to parent free from violence and coercion. We would see reproductive justice as encompassing all of those things and we believe that all of those things are important to facilitate choice and bodily autonomy.⁸
- 1.9. Given its firm premise in reproductive justice, the terms of reference of this inquiry demonstrate a refusal to revisit the debate concerning the criminalisation of abortion.

⁶ Dan Mangan and Kevin Breuninger, 'Supreme Court overturns Roe v. Wade ending 50 years of federal abortion rights', CNBC, 24 June 2022, (accessed 23 February 2023) [Supreme Court overturns Roe v. Wade, ends federal abortion rights \(cnbc.com\)](https://www.cnn.com/2022/06/24/politics/supreme-court-roe-v-wade/index.html)

⁷ EMILY's List Australia, *Submission 17*, p. 2.

⁸ Dr Romy Listo, Senior Health Promotion Officer, Women's Health Matters, *Committee Hansard*, 28 October 2023, p. 78.

- 1.10. Further, this report does not denote an international and philosophical position, solely. This inquiry sourced evidence that revealed significant and tangible local barriers to abortion in the ACT. The Committee has noted gaps between reproductive rights on (policy) paper and lived experience for Canberrans. Abortion has been decriminalised in the ACT⁹ in 2002. The removal of abortion from all criminal codes nationally has only recently been achieved, last year, in South Australia.¹⁰ Fragility of reproductive justice is noted through such legislative tardiness and well as the fact that, today, local abortion access is still not assured. The disparity between law, policy and medical care in the ACT as well as recognition of the wider discourse of reproductive justice comprises the foundation of this report.
- 1.11. Health care, including reproductive health has been recognised by the United Nations as ‘a basic right’ under the Convention on the Elimination of all Forms of Discrimination against Women.¹¹
- 1.12. As the ACT Human Rights Commission notes, the right to health:
- emphasises the right of all people, irrespective of sex or gender, to decide if, and when, to reproduce. This necessitates their ability to access and be informed about safe, effective, affordable and acceptable methods of family planning and available reproductive health care services, including abortion.¹²
- 1.13. It is the view of the Committee that access to contraception and the information, education and means to freely and responsibly decide on the number and spacing of children is a key component of the rights to health and encapsulates the equality that governments must take steps to facilitate.¹³

2. ACT abortion services

- 2.1. The following facilities/health care providers provide abortions in the ACT region:
- two full fee-paying clinics (MSI Australia, Civic) and (Gynaecology Centres Australia (GCA), Queanbeyan), both offering surgical and medical abortion (see Glossary).
 - Canberra Public Hospital restricted to severe foetal abnormality.¹⁴
 - Calvary Public Hospital, only in cases of emergency.¹⁵

⁹ *Crimes (Abolition of Offence of Abortion) Act 2002*

¹⁰ EMILY's List Australia, *Submission 17*, p. 3.

¹¹ CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) <https://www.refworld.org/docid/453882a73.html>

¹² ACT Human Rights Commission, *Submission 49*, p. 5 citing [UN Committee on Economic, Social and Cultural Rights, \(2016\)](#).

¹³ ACT Human Rights Commission, *Submission 49*, p. 5, citing Office of the High Commissioner, United Nations Human Rights (2020).

¹⁴ Women's Health Matters, *Submission 46*, p. 9.

¹⁵ ACT Government, *Submission 47*, p. 11.

- Centenary Hospital for Women and Children including post-16 weeks gestation, only in cases of foetal abnormality or severe maternal morbidity.¹⁶
- approximately 13 active practising GPs are able to perform abortions in the ACT.¹⁷ Overall, there are currently 4.22.4 full-time equivalent GPs in the ACT servicing 453,000 ACT residents.¹⁸
- some pharmacists trained to provide medical abortions.

3. Barriers to abortion and contraception in the ACT

- 3.1. The Committee learned of a series of barriers to abortion in the ACT as discussed below.

Training

General Practitioners

- 3.2. The Committee learned of the need for more and greater quality training in contraception and abortion training for medical students, GPs and obstetric gynaecology specialists. A medical witness at the public hearing asserted that all clinicians training at the Centenary Hospital for Women and Children should be trained in abortion care as a matter of course.¹⁹
- 3.3. The Committee also note that abortion training is not usually included in Doctor of Medicine syllabi or training at the Royal Australian College of General Practitioners, except as an ethical issue. The required clinical skills are usually omitted from medical programs. The absence of abortion training at medical universities and colleges has the effect that 'you do not have the workforce. No-one knows how to do it anymore'.²⁰

Recommendation 1

The Committee recommends that the ACT Government engage with Universities Australia, the Group of Eight, Regional Universities Network, Australian Technology Network of Universities to include reproductive health care as part of core medical training courses.

¹⁶ ACT Government, *Submission 47*, p. 5.

¹⁷ Dr Melanie Dorrington, *Submission 43*, p 5.

¹⁸ Lanie Tindale, '[Canberra GP Workforce Shortage 'Time Bomb' as Ageing Doctors Retire, Next Practice Deakin Dr Paresh Dawda Says](#)', *The Canberra Times*, 6 October 2022.

¹⁹ Dr Melanie Dorrington, *Submission 43*, p. 13.

²⁰ Dr Melanie Dorrington, General Practitioner, *Committee Hansard*, 28 October 2022, p. 29.

Reproductive Health Training

- 3.4. For the purposes of this report, contraception training refers to training in the use of Long-Acting Reversible Contraception (LARC). The report only focuses on LARC training as unlike other forms of contraception LARCs involve a surgical procedure to insert the device and therefore accurate training is vital.
- 3.5. LARCs include intrauterine devices and contraceptive implants. LARCs comprise a variety of methodologies:
- Hormonal implants (Implanon®) work by preventing eggs from being released from the ovaries and thickening mucus in the cervix to provide a barrier against sperm.
 - Hormonal IUDs (Mirena® or Kyleena®) work, amongst other elements, through toxicity to an ovum.²¹
- 3.6. The sole training provider in the application of LARCs in the ACT is Sexual Health and Family Planning ACT (SHFPACT) which has limited resources. Provision of this training was further impacted by COVID such that very little or no training was available during 2020 and 2021.²²
- 3.7. The Committee learned of the disincentive for GPs undertaking LARC evident in the requirement to undertake a supervised, privately-sourced and self-funded clinical placement following completion of the initial training.²³ One option suggested to alleviate these encumbrances is the provision of clinical placements by Canberra Health Services.²⁴

Medical abortion training

- 3.8 The Committee notes that to be able to register to provide abortion services GPs must complete the free half-day online training course for the MS-2 Step providing program. As the glossary explains MS2-Step is the abortifacient drug used in the ACT for medical abortions. To register to provide abortion services, MS2-Step training is mandatory except for those who hold a current Fellowship or Advanced Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.²⁵
- 3.9. Whilst training requirements are not onerous, financial considerations may provide a disincentive:

Medicare rebates are inadequate and result in GPs subsidising the provision of this service. The true costs of providing this service is in the order of the \$500 -

²¹ Family Planning Australia Reproductive and Sexual Health, *Long Acting Reversible Contraception (LARC)* <https://www.fpnsw.org.au/factsheets/individuals/contraception/long-acting-reversible-contraception-larc>

²² Australian Medical Association (ACT) Limited, *Submission 52*, p. 4.

²³ Australian Medical Association (ACT) Limited, *Submission 52*, p. 4.

²⁴ Australian Medical Association (ACT) Limited, *Submission 52*, p. 4.

²⁵ Health Care Consumers' Association, *Submission 50*, p. 11.

\$600 charged by the large not-for-profits operating in this space throughout Australia.²⁶

Pharmacists

- 3.10. Compromised access to MS-2Step is also evident in the limited number of pharmacists who have undertaken training to dispense the drug. Ready access is further compounded by pharmacists keeping limited quantities of the drug in stock if they stock the drug at all. Pharmacists do not generally advertise that they supply MS-2Step and a pharmacist trained to dispense the drug may not be available when a patient presents with a script.²⁷ All these factors combine to restrict ready access to MS2-Step.

Recommendation 2

- a. That the ACT Government identify how many GPs have undertaken medical abortion and LARC training and are applying that training in their practice.
- b. until more than 50 per cent of uptake is identified, then the ACT Government is encouraged to undertake further investigation into the reasons as to why GPs are not completing such training; and
- c. liaise with the Commonwealth and the Australian Medical Association ACT Ltd to facilitate training.

