

**Submission to the Special Rapporteur on the
right of everyone to the enjoyment of the
highest attainable standard
of
physical and mental health,
Ms Tlaleng Mofokeng**

**The right to sexual and reproductive health –
challenges and opportunities
during COVID – 19**

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Introduction

The Castan Centre for Human Rights Law (Castan Centre) is an academic research centre within the Faculty of Law at Monash University in Melbourne, Australia. We undertake research, policy work, student programs and public engagement on human rights and have sought to inform government policy and legislation to ensure that human rights are respected and protected. This submission is written by the Castan Centre's research group leader in gender and sexuality, Dr Tania Penovic and its Deputy Director, Dr Ronli Sifris.

We are grateful for the opportunity to provide a submission to the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Ms Tlaleng Mofokeng.

The COVID-19 pandemic has amplified pre-existing barriers to sexual and reproductive health services, goods and facilities and shed light on the means by which barriers can be dismantled. Before and during the pandemic, abortion has remained among '[the least accessible or equitable healthcare services](#)' in Australia. Barriers to abortion access have been the subject of nationwide empirical research which we undertook between March 2017 and November 2020. Our submission will draw on this research¹ in addressing the key questions in the questionnaire and focus on opportunities and challenges in advancing abortion access in Australia.

AUSTRALIAN ABORTION LAWS

Abortion in Australia is regulated at the state and territory level, with distinct regimes governing the legality of abortion in each jurisdiction. The federal government provides [some funding](#) for the costs of abortion under its Medicare Benefits Scheme (known as 'Medicare') and the cost of certain pharmaceuticals under its [Pharmaceutical Benefits Scheme](#), including mifepristone and misoprostol which are used for medical abortion.

The British *Offences against the Person Act 1861* provided the template for the criminalisation of abortion in Australia's states and territories and abortion was treated as a matter for the criminal law throughout Australia until a trend towards decriminalisation commenced in 2002; all jurisdictions except Western Australia have now decriminalised abortion. The Australian Capital Territory was Australia's first jurisdiction to decriminalise abortion, followed by Victoria in 2008, Tasmania in 2013, the Northern Territory in 2017, Queensland in 2018, New South Wales in 2019 and South Australia in 2021. Most but not all jurisdictions require medical practitioners with a conscientious objection to providing abortion services to disclose their objection and refer persons seeking abortion to a practitioner who does not have a conscientious objection.

Each state and territory has its own legislative regime and stipulates a gestational period in which abortion is available 'on request'. After the stipulated gestational stage is reached, most jurisdictions require the approval of two doctors. Gestational limits vary significantly between jurisdictions. Abortion can be obtained on request in the state of Victoria for pregnancies of up to 24 weeks and in Tasmania for pregnancies of up to 16 weeks, after

¹ We conducted semi-structured, in-depth interviews into the barriers faced when accessing, or attempting to access, abortion services with 41 professionals engaged in health policy, and staff working in clinics providing abortion services in every state and territory.

which the approval of two doctors is required. A 22 week gestational limit applies in New South Wales, Queensland and South Australia. Abortion after 20 weeks' gestation is unlawful in Western Australia unless extremely strict criteria are met while in the Northern Territory, the approval of one doctor is required for an abortion up to 14 weeks' gestation and the approval of two doctors is required between 14 and 23 weeks, after which abortion is only permitted to save a patient's life. Only the Australian Capital Territory imposes no gestational limits.

Gestational limits have undermined women's reproductive autonomy² by setting cut-off points in the form of gestational age which is at best based on 'professional estimates [which] ... are routinely off by one or two weeks, especially later in pregnancy.'³ While late-gestation abortions make up a small proportion of abortions performed, women requiring abortion at a later stage are often in the most difficult and vulnerable circumstances. Gestational limits have furthermore required women to make rushed decisions, stigmatised abortion by treating it differently to other medical procedures and reduced access to later-gestation abortions.⁴ The approach adopted in the Australian Capital Territory manages abortion in the same way as any other medical procedure, reducing stigma and arbitrary barriers to access.