Nurse-led abortion care

- 3.11. The Committee draws the Government's attention to the provisions regulating abortion in the ACT, contained in Division 6.1 of the *Health Act 1993* (the Act) are drafted with an apparent overuse of negative language in that the Act creates offences for the provision of abortion services while the legality of such services is not made explicit. Such a legislative drafting practice could be viewed as reflecting the continuing sensitivity around the procedure, which is perpetuated by linguistic aversion to reproductive rights.
- 3.12. Division 6.1 of the *Health Care Act* (1993) specifies the following abortion-related offences:
- administering an abortifacient where the person is not a doctor or pharmacist²⁸
 - performing a surgical abortion where the person is not a doctor²⁹

²⁶ Health Care Consumers' Association, *Submission 50*, p. 11.

²⁷ Dr Melanie Dorrington, *Submission 43*, p. 6.

²⁸ *Health Act 1993*, s 8.

²⁹ *Health Act 1993*, s 82.

- carrying out of a surgical abortion in a place which is not an approved medical facility.³⁰
- 3.13. Accordingly, it is currently illegal for a nurse practitioner, registered nurse or a midwife to administer an abortifacient.
 - 3.14. The abortion provisions in the *Health Act 1993* (ACT) were amended by the *Health (Improving Abortion Access) Amendment Act 2018* (ACT) and came into effect on 1 July 2019. The purpose of the Act was to make key improvements to abortion access in the ACT.
 - 3.15. The Committee learned that it was the intention of the Health (Improving Abortion Access) Amendment Act 2018 (the Act) to expand the scope of medical abortion prescription to nurse practitioners.³¹ This was retracted through an amendment. This retraction was not informed by any opposition to the policy, but rather because the Therapeutic Goods Administration has only authorised doctors to prescribe MS-2Step.³²
 - 3.16. The Committee understands the value of nurses providing medical abortions as releasing doctors 'to be able to do some more complex work.'³³ and recognised that 'nurses are more than proficient to deliver some of the work, such as medical abortion under nine weeks.'³⁴
 - 3.17. This provision is not merely motivated by the interests of resourceful medical scoping. The Committee is well aware of the international call to expand the role of nurses in the provision of medical abortion care, given the extensive research literature which ensures this as a safe practice.³⁵

Recommendation 3

That the ACT Government liaise with the Therapeutic Goods Administration with the aim of including nurses on the list of persons able to prescribe MS-2Step.

Recommendation 4

The Committee recommends that the ACT Government engage with Universities Australia, the Group of Eight, Regional Universities Network, Australian Technology Network of Universities to include reproductive health care as part of core nursing and midwifery training courses.

³⁰ Health Act 1993, s 83.

³¹ Health (Improving Abortion Access) Amendment Bill 2018, Supplementary Explanatory Statement, p. 3.

³² Ms Fitzharris, Minister for Health and Wellbeing, Health (Improving Abortion Access) Amendment Bill 2018, *Debates Weekly Hansard*, 19 September 2018.

³³ Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard*, 28 October 2022, p. 52.

³⁴ Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard*, 28 October 2022, p. 52.

³⁵ Mainey et al., 'The role of nurses and midwives in the provision of abortion care: a scoping review', *Journal of Clinical Nursing*, 2020:29: 1513-1526:1513-1514.

Medical Equipment

Ultrasound Access

- 3.18. As part of the overall discussion and identification of barriers to reproductive justice in the ACT, the Committee emphasises that access to abortion is time critical. An abortion cannot be treated like other modes of elective surgery. Whilst cognisance of a human gestation may be assumed, this awareness does not necessarily translate to the medical processes, including examinations, that are required prior to termination. A failure to expediently provide this suite of medical services will not only impact on the type of abortion that is provided (administration of abortifacient or surgical abortion) but also on whether a not a patient is forced to endure an unwanted pregnancy.
- 3.19. One of these time critical services is a pregnancy ultrasound, which is essential to establish an intra-uterine pregnancy (as opposed to ectopic) and to assist in determining approximate gestation.
- 3.20. The Committee learned that there is a critical lack of ultrasound equipment in the ACT. A local GP notes:

..[A]ccess to pregnancy ultrasounds for the whole Canberra community, no matter how wealthy or affluent you are, is difficult and hard to get in a very timely way. Particularly in the service where I work, people will present very late with an unplanned pregnancy, for a range of reasons, and so we have often not got the weeks available for people to be able to make their choice of option, which is that they wish to terminate the pregnancy.³⁶

- 3.21. This witness further explained that she spends a long time on the telephone attempting to access ultrasounds and that sometimes even if an ultrasound is sourced, the person needing the ultrasound may not attend the appointment. The latter predicament is not unusual for vulnerable patients who are required to manage other life pressures, resulting in the process to source an ultrasound begins again in a more critical time period.³⁷

Accessing medical abortion through a GP, involves a range of necessary steps and allied health services. Coordination of these is a particular barrier to access for consumers with low health literacy, those in insecure housing or employment, those who are impacted by substance abuse or mental illness or complex trauma. Delayed presentations or difficulty completing the necessary appointments and preparatory steps can mean unwanted pregnancies are continued due to a lack of flexibility in service provision.³⁸

³⁶ Dr Tanya Robertson, General Practitioner, *Committee Hansard*, 28 October 2022, p. 26.

³⁷ Dr Tanya Robertson, General Practitioner, *Committee Hansard*, 28 October 2022, p. 28.

³⁸ Health Care Consumers Association, *Submission 50*, p. 9.

- 3.22. The Committee concludes more ultrasounds and flexibility in access denote the elements of reproductive justice in relation to the critical observations from expert witnesses to this inquiry.

Recommendation 5

That the ACT Government, as a matter of urgency, investigate ways to increase access to ultrasounds for patients seeking abortions, and report back to the Assembly by end-2023.

16-week gestational time limit

- 3.23. Time pressures further abound access to abortion in the ACT. The Committee heard that there is a 16-week gestational limit for the access to surgical abortions in the ACT.³⁹ Gestational limits vary from jurisdictions. For example, NSW's pregnancy gestation limit is 22 weeks whereas Victoria has the longest time limit at 24 weeks. Abortion can be accessed beyond these gestations with two-doctor approvals and in the case of medical emergencies.⁴⁰
- 3.24. Abortions after 16 weeks are more complex and require additional accreditation requirements and adherence to standards.⁴¹ The 16-week gestational time limit in the ACT is not fixed in law but, rather, the result of medical models of care and associated infrastructure not keeping pace with the *Health (Improving Abortion Access) Amendment Act 2018*. The 16-week cut-off is the result of 'a hangover from having developed these models of care and relevant infrastructure under previous legal restrictions'.⁴²
- 3.25. The Committee heard that in order to facilitate abortions post-16 weeks the current clinic:

...would need an improvement in infrastructure, a clinic more suited to that sort of procedure. At the moment it is set up as a day hospital, which is ok for some procedures, but for some that become more complex we would need more equipment, more staff and more access to tertiary hospitals if something were to become too complicated for the clinic.⁴³

³⁹ MSI Australia, *Submission 41*, p. 7.

⁴⁰ Health Care Consumers Association, *Submission 50*, p. 14.

⁴¹ MSI Australia, *Submission 41*, p. 10.

⁴² Health Care Consumers Association, *Submission 50*, p. 9.

⁴³ Ms Melissa Ryan, Nurse Unit Manager, MSI Australia, *Committee Hansard*, 28 October 2022, p. 54.

- 3.26. Due to the lack of ACT services for a surgical abortion post-16 weeks, local patients wishing to access this service are compelled to travel to Sydney to have the procedure.⁴⁴ The Committee also learned of ACT patients travelling as far as Brisbane.⁴⁵
- 3.27. The Committee has noted with understanding the repeated advocacy throughout several submission to this inquiry that this practical limitation to abortion services in the ACT be remedied, including the provision of post-16-week surgical abortion.⁴⁶

Recommendation 6

The Committee recommends that the ACT Government invest in the infrastructure and services necessary to provide post-16-week abortions in the ACT and subsidise interstate patient travel to access this service in the interim, including travel for a support person.

Financial Barriers

- 3.28. As noted in Chapter 2 'ACT abortion services', the only surgical abortion service available in the ACT is performed by MSI and is full fee paying. The cost of abortion services is dependent on a range of factors including the pregnancy gestation period, the abortion method (medical or surgical), access to additional services, for example, counselling or where a patient has complex health needs.⁴⁷
- 3.29. The starting price for a surgical abortion is \$650⁴⁸ and throughout Australia costs can be as high as \$8,000.⁴⁹ These amounts may be out of range for many people. It should be noted that MSI Australia, by way of their Safe Abortion and Contraceptive Choice Fund, does provide some financial assistance for people accessing abortions who are experiencing financial hardship. The fund relies on regular philanthropic donations. The criteria to establish financial hardship is stringent.⁵⁰
- 3.30. While MS-2Step is significantly subsidised by the Pharmaceutical Benefits Scheme costing \$30.00, for patients with Medicare, the cost can be prohibitive at \$353.84⁵¹ without Medicare.
- 3.31. This observation is particularly pertinent for those who live in the ACT and are not eligible for Medicare; international students for example. Whilst student visa holders are required to have Overseas Student Health Cover (OSHC), the Committee learned from one inquiry participant that:

⁴⁴ EMILY's List Australia, *Submission 17*, p. 4.