Safe access zones

The picketing of clinics providing abortions has been a long-standing barrier to healthcare access in Australia. Picketers have assembled outside clinics providing abortion services with posters and sandwich boards bearing confronting images and misleading statements. They have walked alongside, chased, jostled and taken photographs and video recordings of patients and staff approaching clinics and obstructed entry into clinics. Patients have been implored not to murder their babies and handed graphic literature which contains medically inaccurate and misleading information; warning that abortion results in infertility, failed relationships, mental illness and cancer.⁵

Fears about personal safety have been a corollary of anti-abortion picketing in Australia. Clinic staff have told us of pervasive concerns about picketers' unpredictable behaviour and a sense of imminent confrontation and physical threat. We were told about picketers in regional Victoria who would target health professionals by exposing them as 'murderers' in their local community, throw red paint or pigs' blood at their houses and cause fear among health practitioners by threatening to enter clinics masquerading as patients.⁶ Twenty years ago, a

² We use the term 'women' as the preponderance of persons seeking abortions are women while acknowledging that people who do not identify as women may also require abortions.

³ J.N. Erdman, 'Theorising Time in Abortion Law and Human Rights' (2017) 19(1) *Health and Human Rights Journal* 29 at 32.

⁴ Louise Keogh et al., 'Intended and Unintended Consequences of Abortion Law Reform: Perspectives of Abortion Experts in Victoria, Australia' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 18, 21.

⁵ See generally Tania Penovic and Ronli Sifris, 'Expanding the Feminisation Dimension of International Law: targeted anti-abortion protest as violence against women' (2018) *Cambridge International Law Journal*, Vol. 7 No. 2, 241–267; Ronli Sifris, Tania Penovic and Caroline Henckels, '[Advancing Reproductive Rights through Legal Reform: The Example of Abortion Clinic Safe Access Zones](#)' (2020) 43(3) *University of New South Wales Law Journal*, 1078.

⁶ See Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe-Access Zones: An Analysis' (2018) 44 *Monash University Law Review*.

[man who had previously stood with picketers](#) outside a Melbourne clinic entered the clinic planning a massacre and fatally shot its security guard before being apprehended.

In the past eight years, safe access zones have been established around abortion clinics in all jurisdictions except Western Australia, where a Bill is currently before Parliament. The Australian Capital Territory requires the Health Minister to declare a ‘protected area’ of at least 50 metres around a medical facility in which abortions are provided within which certain behaviour is prohibited. Legislation enacted in Tasmania, Victoria, the Northern Territory, New South Wales, Queensland and South Australia creates safe access zones of 150 metres around clinics at which abortions are provided. While each state and territory has its own legislative regime, safe access zone legislation in each jurisdiction specifies conduct that is prohibited within the radius of the designated zone. This conduct includes harassment, intimidation or obstruction of a person; visible anti-abortion protesting; footpath interference and recording a person entering premises at which abortions are provided.

Where safe access zones are in place, staff have observed that they are facilitating a safe environment for women to access health services, free of intimidation, harassment or invasions of privacy. They have prevented the targeting of individuals by requiring picketers to maintain a distance, combating the stigmatisation associated with strangers intruding upon and condemning private medical decisions. Safe access zone legislation has provided a catalyst for generalist practices to offer medical abortion services with the reassurance that they will not be targeted and threatened. This reassurance is not yet available to people seeking abortions in Western Australia, where safe access zone legislation awaits further parliamentary debate and COVID-19 has [not deterred](#) picketers from targeting patients and staff outside clinics.

Ongoing legal barriers

While the liberalisation of abortion laws is sometimes imagined to have removed barriers to access, some legal barriers to access have persisted. These include a lack of clarity around abortion laws and a lack of uniformity between jurisdictions, contributing to uncertainty and a lack of public awareness. Legal restrictions as to who is permitted to perform abortions have also reduced abortion access. Evidence shows that [nurse-led care is a safe](#) means of providing medical abortion and may address some of the barriers to abortion access considered below, including barriers of geography and a lack of service providers. Yet in all jurisdictions except South Australia and the Northern Territory, abortions can only be performed by medical doctors. Furthermore, gestational limits for abortion on request have made doctors the gatekeepers for abortion access after a certain gestational stage, denuding patients of agency and requiring some women to travel interstate to access abortion services, often at great financial cost, and doctors to routinely travel to provide these services.