⁴⁵ MSI Australia, *Submission 41*, p. 9.

⁴⁶ Health Care Consumers Association, *Submission 50*, p 15, Women's Health Matters, *Submission 46*, p. 4, ACT Health Directorate, *Submission 47*, p. 12.

⁴⁷ MSI Australia, *Submission 41*, p. 14.

⁴⁸ MSI Australia, Costs and Prices <https://www.msiaustralia.org.au/costs-and-prices/>

⁴⁹ MSI Australia, *Submission 41*, p. 13.

⁵⁰ MSI Australia, *Submission 41*, p. 13.

⁵¹ Dr Melanie Dorrington, *Submission 43*, p. 10.

my OHSC provider had a 12-month waiting period before any coverage would apply for 'pregnancy related expenses'.⁵²

- 3.32. In addition to the direct cost of a surgical abortion, submitters⁵³ drew attention to the fact that patients experience many indirect costs, some of these costs are also applicable to a medical abortion.
- 3.33. Indirect costs may include travel and accommodation, where an abortion because of the 16-week gestational time limit in the ACT, cannot be accessed in the Territory. Childcare costs are required where a person needs to attend medical appointments and/or counselling. Taking time off work to have the abortion procedure may potentially result in a loss of income. It is noted that the ACT does have an Interstate Patient Travel Assistance Scheme which has a stringent financial criterion and does not cover financial support for meals, parking fees, tolls or taxi services.⁵⁴ Further indirect costs are also associated with post procedure care such as the purchase of pain-relieving medication, menstrual pads and/or contraceptive products.
- 3.34. Whilst GPs may choose to bulk bill⁵⁵, the Committee heard that bulk-billing is not a feasible plan for general practice, with one GP noting that 'the ACT Government cannot expect GPs to be paid less for certain consultations, including provision of abortion care which requires at least three consultations (though the [first] one may be with the patient's own GP)'.⁵⁶ The majority of patients will accordingly experience costs of GP appointments associated with the procedure.

Post-procedure support

- 3.35. Having an abortion is an inherently emotive and confronting matter and for the vast majority of women is not taken lightly.⁵⁷ One study ascertained that 'More than half of the women experienced anxiety (61.7%) and most of the women had depression (85.0%)'.⁵⁸ It should be noted however that mental health problems following an abortion are controversial with many studies challenging this preconception.
- 3.36. Therefore, the Committee encourages the ACT Government to be concerned with not just ready access to the physical procedure but also supportive of the potentially far greater reaching psychological repercussions. Any model of abortion health care should

⁵² Rylee Schuhmacher, Submission 33, p. 3.

⁵³ Women's Health Matters, Submission 46, p. 18; ACTCOSS, Submission 42, p. 16; Dr Melanie Dorrington, Submission 43, p. 9; MSI Australia, Submission 41, pp. 14-15.

⁵⁴ HCCA, Submission 42, p. 16.

⁵⁵ ACT Government, Submission 47, p. 8.

⁵⁶ Dr Melanie Dorrington, Submission 43, p. 9.

⁵⁷ ACT Right to Life Association, Submission 38, p. 4.

⁵⁸ Cansu Akdag and Fuson Terzioglu, 'Assessment of depression, anxiety and social support in the context of therapeutic abortion.' Perspectives in Psychiatric Care, Volume 55, 4, Special Issue: Controversial sexual and gender minority health disparities Wiley online library <https://onlinelibrary.wiley.com/doi/full/10.1111/ppc.12380> (Accessed 23 February 2023).

be tailored and receptive to addressing these important psychological and emotional considerations.

- 3.37. Such a model of care needs to be aware of the potential for feelings of grief and accordingly greater vulnerability to anxiety and depression. Some patients choose to access cremation services, for which there is limited support. Follow up support is crucial for any holistic model of abortion service care.
- 3.38. In 2022 Women's Health Matters conducted a survey into accessing abortion in the ACT and surrounding regions. The survey collected 102 responses and was 'also informed by collaboration and consultation with health care providers, peak bodies and community organisations across the sector'.⁵⁹ The survey 'identified after-care and follow-up as an area of concern for many people who had an abortion in the ACT region,'⁶⁰ demonstrated by the following observations the being made:

A follow up appointment would have been beneficial for myself and my mental health.

I think women have different reasons for having a termination and knowing there is a little more support actually makes a difference. A few follow up phone calls or access to a counsellor.

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.⁶¹

- 3.39. Post-procedure support is even more important for people who are experiencing domestic or family violence or who are socially isolated. The Committee noted a 'a strong correlation between unintended pregnancy and domestic and family violence':⁶²

Reproductive health care services need to be well connected to other social supports and community organisations to ensure that consumers accessing reproductive health care are supported and kept safe.⁶³

For people who are already experiencing reproductive coercion and other forms of domestic violence, abortion follow up care is even more vital because in addition to experiencing potential psychological distress from an inherently confronting procedure, such persons may have compounding stressors stemming from concerns about their safety and wellbeing.

Recommendation 7

⁵⁹ Women's Health Matters, *Submission 46*, p. 3.

⁶⁰ Women's Health Matters, *Submission 46*, p. 2-3.

⁶¹ Women's Health Matters, *Submission 46*, p. 21.

⁶² HCCA Submission 50, p 9 citing [Domestic and family violence in pregnancy and early parenthood | Australian Institute of Family Studies \(aifs.gov.au\)](https://aifs.gov.au/domestic-and-family-violence-in-pregnancy-and-early-parenthood), accessed 18 August 2022

⁶³ HCCA *Submission 50*, pp. 9-10.

The ACT Government's commitment to free access to abortion services include resources for post-procedural support, including mental health support and safety resources for people who may be experiencing social isolation, reproductive coercion or domestic or family violence.

Information

Patients

- 3.40. Absence of relevant and easily available information about abortion comprises a barrier to reproductive justice. Specifically, there are two main information barriers that impact access to abortion:

accessing a GP/pharmacist capable of performing the abortion. How does a patient find out whom to approach?

access to an abortion may be impeded amidst the absence of information lack about the procedure and process what to expect.

- 3.41. This inquiry found that there is a limited number of GPs and pharmacists in the ACT who are trained in providing abortion services. This predicament is compounded by the dearth of publicity of these services.
- 3.42. The major source of information about medical providers is HealthPathways, an information portal for health professionals in the ACT and Southern NSW. The portal allows medical professionals to source information about who provides certain medical procedures and where. However, the Committee learned that HealthPathways does not have a complete list of local abortion providers because some of these providers choose to remain confidential. Women's Health Matters note:

only four 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...⁶⁴

- 3.43. Abortion providers may not wish to publicise their service because of fear of harassment and/or judgement from persons opposed to abortion.⁶⁵
- 3.44. The refusal to promote abortion services may protect abortion providers from harassment but the lack of publicity denotes a barrier to reproductive justice. Whilst the practice in Australia, in an era of illegal abortion, of backyard, floating abortion rings may have ceased, a culture of secrecy still thrives in Canberra's abortion provision, through practitioners' fear of persecution. Following the legality of abortion, societal

⁶⁴ Women's Health Matters, *Submission 46*, p. 19.

⁶⁵ Health Care Consumers Association, *Submission 50*, p. 12.

punitive responses may have ended from State but still they prosper at the hands of the Church (see sections in this report 'Calvary Hospital' and 'Stigma and Harassment').

- 3.45. The Committee understands that *healthdirect*⁶⁶ also exists as a government-funded service which provides health information and advice, including sexual health information but notes that this resource was not identified in any of the evidence presented as part of this inquiry. This may suggest that HealthPathways is largely deemed a dominant, if not sole, information source. If this is the case, then the Committee suggests that any ambiguity surrounding the expedient sourcing of information about abortion providers denotes a barrier to abortion. As the Health Care Consumers Association notes:

Currently, provider information is only available via HealthPathways, which is a resource only available through primary health care clinicians, such as GPs. This forces consumers to approach GPs without knowing their stance on reproductive rights.⁶⁷

- 3.46. The Committee believes given that there are 54 actively certified medical abortion providers in the ACT⁶⁸, HealthPathways should be fully utilised as a primary health care provider resource, enabling providers to have access to a comprehensive list of abortion providers.
- 3.47. In addition to accessing abortion providers, HealthPathways also has the capacity to provide standardised guidelines for best practice abortion care. The Committee agrees with the recommendation of Women's Health Matters that primary health providers should work together to establish a clear model of abortion care on HealthPathways to educate and assist GPs in providing quality and uniform abortion care and service.⁶⁹
- 3.48. The lack of information on GPs and pharmacists that provide medical abortion services in the ACT can be contrasted with the position in Victoria which, via the 1800 My Options website and associated hotline⁷⁰, people seeking an abortion are able to search for an abortion service in their local area. The Committee advocates for the ACT Government to introduce a similar model of communication.⁷¹
- 3.49. As well as the challenges faced in accessing a GP/pharmacist who can perform abortion services, Women's Health Matters

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

⁶⁶ See <https://www.healthdirect.gov.au/>

⁶⁷ Health Care Consumers Association, *Submission 50*, p.12

⁶⁸ Women's Health Matters, *Submission 46*, p. 19.