OTHER BARRIERS TO ABORTION⁷

Beyond persisting barriers under the law, a number of [non-legal barriers have generated a disparity in abortion access](#) across Australia’s six states and two territories. These barriers are

⁷ This part-and subsequent parts- of our submission draw on Ronli Sifris and Tania Penovic, ‘Barriers to abortion faced by Australian women before and during the COVID-19 Pandemic’ Vol 86, May-June 2021 *Women’s Studies International Forum*, Article 102470 at <https://doi.org/10.1016/j.wsif.2021.102470>

in part attributable to the legacy of criminalisation and the failure of the healthcare system to adapt to legislative reform.

Disparities in abortion access reveal the gendered dimension of healthcare inequality in Australia. States are responsible for the provision of abortion services in public hospitals while federal funding is available to subsidise the cost of abortions performed in the private sector for those entitled to access Medicare. A lack of public funding for abortion has resulted in a preponderance of abortions being provided in the private health system, where significant cost discrepancies between clinics have rendered abortion services unaffordable for many. For example, medical abortion is available in Australia up to nine weeks' gestation. Although mifepristone and misoprostol are included on the Pharmaceutical Benefits Scheme and the cost of the medications per patient could be limited to approximately \$41, medical abortions in some parts of Australia cost as much as \$770. The cost of surgical abortions in the private health system rises as pregnancy progresses and later abortions may cost thousands of dollars. Due to the high cost of healthcare, sexual and reproductive healthcare provider Marie Stopes Australia has operated a 'Choice Fund' to subsidise healthcare costs for clients experiencing financial hardship. The fund has been depleted during the COVID-19 pandemic with the consequence that some women seeking abortions have been [turned away](#).

Costs barriers are compounded by [geographic barriers](#). Most abortion providers are located in metropolitan areas and women living in rural or remote parts of Australia must often travel long distances to access healthcare. Some must travel interstate due to restrictions on access in their home state. Additional costs, such as transportation and accommodation costs, compound the existing burden of overcoming distance. Further, financial and geographic disadvantage may create delays in accessing time-critical medical care, generating additional costs and potential complications as gestation progresses.

Further barriers emanate from the [beliefs, attitudes and training of medical professionals](#). Doctors with a conscientious objection to abortion continue to delay and obstruct abortion access, even in jurisdictions which have introduced a statutory obligation to refer a patient to a doctor that does not conscientiously object. A study into conscientious objection has estimated some 15% of Australian health professionals to be conscientious objectors and found some doctors in Victoria to be directly contravening the law by not providing referrals or deliberately delaying abortion access.⁸ The problem of conscientious objection is most pronounced in rural and regional areas and appears to be under-policed because women seeking abortions may not be informed about the obligation to refer and, even if they are aware, are unlikely to complain about their experiences in accessing a medical procedure that continues to be stigmatised.

The stigmatisation of abortion has resulted in the ostracization and shaming of abortion providers and deterred medical practitioners from working in the area, as described to us here by a retired medical practitioner:

In every country town it's a major problem because some have one or two doctors who could be deeply religious and won't provide contraception. They definitely won't refer for a termination. So the country situation is very critical...There is a real

⁸ LA Keogh et al., 'Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers', *BMC Medical Ethics* 20, Article number: 11 (2019).

problem in the country with women accessing proper women's health reproductive advice. The doctors put off training in this area because of the personal attacks that happen, the attacks to your family. You're putting yourself out there if you support terminations.⁹

Australia's abortion care workforce has been described as being at [crisis point](#). The stigmatisation of abortion and legacy of criminalisation have compromised medical training and expertise. Abortion is largely absent from medical curricula and training and there is a shortage of health practitioners willing and able to provide the service. The shortage of providers of later-gestation abortions is particularly acute.¹⁰

IMPACT OF COVID-19

The barriers discussed above have had a disproportionate impact on women who experience intersectional forms of disadvantage, including refugee and migrant women, Indigenous women, culturally and linguistically diverse women, women with disability and women who live in rural and remote areas. These barriers have been exacerbated by the COVID-19 pandemic. Restrictions on movement, including isolation measures and financial stress associated with the pandemic have increased women's exposure to [family violence and reproductive coercion](#). Refugees and migrants on temporary visas (including international students) who are ineligible for Medicare support have faced [difficulties](#) in obtaining access to healthcare [information and services](#), including abortion.