⁶⁹ Women's Health Matters, *Submission 46*, p. 4.

⁷⁰ Women's Health Victoria, 1800 My Options Victoria State Government, <https://www.1800myoptions.org.au/> (accessed 23 February 2023)

⁷¹ Health Care Consumers Association, *Submission 50*, p. 12.

makes accessing abortion difficult for many women and pregnant people, and especially for those subjected to additional disadvantage or discrimination.⁷²

General practitioners

- 3.50. The Committee considers that an absence of judgement and/or stigma from health practitioners towards people seeking an abortion does not go far enough in ensuring a positive, reassuring experience for the person. In addition to an absence of stigma health practitioners need to be aware of and receptive to the culture and background of the patient, which may present additional challenges to a person feeling comfortable and understood when accessing abortion services.

Trauma-informed care

- 3.51. Trauma-informed abortion care is characterised by awareness of other factors in a patient's life (past and/or present) which render it difficult to seek medical care. An appropriate response is not confined to the caring demeanour of the practitioner, for example, but is reflected systematically in the process, communication, networks and information that are involved in the termination of the pregnancy. As one medical practitioner shared with the Committee:

We can start off by being supportive and not trying to make assumptions, but also, when any information is provided [it is important to have]... it reviewed by appropriate consumer groups to make sure that we are not missing something because it is not just our life experience.⁷³

Culturally safe and inclusive care

- 3.52. Health practitioners also need to ensure that the abortion care is culturally safe and inclusive. Reproductive choice should demonstrate an understanding of diversity so that:

...nobody feels that it does not apply to them...Then you get to a service provider and you get that very non-judgemental conversation and trauma-informed approach. I work with vulnerable youth, so most of them have come from complex trauma backgrounds. It is about recognising that it may take multiple attempts; it may take multiple phone calls. A lot of what happens in the health system is that if somebody does not take a phone call, they have their appointments cancelled. There are a whole lot of reasons behind why that happens and that is where we need to be a flexible system. Information is one thing, but accessibility and helping and supporting people through their different journeys may take multiple times, but we need to be there the whole way.⁷⁴

Community service organisations

⁷² Women's Health Matters, *Submission 46*, p. 9.

⁷³ Dr Melanie Dorrington, General Practitioner, *Committee Hansard*, 28 October 2022, p. 23.

⁷⁴ Dr Tanya Robertson, General Practitioner, *Committee Hansard*, 28 October 2023, p. 24.

- 3.53. It is the view of the Committee that information about abortion services and access should be more readily available and accessible in more places. For example, there would be benefit in having information about abortion services available at appropriate community organisations, like ACTCOSS. It is the Committee's view that the availability of abortion information and referral pathways at community services and organisations would not only result in greater awareness of these services but might also have an effect of reducing the stigma and silence around abortion.
- 3.54. It is a commitment of the ACT's 2022-23 Budget to deliver a communications package to improve accessibility of abortion.⁷⁵ The Committee agrees with Women's Health Matters that:

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 organisation, and people with uteruses.⁷⁶

Public

- 3.55. The Committee is of the view that information on abortion care, including the importance of early identification and presentation should be readily available among the general public. Accordingly for all persons capable of pregnancy, understanding of their options for abortion services and knowledge of the procedure is considered advantageous.
- 3.56. As previously mentioned in this report, the Committee notes the time critical nature of abortion services⁷⁷, which in addition to impacting options available, also has an impact on the cost.⁷⁸ For example, the MSI cost calculator tool showed that the cost of an abortion at 14 weeks would be \$1,310.00, as opposed to \$650 below 14-weeks' gestation.⁷⁹ There is also a potentially greater risk of complications the more advanced a pregnancy is. Accordingly greater availability of information among the general populace would result in persons being more informed of their potential options should they wish to consider abortion services and would also make such persons aware of the desirability of early presentation for the service.

Challenges experienced by vulnerable people

- 3.57. In addition to the barriers to abortion outlined above, some sectors of the population face additional challenges. A discussion of the problems faced by certain community

⁷⁵ ACT Government, *Submission 47*, p. 6.

⁷⁶ Women's Health Matters, *Submission 46*, p. 15.

⁷⁷ Dr Tanya Robertson, General Practitioner, *Committee Hansard*, p 26.

⁷⁸ MSI Australia, *Submission 41*, p. 14 'What Will it Cost?' [What Will It Cost | MSI Australia](#).

⁷⁹ MSI Australia, 'Abortion Services' <https://www.msiaustralia.org.au/abortion-services/>

sectors are outlined below In particular a lack of information on abortion services tailored to these sectors.

- 3.58. The Committee noted recommendations that the aforementioned ACT Government's commitment to a communication package go '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'.
- 3.59. In addition to the barriers to abortion outlined above, some sectors of the population face additional challenges. A discussion of the problems faced by certain community sectors are outlined below at In particular a lack of information on abortion services tailored to these sectors.

People with a disability

- 3.60. Women with Disabilities ACT and Advocacy for Inclusion outlined the challenges faced by women with disabilities in accessing abortion services. These include:
- increased likelihood of reproductive coercion noting that women with disabilities are 40 per cent more likely to experience abuse than their abled counterparts. Reproductive coercion is often enacted under the guise of legitimate medical care and concern for the parent and child.⁸⁰
 - lack of support in understanding their reproductive options in order to make informed decisions, exemplified by health care professional speaking to their worker or caregiver rather than directly to themselves.⁸¹
 - legal control that guardians and caregivers can have over people with significant disabilities resulting in further reproductive rights violations.⁸²
 - difficulty in accessing public transport to attend abortion services.⁸³

CALD

- 3.61. That the Committee noted the lack of available information in languages other than English [in the ACT].⁸⁴ This situation can be contrasted with Victoria where the *BetterHealth*⁸⁵ website has abortion information translated into several languages.
- 3.62. In addition, 'some people from CALD backgrounds are hesitant to access abortions and reproductive health care due to cultural stigma and language barriers.'⁸⁶ This was made evident by the 'Canberra Multicultural Community forum⁸⁷, 'a peak body representing more than 100 ethnic and associated community organisations in the Australian Capital

⁸⁰ Women with Disabilities ACT and Advocacy for Inclusion, *Submission 51*, p. 3.

⁸¹ Women with Disabilities ACT and Advocacy for Inclusion, *Submission 51*, p. 2.

⁸² Women with Disabilities ACT and Advocacy for Inclusion, *Submission 51*, p. 2.

⁸³ Women with Disabilities ACT and Advocacy for Inclusion, *Submission 51*, p. 2.

⁸⁴ Dr Melanie Dorrington, *Submission 43*, p 6.

⁸⁵ <https://www.betterhealth.vic.gov.au/health/HealthyLiving/abortion-translated>

⁸⁶ ACTCOSS, *Submission 42*, p. 12.

Territory and its surrounding area,⁸⁸ which highlighted the need for culturally appropriate reproductive counselling and targeted information for CALD communities.⁸⁹

- 3.63. A further challenge faced by CALD communities when accessing abortion services is the fact that:

CALD communities can be small, with many community members attending the same GP or other support services, which can make it difficult to raise issues which are potentially stigmatising. This can make it difficult to raise issues that are potentially stigmatising.⁹⁰

Aboriginal and/or Torres Strait Islander peoples

- 3.64. The Committee notes that there is a lack of targeted information for Aboriginal and/or Torres Strait Islander people wishing to access abortion services leading to uncertainty as to how to find support and access services.⁹¹

- 3.65. ACTCOSS is not aware of any work undertaken on the cultural implications of abortions for Aboriginal and/or Torres Strait Islander people. Consequently:

[there is] a significant gap in the provisions of holistic care for the community. Care cannot be holistic without awareness of and insight into the cultural implications of abortions, including ties to spirituality and individual care needs following treatment. For example, Aboriginal and/or Torres Strait Islander women seeking reproductive care or abortions may only be comfortable with female practitioners, adding a further barrier to access.⁹²

- 3.66. A number of Aboriginal and/or Torres Strait Islanders travel from rural NSW to the ACT to access abortion services. Investment needs to be made to accommodate this interstate travel by way of ensuring a continuum of care, acknowledgment of the financial burden associated with this travel and the need for emotional and cultural supports.⁹³

- 3.67. The Committee emphasises that community-controlled care is critical and this includes the provision of sexual health services by Aboriginal community-controlled health organisations (ACCHOs) as well as government endowment of incentives for ACCHOs to further develop skills in the delivery of sexual health services.

Victims of domestic, family and sexual violence

- 3.68. Victims of domestic and family violence are particularly vulnerable when accessing abortion services:

⁸⁸ Canberra Multicultural Community Forum, Who are we?, <https://cmcf.org.au/> (Accessed 23 February 2023).

⁸⁹ ACTCOSS, *Submission 42*, p 12.

⁹⁰ ACTCOSS, *Submission 42*, p. 12.

⁹¹ ACTCOSS, *Submission 42*, p. 11.

⁹² ACTCOSS, *Submission 42*, p. 11.

⁹³ ACTCOSS, *Submission 42*, p. 12.

Victim survivors of family violence are also subject to coercive reproductive control, surveillance and monitoring of finance, health and activities. This means that there is an incredibly small window available for accessing care, especially if there is a need to conceal their pregnancy from a perpetrator. Financial abuse also makes spending money on access to abortions, appointments with doctors and any associated costs such as travel or leave from employment very difficult. These specific needs must be met with sensitivity and a trauma informed approach from providers.⁹⁴

LGBTQIA+ people

- 3.69. Members of the LGBTQIA+ community face additional barriers in accessing abortion services due to the 'limiting language which fails to recognise that abortion provision affects more than just women.'⁹⁵ Consequently, members of this community face, according to A Gender Agenda (AGA) and Meridian ACT that members of the LGBTQIA+ face consistent stigma in healthcare settings.⁹⁶

Young people

- 3.70. Young people may experience additional challenges in accessing abortion services due to a lack confidence:

Young people in the ACT do not feel well informed as to who they should talk to about having an abortion, where one can be performed, whether you need parental consent, how young you can be to access an abortion and the time, requirements and costs of the procedure.⁹⁷

- 3.71. ACTCOSS heard from Australian National University Students Association that:

cost and a lack of familiarity with the healthcare landscape in Canberra can be significant barriers to accessing quality and inclusive services. Many students do not have a regular GP and are more likely to access on-campus medical clinics or walk-in centres. Walk-in centres are staffed by Nurse Practitioners who do not prescribe medical abortions in the ACT.⁹⁸

- 3.72. The Youth Advisory Council identified the following additional barriers to abortion services faced by young people which include:

- inadequate transport services. These are particularly pertinent if young people do not drive
- heightened stigma and shame
- lack of culturally safe care

⁹⁴ ACTCOSS, *Submission 42*, p. 13.

⁹⁵ ACTCOSS, *Submission 42*, p. 14.

⁹⁶ ACTCOSS, *Submission 42*, p 14.

⁹⁷ Youth Advisory Council, *Submission 40*, p.3

⁹⁸ ACTCOSS, *Submission 42*, p 15.

- cost, given that the majority of young people are employed in casual positions without access to sick or personal leave
- missing school, university
- lack of independence, lack of income, not being able to meet the requirement to have a support person present.⁹⁹

3.73. It is important for abortion services and information to be accessible to all persons and to be receptive among other things, of cultural and linguistic backgrounds. To facilitate this process, the Committee is of the view that it is necessary to investigate current material available on abortion services with a view to establish whether it is tailored to all persons who need to access the service, for example those who have experienced trauma or who have come from culturally and linguistically diverse backgrounds.

Recommendation 8

That the communications package committed to in the 2022-2023 Budget:

- include an audit of current Government-provided information to measure whether it is appropriately trauma-led and meets the needs of people of culturally and linguistically diverse backgrounds
- works with the primary health care network to ensure that HealthPathways reflects all abortion providers in the ACT and communicates a clear model of care to GPs
- builds capacity of all health practitioners and workers to provide non-stigmatising, trauma-informed, culturally safe and inclusive care
- raises awareness about medical and surgical abortion options and referral pathways among community services and organisations
- promotes awareness of the different types of abortion care amongst the general public, including in regard to the importance of early identification and presentation.

Policy makers

3.74. There is no requirement in the ACT to collect data on abortion services at any gestation and there is a paucity of data nationwide.’ South Australia, Western Australia and the Northern Territory are the only jurisdictions that collect data concerning abortion provision.¹⁰⁰ The Committee notes with appreciation the observation by the ACT Government:

⁹⁹ Youth Advisory Council, *Submission 40*, p 4.

¹⁰⁰ Women’s Health Matters, *Submission 46*, p. 24.

Improved availability of data could better inform policy, planning and decision making around service provision. This would enable abortion care to be better included in standard health service planning.¹⁰¹

- 3.75. The Committee also notes the scarcity of data on reproductive coercion in Australia, which, if available, would assist the development of practice guidelines for health practitioners to respond effectively.

Recommendation 9

The Committee recommends that the ACT collect and publish anonymised data on medical and surgical abortions and on reproductive coercion in the ACT and invest in local partnerships (including with service providers and community organisations) to further develop a quantitative and qualitative evidence base on these topics.

Reproductive coercion

- 3.76. MSI defines Reproductive coercion as “behaviour that interferes with the autonomy of a person to make decisions about their reproductive health and is a form of violence”¹⁰². It 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 sterilisation
 - any other behaviour that interferes with the autonomy of a person to make decisions about their sexual and reproductive health.¹⁰³
- 3.77. In terms of barriers to access for abortion services reproductive coercion is relevant in cases where a woman is forced to continue with an unwanted pregnancy.
- 3.78. The Committee notes and appreciates the extensive work undertaken to formulate the ACT’s Women’s Plan 2016-2026 and commends the ACT Minister for Women for this important work. The Committee also commends the attention given to addressing domestic violence in the Plan and recommends that reproductive coercion be acknowledged as a distinctive subset of domestic violence, hence requiring a targeted approach.

¹⁰¹ ACT Government, *Submission 47*, p. 18.

¹⁰² MSI Australia, *Submission 46*, p. 10, citing their own report *Hidden Forces: a white paper on reproductive coercion in contexts of family and domestic violence*, <https://www.maristopes.org.au/advocacy-policy/reproductive-coercion/>

¹⁰³ MSI Australia, *Submission 46*, p. 11.

Recommendation 10

The Committee recommends that the ACT Government amend the Third Action plan of the ACT Women's Plan 2016-2026 to include the threats posed to women from reproductive coercion.

Recommendation 11

That the ACT Government provide:

- training for family, domestic, and sexual violence services to respond to reproductive coercion; and
- reproductive coercion into age-appropriate, culturally-safe education programs for the general community.

Stigma and Harassment

- 3.79. Several participants in the inquiry drew attention to the ongoing stigma associated with abortions.¹⁰⁴ For example the ACT Government's submission stated that stigmatisation leads:

... to prejudice and discrimination that undermine equality, equity and dignity in health care access.¹⁰⁵

- 3.80. Stigma may impact the person accessing the services. For example, a survey conducted by Women's Health Matters showed that 25 per cent of responders reported having experienced judgement and stigma from health care providers.¹⁰⁶
- 3.81. Stigma can also affect the GPs and pharmacists providing the service. SHFPACT has sourced anecdotal evidence of GPs being reluctant to publicise the availability of medical abortion due to the risk of 'professional stigma from colleagues, or having their internal practice referrals dominated by colleagues referring for a service they don't want to provide themselves'.¹⁰⁷
- 3.82. In a jurisdiction where abortion is legal it is the view of the Committee that it is important that the stigma associated with having an abortion does not significantly interfere with a person's decision to go through with the procedure. There is a history in

¹⁰⁴ MSI Australia, *Submission 46*, p. 15, Health Care Consumers Association, *Submission 50*, p 11, Sexual Health and Family Planning ACT, *Submission 45*, p. 5.

¹⁰⁵ Sexual Health and Family Planning ACT, *Submission 45*, p. 8.

¹⁰⁶ Women's Health Matters, *Submission 46*, p. 9.

¹⁰⁷ Sexual health and Family Planning ACT, *Submission 45*, p. 12.