For Indigenous women, access to sexual and reproductive health services cannot be considered in isolation from their lived experience of systemic discrimination and mistreatment, forced children removal, involuntary sterilisation,¹¹ eugenically informed birth control,¹² and forced child removal. Noting the history of abuses perpetrated against Indigenous women, Behrendt has observed that 'Aboriginal women were losing their right to be mothers; the right to be a mother was not an issue for white women who at this time were concerned with right to choose whether or not to be a mother at all by agitating for access to safe contraception and securing safe abortions.'¹³ Suspicions held by Indigenous women around measures of reproductive control coalesce powerfully with other barriers to access; requiring an approach to health care which addresses structural and systemic barriers to service access, 'strengthens culture and takes in the whole of life— starting with women, their partners and extended family and communities.'¹⁴

Opportunities

⁹ Interview with PM, Retired Obstetrician and Gynaecologist, (Ronli Sifris/Tania Penovic, 15 October 2018).

¹⁰ Trish Hayes, Chanel Keane and Suzanne Hurley, "Counselling 'late women' - The experience of women seeking abortion in the eighteen to twenty-four-week gestational period: Critical reflections from three abortion counsellors" 78 (2020) *Women's Studies International Forum*.

¹¹ Larissa Behrendt, 'Aboriginal Women and the White Lies of the Feminist Movement: Implications for Aboriginal Women in Rights Discourse' (1993) 1 *Australian Feminist Law Journal* 27, 29-30

¹² Aileen Moreton-Robinson, *Talkin' up to the White Women: Indigenous Women and Feminism* (University of Queensland Press, St Lucia, 2000) 171.

¹³ Behrendt, note 11 above, 30.

¹⁴ Kerry Arabena, 'Addressing structural challenges for the sexual health and well-being of Indigenous women in Australia' *Sexually Transmitted Infections* 2016 Mar; 92(2): 88–89 doi: <https://doi.org/10.1136/sextrans-2015-052412>

Telehealth services have taken on particular importance during the COVID-19 pandemic due to movement restrictions and the dangers of community transmission via face-to-face healthcare. Adjustments to the Medicare Benefits Scheme through the creation of temporary telehealth item numbers have increased access to government funded, time-sensitive services such as medical abortion. Clinical care is provided by nurses and doctors via telephone and medication delivered by courier, and aftercare accessed by telephone. While telehealth item numbers are now permanent, access is restricted to general practitioners who have consulted face-to-face with a patient in the previous twelve months. Given that only 10% of general practitioners in Australia are authorised prescribers of medical abortion, this restriction creates an arbitrary barrier to access which should be removed.

Tele-abortion is not a substitute for surgical abortion services. It is not available beyond nine weeks' gestation and remains unsuitable for some and unavailable to others, particularly in rural and remote parts of Australia. Nevertheless, the COVID-19 pandemic has illuminated the utility of tele-abortion and the ongoing need for adequate funding of telehealth services. Marie Stopes Australia have reported at [69% increase](#) in medical abortion via telehealth between April and September 2020. Telehealth has furthermore increased access to [services](#) such as emergency contraception and post-exposure prophylaxis, long-acting reversible contraceptives and complex contraceptive issues, services related to endometriosis and other causes of heavy menstrual bleeding, fertility and infertility issues, sexual health advice and cervical cancer screening.

Conclusion

While significant barriers to abortion access under state and territory law have been dismantled, abortion remains a stigmatised area of healthcare. Measures are required to recognise abortion services as an integral part of the right to health and facilitate equitable access. Such measures include adequate public funding and provision of abortion services throughout Australia (in both rural and urban areas), appropriate practitioner training (including university curricula and doctor training) and the removal of gestational limit which stigmatise abortion services and undermine reproductive autonomy.