Australia and around the world of protests, often violent ones, outside facilities which offer abortion services.¹⁰⁸

- 3.83. In order to ensure that persons feel safe and are not impeded from accessing abortion services, Australian jurisdictions, including the ACT have legislated to ensure persons accessing abortion services at a facility are protected from protest by way of a protected area which prohibits protestors within a prescribed area¹⁰⁹. As the Australian Nursing and Midwifery Federation submission indicates the High Court of Australia has acknowledged the importance of protected areas in ensuring the ‘safety, wellbeing, privacy and dignity of persons accessing premises.’¹¹⁰
- 3.84. However, the ACT is the only jurisdiction that has a 50-metre exclusion zone to prevent harassment and intimidation for people accessing abortion services. All other jurisdictions have an exclusion zone of 150 metres.¹¹¹
- 3.85. Submitters recommended expanding the exclusion zone to 150 meters to be in alignment with other jurisdictions.¹¹²
- 3.86. Pro-life supporters have mobilised outside the MSI clinic in Civic. While this group claims that their vigils were peaceful, the presence of praying protestors caused distress to patients:

Unlike other picketing activity, silent prayer is not aggressive or individually targeted. But it is clear from our research that the presence of individuals engaged in silent prayer outside clinics has the effect of shaming and stigmatising women and undermining their privacy and dignity. The presence of people praying outside clinics has been described by our interviewees as deeply judgmental and distressing for women seeking access to reproductive health care services.¹¹³

- 3.87. The Committee refuses any justification of a reduced 50-metre exclusion zone on the basis that Canberra ‘is small’ or it is inconvenient in the Civic region. Instead, the Committee urges the ACT Government to respect the clear mandate throughout Australian courts that 150 metres, and nothing less, comprises a safe access zone to abortion facilities.

¹⁰⁸ Tammy Mills, The Age, ‘From a Murder to the High Court: How abortion clinic safe access zones came in.’, 4 January 2002, <https://www.theage.com.au/national/victoria/murder-to-the-high-court-how-victoria-s-abortion-clinic-buffer-zones-came-in-20220104-p59low.html> (Accessed 23 February 2023).

¹⁰⁹ *Health Act 1993* (ACT) s 86 Declaration of protected area, s 87 Prohibited behaviour in or in relation to a protected area.

¹¹⁰ Australian Nursing and Midwifery Federation, *Submission 48*, p. 4, see *Clubb v Edwards; Preston v Avery* [2019] HCA 11.

¹¹¹ ACTCOSS, *Submission 42*, p. 17.

¹¹² ACT Human Rights Commission, *Submission 49*, P 9; Women’s Health Matters, *Submission 46*, p 25.

¹¹³ Tania Penovic and Ronli Sifris, ‘Silent prayer should have no place outside abortion clinics’, 26 June 2020, Monash University, Castan Centre for Human Rights Law, <https://www.monash.edu/law/research/centres/castancentre/our-areas-of-work/women/policy/silent-prayer-should-have-no-place-outside-abortion-clinics> (accessed 23 February 2023).

Recommendation 12

That the ACT Legislative Assembly amend the *Health Act 1993* part 86(3)(a) 'not less than 50 m at any point from the protected facility' to 'not less than 150 m at any point from the protected facility'.

Conscientious objection

- 3.88. Paragraph 2.2, part 84A of the Health Act 1993 (ACT) enables an authorised person (a doctor or nurse) the right to refuse to offer their services in the performance or assistance of an abortion on religious or other conscientious grounds. This refusal of abortion services for the purposes of this report is referred to as conscientious objection.
- 3.89. The Committee considers that lack of abortion services combined with a lack of information means that a doctor or nurse exercising their right to conscientious objection has a greater impact on a person's ability to access abortion services than would be the case if these services were more prevalent and information more readily available.
- 3.90. In order to mitigate some of the problems associated with exercising conscientious objection, several submitters¹¹⁴ recommended amending the *Health Act 1993* (ACT) to require an obligation to refer the person to a practitioner or practice which they know will perform the service. Women's Health Matters notes that the absence of a requirement of referral to another practitioner in the ACT is inconsistent with other jurisdictions noting that:

Legislation in States/Territories including Victoria, Queensland and the Northern Territory 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 harmonising the ACT with best practice States/Territories.¹¹⁵

Recommendation 13

The Committee recommends that the ACT Legislative Assembly amend the Health Act 1993 part 84A 'Conscientious objection' to insert a requirement for conscientious objectors to provide a referral to an equivalent service.

¹¹⁴ Women's Health Matters, *Submission 46*, p. 5; ACT Human Rights Commission, *Submission 49*, p. 8; Health Care Consumers Association, *Submission 50*, p. 6.

¹¹⁵ Women's Health Matters, *Submission 46*, p. 24, citing [www.mariestopes.org.au/advocacy-policy/abortion-law-in-australia/#The Australian Capital Territory ACT](http://www.mariestopes.org.au/advocacy-policy/abortion-law-in-australia/#The%20Australian%20Capital%20Territory%20ACT).

Calvary Public Hospital

- 3.91. The Committee learned of a distressing experience of a patient at Calvary Public Hospital in Canberra who was refused critical medical treatment following a miscarriage.¹¹⁶
- 3.92. Calvary Public Hospital is a not-for-profit Catholic health care organisation, run by the Sisters of the Little Company of Mary and is funded by the ACT Government. In 2021–22, the ACT Government provided Calvary and Clare Holland House Hospice with \$261 million in recurrent funding for the base services delivered.¹¹⁷
- 3.93. There is a longstanding practice within Australia of private hospitals providing public health services. However, the Australian Senate Standing Committees on Community Affairs, following its inquiry into public hospital funding conducted in 2000, noted that this mode of provision is increasing resulting in a ‘blurring of the roles of private and public sectors’. Further, the Senate Committee expressed concern at the lack of research and ‘lack of clear benefits for public patients’ in governments’ involvement with private operators.¹¹⁸
- 3.94. The ‘lack of benefits’ has been noted in governments’ limited ability to ensure equity in health care when provided by private operators.¹¹⁹ This concern about equity of access is echoed internationally and throughout Australia and is exemplified within the arena of reproductive justice.
- 3.95. In Ireland, a woman went to a Catholic public hospital when her waters broke at 17 - 18 weeks into her pregnancy. The doctors failed to remove the pregnancy because there was a heartbeat, resulting in the death of the patient.
- 3.96. Closer to home, Catholic Health Australia’s Code of Ethics of state:
- Catholic facilities should not provide, or refer for, abortions, that is, procedures, treatments or medications whose primary purpose or sole immediate effect is to terminate the life of a foetus or of an embryo before or after implantation. Such procedures, treatments and medications are morally wrong because they involve the direct and deliberate killing of an innocent human life in the earliest stages of development.¹²⁰

¹¹⁶ Tamara, *Submission 1*.

¹¹⁷ ACT Health Directorate, Annual Report 2021-2022, p. 416.

¹¹⁸ Australian Senate Standing Committees on Community Affairs, *Healing our Hospitals: a report of public hospital funding*, Commonwealth of Australia: 2000: pp. 114-115.

¹¹⁹ Australian Senate Standing Committees on Community Affairs, *Healing our Hospitals: a report of public hospital funding*, Commonwealth of Australia: 2000: p. 101.

¹²⁰ Catholic Health Australia (2001) , *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, Catholic Health Australia: Canberra.

3.97. The Civil Liberties Council of WA has called on the Western Australian Government to reconsider its tender of St John of God Health Care to provide health services in a major hospital, because of the provider's refusal to provide abortion and vasectomy services.¹²¹

3.98. Similarly, Calvary Public Hospital does not provide abortion care. The medical care limited by Calvary's Catholic ethos has implications for life-saving reproductive care beyond the provision of abortion. As a participant in the inquiry noted:

..It is intensely problematic for the ACT to be reliant on a public hospital that will not provide termination of pregnancy services, and whose management (and no doubt many staff) are opposed to providing it on religious grounds, and where those grounds come with an implicit moral judgement.

In a best case scenario, it creates unnecessary anxiety and fear in women who may require a termination, or who need care for complications arising from a termination. They may question whether they are genuinely receiving the best medical advice for their circumstances, and worry how they may be treated by professionals who they are forced to trust with essential procedures and intimate medical and sexual health information.¹²²

3.99. This section opened with the Committee's observation of a patient's distressing experience at Calvary and is detailed below. This incident parallels, locally, the international concerns at governments' outsourcing public health care to Catholic organisations.

3.100. The Canberra patient suffered an incomplete miscarriage, characterised by tissue remaining in her body. She was advised of:

severe infection and other complications if the tissue wasn't removed. First I tried medication. I had severe cramping, I felt faint and had really intense pain. I ended up in the emergency room, but the tissue still didn't leave my body. As the medication had failed, the next option was a procedure called a dilation and curettage (D&C).¹²³

3.101. D&C is a procedure used to remove tissue from the uterus.¹²⁴ Because it is a procedure used for abortion, Calvary Public Hospital refused to perform the procedure on the patient. As the wait time at Canberra Hospital was several months and doctors advised her that the risk of complications would significantly increase during this time period, the patient had no choice but to have the procedure performed, at considerable expense (in excess of \$1000) at a private hospital.¹²⁵

¹²¹ Aleisha Orr, 'Call to dump anti-abortion health provider', WA Today, 16 April 2012, <https://www.watoday.com.au/national/western-australia/call-to-dump-anti-abortion-health-provider-20120415-1x18f.html> (accessed 21 February, 2023.)

¹²² Greg Tannahill, *Submission 2*, pp. 1-2.

¹²³ Tamara, *Submission 1*, p 1.

¹²⁴ Mayo Clinic, 'Dilation and Curettage (D & C)' <https://www.mayoclinic.org/tests-procedures/dilation-and-curettage/about/pac-20384910> (accessed 23 February 2023).

¹²⁵ Tamara, *Submission 1*, p 1.

- 3.102. It is the Committee's view that it is problematic that one of the ACT's major hospitals is, due to an overriding religious ethos, restricted in the services that can be delivered to the Canberra community. It is also reasonable to assume that a significant number of Canberrans would be unaware of the religious model of care which underpins Calvary Hospital's operation and impacts on their available services.
- 3.103. It is the view of the Committee that the aforementioned patient's experience is unacceptable and that the ACT Government needs to address what the Committee perceives as an ethically fraught dependence on the Sisters of the Little Company of Mary for provision of health services. At a minimum, Calvary Public Hospital needs to abide by Recommendation 1 in this report and refer the patient to another publicly funded facility.

Recommendation 14

That the ACT Government advocate Calvary Hospital to provide full reproductive health services in accordance with human rights.

4. Barriers to pregnancy and contraception support in the ACT

Pregnancy

- 4.1. Pregnancy support is interconnected with abortion support in that adequate pregnancy support may in some cases result in the person deciding to bring their pregnancy to full term rather than accessing abortion services.
- 4.2. Pregnancy care encompasses GP fees, ultrasounds and blood tests, midwife and obstetric fees, public hospital and birth centre fees. In addition, patients may require access to pregnancy counselling services.
- 4.3. The majority of non-permanent residents in Australia are ineligible to receive Medicare¹²⁶, posing potential problems financing pregnancy care.
- 4.4. The Catholic Archdiocese of Canberra and Goulburn state:

It is our view that the ACT Government, health and welfare agencies could be doing more to support people in their reproductive choices through improved access to high quality health care that is bulk-billed; improved social housing options; additional financial support – including for those fleeing domestic violence; improved industrial workplace conditions and childcare options; and, improved awareness of support services to sustain pregnancy and parenthood – particularly in the early stages.¹²⁷

¹²⁶ There is an exception to this is a person is a temporary resident covered by a Ministerial Order [Enrolling in Medicare if you're a temporary resident covered by a Ministerial Order - Medicare - Services Australia](#)

¹²⁷ Catholic Archdiocese of Canberra and Goulburn, *Submission 25*, p.1.

- 4.5. In contrast the ACT's 2022-2023 Budget provides funding for free medical and surgical abortions up to 16 weeks regardless of whether the person is or is not eligible for Medicare.¹²⁸ However, the Committee learned that while this is an admirable move to cover abortion costs regardless of Medicare eligibility. For those patients ineligible for Medicare costs associated with carrying a pregnancy to full term would be fully borne by the patient. The Committee considers it important that a pregnancy is not potentially terminated for financial reasons.¹²⁹
- 4.6. Accordingly, it is the Committee's view that persons without access to Medicare should not have this factor as being a decisive consideration into whether or not they decide to terminate a pregnancy. Accordingly, alternative funds for pregnancy care should be made available so that patients do not decide to have an abortion because of financial pressures.

Recommendation 15

That the ACT government fund services and information for patients who choose to bring their pregnancy to full term and do not have access to Medicare.

Long-Acting Contraception

LARCs

- 4.7. The Committee notes the link between access to contraception and the impact on the number of abortions.¹³⁰ Specifically, evidence shows that LARCs:
- reduce unintended pregnancy and abortion rates, subsequently reducing demand on abortion services.¹³¹
- 4.8. ACTCOSS highlighted the great impact that the high costs of birth control and contraceptives have on younger people which is further exacerbated in cases where the birth control is non-PBS listed:
- The lack of free birth control points to a major equity issue and undue cost to people with capacity for pregnancy. Access to a wide variety of birth control options is also an imperative element of reproductive choice and autonomy.¹³²
- 4.9. The Committee considers it important to investigate impediments to ready and affordable contraception as an important factor in preventing unintended pregnancy.

¹²⁸ ACT Government – Open Government, 'Canberrans to have free access to safe abortion services (joint media release), 4 August 2022 (accessed 23 February 2023) [Canberrans to have free access to safe abortion services - Chief Minister, Treasury and Economic Development Directorate \(act.gov.au\)](https://www.act.gov.au/act/newsroom/2022/08/04/canberrans-to-have-free-access-to-safe-abortion-services).

¹²⁹ Women's Health Matters, *Submission 46*, p. 23.

¹³⁰ ACT Government, *Submission 47*, p. 18.

¹³¹ ACT Government, *Submission 47*, p. 18.

¹³² ACTCOSS, *Submission 42*, p. 16.

Vasectomies

- 4.10. The Committee learned that often men access a vasectomy because they have seen side effects from contraception for their intimate partner and their not wanting any more children, take responsibility and share the burden.¹³³
- 4.11. The Committee considers it compelling that there has been significant uptake of vasectomies in Western Australia following the government's decision to provide full funding for the procedure.¹³⁴ Accordingly the Committee considers it apt to investigate the viability of such a scheme in the ACT.

Recommendation 16

That the ACT Government invest in reducing unintended pregnancy by subsidising access to long-acting reversible contraception, alongside a trial of subsidised vasectomies in collaboration with local health providers.

5. Reproductive health and well-being workplace leave

- 5.1. Reproductive health and wellbeing leave is predicated on an understanding that there are biological functions, events and life stages which should be treated as a separate form of workplace leave separate from the general umbrella of sick leave. Such leave would acknowledge and accommodate experiences associated with reproductive health including menstruation and menopause. Accordingly, as a reproductive matter, access to such leave would also encompass leave for an abortion and post-abortion recovery without having to diminish other modes of work leave.
- 5.2. Such leave would not only have the effect that an abortion procedure would not require disclosure to an employer but also that an employer would not be reducing their sick leave for an event which should not be categorised as being unwell.
- 5.3. The issue of menstrual leave is currently prevalent in public discourse evident in calls for amendments to be made to the *Fair Work Act 2009* entitling a person to one day a month or 12 days a year of paid leave. The introduction of sexual and reproductive leave in the ACT can therefore be considered in alignment with the current, wider receptiveness of this leave type at a national level.¹³⁵

¹³³ Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard*, 28 October 2022, p. 57.

¹³⁴ Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard*, 28 October 2022, p. 55.

¹³⁵ Liona Walker, 'There are calls for menstrual leave to be included in the Fair Work Act, but what is it and how would it work?', 24 November 2022, <https://www.abc.net.au/news/2022-11-24/menstrual-and-menopause-leave-explained/101682538> (accessed 23 February 2023)

- 5.4. It is noted that Spain has recently approved a bill granting paid medical leave to women who suffer from severe period pain.¹³⁶ This action recognises the legitimacy and validity of leave for reproductive health care.

Recommendation 17

The Committee recommends that the ACT Government develop and trial a policy for reproductive health and wellbeing leave in ACT Government workplaces.

6. Sexual and Reproductive Health Strategy

- 6.1. Several submissions called on the ACT Government to develop a sexual and reproductive health strategy.¹³⁷ Whilst sexual and reproductive health is included as part of the *National Women's Health Strategy 2020-30* and the *ACT Women's Plan 2012-2026*,¹³⁸ the Committee is concerned that given the vulnerability of reproductive rights and associated threat to services, a dedicated stand-alone and visible strategy is required. The current weakness in reproductive justice is demonstrated by ACTCOSS' consultation with a range of local organisations¹³⁹ which exposed:

a consistent message that abortion and reproductive choice access in the ACT is fraught with lacking infrastructure, limited-service provision and visibility, anti-choice rhetoric, abortion stigma and unaffordability.¹⁴⁰

- 6.2. The Catholic Archdiocese of Canberra and Goulburn state that it is important to address 'the plight of women in the grip of coercive control and domestic violence'.¹⁴¹
- 6.3. The Committee also notes that advice from participants in the inquiry that state that a sexual and reproductive health strategy should:

accessible, safe, and free abortions. KPIs should be created, which will require data collection, as this is a key way to improve information and demonstrate that access to services leads to a reduced need for abortion.¹⁴²

¹³⁶ France 24 Hours, Spanish Lawmakers advance 'menstrual leave' legislation, a first for a European country, 16 December 2022, <https://www.france24.com/en/europe/20221216-spanish-lawmakers-advance-menstrual-leave-legislation-a-first-for-a-european-country> (accessed 23 February 2023).

¹³⁷ Dr Melanie Dorrington, *Submission 43*; Women's Health Matters, *Submission 46*; Sexual Health and Family Planning ACT, *Submission 45*; MSI Australia, *Submission 41*.

¹³⁸ ACT Government, *Submission 47*, p. 4.

¹³⁹ Women's Health Matters (WHM), ACT Domestic Violence Crisis Service (DVCS), A Gender Agenda (AGA), Canberra Multicultural Community Forum (CMCF), Canberra Rape Crisis Centre (CRCC), Sisters in Spirit Aboriginal Corporation, ACT Disability, Aged Care Advocacy Service (ADACAS), ANU Students' Association (ANUSA) and Health Care Consumers Association (HCCA).

¹⁴⁰ ACTCOSS, *Submission 42*, p. 6.

¹⁴¹ Catholic Archdiocese of Canberra and Goulburn, *Submission 25*, p. 1.

¹⁴² Dr Melanie Dorrington, *Submission 43*, p. 13.

cover the whole gamut, from what we are actually doing in schools, in terms of education in schools, to what we have out there that is language accessible and disability accessible.¹⁴³

- 6.4. The Committee notes that a standalone sexual and reproductive health strategy is important in order to ensure that attention is paid to men's health and role in reproductive justice and that vital data is collected:

A sexual reproductive health strategy is really critical because it is about linking to both the men's health strategy and the women's health strategy nationally. It is about ensuring that it is co-designed with consumers, with the industry, with doctors, to ensure that what you need to deliver from a priorities perspective, as you have said before, is actually delivered and we have a road map, we are measuring it. You cannot deliver if you do not measure something.¹⁴⁴

Recommendation 18

The Committee recommends that the ACT Government develop a sexual and reproductive health strategy that:

- addresses the needs of vulnerable people
- is informed by an intersectional approach (overlaps in the categories of races, class, gender, disability)
- is co-designed with key stakeholders including community organisations, service providers, specialists, women, and people with uteruses
- is linked to appropriate national health strategies, and
- addresses the issue of reproductive coercion.

7. Conclusion

- 7.1. The inquiry received 52 submissions. The majority of submitters did not address the Committee's terms of reference and instead applied the inquiry to a means for anti-abortion protest.
- 7.2. The Committee makes 18 recommendations.
- 7.3. The Committee would like to thank everyone who contributed to this inquiry, including all witnesses who appeared at the hearing, and those who made a written submission, noting, with profound appreciation, those who courageously related their personal medical experiences.

¹⁴³ Dr Melanie Dorrington, General Practitioner, *Committee Hansard*, p. 30.

¹⁴⁴ Mr Jamal Hakim, Managing Director, MSI Australia, *Committee Hansard*, 28 October 2022, p. 55.

Mr Johnathan Davis MLA

Chair, Standing Committee on Health and Community Wellbeing

April 2023

Appendix A: Submissions

No.	Submission by	Received	Published
1	Tamara	27/07/2022	10/08/2022
2	Greg Tannahill	04/08/2022	10/08/2022
3	Rita Joseph	10/08/2022	07/09/2022
4	Ruth Keast	10/08/2022	07/09/2022
5	Tessa Keast	10/08/2022	07/09/2022
6	Kath Woolf	11/08/2022	07/09/2022
7	Australian Christian Lobby	11/08/2022	14/09/2022
8	Terry Dwyer	12/08/2022	08/09/2022
9	Withheld	12/08/2022	08/09/2022
10	Ron Gane	13/08/2022	08/09/2022
11	Moya Homan	13/08/2022	08/09/2022
12	Frances Pearson	13/08/2022	08/09/2022
13	John L Smith	14/08/2022	08/09/2022
14	Dominica Rossi	14/08/2022	08/09/2022
15	Catherine Cunningham	14/08/2022	08/09/2022
16	Lita Stacey	14/08/2022	08/09/2022
17	EMILY's List Australia	14/08/2022	08/09/2022
18	Bernadette Ellis Raya	14/08/2022	08/09/2022
19	Naji Raya	14/08/2022	08/09/2022
20	Natalia Alvarez	14/08/2022	08/09/2022
21	Name Withheld	14/08/2022	08/09/2022
22	Denis Strangman AM	14/08/2022	08/09/2022
23	Daryl Murphy	14/08/2022	08/09/2022
24	Dr Brendan Scott	15/08/2022	08/09/2022
25	Catholic Archdiocese of Canberra & Goulburn	15/08/2022	08/09/2022
26	Name Withheld	15/08/2022	08/09/2022
27	ANU LRSJ Research Hub	15/08/2022	08/09/2022
28	Tobis and Tracey Preston	15/08/2022	08/09/2022
29	Geoff Stannard	15/08/2022	08/09/2022
30	Name Withheld	15/08/2022	08/09/2022
31	Michelle Welch	15/08/2022	09/09/2022

32	Dr Tim Coyle	15/08/2022	09/09/2022
33	Rylee Schuhmacher	15/08/2022	09/09/2022
34	Martin Dunn	15/08/2022	09/09/2022
35	Michael J Carton and Carmel M Carton	11/08/2022	09/09/2022
36	Brian and Heather Robinson	15/08/2022	09/09/2022
37	Name Withheld	15/08/2022	14/09/2022
38	ACT Right to Life Association	15/08/2022	09/09/2022
39	Beverly Cains	19/08/2022	09/09/2022
40	Youth Advisory Council	14/08/2022	09/09/2022
41	MSI Australia	22/08/2022	09/09/2022
42	ACTCOSS	22/08/2022	09/09/2022
43	Dr Melanie Dorrington	22/08/2022	09/09/2022
44	Withheld	22/08/2022	09/09/2022
45	Sexual Health and Family Planning ACT	22/08/2022	09/09/2022
46	Women's Health Matters	22/08/2022	09/09/2022
47	ACT Government	22/08/2022	09/09/2022
48	Australian Nursing and Midwifery Federation	22/08/2022	09/09/2022
49	ACT Human Rights Association	22/08/2022	09/09/2022
50	Health Care Consumers Association	26/08/2022	09/09/2022
51	Women with Disabilities ACT and Advocacy for Inclusion	29/08/2022	09/09/2022
52	AMA (ACA) Limited	01/11/2022	25/11/2022

Appendix B: Witnesses

Friday, 28 October 2022

Ms Rylee Schuhmacher, University Exchange Student

Mr Greg Tannahill

Dr Melanie Dorrington, General Practitioner and member of Deep End GP's

Dr Tanya Robertson, General Practitioner and member of Deep End GP's

Women's Health Matters

- **Dr Merri Andrew**, Senior Health Promotion Officer, Women's Health Matters
- **Dr Romy Listo**, Senior Health Promotion Officer, Women's Health Matters

Sexual Health and Family Planning ACT

- **Dr Timothy Bavinton**, Executive Director, Sexual Health and Family Planning ACT

ACT Government

- **Ms Maria Travers**, Executive Branch Manager, Partnerships and Programs Division, Act Health Directorate
- **Ms Rachel Stephen-Smith**, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Families and Community Services and Minister for Health

Human Rights Commission

- **Ms Karen Toohey**, Discrimination, Health Services, Disability and Community Services Commissioner, ACT Human Rights Commission

ANU Law Reform and Social Justice Research Hub

- **Ms Jae Briefies**, Student Researcher

ACT Right to Life

- **Ms Beverly Cains, President**, ACT Right to Life Association Inc
- **Mr Christopher Rule**, Councillor, ACT Right to Life Association Inc

ACT Council of Social Services

- **Ms Avan Daruwalla**, Policy Officer, ACT Council of Social Services
- **Dr Gemma Killen**, Acting Chief Executive Officer and Head of Policy, ACT Council of Social Services

MSI Australia

- **Mr Jamal Hakim**, Managing Director, MSI Australia
- **Ms Melissa Ryan**, Nurse Unit Manager, MSI Canberra

ACT Youth Advisory Council

- **Mr Nicholas Villers**, Co-Chair, ACT Youth Advisory Council
- **Ms Lily Harrison**, Co-Chair, ACT Youth Advisory Council

Catholic Archdiocese of Canberra and Goulburn

- **Archbishop Christopher Prowse**, Chancellor, Catholic Archdiocese of Canberra and Goulburn
- **Dr Patrick McArdle**, Chancellor, Catholic Archdiocese of Canberra and Goulburn